CLINICAL JUDGMENT BIAS IN RESPONSE TO
CLIENT SEXUAL ORIENTATION AND
THERAPIST HETEROSEXUALITY IDENTITY DEVELOPMENT

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ABSTRACT

The current study examined the effect of client sexual orientation and gender role on psychologists’ clinical judgment. A secondary purpose was to examine the extent that psychologist heterosexual identity development status affects the level of heterosexist judgment error displayed when working with lesbian and gay male clients. It was hypothesized that psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when therapist heterosexual identity development status is controlled for, with psychologists providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and therapist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles. It was also hypothesized that psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone.

Eight hundred randomly selected members of the American Psychological Association, were presented with a clinical vignette describing fictions client seeking psychological services. The vignettes were identical except for client sex (female or male), sexual orientation (heterosexual or lesbian/gay), and gender role (feminine or masculine), which were manipulated to produce eight different vignettes. After reviewing the vignette, participants provided their diagnostic impressions of the
client, rated the overall attractiveness of the client, and completed a measure designed to assess their level of heterosexual identity development.

One hundred and thirty-five participants completed the study’s materials and were included in the main analyses. Results of the randomized 2 (Client Sex) x 2 (Client Sexual Orientation) x 2 (Client Gender Role) multivariate analysis of covariance (MANCOVA), controlling for psychologist heterosexual identity development status, found that psychologists significantly differed in their assessment of lesbian and gay male clients and heterosexual female and male clients on a variety of clinical factors. Results of a series of multiple linear regressions found that psychologist heterosexual identity development status and client sexual orientation together were better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone.
CHAPTER I
INTRODUCTION

Mental health therapists are continually required to form impressions about their clients and to develop hypotheses about the nature of their presenting concerns (Morrow & Deidan, 1992). Within the bounds of the scientist-practitioner model (Pepinsky & Pepinsky, 1954) and the local clinical scientist model (Stricker, 2002) clinicians are encouraged to utilize the scientific method of observation, information gathering, and hypothesis formation when working with clients. Stricker (2002), in describing the necessary components of a local clinical scientist’s attitude, noted that personal biases and attitudes may shape local observations made during the course of therapy and influence the individual impressions and hypotheses developed over the course of therapy. Morrow and Deidan (1992) noted that such errors in judgment can lead to improper diagnoses and treatment, which may worsen the client’s presenting problem.

Citing the potential for misdiagnosis, prolonged treatment, and client harm, Garb (1998) noted the importance of researching such clinical judgment bias. Garb contended that such research can help to inform and guide individual therapists and training programs with the ultimate goal of reducing bias and improving the reliability and validity of their clinical judgments. While some areas of potential bias have received much attention, other areas of potential clinical error have received little research attention.
One area of potential bias that has failed to garner much research attention is that of client sexual orientation. The few studies examining the effects of client sexual orientation on clinicians’ judgment are either dated or limited in their generalizability. For example, a large proportion of the studies addressing clinical bias with the lesbian and gay population have also experimentally manipulated the clients’ HIV/AIDS status, which has been shown to overshadow other client variables (Walker & Spengler, 1995). Additionally, no studies have specifically addressed the therapist variables that may predict the level of clinical bias toward lesbian and gay male clients. Nor has any research examined related biases associated with lesbians and gay men that may affect the overall level of clinical judgment error. Specifically, while there are numerous studies (e.g., Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Taylor, 1983; Taywaditep, 2001) that suggest that the general population perceives lesbians and gay men as possessing opposite sexed characteristics, no study has examined the interaction between these two client variables. The purpose of this study is to examine the potential for therapist clinical bias in judgment based upon the interaction of client’s sexual orientation and client gender role. A second purpose of the present study is to examine the client and therapist factors that may mediate this potential bias. Specifically, this study will examine whether therapist sexual identity and client’s gender role influence the level of bias observed.

**Therapist Attitudes Toward Gay and Lesbian Individuals**

Mental health therapists are encapsulated in and influenced by the dominant culture’s values (Fukuyama & Ferguson, 2000; Morrow, 2000; Rudolph, 1988). Since therapists are not, nor can they be, value-free, they may inadvertently project
heterosexist beliefs into the therapeutic process (Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2004; Morrow, 2000). Therapists find themselves in the middle of two competing views regarding lesbian and gay individuals. On one hand, most mental health professional organizations promote a gay-affirmative stance while, on the other hand, the dominant culture continues to hold heterosexist and homonegative attitudes toward lesbian and gay individuals (Morrow, 2000; Rudolph, 1988). Further, therapists’ religious beliefs, gender-role beliefs, personal sexual identity development, and knowledge of lesbian and gay issues, among other factors, can influence therapists’ attitudes regarding lesbian and gay male clients (Beutler et al., 2004; Morrow, 2000).

Two broad heterosexist responses were noted among therapists following the removal of “homosexuality” from the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973 (Dworkin, 2000). One category of therapists continued to view lesbians and gay men as sick and pathological based solely upon the clients’ sexual orientation. Several studies examining clinical judgments made regarding lesbians and gay men have demonstrated that lesbian and gay clients are often judged as being more pathological, disordered, and deviant than similar heterosexual clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Morrow, 2000). The second heterosexist reaction to the removal of “homosexuality” from the DSM was that some therapists stopped diagnosing lesbian and gay male clients all together, even when psychopathology was present (Dworkin, 2000). Gonsiorek (1982) and Smith (1988), for example, separately reported that some therapists, in an attempt to act in a gay-affirmative manner, began to view all of their lesbian and gay male
clients’ presenting problems as solely the byproduct of a heterosexist culture and experienced homonegativity rather than actual psychopathology, even when it was clearly indicated.

The studies examining therapists’ clinical judgment regarding lesbian and gay individuals present a limited glimpse into the potential for bias when working with lesbian and gay male clients. The first empirical study located that examined clinical judgment bias when working with lesbian and gay individuals was that of Garfinkle and Morin (1978); they found that psychologists rated lesbian and gay male clients less favorably overall and as needing to accept a greater responsibility for the presenting problems than heterosexual clients. Since this groundbreaking study, a majority of articles addressing clinicians’ judgment toward this population have focused primarily on gay males and have also examined the effect of client’s HIV/AIDS status on judgment (e.g., Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Fliszar & Clopton, 1995; Hayes & Gelso, 1993). Focusing specifically on gay males and making sexual orientation secondary to HIV/AIDS status limits the generalizability of these findings to HIV/AIDS negative lesbian and gay individuals. Clearly, research focused on the factors affecting the majority of lesbians and gay men (i.e., those who are not HIV positive) is needed.

Therapist Variables in Judgment Error with Lesbian and Gay Individuals

The small body of literature about therapy with lesbians and gay men has only documented the existence of clinical judgment bias toward this population. No studies have gone on to address what therapist variables predict higher levels of clinical bias. Extrapolating research examining the general population’s attitudes toward lesbians
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and gay men to potential therapist attitudes suggests that therapist and client sex may partially determine the amount of heterosexist bias seen in the therapeutic process. For example, in their meta-analyses of studies looking at attitudes toward lesbians and gay men, Kite (1984) and Kite and Whitley (1996) reported that heterosexual males tend to hold more negative attitudes about lesbians and gay men than do heterosexual females. No study, however, has specifically addressed this potential moderating variable.

Worthington, Savoy, Dillon, and Vernaglia (2002) and Mohr (2002), in presenting complimentary heterosexual identity models, further suggested that attitudes toward lesbians and gay men may be closely related to a heterosexual individual’s overall level of heterosexual identity development. Mohr (2002) spoke more directly about therapists working with lesbians and gay men when he proposed that “…biased practice exhibited by heterosexual therapists can be profitably viewed as a manifestation of their efforts to process and respond to sexual orientation issues in ways that foster a positive and coherent [heterosexual] identity” (pg. 533).

Simoni and Walters (2001) similarly hypothesized about a link between heterosexual identity development and heterosexist beliefs. Simoni and Walters theorized that individual heterosexual identity development closely parallels Helms’ (1995) white racial identity development model. After modifying Helms and Carter’s (1990) White Racial Identity Attitude Scale (WRIAS), Simoni and Walters found that levels of heterosexual identity development were negatively correlated with heterosexist attitudes in their sample of 154 heterosexual undergraduate and graduate
students (as level of heterosexual identity development increased heterosexist attitudes decreased).

Simoni and Walters’ (2001) sample utilized a non-random selection of students across undergraduate, Master’s, and doctoral level psychology and women’s and ethnic studies classes, limiting its generalizability to the therapist-client dyad. Limited as it may be, Simoni and Walters’ (2001) results do offer at least a partial empirical basis for Worthington et al.’s (2002) and Mohr’s (2002) assertion that heterosexual identity development influences heterosexist attitudes. While both Worthington et al.’s and Mohr’s models of heterosexual identity development are complimentary to one another, they depart from one another in significant terms, especially in terms of scope (Bieschke, 2002). Mohr’s model attempts to explain the variability in attitudes displayed among therapists toward lesbian and gay male clients, while Worthington et al. offers a comprehensive biopsychosocial model to explain how an individual develops a heterosexual identity. Worthington et al. suggested that, long before heterosexually-oriented individuals begin to understand what it means to be heterosexual, they are raised to understand how their culture defines what it means to be a man or a women. This socialization into the meaning of femininity and masculinity also carries with it a patriarchal system of understanding gender (Gilbert & Rader, 2002). Rich (1980) went so far as to link patriarchy and heterosexism together. Despite this, no study has looked beyond client sexual orientation to examine to what extent gender influences heterosexist bias.
Gender-Role Bias

Similar to that of sexual orientation, therapists are part of a patriarchal culture where masculinity and masculine characteristics are valued and feminine characteristics are devalued (Gilbert & Rader, 2002). As such, therapists who hold patriarchal attitudes may inadvertently project their beliefs into the therapeutic process which may produce errors in judgment, misdiagnosis, and the worsening of client’s presenting issues. Since the early 1970s, a debate has been going on within psychology as to whether mainstream counseling and psychotherapy are used to stress and reinforce traditional gender-roles, thus supporting the status quo of a male dominated culture (Robertson & Fitzgerald, 1990).

Numerous studies (e.g., Baskin, Sommers, Tesslet, & Steadman, 1989; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Lidz, Mulvey, & Gardner, 1993; Robertson & Fitzgerald, 1990) have demonstrated that gender-role incongruity, in and of itself, can bias therapist’s attitudes and create errors in clinical judgment. For instance, Ivey (1995) had therapists view one of two videotapes of actors portraying a family referred for therapy. The videotapes showed a family system that either demonstrated a matriarchal family system or a patriarchal family system. After watching the videotape, the therapists were asked to assess the level of global functioning demonstrated in the family system they observed. Results from these ratings showed a significant difference between the ratings of global functioning for each family. The matriarchal family system was rated as having a lower level of global functioning than the patriarchal family.
Worthington et al. (2002) noted that there is a complex relationship between an individual’s sexual orientation and her or his gender-role. For Worthington et al. an individual’s sense of being heterosexual is, in part, a product of the gender norms and socialization process, whereby individuals are taught what it means to be a woman or a man in the culture in which they are raised. Other researchers have noted the strong link between sexual orientation and gender role, especially in terms of attitudes toward and beliefs about lesbians and gay men.

Therapists and nonprofessionals alike have historically viewed lesbians and gay men as possessing non-congruent gender-roles, that is, possessing qualities and traits of the opposite sex (Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Taylor, 1983; Taywaditep, 2001). Kite and Deaux (1987), for instance, found that when participants were asked to provide characteristics associated with lesbians and gay men, gay men were described as having high-pitched voices, feminine qualities and a feminine walk, wearing jewelry and feminine clothing, and talking with a lisp. Frequently mentioned attributes for lesbians included having a masculine appearance, having short hair, wearing masculine clothes, and being shy, unattractive, and athletic. Despite this strong perceived association between sexual orientation and gender role, no studies were located that have addressed this potential source of double oppression.

**Summary**

Despite the gay affirmative stances presented by each of the major mental health professional organizations following the removal of “homosexuality” from the DSM in 1973, individual therapists remain encapsulated in a dominant culture that
favors White, heterosexual, male, Christian, and Euro-centric values (Fukuyama & Ferguson, 2000; Morrow, 2000). As a result, several studies have reported a tendency for therapists to make heterosexist clinical judgment errors when working with lesbian and gay individuals. Additional clinical judgment errors have been noted in regard to clients who display gender-incongruent traits. Lesbians and gay men, who have historically been viewed as possessing such gender-incongruent traits, therefore may face a type of double oppression when seeking therapeutic services. Unfortunately, the clinical judgment literature regarding lesbian and gay male clients is limited and no study has examined the potential source of clinical bias toward these clients. The literature base is also limited in terms of what therapist variables act to strengthen or lessen the potential for such bias. One potential mediating factor that has been identified is the level of heterosexual identity development of the therapist, though no study to date has examined this relationship.

**Purpose of the Current Study**

The main purpose of the present study is to examine the potential relationship between client sexual orientation and gender-role in regard to therapists’ heterosexist judgment errors. A secondary purpose of the current study is to determine to what extent therapist heterosexual identity development can predict the overall level of heterosexist judgment error displayed.

**Research Questions**

1: What effect does the sexual orientation and gender-role of a client have on psychologists’ judgment related to overall level of psychopathology noted, client desirability, and treatment recommendations?
2: Can psychologist heterosexual identity development status and client sexual orientation together predict the variation observed in psychologist clinical decisions?

**Hypotheses**

H1) Psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when therapist heterosexual identity development status is controlled for, with psychologists providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and therapist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles.

H2) Psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone.

**Definition of Terms**

The following is a list of terms frequently used in this study. The accompanying definitions are utilized to facilitate the reader’s understanding of the terms used.

*Therapist* is used in this study as a generic term for any professional mental health worker (i.e., post-graduate degree, working in the field). This term will be utilized throughout the study except when citing research that specifically labels the participants’ professional qualifications.
Sexual Orientation refers to an individual’s predisposed set of emotional, romantic, sexual, and/or affectual attractions to another person that may range from exclusively opposite- to same-sexed individuals. Sexual orientation is one part of an individual’s overall sexual identity (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 1998; Broido, 2000; Worthington et al., 2002).

Sexual Identity is a multifaceted concept whereby an individual adopts an understanding of him or herself as a sexual being (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 1998; Broido, 2000; Worthington et al., 2002). Sexual identity is comprised of a person’s biological sex, gender-role, sexual orientation, social identity, sexual needs and values, and preferences for activities, partner characteristics, and modes of expression (Shively & DeCecco, 1977; Worthington et al., 2002).

Heterosexual Identity Development refers to the process by which an individual comes to understand him or herself as a heterosexual sexual being. Implicit in this process is the coming to terms with having a place of privilege in society based upon one’s identification with the dominant sexual orientation group (Mohr, 2002; Worthington et al., 2002).

Gender Role refers to the extent to which an individual conforms to the stereotypic traits, behaviors, values, beliefs, and attitudes ascribed to either women and men based on, created by, and maintained by cultural norms of a society (Gilbert & Rader, 2002; Ossana, 2000).
On December 15, 1973 the American Psychiatric Association removed the diagnosis of “homosexuality” from the *Diagnostic and Statistical Manual of Mental Disorders* ([DSM] Adam, 1987). The American Psychological Association (APA) affirmed this decision in 1975 and adopted a policy that stated, in part, that “homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities” (Conger, 1975, p. 633). The APA’s report further urged all mental health professionals to be active and “take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations” (Conger, 1975, p. 633).

Despite the gay affirmative stances presented by each of the major mental health professional organizations following the removal of “homosexuality” from the DSM in 1973, several studies (e.g., Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets, Hancock, Cochran, Goodchilds, & Paplau, 1991; Hartman, 2001; Hayes & Gelso, 1993; Mohr, Israel, & Sedlacek, 2001; Walker & Spengler, 1995) have reported a continued tendency for therapists to make heterosexist clinical judgment errors when working with lesbian and gay male clients. Additional clinical judgment research (e.g., Baskin, Sommers, Tesslet, & Steadman, 1989; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Lidz, Mulvey, & Gardner, 1993; Robertson & Fitzgerald, 1990) has been shown that therapists show bias toward clients who
display gender-incongruent traits. Lesbians and gay men, who have historically been viewed as possessing such gender-incongruent traits, therefore may face a type of double oppression when seeking therapeutic services. Unfortunately, the clinical judgment literature regarding lesbians and gay men is limited and no study has examined the potential source of clinical bias toward these clients. The literature base is also limited in terms of what therapist variables act to strengthen or lessen the potential for such bias. One potential mediating factor that has been identified is the level of heterosexual identity development of the therapist, though no study to date has examined this relationship. The following chapter addresses various issues in the clinical judgment literature regarding lesbian and gay male clients, including: clinical judgment research, bias when working with lesbian and gay male clients, historical attributions of sexual orientation, gender-role incongruity bias, and heterosexual identity development and its potential for moderating heterosexist bias.

**Introduction to Clinical Judgment Research**

In their clinical work, therapists are often required to make sense of the large amounts of sometimes contradictory information about their clients. In an effort to simplify and make sense of this vast amount of information, therapists tend to use judgmental heuristics or cognitive simplification strategies to aid in the processing of clinical information (Spengler & Strohmer, 1994). While these cognitive information reduction strategies have been demonstrated to lead to accurate clinical judgments (e.g., Cline, 1985; Garb, 1984; Kleinmuntz, 1963; Rock, Bransford, Maisto, & Morey, 1987; Spengler, 1991; Spengler et al., 2009), they have also been shown to lead to therapists’ clinical judgment being limited and inaccurate, leading to clinical
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judgment bias (e.g., Barkin, 1991; Baskin et al., 1989; Broverman et al., 1970; Crawford et al., 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets et al., 1991; Hartman, 2001; Hayes & Gelso, 1993; Lidz et al., 1993; Mohr et al., 2001; Robertson & Fitzgerald, 1990; Walker & Spengler, 1995).

Most of the cognitive processes involved in sense-making activities are carried out automatically, outside the control of conscious thought. Therapists’ judgments can be influenced by cultural and other idiosyncratic social knowledge, beliefs, and theories about the world (Kunda, 1999; Nisbett & Ross, 1980). Clinical judgment research examines the judgments and decisions made by clinicians in therapeutic settings (Garb, 1998). Since individual therapists are encapsulated in a dominant culture that favors White, heterosexual, male, Christian, and Euro-centric values (Fukuyama & Ferguson, 2000; Morrow, 2000), these cultural attitudes can adversely affect therapists’ judgments.

In describing macro-trends that can be seen as meaningful distinctions of counseling psychology as a unique specialty, Watkins (1994) noted that counseling psychology maintains a focus of researching the act of psychotherapy. Watkins continued by stating that counseling psychology’s focus on examining the act of psychotherapy has made significant contributions to understanding the counseling process. Despite the importance of and potential insight into the therapeutic process, Garb (1998) noted that interest in this research area is not as great in the mental health professions as it is in other fields such as the medical profession. Further, while research on clinical judgment continues, Garb stated that while some issues have received much attention, other areas have received little. One area of potential bias
that has failed to garner much research attention is that of client sexual orientation and the potential moderating factors that may influence therapists’ practice with lesbian and gay male clients. The remainder of this chapter will present a description of the existing literature regarding clinical judgments with lesbian and gay male clients and two potential moderating factors: client gender-role and therapist heterosexual identity development.

Heterosexist Bias Toward Lesbian and Gay Male Clients

Following the decision by the American Psychiatric Association and the statement from the APA urging therapists to take the lead in eliminating the stigma of mental illness that had been associated with lesbians and gay males, Garfinkle and Morin (1978) conducted the first empirical study examining the effect that client sexual orientation has on clinical practice. Garfinkle and Morin presented 40 male and 40 female psychotherapists with one of four case histories of a fictitious client. Each case history was identical except that the client’s sex and sexual orientation were manipulated to form four experimental conditions (heterosexual male, gay male, heterosexual female, and lesbian female). Participants were asked to rate the client on a set of adjective pairs (e.g., gentle-rough, quiet-loud, strong need for security-little need for security) and to describe the major problems that should be addressed in therapy by providing a treatment plan and therapeutic strategies for working with the client. Overall, the lesbian and gay male clients were rated less favorably and as having higher levels of psychopathology than were the heterosexual female and heterosexual male clients. Participants also provided different treatment plans for the lesbian and gay male clients, apparently reflecting the participants’ belief that the
lesbian and gay male clients needed to accept greater responsibility for their presenting problems than did the heterosexual female and male clients.

Subsequent studies have gone on to provide further empirical evidence for the existence of bias in the therapeutic relationships between therapist and their lesbian and gay male clients. Decell (1981), for example, provided participants with one of twelve clinical vignettes describing a client attending therapy. The case descriptions differed in terms of the client’s sex (female or male), sexual orientation (heterosexual or lesbian/gay), and level of pathology (healthy, neurotic, and psychotic), along with a statement describing where most of their social contacts or social activities occurred (gay community center or apartment complex). After reading the vignette participants were asked to make evaluations about the client’s gender traits, diagnosis, prognosis, and treatment plan. While the results for this study were largely insignificant, lesbian clients were generally judged to be more neurotic and as having a worse prognosis than those clients described in the heterosexual female and heterosexual male vignettes.

In a similar study examining the effects of stereotypes on clinical judgment, Casas et al. (1983) found that therapists’ stereotypes of lesbians and gay men affected the way in which they processed information presented about lesbian and gay male clients. Participants in this study were presented with a series of cards that identified hypothetical individuals. These individuals were described as being female or male, lesbian/gay or heterosexual, and as possessing two randomly selected stereotypically feminine or masculine characteristics. After participants were given time to examine the cards they were asked to make judgments about the relationship between sex and
sexual orientation. Participants made fewer errors on items where correct responses were congruent with the prevailing stereotypes than on those items for which the correct response was incongruent. Casas et al. reported that this indicated that participants’ stereotypes affected the way in which they processed the information regarding sexual orientation on the cards.

Noting that changes in practice do not quickly follow APA policy changes, in 1984 an APA taskforce cosponsored by the Committee on Lesbian and Gay Concerns and the Board of Social and Ethical Responsibility in Psychology and the Board of Professional Affairs was formed to investigate the extent to which therapists had adapted their practice to coincide with the APA’s guidelines for working with lesbian and gay male clients. In 1986 this taskforce conducted a major national survey of APA members. Surveys were sent to 4,000 licensed APA members asking for specific incidents of biased, inadequate, or inappropriate clinical practices with lesbian and gay male clients (Garnets, Hancock, Cochran, Goodchilds, & Paplau, 1991).

Content analysis of the over 2,500 responses produced 17 general themes related to biased practice with lesbian and gay male clients across all levels of professional practice; themes included assessment, intervention, gay and lesbian identity issues, gay and lesbian relationship and family issues, and therapist expertise and education in issues related to lesbian and gay male clients. In terms of assessment, biased practice was identified in the continued belief that same-sex sexual orientations represents psychopathology, automatic assumption that client’s presenting problems are a result of sexual orientation without corroborating evidence,
failure to recognize the extent to which internalized homophobia may cause client distress, and assumption that all clients are heterosexual and discounting those individuals who identify as lesbian or gay.

Garnets et al. reported general themes of biased practice related to clinical interventions: the therapist may focus on the client’s sexual orientation during the course of therapy when it is not relevant, discourage clients from identifying as gay or lesbian, making the client's renunciation of her/his sexual orientation a condition of therapy, or working to change the client’s sexual orientation without consent of the client, express beliefs and attitudes that trivialize a client's sexual orientation, and discontinue services or transfer clients after the client self-discloses his or her sexual orientation. It was also reported that therapists generally lacked a basic knowledge and understanding of the nature of lesbian and gay identity development, failed to understand how internalized homophobia can complicate and hinder the process of identifying as gay or lesbian, underestimated the possible negative consequences in disclosing one's sexual orientation to others, failed to recognize the importance of close, intimate relationships, and inappropriately applied heterosexual relationship models to lesbian and gay relationships. In relationship to lesbian and gay families, biased practice was seen in beliefs that lesbian and gay male individuals cannot be good parents to children and underestimates of the effects of societal homophobia on lesbian and gay male parents and their children. Finally, bias was seen in the areas of expertise and education in that therapists relied unduly on the client to inform the therapist regarding lesbian and gay issues, and were taught information about lesbians and gay men that is inaccurate, prejudicial, or discriminatory (Garnets et al., 1991).
For each of the seventeen themes of clinical bias Garnets et al. (1991) provided representative examples chosen to illustrate each theme. Some examples displayed overtly negative attitudes toward lesbian and gay male clients. For example, a lesbian client, after revealing to her therapist that she was “into women,” was told by her male therapist that “I don’t care, I have a client who is ‘into dogs’” (p. 967). Other incidents of heterosexist bias do not represent such overt heterosexist attitudes. For example, one participant described other therapists’ denial of existence of societal homophobia and/or failure to recognize how societal and internalized homophobia may cause depression and low self-esteem in lesbian and gay male clients.

In the early 1990’s more research attention began to be devoted to the lesbian and gay community and on how client HIV/AIDS status impacted clinician’s judgment. In a series of studies (e.g., Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Fliszar & Clopton, 1995; Hayes & Gelso, 1993) researchers manipulated an analogue male client’s HIV status (HIV positive, HIV negative) and sexual orientation (heterosexual or gay). All of these studies found varying levels of heterosexist bias ranging from the gay client being perceived as requiring more sessions and as more likely to cancel a session than the heterosexual client.

Barkin (1991), for example, presented professional psychologists with one of four videotapes showing a section of a therapy session with an analogue male client. All four tapes showed the same actor portraying a client, all tapes were identical expect for the physical health status (HIV positive, terminal cancer, or no diagnosed medical condition) and sexual orientation (heterosexual or gay). After viewing the
videotape participants were asked to complete a 19-item questionnaire designed to assess their clinical judgments of the client. The participants’ ratings showed that, regardless of physical health, the gay male client was perceived as requiring more sessions per week than the heterosexual male client and as more likely to cancel a session than the heterosexual male client.

In two nearly identical studies Crawford et al. (1991) and Fliszar and Clopton (1995) presented participants with one of four clinical vignettes describing an analogue male client who was described as being HIV positive or as having leukemia, and as being heterosexual or gay. While Crawford et al. found that the main effect of sexual orientation in this study was not significant, analysis of the data received by participants who only received the vignettes describing the client as gay showed that participants with higher levels of homophobia were less likely to take the gay male on as a client, were more likely to refer the client to another clinician, and would be uncomfortable working with the client. Similarly, Fliszar and Clopton (1995) found that the main effect of sexual orientation in this study was not significant but did find that participants were less willing to attend a party where the gay HIV positive client was preparing food than they were with either the gay leukemia and heterosexual leukemia client.

Hayes and Gelso (1993) similarly had participants watch one of four videotapes showing a section of a therapy session with an analogue male client. All four tapes showed the same actor portraying client and were identical expect for the HIV status (HIV positive, HIV negative) and sexual orientation (heterosexual, gay). After viewing the videotape participants were asked to assess the verbal responses of
the client, their self-reported level of anxiety, and to recall certain words used during
the session. Results showed that counselors’ level of homophobia predicted their level
of anxiety with the gay client. The results also indicated, however, that client sexual
orientation did not affect participants’ overall anxiety with lesbian and gay male
clients.

Relatively few studies have been published since 2000 that have examined the
effects of client’s sexual orientation on the therapeutic process. Hartman (2001) found
that therapists viewed lesbian and gay male clients as having lower levels of global
functioning, as measured on the Global Assessment of Functioning scale, than
identical heterosexual female and male clients. Participants in this study were
provided with case vignettes describing a fictitious client with depressive symptoms.
The clinical vignettes were identical in their presentation except for the client’s sex
and sexual orientation. Participants were asked to provide information regarding the
clinical impressions of the client including Axis I and II diagnoses, global assessment
of functioning (GAF) scores, prognosis, and treatment recommendations. Significant
results were found when the GAF scores were examined. The participants rated the
lesbian and gay male clients as having lower levels of global functioning than they
did the heterosexual clients.

Reflecting a relative lack of literature regarding bisexual individuals in
general, only one study was found that examined clinical judgment biases based upon
a client’s bisexuality. Mohr, Israel, and Sedlacek (2001) presented participants with
an intake report for a fictitious bisexual woman seeking counseling services. The
clinicians were asked to rate the woman’s level of psychological functioning and their
own reactions to having the woman as their client. The authors reported that participants with the most negative attitudes regarding bisexuality rated the client as having lower levels of psychological functioning, anticipated responding to the client in a biased manner, and believed that the client’s problems were related to her bisexuality at higher rates than those clinicians who had less negative attitudes regarding bisexuality.

**Summary and Limitations**

Since the removal of the diagnosis of “homosexuality” from the DSM in 1973 numerous studies have demonstrated that therapists display a tendency to make heterosexist clinical judgment errors when working with lesbian and gay male clients. These studies are either dated or limited in their generalizability however. Since Garfinkle and Morin’s (1978) original study examining clinicians’ potential heterosexist bias a majority of articles addressing clinicians’ judgment toward this population have focused primarily on gay men to the exclusion of lesbians and on HIV positive clients, ignoring the majority of lesbian and gay male clients who are HIV negative (e.g., Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Fliszar & Clopton, 1995; Hayes & Gelso, 1993). While these studies show varying levels of bias toward against lesbians and gay men they may be limited in their generalizability. Walker and Spengler (1995) found that HIV status often biases clinicians’ judgment by overshadowing other clinical variables. For example, Walker and Spengler presented participants with one of three clinical vignettes describing a client with depressive symptoms. All three vignettes were identical except for the client’s health status (AIDS, cancer, and no medical problem). Results showed that
participants’ treatment recommendations were significantly different across all conditions, regardless of their attitudes about persons with HIV/AIDS.

Additionally, the publication dates of the studies reviewed span the 23 years between 1978 and 2001. Worthington, Dillon, and Becker-Schutte (2005) argued that studies measuring heterosexual attitudes and clinical bias toward lesbians and gay men accurately reflect the attitudes and beliefs about lesbians and gay men at the time the study was conducted but may not maintain their validity as the larger culture’s views change in regards to sexual minorities. Evidence suggests that dominant cultural views toward lesbian and gay males are shifting toward being more tolerant and accepting over the past decade. For example, national polling data suggests that cultural attitudes regarding same-sex marriage and civil unions (Jones, 2009; Lax & Phillips, 2009; Saad, 2005, 2006, 2007, 2008), perceived morality of same-sex relationships (Lax & Phillips, 2009; Saad, 2005, 2007, 2008, 2009), acceptance of lesbian and gay lifestyles (Saad, 2005, 2006, 2007, 2008), beliefs about the legality of same-sex sexual relations between consenting adults (Jones, 2009; Saad, 2005, 2007, 2008), perceived biological causes of same-sex sexual attractions (Saad, 2007), equal rights to job opportunities (Saad, 2006, 2007, 2008), and acceptability of lesbians and gay men serving openly in the Armed Services (Kiefer, 2004; Morales, 2009, 2010) have become more accepting over the last decade. This larger cultural change in attitudes suggests that a study conducted in 2001 has little validity to the cultural attitudes close to 10 years later.

While limited, the small literature base regarding clinical judgment with lesbian and gay male clients has documented the existence of clinical judgment bias
toward this population. Little research has gone beyond documenting the existence of bias to examine what factors strengthen or lessen the level of bias seen. Other research on attitudes toward lesbians and gay men (e.g., Deaux & Lewis, 1984; Hegarty & Pratto, 2001, 2004; Ellis, 1915; Freud, 1905; Kite & Deaux, 1987; Levitt & Klassen, 1974; Oudshoorn, 1995; Taylor, 1983; Taywaditep, 2001) suggests that client gender-role may partially determine the amount of heterosexist bias seen in the therapeutic process.

**Historical Attributions of Sexual Orientation**

Therapists and nonprofessionals have historically viewed lesbians and gay men as possessing non-congruent gender-roles, that is, possessing qualities and traits of the opposite sex (i.e., Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Taylor, 1983; Taywaditep, 2001); research has demonstrated bias toward individuals displaying non-congruent gender-roles (e.g., Baskin, Sommers, Tesslet, & Steadman, 1989; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Lidz, Mulvey, & Gardner, 1993; Robertson & Fitzgerald, 1990). Oudshoorn (1995) reported that gender and sexuality have been linked together since the closing decades of the nineteenth century. In tracing the biomedical dialogue regarding homosexuality to the beginning of the field’s examinations of the subject, Oudshoorn found that same-sex sexual attractions have been understood as being a result of lesbians and gay men possessing characteristics of members of the opposite sex. Early researchers into the underlying causes of homosexuality focused on examining lesbians and gay men for cross-sexed physical characteristics (e.g., chest shape, musculature, and width of shoulders and hips). When the fields of genetics and endocrinology were developed
researchers began to focus on sex chromosomes and hormones. Specifically, researchers theorized that lesbians and gay men possessed or were exposed to the opposite sex’s hormones at critical points in their development, fundamentally altering the underlying function of the brain (e.g., Baucom, Besch, & Callahan, 1985; Ellis & Ames, 1987; Gorski, 1998; Langevin, 2004; Martin & Nguyen, 2004; Meyer-Bahlburg, 1977; Morris, Jordan, & Breedlove, 2004; Newmark, Rose, Todd, Birk, & Naftolin, 1979).

This association between sexual orientation and gender is found within the psychological literature as well. Inversion theory, based upon the works of Freud (1905) and Ellis (1915), posited that during the course of psychosexual development some women and men come to strongly identify with their opposite-sexed parent and begin to take on their characteristics. Individuals so strongly identify with their opposite-sexed parent that they exhibit characteristics of the opposite sex and become sexually attracted to members of the same-sex (Kite & Deaux, 1987).

Numerous researchers also have demonstrated that this association between sexual orientation and gender is also present in the attitudes and beliefs of nonprofessionals. Levitt and Klassen (1974) for example, in association with the National Institute of Mental Health, conducted two-hour phone interviews with over 3,000 Americans to assess the prevalence and interrelatedness of attitudes and perceptions of lesbians and gay men. A majority of participants reported that they believed lesbians and gay men acted like the opposite sex. Participants further reported that gay men were suited to work in unmasculine careers such as artists,
beauticians, and florists and not masculine careers such as judges, doctors, and ministers.

Taylor (1983) also found that a majority of participants, when given four copies of the Personal Attributes Questionnaire labeled “men,” “women,” “male homosexuals,” and “lesbians,” reported that lesbians and gay men behaved like individuals of the opposite sex. Gay males were further described as having higher needs for others’ approval, and being less likely to seek leadership opportunities, more helpful, and more emotionally expressive than heterosexual men. Conversely, lesbians were described as less likely to need others’ approval, more likely to seek leadership opportunities, generally unhelpful, and less likely to easily express feelings than heterosexual women. Deaux and Lewis (1984) similarly found that participants readily labeled males who demonstrated traditionally feminine traits as being gay and women who demonstrated traditional masculine traits as being lesbians.

Kite and Deaux (1987) asked participants to provide characteristics associated with heterosexual males, heterosexual females, gay males, and lesbians. Results showed that lesbians and gay men were frequently assigned cross-gendered characteristics. Gay men were frequently cited as having high-pitched voices, possessing feminine qualities, having a feminine walk, wearing jewelry, wearing feminine clothing, and talking with a lisp. Lesbians were seen as being more masculine, having short hair, having a masculine appearance, wearing masculine clothes, shy, unattractive, and being more athletic than heterosexual women. Participants in this study were also asked to rate the probability of heterosexual males, heterosexual females, gay males, and lesbians possessing certain attributes
including masculine and feminine traits, behaviors, physical characteristics, and occupations. Attributes associated with gay males were positively correlated with those of heterosexual females and lesbians but not with heterosexual males. Similarly, ratings for lesbians were positively correlated with those of heterosexual males.

In similar studies, Hegarty and Pratto (2001, 2004) found that participants rated heterosexual females as being more typical members of the category “women” than were lesbians and that heterosexual males were more typical of the category “men” than were gay men.

Summary

Historically, sexual orientation and gender-role have been linked in the psychological literature. From the beginnings of the field of psychology (i.e., Ellis, 1915; Freud, 1905), to more recent genetics and endocrinology explanations (e.g., Baucom et al., 1985; Ellis & Ames, 1987; Gorski, 1998; Langevin, 2004; Martin & Nguyen, 2004; Meyer-Bahlburg, 1977; Morris et al., 2004; Newmark et al., 1979) of sexual orientation, lesbians and gay men have been perceived as possessing non-congruent gender-roles. Numerous studies (e.g., Baskin, Sommers, Tesslet, & Steadman, 1989; Bowman, 1982; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Chesler, 1972; Dailey, 1983; Feinblatt & Gold, 1976; Gilbert & Rader, 2002; Ivey, 1995; Lidz, Mulvey, & Gardner, 1993; Miller, 1974; Robertson & Fitzgerald, 1990; Rosenfield, 1982; Thomas & Stewart, 1971) have demonstrated that gender-role incongruity, in and of itself, can bias therapist’s attitudes and create errors in clinical judgment.
**Gender-Role Incongruity Bias**

Gilbert and Rader (2002) noted that therapists belong to a patriarchal culture that tends to value masculinity and masculine characteristics while devaluing feminine characteristics. Therapists who possess unexamined patriarchal beliefs and attitudes may consciously or unconsciously project their beliefs into the therapeutic process producing errors in judgment, misdiagnosis, therapeutic alliance ruptures, and the worsening of client’s presenting issues. In the early 1970s, a debate began within the field of psychology as to whether the mainstream of psychology and psychotherapy stresses and reinforces traditional gender-roles and supports the underlying structure and status quo of a patriarchal, male dominated culture (Robertson & Fitzgerald, 1990). Some in this debate have gone so far as to assert that psychotherapy operates as an agent of social control, rewarding individuals for biological sex/gender-role congruence and pathologizing those who exhibit non-congruent gender-roles (Chesler, 1972). Moreover, this bias is seen in client assessment, treatment recommendation and goal setting, behavioral predictions, in adults and children, and in analogue and field studies.

In the first available study located, Broverman et al. (1970) asked participants (clinically trained psychologists, psychiatrists, and social workers) to describe their concepts of normal adult men, normal adult women, and normal adults. Participants were asked to do so using a list of 122 items that described particular behavioral traits or characteristics. Participants were randomly assigned to one of three conditions and asked to rate which polarity a normal, healthy male, female, or adult (sex unspecified) would exhibit. Results showed the descriptions of normal adults were more similar to
those of normal men than the descriptions of normal women. Stated another way, clinicians held views that reflect a belief that a healthy, mature man does not differ significantly from that of a healthy, mature adult. However, a healthy, mature woman did differ significantly from that of a healthy, mature adult. Further, these results did not differ based on the sex of the participants.

Bias with regard to a client’s incongruent gender-role has been demonstrated in a variety of different clinical contexts such as client assessment, treatment recommendation and goal setting, and behavioral predictions, in adults and children, and in analogue and field studies. Thomas and Stewart (1971) for instance, found that high school guidance counselors, when presented with female and male students’ career goals, rated female students who chose a male-dominated field (engineering) as having inappropriate goals as compared to those choosing a female-dominated field (home economics). Conversely, male students who chose home economics were judged to be more inappropriate than those males choosing engineering.

Gender bias also was evident when clinicians were asked to establish treatment goals for clients. Miller (1974) for example, randomly presented participants with an identical case description of a client described as being passive female or passive male. Participants were asked to provide relevant treatment goals for the female or male client that they were presented. Miller found that participants were more likely to identify reducing the client’s level of passivity as a clinical goal for the male client than the female client.

Feinblatt and Gold (1976) found that clinicians judged children exhibiting inappropriate gender-role behaviors as more severely disturbed than those
demonstrating traditional gender-role behaviors. When the problem behaviors involved passivity, male children were described as being more disturbed than female children. Conversely, when the problem behaviors were labeled as aggressive female children were described as being more disturbed than male children.

Similar to Miller (1974), Bowman (1982) demonstrated how incongruent gender-roles could influence clinical goal setting. Bowman randomly presented participants with an identical case description of a female or male client coming to therapy for depression. The client was described as having difficulty maintaining balance between home and career responsibilities leading to depression. Bowman found that participants viewed achieving a satisfactory balance between home and career responsibilities as a more salient therapy goal for female clients than for male clients.

Gender-role incongruity bias has also been demonstrated in field studies. Rosenfield (1982) examined data collected at a psychiatric ward at a large hospital in New York City. Rosenfield examined the factors influenced whether a patient was admitted to or released from the psychiatric ward based upon the client sex, and diagnosis. Results showed that patient sex alone was not significantly correlated with whether or not they were hospitalized. Significant differences were found, however, when the diagnosis was inconsistent with traditional gender-roles. For example, Rosenfield found that women were more often diagnosed with depression or neurosis than men. Men who were diagnosed with depression or neurosis, however, were hospitalized at disproportionately higher rates than women. Similarly, while men were more often diagnosed with antisocial personality disorder or substance abuse,
women female patients were hospitalized at disproportionately higher rates than males for these diagnoses.

Positively biased gender-role results were also observed by Dailey (1983), who found that clinicians judged clients with androgynous personality traits as better adjusted than clients with either masculine or feminine personality traits, even though all three were described as having the same symptoms. More specifically, clients who were described as having both aggressive and passive personality characteristics were judged to be significantly more mature and intelligent than clients who were described as having only passive personality characteristics or only aggressive personality characteristics.

Gender-role bias has also been found when clinicians are asked to make predictions about the likelihood of violence behavior in clients. Baskin et al. (1989), conducted a field study in prison health facilities and found that, in general, female inmates were more likely than males to be placed in the mental health facility even when actual psychological need was the same. When inmates became violent, however, Baskin et al. found that women were significantly more likely to be placed in the mental health facility than men. Female inmates were also judged to have a higher likelihood of continued violence than were male inmates, even after controlling for the severity of the initial violence.

Robertson and Fitzgerald (1990) asked licensed marriage and family therapists to watch one of two videotapes that purportedly showed segments of therapy sessions taken over the course of six weeks. Both tapes showed the same male actor portraying a client reporting symptoms of depression including poor
appetite, boredom, sleeplessness, and guilt. The tapes differed, however, in the
gender-roles of the identified client. In one tape the male client was portrayed as
being responsible for taking care of the home and children while his wife worked as an
engineer. The second tape portrayed the male client as being employed as an
engineer while his wife was responsible for taking care of the home and children.
Participants were asked to rate the client’s personality traits. Participants described
the nontraditional male client as being more feminine and generally less masculine
(e.g., less independent, assertive, forceful, and ambitious) than the traditional male
client. Participants also conceptualized the nontraditional male’s depression as being
a result of marriage and children more frequently than they did for the male who
possessed a traditional gender-role.

Similar to Baskin et al. (1989), Lidz et al. (1993) demonstrated that gender-
role incongruity impacts therapists’ ability to make predictions about the likelihood of
violent behavior in clients. Lidz et al. (1989) followed patients of an emergency
department of a large metropolitan psychiatric hospital for six months following
admission. Clinicians were asked to predict the likelihood that the clients would
become violent during this period. Lidz et al. found that participants predicted that
men were likely than women to become violent over the course of the six-month
observation period. In the sample, however, female patients committed more violent
behaviors than male patients.

Ivey (1995) showed therapists one of two videotapes of actors portraying a
family referred for therapy. The family system depicted in one tape was patriarchal
while the other was matriarchal; otherwise the tapes were identical. After watching
the videotape the therapists were asked to assess the level of global functioning demonstrated in the family system they observed. Results from these ratings showed a significant difference between the ratings of global functioning for each family. The matriarchal family system was rated as having an overall lower level of global functioning than the patriarchal family system.

**Summary**

Therapists are encapsulated in a larger culture that tends to value White, heterosexual, male, Christian, and Euro-centric values (Fukuyama & Ferguson, 2000; Morrow, 2000). The larger dominant culture also tends to strongly value gender-role congruity (Chesler, 1972). Mental health professionals are seen by some (e.g., Chestler, 1972; Herzfeld, 2001) as agents of social control, validating congruent gender-roles and pathologizing incongruity. Since Broverman et al.’s (1970) classic study demonstrating that mental health professionals tend to equate traditional male gender-roles with those that are indicative of a healthy, mature adult, numerous studies have demonstrated that a client’s incongruent gender-role can significantly bias therapists’ clinical judgments. This bias has been demonstrated in therapists’ treatment goals (e.g., Bowman, 1982; Dailey, 1983; Ivey, 1995; Miller, 1974; Robertson & Fitzgerald, 1990), in field studies regarding psychiatric hospitalization admission rates (e.g., Baskin et al., 1989; Rosenfield, 1982) and predictions about the likely of violence in clients (e.g., Baskin et al., 1989; Lidz et al., 1993), and in children (e.g., Feinblatt & Gold, 1976; Thomas & Stewart, 1971).

Numerous researchers (e.g., Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Mohr, 2002; Taylor, 1983; Taywaditep, 2001; Worthington et al., 2002) have
noted a complex relationship between a person’s sex, sexual orientation, and gender-role. Some have gone so far as to suggest that heterosexism would not be possible without the underlying cultural patriarchal values (Gilbert, 2001, 2002; Pleck, 1981; Rich, 1980). Worthington et al. (2002) and Mohr (2002) have proposed complimentary models of heterosexual identity development that attempt to provide a theoretical base for understanding interplay of sex, gender, and sexual orientation and the possible barriers to non-heterosexist professional practice.

**Heterosexual Identity Development and its Effects on Attitudes**

Numerous researchers (e.g., Devine, Evett, & Vasquez-Suson, 1996; Eliason, 1995; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; Mohr, 2002; Simoni & Walters, 2001; Sullivan, 1998; Worthington, Savoy, Dillon, & Vernaglia, 2002) have noted the complex relationship between attitudes and heterosexist behavior. For example, Gelso, Fassinger, Gomez, and Latts (1995) and Hayes and Gelso (1993) found significant levels of heterosexist bias and discomfort among participants when working with lesbian and gay male clients. Both studies, however, found generally low levels of homonegative attitudes among participants. Gelso et al. (1995) found that the participants’ mean score on Daly’s (1990) Attitude Scale—LG, a measure designed to assess an individual’s level of homophobic attitudes, was one and a half standard deviations below Daly’s normative sample. Hayes and Gelso (1993) found that participants’ level of homophobic attitudes were similarly below that of the general population. Devine, Evett, and Vasquez-Suson (1996) found that even therapists who exhibited moderately low levels of negative attitudes toward
lesbians and gay men avoided discussing issues related to sexuality and sexual behavior in session, fearing that they would offend their lesbian and gay male clients.

Recent publications have begun to look for alternative explanations for the heterosexist bias displayed by therapists toward lesbian and gay male clients. Eliason (1995) and Sullivan (1998), for example, suggested that therapists’ individual level heterosexual identity may play a vital role in determining both attitudes toward lesbians and gay men and in clinical bias displayed in therapy.

**Heterosexual Identity Development**

Numerous models of sexual minority identity (e.g., Cass, 1979; Troiden, 1988; McCarn & Fassinger, 1996; Fassinger & Miller, 1996) have been presented in the literature. Until recently, however, no models attempted to describe how heterosexual individuals understand themselves as sexual individuals. Past models of sexual development have focused on “normal” sexual development. These models often made no distinction between heterosexual and non-heterosexual orientations other than noting how non-heterosexual orientations deviate from the norm and what pathological processes may account for this (Worthington, Savoy, Dillon, & Vernaglia, 2002).

Recent models of heterosexual identity offer a theoretical framework through which heterosexual identity development and heterosexist bias in therapy can be better understood. In 2002, *The Counseling Psychologist* dedicated one of its Major Contribution sections to the topic of heterosexual identity. Two models of heterosexual identity were presented. The first, by Worthington et al. (2002), produced a model of heterosexual identity development. The second model (Mohr,
2002) utilized social psychological literature to construct a model that provides a theoretical framework for the conceptualization of heterosexual bias observed in therapists’ work with lesbian, gay, and bisexual clients. While these models differ in their scope and approach, each provides a basis for understanding the interplay of sex, gender, and sexual orientation and the possible barriers to non-heterosexist professional practice.

**Worthington et al., (2002): A Multidimensional Model of Individual and Social Identity.** Worthington et al. theorized a multifaceted heterosexual identity development model. Their model, which utilized a broad literature base (i.e., majority and minority group identity development, heterosexuality, and contextual influences on development, feminist, multicultural, and LGBT literature bases), suggested that heterosexual identity development parallels an individual’s overall individual and social identity development processes. This identity development, Worthington et al. theorized, occurs within the context of six biopsychosocial influences: biology; microsocial context; gender norms and socialization; culture; religious orientation; and systemic homonegativity, sexual prejudice, and privilege.

*Biological processes* influences the overall sexual health, development, desire, behavior, reproduction, and orientation of an individual. While largely unconcerned about the biological underpinnings of sexual orientation, the researchers acknowledged that biology plays a larger role in determining sexual identity beyond the narrow confines of sexual orientation. For example, the authors note how largely biological processes such as the influence of sex hormones and physical maturation influence overall sexual identity development. Unger and Crawford (1992), for
instance, found that boys who matured earlier were better adjusted when compared to their later developing peers. Girls, however, displayed a curvilinear pattern of adjustment where early and late developing girls showed more negative adjustment patterns when compared to their middle developing peers.

The microsocial context in Worthington et al.’s model includes those individuals with whom one has immediate and regular contact such as family, peers, coworkers, and neighbors. These individuals’ views, needs, values, and beliefs influence a child’s overall sexual identity development. For example, a child’s values and beliefs may be influenced by his/her parents’ traditional, gender stereotyped roles; the child may begin to define and adopt sexual and gender identity roles that reflect what she/he sees modeled in her/his family of origin. As the child grows and matures, the parental influence on her/his identity may become secondary to the influences of members of her/his other social reference groups. Worthington et al. suggested that the basis of a person’s gender-role conformity, sexual knowledge base, sexual attitudes, sexual values, and some sexual behaviors can be formed by their unique microsocial contexts.

Worthington et al. note that individuals’ culture begins to instill in them a sense of the culturally acceptable gender norms almost from the moment a newborn is labeled a girl or a boy. Through a process of socialization individuals learn what specific characteristics and roles are attributed to which sex. This gender socialization process also possesses its own cultural language that shapes discourses on gender and helps to foster an internalization of the societal constructions of gender differences. This restricted gender identity development is both subordinate and concomitant to an
individual’s sexual identity development. As such, an individual’s sexual identity is ultimately influenced by their interactions with social and cultural gender norms. According to the authors, how a person ultimately understands her/himself as a sexual being will be influenced by the level in which she/he internalizes these gender-role expectations and norms. Within most cultures gender is dichotomized into two distinct categories (male and female). This dichotomization, Worthington et al. contend, comes with persistent double standards regarding appropriate gender stereotyped sexual behaviors that ultimately shape and confine sexual identity development. The resulting consequences for females and males who do not conform to the gender orthodoxy of the culture may include harsh judgments and potential ridicule.

Culture also directly impacts heterosexual identity development. Worthington et al. asserted that human sexuality is shaped and given meaning by the unique culture contexts that individuals belong to. As such, cultural attitudes toward sexuality may change as the culture changes over time. As cultures evolve and adapt to new cultural influences, such as drug therapies for common sexual dysfunctions (e.g., hormone replacement therapies for dyspareunia and medication for erectile dysfunction), technological advances (e.g., technologies leading to increased availability of sexually explicit materials), and the impact of increased education (e.g., sexually transmitted infections, safer sex practices), culturally-bound attitudes toward sex and sexuality adjust to find ways to adjust and adapt to these influences. The cultural influences of family, community, cultural norms, and oppression can
shape an individual’s preferred mode of sexual expressions, affectional preferences, and sexual behaviors.

For many persons, religious orientation and sexual identity are intertwined. Worthington et al. noted that most religious traditions attempt to prescribe acceptable sexual behavior among its adherents. These moral pronouncements regarding sexual needs, values, practices, and orientations can have a major impact on an individual’s overall sexual identity development. The authors note that persons’ levels of religiosity have been found to impact their acceptance or condemnation of specific sexual practices, differing sexual orientations, and levels of sexual permissiveness, commitment, and exploration.

Finally, Worthington et al. described how systemic homonegativity and sexual prejudice and privilege may have a strong impact on an individual’s sexual identity development. In the United States, heterosexual individuals possess a level of privilege and power due to their majority group status. As such, generally positive heterosexual images, role models, and stereotypes are easily found while the same cannot be said for non-heterosexual references. Such societal mandated heterosexism and homonegative values and mores encourage prejudice, harassment, and violence at all levels of society. The compulsory heterosexuality that is persistent in society can influence an individual’s development in many, sometimes subtle ways. For example, some individuals may feel inhibited from forming close, intimate relationships with same-sex individuals for fear of being labeled as being non-heterosexual. Individuals may also feel pressure to marry or engage in heterosexual sexual activity before they are ready to do so to prove themselves as being “normal.” Such premature sexual
activity may result in increased chances of unplanned pregnancies and spread of sexually transmitted infections. The perceived supremacy of heterosexual orientation may also reduce the accuracy of knowledge and information taught in school-based sex education, limiting the discussion to heterosexual sexual behaviors, issues, and risks.

Worthington et al. theorized that these six biopsychosocial factors (biology; microsocial context; gender norms and socialization; culture; religious orientation; and systemic homonegativity, sexual prejudice, and privilege) interact with the individual to constrain or facilitate their sexual identity development. For these theorists, a person’s sexual identity involves “(a) identification and awareness of one’s sexual needs . . . , (b) adoption of personal sexual values, (c) awareness of preferred sexual activities, (d) awareness of preferred characteristics of sexual partners, (e) awareness of preferred modes of sexual expression, and (f) recognition and identification with sexual orientation (i.e., sexual orientation identity)” (p. 512).

Worthington et al. posited five separate heterosexual identity statuses that heterosexual identified individuals develop. During the unexplored commitment status individuals may identify as heterosexual due to the imposed compulsory heterosexuality that is persistent in the culture. From the unexplored commitment individuals will enter into one of three statuses: active exploration, diffusion, and deepening and commitment.

During the active exploration status a person, either through behavioral or cognitive exploration, purposefully evaluates and experiments with her/his sexual needs, values, orientation, and preferences of sexual expression. Unlike the active
exploration, the diffusion status is often the result of an identity crisis. A person in the diffusion status may seem similar to someone in active exploration but her/his actions will lack the goal-directedness of individuals in the active exploration status. Worthington et al. suggested that it is also possible for heterosexually identified individuals, either through maturation or societal pressure, to bypass the active exploration and diffusion status and experience a deepening and commitment of their heterosexual identity. In the most advanced identity state, Worthington et al.’s synthesis status is characterized by congruence between individual identity, individual sexual identity, group membership identity, and attitudes toward sexual minorities. Once an individual leaves the unexplored commitment status, Worthington et al. theorized that a person may cycle through the remaining status because of internal and external processes.

Worthington et al. theorized that an individual’s heterosexual identity development status would also have a direct impact on her/his attitudes and values relating to non-heterosexual individuals. While utilizing a different model of identity development, Simoni and Walters (2001) similarly hypothesized that individuals displaying higher levels of heterosexual identity development would exhibit lower levels of negative attitudes toward non-heterosexual persons. Noting that no instrument existed that measured an individual’s heterosexual identity, Simoni and Walters utilized a modified version of Helms and Carter’s (1990) White Racial Identity Attitude Scale (WRIAS) to demonstrate the association between identity states and heterosexist attitudes. Theorizing that the process of heterosexual identity development parallels that of white racial identity development (Helms, 1995),
Simoni and Walter developed the Heterosexual Identity Attitude Scale by modifying Helms and Carter’s WRIAS, replacing the terms “whites,” “blacks,” and “race” with “straight people,” “lesbians and gay men,” and “sexual orientation.”

Simoni and Walters’ HIAS, similar to Helms and Carter’s WRIAS, produces five heterosexual identity schemas or strategies that individuals use to interpret and respond to their own and others’ sexual orientation. In the first ego state, labeled Contact, individuals are unaware of sexual orientation issues and approach the world with an aspect of naiveté. Individuals in the second ego-state, disintegration, will be aware of sexual orientation issues, but will also experience a sense of confusion about the effects of being heterosexual and may display ambivalent attitudes toward non-heterosexual individuals and issues. While in the reintegration ego-state, individuals tend to place value on things that represent heterosexual culture, deprecate things associated with non-heterosexual cultures, and actively or passively endorse heterosexist attitudes. Pseudo-independence ego-states bring an intellectual acknowledgement of their own heterosexual identity while only partially recognizing the sociopolitical privilege that this identification brings. In the final autonomy ego-state, individuals have fully developed a positive, integrated heterosexual identity that acknowledges and values their own heterosexual identity while also possessing anti-heterosexist attitudes and values.

The HIAS was given to four groups of participants: 1) an undergraduate psychology subject pool at a large public university; 2) four ethnic and women’s studies undergraduate classes at a public university; 3) a master’s level human sexuality class at a private university, and 4) a doctoral human sexuality class at a
professional school of psychology. The researchers found that after controlling for the effects of sex, age, education, and ethnicity, participants in varying stages of heterosexual identity development displayed significant differences in their heterosexist attitudes as assessed with Herek’s (1988) Attitudes Toward Gays and Lesbians (ATLG) scale. Specifically, the authors found that individuals who were in *disintegration* and *reintegration* states were more likely to hold heterosexist attitudes than were persons in *pseudo-independent* states. Results for contact and autonomy were not examined due to low reliability scores and non-significance, respectively.

While utilizing a different model of identity development, Simoni and Walters’ results seemingly support Worthington et al.’s assertion that attitudes toward non-heterosexual individuals are based, in part, on the level of the heterosexual identity exhibited by the individual. Although the participants in Simoni and Walters’ study may limit its generalizability in understanding how therapists’ overall identity development influences their work with lesbian and gay male clients, it does support the general premise that identity influences attitudes. Mohr (2002) offered a complimentary model to Worthington et al.’s that provides a framework for understanding the potential for therapists’ identity to influence how they perceive and work with their non-heterosexual clients.

**Mohr (2002): Heterosexual Identity and the Heterosexual Therapist.**

Mohr’s model of heterosexual identity development provides a way to understand the heterosexist bias demonstrated across the research literature regarding provision of care with lesbian and gay male clients. For Mohr, this bias can be conceptualized as heterosexual therapists’ efforts to process and respond to potentially identity
challenging materials in a way that leads to a positive and concise personal and sexual identity. Central to Mohr’s model is the belief that the precursors of adult heterosexual identities – personal sexuality (i.e. attractions, fantasies, and sex experiences) and exposure to information about sexual orientation (i.e., media, peers, family, school, and church influence) – form the basis of an individual’s working models of sexual orientation, the first determinant of adult heterosexual identity. According to Mohr’s model, these working models provide a cognitive schema by which individuals understand sexual orientation, their own as well as that of others. Mohr believed that individuals have multiple working models for sexual orientation and that the working model used can vary across situation and time. That said, Mohr stated that each person will favor a particular working model and take it as his or her dominant working model. According to Mohr, when faced with new information regarding sexual orientation, individuals attempt to process the new material using their dominant working model. If the new information is successfully processed, the individual is said to have assimilated the material into his or her dominant working model. If the existing dominant working model cannot assimilate the material, individuals must defer to another working model, ignore the new information, or create a new working model that is capable of handling the new information. While Mohr acknowledged that there are as many working models as there are experiences associated with that sexual orientation, he theorized the existence of four working models that encompass a large portion of this variability: democratic heterosexuality; compulsory heterosexuality; politicized heterosexuality; and integrative heterosexuality.
Individuals who utilize *democratic heterosexuality* as their primary working model tend to view all individuals and sexual orientations as essentially the same with the only variability coming from the object of sexual and affectual attraction and lifestyle differences associated with these differing orientations. Individuals with this dominant working model tend to perceive sexual orientation as just an expression of largely insignificant individual differences. While focusing on commonalities and away from differences may be seen by these individuals as forming the basis of tolerance toward non-heterosexual orientations, this focus diminishes sexual orientation issues such as heterosexual privilege, cultural heterosexism and homonegativity, and culturally mandated compulsory heterosexuality. Individuals utilizing this schema may also assume that acknowledging potential differences is a sign of prejudice, and would be less likely to seek out information about group differences and more likely to accept stereotypes in the absence of accurate and complete information than other working models.

In the second working model, *compulsory heterosexuality*, individuals view heterosexuality as the only acceptable sexual orientation. Persons utilizing this model view sexual orientation mostly as forms of behavior. In other words, whether a person is attracted to someone of the same- or opposite sex is less important than whether she or he “acts” heterosexual. An individual with a compulsory working model would view a heterosexual orientation as “normal.” Under this model, persons holding other orientations would be perceived as a threat to the heterosexual worldview, which may lead individuals to hold homonegative attitudes.
In the *politicized heterosexuality* working model, LGB individuals are viewed solely through the lens of being members of an oppressed group and survivors of a homonegative culture. Individuals who use this model understand their own sexual orientation in terms of the privileges that come from being heterosexual. These individuals may exhibit anger at the larger heterosexist culture and feel a personal sense of guilt related to their role in heterosexist practice. They may be hypervigilant regarding their own and others’ thoughts, attitudes, and behaviors attempting to dissuade any possible prejudice, discrimination, and inequity. When they become aware of prejudicial thoughts they may demonstrate a lack of patience and empathy toward those individuals possessing elements of heterosexism. Persons using this model view issues related to sexual orientation, privilege, and heterosexism and homonegativity in stark black and white terms and utilize rigid cognitive schemas regarding “political correctness.”

The fourth working model, *integrative heterosexuality*, presents a balanced sexual orientation wherein the extremes of the compulsory and politicized are replaced with a view where all orientations are seen as being equally valid and everyone is seen as being a part of an oppressive heterosexist system. The integrative model also allows for within- and between-group differences to be recognized with regard to sexual orientations. Individuals using the integrative model adopt an gay-affirmative stance without subscribing to an inflexible level of political correctness.

Mohr suggested that a person’s working models both affect and are influenced by an individual’s *core motivations*, the second determinant of adult heterosexual identity. The dominant style that a person exhibits in any given time or situation is
motivated by a person’s need for social acceptance or internal consistency. For individuals motivated by *social acceptance*, the social reference group that they are a part of dictates the model utilized; individuals will choose a working model that most conforms to the values of the group and gaining the highest level of acceptance. For example, a therapist may exhibit an integrative model at her/his place of work when surrounded by individuals and organizational structures espousing a strong gay-affirmative stance. When this same therapist takes part in conservative religious activities in her/his personal life, she/he may exhibit a compulsory model that better conforms to the group’s values.

An individual may also be motivated by a need to have *internal consistency* between her/his working model and sense of self as a way to minimize the effects of cognitive dissonance. For example, a therapist who utilizes a dominant democratic model may find it difficult to work with a lesbian client who reports workplace harassment and discrimination due to her sexual orientation. The therapist may have a difficult time assimilating the homonegative actions being reported by the client with his or her dominant model that emphasizes the commonalities between sexual orientations and dismisses the societal privilege that being heterosexual carries. For this therapist, she/he may engage in cognitive reduction strategies to resolve the inconsistency between her/his democratic model that views all individuals and sexual orientations as essentially the same with the only variability coming from the object of sexual and affectual attraction and her/his client’s experiences.

Mohr theorized that each individual model would come with its own cognitive dissonance reduction strategies and potential for biased care with clients. For
example, therapists who use a democratic working model may tend to make the common error of assuming that their clients are heterosexual and fail to understand or even recognize the negative effects of heterosexism and homonegativity on the lives of lesbians and gay men. The may also fail to recognize their own heterosexism and vulnerability to stereotypes. Through their inability to understand potential between-group differences, they may erroneously assume that their own experiences as a heterosexual individual will be the same as their lesbian- and gay-identified clients.

Therapists utilizing a compulsory heterosexuality model would work toward seeing non-heterosexuality eliminated and suppressed, while introducing more traditional heterosexual relationships and gender-roles as the norm. These therapists would likely view nonheterosexual orientations as a disorder and thus encourage their nonheterosexual clients to adopt a traditional heterosexual life-style as a way to address their symptoms of distress, which are seen to be a result of their deviant sexual orientation.

Therapists who operate using a politicized heterosexual identity tend to make clinical judgment errors by over focusing clinical attention and interventions on sexual orientation and identity development issues. This may take the form of encouraging clients to come out to significant figures before they may be ready or without consideration of possible negative consequences, idealizing lesbian and gay male clients and focusing of the “heroic” aspects of their distress, exhibit inappropriate boundaries by inappropriately advocating for the client against perceived injustice, or conceptualizing the source of the client’s distress as being the result of society homonegativity and heterosexism. Tending to not see within-group
differences, these therapists may have difficulty with all-or-nothing thinking regarding sexual orientation. Seeing people as either gay-affirmative or homophobic, therapists with this dominant model may have difficulty accurately assessing their own, their client’s and society’s levels of homonegativity and heterosexism.

Therapists in the final integrative model tend to have a flexible and balanced understanding of their own and their client’s sexual orientation and the appropriate level to which the client’s orientation and identity may be causing their distress. Unlike the previous models, they view sexual orientation one of many important aspects of their client’s lives.

While Worthington et al. (2002) and Mohr’s (2002) models present comprehensive models of overall heterosexual identity development and heterosexual bias observed in therapists’ work with gay, lesbian, and bisexual clients, respectively, their models are theoretical. While these researchers draw upon strong theoretical and empirical research bases they note that continued research is needed to confirm various aspects of their theories. The purpose of the present study is, in part, will examine the extent to which therapist’s levels of heterosexual development influences their clinical judgments.

**Summary and Limitations**

Several researchers (e.g., Eliason, 1995; Mohr, 2002; Simoni & Walters, 2001; Sullivan, 1998; Worthington et al., 2002) have suggested that therapists’ individual levels of heterosexual identity may play a vital role in determining both attitudes toward lesbians and gay men and in clinical bias displayed in therapy. Mohr (2002) and Worthington et al. (2002) presented two models of heterosexual identity.
that describes the process of identity development and provides a framework for the conceptualization of heterosexual bias observed in therapists’ work, respectively.

Worthington et al.’s (2002) model theorized that heterosexual identity development parallels an individual’s overall and social identity development processes. For Worthington et al., an individual’s heterosexual identity development occurs within the context of six interdependent biopsychosocial influences: biological processes; microsocial context; gender norms and socialization; culture; religious orientation, and; systemic homonegativity, sexual prejudice, and privilege. These six biopsychosocial factors interact with the individual to influence a person’s sexual needs, sexual values, preferred sexual activities, preferred characteristics of sexual partners, preferred modes of sexual expression, and identification with sexual orientation. These biopsychosocial factors influence the developmental course of an individual’s identity through five separate heterosexual identity statuses that a person may cycle through: unexplored commitment, active exploration, diffusion, deepening and commitment, and synthesis.

Mohr’s (2002) provides a theoretical model to understand heterosexist bias demonstrated across the research literature regarding the provision of care with lesbian and gay male clients. Mohr viewed the precursors of adult heterosexual identities as being the therapist’s personal sexuality (i.e. attractions, fantasies, and sex experiences) and exposure to information about sexual orientation (i.e., media, peers, family, school, and church influence). These precursors form the basis of an individual’s working models of sexual orientation, which provide cognitive schemas through which therapists understand sexual orientation. Mohr indentified four
working models (democratic heterosexuality; compulsory heterosexuality; politicized heterosexuality, and; integrative heterosexuality) that individuals will utilize when required to process information regarding sexual orientation. Mohr theorized that an individual’s core motivations of social acceptance and/or internal consistency can influence her/his dominant working model.

Worthington et al. (2002) and Mohr’s (2002) heterosexual identity development models are groundbreaking because they are the first to present frameworks for understanding the process of heterosexual identity development. However, their models do have limitations. First, both Worthington et al. and Mohr acknowledge that their models, while grounded in existing literature, have not been empirically validated. Further, no instruments have been developed to specifically assess the constructs and processes described in the two models.

Gilbert and Rader (2002) and Hoffman (2004) also criticized Worthington et al. (2002) and Mohr’s (2002) models for their failure to include gender-role theory as a greater feature of their models. Citing research (e.g., Horney, 1934; Pleck, 1981; Rich, 1980) that demonstrates the interrelatedness of sexuality and gender-role, Gilbert and Rader and Hoffman argued that gender-role serves as a fundamental framework to the process of sexual identity development. As has been mentioned previously, sexual orientation and gender-role have often been linked in the psychological literature. From early researchers in the field (i.e., Ellis, 1915; Freud, 1905), to modern research into the underlying mechanisms of sexuality and sexual orientation (e.g., Baucom et al., 1985; Ellis & Ames, 1987; Gorski, 1998; Langevin, 2004; Martin & Nguyen, 2004; Meyer-Bahlburg, 1977; Morris et al., 2004; Newmark
et al., 1979), gender and sexuality have been often been linked. Gilbert and Rader and Hoffman argued that Worthington et al. and Mohr’s models of heterosexual identity development are limited in that they do not accurately reflect the central role of gender in the process of heterosexuality identity development.

Finally, Bieschke (2002) expressed concern regarding Mohr’s (2002) working models. While Mohr stated that the list of working models presented was not meant to be exhaustive, Bieschke noted that the rationale Mohr offered as to which working models were presented was unclear. While Mohr intended to “highlight types of heterosexual identity that exemplify common distinctions in the ways that individuals understand their own and others’ sexual orientation” (p. 540), the ambiguity in the rationale used to determine the “common distinctions” does not allow for an adequate explanation as to why the presented working models were chosen and others excluded.

**Chapter Summary**

Therapists are required to attend to and make sense of a large amount of information about their clients. As a way to handle this large amount of information, therapists utilize largely unconscious data reduction strategies (Spengler & Strohmer, 1994). Unfortunately, these strategies are susceptible to the effects of the broader cultural milieu that the therapist is a part of (e.g., Barkin, 1991; Baskin et al., 1989; Broverman et al., 1970; Crawford et al., 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets et al., 1991; Hartman, 2001; Hayes & Gelso, 1993; Lidz et al., 1993; Mohr et al., 2001; Robertson & Fitzgerald, 1990; Spengler & Strohmer, 1994; Walker & Spengler, 1995). Since individual therapists are
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encapsulated in a dominant culture that favors White, heterosexual, male, Christian, and Euro-centric values (Fukuyama & Ferguson, 2000; Morrow, 2000), these cultural attitudes can adversely affect therapists’ judgments.

Numerous studies (e.g., Barkin, 1991; Casas et al., 1983; Crawford et al., 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets et al., 1991; Hartman, 2001; Hayes & Gelso, 1993; Mohr et al., 2001) have demonstrated that therapists tend to make heterosexist clinical judgment errors when working with lesbian and gay male clients. These studies are either dated or limited in their generalizability, however. Since Garfinkle and Morin’s study published in 1978, the dominant culture’s attitudes regarding lesbians and gay men have become more accepting and tolerant (e.g., Jones, 2009; Kiefer, 2004; Lax & Phillips, 2009; Morales, 2009, 2010; Saad, 2005, 2006, 2007, 2008, 2009) minimizing the current validity of these studies. The studies demonstrating therapist heterosexist clinical judgment errors are also limited in their generalizability because of studies’ manipulation of HIV status, which has been shown to overshadow other clinical variables (Walker & Spengler, 1995).

Numerous researchers (e.g., Gilbert & Rader, 2002; Hegarty & Pratto, 2001, 2004; Mohr, 2002; Oudshoorn, 1995; Robertson & Fitzgerald, 1990; Simoni & Walters, 2001; Taywaditep, 2001; Worthington et al., 2002) have also theorized the existence of a link between heterosexist judgment errors and client gender-role. Encapsulated in a larger culture that tends to value andro-centric values (Fukuyama & Ferguson, 2000; Morrow, 2000), numerous studies (e.g., Baskin et al., 1989; Bowman, 1982; Broverman et al., 1970; Dailey, 1983; Feinblatt & Gold, 1976; Ivey,
Sexual Orientation, Heterosexuality Identity, and Clinical Judgment Bias

1995; Lidz et al., 1993; Miller, 1974; Robertson & Fitzgerald, 1990; Rosenfield, 1982; Thomas & Stewart, 1971) have shown that a client’s incongruent gender-role can, independent of other clinical variables, significantly bias therapists’ clinical judgments. Historically lesbians and gay men have been perceived by both therapists and non-professionals as possessing incongruent gender-roles (e.g., Baucom et al., 1985; Deaux & Lewis, 1984; Ellis, 1915; Ellis & Ames, 1987; Freud, 1905; Gorski, 1998; Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Langevin, 2004; Levitt & Klassen, 1974; Martin & Nguyen, 2004; Meyer-Bahlburg, 1977; Morris et al., 2004; Newmark et al., 1979; Oudshoorn, 1995; Taylor, 1983; Taywaditep, 2001).

Worthington et al. (2002) and Mohr (2002) both presented models of complimentary heterosexual identity models that suggested that attitudes toward lesbian and gay individuals is tied to may be closely related to a heterosexual individual’s overall level of heterosexual identity development. Within both of these models, the authors acknowledge that a therapist’s sexual identity, which includes sex, gender-role, sexual orientation, social identity, sexual needs and values, and preferences for activities, partner characteristics, and modes of expression (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 1998; Broido, 2000; Shively & DeCecco, 1977; Worthington et al., 2002), has the potential of biasing attitudes toward lesbians and gay men. Simoni and Walters (2001) provided empirical evidence regarding the link between heterosexual identity development and heterosexist beliefs. Simoni and Walter found that levels of heterosexual identity development were negatively correlated with heterosexist attitudes in their sample of
154 heterosexual undergraduate and graduate students (as level of heterosexual identity development increased heterosexist attitudes decreased).

However, to date no studies have explored current clinical judgment bias toward lesbians and gay men. Further, no studies have examined the potential relationship between client sexual orientation and gender-role in regard to therapist’s heterosexist judgment errors. Additionally, no research has examined the extent to which therapist heterosexual identity development impacts the overall level of heterosexist judgment error displayed. Therefore, this study will also explore the potential relationship between client sexual orientation and gender-role in regard to the therapist’s heterosexist judgment errors. A secondary purpose of the current study is to determine to what extent therapist heterosexual identity development can predict the overall level of heterosexist judgment error displayed.

Hypotheses

H1) Psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when psychologist heterosexual identity development status is controlled for, with psychologists providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and therapist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles.
Sexual Orientation, Heterosexuality Identity, and Clinical Judgment Bias

Previous research (e.g., Barkin, 1991; Casas et al., 1983; Crawford et al., 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets et al., 1991; Hartman, 2001; Hayes & Gelso, 1993; Mohr et al., 2001) indicates that therapists tend to make heterosexist clinical judgment errors when working with lesbians and gay men. Numerous researchers have also noted a link between sexual orientation and gender-role both in relationship to attitudes regarding lesbians and gay men (e.g., Barkin, 1991; Baskin et al., 1989; Broverman et al., 1970; Crawford et al., 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets et al., 1991; Hartman, 2001; Hayes & Gelso, 1993; Lidz et al., 1993; Mohr et al., 2001; Robertson & Fitzgerald, 1990; Walker & Spengler, 1995) and in the attribution of stereotypes to lesbians and gay men (e.g., Baskin et al., 1989; Broverman et al., 1970; Hegarty & Pratto, 2001, 2004; Kite & Deaux, 1987; Lidz, Mulvey, & Gardner, 1993; Oudshoorn, 1995; Robertson & Fitzgerald, 1990; Taylor, 1983; Taywaditep, 2001). It has also been shown that therapists have a tendency to exhibit clinical judgment bias when working with individuals who possess incongruent gender-roles. This link between the perceived gender incongruity of lesbians and gay men have led some to believe that heterosexism would not be possible without the underlying cultural patriarchal values and rigid gender-roles of the dominant culture (Gilbert, 2001; Pleck, 1981; Rich, 1980). This suggests that the clinical judgment bias toward lesbian and gay male clients may be partially the result of the underlying patriarchal gender-role of the larger culture. As a result, it is hypothesized that
when presented with a clinical vignette describing a client (female or male) seeking therapy that the participants will make clinical judgments that will be significantly different based upon the client’s sexual orientation (heterosexual or lesbian/gay), and gender-role (traditionally feminine or traditionally masculine).

**H2)** Psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone. Several researchers (e.g., Devine, Evett, & Vasquez-Suson, 1996; Eliason, 1995; Gelso, Fassinger, Gomez, & Latts, 1995; Hayes & Gelso, 1993; Mohr, 2002; Simoni & Walters, 2001; Sullivan, 1998; Worthington, Savoy, Dillon, & Vernaglia, 2002) have noted a complex relationship between attitudes and heterosexist behavior. Specifically, it has been shown that while therapists tend to show significant levels of heterosexist bias when working with lesbian and gay male clients, they also report low levels of homonegative attitudes in general. Various researchers (e.g., Eliason, 1995; Mohr, 2002; Sullivan, 1998; Worthington et al., 2002) have speculated that therapist heterosexual identity development strongly influences attitudes regarding lesbians and gay men and heterosexist clinical judgment bias when working with non-heterosexual identified clients. Simoni and Walters (2001) empirically demonstrated that higher levels of heterosexual identity development leads to lower levels of negative attitudes toward non-heterosexual persons among participants (undergraduate psychology students; ethnic and women’s studies
undergraduate students; master’s level human sexuality students, and; doctoral human sexuality students). Worthington et al.’s (2002) model of heterosexual identity development suggests that a therapist’s heterosexual identity development status has a direct impact on attitudes and values related to non-heterosexual identified individuals. Mohr’s (2002) model of heterosexual identity development strongly asserted that a therapist’s ability to process client information is greatly influenced by the therapist’s heterosexual identity development status and their dominant working model for understanding information related to sexual orientation. As a result, it is hypothesized that heterosexual identity development status and client sexual orientation together will account for a larger share of variation observed in therapist clinical decisions than client sexual orientation alone.
CHAPTER III
METHODOLOGY

Methods

Power Analysis

A power analysis was conducted using Cohen’s (1988, 1992) method for determining sample size based upon alpha level, desired statistical power, and predicted effect size. The alpha level for the current study was set at .05. The desired power for the present study was .80, which Cohen (1988, 1992) suggested is adequate for most behavioral science research. The effect size for this study was estimated at .30, which Cohen (1988, 1992) operationally defined as a medium effect, meaning that the observed effects would be noticeable to the naked eye of a trained observer. Combining these three elements and entering them into Cohen’s (1988) table, it was determined that 40 participants were needed per cell or 340 participants total. A second factor in determining the minimum number of participants required was anticipated return rate of the research material. Assuming a conservative 40% return rate, it was determined that 800 potential participants be contacted and invited to complete the surveys.

Participants

A list of 800 potential participants was solicited from the American Psychological Association’s Center for Workforce Studies. The method of contacting participants is detailed in the Procedures section. Surveys were collected from 146 participants; 11 participants were removed from the sample because they submitted
incomplete surveys. Another eight participants omitted their demographic information but completed the surveys themselves, so their data were included in the main analyses. Thus, the final sample included 135 professional psychologists who were, at the time of this study, members of the American Psychological Association.

**Descriptive Information.** Frequencies were computed on the demographic data for the respondents (see Table 1). Seventy-nine (58.5%) of the participants were female; another 49 (36.3%) identified as male, while seven (5.2%) failed to give information regarding their sex. The average age of all respondents was 60.65 years old, with a range between 35 and 85 years old. The vast majority of the participants were Caucasian (non-Hispanic) (126, 92.3%); in addition, the final pool included one (0.7%) African American/Black (non-Hispanic) participants, and one (0.7%) Hispanic /Latino participant, respectively. Another seven (5.2%) did not provide information regarding their racial/ethnic backgrounds. In regard to sexual orientation, 94 (69.6%) self-identified as exclusively heterosexual, 27 (20.0%) as predominantly heterosexual, 1 (.7%) as exclusively lesbian/gay, and 5 (3.7%) predominantly lesbian/gay. Eight participants (5.9%) did not provide information regarding their sexual identity.

In the present sample 123 (91.1%) reported that the highest degree achieved was a Ph.D., Psy.D., or Ed.D; 3 (2.2%) had achieved a M.S. or M.A. degree; and 9 (7.6.7%) failed to provide information regarding their highest degree achieved. Since a majority of participants in the present study were psychologists, the sample will be referred to as psychologists throughout the study.
The average number of years of counseling experience was 31.51 years with a range of 9 to 60 years. Almost all of the participants reported that they were currently licensed (92.6%) and practicing (91.2%) professionals. Participants reported that 10% of their current clientele, on average, identified as gay or lesbian (with a range of 0 to 60 percent). Participants reported that they had engaged in an average of 18.61 hours of formal coursework and/or training regarding lesbian and gay male issues with a minimum of 0 and a maximum of 500+ hours. Participants additionally had participated in an average of 18 hours of professional consultation regarding gay and lesbian with a minimum of 0 and a maximum of 1000+ hours.

**Creation of Clinical Vignette**

There were three phases in the construction of the clinical vignette used in this study: (1) construction of clinical vignette, (2) validation, and (3) final decision. In the first phase of development, the clinically validated vignette used by Mohr, Israel, and Sedlacek (2001) was slightly modified to meet the needs of the current study. In Mohr et al.’s (2001) scenario the client was described as a 21-year old, bisexual, white individual (sex undefined) seeking services for multiple presenting problems including (1) difficulty in making a career choice (because of issues relating to family of origin, being a first-generation college student, and coming from a working-class background), (2) difficulty coming to terms with the dissolution of a two-year romantic relationship six months prior to seeking services, and (3) relationship difficulties with new romantic partner. Mohr et al.’s clinical vignette also presented a brief psychosocial history and contained information about the history of the client’s presenting problems. The present study used Mohr et al.’s vignette but modified the
Table 1

Demographic Characteristics of Participants (N=135)

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Table 1

Demographic Characteristics of Participants Continued (N=135)

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<td>18</td>
<td>13.2</td>
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</table>
client’s sexual orientation. The client was described as either heterosexual or
lesbian/gay. Information regarding the vignette client’s self-report was also presented.
The client was reported to be experiencing symptoms consistent with the Diagnostic
and Statistical Manual of Mental Disorders’ 4th Edition, Text Revision (DSM-TR;
American Psychiatric Association, 2004) diagnosis of major depressive disorder (e.g.,
depressed mood, feelings of overwhelming sadness, anhedonia, decrease in appetite
and marked weight loss, mild hypersomnia, fatigue, and intense feelings of guilt and
worthlessness).

Eight counseling psychology doctoral students who were unfamiliar with the
nature of the study rated the modified vignette in terms of the overall believability
and provided a diagnosis for the vignette client. Consistent with the procedures used
by Mohr et al. (2001) and Gelso, Fassinger, Gomez, and Latts (1995), ratings were
made on a five-point Likert-type scale ranging from 1 (Not at all believable) to 3
(Moderately believable) to 5 (Extremely believable). If the overall believability rating
was less than 4 the vignette was to be rewritten and reevaluated to ensure clinical
validity. The overall range of scores was between 3 and 5 (M = 4.25; SD = .707. The
majority of the raters indicated that a diagnosis of major depressive disorder was the
most appropriate diagnosis for the vignette, with six of the eight indicating this
disorder; the remaining two selected adjustment disorder with depression. The
vignette was, therefore, retained for the present study. Feedback regarding minor
wording and word choice was taken into consideration, and the vignette was rewritten
accordingly.
Once the basic clinical vignette was selected, the client’s name, the name of and adjectives referring to the client’s dating partners, and the client’s values and interests were manipulated to create eight clinical vignettes. These vignettes portrayed the client as either (1) a heterosexual female with a traditionally female gender-role, (2) a heterosexual female with a traditionally male gender-role, (3) a lesbian female with a traditionally feminine gender-role, (4) a lesbian female with a traditionally masculine gender-role, (5) a heterosexual male with a traditionally feminine gender-role, (6) a heterosexual male with a traditionally male gender-role, (7) a gay male with a traditionally feminine gender-role, or (8) a gay male with a traditionally masculine gender-role (see Appendix A). Research into traditionally masculine and feminine stereotypic gender-roles (i.e., Bem, 1974; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Deaux, 1985; Hegarty & Pratto, 2004) was used to guide the manipulation of gender-role in the clinical vignette construction.

**Instruments**

**Diagnostic Impression Questionnaire.** Consistent with Mohr et al. (2001), to measure the participants’ clinical judgments related to the vignette client participants were presented with a list of 13 clinical issues modified from an intake checklist used by a university counseling center at a mid-sized, mid-western, public university (see Appendix B). Using a 9-point Likert-type scale (1=Low likelihood, 9=High likelihood) participants were asked to use their clinical judgment to estimate the degree to which each diagnostic category reflected the client’s current state. No information was available regarding reliability or validity for the checklist utilized for
the present study. Consistent with Mohr et al.’s (2001) study, in order to reduce the possibility of participant fatigue the original number of diagnostic categories in the counseling centers’ intake checklist was reduced to 13 from the original list of 24. To facilitate this, the same eight counseling psychology doctoral students used to determine the overall believability of the clinical vignette used in the present study were asked to provide feedback regarding which diagnostic categories would be most reflective of the clinical vignette used in the present study. Based upon this feedback, diagnostic categories that had little to no relevance to the clinical vignette (e.g., “Damaging property,” “Medication/drug usage,” etc.) and those which would not apply across all experimental conditions (“GLB issues”) were eliminated from the list.

In addition to the diagnostic category rating scale, participants were asked to estimate the number of sessions they believed that they would need to adequately work with the client to address the clinical issues presented. Additionally, participants were asked to rate the level of personal responsibility that the client held for his or her clinical issues using a 9-point Likert-type scale (1=No Personal Responsibility, 9=Total Personal Responsibility).

**Assessment of Functioning.** The Global Assessment of Functioning scale (GAF) was used to rate the vignette client’s overall level of psychological functioning (see Appendix C). The GAF is part of the multi-axial diagnosis system described in the DSM-IV-TR (American Psychiatric Association, 2004). Ratings on the GAF are made on a continuum from 1 (i.e., lowest level of psychological functioning) to 100 (i.e., highest level of psychological functioning). Rating anchors are provided at 10-
point increments along the length of the scale. The Global Assessment of Relationship Functioning (GARF; APA, 2004) was used by participants to rate the client’s current romantic relationship functioning (see Appendix D). Analogous to the GAF, the GARF is used to rate the overall functioning of the client’s ongoing familial or other significant relationships. Ratings on the GARF are made on a continuum from 1 (i.e., severely dysfunctional functioning) to 100 (i.e., optimal relationship functioning). Anchors are provided at increments of 20 points along the scale.

Numerous studies have demonstrated the reliability of the GAF (e.g., Dworkin, Friedman, & Telschow, 1990; Jones, Thornicroft, Coffey, & Dunn, 1995) and GARF (e.g., Rosen, McCollum, Middleton, Locke, & Bird, 1997; Ross & Doherty, 2001). Hilsenroth, Ackerman, Blagys et al. (2000), for example, reported high interrater reliability among trained clinicians for both the GAF (ICC=.86) and the GARF (ICC=.85). Several studies (e.g., Bodlund et al., 1994; Byrne, Dagadakis, Unutzer, & Ries, 1996; Dausch, Miklowitz, & Richards, 1996; Patterson & Shin-Lee, 1995; Skodol, Link, Shrout, & Horwath, 1988) were used to establish the predictive validity for the GAF. Skodol et al. (1988), for example, reported that GAF scores significantly discriminated between ten diagnostic groups of both psychiatric inpatients and outpatients. Dausch et al. (1996) demonstrated predictive validity for the GARF when it was shown that GARF ratings significantly discriminated between families that expressed differing levels of expressed emotions and emotional involvement.

**Therapist Personal Reaction Questionnaire (TPRQ; Davis, Cook, Jennings, & Heck, 1977).** The TPRQ is a 15-item instrument that measures overall
client attractiveness from the therapist’s perspective (see Appendix E). Items on the TPRQ are answered using a 5-point Likert-type scale (1 = Not characteristic, 5 = Highly characteristic) as to how each statement reflects the therapist’s feelings regarding the client. Scores for the full scale range from 15 to 75, with higher scores indicating greater client attractiveness. The full-scale score was used in the current study; there are no subscales. Internal consistency for the TPRQ was reported by Tryon (1989) as being greater than .80. Tryon (1992) additionally reported internal consistency of .87 for the full scale. Mohr et al. (2001) used a modified version of the TPRQ, altering the wording to reflect the analogue nature of their study. Since the TPRQ is intended to measure the attractiveness of real clients, the wording of items were slightly altered to reflect the analogue nature of the present study. For example, “I disagreed with this client about some basic matters” was modified to “I would disagree with this client about some basic matters.” Mohr et al.’s modified version of the TPRQ produced an internal consistency on .79. Mohr’s modified version of the TPRQ was used for the present study.

**Heterosexual Identity Attitude Scale (HIAS; Simoni & Walters, 2001).**

Simoni and Walters (2001) developed the 50-item HIAS by modifying Helms and Carter’s (1990) White Racial Identity Attitude Scale (WRIAS), replacing the terms “whites,” “blacks,” and “race” with “straight people,” “lesbians and gay men,” and “sexual orientation” (see appendix F). The HIAS measures five heterosexual identity schemas or strategies for interpreting and responding to one’s own sexual orientation: Contact (“I hardly think about what my sexual orientation is.”); Disintegration (“I don’t understand what lesbians and gay men want from straight people.”);
Reintegration (“There is nothing I want to learn from gay men and lesbians.”);
Pseudo-Independence (“In many ways, lesbians/gay men and straight people are
similar, but they are also different in some important ways.”); and Autonomy (“I understand that straight people must end heterosexism in this country because heterosexual people created it.”). Items on the HIAS are scored on a 5-point Likert-type scale (1=Strongly Disagree, 5=Strongly Agree) as to the degree that the participant agrees or disagrees with each item. Scores on each subscale are determined by averaging the raw scores of the 10 items for each attitude scale. Higher scores on the subscales represent attitudes more closely related to that particular schema. Participants’ five subscore scales were used in the present study.

Internal consistency for the HIAS ranged from an alpha of .29 (Stage 1: Contact) to .85 (Stage 2: Disintegration). The small alpha on Stage 1 on the HAIS was also noted in Helms and Carter’s (1990) WRIAS. Helms and Carter suggested that the suppressed alpha coefficient may be a result of the homogeneity of experiences seen in individuals in the beginning stages of racial identity development. Excluding Stage 1 from their main analysis because of the low alpha level, Simoni and Walters found that scores on the HAIS significantly predicted heterosexist attitudes, accounting for 71% of the total variance seen on the Attitudes Toward Lesbians and Gay Men Scale (Herek, 1988).

**Demographic Information.** In the final section of the survey participants were asked about their level of formal training in gay and lesbian issues and demographic variables (see Appendix G). Demographic information gathered from participants included age, sex, ethnicity, sexual orientation, highest degree earned,
and number of years of clinical experience. Information regarding amount of formal training in gay and lesbian issues, as measured by formal coursework and/or training, supervised clinical experience with gay and lesbian clients, and consultation regarding gay and lesbian clients was also assessed.

Procedure

Participants for the current study were selected by the American Psychological Association’s Center for Workforce Studies. Initially, participants were to be drawn from the membership rolls of Division 12 (Society of Clinical Psychology), Division 17 (Society of Counseling Psychology) and Division 29 (Psychotherapy). Through consultation with the Center for Psychology Workforce Analysis and Research, however, it was determined that selecting participants based upon current major field (counseling/clinical), interest area (clinical, counseling, psychotherapy), and primary professional activity (health service provision) would provide a more representative sample of therapists. A representative sample of therapists who have at least a Master’s degree were considered for inclusion in the present study. Since a random sampling procedure was used and a representative sample sought, a priori statements regarding expected relevant demographic information (i.e., years of clinical experience, age, ethnicity, sex, and sexual orientation) could not be made.

The 800 potential participants were mailed a letter of invitation to participate in the present study and were directed to the internet site (www.surveymonkey.com) that was used to host the study and collect the data (see Appendix H). Participants were told that two persons who completed the survey would receive a $50 VISA gift
card. Each participant was assigned a numerical code that was entered prior to taking the survey online to determine who had successfully completed the survey. Of the 800 participants contacted, 11 responded. Three weeks after the initial letter was mailed a follow-up letter was mailed to participants encouraging those who had not participated to do so (see Appendix I). Another 26 potential participants responded to this request. A third letter was mailed two weeks later to those participants who had not completed the survey online encouraging their participation and stressing the importance of the study and their involvement (see Appendix J). In an effort to increase participation a paper copy of the study materials was also sent along with the third letter along with a self-addressed, stamped envelope. An additional 96 participants responded to this third request. Finally, two weeks after the final mailing, emails with hyperlinks to the website hosting the study were sent to the remaining participants encouraging participation (see Appendix K). Another 14 participants responded this final request, for a total of 146 surveys returned.

After accessing the website, participants were shown an introductory letter that described the voluntary nature of the study, their rights as participants, the confidential nature of all materials, compensation, risks and benefits, and primary researcher contact information (see Appendix L). The introductory letter invited participants to take part in the study and stated that those who did not wish to do so were free to disregard the study materials and withdraw from the study at any point without prejudice or penalty from the researcher. In keeping with Mohr et al.’s (2001) study, a mild form of deception was be used to mask the focus of the study, reducing potential social desirability effects. The study was described in the introductory letter
as an examination of the clinic assessment procedures for clinicians working with clients with multiple presenting problems.

Participants who chose to continue were randomly presented with one of the eight clinical vignettes used in the current study (see Appendix M). After reviewing the clinical vignette participants were asked to complete the Diagnostic Impression Questionnaire and to give their impression about the client’s level overall and relationship functioning using the GAF and GARF, respectively, based upon the vignette that they were presented. Participants were then asked to rate the overall attractiveness of the client using the TPRQ. Participants were then presented with the HIAS to determine their overall level of heterosexual identity development. Finally participants were asked to complete the demographic questions.

Participants who received paper copies of the study’s materials were sent an introductory letter, random clinical vignette (as assigned by a true random number generator), Diagnostic Impression Questionnaire, GAF and GARF scales, TPRQ, HIAS, demographic questionnaire, and debriefing letter. After completing the study materials, participants were instructed to mail the materials back to the principal investigator using the supplied self-addressed, stamped envelope.

After completing the study materials, participants were shown a debriefing letter explaining the true nature of the study and given contact information for the lead researcher and his supervisor (see Appendix N). Since a mild form of deception was used in the present study, participants were told in the debriefing letter that they had the option to opt out of the present study. No participants chose to opt out of the present study after completing the study materials.
Throughout the data collection process, several potential participants provided feedback regarding their decision not to participate in the present study. Reasons provided by participants for not participating varied, including not having the approximately 20-30 minutes estimated to complete the materials. One participant asked to be compensated $75 per hour to complete the present study. Others stated that they felt deceived by being asked to complete a questionnaire about their own identity when the introductory letter did not mention this. Two participants questioned whether the current study had Departmental and/or Institutional Review Board approval. Several others critiqued the study materials (one refused to participate until the study was redesigned). Some asked to be taken off the study’s mailing list and inquired about how their names had been selected for inclusion in the current study. Several participants returned blank study materials in the pre-stamped return envelope. One empathized with the frustrations of the dissertation process but refused after having been “burned” too many times by previous research participation requests.

At the completion of data collection, 146 participants had returned the study materials. Of these, only 135 could be included in the present study due to 11 participants returning partially completed study materials. This number was far short of the 340 total needed as determined by the a priori power analysis. A post hoc power analysis was conducted to determine the observed power of the data obtained. The observed power for the MANCOVA main effects (Client Sex X Client Sexual Orientation X Client Gender Role) were robust with power estimates of .874, .969, and .992, respectively. The observed power estimates for the interactions of the
variables varied. The interaction of Client Sex and Client Sexual Orientation was .862. Additional interactions produced power estimates ranging between .525 and .561. Due to the constricted power estimates for many of the interactions, only the interaction of client sex and client sexual orientation will be included in further analyses.

**H1) Psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when psychologist heterosexual identity development status is controlled for, with therapists providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and psychologist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles.**

**H2) Psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone.**

The first hypothesis for this study was tested using a randomized 2 (Client Sex) x 2 (Client Sexual Orientation) x 2 (Client Gender Role) multivariate analysis of covariance (MANCOVA) design, controlling for psychologist heterosexual identity development status and applying the full general linear model to a linear combination of diagnostic and attitude variables. The main effects of Client Sex, Client Sexual Orientation, and Client Gender Role and the interaction of Client Sex and Client
Sexual Orientation were used to test the effect of these variables on psychologists’ judgment (H1).

The second hypothesis was tested by using a series of multiple linear regressions on those variables found to be significantly different as a result of Client Sexual Orientation and psychologist heterosexual identity development status in the MANCOVA conducted to test Hypothesis 1. To determine whether psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions pairs of multiple regression analyses were conducted in which one analysis of the pair included four heterosexual identity development statuses and client sexual orientation as predictors, while the second regression analysis included only client sexual orientation as a predictor.
CHAPTER IV

RESULTS

Initial Analyses

Initial data analyses were conducted to obtain descriptive information about participants. These data were reported in Chapter 3.

Reliability

A reliability analysis was conducted on the Heterosexual Identity Attitude Scale (HIAS; Simoni & Walters, 2001) in response to the previously reported low reliability of several subscales on the HIAS and White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990), on which the HIAS was based. Analysis of the HIAS was conducted using Cronbach’s internal reliability coefficient, which DeVellis (2003) noted is a widely used reliability measure. DeVellis’ (2003) guidelines were used to determine the acceptability of the internal reliability coefficient: below .60 = unacceptable; .60-.65 = undesirable; .65-.70 = minimally acceptable; .70-.80 = respectable; and .80-.90 = very good.

Simoni and Walters (2001) reported the following Cronbach’s alpha coefficients for the individual subscales: Contact = .29; Disintegration = .85; Reintegration = .81; Pseudo-Independence = .72; and Autonomy = .66. For the present study, internal reliability results for the individual subscales were as follows: Contact = .078 (unacceptable); Disintegration = .793 (respectable); Reintegration = .700 (respectable); Pseudo-Independence = .707 (respectable); and Autonomy = .660 (minimally acceptable).
Reliability results were found to be acceptable for the total scale and for four of the five subscales (Disintegration, Reintegration, Pseudo-Independence, Autonomy), but not for the Contact subscale. Both Simoni and Walters (2001) and Helms and Carter (1990) noted depressed alpha coefficients on the initial stage of their respective models. Helms and Carter (1990) suggested that the suppressed alpha coefficient of the Contact subscale may be a result of the homogeneity of experiences of individuals at the beginning stages of identity development. Due to the constricted alpha coefficient of the Contact subscale, this subscale was excluded from analysis.

**Main Analyses**

To address the identified hypotheses of the present study, data were analyzed using a randomized 2 (Client Sex) x 2 (Client Sexual Orientation) X 2 (Client Gender Role) multivariate analysis of covariance (MANCOVA) and a series of Linear Regressions.

**Hypothesis 1**

Hypothesis one stated that psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when psychologist heterosexual identity development status is controlled for, with psychologists providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and psychologist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles. A randomized 2 (Client Sex) x 2 (Client Sexual Orientation) X 2 (Client Gender Role) multivariate analysis of covariance
MANCOVA was conducted on participants’ diagnostic impression ratings, global and relational functioning ratings, and psychologist reported client attractiveness while controlling for psychologist heterosexual identity development status. The main effects of Client Sex, Client Sexual Orientation, and Client Gender Role as well as the interaction of Client Sex and Client Sexual Orientation were used to test Hypothesis 1.

The main effects of Client Sexual Orientation, Wilks’ $\Lambda = 0.696$, $F(19, 89) = 2.047, p = .013$, and Client Gender Role, Wilks’ $\Lambda = .651$, $F(19, 89) = 2.509, p = .002$, indicated significant effects on the combined DV. Analyses indicated no significant main effect for Client Sex, Wilks’ $\Lambda = .760$, $F(19, 89) = 1.483, p = .111$, or interaction of Client Sex and Client Sexual Orientation, Wilks’ $\Lambda = .765$, $F(19, 89) = 1.441, p = .128$, on the combined DV. The Disintegration Heterosexual Identity Status covariate significantly influenced the combined DV, Wilks’ $\Lambda = .664$, $F(19, 89) = 1.441, p = .003$.

Univariate ANOVA post hoc tests were conducted as follow-up tests. When conducting between-subjects effects comparisons for the main effect of Client Sexual Orientation, results suggested that the Adjustment to University, $F(1, 107) = 7.865, p = .006$, Relationship with Romanic Partner, $F(1, 107) = 5.887, p = .017$, and Sexual Concerns scales, $F(1, 107) = 5.579, p = .020$, differed significantly between groups. Between-subjects analysis for the main effect of Client Gender Role also indicated that the Self-Esteem/Self-Confidence scale, $F(1, 107) = 13.967, p < .001$, differed significantly between groups. Findings indicate that participants viewed the diagnostic category of having difficulty adjusting to university as more reflective of
heterosexual female and male clients ($M = 3.62; \ SE = 2.025$) than lesbian and gay male clients ($M = 2.58; \ SE = 2.011$). Findings also indicated that participants viewed the diagnostic category of having difficulty with current romantic relationship was more reflective of lesbian and gay male clients ($M = 7.35; \ SD = 1.549$) than heterosexual female and male clients ($M = 6.75; \ SD = 1.748$). Also, findings indicate that participants viewed the diagnostic category of having difficulty with sexual issues was more reflective of heterosexual female and male clients ($M = 3.92; \ SD = 2.269$) than lesbian and gay male clients ($M = 3.15; \ SD = 2.193$). Findings indicated that participants viewed the diagnostic category of having difficulty with self-esteem and self-confidence was more reflective of those clients with a traditionally feminine gender role ($M = 7.78; \ SD = 1.349$) than those clients with a traditionally masculine gender role ($M = 6.48; \ SD = 2.071$).

Results suggest this hypothesis was partially supported. Findings indicated that participants’ clinical decisions differed as a result of client sexual orientation and client gender role when psychologist heterosexual identity development status was controlled for, with psychologists providing significantly different clinical judgments in their diagnostic impression ratings for lesbian and gay male clients and those displaying feminine gender roles than heterosexual female and male clients and those displaying masculine gender roles.

**Hypothesis 2**

Hypothesis two stated that psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone. The
second hypothesis was tested using a series of multiple linear regressions. Participants’ subscores on the HIAS and the client’s sexual orientation and client sexual orientation alone were regressed on those variables found to be significantly different as a result of Client Sexual Orientation (Adjustment to University scale, Relationship with Romantic Partner, and Sexual Concerns) or Disintegration Heterosexual Identity Development Status (Sexual Concerns, Loss of Significant Person, GAF, and TPRQ).

Five pairs of multiple regression analyses were conducted to evaluate whether psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in the Relationship with Romantic Partner, Sexual Concerns, and Loss of Significant Person scales and GAF and TRPQ ratings, than client sexual orientation alone. One analysis of these pairs included four heterosexual identity development statuses and client sexual orientation as predictors, while the second regression analysis included only client sexual orientation as a predictor.

On the Relationship with Romantic Partner scale, the client sexual orientation alone regression, $R^2 = .040$, $F(1, 126) = 5.286$, $p = .023$, was significant. However, the regression equation with heterosexual identity development statuses and client sexual orientation was not significant, $R^2 = .079$, $F(5, 121) = 2.103$, $p = .070$. These results indicate that client sexual orientation alone appears to be a better predictor of ratings on the Relationship with Romantic Partner scale than psychologist heterosexual identity development status and client sexual orientation.
On the Sexual Concerns scale, the regression equation with heterosexual identity development statuses and client sexual orientation, $R^2 = .122$, $F(5, 122) = 3.382$, $p = .007$, was significant. However, the regression equation with client sexual orientation alone was not significant, $R^2 = .026$, $F(1, 126) = 3.367$, $p = .069$. Based on these results, heterosexual identity development status and client sexual orientation together appear to be a better predictor of ratings on the Sexual Concerns scale than client sexual orientation alone.

In terms of the Loss of Significant Person scale, the regression equation with heterosexual identity development statuses and client sexual orientation, $R^2 = .121$, $F(5, 122) = 3.344$, $p = .007$, was significant. However, the regression equation with client sexual orientation alone was not significant, $R^2 = .020$, $F(1, 126) = 2.601$, $p = .109$. Based on these results, heterosexual identity development status and client sexual orientation together appear to be a better predictor of ratings on the Loss of Significant Person scale than client sexual orientation alone.

Relating to the GAF ratings, the regression equation with heterosexual identity development statuses and client sexual orientation, $R^2 = .086$, $F(5, 124) = 2.325$, $p = .047$, was significant. However, the regression equation with client sexual orientation alone was not significant, $R^2 = .004$, $F(1, 128) = 0.450$, $p = .503$. Based on these results, heterosexual identity development status and client sexual orientation together appear to be a better predictor of ratings on the GAF than client sexual orientation alone.

Finally, regarding TPRQ ratings, the regression equation with heterosexual identity development statuses and client sexual orientation, $R^2 = .111$,
$F(5, 124) = 3.106, p = .011$, was significant. However, the regression equation with client sexual orientation alone was not significant, $R^2 = .001, F(1, 128) = .094, p = .759$. Based on these results, heterosexual identity development status and client sexual orientation together appear to be a better predictor of ratings on the TPRQ than client sexual orientation alone.

Results suggest this hypothesis was partially supported. Findings indicated that psychologist heterosexual identity development status and client sexual orientation together were better predictors of the variation observed in the Sexual Concerns and Loss of Significant Person scales and GAF and TRPQ ratings than was client sexual orientation alone. Sexual orientation alone was found to be a better predictor of the variation in the Relationship with Romanic Partner scale than psychologist heterosexual identity development status and client sexual orientation together.
Table 2

*Mean Scores for Heterosexual Identity Development States*

<table>
<thead>
<tr>
<th>Heterosexual Identity Development States</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disintegration</td>
<td>18.0635</td>
<td>4.80884</td>
</tr>
<tr>
<td>Reintegration</td>
<td>18.1429</td>
<td>4.17696</td>
</tr>
<tr>
<td>Pseudo-Independence</td>
<td>38.6349</td>
<td>4.54121</td>
</tr>
<tr>
<td>Autonomy</td>
<td>36.0952</td>
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Table 3

*Mean Scores for Diagnostic Impression Variables*

<table>
<thead>
<tr>
<th>Diagnostic Impression Variables</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Work/Grades</td>
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<td>2.462</td>
</tr>
<tr>
<td>Decision about Major/Career</td>
<td>7.51</td>
<td>1.933</td>
</tr>
<tr>
<td>Adjustment to University</td>
<td>2.67</td>
<td>2.079</td>
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<tr>
<td>Relationship with Parents/Family</td>
<td>8.03</td>
<td>1.481</td>
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<tr>
<td>Relationship with Romantic Partner</td>
<td>7.35</td>
<td>1.608</td>
</tr>
<tr>
<td>Loss of Significant Person</td>
<td>7.11</td>
<td>1.752</td>
</tr>
<tr>
<td>Sexual Concerns</td>
<td>3.21</td>
<td>2.171</td>
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<tr>
<td>Self-Esteem/Self-Confidence</td>
<td>6.98</td>
<td>1.972</td>
</tr>
<tr>
<td>Depression</td>
<td>8.02</td>
<td>1.264</td>
</tr>
<tr>
<td>Anxiety, Fear, Worries</td>
<td>7.63</td>
<td>1.395</td>
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<tr>
<td>Sleep Problems</td>
<td>6.49</td>
<td>2.299</td>
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<tr>
<td>Eating Problems</td>
<td>6.10</td>
<td>2.487</td>
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<tr>
<td>Alcohol Usage</td>
<td>2.67</td>
<td>2.170</td>
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<tr>
<td>Number of Sessions</td>
<td>18.33</td>
<td>10.006</td>
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<tr>
<td>Personal Responsibility</td>
<td>6.78</td>
<td>1.276</td>
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Table 4

*Mean Scores for Clinical Judgment Variables*

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<tr>
<th>Clinical Judgment Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
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<tr>
<td>Global Assessment of Functioning</td>
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<tr>
<td>Global Assessment of Relationship Functioning</td>
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<td>15.608</td>
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<tr>
<td>Therapist Personal Reaction Questionnaire</td>
<td>40.3906</td>
<td>6.97755</td>
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Table 5

*Clinical Judgments and Heterosexual Identity Development States Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Disintegration</th>
<th>Reintegration</th>
<th>Pseudo-Independence</th>
<th>Autonomy</th>
</tr>
</thead>
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<tr>
<td>School work/Grades</td>
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<td>.054</td>
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<td>Decision about Major/Career</td>
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<td>Relationship with Parents/Family</td>
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<td>.221</td>
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<td>Relationship with Romantic Partner</td>
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<td>Loss of Significant Person</td>
<td>-.333**</td>
<td>-.175</td>
<td>.261*</td>
<td>-.040</td>
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<td>Sexual Concerns</td>
<td>.400**</td>
<td>.289*</td>
<td>-.267*</td>
<td>-.201</td>
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<td>Self-Esteem/Self-Confidence</td>
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<td>Depression</td>
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<tr>
<td>Anxiety, Fear, Worries</td>
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<td>-.190</td>
<td>.261*</td>
<td>.172</td>
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<td>Sleep Problems</td>
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<td>.268*</td>
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<td>Eating Problems</td>
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<td>.021</td>
<td>.061</td>
<td>-.086</td>
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<tr>
<td>Alcohol Usage</td>
<td>.002</td>
<td>.069</td>
<td>-.042</td>
<td>-.071</td>
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<td>Pathology</td>
<td>-.055</td>
<td>-.057</td>
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<td>Number of Sessions</td>
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<td>.187</td>
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<tr>
<td>Personal Responsibility</td>
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<td>.019</td>
<td>-.046</td>
<td>-.170</td>
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<td>GAF</td>
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<td>-.197</td>
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<td>GARF</td>
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<td>-.010</td>
<td>.162</td>
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<td>Therapist Personal Reaction Questionnaire</td>
<td>.138</td>
<td>.019</td>
<td>.116</td>
<td>.014</td>
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</tbody>
</table>

**. Correlation is significant at the 0.01 level.
* . Correlation is significant at the 0.05 level.
CHAPTER V
DISCUSSION

The purpose of this study was to investigate the effect client sexual orientation and client gender role has on therapists’ judgment related to overall level of psychopathology noted, client desirability, and treatment recommendations. This study also examined the effect of psychologist heterosexual identity development status on the level of heterosexist bias seen. Prior studies (e.g., Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets, Hancock, Cochran, Goodchilds, & Paplau, 1991; Hartman, 2001; Hayes & Gelso, 1993; Mohr, Israel, & Sedlacek, 2001; Walker & Spengler, 1995) have explored how sexual orientation can influence psychologists’ clinical judgments. These studies are limited in their validity and generalizablity.

Previous researchers (e.g., Eliason, 1995; Mohr, 2002; Simoni & Walters, 2001; Sullivan, 1998; Worthington, Savoy, Dillon, & Vernaglia, 2002) have also theorized a link between heterosexist bias and heterosexual identity development status. One study (Simoni & Walters, 2001) empirically demonstrated this with undergraduate and graduate students. No studies however, have demonstrated this association in psychologists.

Client Sexual Orientation Effects on Psychologist Clinical Judgment

It was predicted that psychologists’ clinical decisions will differ as a result of client sex, client sexual orientation, and client gender role when psychologists heterosexual identity development status is controlled for, with psychologists
providing significantly different clinical judgments (as measured by diagnostic impression ratings, global and relational functioning ratings, and psychologist reported client attractiveness) for lesbian and gay male clients and those displaying cross gendered gender roles than heterosexual female and male clients and those displaying gender-congruent gender roles. Findings partially supported this hypothesis. In other words, there were some significant differences in psychologists’ assessments of lesbian and gay male clients and heterosexual female and male clients on three clinical factors, including: Adjustment to University, Relationship with Romantic Partner, and Sexual Concerns. These findings are consistent with previous research (Barkin, 1991; Crawford, Humfleet, Ribordy, Ho, & Vickers, 1991; Decell, 1981; Fliszar & Clopton, 1995; Garfinkle & Morin, 1978; Garnets, Hancock, Cochran, Goodchilds, & Paplau, 1991; Hartman, 2001; Hayes & Gelso, 1993; Mohr, Israel, & Sedlacek, 2001; Walker & Spengler, 1995) that have demonstrated varying levels of judgment errors with lesbian and gay male clients.

Following the removal of “homosexuality” from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), two broad heterosexist responses were noted among therapists (Dworkin, 2000). First, some therapists continued to view lesbians and gay men as pathological based solely upon the clients’ sexual orientation (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Morrow, 2000). The second heterosexist reaction to the removal of “homosexuality” from the DSM was that some therapists minimized the level of psychopathology present or stopped diagnosing lesbian and gay male clients altogether, even when psychopathology was present, in an attempt to act in a gay-affirmative manner. The
present study’s results appear to demonstrate both of these heterosexist clinical judgment errors. For example, in the present study psychologists described lesbian and gay male clients as having more difficulty with their current romantic relationship than heterosexual female and male clients. Conversely, participants viewed heterosexual female and male clients as having more difficulty adjusting to university and having more sexual concerns than lesbian and gay male clients. It is possible that psychologists, wishing to demonstrate a gay-affirmative stance, might minimize the clinical importance of a gay or lesbian client’s sexually-laden presenting concerns.

Only three of 18 psychologist clinical judgments assessed in the present study proved significantly different for the lesbian and gay male client and heterosexual female and male client prompts. In addition, all of the interaction effects in the study’s analysis were insignificant despite a strong theoretical basis for an interaction. Several factors may contribute to the lack of a relationship. While previous studies found heterosexist bias among therapists, these studies have been dated or limited in their generalizability due to methodological concerns. The publication dates of the studies reviewed span 23 years between 1978 and 2001. Worthington, Dillon, and Becker-Schutte (2005) noted that studies assessing heterosexual attitudes and clinical bias toward lesbians and gay men reflect the attitudes and beliefs about lesbian and gay individuals at the time the study was conducted. These studies do not necessarily maintain their validity, as cultural views change over time. Evidence suggests that dominant cultural views toward lesbians and gay men have shifted over the past decade toward being more tolerant and accepting. It is possible that the lack of relation between client sexual orientation and psychologist clinical assessments
reflects this larger cultural attitude shift. Psychologists’ attitudes toward lesbian and gay male clients may have become more accepting as well, leading to a decrease in heterosexist judgment errors when working with lesbian- and gay-identified clients.

It is also possible that the lack of relation between client sexual orientation and psychologist clinical assessment may be the result of social desirability effects. While a mild form of deception was used in an attempt to mask the focus of the present study and study materials pertaining to sexual orientation were presented after participants made their clinical assessments, the impact of social desirability effects cannot be discounted. Participants who were presented a clinical vignette describing a lesbian woman or gay man may have responded in a manner to present themselves as more gay-affirmative to reflect the stated views of various professional organizations. For example, the American Psychological Association (APA) stated that psychologists need to adopt a gay-affirmative stance and work toward reducing the larger cultural stigma toward non-heterosexually identified individuals. This would be consistent with Mohr’s (2002) assertion that therapists’ dominant working models for understanding and processing information regarding lesbian and gay men may be motivated by a person’s need for social/professional acceptance or internal consistency. When presented with a clinical vignette portraying a lesbian or gay male client, participants may have felt compelled to provide a more gay-affirmative assessment of the client to meet their own need for social/professional acceptance.

The present study’s materials also may have lacked the sensitivity to detect psychologist bias. The materials used in the present study were designed to examine psychologist clinical assessment and clinical judgment of fictitious clients. While
findings suggest that participants did not significantly differ in their assessment of fictitious lesbian and gay male clients and heterosexual female and male clients, this does not mean that psychologists would assess a real client the same way as they would a clinical vignette of a fictitious client. Similarly, while the results show that participants did not assess the lesbian and gay male clients significantly differently than the heterosexual female and male client, this does not necessarily mean that they would act in a non-biased manner in therapy. Many of the general themes of biased practice with lesbian and gay male clients identified by Garnets, Hancock, Cochran, Goodchilds, and Paplau (1991) do not directly pertain to clinical assessment. For example, the present study did not assess whether psychologists’ clinical intervention choices would differ as a result of client sexual orientation. Other areas of clinical bias, such as psychologists failing to understand how internalized homophobia can complicate and hinder the process of identifying as lesbian or gay and exacerbate other conditions such as depression and anxiety, pressuring lesbian and gay male clients to self-disclose their sexual orientation to others while underestimating the possible negative consequences in disclosing one’s sexual orientation, and relying on the client to teach the psychologist about lesbian and gay issues, are all forms of biased clinical practice that were not addressed in the present study.

It is important to note that it would be inappropriate to understand this study’s findings as suggesting that psychologists do not exhibit bias in the course of the therapeutic process. Therapy is a complex undertaking with numerous potential areas where heterosexist bias can be displayed. Also, as noted previously, one weakness in the current clinical judgment bias literature related to lesbian and gay male clients is
that potential psychologist variables that may mediate the presence of heterosexist bias have not been addressed. When other factors such as heterosexual identity development status are examined, the potential for bias can be seen.

**Psychologists’ Heterosexual Identity Development Status Effects on Heterosexist Bias**

Hypothesis 2 stated that psychologist heterosexual identity development status and client sexual orientation together are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone. As predicted, psychologist heterosexual identity development status and client sexual orientation together were better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone. Specifically, it was found that heterosexual identity development statuses and client sexual orientation was a better predictor of the variation observed in psychologists’ ratings on the Sexual Concerns, Loss of Significant Person, and Global Assessment of Functioning, and Psychologist Personal Reactions ratings than was client sexual orientation alone.

These findings support previous research (Simoni & Walters, 2001) suggesting that heterosexual identity development affects an individual’s attitudes related to lesbians and gay men. These findings also provide empirical support to those researchers (e.g., Eliason, 1995; Sullivan, 1998; Mohr, 2002; Worthington et al., 2002) who have theorized that a psychologist’s level of heterosexual identity development may play a vital role in determining both attitudes toward lesbian and gay individuals and in clinical bias displayed in therapy.

While it did produce significant relationships between attitude states and
clinical judgment, the available measure of heterosexual identity development status does have its limitations. Eliason (1995), Sullivan (1998), Mohr (2002) and Worthington et al. (2002) have all noted that there is a lack of measures designed to assess heterosexual identity development. To get around this limitation, the present study utilized an adapted version (Simoni & Walters, 2001) of Helms and Carter’s (1990) White Racial Identity Attitude Scale to assess participants’ heterosexual identity development. While this adapted measure may have served as an approximate measure of heterosexual identity development, it is limited, however. An instrument specifically developed to assess heterosexual identity development, grounded in literature related to this process, may have been more likely to find relationships between identity status and clinical judgment variables.

While the available measure of heterosexual identity development does have its limitations, it did produce significant relationships between attitude states and clinical judgment. Among these findings, the correlation between psychologists’ heterosexual identity status and the sexual concerns variable is of special significance in that it seemingly parallels one of Garnets et al.’s (1991) observed themes of biased practice with lesbian and gay male clients. These authors found that psychologists act in a biased manner with lesbian and gay male clients by focusing on the client’s sexual orientation and sexuality during the course of therapy when it is not relevant to the client’s presenting concerns. Results of the present study suggest that psychologists exhibiting lower levels of heterosexual identity development perceived the client as having more difficulties with sexual-related concerns than did psychologists in higher developmental statuses. The results are consistent across the
three identity states that were correlated, disintegration, reintegration, and pseudo-independence. It is possible that individuals who exhibit lower heterosexual identity development statuses perceived the client’s sexuality as a more salient clinical feature because of the client’s lesbian- or gay-identification independent of the client’s actual reported concerns. In overshadowing the client’s other presenting concerns, psychologists who focus on the client’s sexuality may exhibit biased practices when working with lesbian and gay male clients. For example, psychologists who focus on the client’s sexuality when it is not relevant to the client’s presenting concerns may choose inappropriate clinical interventions, alienate the client by focusing on areas that are not salient to the client, or form inaccurate clinical judgments of the client and their clinical concerns.

**Strengths of the Study**

An important strength of this study is that it investigated the effects of psychologist heterosexual identity development on psychologists’ clinical assessment and judgments when working with lesbian and gay male clients. While other studies have investigated the impact that heterosexual identity development has on non-professional individuals’ attitudes of lesbian women and gay men, no study was located that examined the impact on professional psychologists. While previous research has noted a tendency for psychologists to display biased practice in work with lesbians and gay men, no study was found that examined the potential of psychologist heterosexual identity development to influence this potential. This study provides empirical findings that support the theoretical link between psychologist heterosexual identity development and heterosexist judgment errors with clients that
several authors (e.g., Eliason, 1995; Sullivan, 1998; Mohr, 2002; Worthington et al., 2002) have proposed.

Another strength of the study is that it provides a more accurate and valid assessment of the potential for clinical judgment bias in psychologists working with lesbians and gay men than previous studies. As larger cultural attitudes regarding lesbians and gay men change, past research related to clinical judgment bias and clinician’s attitudes regarding this population begins to lose its current validity. The current study utilized a representative sample of American Psychological Association members to determine the current levels of clinical judgment bias in practicing psychologists. The present study presents a more representative picture of the attitude of members of one of the largest professional organizations for professional psychologists.

**Limitations**

A major limitation of this study is the smaller than expected sample size that was achieved during data collection. This sample size was possibly the result of participants having negative reactions to some of the study’s materials asking questions regarding their sexual identity, the time requirement being too high, or participants not feeling competent to answer the study’s questions regarding a client presented as a college-age student with some presenting concerns unique to this age-group. Whatever the reason, the limited sample size required necessitated scaling back this study’s original research questions by eliminating an examination of the interaction effects of client sexual orientation and gender-role on psychologists’ judgment and attitudes.
A second limitation relates to the presenting concerns and demographic profile of the client presented in the clinical vignettes. The client was described as a 21-year old, white woman or man seeking services at a college counseling center for multiple presenting problems including (1) difficulty in making a career choice (because of issues relating to family of origin, being a first-generation college student, and coming from a working-class background), (2) difficulty coming to terms with the dissolution of a two-year romantic relationship six months prior to seeking services, and (3) relationship difficulties with her/his new romantic partner. The validity of the participants’ clinical judgments and assessments may have been jeopardized by requiring participants to make clinical assessments with a client, age-group, or presenting concerns that were outside their areas of competency. It is possible that some of the participants have not worked with a college-aged population, and may not be fully aware of the unique clinical concerns of college-age clients. For example, psychologists who typically work with young children, adolescents, and older adults may not feel competent addressing early career development and decision-making concerns referenced in the vignette. Additionally, those who do not regularly work with issues such as individuation and the educational challenges that first-generation college students might face may not have been able to assess the client as accurately as psychologists who regularly work with these clinical issues.

A third limitation is that the participants were not asked to provide a formal DSM-IV-TR diagnosis. While the ratings of the Diagnostic Questionnaire used in the present study provided easily quantifiable information regarding participants’
attitudes and clinical impressions, not specifically asking participants to provide a DSM-IV-TR diagnosis is a limitation for several reasons. Diagnoses using DSM-IV-TR criteria provide psychologists with a common diagnosis system through which psychologists can share clinically relevant information about clients and their clinical presentation. Not asking participants to use their clinical judgment to provide a formal diagnosis limits the practical, real world information that could have been obtained had participants been asked to provide a formal diagnosis. For example, the clinical vignettes used for the present study were written to be consistent with an individual displaying symptoms of a diagnosis of major depressive disorder. Failure to ask participants to provide a formal diagnosis also limits the amount of information available regarding the validity of the clinical vignette. While eight counseling psychology doctoral students were used to test the validity of the vignettes, having the validation of the participants would have produced additional information about the validity of the vignette.

A fourth limitation is that, while the APA is one of the largest professional organizations in the field of psychology, APA members are not representative of the larger mental health provider community. This limits the generalizability of this study’s findings to the larger field. For example, the average age of respondents in this study was 60.65 years old, with a broad range of between 35 and 85 years old. Additionally, 90.5% of the present sample reported that their highest degree achieved was a Ph.D., Psy.D., or Ed.D. Participants also reported having an average of 31.51 years of counseling experience. While this sample may be representative of the membership of the APA, it may not be representative of the larger field. By sampling
only APA members, many Master’s and doctoral level counselors, social workers, and other mental health providers were not included in the sample.

A fifth limitation to the present study is the lack of a measure designed to assess participants’ level of heterosexual identity development. While two models of heterosexual identity development have been developed (Mohr, 2002; Worthington et al., 2000), no measures have been published that assess this process. As a result, a modified version of a related majority identity development assessment was utilized in the present study. While this instrument produced several significant results, it does have its limitations. Using the adapted measure assumes that the process of white racial identity development parallels that of heterosexual identity development. While there may be similarities between the two processes, existing models of heterosexual identity development (e.g., Mohr, 2002; Worthington et al., 2002) suggest that heterosexual identity development is a dynamic, multi-faceted process that differs from white racial identity development. It is possible that the small number of significant correlations between identity development statuses and clinical judgment variables is the result of the lack of sensitivity of the adapted measure to assess such a multifaceted development identity development process.

**Directions for Future Research**

This study contributes to the field’s understanding of the potential for psychologists to display clinical judgment bias with lesbian and gay male clients. It additionally contributes to our understanding of the effect of psychologist heterosexual identity development on psychologist bias with this population. While this study expands upon existing literature and opens a new area of inquiry, there is
still more to be learned both about clinical judgment bias with lesbian and gay clients and potential mediating factors.

This study is the first to investigate how client sexual orientation and the interaction of client sexual orientation and gender-role affect psychologist clinical judgment and whether psychologist heterosexual identity development acts as a mediating factor for clinical judgment bias. Results indicate no significant interaction effects of client sexual orientation and gender-role on psychologist clinical judgment. Continued study in this area, with a larger sample with a high power, would be important to fully understand the interaction effects that these related variables have on each the clinical judgment formation process.

As mentioned previously, all of the participants in the present study were members of the APA. Members of the APA, however, may not present an accurate representation of the larger mental health provider community in terms of level of training, age, and number of years of practice. As such, another area suggested for future research involves obtaining a larger, more representative sample of the field as a whole with steps taken to ensure collection of data from master’s- and doctoral-level clinicians with a broader range of age and experience levels.

The present study focused on one aspect of the therapeutic process, clinical assessment. It was found that participants did significantly differ in their initial clinical assessments of lesbian and gay male and heterosexual female and male clients on only a few clinical judgment variables. This however, does not necessarily imply that psychologists do not display heterosexist bias in other areas of the assessment and therapeutic process. Biased practice can occur in every aspect of the clinical
process. Garnets et al.’s (1991) content analysis of surveys from over 2,500 licensed APA members produced 17 general themes related to biased practice with lesbian and gay male clients across all levels of professional practice. The present study only addressed one of these themes, clinical assessment. Other areas of potential clinical bias such as intervention choice, familiarity with lesbian and gay identity issues, knowledge of lesbian and gay relationship and family issues, and psychologist expertise and education in issues related to lesbian and gay male clients were beyond the purview of the present study but are no less important. It is recommended, therefore, that future research be targeted at determining the effects of client sexual orientation on the therapeutics beyond initial clinical assessment.

One the unique elements of the present study is the examination of how psychologist heterosexual identity development status affects the clinical judgment formation process. While numerous authors have theorized a link between identity status and potential clinical judgment error, no study has empirically demonstrated this. The present study is the first to empirically demonstrate that heterosexual identity development status can influence psychologists’ clinical assessment process. As noted above, however, one limitation of the present study is that it used a modified version of a related majority identity development assessment to measure participant heterosexual identity development status. Further research on the effects of heterosexual identity development status on the therapeutic processes would benefit from having an instrument specifically developed to assess heterosexual identity development. It is strongly recommended that future research be focused on scale
development to construct a valid instrument that specifically assesses individual heterosexual identity development.

The present study is one of the first to assess the effects of psychologist heterosexual identity development on the therapeutic process. Results indicate that client sexual orientation and psychologist heterosexual identity development status are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone. Continued study in this area would be important to understand the relationship between psychologist heterosexual identity and the therapeutic process. For example, while the present study indicates that client sexual orientation and psychologist heterosexual identity development status are better predictors of the variation observed in psychologist clinical decisions than client sexual orientation alone, it is uncertain how this would affect the therapeutic process. Future research focusing on the effects of psychologist heterosexual identity development on the clinical assessment and therapeutic processes is strongly recommended.

Finally, since heterosexual identity development has been shown to be associated with psychologist assessment of lesbian and gay male clients’ presenting concerns, it would be beneficial to understand whether targeted training and experiential interventions could be used to foster increased levels of heterosexual identity development. This knowledge may lead to training experiences designed to increase heterosexual identity development and decrease the likelihood of heterosexist bias in therapy with lesbian and gay male clients. Since this line of research has relevance both for the research base related to heterosexual identity
Sexual Orientation, Heterosexuality Identity, and Clinical Judgment Bias

development and clinical bias and to psychologist training and practice continued
research is strongly recommended.

**Implications for Training and Practice**

As has been mentioned throughout, clinicians’ clinical judgments when
working with lesbian and gay male clients can be biased by a number of personal and
socio-cultural factors. This clinical judgment bias has the potential to lead to
misdiagnosis, improper and/or prolonged treatment, and client harm. As such, it is
important to be aware of the potential to be biased in clinical practice and of those
variables associated with increased potential for biased practice. From a clinical
practice perspective, recognizing these variables becomes necessary if one is to
successfully work with lesbians and gay men.

The present study indicates that psychologist heterosexual identity development
status may play a role in how individual psychologists view and make clinical
judgments when working with lesbians and gay men. This suggests that heterosexual-
identified psychologists who have not explored or achieved a clear understanding of
their own heterosexual identity are at increased risk of acting in a heterosexist manner
when working with lesbian and gay male clients and may act in a biased manner in
practice with lesbian and gay male clients. For example, psychologists who have not
achieved a more advanced level of heterosexual identity development may be non-
affirmative when working with lesbian and gay male clients, overly focus on the
client’s sexuality, feel uncomfortable discussing sexuality-related material in
counseling, or allow personal sexual values to unduly influence their work with
clients. In order to practice effectively and in a non-heterosexist manner, the present
study suggests that it is important for heterosexual-identified psychologists to seek out opportunities for introspection and personal growth that fosters increased understanding of one’s own heterosexual identity.

Similarly, the present study indicates a need to develop educational and personal growth-producing experiences that specifically address overall sexual identity development with the goal of fostering self-knowledge and more highly integrated levels of heterosexual identity development. Training programs may also benefit from providing educational experiences and opportunities that allow for trainees to better understand their own heterosexual identity development and foster increased identity development. This may reduce trainees’ tendency to dichotomize sexual orientation into two distinct groups and foster an increased understanding of and comfort with sexuality related issues that clients may present in therapy.

Additionally, while many researchers note the importance of having a strong grounding in one of the existing lesbian and gay identity development models to better understand the process of minority identity development that lesbians and gay men experience, it may also be beneficial for psychologists and trainees to have a solid understanding of the process of heterosexual identity development. This knowledge of heterosexual identity development processes may lead heterosexual-identified psychologists to have increased levels of self-knowledge, achieve more integrated levels of heterosexual identity development, and exhibit decreased clinical bias when working with lesbian and gay male clients.

Finally, similar to how heterosexual psychologists require personal reflection of their own sexual identity to better understand their interactions with lesbian and gay
clients, faculty members and supervisors may also benefit from better understanding their own identity process and level of development. This will allow faculty members and supervisors to aid in the development of their trainees by allowing them to provide a framework through which they can guide their heterosexual-identified trainees in developing counseling competencies for working with lesbian and gay male clients.

Summary

Mental health psychologists are continually required to form impressions about their clients and develop hypotheses about the nature of their presenting concerns. Past research has demonstrated how client sexual orientation can influence and bias clinicians’ judgments. Given the potential for misdiagnosis, improper and/or prolonged treatment, and client harm, understanding this potential for bias and possible moderating variables of this bias is vital to providing competent care to lesbians and gay males seeking services. The existing research about the existence of biased clinical judgment with lesbian and gay male clients is dated and limited in its current generalizability. Further, while researchers have theorized the existence of several variables that may moderate potential bias, little empirical research attention has been given to this topic. This study adds to the literature regarding clinical bias when working with lesbian and gay male clients and how psychologist heterosexual identity development may impact their judgments. Results from this study show that psychologists, in general, view lesbian women and gay men clients differently as compared to similar heterosexual women and men in several clinically relevant areas. This finding is consistent with previous findings regarding bias with lesbians and gay
Results from this study provide a foundation from which to build knowledge regarding how heterosexual identity development influences a psychologist’s clinical judgment when assessing lesbians and gay men. Specifically, it was found that heterosexual identity development may affect an individual psychologist’s attitudes and clinical judgments of lesbians and gay men in therapy. This finding supports several researchers’ belief that there is a relation between psychologists’ heterosexual identity and attitudes regarding lesbians and gay men.

Past researchers have theorized that gender-role and sexual orientation have a vital role in heterosexual identity development. While the present study did not produce significant interaction effects, it is possible that a larger, more powerful sample may find a significant interaction between these two variables and it is recommended that future research should investigate this potential area of bias. Larger scale studies examining the effects of psychologist heterosexual identity development level on clinical judgment with lesbian and gay male clients are encouraged. Additionally, further research examining how psychologist heterosexual identity develop influences clinical judgment formation and whether interventions focused on bringing about higher levels of heterosexual identity integration can lessen the incident of heterosexist clinical bias are encouraged. The findings from this study show the importance of continuing to gather knowledge about these issues.
REFERENCES


*Sex Roles, 32*, 821-834.


Sexual Orientation, Heterosexuality Identity, and Clinical Judgment Bias


APPENDICES
Appendix A

List of Clinical Vignettes

Vignette 1
Sex: Female
Sexual Orientation: Heterosexual
Gender-role: Feminine

Vignette 2
Sex: Female
Sexual Orientation: Heterosexual
Gender-role: Masculine

Vignette 3
Sex: Female
Sexual Orientation: Lesbian
Gender-role: Feminine

Vignette 4
Sex: Female
Sexual Orientation: Lesbian
Gender-role: Masculine

Vignette 5
Sex: Male
Sexual Orientation: Heterosexual
Gender-role: Feminine

Vignette 6
Sex: Male
Sexual Orientation: Heterosexual
Gender-role: Masculine

Vignette 7
Sex: Male
Sexual Orientation: Gay
Gender-role: Feminine

Vignette 8
Sex: Male
Sexual Orientation: Gay
Gender-role: Masculine
Appendix B

Diagnostic Impression Questionnaire

Please indicate the degree to which each diagnostic category reflects the client’s current state.

<table>
<thead>
<tr>
<th></th>
<th>LOW LIKELIHOOD</th>
<th>HIGH LIKELIHOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) School Work/Grades</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>2) Decision about Major/Career</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>3) Adjustment to University</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>4) Relationship with Romantic Partner</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>5) Relationship with Parents/Family</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>6) Loss of Significant Person</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>7) Sexual Concerns</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>8) Self-esteem, Self-confidence</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>9) Depression</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>10) Anxiety, Fear, Worries</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>11) Sleep Problems</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>12) Eating Problems</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
<tr>
<td>13) Alcohol Usage</td>
<td>1   2   3   4   5</td>
<td>6   7   8   9</td>
</tr>
</tbody>
</table>

Please estimate the number of sessions you believe that you would need to adequately work with this client to address the clinical issues. ___________________________
Please rate the level of personal responsibility that you believe the client holds for the clinical issues.

<table>
<thead>
<tr>
<th>No Personal Responsibility</th>
<th>Total Personal Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  2  3  4  5  6  7  8  9</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Global Assessment of Functioning Scale

Please assess the global level of functioning that this client displays using the DSM-IV-TR Global Assessment of Functioning scale criteria below.

GAF Score = ____________

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>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.</td>
</tr>
<tr>
<td>90</td>
<td>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).</td>
</tr>
<tr>
<td>80</td>
<td>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 falling behind in schoolwork).</td>
</tr>
<tr>
<td>70</td>
<td>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.</td>
</tr>
<tr>
<td>60</td>
<td>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).</td>
</tr>
<tr>
<td>50</td>
<td>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).</td>
</tr>
<tr>
<td>40</td>
<td>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).</td>
</tr>
<tr>
<td>30</td>
<td>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).</td>
</tr>
<tr>
<td>Score</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>20</td>
<td>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).</td>
</tr>
<tr>
<td>10</td>
<td>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.</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Appendix D

Global Assessment of Relational Scale

Please assess the level of relational functioning that this client displays in [his/her] CURRENT romantic relationship using the DSM-IV-TR Global Assessment of Relational Functioning scale criteria copied below.

GARF Score = ____________

<table>
<thead>
<tr>
<th>81-100 Overall: Relational unit is functioning satisfactorily from self-report of participants and from perspectives of observers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed-on patterns or routines exist that help meet the usual needs of each family/couple member; there is flexibility for change in response to unusual demands or events; and occasional conflicts and stressful transitions are resolved through problem-solving communication and negotiation.</td>
</tr>
<tr>
<td>There is a shared understanding and agreement about roles and appropriate tasks, decision making is established for each functional area, and there is recognition of the unique characteristics and merit of each subsystem (e.g., parents/spouses, siblings, and individuals).</td>
</tr>
<tr>
<td>There is a situationally appropriate, optimistic atmosphere in the family; a wide range of feelings is freely expressed and managed within the family; and there is a general atmosphere of warmth, caring, and sharing of values among all family members. Sexual relations of adult members are satisfactory.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>61-80 Overall: Functioning of relational unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily routines are present, but there is some pain and difficulty in responding to the unusual. Some conflicts remain unresolved but do not disrupt family functioning.</td>
</tr>
<tr>
<td>Decision making is usually competent, but efforts at control of one another quite often are greater than necessary or are ineffective. Individuals and relationships are clearly demarcated but sometimes a specific subsystem is depreciated or scapegoated.</td>
</tr>
<tr>
<td>A range of feeling is expressed, but instances of emotional blocking or tension are evident. Warmth and caring are present but are marred by a family member's irritability and frustrations. Sexual activity of adult members may be reduced or problematic.</td>
</tr>
</tbody>
</table>
**41-60 Overall:** Relational unit has occasional times of satisfying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate.

Communication is frequently inhibited by unresolved conflicts that often interfere with daily routines; there is significant difficulty in adapting to family stress and transitional change.

Decision making is only intermittently competent and effective; either excessive rigidity or significant lack of structure is evident at these times. Individual needs are quite often submerged by a partner or coalition.

Pain or ineffective anger or emotional deadness interferes with family enjoyment. Although there is some warmth and support for members, it is usually unequally distributed. Troublesome sexual difficulties between adults are often present.

**21-40 Overall:** Relational unit is obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare.

Family/couple routines do not meet the needs of members; they are grimly adhered to or blithely ignored. Life cycle changes, such as departures or entries into the relational unit, generate painful conflict and obviously frustrating failures of problem solving.

Decision making is tyrannical or quite ineffective. The unique characteristics of individuals are unappreciated or ignored by either rigid or confusingly fluid coalitions.

There are infrequent periods of enjoyment of life together; frequent distancing or open hostility reflect significant conflicts that remain unresolved and quite painful. Sexual dysfunction among adult members is commonplace.
<table>
<thead>
<tr>
<th>1-20</th>
<th><strong>Overall:</strong> Relational unit has become too dysfunctional to retain continuity of contact and attachment.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family/couple routines are negligible (e.g., no mealtime, sleeping, or waking schedule); family members often do not know where others are or when they will be in or out; there is a little effective communication among family members.</td>
</tr>
<tr>
<td></td>
<td>Family/couple members are not organized in such a way that personal or generational responsibilities are recognized. Boundaries of relational unit as a whole and subsystems cannot be identified or agreed on. Family members are physically endangered or injured or sexually attacked.</td>
</tr>
<tr>
<td></td>
<td>Despair and cynicism are pervasive; there is little attention to the emotional needs of others; there is almost no sense of attachment, commitment, or concern about one another's welfare.</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Appendix E

Therapist Personal Reaction Questionnaire

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SD=Strongly Disagree</td>
<td>D=Disagree</td>
<td>U=Uncertain</td>
<td>A=Agree</td>
<td>SA=Strongly Agree</td>
<td></td>
</tr>
<tr>
<td>1. I would like this client more than most.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>2. I would have a warmer, friendlier reaction to this client than to others I have seen.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>3. I would seldom doubt what the client was trying to say.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>4. In general, I couldn’t ask for a better client.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>5. I would usually find significant things to respond to in what the client said.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>6. I would feel pretty ineffective with this client.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>7. I think I would do pretty competent job with this client.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>8. I would disagree with this client about some basic matters.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>9. I think this client would try harder to solve this or her problems than most others I’ve seen.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>10. It would be hard to know how to respond to this client in a helpful way.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>11. It would be easier for me to see exactly how this client would feel in the situations her or she describes than it is with other clients.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>12. I would be more confident that this client will work out his or her problems than I’ve been with others.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>13. In comparison with other clients, I would find it hard to get involved with this client’s problems.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
</tbody>
</table>
14. It would be difficult to feel warmth toward this client.  

15. I would sometimes resent the client’s attitude.  

16. I think it is exciting to discover the little ways in which lesbians/gay men and straight people are different.  

17. I think it is exciting to discover the little ways in which lesbians/gay men and straight people are different.
APPENDIX F

Heterosexual Identity Attitude Scale

<table>
<thead>
<tr>
<th></th>
<th>SD=Strongly Disagree</th>
<th>D=Disagree</th>
<th>U=Uncertain</th>
<th>A=Agree</th>
<th>SA=Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I hardly think about what my sexual orientation is.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>2. I do not understand what lesbians and gay men want from straight people.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>3. I get angry when I think about how straight people have been treated by gay men and lesbians.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>4. I feel as comfortable around lesbians and gay men as I do around straight people.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>5. I involve myself in causes regardless of the sexual orientation of the people involved in them.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>6. I find myself watching gay men and lesbians to see what they are like.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>7. I feel depressed after I have been around lesbians and gay men.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>8. There is nothing that I want to learn from gay men and lesbians.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>9. I seek out new experiences even if I know a large number of lesbians and gay men will be involved in them.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>10. I enjoy watching the different ways that gay men/lesbians and straight people approach life.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>11. I wish I had more gay male or lesbian friends.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
<tr>
<td>12. I do not feel that I have the social skills to interact with lesbians and gay men effectively.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
<td>SA</td>
</tr>
</tbody>
</table>
13. A gay man or lesbian who tries to get close to you is usually after something.  
14. When a lesbian or gay man holds an opinion with which I disagree, I am not afraid to express my viewpoint.  
15. Sometimes jokes based on gay men's and lesbians' experiences are funny.  
16. I think it is exciting to discover the little ways in which lesbians/gay men and straight people are different.  
17. I used to believe that gay men/lesbians could live together and work closely together with straight people, but now I have my doubts.  
18. I'd rather socialize with straight people only.  
19. In many ways lesbians/gay men and straight people are similar, but they are also different in some important ways.  
20. Lesbians/gay men and straight people have much to learn from each other.  
21. For most of my life, I did not think about issues related to sexual orientation.  
22. I have come to believe that gay men/lesbians and straight people are very different.  
23. Straight people have bent over backwards trying to make up for other straight people's past mistreatment of gay men and lesbians, now it is time to stop.  
24. It is possible for lesbians/gay men and straight people to have meaningful social relationships with each other.  
25. There are some valuable things that straight people can learn from lesbians and gay men that they can't learn from other straight people.
26. I am curious to learn in what ways gay men/lesbians and straight people differ from each other. SD D U A SA

27. I limit myself to straight people's activities. SD D U A SA

28. Society may have been unjust to gay men and lesbians, but it has also been unjust to straight people. SD D U A SA

29. I am knowledgeable about which values lesbians/gay men and straight people share. SD D U A SA

30. I am comfortable wherever I am. SD D U A SA

31. In my family, we never talked about issues related to sexual orientation. SD D U A SA

32. When I must interact with a lesbian or gay man, I usually let him or her make the first move. SD D U A SA

33. I feel hostile when I am around gay men and lesbians. SD D U A SA

34. I think I understand lesbians' and gay men's values. SD D U A SA

35. Gay men/lesbians and straight people can have successful close relationships. SD D U A SA

36. I was raised to believe that people are people regardless of their sexual orientation. SD D U A SA

37. Nowadays, I go out of my way to avoid associating with gay men and lesbians. SD D U A SA

38. I believe that lesbians and gay men are inferior to straight people. SD D U A SA

39. I believe I know a lot about gay men's and lesbians' customs. SD D U A SA

40. There are some valuable things that straight people can learn from lesbians and gay men that they can't learn from other straight people. SD D U A SA
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<tr>
<td>41.</td>
<td>I think that it's okay for lesbians/gay men and straight people to be acquaintances as long as they are not close friends.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>42.</td>
<td>Sometimes I'm not sure what I think or feel about gay men and lesbians.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>43.</td>
<td>When I am the only straight person in a group of lesbians and gay men, I feel anxious.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>44.</td>
<td>Gay men/lesbians and straight people differ from each other in some ways, but neither sexual orientation is superior.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>45.</td>
<td>It is embarrassing to admit being straight.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>46.</td>
<td>I think straight people should become more involved in socializing with gay men and lesbians.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>47.</td>
<td>I don't understand why lesbians and gay men blame all straight people for their social misfortunes.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>48.</td>
<td>I believe that straight people look and express themselves better than gay men and lesbians.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<td>49.</td>
<td>I feel comfortable talking to lesbians and gay men.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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<tr>
<td>50.</td>
<td>I value the relationships that I have with my gay male and lesbian friends.</td>
<td>SD</td>
<td>D</td>
<td>U</td>
<td>A</td>
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APPENDIX G

Demographic Information

What is your gender?
_____ Female
_____ Male

What is your current age?
__________ years

Highest degree level completed?
_____ M.A./M.S.
_____ Ph.D./Psy.D.
_____ Other (Please describe: ___________________________________________)

How would you describe your race/ethnicity?
_____ African American/Black (non-Hispanic)
_____ Asian American/Pacific Islander
_____ Caucasian (non-Hispanic)
_____ Hispanic/Latino
_____ Native American
_____ Other (Please describe: ___________________________________________)

How would you best describe your sexual orientation?

1  2  3  4  5  6  7
Exclusively Exclusively
Heterosexual Heterosexual
Equally and Lesbian/Gay
Lesbian/Gay

Including graduate training, how many years of counseling experience do you have?
__________ years

How many hours of formal coursework and/or training have you participated in regarding lesbian and gay male issues?
__________ hours

How many hours of clinical experience with gay and lesbian clients do you have?
__________ hours
How many hours of consultation regarding gay and lesbian clients have you participated in?

__________ hours
Appendix H

Recruitment Letter # 1

(Recipient’s Name)
(Address)

Dear (Recipient’s Name),

We are requesting your participation in a study designed to study the clinical assessment process, which will increase our understanding of how therapists form diagnostic impressions and treatment recommendations when working with clients with multiple presenting problems. The results could have important implications for both training and practice.

Your name was selected as part of a small national random sample of therapists who are being asked to give their opinion on these matters. In order for the results to be truly representative, it is vitally important that each questionnaire be completed and returned.

It will take approximately 45 minutes to complete the questionnaires. Two participants who successfully complete the research materials will be randomly chosen at the end of the study to receive one of two fifty dollar VISA gift certificates.

One benefit you may gain from your participation in this study is a better understanding of how therapists form diagnostic impressions and make treatment recommendations when working with clients with multiple presenting problems.

The present study’s material may be accessed in one of two ways. Typing the following website address into any web-browser will allow you to access the present study.

[WEB ADDRESS]

If you would prefer receiving a paper copy of the study, please contact the principal investigator at tdgordon@bsu.edu or by phone at 859-640-7742 and one will be mailed to you.

Your participation in this study is completely voluntary and you are free to withdraw from the study at anytime for any reason without penalty or prejudice from the investigator. Please feel free to contact the primary investigator with any questions prior to beginning the study.

Your responses will remain strictly confidential. Physical data will be stored in a locked filing cabinet computer in the researcher’s office and all computer data will
be kept on a secure, password-protected computer. Only group data will be used in the analysis. The questionnaire has an identification number for mailing purposes only. This is so we may check your name off the mailing list when your questionnaire is completed. Your name will never be placed on the questionnaire. You may request a summary of results by sending an email with the heading “copy of results requested” to tdgordon@bsu.edu. Please do not put this information on the questionnaire itself.

For one’s rights as a research subject, the following person may be contacted: Coordinator of Research Compliance, Office of Academic Research and Sponsored Programs, Ball State University, Muncie, IN 47306, (765) 285-5070.

We would be very happy to answer any questions you might have. Thank you in advance for your anticipated response.

Sincerely,

Principal Investigator

Timothy D. Gordon, MS
Doctoral Student
Counseling Psychology and Guidance Services
Ball State University
Muncie, IN 47306
Telephone: (859) 640-7742
Email: tdgordon@bsu.edu

Faculty Supervisor:

Dr. Sharon Bowman
Counseling Psychology and Guidance Services
Ball State University
Muncie, IN 47306
Telephone: (765) 285-8040
Email: sbowman@bsu.edu
Appendix I

Recruitment Letter # 2

(Recipient’s Name)
(Address)

Dear (Recipient’s Name),

About two weeks ago a questionnaire was mailed to you; it has important implications for the treatment and diagnosis of mental disorders.

Because this questionnaire has been sent to a small but representative sample of therapists, it is important that your response be included. If you have already completed and returned the questionnaire please accept our thanks. If no, we would greatly appreciate your doing so as soon as possible.

It will take approximately 30 minutes to complete the questionnaires. Two participants who successfully complete the research materials will be randomly chosen at the end of the study to receive one of two fifty dollar VISA gift certificates.

One benefit you may gain from your participation in this study may be a better understanding of how therapists form diagnostic impressions and make treatment recommendations when working with clients with multiple presenting problems.

The present study’s material may be accessed in one of two ways. By typing the following website address into any web-browser will allow you to access the present study.

[WEB ADDRESS]

If you would prefer to receive a paper copy of the study, please contact the principal investigator at tgdordon@bsu.edu or by phone at 859-640-7742 and one will be mailed to you. Please do not put this information on the questionnaire itself.

We would be very happy to answer any questions you might have. Thank you in advance for your anticipated response.

Sincerely,

Principal Investigator: Timothy D. Gordon, MS  
Faculty Supervisor: Dr. Sharon Bowman  
Doctoral Student: Counseling Psychology and Guidance Services  
Guidance Services: Ball State University  
Ball State University: Muncie, IN 47306  
Muncie, IN 47306: Telephone: (765) 285-8040  
Telephone: (859) 640-7742: Email: sbowman@bsu.edu  
Email: tgdordon@bsu.edu
Appendix J

Recruitment Letter # 3

(Recipient’s Name)
(Address)

Dear (Recipient’s Name),

Several weeks ago, we invited you to participate in a study of the assessment procedures clinicians use when working with clients with multiple presenting problems. We want to increase understanding of how therapists form diagnostic impressions and treatment recommendations when working with clients with multiple presenting problems.

Because this questionnaire has been sent to a small but representative sample of therapists it is extremely important that your response to be included for the results to be meaningful. If you have already completed the questionnaire, thank you so much for your prompt attention to the survey. If you did not receive it the first time, or your copy was misplaced, we have included a copy of the questionnaire with this letter.

The study may also be accessed at the following website address:

[WEB ADDRESS]

Your responses will remain strictly confidential. Physical data will be stored in a locked filing cabinet computer in the researcher’s office and all computer data will be kept on a secure, password-protected computer. Only group data will be used in the analysis. The questionnaire has an identification number for mailing purposes only. This is so we may check your name off the mailing list when your questionnaire is completed. Your name will never be placed on the questionnaire. You may request a summary of results by sending an email with the heading “copy of results requested” to tdgordon@bsu.edu. Please do not put this information on the questionnaire itself.

For one’s rights as a research subject, the following person may be contacted:
Coordinator of Research Compliance, Office of Academic Research and Sponsored Programs, Ball State University, Muncie, IN 47306, (765) 285-5070.

We would be very happy to answer any questions you might have. Thank you in advance for your anticipated response.

Sincerely,

Principal Investigator

Faculty Supervisor:
Appendix K

Recruitment E-mail # 1

Dear (Recipient’s Name,)

Several weeks ago, we invited you to participate in a study of the assessment procedures clinicians use when working with clients with multiple presenting problems. We want to increase understanding of how therapists form diagnostic impressions and treatment recommendations when working with clients with multiple presenting problems.

Because this questionnaire has been sent to a small but representative sample of therapists it is extremely important that your response to be included for the results to be meaningful. If you have already completed the questionnaire, thank you so much for your prompt attention to the survey.

The study may also be accessed at the following website address:

[WEB ADDRESS]

Your responses will remain strictly confidential. Physical data will be stored in a locked filing cabinet computer in the researcher’s office and all computer data will be kept on a secure, password-protected computer. Only group data will be used in the analysis. The questionnaire has an identification number for mailing purposes only. This is so we may check your name off the mailing list when your questionnaire is completed. Your name will never be placed on the questionnaire. You may request a summary of results by sending an email with the heading “copy of results requested” to tgdordon@bsu.edu. Please do not put this information on the questionnaire itself.

For one’s rights as a research subject, the following person may be contacted:, Coordinator of Research Compliance, Office of Academic Research and Sponsored Programs, Ball State University, Muncie, IN 47306, (765) 285-5070.

We would be very happy to answer any questions you might have. Thank you in advance for your anticipated response.

Sincerely,

Principal Investigator                  Faculty Supervisor:

Timothy D. Gordon, MS                  Dr. Sharon Bowman
Doctoral Student                      Counseling Psychology and
Counseling Psychology and            Guidance Services
Guidance Services                    Ball State University
Ball State University                 Muncie, IN 47306
Muncie, IN 47306                     Telephone: (765) 285-8040
Telephone: (859) 640-7742             Email: sbowman@bsu.edu
Email: tgdordon@bsu.edu
Appendix L

Informed Consent Form

The Effect of Multiple Presenting Problems on the Clinical Assessment Process

The purpose of this research study is to examine how multiple presenting problems affect clinical assessment procedures for therapists. Findings from this research may help therapists understand better how to limit clinical judgment errors with working with clients presenting with multiple presenting problems. To be eligible to participate in this study, you must be a member of Division 12 (Society of Clinical Psychology), Division 17 (Society of Counseling Psychology) or Division 29 (Psychotherapy) of the American Psychological Association and have at least a masters degree.

For this study, you will be asked to read a clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client. It will take you approximately 60 minutes to complete the questionnaires.

All data will be maintained as confidential and no identifying information such as names will appear in any publication or presentation of the data. Paper data will be stored in a locked filing cabinet in the researcher’s office for three years and will then be shredded. The data will also be entered into a software program and stored on the researcher’s password-protected computer for three years and then deleted. Only members of the research team will have access to the data.

The foreseeable risks or ill effects from participating in this study are minimal. There is a small possibility that answering some of the questions on the questionnaires may evoke some feelings of anxiety. You may choose not to answer any question that makes you uncomfortable and you may quit the study at any time. Should you experience any feelings of anxiety contact the principal investigator at the contact information listed below.

One benefit you may gain from your participation in this study is a better understanding of how multiple presenting problems influence the clinical assessment process. Two participants who successfully complete the research materials will be randomly chosen at the end of the study to receive one of two fifty dollar VISA gift cards.

Your participation in this study is completely voluntary and you are free to withdraw your permission at anytime for any reason without penalty or prejudice from the investigator. Please feel free to ask any questions of the investigator before signing this form and at any time during the study.

For one’s rights as a research subject, you may contact the following office: Research Compliance, Sponsored Programs Office, Ball State University, Muncie, IN 47306, (765) 285-5070, irb@bsu.edu.
I, _____________________________________, agree to participate in this research project entitled, “The Effect of Multiple Presenting Problems on the Clinical Assessment Process.” I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I will receive a copy of this informed consent form to keep for future reference.

To the best of my knowledge, I meet the inclusion/exclusion criteria for participation (described on the previous page) in this study.

________________________________   _________________
Participant’s Signature     Date

Researcher Contact Information

Principal Investigator
Timothy D. Gordon, MS
Doctoral Student
Counseling Psychology and Guidance Services
Ball State University
Muncie, IN 47306
Telephone: (859) 640-7742
Email: tdgordon@bsu.edu

Faculty Supervisor:
Dr. Sharon Bowman
Counseling Psychology and Guidance Services
Ball State University
Muncie, IN 47306
Telephone: (765) 285-8040
Email: sbowman@bsu.edu
Appendix M

Clinical Vignettes

Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then be asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

Sarah is a 21-year old, White undergraduate student who has come to the Counseling Center at her university at the insistence of her boyfriend for help with choosing a college major and with romantic relationship issues. At her intake session, she appeared to be in great distress regarding her choice of college major. She had recently elected to major in business at the insistence of her parents, but she would rather pursue her longtime interest in nursing. Although Sarah was considering switching her major to nursing, she was very concerned of the prospect of upsetting her parents. Sarah’s parents are from a working class background, and Sarah is the first in her family to attend college. She feels pressure to choose a career her parents approve of since her parents have struggled to put her through school. Sarah shared that she feels a lot of guilt about considering going against her parents’ wishes.

Sarah has always had difficulty making decisions in the past. She has always viewed herself as a person who is lacking self-confidence, very aware of other people’s feelings, and gentle by nature. The current situation has confirmed Sarah’s sense of who she is. Having a strong need for security in relationships, Sarah feels that her parents’ would be disappointed in her for going against their wishes. This pressure to conform to her parents’ desires has caused Sarah to feel sad and depressed from not knowing what to do. She was very tearful while talking about this dilemma. She sometimes becomes so agitated with the pressure that she cannot eat and has lost 10 pounds.

Further complicating her situation were difficulties related to the end of a two-year romantic relationship with a male graduate student, as well as her current relationship with a man she met through a friend. She admitted that she was still grieving over the loss of her ex-boyfriend, although Sarah was responsible for terminating the relationship. She reported being satisfied with her current boyfriend, but noted that her current boyfriend is having difficulty dealing with Sarah’s irritability, general loss of interest in spending time with him, and fatigue despite sleeping a lot. She is unsure how to resolve the conflict around these issues. Although Sarah stated that she is committed to working through these issues with her boyfriend, she confessed occasional desires to return to her ex-boyfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

Sarah is a 21-year old, White undergraduate student who has come to the Counseling Center at her university at the insistence of her boyfriend for help with choosing a college major and with romantic relationship issues. At her intake session, she appeared to be in great distress regarding her choice of college major. She had recently elected to major in business at the insistence of her parents, but she would rather pursue her longtime interest in engineering. Although Sarah was considering switching her major to engineering, she was very concerned of the prospect of upsetting her parents. Sarah’s parents are from a working class background, and Sarah is the first in her family to attend college. She feels pressure to choose a career her parents approve of since her parents have struggled to put her through school. Sarah shared that she feels a lot of guilt about considering going against her parents’ wishes.

Sarah has never had difficulty making decisions in the past. She has always viewed herself as a person with high self-confidence, comfortable with confrontation, and self-reliant. The current situation has shaken Sarah’s sense of who she is. Even though he does not have a strong need for security in relationships, Sarah feels that her parents’ would be disappointed in her for going against their wishes. This pressure to conform to her parents’ desires has caused Sarah to feel sad and depressed from not knowing what to do. Despite this, she was very stoic, showing little emotion while talking about this dilemma. She sometimes becomes so agitated with the pressure that she cannot eat and has lost 10 pounds.

Further complicating her situation were difficulties related to the end of a two-year romantic relationship with a male graduate student, as well as her current relationship with a man she met through a friend. She admitted that she was still grieving over the loss of her ex-boyfriend, although Sarah was responsible for terminating the relationship. She reported being satisfied with her current boyfriend, but noted that her current boyfriend is having difficulty dealing with Sarah’s irritability, general loss of interest in spending time with him, and fatigue despite sleeping a lot. She is unsure how to resolve the conflict around these issues. Although Sarah stated that she is committed to working through these issues with her boyfriend, she confessed occasional desires to return to her ex-boyfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

Sarah is a 21-year old, White undergraduate student who has come to the Counseling Center at her university at the insistence of her girlfriend for help with choosing a college major and with romantic relationship issues. At her intake session, she appeared to be in great distress regarding her choice of college major. She had recently elected to major in business at the insistence of her parents, but she would rather pursue her longtime interest in nursing. Although Sarah was considering switching her major to nursing, she was very concerned of the prospect of upsetting her parents. Sarah’s parents are from a working class background, and Sarah is the first in her family to attend college. She feels pressure to choose a career her parents approve of since her parents have struggled to put her through school. Sarah shared that she feels a lot of guilt about considering going against her parents’ wishes.

Sarah has always had difficulty making decisions in the past. She has always viewed herself as a person who is lacking self-confidence, very aware of other people’s feelings, and gentle by nature. The current situation has confirmed Sarah’s sense of who she is. Having a strong need for security in relationships, Sarah feels that her parents’ would be disappointed in her for going against their wishes. This pressure to conform to her parents’ desires has caused Sarah to feel sad and depressed from not knowing what to do. She was very tearful while talking about this dilemma. She sometimes becomes so agitated with the pressure that she cannot eat and has lost 10 pounds.

Further complicating her situation were difficulties related to the end of a two-year romantic relationship with a female graduate student, as well as her current relationship with a woman she met through a friend. She admitted that she was still grieving over the loss of her ex-girlfriend, although Sarah was responsible for terminating the relationship. She reported being satisfied with her current girlfriend, but noted that her current girlfriend is having difficulty dealing with Sarah’s irritability, general loss of interest in spending time with her, and fatigue despite sleeping a lot. She is unsure how to resolve the conflict around these issues. Although Sarah stated that she is committed to working through these issues with her girlfriend, she confessed occasional desires to return to her ex-girlfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then be asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

Sarah is a 21-year old, White undergraduate student who has come to the Counseling Center at her university at the insistence of her girlfriend for help with choosing a college major and with romantic relationship issues. At her intake session, she appeared to be in great distress regarding her choice of college major. She had recently elected to major in business at the insistence of her parents, but she would rather pursue her longtime interest in engineering. Although Sarah was considering switching her major to engineering, she was very concerned of the prospect of upsetting her parents. Sarah’s parents are from a working class background, and Sarah is the first in her family to attend college. She feels pressure to choose a career her parents approve of since her parents have struggled to put her through school. Sarah shared that she feels a lot of guilt about considering going against her parents’ wishes.

Sarah has never had difficulty making decisions in the past. She has always viewed herself as a person with high self-confidence, comfortable with confrontation, and self-reliant. The current situation has shaken Sarah’s sense of who she is. Even though he does not have a strong need for security in relationships, Sarah feels that her parents’ would be disappointed in her for going against their wishes. This pressure to conform to her parents’ desires has caused Sarah to feel sad and depressed from not knowing what to do. Despite this, she was very stoic, showing little emotion while talking about this dilemma. She sometimes becomes so agitated with the pressure that she cannot eat and has lost 10 pounds.

Further complicating her situation were difficulties related to the end of a two-year romantic relationship with a female graduate student, as well as her current relationship with a woman she met through a friend. She admitted that she was still grieving over the loss of her ex-girlfriend, although Sarah was responsible for terminating the relationship. She reported being satisfied with her current girlfriend, but noted that her current girlfriend is having difficulty dealing with Sarah’s irritability, general loss of interest in spending time with her, and fatigue despite sleeping a lot. She is unsure how to resolve the conflict around these issues. Although Sarah stated that she is committed to working through these issues with her girlfriend, she confessed occasional desires to return to her ex-girlfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

John is a 21-year old, White undergraduate student who has come to the Counseling Center at his university at the insistence of his girlfriend for help with choosing a college major and with romantic relationship issues. At his intake session, he appeared to be in great distress regarding his choice of college major. He had recently elected to major in business at the insistence of his parents, but he would rather pursue his longtime interest in nursing. Although John was considering switching his major to nursing, he was very concerned of the prospect of upsetting his parents. John’s parents are from a working class background, and John is the first in his family to attend college. He feels pressure to choose a career his parents approve of since his parents have struggled to put him through school. John shared that he feels a lot of guilt about considering going against his parents’ wishes.

John has always had difficulty making decisions in the past. He has always viewed himself as a person who is lacking self-confidence, very aware of other people’s feelings, and gentle by nature. The current situation has confirmed John’s sense of who he is. Having a strong need for security in relationships, John feels that his parents’ would be disappointed in him for going against their wishes. This pressure to conform to his parents’ desires has caused John to feel sad and depressed from not knowing what to do. He was very tearful while talking about this dilemma. He sometimes becomes so agitated with the pressure that he cannot eat and has lost 10 pounds.

Further complicating his situation were difficulties related to the end of a two-year romantic relationship with a female graduate student, as well as his current relationship with a woman he met through a friend. He admitted that he was still grieving over the loss of his ex-girlfriend, although John was responsible for terminating the relationship. He reported being satisfied with his current girlfriend, but noted that his current girlfriend is having difficulty dealing with John’s irritability, general loss of interest in spending time with her, and fatigue despite sleeping a lot. He is unsure how to resolve the conflict around these issues. Although John stated that he is committed to working through these issues with his girlfriend, he confessed occasional desires to return to his ex-girlfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then be asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

John is a 21-year-old, White undergraduate student who has come to the Counseling Center at his university at the insistence of his girlfriend for help with choosing a college major and with romantic relationship issues. At his intake session, he appeared to be in great distress regarding his choice of college major. He had recently elected to major in business at the insistence of his parents, but he would rather pursue his longtime interest in engineering. Although John was considering switching his major to engineering, he was very concerned of the prospect of upsetting his parents. John’s parents are from a working class background, and John is the first in his family to attend college. He feels pressure to choose a career his parents approve of since his parents have struggled to put him through school. John shared that he feels a lot of guilt about considering going against his parents’ wishes.

John has never had difficulty making decisions in the past. He has always viewed himself as a person with high self-confidence, comfortable with confrontation, and self-reliant. The current situation has shaken John’s sense of who he is. Even though he does not have a strong need for security in relationships, John feels that his parents’ would be disappointed in him for going against their wishes. This pressure to conform to his parents’ desires has caused John to feel sad and depressed from not knowing what to do. Despite this, he was very stoic, showing little emotion while talking about this dilemma. He sometimes becomes so agitated with the pressure that he cannot eat and has lost 10 pounds.

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Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

John is a 21-year old, White undergraduate student who has come to the Counseling Center at his university at the insistence of his boyfriend for help with choosing a college major and with romantic relationship issues. At his intake session, he appeared to be in great distress regarding his choice of college major. He had recently elected to major in business at the insistence of his parents, but he would rather pursue his longtime interest in nursing. Although John was considering switching his major to nursing, he was very concerned of the prospect of upsetting his parents. John’s parents are from a working class background, and John is the first in his family to attend college. He feels pressure to choose a career his parents approve of since his parents have struggled to put him through school. John shared that he feels a lot of guilt about considering going against his parents’ wishes.

John has always had difficulty making decisions in the past. He has always viewed himself as a person who is lacking self-confidence, very aware of other people’s feelings, and gentle by nature. The current situation has confirmed John’s sense of who he is. Having a strong need for security in relationships, John feels that his parents’ would be disappointed in him for going against their wishes. This pressure to conform to his parents’ desires has caused John to feel sad and depressed from not knowing what to do. He was very tearful while talking about this dilemma. He sometimes becomes so agitated with the pressure that he cannot eat and has lost 10 pounds.

Further complicating his situation were difficulties related to the end of a two-year romantic relationship with a male graduate student, as well as his current relationship with a man he met through a friend. He admitted that he was still grieving over the loss of his ex-boyfriend, although John was responsible for terminating the relationship. He reported being satisfied with his current boyfriend, but noted that his current boyfriend is having difficulty dealing with John’s irritability, general loss of interest in spending time with him, and fatigue despite sleeping a lot. He is unsure how to resolve the conflict around these issues. Although John stated that he is committed to working through these issues with his boyfriend, he confessed occasional desires to return to his ex-boyfriend.
Please read the following clinical vignette describing an analogue client presenting with multiple clinical concerns. You will then be asked to complete a series of questionnaires in which you will be asked to form a series of clinical impressions regarding the analogue client.

John is a 21-year old, White undergraduate student who has come to the Counseling Center at his university at the insistence of his boyfriend for help with choosing a college major and with romantic relationship issues. At his intake session, he appeared to be in great distress regarding his choice of college major. He had recently elected to major in business at the insistence of his parents, but he would rather pursue his longtime interest in engineering. Although John was considering switching his major to engineering, he was very concerned of the prospect of upsetting his parents. John’s parents are from a working class background, and John is the first in his family to attend college. He feels pressure to choose a career his parents approve of since his parents have struggled to put him through school. John shared that he feels a lot of guilt about considering going against his parents’ wishes.

John has never had difficulty making decisions in the past. He has always viewed himself as a person with high self-confidence, comfortable with confrontation, and self-reliant. The current situation has shaken John’s sense of who he is. Even though he does not have a strong need for security in relationships, John feels that his parents’ would be disappointed in him for going against their wishes. This pressure to conform to his parents’ desires has caused John to feel sad and depressed from not knowing what to do. Despite this, he was very stoic, showing little emotion while talking about this dilemma. He sometimes becomes so agitated with the pressure that he cannot eat and has lost 10 pounds.

Further complicating his situation were difficulties related to the end of a two-year romantic relationship with a male graduate student, as well as his current relationship with a man he met through a friend. He admitted that he was still grieving over the loss of his ex-boyfriend, although John was responsible for terminating the relationship. He reported being satisfied with his current boyfriend, but noted that his current boyfriend is having difficulty dealing with John’s irritability, general loss of interest in spending time with him, and fatigue despite sleeping a lot. He is unsure how to resolve the conflict around these issues. Although John stated that he is committed to working through these issues with his boyfriend, he confessed occasional desires to return to his ex-boyfriend.
Appendix N

Debriefing Letter

Thank you for participating in our study.

The main purpose of this study is to examine the potential relationship between client sexual orientation and gender-role in regard to therapists’ potentially heterosexist judgment errors. In addition, the current study is to determine to what extent therapist heterosexual identity development can predict the overall level of heterosexist judgment error displayed.

If you have any questions or comments pertaining to this study please contact the principal investigator at the contact information listed below. You may also request a summary of results by sending an email with the heading “copy of results requested” to tdgordon@bsu.edu.

Since a mild form of deception was used in the present study, you are being given the option to opt out of the present study by not returning the study material. Should you choose to opt of the present study all of your data will be permanently destroyed and all of your identifying information will be removed from the study’s master mailing list and key of three-digit codes.

Thank you again for your participation.

Sincerely,

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