

CLINICAL DECISION-MAKING AND CLIENT SEXUAL ORIENTATION

A DISSERTATION  
SUBMITTED TO THE GRADUATE SCHOOL  
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE  
DOCTOR OF PHILOSOPHY  
BY  
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BALL STATE UNIVERSITY

MUNCIE, INDIANA

DECEMBER 2023

### **Acknowledgements**

I would like to thank those who have supported me along the way to this stage in my career. First and foremost, I would like to thank my advisor and chair Dr. Mary Kite. I have truly become a better writer through your guidance and mentorship. Thank you for pushing me and for your patience when progress felt like trudging through molasses.

Secondly, I would like to thank my doctoral committee. Drs. Sharon Bowman, Holmes Finch, and Alexander Tatum, I am immensely grateful for your support and guidance over the past few years. I want to extend a special thanks to Dr. Bowman for joining my committee in the latter stages of this project, and I am incredibly grateful for you being willing to take on this task.

I would like to thank my cohort (the Squarehort) for the immeasurable support and friendship we have cultivated over the years. Thank you for your support, encouragement, empathy, commiseration, and humor. None of us imagined that we would be earning our doctorates during a global pandemic, and I also cannot imagine doing this without you all.

Thank you to my family and my friends who have patiently provided support throughout this entire process – especially my parents Robin and David. You believed in me during the times where I didn't believe in myself. Thank you for always being a safe place to land. I am very excited to go back to normal life with you all, again!

I am forever indebted to my grandfather, Dr. Donald Boswell, who led me to the field of counseling psychology. There were countless times I wished I could have talked with you about the process of my doctoral program, my research, my clinical training, and my career trajectory over the past few years. To say that you were incredibly excited for me is an understatement. I'm so thankful to have been introduced to this field as it has afforded me the opportunities to grow

as a person and as a professional. Without a doubt, the past few years have acted as a slingshot for my growth and development, and my life has been changed for the better.

Finally, I would like to thank my partner, Parker. Thank you for the emotional, mental, and physical support you have provided in the final stages of this dissertation as I've need to lock myself away to read, write, edit, analyze, and edit some more. Thank you for your words of affirmation, for keeping me company while I worked late into the evening, and for helping me take much needed breaks.

I could not have accomplished this degree without all these wonderful people in my life, and many more that were not listed by name. Thank you.

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### **Clinical Decision-Making and Client Sexual Orientation**

Clinicians need to be aware of the potential for bias and the importance of being culturally competent when working with asexual clients. This awareness includes understanding the experiences of asexual individuals, as well as their own biases about the nature of human sexuality. Asexual clients anticipate negative interactions in therapy and fear being pathologized or misunderstood by their therapists (Flanagan & Peters, 2020; Foster & Scherrer, 2014; Gupta, 2017a); however, there is a dearth of information regarding the therapists' decisions when working with asexual clients and how these decisions compare to those made for clients with other sexual orientations. Clinicians' biases have been found to bias their clinical decision-making when working with gay, lesbian, and bisexual clients (Biaggio et al., 2000; Bowers & Bieschke, 2005; Mohr et al., 2009). It is currently unknown whether this bias extends to asexual clients. This study examines this issue by considering the effects of client sexual orientation on clinical judgment. The study further explores whether counselors' anti-lesbian and anti-asexual attitudes impact their clinical judgment when working with sexual minority clients compared to heterosexual clients.

### **Cultural Terminology**

The terminology that is used to describe sexual and gender minorities continues to evolve. However, it is clear that sexual orientation and gender identity, although often combined into one larger category, are separate concepts. According to the American Psychological Association (APA, 2015), sexual orientation is the pattern of romantic and sexual attraction to other people, with specific identity labels varying based on the gender of the individual and the gender(s) of those to whom they are attracted. Gender identity refers to one's self-concept as a man, woman, a blend of both, or an alternative gender. Gender identity is distinct from sex

assigned at birth, which is based on an individual's phenotype and genotype; however, one's gender identity can align with one's sex assigned at birth, or it can differ. Individuals can hold both a sexual minority identity and a gender minority identity simultaneously. Sexuality and gender are often conflated. For example, it is a common practice to use the acronym LGBTQ+, meaning lesbian, gay, bisexual, transgender, queer/questioning, plus additional identities, without drawing distinctions among the identities represented in this umbrella term (Airton, 2009). It is more accurate to use acronyms, such as LGB or LGBT, that reflect whether their study is looking specifically at sexual minority individuals, gender minority individuals, or both. I will use the acronym that best represents the population included in a described research study.

The LGBTQ+ community is heterogeneous and comprised of a plethora of identities; it is important to note that people may hold different attitudes towards each of the identities (Norton & Herek, 2013). Because many identities are housed under one category, it may lead individuals to believe prejudice and stereotypes can be generalized from one group within the category to another group within the same category. Although people may hold a generalized prejudice towards sexual minority individuals, there is evidence to suggest that attitudes and prejudice change depending on the target's identity as a sexual orientation or gender identity minority (Worthen, 2013). Although predictors of negative attitudes toward these minority groups are similar (e.g., Herek, 2016), whether negative attitudes and prejudice toward asexuality are related to having negative attitudes and prejudice toward other sexual minority identities is currently unknown.

As I will discuss in more detail later, asexuality is generally considered a sexual orientation. The definition of the term "asexuality" or "ace," varies depending on specific groups being studied. The Asexual Visibility and Education Network (AVEN; n.d.) defines an asexual

person as one who does not experience sexual attraction. Asexuality is considered to be an intrinsic part of who people are, just like other known sexual orientations. AVEN further differentiates asexuality from celibacy, defined as a choice to abstain from sexual activity. Researchers have primarily operationalized asexuality as both a lack of sexual attraction to anyone and one's own self-identification as asexual (Catri, 2021).

Asexuality is also used as an umbrella term, meaning that multiple identities can fit within this category of sexual orientation. Thus, it is important to distinguish sexual attraction from romantic attraction. For example, someone who identifies as aromantic does not experience romantic attraction (Antonsen et al., 2020; Chasin, 2013). The separation of romantic attraction and sexual attraction means that there can be any number of identities that fall within the Ace spectrum, such as biromantic asexual (romantic attraction to same-gender and other-gender individuals, and sexual attraction to no one), and homoromantic graysexual (same-gender romantic attraction and low levels of sexual attraction). Graysexuality, which can be shortened to "grace" or "gray-ace," is the presence of sexual attraction at low levels (i.e., it is in the gray-area between sexuality and asexuality; Chasin, 2013). Demisexuality is the requirement of emotional attraction to an individual in order to develop sexual attraction (Chasin, 2013).

### **Asexuality**

Alfred Kinsey and colleagues were the first researchers who indicated that some individuals lack sexual attraction. In their landmark publication *Sexual Behavior in the Human Male* (Kinsey et al., 1948), these researchers utilized a 7-point scale measuring heterosexual-homosexual attraction. Kinsey and colleagues also included an eighth rating for individuals who did not experience sexual attraction at all: X. However, it was not until the early 2000s and into the 2010s that researchers began to give any attention to asexuality, beginning with Bogaert

(2004) who examined data from a national probability sample of British residents and identified that approximately 1% of the sample indicated they were asexual.

The prevalence of asexuality differs depending upon the definition used the literature, which varies widely. When defined as a lack of sexual attraction to others, estimates range from approximately 0.5% (Bogaert, 2013) to 1.8% of the population (Lucassen et al., 2011). Poston and Baumle (2010) reported prevalence rates from 0.6% when asexuality was defined as a combination of absence of sexual behavior and absence of desire; these rates increased to 5.5% when asexuality was defined as an absence of sexual behavior.

Researchers have debated whether asexuality can be considered as a unique sexual orientation, a lack of sexual orientation, or related to a disorder or paraphilia. The preponderance of studies support considering it as a unique sexual orientation. Scherrer (2008) provided support for the idea that asexuality was similar to other sexual orientations across a variety of factors, including navigating a “coming out” process. Brotto and Yule’s (2017) study offered moderate support that asexuality is best understood as a sexual orientation; however, this conclusion was hesitantly given due to the heterogeneity of the experience of asexuality. As noted, this heterogeneity is evidenced in the use of the term “asexuality” as an umbrella term that includes a spectrum of identities. Van Houdenhove and colleagues (2017) reviewed the qualitative literature on asexual identity development and how similar asexual identity development is to the development of other LGBTQ+ identities. Their review provided further support for considering asexuality as a unique sexual orientation. They further concluded that viewing asexuality as a sexual disorder may not be appropriate.

## **Prejudice**

Prejudice is defined as affect, or emotions, that perceivers have toward outgroups. Cottrell and Neuberg (2005) proposed a sociofunctional framework to explain prejudice toward outgroup members by which people are sensitive to potential threats to their success as individuals and as a group. The framework posits that people have evolved to be social and depend on others in their own group to promote individual and group success. These groups tend to have specific structures, values, and rules to promote group success and, when these structures, values, rules, or the safety of the group are threatened by an outgroup, individuals work to remediate these threats. These perceived threats then strengthen negative emotions associated with the outgroup. In addition, Cottrell and Neuberg found that different outgroups elicit different threats and consequent negative emotions. For example, if an ingroup is threatened by a contamination to either group health or to group values and morals, the primary emotional response was disgust, followed by secondary emotions such as fear, pity, and anger. Ingroups also respond behaviorally in ways that would prevent disease or would maintain the current value system. Thus, if an ingroup's physical safety was threatened, it would elicit a fear of the outgroup, resulting in a behavioral response to protect oneself and others.

## ***Dehumanization***

Dehumanization is a distinct concept that is related to prejudice and is a process by which targets are denied their full humanity. This process is a spectrum from blatant dehumanization to subtle dehumanization. Kteily and Landry (2022) defined blatant dehumanization as an obvious denial of a target's full humanity (e.g., calling someone an animal) and subtle humanization as a more ambiguous denial of a target's humanity (e.g., rating an individual as having fewer or reduced emotional experiences of embarrassment or nostalgia). Dehumanization can occur in

intergroup relations as well as interpersonal relations (Bastian & Haslam, 2010; Kteily & Landry, 2022).

Haslam's (2006) dual model of dehumanization is an example of subtle dehumanization which proposes that humans are perceived as having traits that are uniquely human (e.g., rationality and civility) and traits that are human nature (e.g., curiosity and warmth); therefore, humans have the cognitive capacity to differentiate themselves from other animals and can emotionally differentiate themselves from machines. From this perspective, to dehumanize an individual or group of people is to liken them to animals or objects. Perceivers who deny individuals uniquely human traits are more likely to experience feelings disgust in relation to those group members, and a denial of human nature traits leads to feelings of coldness toward those individuals (Haslam, 2006).

Dehumanization is associated with violence or justification of violence toward outgroup members (Goff et al., 2008; Kteily & Landry, 2022) and to an indifference to the exploitation or ostracization of others (Bastian & Haslam, 2010; Kteily & Landry, 2022). Experiencing dehumanization also has significant negative emotional and cognitive effects on people who are members of the shunned group (Bastian & Haslam, 2011). Individuals who are denied human uniqueness may experience feelings of guilt and shame, whereas those who are denied human nature may feel anger, sadness, numbness, and reduced clarity of thought. Bastian and Haslam (2011) further elaborated that the experiencing the of denial of human nature traits has more severe effects on the self-concept and interpersonal relationships than denial of human uniqueness traits.

### *Prejudice Against Sexual Minorities*

Because many identities are housed under one category, there may be an assumption that prejudice and stereotypes can be generalized from one group within the category to another group within the same category. Yet, although people may hold a generalized prejudice towards sexual minority individuals, there is evidence to suggest unique biases emerge for specific identities within the LGBTQ+ community and that attitudes and prejudice changes depending on those identities (Herek, 2016; Norton & Herek, 2013; Worthen, 2013). One prominent theme across sexual prejudice is the focus on gender roles and gendered expectations. According to the implicit inversion theory, gay men are stereotyped to be more similar to heterosexual women than they are to heterosexual men, and lesbian women are stereotyped to be more similar to heterosexual men than they are to heterosexual women; however, the inversion effects are more strongly associated with gay men than with lesbian women (Kite & Deaux, 1987). Geiger et al. (2006) examined college students' stereotypes about lesbians and found beliefs were clustered into various subgroups based on judgments of positivity versus negativity, and weakness versus strength. Specifically, lesbians who were categorized more positively were perceived to be more feminine and those who were categorized more negatively were perceived to be more masculine. These results suggest that implicit inversion theory primarily addresses negative stereotypes, and this may partially explain Kite and Deaux's (1987) finding that inversion theory more clearly applied to gay men than to lesbian women.

In addition to associations with gendered expectations, prejudice against gay men is also strongly associated with feelings of disgust (Cottrell & Neuberg, 2005; Kiss et al., 2018; Morrison et al., 2018). Disgust-based prejudice is also linked to inferred threat of infectious disease (Schaller & Neuberg, 2012), which can be directly linked to people's fear of Human

Immunodeficiency Virus (HIV) and the association between HIV and gay and bisexual men (Morrison et al., 2018; Rozin et al., 1994) and the association between gay men and other sexually transmitted infections (Rice et al., 2021). The link between the perceived threat of infectious disease and anti-gay bias is also found in the stereotypes about gay men and anal sex (Morrison et al., 2018; Olatunji, 2008) and these stereotypes also serve as a threat of moral contagion (Crawford et al., 2014).

Biases against some identities, such as plurisexual (e.g., bisexuality, pansexuality) and transgender and gender expansive identities, tend to be more negative than biases against individuals with gay or lesbian identities (MacInnis & Hodson, 2012; Norton & Herek, 2013). For example, bisexual individuals are subject to unique stereotypes or beliefs that they are confused, sexually promiscuous, sitting on the fence, or just looking for attention (Spalding & Peplau, 1997; Yost & Thomas, 2012). Another common stereotype about bisexual individuals is that they will cheat on their partners and cannot stay in a monogamous relationship (Eliason, 2001; Spalding & Peplau, 1997). Stereotypes about bisexual people also differ depending on their gender identity. For example, bisexual women are often overly sexualized (Yost & Thomas, 2012) whereas bisexual men are often viewed as invisible or forgotten (Zivony & Lobel, 2014). Bisexual people, regardless of gender, are all believed to be more attracted to men than to women, leading to stereotypes that bisexual men are “secretly gay” and bisexual women are “secretly straight” (Matsick & Rubin, 2018). These stereotypes may be perpetuated from within the LGBTQ community as well (Ochs, 1996; Rust, 1993), although the evidence is mixed. Results from recent studies indicate that lesbian women and gay men hold more positive attitudes towards bisexual people than heterosexual people do (Burke & LaFrance, 2016; Dodge et al., 2016); however, there is also evidence to suggest that gay men and lesbian women

perceive bisexuality as unstable (Burke & LaFrance, 2016; Matsick & Rubin, 2018) and that lesbian women hold more negative affect than gay men toward bisexual men and women (Matsick & Rubin, 2018). Additionally, these negative stereotypes lead to actual behaviors in which heterosexual people, gay men, and lesbian women will choose not to date bisexual individuals (Armstrong & Reissing, 2014; Ess et al., 2023; Feinstein et al., 2014), with particularly strong preferences against dating bisexual men (Ess et al., 2023; Gleason et al., 2018).

It is currently unknown how negative attitudes and prejudice toward asexuality are related to having negative attitudes and prejudice toward other sexual minority identities. As asexuality is under the umbrella term of “sexual minority,” it is likely that asexual people would also be the targets of generalized heterosexist prejudice and discrimination; however, because asexuality is outside of the mainstream sexual minority identities it is also likely that asexual people would be subjected to specific stereotypes and biases, like bisexual people; thus, experiencing a double discrimination.

In another parallel, Hegarty and colleagues (2021) explored the implications of the umbrella terms “hermaphrodite,” “intersex” and “disorders of sex development.” They found that people saw significant overlap in their associations between the three terms, but they also had unique associations with each umbrella term, such as ascribing nonhuman traits more frequently with the term “hermaphrodite,” and ascribing social identities more frequently with the term “intersex.” Additionally, participants who identified as more politically conservative, had high levels of right-wing authoritarian beliefs, and held greater belief in the gender binary demonstrated greater support for early medical intervention and less support for social equity for people with intersex characteristics. Taken together, their results are indicative of each umbrella

term revealing both shared and specific associations, and that these associations are linked with other predictors of general prejudice.

### ***Prejudice Against Asexual People***

There is some evidence that anti-asexual bias may be just as strong as sexual prejudice directed at other minoritized sexual identities. Specifically, there is evidence that suggests greater dehumanization of asexual people than other sexual minority groups (MacInnis & Hodson, 2012; Rothblum et al., 2020). MacInnis and Hodson (2012) used a sample of heterosexual undergraduate students to explore the extent of anti-asexual prejudice when compared with other sexual minorities and with heterosexuals. Participants rated asexual people less warmly than heterosexual people and other sexual minorities. Participants attributed fewer human nature traits and human emotions to asexual people than heterosexual people, gay men, lesbian women, and bisexual people, demonstrating the dehumanization of asexual individuals. More human nature traits and human emotions were attributed to heterosexuals than to any other group, demonstrating a heterosexism toward sexual minorities. Taken together, this research suggests that asexual individuals may face unique stereotypes, prejudice, and discrimination compared to other sexual minority individuals (MacInnis & Hodson, 2012). Underlying the dehumanization of asexual individuals is a strong belief that humans are sexual beings, and if people are not sexual, then they must be less human. Findings from Zivony and Reggev (2023) echo the results from MacInnis and Hodson (2012) in that they found asexual people were uniquely stereotyped to be cold, non-social, and immature – all traits that are associated with a denial of human nature and uniquely human traits.

Asexual individuals experience pathologization of their identity outside of the therapy room (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Friends and family members may deny or

reject an individual's attempt to "come out" to them (Gupta, 2017a; Mitchell & Hunnicutt, 2019). This rejection can take the form of people telling individuals they "haven't met the right one yet," or that they are "sexually repressed" due to a history of trauma (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Many asexual people were told to seek help from medical or mental health professionals in order to find the cause of their lack of sexual desire (Gupta, 2017a).

Similar to other sexual minorities, asexual individuals suffer from social stigma related to their sexual identity, which further highlights the importance of their receiving multiculturally sensitive counseling (Mongelli et al., 2018). There is also evidence that suggests asexual individuals experience unique discrimination that differs from the experiences of people who hold other sexual minority identities (MacInnis & Hodson, 2012; Rothblum et al., 2020; Thorpe & Arbeau, 2020). Rothblum and colleagues (2020) compared responses on several measures, including perceived stigma and discrimination, between asexual and non-asexual members of the LGBTQ+ community. They found that asexual people reported experiencing more everyday discrimination than non-asexual men, but not non-asexual women. They also found that asexual people reported more felt stigma than non-asexual men and women.

Additionally, anti-asexual bias may come from other members of the LGBTQ+ community (Mitchell & Hunnicutt, 2019). Asexual people indicated feeling invisible and erased within the LGBTQ+ community (Mitchell & Hunnicutt, 2019). As a result of the experience of erasure, asexual people voiced having numerous experiences in which their asexual and aromantic identities did not count as being LGBTQ+. This invisibility was primarily due to others' lack of knowledge about asexuality's existence, and secondarily because of the ease of faking sexuality to "pass" as allosexual (i.e., individuals who experience sexual attraction).

### *Individual Differences as Predictors of Sexual Prejudice*

There are individual differences in attitudes toward members of the LGBTQ+ community. Men are more likely than women to hold prejudice toward sexual and gender minorities (Herek, 2002; Kite et al., 2020; Norton & Herek, 2013). Specifically, cisgender men are more likely than cisgender women to have more negative attitudes toward gay people, and especially gay men (Blashill & Powlishta, 2009; Everly et al., 2016; Kite et al., 2020), bisexual people, and especially bisexual men (Herek, 2002; Mohr & Rochlen, 1999; Rubinstein et al., 2013; Yost & Thomas, 2012) and transgender individuals (Harrison & Michelson, 2019; Norton & Herek, 2013). Ratings of bisexual women tend to be similar across perceiver gender, with studies showing that men have relatively positive attitudes toward bisexual women (Eliason, 1997; Herek, 2002; Yost & Thomas, 2012) and toward lesbians (Kite et al., 2020).

Individuals who are prejudiced toward one outgroup are likely to hold prejudice against other outgroups, as well (Akrami et al., 2010; Allport, 1954; Ekehammar et al., 2004; MacInnis & Hodson, 2012; McFarland, 2010); this is referred to as generalized prejudice. McFarland (2010) found that authoritarianism and social dominance orientation were the greatest contributors to generalized prejudice. The authoritarian personality is a multi-faceted personality trait that values submission to authorities, authoritarian aggression, and conventionalism (Bizumic & Duckitt, 2018). Individuals high in authoritarian beliefs are likely to hold negative attitudes toward groups they perceive to be threatening authority figures or the current social order (Duckitt, 2006). Authoritarianism has been positively correlated with self-rated religiosity and fundamentalist religious beliefs (Duckitt et al., 2010) and is positively correlated with social dominance orientation (McFarland, 2010).

Social dominance orientation (SDO) refers to individual differences in preference for a social hierarchy (Pratto et al., 1994). Social dominance orientation was developed out of social dominance theory which explains the various aspects, including psychological factors, cultural factors, and discrimination, which combine to represent individual differences in the desire to preserve these social hierarchies (Sidanius & Pratto, 1998). Individuals who are higher in social dominance orientation are more likely to have interest in careers that enhance existing social hierarchies, such as law enforcement and politics (Pratto et al., 1994). Empathy, communality, altruism, and egalitarianism are negatively correlated with social dominance orientation, even when controlling for gender differences (Pratto et al., 1994). Men are more likely than women to prefer a social hierarchy (Pratto et al., 1994).

The Modern Homophobia Scale (MHS) is a commonly used measure of sexual prejudice (Morrison & Morrison, 2003). Measures of modern sexual prejudice are distinct from old fashioned measures of sexual prejudice which focus on moral objections to sexual minority individuals. Thus, measures of modern homophobia assess more abstract concerns related to the status quo (Morrison & Morrison, 2003). Old-fashioned measures are more susceptible to floor effects than measures of modern sexual prejudice, especially when used with undergraduate populations. Men tend to have higher levels of modern homonegativity than women (Kite et al, 2020; Morrison & Morrison, 2003; 2011). Higher levels of modern homophobia are positively correlated with a likelihood of avoiding contact with presumed sexual minority individuals (Morrison & Morrison, 2003) and discriminatory behaviors, such as not supporting a gay mayoral candidate (Morrison & Morrison, 2011).

The Attitudes Toward Asexuals scale (ATA) was created to measure anti-asexual bias, specifically (Hoffarth et al., 2016). People who are high in right-wing authoritarianism (RWA;

Altemeyer, 1996) and SDO (Pratto et al., 1994) show more negative attitudes toward asexual people, as do people who hold traditional gender-role attitudes (Hoffarth et al., 2016). Unlike other measures of sexual prejudice, scores on the ATA do not consistently differ by perceiver gender. For example, Hoffarth and colleagues (2016) found that men were more likely to hold greater anti-asexual bias than women, but Vu and colleagues (2021) did not find a gender difference. Vu and colleagues also found that heterosexual participants reported greater anti-asexual bias than non-asexual LGBTQ+ identified participants. Further, among their sample of undergraduate psychology students, greater levels of anti-asexual bias were related to decreased comfort with providing mental health care to asexual clients in the future (Vu et al., 2021).

### **Decision-Making**

People make decisions through two types of thinking: an automatic process and a deliberate process (Evans & Stanovich, 2013). The automatic process, sometimes referred to as Type 1 processing, is generally considered the “go-to,” or intuitive, process in many situations (Kahneman, 2011). Because the mind has limited resources, making decisions efficiently is important and Type 1 processing allows perceivers to do so. Taylor (1981) coined the term cognitive miser to describe this effort to be as efficient as possible without trading off too much accuracy. Type 1 processing is aided by the use of heuristics – a set of rules that people internalize for categorizing information (Gigerenzer, 2008). However, in exchange for this efficiency, accuracy may be reduced (Payne et al., 1996).

Deliberate process, sometimes referred to as Type 2 processing, is a slower, intentional process of decision making that involves actively engaging with the information (Kahneman, 2011) utilizes working memory (Evans, 2019) and supports hypothetical thinking (Evans & Stanovich, 2013). The deliberate process takes more time and more mental resources, which may

be taxing over time; however, it is likely to result in more accurate decision-making than Type 1 processing if individuals are motivated, have the relevant knowledge, and the cognitive capacity to apply Type 2 reasoning (Evans & Stanovich, 2013; Kunda & Spencer, 2003). Depending on the situation, people may be motivated to use one type of thinking over the other. In situations where accuracy is more important, individuals may utilize Type 2 processing in order to make decisions and weigh the evidence to consider what information is relevant (Kahneman, 2011; Kunda & Spender, 2003).

People make errors in judgment when they do not attend to information, or they attend to the wrong information. These errors in judgment are also referred to as cognitive biases. Cognitive biases may arise if people over-rely on heuristics, or when relevant information is not included and/or irrelevant information is included in the heuristic process (Frankish, 2010; Kahneman, 2011). For example, the availability heuristic can result in cognitive bias. The availability heuristic is a proclivity to estimate the likelihood of something based on how easily examples of it come to mind (Kahneman, 2011; Tversky & Kahneman, 1973). The availability heuristic deems the information that is most recent, frequent, or extreme as significant to make a decision – sometimes incorrectly. For example, a person who watches the 1975 thriller “Jaws” before taking their beachside vacation may experience increased worries about shark attacks, despite shark attacks being quite rare. Schwarz and colleagues (1991) demonstrated the availability heuristic on self-assessments of people’s assertiveness. They demonstrated that it was the ease in which examples came to mind that influenced people’s self-assessment by asking participants to recall examples of assertive or unassertive behaviors and then assess their own assertiveness or unassertiveness. Participants were either asked to recall a high number of behaviors (12), which was difficult, or a low number of behaviors (6), which was easy. Those

who were more easily able to produce a list of assertive behaviors assessed their own assertiveness as higher than those who had a more difficult time producing a list of assertive behaviors.

The representativeness heuristic is another example of a heuristic that can lead to cognitive bias. The representativeness heuristic refers to whether the object or subject in question is representative, or prototypical, of a group or category (Tversky & Kahneman, 1974). An example of the representativeness heuristic is when women doctors are often mistaken for nurses by their patients. This is because many people associate men with doctors and women with nurses, thus creating a representative image that they then use to inform their decision-making. Brannon and Carson (2003) demonstrated the impact of the representativeness heuristic on clinical decision-making with a sample of nurses and student nurses by asking participants to read through case descriptions and generate diagnoses for these hypothetical patients. They found that participants were less likely to diagnose patients with a physical illness when the clinical vignettes indicated extra-symptom characteristics, such as a recent job loss or the smell of alcohol on the patient's breath, as many participants believed these characteristics were more representative of a situational explanation rather than a medical explanation.

Confirmation bias can also result in cognitive bias. Confirmation bias refers to the tendency to seek and interpret information in a manner that confirms or reinforces one's existing beliefs (Nickerson, 1998). This tendency to seek confirmatory information may be motivated or unmotivated, meaning that individuals may intentionally seek information that reinforces their own intuitive beliefs, as well as when individuals process information from a predetermined perspective. Mynatt and colleagues (1977) demonstrated the effect of confirmation bias with a sample of undergraduate students who were asked to formulate a hypothesis regarding a false

research task and then choose between environments that would either allow them to make observations that might confirm their hypothesis, or that would allow them to explore alternative hypotheses. Participants overwhelmingly selected environments that would allow them to potentially confirm their hypothesis rather than to explore alternative hypotheses.

Cognitive biases may also arise from applying deliberate thinking and drawing conclusions when an underlying ideological motivation is present. Although heuristics may drive stereotypic thinking, Type 2 processing may magnify these effects if there is enough ideological motivation to maintain beliefs that align with ideological groups, such as political parties (Kahan, 2013). Evans (2019) proposed that Type 2 processing serves a dual function of rationalizing intuitive decision making and “reasoning-out” alternative decisions. Cognitive biases can arise via the automatic assumption that our intuitions are correct until proven incorrect, and our own motivation and situational factors influence how much we engage in testing our own intuition. Regarding motivation, Evans described how some individuals play chess purely based on intuition, without any integration of theory or calculating one’s own moves, or the moves of their opponent, and are quite content to play at this level, despite making numerous errors. Alternatively, players with greater motivation to improve their chess game will put in the cognitive effort; for these individuals the end goal is important.

### **Clinical Decision-Making**

Mental health clinicians need to make important decisions in their clinical work, including the provision of diagnoses, treatment planning, assessments, and interventions utilized in treatment (Spengler et al., 1995). Clinicians may maintain large caseloads and need to make quick judgments regarding their clients’ care. Clinicians who bill insurance may be required to provide diagnoses after the first session, which gives them very little time to gather information

about clients and their presenting concerns. Larger caseloads may also limit the amount of time clinicians are able to spend contemplating each individual client's case. Thus, clinicians are consistently working in conditions that increase the likelihood they will use heuristics to aid in decision-making; this can increase the risk of cognitive bias. Namely, these are conditions that are high in complexity (Tversky & Kahneman, 1974), with a high cognitive load (Croskerry, 2002), and made with limited time (Groopman, 2007).

Clinical judgment bias is defined as factors that influence the process and outcome of a clinical decision. A wide range of consequences can result from judgment bias in clinical decision-making, including incorrect diagnoses, overpathologization of an individual's presenting concerns (i.e., providing diagnoses for a problem that might otherwise be a normative event), and ruptures in the therapeutic alliance. These consequences might mean that clients are receiving incorrect treatment or may have negative financial implications (i.e., needing to pay for more sessions than required, insurance companies not covering care).

Cognitive biases likely contribute to misdiagnosis and substandard treatment decisions in medical and mental health treatment (Croskerry, 2002; Crumlish & Kelly, 2009; Mendel et al., 2011; McDermott, 1980). For example, McDermott (1980) asked school psychologists to review clinical case studies and provide potential diagnoses. Results showed that, regardless of their level of experience, raters showed little or no diagnostic agreement. McDermott proposed that the lack of diagnostic agreement was indicative of errors in decision-making; specifically, McDermott divided these errors into errors of inconsistency and errors of consistency. Errors of inconsistency were demonstrated by clinicians who inconsistently applied diagnostic standards and criteria, as well as inconsistent theoretical orientation within specific clinicians. Errors of consistency were demonstrated by clinicians' consistent use of overly general diagnoses, such as

“emotional disturbance,” or “learning disability.” Similarly, psychiatrists and medical students who provided a preliminary diagnosis for a hypothetical case and then searched for new information about the case were prone to confirmation bias in their final diagnosis. As a result, they were significantly more likely to make an incorrect diagnosis and this, in turn, impacted which treatment options they prescribed (Mendel et al., 2011).

Clinicians may work with clients who share a variety of symptoms but meet criteria for different diagnoses. The availability heuristic can bias diagnostic decision-making when clinicians assume shared symptoms among clients mean shared diagnoses (Bowes et al., 2020). The representativeness heuristic also is highly applicable to mental health counselors, as diagnostic impressions of a client can be related to how representative that client’s symptoms are of a particular diagnosis (Garb, 1996; Whaley & Geller, 2007). This can be a problem if clinicians stray too far from consulting diagnostic criteria as a guide as it could lead to misdiagnosis (Garb, 1996). Clinicians may neglect assessing for symptoms or experiences or may ignore information that does not fit the prototype of a specific diagnosis or client demographic.

### ***Clinicians’ Biases: Values, Attitudes, and Beliefs***

There is potential for judgment bias when clinicians work with individuals who belong to marginalized groups (Boysen, 2009; Garb, 1997; Hays et al., 2010) because clinicians’ own values, attitudes, and beliefs can bias their clinical judgment (Boysen, 2009; Schlossberg & Pietrofesa, 1973; Whaley & Geller, 2007). Bias can be either explicit or implicit, with explicit bias being the conscious negative beliefs, prejudice, and stereotypes an individual holds, and implicit bias being the unconscious negative beliefs, prejudice, and stereotypes that an individual holds (Greenwald & Banaji, 1995). The phenomenon of clinicians’ biases based on their own

cultural values or their client's identities has also been defined as *client variable bias* (Garb, 1997; López, 1989). These biases may inform what clinical information clinicians attend to and what decisions they make regarding the course of treatment (Schlossberg & Pietrofesa, 1973).

Garb (1997) reviewed the clinical judgment literature, with a specific focus on how client variables such as race, social class, and gender, impacted clinical judgment. Biases in rates of over- or under-diagnosing individuals based on their racial, gender, and/or social class were identified. Specifically, they found that African American and Hispanic clients were more frequently misdiagnosed with schizophrenia than White clients due to clinicians' racial biases. They also found that men were more likely to be diagnosed with antisocial personality disorder than women, and women were more likely to be diagnosed with histrionic personality disorder than men due to clinicians' gender biases. Additionally, they found that referrals for therapy were more often made for middle-class clients than lower-class clients and that clinicians' social class biases affected the types of therapy recommended for people from different socioeconomic classes. These biases against clients with marginalized social identities demonstrate the impact of clinicians' bias on their clinical decision-making and highlight the possibility that other marginalized social identities may be impacted by clinicians' bias.

López (1989) also reviewed the literature on how client-variable biases impact clinical judgment and found consistent evidence that clinicians' racial bias and gender bias impacted clinical judgment. Specifically, clients with minoritized racial identities were more likely to experience overdiagnosis and underdiagnosis than White clients, and clients who were women were more likely to have their symptoms minimized if they aligned with gender stereotypes.

Hays et al. (2010) highlighted that counselors with lower levels of awareness of their cultural

biases were less likely to indicate positive prognoses for their clients, instead engaging in overpathologization, which emphasizes the potential risk of implicit bias.

### *Clinicians' Countertransference*

The term countertransference is sometimes used to describe therapists' personal responses to clients and to session content. Specifically, countertransference is defined as therapists' thoughts and feelings that arise from reactions to clients; thoughts and feelings that arise in response to client characteristics that evoke reactions from others; and thoughts and feelings that are unique to the therapeutic relationship (Homqvist & Armelius, 1996).

Countertransference may be elicited by client diagnoses. For example, Brody and Farber (1996) explored countertransference by therapist experience level and client diagnosis and found that clients with depression typically elicited positive countertransference reactions from therapists (e.g., compassion, empathy, nurturing feelings, and the absence of anger). They also found that clients with borderline personality disorder elicited negative countertransference reactions (e.g., feelings of anger, irritation, and frustration).

Intensity of symptoms, including suicidal ideation, may also elicit countertransference (Richards, 2000). Client suicidality was found to elicit feelings of hopelessness, frustration, and anxiety in therapists, which may result in more negative appraisals of clients with suicidal ideation (Richards, 2000). There is also some evidence that therapists who have experienced trauma within their own lives demonstrate greater countertransference reactions to clients presenting with trauma as a presenting problem (Cavanagh et al., 2015). Taken together, these studies indicate that therapists' personal reactions to a client's presenting problem may be varied and may potentially impact perceptions of client functioning.

Trauma can be particularly difficult for therapists to navigate their personal reactions, as it can increase feelings of discomfort or even elicit symptoms of vicarious trauma (Gartner, 2014). Symptoms of vicarious trauma can include anxiety, grief, a sense of helplessness, cognitive impairment, and symptoms of post-traumatic stress disorder (Beckerman, 2003; Newell & MacNeil, 2010). Difficult feelings, such as anxiety, may increase therapists' dislike toward clients (Linn-Walton & Pardasani, 2014). Therapists may avoid discussion about details of trauma or transfer clients to other clinicians to cope with these feelings (Linn-Walton & Pardasanni, 2014; Smart et al., 2022). Although therapists may have great empathy for clients who experienced trauma, therapists' countertransference can also increase the likelihood for more negative personal reactions to client trauma (Gartner, 2014).

### ***Clinicians' Biases and Client Sexual Orientation***

Clinicians' bias toward clients who hold minoritized sexual or gender identities has also been demonstrated. Clinicians who believe that being heterosexual is the norm or is desirable may also believe that sexual minority clients are in greater need of therapy or have more severe pathology; they may also conclude that the client's sexual orientation is the problem (Casas et al., 1983; McCabe & Rubinson, 2008). Clinicians perpetuate microaggressions toward sexual minority clients (Shelton & Delgado-Romero, 2013; E. Spengler et al., 2016). Sexual minority clients who experienced microaggressions in a therapy session reported doubting the effectiveness of therapy and the therapeutic relationship (Shelton & Delgado-Romero, 2013). Further, it prompted clients to experience negative affect, such as anger, frustration, and helplessness. E. Spengler et al. (2016) proposed that microaggressions are clinical errors rooted in cognitive biases and heuristics.

Mohr and colleagues (2013) explored counselors' stereotypic beliefs about gay, bisexual, and heterosexual men and found that therapists often endorsed stereotypes that were unique to each sexual orientation. Specifically, therapists associated bisexual and gay men with feminine attributes more than heterosexual men. Additionally, bisexual men were associated with being more confused, daring, and open-minded than either gay or heterosexual men. Finally, therapists associated traits of being entertaining, intelligent, and insightful with gay men more than heterosexual and bisexual men. Mohr and colleagues (2013) noted in their discussion that it was unclear how these stereotypes may impact therapists' behavior in their clinical work.

Bowers and Bieschke (2005) surveyed counselors regarding their clinical judgment across client sexual orientation (Lesbian/Gay; Bisexual; Heterosexual) and gender (Cisgender man; Cisgender woman). Participants read a clinical vignette and responded to a series of questions regarding the prognosis, severity, and clinical conceptualization. Results showed that male clinicians demonstrated more negative attitudes towards LGB clients than did female clinicians. Specifically, male clinicians believed that LGB clients were more likely to threaten harm to someone than would heterosexual clients. Additionally, they found that female clinicians indicated a more positive prognosis for bisexual clients than for heterosexual clients. It is interesting to consider that female clinicians saw a more positive prognosis for bisexual clients than for heterosexual clients as anti-bisexual bias is pervasive among the general population, as well as among mental health clinicians (Ferster & Zivony, 2023).

The impact of anti-bisexual bias on clinical judgment is of particular interest when considering how anti-asexual bias might impact clinical judgment. Mohr and colleagues' (2009) examined the effect of client sexual orientation on clinicians' clinical judgment. Their participants were psychotherapists who reviewed a fictitious intake summary in which client

sexual orientation (heterosexual, gay, or bisexual) was manipulated. Participants rated the client's overall psychosocial functioning, their perceived salience of clinical issues (including the client's sexual orientation), their anticipated reactions to working with the fictitious client, and their awareness of their own values. Therapists were more likely to indicate that the client's bisexuality was related to the presenting problems than client heterosexuality or homosexuality. Regarding therapist factors, therapist gender, amount of graduate training in LGB issues, experience working with LGB clients, and licensure type did not contribute to the observed differences; however, therapists who indicated greater endorsement of the stereotypic beliefs that bisexual people are confused and conflicted were more likely to demonstrate bias in their clinical judgment. Additionally, Mohr et al.'s results supported the notion that therapists' self-estimated multicultural counseling competence is unrelated to their actual multicultural competence as their results remained significant and substantial even after controlling for self-efficacy for avoiding bias, social desirability, and tendency to pathologize clients.

Extrapolating from these results, it is hypothesized that a similar pattern might emerge for clinicians in their work with asexual clients, especially given the documented risk for pathologization of asexual identities and that stereotypes about asexual individuals differ from stereotypes about gay and bisexual people. The representativeness heuristic may enhance stereotypic thinking regarding client demographics (Bowes et al., 2020). Additionally, the representativeness heuristic may be especially important for clinicians working with asexual clients due to a lack of sexual desire being representative of several diagnoses. For example, when asexual clients present to therapy with primary concerns of depression and conflict within their romantic relationship due to sexual desire discrepancies, a clinician may perceive the client's little to no sexual desire as a symptom of depression. Confirmatory hypothesis testing

may also increase the risk of applying stereotypes in clinical decision-making (Mohr et al., 2009; Pfeiffer et al., 2000).

A common belief that clinicians may hold is that sexuality is central to humanity. Clinicians who hold this belief may have biases against individuals who are unpartnered, have little sexual desire, or engage in non-normative sexual practices. Such beliefs may lead clinicians to perceive that unpartnered clients are in greater distress than partnered clients. Additionally, clinicians may erroneously believe that there is a pathological cause for a client's low sexual desire, especially if they are unaware of asexual identities. Clinicians who hold this belief may attend to clinical information that highlights an individual's distress related to low sexual desire or they may assess for information they believe to be a cause of low sexual desire, such as the presence of sexual trauma, depressive symptoms, and current medications (e.g. selective-serotonin reuptake inhibitors [SSRIs]).

### ***Clinicians' Biases: Asexual Marginalization and Pathology***

There is a need for clinicians to be culturally competent when working with asexual clients, and to be aware of the experiences of asexual individuals, as well as their own biases about the nature of human sexuality. There is currently no literature exploring clinicians' potential biases about asexuality. Counselors can hold prejudice against other sexual minority individuals (Bowers & Bieschke, 2005; Satcher & Schumacker, 2009); therefore, it stands to reason that counselors may also hold prejudice toward asexual individuals.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.; DSM-5; American Psychiatric Association, 2013) the existing boundaries that differentiate between asexuality being a disorder or an identity are typically framed around whether the experience is personally distressing to the individual; however, sexual desire discrepancies within partnered

relationships and development of a sexual minority identity may be distressing to some, which blurs this line between asexuality as a disorder or an identity (Brotto & Yule, 2011; Gupta, 2017a; Steelman & Hertlein, 2016). Thus, partners receiving couples counseling in which one individual is asexual and the other is allosexual (i.e., someone who experiences sexual attraction to others) need to be distinguished from couples where one individual is experiencing low sexual desire because of a sexual disorder. This may be difficult; however, if both individuals experience marked distress as a result of the conflict surrounding one partner's low sexual desire. The extent to which clinicians consider an asexual identity as an alternative to a sexual disorder is currently unknown.

The preponderance of the evidence in the debate about whether asexuality is best conceptualized as a sexual disorder, such as hypoactive sexual desire disorder (HSDD) or as female sexual interest/arousal disorder (SIAD) points to distinct differences between individuals who meet the criteria for HSDD and those who meet the criteria for asexuality (Brotto et al., 2015; Prause & Graham, 2007; Van Houdenhove et al., 2014). Asexual individuals themselves, for the most part, strongly reject the idea that asexuality is an extreme case of a sexual desire disorder (Brotto et al., 2010; Mitchell & Hunnicutt, 2019). However, some asexual-identified people have reported that there was something wrong with them for their lack of sexual attraction, and some asexual-identified individuals have indicated wanting to increase their sexual desire (Mitchell & Hunnicutt, 2019).

This distress may influence clinicians to pathologize an asexual individual's experience related to their identity development. Chasin (2017) indicated that this very pathologization occurs because of the fuzzy boundaries between asexuality and lifelong and acquired sexual disorders. This boundary becomes especially blurred when considering that sexual orientation

has been demonstrated to have some variation over time (Chasin, 2017; Diamond, 2008) and clients may seek therapy prior to considering an asexual identity. Given the complicated relationship between asexuality and HSDD, an uneducated or biased clinician may inappropriately pathologize a person with an asexual identity.

Exploration of an asexual identity in therapy may be protective for individuals who experience little-to-no sexual attraction. Mitchell and Hunnicutt (2019) interviewed self-identified asexual people and found that most experienced a sense of relief when they learned about asexuality and adopted an asexual identity. Additionally, they found that several participants endorsed a reduction in internalized pathologization after adopting an asexual identity. Specifically, participants were able to challenge internalized beliefs that there was something wrong with them due to not experiencing sexual attraction.

### **Asexual Clients' Experiences with Mental Health Professionals**

Given the evidence that suggests that asexuality is a unique sexual orientation within the LGBTQ+ community, and that at least some asexual individuals are subject to experiences of discrimination related to their sexual identity, it can be assumed that asexual individuals experience minority stress. Yule and colleagues (2013) found that asexual individuals do have increased mental health concerns compared to heterosexual individuals. Additionally, asexual youth tend to internalize negative social attitudes about sexual minority identities at high rates (McInroy et al., 2020). The high rates of minority stress and mental health concerns among asexual individuals highlight the need for multicultural competence among clinicians when working with sexual minority clients.

There is some evidence to suggest that asexual individuals are wary of health and mental health professionals due to concern that they will be misunderstood, pathologized, or dismissed

(Foster & Scherrer, 2014). For example, Flanagan and Peters (2020) surveyed 136 asexual participants about their experiences with health care and mental health care professionals. They found that most of their participants were uncomfortable disclosing their sexual identity to their providers, but they were more likely to disclose their identity to mental health professionals than medical professionals. Further, Flanagan and Peters (2020) found asexual clients were more positive toward clinicians who educated themselves about asexuality than clinicians who demonstrated a lack of knowledge about asexuality or prejudiced attitudes towards asexuality. Unfortunately, between one quarter and one half of the participants indicated that their health and mental health professionals pathologized their asexuality by stating that it was due to a health condition. Another troubling finding is that some participants who disclosed their sexual identity only did so because they felt pressured by their practitioner's lack of understanding when the client stated they did not engage in sexual activity. Participants strongly endorsed the belief that therapists have an ethical imperative to learn about asexuality and to stop trying to understand what "caused" their client's asexuality.

Foster and Scherrer (2014) qualitatively explored asexual clients' experiences in clinical settings. They found that asexual clients routinely anticipate negative interactions with their health and mental health care providers. Asexual clients reported having specific worries that therapists would attempt to "fix" their asexuality or would focus on their asexuality when it was not relevant. However, clinicians who responded positively to participants' identity disclosure had a positive impact on their client's wellbeing. Participants interpreted positive responses by clinicians as evidence for their multicultural competence in working with sexual minority clients.

**Significance/Novel Contribution**

This study aims to fill a significant gap in the literature in identifying possible biases when working with asexual clients. Holding anti-asexual bias or sexual bias may bias clinicians' judgment when working with asexual or lesbian clients compared to heterosexual clients. These clinical judgment errors and biases could hinder therapy progress and create greater distress in asexual and lesbian clients. These findings may have implications for training purposes in increasing clinicians' cultural responsiveness. Further, it may have implications for current conceptualization about LGBTQ+ issues in counseling psychology by means of differentiating the unique experiences of asexual individuals and their specific counseling needs.

One potential way to measure clinical judgment bias is through comparing perceptions of client functioning. Should client functioning differ across conditions of sexual orientation, it may indicate that clinicians' biases are impacting these ratings. The Global Assessment of Functioning (GAF; Hall, 1995) is a common clinical assessment of functioning that could be easily compared across conditions.

Other ways to measure clinical judgment bias could be through participants' personal reactions to hypothetical clients. This can be measured using the Therapist Personal Reaction Questionnaire (TPRQ; Davis et al., 1977) and the Feeling Thermometer (Nelson, 2008). The Feeling Thermometer (Nelson, 2008) was chosen due to the consistent links in the literature that asexual individuals are rated more coldly than heterosexual individuals and other non-asexual LGBTQ+ individuals (MacInnis & Hodson, 2012). The TPRQ (Davis et al., 1977) assesses therapists' immediate personal reactions to working with a particular client, which could identify particular biases across conditions.

## Hypotheses

Hypothesis 1: There will be a main effect of client sexual orientation. Heterosexual clients will be rated more warmly, more favorably, and as having better functioning than lesbian clients, who will be rated more favorably, more warmly, and as having better functioning than asexual clients.

Hypothesis 2: There will be a main effect of presenting problem, with clients presenting with sexual trauma being rated less favorably, more coldly, and having worse functioning than clients presenting with depression.

Hypothesis 3: There will be no interaction effect between client sexual orientation and presenting problem.

Hypothesis 4: Anti-asexual attitudes will moderate ratings on the GAF, TPRQ, and feeling thermometer. Specifically, participants with greater anti-asexual bias will rate asexual clients less favorably, colder, and as having worse functioning than heterosexual and lesbian clients. Participants with lower levels of anti-asexual bias will not rate clients differently across client sexual orientation.

Hypothesis 5: Homonegative beliefs will moderate ratings on the GAF, TPRQ, and feeling thermometer. Participants with greater modern homophobia will rate asexual and lesbian clients less favorably, colder, and as having worse functioning than heterosexual clients. Participants with lower levels of homonegativity will not rate clients differently across client sexual orientation.

### **Method: Pilot Study**

The pilot study was designed to validate the client demographics form and the clinical vignettes. The pilot study was also used to establish a mean score of client level of functioning that could be used to compare participant ratings of client level of functioning in the main study.

### **Vignette Construction and Validation**

Mohr and colleagues (2009) created vignettes to explore the impact of client bisexuality on mental health clinicians' clinical judgment. They validated their vignettes by asking advanced clinical psychology graduate students and psychologists to rate their believability. They found that participants rated their vignettes as reasonably realistic. Mohr and colleagues' vignettes were modified so client information varied by sexual orientation (asexual, heterosexual) and presenting problem (sexual trauma, depression). Asexuality cannot be inferred by partner gender or relationship history. Therefore, sexual orientation needed to be overtly identified in this study. In addition to content validity and believability, levels of severity across presenting problem (e.g., sexual trauma and depression) were measured.

### **Participants**

After obtaining IRB approval (Protocol 1825087-1), doctoral students in counseling psychology programs were recruited by contacting program directors of counseling psychology programs, through counseling psychology listservs, and via snowball sampling. Licensed therapists and psychologists were recruited via snowball sampling. Participants were 31 clinicians, including counseling psychology doctoral students ( $n = 22$ ), and licensed therapists and psychologists ( $n = 9$ ). Participants were 24 cisgender woman, six cisgender men, and one nonbinary individual. The majority of participants identified as White (74.2%). Other racial/ethnic group representation was 9.7% Black, 6.5% Hispanic, 3.2% Asian American/Pacific

Islander, 3.2% Multiracial; 3.2% did not respond. Self-reported sexual orientation was as follows: 45.2% heterosexual, 35.5% bisexual, 3.2% asexual, 3.2% gay, 3.2% lesbian, 3.2% pansexual, 3.2% queer; 3.2% did not respond.

### **Procedure**

Participants were informed that the purpose of the study was to validate materials for a clinical judgment study. Participants provided informed consent; they then were randomly assigned to one of four conditions that varied by Client Presenting Problem (Depression, Sexual Trauma) and Client Sexual Orientation (Asexual, Heterosexual). In each condition, participants read clinical vignette describing a hypothetical client and reviewed the client's demographic information (see Appendix A and Appendix B). Participants then completed questions pertaining to the believability of the stimuli, the perceived level of client functioning, factors affecting the believability of the stimuli, and a manipulation check. Believability was measured on a 5-point rating scale (1 = *not at all believable*, 3 = *moderately believable*, and 5 = *extremely believable*). Level of severity was measured using the Global Assessment of Functioning (GAF; Hall, 1995). The GAF is a one-item measure with scores ranging from 1 (*lowest level of functioning*) to 90 (*highest level of functioning*), with intervals every 10 points. Participants recalled the client sexual orientation and gender identity as a manipulation check.

### **Results**

A mean of 4 or higher was established as a cutoff score to indicate reasonable believability. Participants rated the believability of the demographic stimuli separately from the believability of the vignette. All demographic stimuli and vignettes were rated to be reasonably believable by participants (see Table 1).

A two-way ANOVA was conducted to examine the effect of client sexual orientation and presenting problem on GAF scores. This analysis revealed that there was no main effect of client sexual orientation,  $F(1, 26) = 1.30, p = .26, \eta^2 = .05$ , there was no main effect of client presenting problem,  $F(1, 26) = 1.33, p = .26, \eta^2 = .05$ , and there was not a statistically significant interaction between the effects of client sexual orientation and presenting problem  $F(1,26) = 0.17, p = .69, \eta^2 = .00$ . The means and standard deviations for GAF scores are presented in Table 2.

### **Method: Main Study**

#### **Participants**

Participants were 140 clinicians who were licensed at either the Master's (68.1%) or Doctoral (30.5%) level of practice. Participants were between the ages of 22 and 75 ( $M = 43.82, SD = 11.72$ ) and had been practicing as a clinician anywhere from 1 year to 50 years ( $M = 12.10, SD = 9.30$ ). Participants were majority White/European American (82.3%), heterosexual (73%), and cisgender women (76.6%). Additionally, most participants primarily worked in private practice (56%). See Table 3 for full participant demographics.

Participants were recruited from profiles of clinicians in private practice listed on psychologytoday.com, emails distributed on listservs, and from 59 University Counseling Centers. Contact information was compiled from profiles from psychologytoday.com for private practice clinicians in 34 states. To ensure that the number of practitioners from more populous states (e.g., New York) were not overrepresented, caps were set at 75 participants from each state. This process yielded a potential pool of 1,277 clinicians. An additional sample was collected because some clinicians shared the recruitment emails with colleagues. The goal was to obtain a representative sample across clinicians' demographics and years of experience. An a priori

power analysis conducted using G\*Power version 3.1.9.7 (Faul et al., 2007) indicated the required sample size to achieve 95% power for detecting a medium effect, at a significance criterion of  $\alpha = .05$ , was  $N = 158$  for a multiple regression model. Due to time constraints, a sample of 158 participants could not be obtained and data collection was discontinued at 140 participants.

Participants were contacted on two occasions, with each email containing slightly different content and subject lines. Follow-up emails were sent 1-week after first contact. Out of 1,326 emails, 28 were undeliverable, and an additional 142 triggered responses noting individuals were currently out of the office, resulting in an email list of 1,156 mental health professionals.

### **Design**

The study uses a 3 (Client Sexual Orientation: Asexual cisgender woman/cisgender male partner; Lesbian cisgender woman/cisgender female partner; heterosexual cisgender woman/cisgender male partner) x 2 (Presenting Problem: Depression or Sexual Trauma) factorial design.

### **Procedure**

This research was reviewed and approved by Ball State University's Institutional Review Board (IRB; Protocol 2025876-1). Due to slow recruitment, an amendment was submitted to the IRB to provide an opportunity for compensation. Upon approval, participants were offered a chance for one of ten \$10 Tango gift cards as compensation for their time and effort in completing the study. Participants completed the online study via Qualtrics. They were told that the purpose of the study was to investigate their clinical assessment of clients with multiple presenting problems. After signing an informed consent, all participants read the same distractor

vignette about a client, her symptoms (e.g., conflicting feelings about career decisions), and her relational functioning (e.g., lack of support from her romantic partner). They also reviewed an accompanying client file demographics form. Participants then completed the Global Assessment of Functioning (GAF; Hall, 1995) followed by the Therapist Personal Reaction Questionnaire (TPRQ; Davis et al., 1977). These measures are described below. This vignette was included to orient participants to the study and to distract participants from the true nature of the study. Data from this vignette was not analyzed.

Next, participants were randomly assigned to one of the six vignette conditions described above and again completed the GAF (Hall, 1995) followed by the TPRQ (Davis et al., 1977) and the Feeling Thermometer (Nelson, 2008). Participants were not able to go back to adjust their responses. Participants then completed the Attitudes Towards Asexuals (ATA) scale (Hoffarth et al., 2016), the Modern Homonegativity Scale (MHS; Morrison & Morrison, 2003), and Marlowe-Crowne Social Desirability Scale Form XX (MC-XX; Strahan & Gerbasi, 1972). These measures were presented in a random order and the items within the scales were also randomized to control for order effects. Additionally, two items to check for attention were added (e.g., “I always pay for my groceries in gold coins.” and “I always drive my car while blindfolded.”). One attention check item appeared within both the ATA scale and the MHS. Three participants did not pass the attention check, and their data excluded from the analyses. A demographic form was then completed. Participants were thanked and debriefed and were then given a link to a separate Qualtrics survey to provide their email address for an opportunity for one of ten \$10 Tango gift cards.

### **Stimulus Materials**

The distractor vignette (Appendix B) was a one-paragraph fictional scenario summarizing a clinical intake session with a client named Celia, who is a 33-year-old Hispanic, heterosexual, cisgender woman. Celia's presenting concerns were primarily related to career and interpersonal relations as she contemplated leaving her current job to work in a more prestigious law firm further away, and without the support of her romantic partner. In addition to a vignette, participants reviewed Celia's demographic information (Appendix C).

All target vignettes were a one-paragraph fictional scenario summarizing a clinical intake session with a client named Elizabeth (see Appendix B). She was described as a 28-year-old, White cisgender woman. A demographic form was also provided (Appendix C). Target vignettes and client demographics differed across the six conditions by Presenting Problem (Depression and Sexual Trauma) and Client Sexual Orientation (Asexual, Heterosexual, and Lesbian). The vignettes described a client struggling with moderate psychological distress and interpersonal difficulties, but who did not appear to have difficulty accepting her sexual orientation. In both scenarios, the client indicated low family support and current conflict with her romantic partner due to low sexual desire. Additionally, both scenarios took place in a community counseling center.

In the depression scenario, the presenting problems also included symptoms of depression, including suicidal ideation without plan or intent, sleep difficulties, fatigue, unintentional weight loss, feelings of sadness, worthlessness, and guilt, loss of interest in activities, and difficulty concentrating. In the sexual trauma scenario, the presenting problems included symptoms of posttraumatic stress disorder including intrusive thoughts related to her assault, sleep difficulties, fatigue, avoidance of things that remind her of the assault, feelings of

sadness, worthlessness and guilt, loss of interest in activities, and difficulty concentrating. In the scenarios in which the client identified as asexual and heterosexual, her romantic partner was indicated as a cisgender man. In the scenarios in which the client identified as lesbian, her romantic partner was indicated as a cisgender woman.

## Measures

### *The Modified Global Assessment of Functioning*

The modified Global Assessment of Functioning (GAF) is a measure of a clinician's rating of the overall level of a client's psychological functioning (Appendix D). The modified GAF was developed to improve interrater reliability compared to the original GAF (Hall, 1995). The modified GAF is a one-item measure with responses ranging from 1 (*lowest level of functioning*) to 90 (*highest level of functioning*) at 10-point intervals. Hall (1995) demonstrated that the modified GAF had higher interrater reliability than the original GAF as indicated by the original GAF having higher standard error variability than the modified GAF. Intraclass correlation coefficients between patient admission and discharge ratings were 0.62 for the original GAF and 0.81 for the modified GAF (Hall, 1995). Hall demonstrated concurrent validity for the modified GAF. Specifically, the correlation between GAF scores and the Zung (1965) depression test ( $r = -.73$ ), indicated that as perceived functioning increased, perceived depression decreased. Hall also found that as clinician-rated patient functioning on the GAF increased, patients' self-rated functioning also increased ( $r = .58$ ).

In this study, five anchors were provided to participants to guide their understanding of the GAF: "In persistent danger of severely hurting self or others," "Inability to function in almost all areas," "Some serious symptoms or impairment in functioning," "Some persistent mild symptoms," and "Absent or minimal symptoms." Late in data collection it was discovered that

one of the anchors “Absent or minimal symptoms” was incorrectly labeled as “Some serious symptoms or impairment in functioning” in five of the six conditions. The Asexual client presenting with Depression was unaffected by the anchoring error. The Distractor client was also unaffected by the anchoring error. After this error was corrected 29 participants completed the survey. Participants with GAF scores above 70 ( $N=4$ ) were determined to be outliers and were excluded from analyses.

### ***Therapist Personal Reaction Questionnaire***

Clinicians’ anticipated reactions to working with the fictional client were assessed by the modified Therapist Personal Reaction Questionnaire (TPRQ; Davis et al., 1977; Appendix D). The original questionnaire was composed of two 35-item scales, with one scale assessing negative reactions toward clients and the other assessing positive reactions toward clients (Ashby et al., 1957). The modified version contains 15 items assessed on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Internal consistency estimates range from .75 (Mohr et al., 2009) to .80 (Tryon, 1989). Tryon (1989) conducted a cluster analysis on the TPRQ and found that the measure contains two factors: counselor’s feelings about the person (e.g., “I have a warmer, friendlier reaction to this client than to others I have seen.” “I disagree with this client about some basic matters.”) and counselor’s self-efficacy in working with the client (e.g., “I felt pretty ineffective with this client.” “It was hard to know how to respond to this client in a helpful way.”). Following Mohr et al. (2009), items were slightly modified to reflect that respondents are rating a fictional client (e.g., “I would like this client”).

The TPRQ (Davis et al., 1977) is scored by taking the sum of responses on each item. Nine of the items are positive (e.g., ranging from 1 to 5) and the remaining six are negative (e.g.,

ranging from -1 to -5). The range of possible scores is -21 (most negative personal reaction) to 39 (most positive personal reaction).

### *Attitudes Towards Asexuals*

Anti-asexual bias was assessed by the Attitudes Towards Asexuals Scale (ATA; Hoffarth et al., 2016; Appendix D). The ATA has 16 items (3 items reverse-coded) rated on 5-point Likert scales ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Items load onto a single factor with strong internal reliability ( $\alpha = .94$ ). Items are summed to create a total score; higher scores represent greater anti-asexual bias with the range of possible scores being 16-80. Items include “Asexuality is probably just a phase.” “Asexual people are sexually repressed.” and “There is nothing wrong with not having sexual attraction.” Demonstrating construct validity, holding greater anti-asexual attitudes was correlated with singlism (e.g., negative attitudes towards individuals who are not in romantic relationships;  $r = .58$ ; Pignotti & Abell, 2009), hostile and benevolent sexist attitudes ( $r = .35$  to  $.49$ ; Glick & Fiske, 1996), and a stronger endorsement of both traditional masculine and feminine gender roles ( $r_s = .38$  to  $.54$ ; Levant et al., 2007; Thompson & Pleck, 1986). Greater anti-asexual prejudice was associated with rating asexual people as unlikeable ( $r = -.61$ ) and this relationship remained significant when accounting for singlism ( $r = -.53$ ; Hoffarth et al., 2016),

Higher levels of anti-asexual bias are also associated with right-wing authoritarianism ( $r = .49$ ; RWA; Altemeyer, 1996) and social dominance orientation ( $r = .35$ ; SDO; Pratto et al., 1994), even when controlling for singlism ( $r_s = .35$  and  $.26$ , respectively; Hoffarth et al., 2016), indicating that individuals who hold greater anti-asexual attitudes are also likely to hold conventional beliefs, submit to authority figures, endorse traditional right-wing ideology, and prefer inequality among groups.

No known studies have directly measured the correlation between anti-asexual bias and homonegativity; however, anti-asexual bias has been found to be associated with other predictors of general sexual prejudice including greater RWA (Hoffarth et al., 2016; Thorpe & Arbeau, 2020), SDO (Hoffarth et al., 2016; Thorpe & Arbeau, 2020; Zivony & Reggev, 2023), and sexism and gender norm endorsement (Hoffarth et al., 2016). Thorpe and Arbeau (2020) provided additional support for the notion that anti-asexual bias is a distinct bias due to unique positive correlations with singlism, although it shares commonalities with general sexual prejudice including associations with greater RWA and SDO. No studies were found that utilized the ATA in a clinical setting to measure counselors' anti-asexual bias.

### ***Modern Homonegativity Scale – Lesbian Version***

Morrison and Morrison (2003) developed and validated the Modern Homonegativity Scale (MHS) which consists of two versions (gay men or lesbian). Only the 12-item (3 items reverse-coded) lesbian scale (MHS-L) was used in the present study given that clients in all of the clinical vignettes are cisgender women (Appendix D). Attitudes are assessed on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Total scores range from 12-60, with higher scores indicating greater anti-lesbian bias. Items on the MHS-L include “Lesbians should stop shoving their lifestyle down other people’s throats.” “Lesbians do not have all the rights they need.” and “Lesbians should stop complaining about the way they are treated in society and simply get on with their lives.” Morrison and Morrison (2003) reported reliability estimates of  $\alpha = .89$  for men and  $\alpha = .85$  for women for the MHS-L and that men had higher levels of anti-lesbian homonegativity than women. Morrison et al., (1999) found that responses to the full MHS correlated with responses on measures of modern sexism ( $r = .56$ ; Tougas et al., 1995), the Attitudes Toward Women scale ( $r = .32$ ; Spence et al., 1973), and old-

fashioned homonegativity ( $r = .57$ );), indicating that respondents who demonstrate higher levels of modern homonegativity are also likely to hold sexist beliefs about women. Responses on the MHS-L are uncorrelated with social desirability ( $r = .03$ ; Morrison et al., 1999).

Morrison and colleagues (2009) replicated Morrison and Morrison's (2003) findings that the MHS-L loads onto a single factor. An additional study using a community sample of Canadian participants showed that higher scores on the MHS predicted unwillingness to a) vote for a gay mayoral candidate; b) assist the candidate by making election posters; c) encourage others to vote for the gay candidate; d) become the candidate's campaign manager; e) help write or edit the candidate's speeches; f) trust the candidate to make decisions as mayor; and g) befriend the candidate (Morrison & Morrison, 2011).

### ***Feeling Thermometer***

Participants rated their feelings of warmth and coldness towards the client using a feeling thermometer (Nelson, 2008; Appendix D) ranging from 0 (*very cold*), indicating the client is not liked, to 100 (*very warm*), indicating the client is liked very much. A rating of 50 indicates neutral feelings towards the client.

The feeling thermometer can produce highly variable results due to respondents' individual differences; however, women tend to respond more warmly, as do respondents who hold more liberal ideology, respondents with less education, and respondents with a minoritized racial identity (Wilcox et al., 1989).

### ***Social Desirability Scale***

Participants' levels of social desirability were assessed using the 20-item short version of the Marlowe-Crowne (1960) Social Desirability Scale XX (MC-XX; Strahan & Gerbasi, 1972; Appendix D). The MC-XX is a dichotomous scale with *True* and *False* responses. Items are

scored as one point for “true” and zero points for “false.” The total score is found from the sum of the “true” statements. Higher total scores indicate a greater level of socially desirable responding. Ten of the items measure participants’ agreement with statements that are socially desirable, but unlikely (e.g., “I’m always willing to admit it when I make a mistake.”). The remaining ten items measure participants’ agreement with statements that are socially undesirable, but common (e.g., “I like to gossip at times.”) and are reverse scored.

Strahan and Gerbasi (1972) reported a reliability estimate of  $\alpha = .78$  for men and  $\alpha = .83$  for women for the MC-XX in a university sample. Responses to the MC-XX correlate with responses on the original Marlowe and Crown (1960) scale ( $r = .90$ ), indicating that the shortened scale adequately measures socially desirable responses. Reynolds (1982) reported a reliability estimate of  $\alpha = .79$  for the MC-XX in a university sample, indicating an acceptable level of reliability. Additionally, Reynolds (1982) demonstrated that responses on the MC-XX correlate with responses on the original Marlowe and Crown (1960) scale ( $r = .95$ ).

### ***Demographic Form***

Participants self-reported their sexual orientation, gender identity, race/ethnicity, age, highest educational level, licensure type, number of years working as a mental health clinician or psychologist, conservative/liberal ideological continuum, and theoretical orientation (Appendix D).

## **Results**

### **Preliminary Analyses**

Pearson correlations were used to determine whether the ATA (Hoffarth et al., 2015), MHS (Morrison & Morrison, 2003), MC-XX (Strahan & Gerbasi, 1972), GAF (Hall, 1995), TPRQ (Davis et al., 1977), and Feeling Thermometer (Nelson, 2008) were intercorrelated. The

results indicated a positive correlation between the ATA and MHS,  $r(138) = .58, p < .001$ , indicating that people with negative attitudes toward asexual people were also more negative toward lesbian women; a negative correlation between ATA and TPRQ,  $r(138) = -.18, p = .38$ , indicating that higher scores on the ATA (more bias) were associated with lower scores on the TPRQ (less positive reactions toward client); and a positive correlation between the Feeling Thermometer and the TPRQ,  $r(138) = .46, p < .001$ , indicating people who felt more warmly toward the hypothetical clients also felt more positively about working with that hypothetical client. None of the variables correlated with the measure of social desirability (MC-XX; Strahan & Gerbasi, 1972). Participants rated the distractor client as functioning well with some mild symptoms,  $M = 70.02, SD = 10.33$ , and rated her as favorable to work with as a hypothetical client,  $M = 21.84, SD = 5.47$ . Means and standard deviations of all variables and bivariate correlations among variables are reported in Table 4.

### **Analyses of Variance (ANOVAs)**

A 3 (Client Sexual Orientation) X 2 (Client Presenting Problem) analysis of variance (ANOVA) was performed to evaluate whether scores on the Attitudes Toward Asexuals scale differed by condition. The results indicated no significant main effect for Client Sexual Orientation,  $F(2, 136) = .75, p = .47, \eta^2 = .01$ ; no significant main effect for Client Presenting Problem,  $F(1, 136) = 3.81, p = .05, \eta^2 = .03$ ; and no significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 136) = .32, p = .72, \eta^2 = .01$ . Thus, random assignment ensured that attitudes scores were similar across conditions. See Table 5 for means and standard deviations.

Similarly, analysis of the Modern Homonegativity ratings indicated no significant main effect for Client Sexual Orientation,  $F(2, 136) = .40, p = .67, \eta^2 = .01$ ; no significant main effect

for Client Presenting Problem,  $F(1, 136) = .14, p = .71, \eta^2 = .01$ ; and no significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 136) = .06, p = .94, \eta^2 = .01$ . Thus, random assignment ensured that attitude scores were similar across conditions (see Table 5). Additionally, analysis of social desirability ratings indicated no significant main effect for Client Sexual Orientation,  $F(2, 135) = .27, p = .76, \eta^2 = .01$ ; no significant main effect for Client Presenting Problem,  $F(1, 135), p = .41, \eta^2 = .01$ ; and no significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 135) = 1.73, p = .18, \eta^2 = .03$ . Thus, social desirability ratings did not differ by condition (see Table 5).

### **Main Analyses**

It was predicted that there would be a main effect of client sexual orientation on ratings of client functioning with heterosexual clients being rated as having better functioning than lesbian clients and lesbian clients being rated as having better functioning than asexual clients. It was predicted there would be a main effect of presenting problem, with clients with sexual trauma being rated as having worse functioning than clients with depression. Additionally, it was predicted there would be no interaction effect between client sexual orientation and presenting problem. Analysis of the Global Assessment of Functioning ratings revealed no significant main effect for Client Sexual Orientation,  $F(2, 129) = 1.61, p = .20, \eta^2 = .03$ ; no significant main effect for Client Presenting Problem,  $F(1, 129) = .01, p = .95, \eta^2 = .00$ ; and no significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 129) = 1.19, p = .31, \eta^2 = .02$  (see Table 5). Therefore, Hypotheses 1 and 2 were not supported. Hypothesis 3 was supported as there was no interaction between client sexual orientation and presenting problem.

It was predicted there would be a main effect of client sexual orientation on participants' personal reactions to working with hypothetical clients, with participants rating heterosexual clients more favorably than lesbian clients and rating lesbian clients more favorably than asexual clients. It was predicted there would be a main effect of presenting problem, with clients presenting with sexual trauma being rated less favorably than clients presenting with depression. Additionally, it was predicted there would be no interaction effect between client sexual orientation and presenting problem. Results for the Therapist Personal Questionnaire ratings indicated no significant main effect for Client Sexual Orientation,  $F(2, 136) = .03, p = .97, \eta^2 = .00$ ; no significant main effect for Client Presenting Problem,  $F(1, 136) = 1.42, p = .23, \eta^2 = .01$ ; and no significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 136) = .12, p = .89, \eta^2 = .01$  (see Table 5). Thus, Hypotheses 1 and 2 were not supported. Hypothesis 3 was supported as there was no interaction between client sexual orientation and presenting problem.

Finally, it was predicted there would be a main effect of sexual orientation on ratings of feelings of warmth toward the hypothetical clients, with heterosexual clients being rated more warmly than lesbian clients and lesbian clients being rated more warmly than asexual clients. It was predicted there would be a main effect of presenting problem with clients presenting with sexual trauma being rated less warmly than clients presenting with depression. Additionally, it was predicted there would be no interaction effect between client sexual orientation and presenting problem. Results for the Feeling Thermometer indicated no significant main effect for Client Sexual Orientation,  $F(2, 106) = 2.73, p = .07, \eta^2 = .05$ ; a significant main effect for Client Presenting Problem,  $F(1, 106) = 4.23, p = .04, \eta^2 = .04$ , with participants rating clients in the Sexual Trauma condition more warmly than clients in the Depression condition; and no

significant interaction between Client Sexual Orientation and Client Presenting Problem,  $F(2, 106) = 2.37, p = .10, \eta^2 = .05$  (see Table 5). Therefore, Hypotheses 1 and 2 were not supported. Hypothesis 3 was supported as there was no interaction between client sexual orientation and presenting problem.

### **Moderation Effects of Attitudes Toward Asexuals**

It was predicted that anti-asexual attitudes would moderate ratings of client functioning, personal reactions to working with hypothetical clients, and feelings of coldness and warmth toward hypothetical clients. Specifically, it was predicted that participants with greater anti-asexual bias would rate asexual clients less favorably, colder, and as having worse functioning than heterosexual and lesbian clients. Additionally, it was predicted that participants with lower levels of anti-asexual bias would not rate clients differently across client sexual orientation.

Hayes' (2013) PROCESS Model 1 was used to assess the relationships between Client Sexual Orientation and ratings on the dependent variables and the relationships between Client Presenting problem and ratings on the dependent variables at varying levels of Anti-Asexual Bias using a simple slopes analysis with mean-centered terms. PROCESS divided participants into three groups based on the value of the moderating variable Attitudes Towards Asexuals (ATA). The three groups are determined by three different values of the moderator:  $-1 SD$ , the mean, and  $+1 SD$ . Separate analyses were conducted comparing Asexual and Heterosexual clients and Asexual and Lesbian clients with Attitudes Toward Asexuals as the moderating variable.

#### ***Asexual and Heterosexual Clients***

**Global Assessment of Functioning.** The results revealed a positive and significant moderating impact of Anti-Asexual Bias on the relationship between Client Sexual Orientation

and the GAF ( $b = 0.78, t(83) = 2.26, p = .03$ ). These results were significant for participants with high levels of anti-asexual bias,  $t(83) = 2.76, p = .01$ . For participants with low levels of anti-asexual bias (i.e., scores were one standard deviation below the mean) there was no relationship between Client Sexual Orientation and GAF ratings,  $t(83) = -.15, p = .88$ . Similarly, participants with average levels of anti-asexual bias (i.e., scores were within one standard deviation of the mean) there was no relationship between Client Sexual Orientation and GAF ratings,  $t(83) = 1.66, p = .10$ . Therefore, Hypothesis 4 was partially supported. Specifically, heterosexual clients were rated as having better functioning than asexual clients by participants with greater anti-asexual bias. Results of the simple slope analysis conducted to better understand the nature of the moderating effects. As can be seen in Figure 1, the line for high anti-asexual bias is much steeper than at mid (average) or low levels of anti-asexual bias.

**Feeling Thermometer.** The results indicated that anti-asexual bias did not moderate the relationship between Client Sexual Orientation and the Feeling Thermometer when comparing Asexual and Heterosexual client conditions,  $b = -.28, t(69) = -.38, p = .71$ . Thus, Hypothesis 4 was not fully supported.

**Therapist Personal Reaction Questionnaire.** Anti-asexual bias did not moderate the relationship between Client Sexual Orientation and TPRQ when comparing Asexual and Heterosexual client conditions,  $b = -.29, t(89) = -1.41, p = .16$ . Thus, Hypothesis 4 was not fully supported.

### *Asexual and Lesbian Clients*

When comparing Asexual and Lesbian client conditions, results showed that anti-asexual bias did not moderate the relationship between Client Sexual Orientation and ratings on the GAF,  $b = .27, t(86) = .82, p = .41$ , or the relationship between Client Sexual Orientation and the

Feeling Thermometer,  $b = .85$ ,  $t(74) = 1.62$ ,  $p = .11$ . Anti-asexual bias did not moderate the relationship between Client Sexual Orientation and ratings on the TPRQ conditions,  $b = .15$ ,  $t(89) = .76$ ,  $p = .45$ . Thus, Hypothesis 4 was not fully supported.

### ***Client Presenting Problem***

Anti-asexual bias did not moderate the relationship between Client Presenting Problem and the GAF,  $b = .12$ ,  $t(128) = .43$ ,  $p = .67$ , the Feeling Thermometer,  $b = .53$ ,  $t(106) = 1.18$ ,  $p = .24$ , or the TPRQ,  $b = .23$ ,  $t(135) = 1.44$ ,  $p = .15$ .

### **Moderation Effects of Modern Homonegativity**

It was predicted that anti-lesbian bias would moderate ratings of client functioning, personal reactions to working with hypothetical clients, and feelings of coldness and warmth toward hypothetical clients. Specifically, it was predicted that participants with greater anti-lesbian bias would rate asexual and lesbian clients less favorably, colder, and as having worse functioning than heterosexual clients. Additionally, it was predicted that participants with lower levels of anti-lesbian bias would not rate clients differently across client sexual orientation.

Hayes' (2013) PROCESS Model 1 was used to assess the relationships between Client Sexual Orientation and ratings on the dependent variables and the relationships between Client Presenting problem and ratings on the dependent variables at varying levels of Modern Homonegativity using a simple slopes analysis with mean-centered terms. PROCESS divided participants into three groups based on the value of the moderating variable Modern Homonegativity (MHS). The three groups are determined by three different values of the moderator:  $-1 SD$ , the mean, and  $+1 SD$ . Separate analyses were conducted comparing Asexual and Lesbian clients and Lesbian and Heterosexual clients with Modern Homonegativity as the moderating variable.

### *Asexual and Lesbian Clients*

Results comparing Asexual and Lesbian client conditions showed that Modern Homonegativity did not moderate the relationship between Client Sexual Orientation and GAF,  $b = .05$ ,  $t(87) = .15$ ,  $p = .88$ , or the relationship between Client Sexual Orientation and Feeling Thermometer,  $b = .50$ ,  $t(74) = 1.08$ ,  $p = .28$ . Modern Homonegativity also did not moderate the relationship between Client Sexual Orientation and TPRQ when comparing Asexual and Lesbian client conditions,  $b = -.01$ ,  $t(90) = -.07$ ,  $p = .95$ . Therefore, Hypothesis 5 was not supported.

### *Lesbian and Heterosexual Clients*

Results comparing ratings of Lesbian and Heterosexual Clients showed that Modern Homonegativity did not moderate the relationship between Client Sexual Orientation and the GAF,  $b = .39$ ,  $t(86) = .94$ ,  $p = .35$ , or between Client Sexual Orientation and the Feeling Thermometer,  $b = -.42$ ,  $t(68) = -.75$ ,  $p = .46$ . Modern Homonegativity also did not moderate the relationship between Client Sexual Orientation and TPRQ,  $b = -.43$ ,  $t(91) = -1.91$ ,  $p = .06$ . Therefore, Hypothesis 5 was not supported.

### *Client Presenting Problem*

Modern Homonegativity did not moderate the relationship between Client Presenting Problem and the GAF,  $b = .05$ ,  $t(128) = .16$ ,  $p = .87$  or the relationship between Client Presenting Problem and the Feeling Thermometer,  $b = -.27$ ,  $t(105) = -.61$ ,  $p = .54$ . Modern Homonegativity also did not moderate the relationship between Client Presenting Problem and the TPRQ,  $b = .15$ ,  $t(135) = .85$ ,  $p = .40$ .

## **Discussion**

The present study explored clinicians' clinical judgment when working with asexual clients in order to identify the potential impact of anti-asexual bias. It was predicted that ratings

of functioning, therapists' personal reactions, and warm-cold ratings would differ across client sexual orientation. Specifically, it was predicated that heterosexual clients would be rated the most warmly and as having the best functioning, and that they would elicit the most positive therapist reactions. Additionally, it was predicated that lesbian clients would be rated more coldly, as having worse functioning, and elicit less positive therapist reactions than heterosexual clients, and that asexual clients would be rated the most coldly, elicit the most negative personal reactions, and be rated as having the worst functioning of the three client sexual orientation groups. Against predictions, heterosexual, lesbian, and asexual clients were rated similarly, overall, across warm-cold ratings, therapists' personal reactions, and in perceived functioning. These findings are in contrast with previous research that has indicated therapists may perceive sexual minority clients as having more severe pathology or are in greater need of therapy (Cases et al., 1983; McCabe & Rubinson, 2008), and that clinicians may hold more negative attitudes towards LGB clients than heterosexual clients (Bowers & Bieschke, 2005); however, therapists have also demonstrated more positive attitudes toward lesbian clients than even heterosexual clients, so this may reflect shifting attitudes or shifting expectations for clients (Thompson et al., 2019).

It was predicted that ratings of functioning, therapists' personal reactions, and warm-cold ratings would differ across client presenting problem. Specifically, it was predicted that clients experiencing symptoms of depression would be rated more warmly, elicit more positive therapist reactions, and be rated as having better functioning than the clients experiencing symptoms of sexual trauma. Additionally, against predictions, the sexual trauma condition was rated more warmly than the depression condition, but both conditions were rated similarly across therapists' personal reactions and perceived functioning. These results are in contrast with previous

literature, as clients with depression have consistently elicited therapists' feelings of empathy, compassion, and warmth (Brody & Farber, 1996). Clients who have experienced sexual trauma elicit empathy, but also may elicit feelings of anxiety, sadness, anger, and hopelessness (Gartner, 2014; Pearlman & Saakvitne, 1995). It is also possible that the client experiencing depression's symptoms were perceived to be severe enough to elicit some participants' anxiety. Specifically, the client was experiencing some passive suicidal ideation, which can cause therapists to feel hopeless, frustrated, and anxious (Richards, 2000).

It was predicted that anti-asexual bias would moderate ratings of client functioning, therapists' personal reactions, and warm-cold ratings. Specifically, it was predicted that therapists with greater anti-asexual bias would rate asexual clients less favorably, colder, and as having worse functioning than heterosexual and lesbian clients. Results supported the hypothesis that counselors with greater anti-asexual bias would regard asexual clients as having worse functioning than heterosexual clients but did not demonstrate a significant difference between asexual and lesbian clients. Anti-asexual bias did not moderate warm-cold ratings or ratings of therapists' personal reactions. These mixed findings have some basis in previous literature. The finding that anti-asexual bias moderated ratings of client functioning between heterosexual and asexual clients parallels findings that clinicians with negative attitudes towards bisexual people were more likely to indicate that bisexual clients were experiencing lower levels of functioning than heterosexual clients (Mohr et al., 2001). No previous studies had explored therapists' personal reactions to asexual clients, so there is no standard in the literature for how anti-asexual bias may impact therapists' personal reactions; however, Mohr and colleagues (2001) found that therapists with negative attitudes toward bisexuality were more likely to report negative personal reactions when considering their feelings about working with a hypothetical bisexual client.

Therefore, it was reasonable to believe that negative attitudes toward asexuality would negatively impact ratings of asexual clients on the TPRQ. The finding that anti-aexual bias did not moderate warm-cold ratings does not align with prior research that asexual people are rated more coldly than heterosexuals and other sexual minority individuals (MacInnis & Hudson, 2012; Zivony & Reggev, 2023).

Finally, it was predicted that anti-lesbian bias would moderate ratings of client functioning, therapists' personal reactions, and warm-cold ratings. Specifically, it was hypothesized that participants with greater anti-lesbian bias would rate asexual and lesbian clients less favorably, colder, and having worse functioning than heterosexual clients. The data did not support the hypothesis that anti-lesbian bias moderated these ratings. The evidence for anti-lesbian bias impacting clinical judgment is mixed. A recent study provides evidence that clinicians may actually perceive lesbian clients quite positively in comparison to working with heterosexual clients in regard to client functioning and their own personal reactions (Thompson et al., 2019). Additionally, there is evidence to suggest that therapists judge bisexual clients and gay men more harshly than they judge lesbian women (Eubanks-Carter & Goldfried, 2006; Mohr et al., 2001). Lesbian clients also experience more microaggressions in counseling than heterosexual clients (Anzani et al., 2021), and microaggressions in therapy are found to be harmful to the client and to the therapeutic relationship (E. Spengler et al., 2016). Finally, even when self-reported bias is low, lesbian clients elicit avoidant behavioral responses in therapists with greater sexual prejudice (Gelso et al., 1995).

There are many possibilities for why the expected results were not found, including a lack of statistical power. The goal of 158 participants was not reached due to needing to end data collection due to time constraints. Additionally, anti-aexual bias was relatively low among

participants. The range of possible scores on ATA (Hoffarth et al., 2016) is 16 to 80; whereas the highest observed score in this dataset was a 47 with the Mean score equaling 22.04 and the Mode equaling 16. There have been no other studies conducted to date that have explored therapists' anti-asexual attitudes, so it is unknown how representative these scores are of the general population of therapists. Low levels of anti-asexual bias did not moderate ratings of clinical judgment; therefore, a majority of participants rated clients similarly across client sexual orientation and presenting problem.

It could also be that the manipulated stimuli were strong enough to elicit therapist biases. Vignette-based surveys have not consistently demonstrated ability to translate real-life therapeutic interactions (Bieschke et al., 2007; Shelton & Delgado-Romero, 2013). A critique of the use of vignettes in the clinical judgment literature is that vignettes may not be strong enough to consistently elicit therapist biases (Boysen, 2009; Hayes & Erkis, 2000). Therefore, high quality stimuli are required to improve the reliability and validity of findings (Brauer et al., 2009; Miller et al., 2015; Spengler et al., 2009). It may be the case that, despite establishing the stimuli was realistic and believable, the vignettes and accompanying demographic forms were not strong enough to elicit biases.

### **Limitations and Future Directions**

There were several limitations to this study, including errors discovered during data collection and data analysis. One such error was the accidental exclusion of manipulation check questions to verify that participants noticed the client's sexual orientation and presenting problem. Without this question, it is unknown whether all participants understood, or were attentive to, the client's sexual orientation. Specifically, the asexual client was a cisgender woman in a relationship with a cisgender man, which may have resulted in confusion among

participants if they believe that asexual individuals do not have romantic relationships.

Additionally, participants may have assumed the client was heterosexual due to her gender and her partner's gender. This error may have impacted participants' interpretation of the stimuli and therefore their responses to questions about that client, which reduces the generalizability of these results.

Another error, as addressed in the Method section, was the anchoring error on the Global Assessment of Functioning measure in five out of six conditions. This error was identified near the end of data collection; therefore, most participants were impacted by this error. It is unknown how many participants were influenced by this error in their response to this item, which reduces the generalizability of these results. Additionally, items that utilized a sliding scale format (e.g., GAF and Feeling Thermometer) were the most frequently skipped by participants. It is unclear why the sliding scales, in particular, were skipped; however, future studies may use additional measures of functioning and feelings toward the target that do not utilize sliding scales for higher rates of study completion.

Another limitation of this study is that participants were not a representative sample with a majority being White (82.3%), heterosexual (73%), cisgender women (76.6%). Most participants also rated themselves as more liberal on a conservative (0) to liberal (100) continuum,  $M = 74.36$ ,  $SD = 21.77$ , mode = 100, minimum = 0, maximum = 100. As previously discussed, cisgender men tend to demonstrate greater sexual prejudice than cisgender women, therefore a more balanced sample across gender may impact results. Additionally, conservatism is associated with greater sexual prejudice (Etengoff & Lefevor, 2021; Hoyt & Parry, 2018; Prusaczyk & Hodson, 2020); therefore, respondents from a more liberal sample may not demonstrate explicit sexual prejudice as readily.

Results are limited to our understanding of asexual cisgender women. There is evidence to suggest that asexual cisgender men may experience more discrimination or prejudice than asexual cisgender women due to gender role expectations that cisgender men are more sexual than cisgender women, and therefore it is less “natural” (Mitchell & Hunnicutt, 2019). Clients in the present study were all cisgender women due to the sexual trauma condition and cisgender men experiencing other related prejudice and victim-blaming in response to experiencing sexual trauma (Davies et al., 2006; Davies & Rogers, 2006). Future research should explore the impact of target gender on asexual bias on clinical judgment.

It is also unclear what knowledge therapists have about asexuality. Knowledge is one of the key components of multicultural competence (Bidell & Whitman, 2013) and asexual people strongly endorsed the belief that therapists have an ethical imperative to learn about asexuality (Flanagan & Peters, 2020). Future research should focus on assessing therapists’ knowledge about asexuality in addition to anti-asexual bias, as a lack of knowledge about asexuality, even in the absence of bias, may also negatively impact asexual clients. Future research should also focus on therapists’ endorsement of stereotypic beliefs about asexual people, specifically as therapist endorsement of stereotypic beliefs are more likely to demonstrate bias in their clinical judgment (Mohr et al., 2009).

Additionally, future research should explore therapists’ understanding of the difference between sexual orientation and gender identity. During data collection a few participants emailed with question about the study; one such question conflated “cisgender” with “heterosexual.” Additionally, some participant responses on the demographic question regarding their gender identity also indicate some conflation of gender and sexual orientation with responses such as “straight man.” From a researcher’s perspective, if participants do not understand the difference

between sexual orientation and gender identity it can be difficult to understand whether the study is eliciting heterosexism or cissexism from participants. From a clinician's perspective, if therapists do not understand the difference between sexual orientation and gender identity, they are more likely to engage in harmful microaggressions in therapy with their LGBTQ+ clients (E. Spengler et al., 2016).

Future research should also add questions related to therapists' conceptualization of hypothetical clients. Specifically, a question about the degree to which participants considered the client's sexual orientation when rating the client's functioning, warmth, and personal reactions would be a helpful and insightful addition. Also, exploring therapists' conceptualization of asexual clients through qualitative methods could provide rich information about how therapists are considering asexual clients' sexual orientation and symptoms.

Finally, this research is limited to hypothetical clients with limited information and limited measures of clinical judgment. Therapy in the "real world" is much more complicated, and the presenting problems of clients are also multifaceted. Future research is needed to determine what clinicians are doing in actual practice with their asexual clients.

### **Implications for Counseling**

There is evidence that asexual clients have reported pathologizing experiences in therapy (Flanagan & Peters, 2020; Foster & Scherrer, 2014). The finding that therapists with higher levels of anti-asexual bias rated asexual clients as having worse functioning than heterosexual clients suggests a possibility that therapists' personal biases may increase asexual clients' experiences of pathologization in therapy. The mechanisms regarding therapists' clinical judgment resulting in pathologizing experiences is still unclear; however, it is still important that

therapists reflect on their therapeutic approach and strive to develop their multicultural competence when working with asexual clients.

There are a number of ways clinicians can increase their multicultural competence. For example, Foster and Scherrer (2014) recommended that clinicians working with asexual clients find ways to signal to their clients that they are affirming of LGBT and asexual identities. Additionally, they suggest that clinicians analyze their own attitudes toward asexuality and improve their knowledge of the asexual community's experiences of pathologization and marginalization. Based on a qualitative study of asexually identified people, Gupta (2017b) recommended that clinicians should be educated about Hypoactive Sexual Desire Disorder (HSDD), should allow their clients to determine whether asexuality or HSDD (or neither, or both) best describe them, and should affirm the clients' asexual identities. They also recommend that clinicians examine their own biases about human sexuality and consider how these biases are affecting their work. Finally, if the asexual person and their partner are in couples counseling, it is important that any sexual desire discrepancy between partners be viewed as a relationship issue and not as a problem of the asexual partner.

Pinto (2014) laid a foundation and a model for asexual ally development and emphasized the importance of counselors utilizing the model in their unique role in aiding in the destigmatization of asexuality. Pinto's (2014) model consists of four stages: precontact, in which an individual becomes aware of asexuality, but has no contact with asexual people and holds a negative view of asexuality; contact and retreat, in which an individual has interpersonal contact with an asexual person and either leads to increased interest in asexual concerns or the individual reverts back to stage one; internal identification, in which an individual internally identifies as an ally to the asexual community but worries about making mistakes in their allyship; and external

identification, in which an individual outwardly expresses their allyship to the asexual community, they hold positive views about the asexual community, and they have significant knowledge about the asexual community. It remains unclear whether this model is being used in practice and what training opportunities there are for clinicians wanting to learn more about asexuality. Revisiting Foster and Scherrer's (2014) study, it would seem that some clinicians are affirming, but it is unknown whether this is the norm or the exception.

### **Conclusion**

To date, this is the first study to examine counselors' attitudes toward asexual clients and to explore counselors' clinical judgment regarding asexual clients. Results of this study provide implications that counselors' anti-asexual bias may negatively impact the assessment of asexual clients' functioning in the therapeutic process. It is possible that this bias is one of the mechanisms in which asexual clients are overpathologized by their counselors, thus resulting in culturally incompetent care at best, and harmful care or discrimination at worst. Due to the risk of potential harm, it is important that counselors become educated about asexuality and strive to provide affirmative counseling services to asexual individuals.

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**Table 1*****Demographic Stimuli and Vignette Believability by Condition***

	<b>Demographic Stimuli Believability</b>	<b>Vignette Believability</b>
Heterosexual Depression	$M = 4.5; SD = .76$ ( $n = 8$ )	$M = 4.38; SD = .74$ ( $n = 8$ )
Heterosexual Trauma	$M = 5.00; SD = 0.00$ ( $n = 9$ )	$M = 4.88; SD = .35$ ( $n = 8$ )
Asexual Depression	$M = 4.75; SD = .71$ ( $n = 8$ )	$M = 4.38; SD = .74$ ( $n = 8$ )
Asexual Trauma	$M = 4.71; SD = .49$ ( $n = 8$ )	$M = 4.57; SD = .79$ ( $n = 7$ )

**Table 2*****Mean Global Assessment of Functioning by Condition***

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Heterosexual Depression	$M = 51.25; SD = 10.50$ ( $n = 8$ )
Heterosexual Trauma	$M = 44.38; SD = 9.16$ ( $n = 8$ )
Asexual Depression	$M = 44.43; SD = 15.72$ ( $n = 7$ )
Asexual Trauma	$M = 41.14; SD = 12.43$ ( $n = 7$ )

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**Table 3*****Participant Demographics***

<b>Gender Identity</b>	
Cisgender woman	76.6%
Cisgender man	18.4%
Transgender, gender diverse, and nonbinary	2.1%
Prefer to self-describe	1.4%
Unknown gender identity	1.4%
<b>Sexual Orientation</b>	
Bisexual	6.4%
Gay	5.0%
Heterosexual	73.0%
Lesbian	5.7%
Pansexual	.7%
Queer	2.8%
Listed multiple identities	2.8%
Prefer to self-describe	.7%
Unknown sexual orientation	.7%
<b>Racial Identity</b>	
Arab/Middle Eastern/North African	.7%
Asian/Asian American	2.1%
Black/African American	2.8%
Hispanic/Latine	2.1%
Multiracial	7.0%
Native American/Indigenous American	.7%
White/European American	82.3%

Prefer to self-describe	1.4%
Unknown racial identity	.7%

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**Primary Work Setting**

Private Practice	56.0%
University Counseling Center	8.5%
Hospital	2.1%
Community Mental Health Center	1.4%
Not listed: Group Practice; Rehab;	2.1%
Unknown work setting	29.8%

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**Level of Licensure**

MA Licensure (e.g., LCSW, LMHC, LMFT)	68.1%
Doctoral (e.g., HSPP, LP)	30.5%
Unknown licensure level	1.4%

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*Note.*  $N = 140$

**Table 4***Descriptive Statistics and Correlations Between Measures*

<b>Variables</b>	<i>M</i>	<i>SD</i>	GAF	FT	TPRQ	ATA	MHS	MC-XX
GAF	37.43	11.37	[1]					
FT	72.56	13.77	.04	[1]				
TPRQ	19.20	6.62	.10	.46**	[1]			
ATA	22.04	7.31	-.00	-.13	-.18*	[1]		
MHS	23.61	6.32	.04	.12	-.05	.58**	[1]	
MC-XX	11.61	2.04	.04	-.12	-.01	-.12	-.14	[1]

\*\*Correlation is significant at the 0.01 level (2-tailed)

\*Correlation is significant at the 0.05 level (2-tailed)

**Table 5*****Descriptive Statistics by Condition***

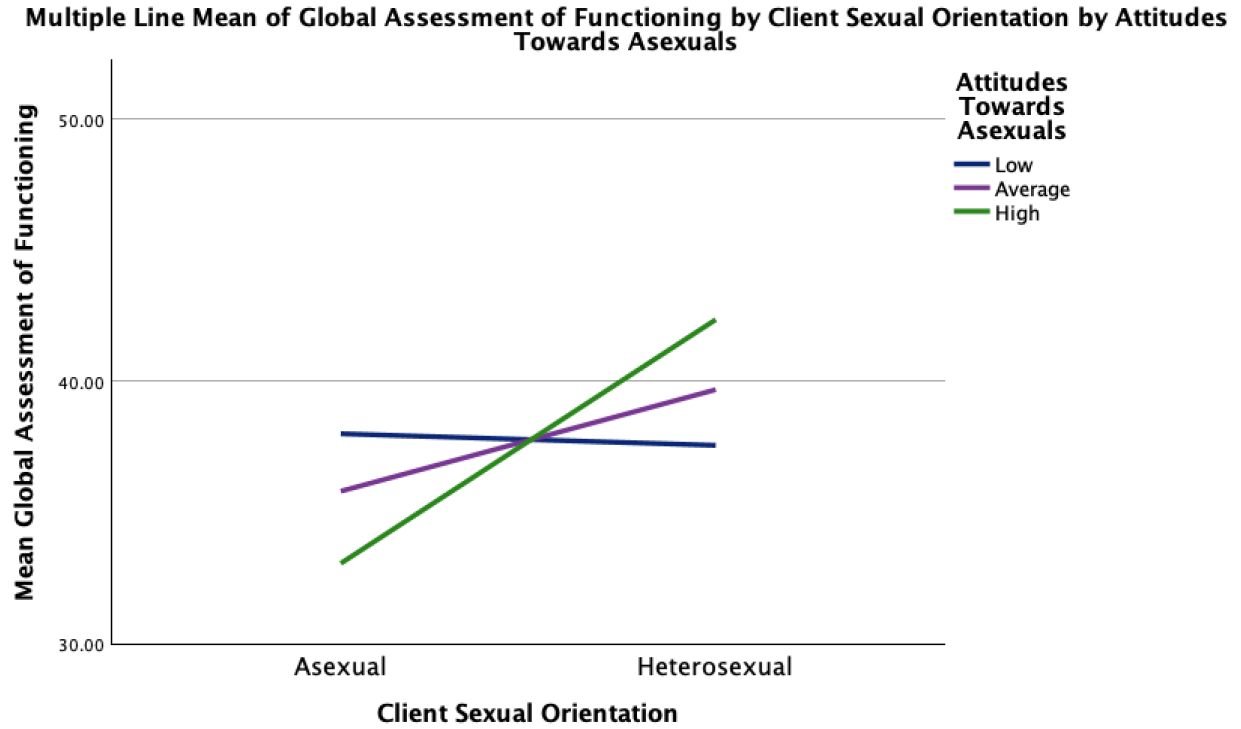
<b>Client Presenting Problem</b>	<b>Client Sexual Orientation</b>		
	Asexual	Lesbian	Heterosexual
<b>Feeling Thermometer</b>			
Depression	63.06 (14.42) <i>n</i> = 18	72.79 (13.12) <i>n</i> = 19	71.18 (20.25) <i>n</i> = 17
Sexual Trauma	74.95 (8.85) <i>n</i> = 20	71.61 (13.74) <i>n</i> = 18	79.00 (10.28) <i>n</i> = 17
<b>Therapist Personal Reaction Questionnaire</b>			
Depression	18.59 (6.37) <i>n</i> = 22	18.29 (6.57) <i>n</i> = 24	18.88 (7.76) <i>n</i> = 25
Sexual Trauma	20.00 (6.82) <i>n</i> = 23	20.45 (6.82) <i>n</i> = 22	19.74 (6.21) <i>n</i> = 23
<b>Global Assessment of Functioning</b>			
Depression	33.55 (10.99) <i>n</i> = 22	38.60 (13.48) <i>n</i> = 25	39.45 (10.34) <i>n</i> = 22
Sexual Trauma	37.62 (6.68) <i>n</i> = 21	35.10 (9.50) <i>n</i> = 20	39.48 (10.34) <i>n</i> = 22
<b>Attitudes Towards Asexuals</b>			
Depression	22.95 (7.56) <i>n</i> = 21	23.68 (8.84) <i>n</i> = 25	22.72 (7.11) <i>n</i> = 25

Sexual Trauma	19.09 (3.45) <i>n</i> = 23	22.14 (7.26) <i>n</i> = 22	21.13 (7.80) <i>n</i> = 23
<b>Modern Homonegativity – Lesbian Version</b>			
Depression	23.45 (5.17) <i>n</i> = 22	24.44 (7.03) <i>n</i> = 25	23.33 (5.43) <i>n</i> = 24
Sexual Trauma	22.57 (7.15) <i>n</i> = 23	24.00 (6.58) <i>n</i> = 22	23.57 (6.44) <i>n</i> = 23
<b>Social Desirability Scale</b>			
Depression	11.45 (2.42) <i>n</i> = 22	11.96 (2.07) <i>n</i> = 24	12.04 (2.29) <i>n</i> = 24
Sexual Trauma	12.13 (1.71) <i>n</i> = 23	11.27 (1.98) <i>n</i> = 22	11.04 (1.85) <i>n</i> = 23

*Note.* Numbers in parentheses are standard deviations.

**Figure 1**

*Multiple Line Mean of GAF by Client Sexual Orientation Moderated by ATA*



### **Appendix A: Extended Literature Review**

Clinicians need to be aware of the potential for bias and the importance of being culturally competent when working with asexual clients. This awareness includes understanding the experiences of asexual individuals, as well as their own biases about the nature of human sexuality. Asexual clients anticipate negative interactions in therapy and fear being pathologized or misunderstood by their therapists (Flanagan & Peters, 2020; Foster & Scherrer, 2014; Gupta, 2017a); however, there is a dearth of information regarding the therapists' decisions when working with asexual clients and how these decisions compare to those made for clients with other sexual orientations. Clinicians' biases have been found to bias their clinical decision-making when working with gay, lesbian, and bisexual clients (Biaggio et al., 2000; Bowers & Bieschke, 2005; Mohr et al., 2009). It is currently unknown whether this bias extends to asexual clients. There are few studies focused on asexuality in the field of mental health care; however, the existing literature indicates that asexual clients anticipate negative interactions with their therapists and fear being pathologized or misunderstood by their therapists (Flanagan & Peters, 2020; Foster & Scherrer, 2014; Gupta, 2017b). Further, limited availability of asexual-specific training may exacerbate these concerns.

Therapists are bound to ethical standards in their work with clients, and specific guidelines have been written to improve therapists' work with clients who hold marginalized identities, including sexual minority individuals (American Counseling Association [ACA], 2009; American Psychological Association [APA], 2011; Logan & Barret, 2006). Training in graduate and continuing education courses is used to improve clinicians' multicultural competence (Bidell, 2013; Rock et al., 2010; Rutter et al., 2008). However, there is evidence that clinicians are not receiving enough training to competently work with sexual minority clients

(Graham et al., 2012; Rock et al., 2010). This sparks concern regarding the quality of the actual treatment provided to sexual and gender minority individuals and especially those with understudied identities, such as asexuality. This study examines this issue by considering the effects of client sexual orientation on clinical judgment. The study further explores whether counselors' anti-lesbian and anti-asexual attitudes impact their clinical judgment when working with sexual minority clients compared to heterosexual clients.

### **Cultural Terminology**

The terminology that is used to describe sexual and gender minorities continues to evolve. However, it is clear that sexual orientation and gender identity, although often combined into one larger category, are separate concepts. According to the American Psychological Association (APA, 2015), sexual orientation is the pattern of romantic and sexual attraction to other people, with specific identity labels varying based on the gender of the individual and the gender(s) of those to whom they are attracted. Gender identity refers to one's self-concept as a man, woman, a blend of both, or an alternative gender. Gender identity is distinct from sex assigned at birth, which is based on an individual's phenotype and genotype; however, one's gender identity can align with one's sex assigned at birth, or it can differ. Individuals can hold both a sexual minority identity and a gender minority identity simultaneously. Sexuality and gender are often conflated. For example, it is a common practice to use the acronym LGBTQ+, meaning lesbian, gay, bisexual, transgender, queer/questioning, plus additional identities, without drawing distinctions among the identities represented in this umbrella term (Airton, 2009). It is more accurate to use acronyms, such as LGB or LGBT, that reflect whether their study is looking specifically at sexual minority individuals, gender minority individuals, or both. I will use the acronym that best represents the population included in a described research study.

The LGBTQ+ community is heterogeneous and comprised of a plethora of identities; it is important to note that people may hold different attitudes towards each of the identities (Norton & Herek, 2013). Because many identities are housed under one category, it may lead individuals to believe prejudice and stereotypes can be generalized from one group within the category to another group within the same category. Although people may hold a generalized prejudice towards sexual minority individuals, there is evidence to suggest that attitudes and prejudice change depending on the target's identity as a sexual orientation or gender identity minority (Worthen, 2013). Although predictors of negative attitudes toward these minority groups are similar (e.g., Herek, 2016), whether negative attitudes and prejudice toward asexuality are related to having negative attitudes and prejudice toward other sexual minority identities is currently unknown.

As I will discuss in more detail later, asexuality is generally considered a sexual orientation. The definition of the term "asexuality" or "ace," varies depending on specific groups being studied. The Asexual Visibility and Education Network (AVEN), created in 2001, provides the following definition: "An asexual person is a person who does not experience sexual attraction" (n.d.). AVEN further differentiates asexuality from celibacy, indicating that celibacy is a choice to abstain from sexual activity. Researchers have primarily operationalized asexuality as both a lack of sexual attraction to anyone and one's own self-identification as asexual (Catri, 2021). Asexuality is an intrinsic part of who people are, just like other known sexual orientations. Asexuality can also be shortened to "ace."

Asexuality is also used as an umbrella term, meaning that multiple identities can fit within this category of sexual orientation. Thus, it is important to distinguish sexual attraction from romantic attraction. For example, someone who identifies as aromantic does not experience

romantic attraction (Antonsen et al., 2020; Chasin, 2013). The separation of romantic attraction and sexual attraction means that there can be any number of identities that fall within the Ace spectrum, such as biromantic asexual (romantic attraction to same-gender and other-gender individuals, and sexual attraction to no one), and homoromantic graysexual (same-gender romantic attraction and low levels of sexual attraction). Demisexuality is the requirement of emotional attraction to an individual in order to develop sexual attraction (Chasin, 2013). Graysexuality is the presence of sexual attraction at low levels, (i.e., it is in the “gray-area” between sexuality and asexuality; Chasin, 2013). Graysexuality can also be shortened to “grace” or “gray-ace.”

### **Asexuality**

Alfred Kinsey and colleagues were the first researchers who indicated that some individuals lack sexual attraction. In their landmark publication *Sexual Behavior in the Human Male* (Kinsey et al., 1948), these researchers utilized a 7-point scale measuring heterosexual-homosexual attraction. Kinsey and colleagues also included an eighth rating for individuals who did not experience sexual attraction at all: X. However, it was not until the early 2000s and into the 2010s that researchers began to give any attention to asexuality, beginning with Bogaert (2004) who examined data from a national probability sample of British residents and identified that approximately 1% of the sample indicated they were asexual.

The prevalence of asexuality differs depending upon the definition used the literature, which varies widely. When defined as a lack of sexual attraction to others, estimates range from approximately 0.5% (Bogaert, 2013) to 1.8% of the population (Lucassen et al., 2011). Poston and Baumle (2010) reported prevalence rates from 0.6% when asexuality was defined as a

combination of absence of sexual behavior and absence of desire; these rates increased to 5.5% when asexuality was defined as an absence of sexual behavior.

Researchers have debated whether asexuality can be considered as a unique sexual orientation, a lack of sexual orientation, or related to a disorder or paraphilia. The preponderance of studies support considering it as a unique sexual orientation. Scherrer (2008) provided support for the idea that asexuality was similar to other sexual orientations across a variety of factors, including navigating a “coming out” process. Brotto and Yule’s (2017) study offered moderate support that asexuality is best understood as a sexual orientation; however, this conclusion was hesitantly given due to the heterogeneity of the experience of asexuality. As noted, this heterogeneity is evidenced in the use of the term “asexuality” as an umbrella term that includes a spectrum of identities. Van Houdenhove and colleagues (2017) reviewed the qualitative literature on asexual identity development and how similar asexual identity development is to the development of other LGBTQ+ identities. Their review provided further support for considering asexuality as a unique sexual orientation. They further concluded that viewing asexuality as a sexual disorder may not be appropriate.

There is also some empirical support that, for some individuals, asexuality is linked to trauma (Parent & Ferriter, 2018) and Autism Spectrum Disorder (Brotto et al., 2010; Brotto & Yule, 2017). There has been ongoing debate that asexuality may be best conceptualized as a sexual disorder, such as hypoactive sexual desire disorder (HSDD); however, a majority of the literature is in agreement that there are distinct differences between individuals who meet criteria for HSDD and asexuality (Brotto et al., 2015; Van Houdenhove et al., 2014). Asexual individuals, for the most part, strongly reject the idea that asexuality is an extreme case of a sexual desire disorder (Brotto et al., 2010; Mitchell & Hunnicutt, 2019). However, some asexual-

identified people have felt that there was something wrong with them for their lack of sexual attraction, and some asexual-identified individuals have indicated wanting to increase their sexual desire (Mitchell & Hunnicutt, 2019).

### ***Asexual Marginalization and Pathology***

The beginnings of asexuality literature explored what asexuality is and how it should best be viewed: as a sexual orientation, a sexual dysfunction, or a reaction to sexual trauma. The latter understanding has some empirical support with asexual identity being associated with greater likelihood of having a posttraumatic stress disorder (PTSD) diagnosis and sexual trauma within the past 12 months (Parent & Ferriter, 2018). This relationship, taken at face value, may imply that individuals may identify as asexual as a reaction to sexual trauma; however, it may also be that as asexual individuals begin to explore their sexual identity, they come to realize that their sexual experiences were unwanted or coerced, resulting in a reappraisal of previous sexual experiences as traumatic (Parent & Ferriter, 2018). Findings from Gupta (2017a) indicate that asexual women are more likely to report having “consensual but unwanted sex” with a romantic partner due to social pressures to engage in sexual activity, or pressures from partners.

There are several studies that support the notion that asexuality is a unique sexual orientation (Mitchell & Hunnicutt, 2019; Prause & Graham, 2007; Scherrer, 2008). Brotto and Yule’s (2017) study offers moderate support that asexuality is best understood as a sexual orientation; however, this conclusion is hesitantly given due to the heterogeneity of the experience of asexuality. This heterogeneity is evidenced in the use of the term “asexuality” as an “umbrella” term, or the notion that asexuality is a “spectrum” of identities. Van Houdenhove and colleagues (2017) indicate further support for considering asexuality as a unique sexual

orientation and also indicate that a sexual disorder may not be an appropriate way to view asexuality.

The confusion about what asexuality is may impact clinicians' attitudes about asexuality, and therefore their treatment of asexual individuals. There is some evidence to suggest that asexual individuals are wary of health providers and mental health professionals due to concern that they will be misunderstood, pathologized, or dismissed (Foster & Scherrer, 2014). To add to that concern, among clinicians, much of the dialogue about asexuality is its potential connection to HSDD (Gupta, 2017a). Given the relationships to HSDD and PTSD, an uneducated or biased clinician may pathologize an asexual identity. Chasin (2017) indicated that this very pathologization occurs due to the "fuzzy boundaries" between asexuality and lifelong sexual disorders. The existing boundaries that differentiate between asexuality being a disorder or an identity are typically framed around whether the experience is personally distressing to the individual.

A further complication is that the asexual identity may not be distressing to the individual, but the resulting relationship distress with a romantic partner may increase distress around the lack of sexual attraction and desire (Steelman & Hertlein, 2016; Gupta, 2017a). Partners receiving couples counseling in which one individual is asexual and the other is allosexual need to be distinguished from couples where one individual is experiencing low sexual desire as a result of a sexual disorder, but this may be difficult if both individuals experience marked distress as a result of the conflict surrounding one partner's low sexual desire. Asexual-identified individuals may also experience distress related to social stigma (Gupta, 2017a; Mitchell & Hunnicutt, 2019).

Asexual individuals experience pathologization of their identity outside of the therapy room (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Friends and family members may deny or reject an individual's attempt to "come out" to them (Gupta, 2017a; Mitchell & Hunnicutt, 2019). This rejection can take the form of people telling individuals they "haven't met the right one yet," or that they are "sexually repressed" due to a history of trauma (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Many asexual people were told to seek help from medical or mental health professionals in order to find the cause of their lack of sexual desire (Gupta, 2017a).

Similar to other sexual minorities, asexual individuals suffer from social stigma related to their sexual identity, which further highlights the importance of multiculturally sensitive counseling (Mongelli et al., 2018). There is also evidence suggesting that asexual individuals experience greater levels of discrimination than people who hold other sexual minority identities (MacInnis & Hodson, 2012; Rothblum et al., 2020). Additionally, this anti-asexual bias comes from other members of the LGBTQ+ community (Mitchell & Hunnicutt, 2019). Asexual participants indicated feeling "invisible" and "erased" within the LGBTQ+ community (Mitchell & Hunnicutt, 2019).

### **Prejudice**

Prejudice is defined as affect, or emotions, that perceivers have toward outgroups. Cottrell and Neuberg (2005) proposed a sociofunctional framework to explain prejudice toward outgroup members by which people are sensitive to potential threats to their success as individuals and as a group. The framework posits that people have evolved to be social and depend on others in their own group to promote individual and group success. These groups tend to have specific structures, values, and rules to promote group success and, when these structures, values, rules, or the safety of the group are threatened by an outgroup, individuals

work to remediate these threats. These perceived threats then strengthen negative emotions associated with the outgroup. In addition, Cottrell and Neuberg found that different outgroups elicit different threats and consequent negative emotions. For example, if an ingroup is threatened by a contamination to either group health or to group values and morals, the primary emotional response was disgust, followed by secondary emotions such as fear, pity, and anger. Ingroups also respond behaviorally in ways that would prevent disease or would maintain the current value system. Thus, if an ingroup's physical safety was threatened, it would elicit a fear of the outgroup, resulting in a behavioral response to protect oneself and others.

### ***Dehumanization***

Dehumanization is a distinct concept that is related to prejudice and is a process by which targets are denied their full humanity. This process is a spectrum from blatant dehumanization to subtle dehumanization. Kteily and Landry (2022) defined blatant dehumanization as an obvious denial of a target's full humanity (e.g., calling someone an animal) and subtle humanization as a more ambiguous denial of a target's humanity (e.g., rating an individual as having fewer or reduced emotional experiences of embarrassment or nostalgia). Dehumanization can occur in intergroup relations as well as interpersonal relations (Bastian & Haslam, 2010; Kteily & Landry, 2022).

Haslam's (2006) dual model of dehumanization is an example of subtle dehumanization which proposes that humans are perceived as having traits that are uniquely human (e.g., rationality and civility) and traits that are human nature (e.g., curiosity and warmth); therefore, humans have the cognitive capacity to differentiate themselves from other animals and can emotionally differentiate themselves from machines. From this perspective, to dehumanize an individual or group of people is to liken them to animals or objects. Perceivers who deny

individuals uniquely human traits are more likely to experience feelings disgust in relation to those group members, and a denial of human nature traits leads to feelings of coldness toward those individuals (Haslam, 2006).

Dehumanization is associated with violence or justification of violence toward outgroup members (Goff et al., 2008; Kteily & Landry, 2022) and to an indifference to the exploitation or ostracization of others (Bastian & Haslam, 2010; Kteily & Landry, 2022). Experiencing dehumanization also has significant negative emotional and cognitive effects on people who are members of the shunned group (Bastian & Haslam, 2011). Individuals who are denied human uniqueness may experience feelings of guilt and shame, whereas those who are denied human nature may feel anger, sadness, numbness, and reduced clarity of thought. Bastian and Haslam (2011) further elaborated that the experiencing the of denial of human nature traits has more severe effects on the self-concept and interpersonal relationships than denial of human uniqueness traits.

### ***Prejudice Against Sexual Minorities***

Because many identities are housed under one category, there may be an assumption that prejudice and stereotypes can be generalized from one group within the category to another group within the same category. Yet, although people may hold a generalized prejudice towards sexual minority individuals, there is evidence to suggest unique biases emerge for specific identities within the LGBTQ+ community and that attitudes and prejudice changes depending on those identities (Herek, 2016; Norton & Herek, 2013; Worthen, 2013). One prominent theme across sexual prejudice is the focus on gender roles and gendered expectations. According to the implicit inversion theory, gay men are stereotyped to be more similar to heterosexual women than they are to heterosexual men, and lesbian women are stereotyped to be more similar to

heterosexual men than they are to heterosexual women; however, the inversion effects are more strongly associated with gay men than with lesbian women (Kite & Deaux, 1987). Geiger et al. (2006) examined college students' stereotypes about lesbians and found beliefs were clustered into various subgroups based on judgments of positivity versus negativity, and weakness versus strength. Specifically, lesbians who were categorized more positively were perceived to be more feminine and those who were categorized more negatively were perceived to be more masculine. These results suggest that implicit inversion theory primarily addresses negative stereotypes, and this may partially explain Kite and Deaux's (1987) finding that inversion theory more clearly applied to gay men than to lesbian women.

In addition to associations with gendered expectations, prejudice against gay men is also strongly associated with feelings of disgust (Cottrell & Neuberg, 2005; Kiss et al., 2018; Morrison et al., 2018). Disgust-based prejudice is also linked to inferred threat of infectious disease (Schaller & Neuberg, 2012), which can be directly linked to people's fear of Human Immunodeficiency Virus (HIV) and the association between HIV and gay and bisexual men (Morrison et al., 2018; Rozin et al., 1994) and the association between gay men and other sexually transmitted infections (Rice et al., 2021). The link between the perceived threat of infectious disease and anti-gay bias is also found in the stereotypes about gay men and anal sex (Morrison et al., 2018; Olatunji, 2008) and these stereotypes also serve as a threat of moral contagion (Crawford et al., 2014).

Biases against some identities, such as plurisexual (e.g., bisexuality, pansexuality) and transgender and gender expansive identities, tend to be more negative than biases against individuals with gay or lesbian identities (MacInnis & Hodson, 2012; Norton & Herek, 2013). For example, bisexual individuals are subject to unique stereotypes or beliefs that they are

confused, sexually promiscuous, sitting on the fence,, or just looking for attention (Spalding & Peplau, 1997; Yost & Thomas, 2012). Another common stereotype about bisexual individuals is that they will cheat on their partners and cannot stay in a monogamous relationship (Eliason, 2001; Spalding & Peplau, 1997). Stereotypes about bisexual people also differ depending on their gender identity. For example, bisexual women are often overly sexualized (Yost & Thomas, 2012) whereas bisexual men are often viewed as invisible or forgotten (Zivony & Lobel, 2014). Bisexual people, regardless of gender, are all believed to be more attracted to men than to women, leading to stereotypes that bisexual men are “secretly gay” and bisexual women are “secretly straight” (Matsick & Rubin, 2018). These stereotypes may be perpetuated from within the LGBTQ community as well (Ochs, 1996; Rust, 1993), although the evidence is mixed. Results from recent studies indicate that lesbian women and gay men hold more positive attitudes towards bisexual people than heterosexual people do (Burke & LaFrance, 2016; Dodge et al., 2016); however, there is also evidence to suggest that gay men and lesbian women perceive bisexuality as unstable (Burke & LaFrance, 2016; Matsick & Rubin, 2018) and that lesbian women hold more negative affect than gay men toward bisexual men and women (Matsick & Rubin, 2018). Additionally, these negative stereotypes lead to actual behaviors in which heterosexual people, gay men, and lesbian women will choose not to date bisexual individuals (Armstrong & Reissing, 2014; Ess et al., 2023; Feinstein et al., 2014), with particularly strong preferences against dating bisexual men (Ess et al., 2023; Gleason et al., 2018).

It is currently unknown how negative attitudes and prejudice toward asexuality are related to having negative attitudes and prejudice toward other sexual minority identities. As asexuality is under the umbrella term of “sexual minority,” it is likely that asexual people would

also be the targets of generalized heterosexist prejudice and discrimination; however, because asexuality is outside of the mainstream sexual minority identities it is also likely that asexual people would be subjected to specific stereotypes and biases, like bisexual people; thus, experiencing a double discrimination.

In another parallel, Hegarty and colleagues (2021) explored the implications of the umbrella terms “hermaphrodite,” “intersex” and “disorders of sex development.” They found that people saw significant overlap in their associations between the three terms, but they also had unique associations with each umbrella term, such as ascribing nonhuman traits more frequently with the term “hermaphrodite,” and ascribing social identities more frequently with the term “intersex.” Additionally, participants who identified as more politically conservative, had high levels of right-wing authoritarian beliefs, and held greater belief in the gender binary demonstrated greater support for early medical intervention and less support for social equity for people with intersex characteristics. Taken together, their results are indicative of each umbrella term revealing both shared and specific associations, and that these associations are linked with other predictors of general prejudice.

### ***Prejudice Against Asexual People***

There is some evidence that anti-asexual bias may be just as strong as sexual prejudice directed at other minoritized sexual identities. Specifically, there is evidence that suggests greater dehumanization of asexual people than other sexual minority groups (MacInnis & Hodson, 2012; Rothblum et al., 2020). MacInnis and Hodson (2012) used a sample of heterosexual undergraduate students to explore the extent of anti-asexual prejudice when compared with other sexual minorities and with heterosexuals. Participants rated asexual people less warmly than heterosexuals and other sexual minorities. Participants attributed fewer human nature traits and

human emotions to asexual people than heterosexual people, gay men, lesbian women, and bisexual people, demonstrating the dehumanization of asexual individuals. More human nature traits and human emotions were attributed to heterosexuals than to any other group, demonstrating a heterosexism toward sexual minorities. Taken together, this research suggests that asexual individuals may face unique stereotypes, prejudice, and discrimination compared to other sexual minority individuals (MacInnis & Hodson, 2012). Underlying the dehumanization of asexual individuals is a strong belief that humans are sexual beings, and if people are not sexual, then they must be less human. Findings from Zivony and Reggev (2023) echo the results from MacInnis and Hodson (2012) in that they found asexual people were uniquely stereotyped to be cold, non-social, and immature – all traits that are associated with a denial of human nature and uniquely human traits.

Asexual individuals experience pathologization of their identity outside of the therapy room (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Friends and family members may deny or reject an individual's attempt to "come out" to them (Gupta, 2017a; Mitchell & Hunnicutt, 2019). This rejection can take the form of people telling individuals they "haven't met the right one yet," or that they are "sexually repressed" due to a history of trauma (Gupta, 2017a; Mitchell & Hunnicutt, 2019). Many asexual people were told to seek help from medical or mental health professionals in order to find the cause of their lack of sexual desire (Gupta, 2017a).

Similar to other sexual minorities, asexual individuals suffer from social stigma related to their sexual identity, which further highlights the importance of their receiving multiculturally sensitive counseling (Mongelli et al., 2018). There is also evidence that suggests asexual individuals experience unique discrimination that differs from the experiences of people who hold other sexual minority identities (MacInnis & Hodson, 2012; Rothblum et al., 2020; Thorpe

& Arbeau, 2020). Rothblum and colleagues (2020) compared responses on several measures, including perceived stigma and discrimination, between asexual and non-asexual members of the LGBTQ+ community. They found that asexual people reported experiencing more everyday discrimination than non-asexual men, but not non-asexual women. They also found that asexual people reported more felt stigma than non-asexual men and women.

Additionally, anti-asexual bias may come from other members of the LGBTQ+ community (Mitchell & Hunnicutt, 2019). Asexual people indicated feeling invisible and erased within the LGBTQ+ community (Mitchell & Hunnicutt, 2019). As a result of the experience of erasure, asexual people voiced having numerous experiences in which their asexual and aromantic identities did not count as being LGBTQ+. This invisibility was primarily due to others' lack of knowledge about asexuality's existence, and secondarily because of the ease of faking sexuality to "pass" as allosexual (i.e., individuals who experience sexual attraction).

Hoffarth and colleagues (2015) published the first measure of anti-asexual bias. The Attitudes Towards Asexuals (ATA) scale has 16 items that are rated on 9-point scales. These items load onto a single factor with strong internal reliability ( $\alpha = .94$ , mean inter-item correlation = .50). Higher scores represent greater anti-asexual bias. ATA scores correlate with singlism, benevolent and hostile sexism, and endorsement of traditional gender norms. It is not surprising, then, that higher levels of anti-asexual bias are also associated with right-wing authoritarianism (RWA; Altemeyer, 1996), social dominance orientation (SDO; Pratto et al., 1994), and dehumanization of asexual individuals. Underlying the dehumanization of asexual individuals is the belief that humans are sexual beings, and if people are not sexual, then they must be less "human," somehow. In fact, anti-asexual bias may be just as strong, if not stronger, than general anti-sexual minority prejudice, especially when considering dehumanization

(MacInnis & Hodson, 2012; Rothblum et al., 2020). The ATA has not been utilized in a clinical setting to measure counselors' anti-asexual bias.

Aligning with contact theory, individuals who have positive interactions with asexual individuals are more likely to have positive attitudes towards asexuality (Hoffarth et al., 2015). This aligns with Cullen and colleague's (2002) findings that prior positive contact with an LGB individual is linked to lower levels of homophobia. However, mere contact or exposure may not be enough to improve attitudes toward asexuality. The most beneficial kind of contact is cross-group intimate relationships, such as friendships (Pettigrew et al., 2011). Therapists who have never met an asexual person or do not have a close, personal relationship with at least one asexual person may have higher levels of anti-asexual bias.

### **Minority Stress Model**

The minority stress model is a framework that explains disparities in mental health outcomes in sexual minority populations compared to heterosexual populations (Brooks, 1981; Meyer, 1995). The minority stress model has also been applied to understanding the experiences of racial and ethnic minorities and can the experiences of individuals with intersecting oppressed identities (e.g. sexual minority individuals with marginalized racial identities; Balsam et al., 2011). Minority stress occurs internally and externally (Meyer, 2003). For example, sexual minorities may experience stressful external events and conditions, expect that these stressful events may happen to them or could continue to happen to them. They also may experience vigilance as a result of this expectation, internalize negative social attitudes expressed by others, and conceal their sexual identities (Meyer, 2003). In accordance with these stressors, there is an increased incidence of sexual minority individuals seeking mental health treatment compared to

heterosexual individuals (Cochran et al., 2003; Eubanks-Carter et al., 2005; Graham et al., 2012; Safran, 2005).

Given the evidence that suggests that asexuality is a unique sexual orientation within the LGBTQ+ community, and that asexual individuals are subject to experiences of discrimination related to their sexual identity, it can be assumed that asexual individuals experience minority stress. It can also be assumed that asexual individuals seek mental health treatment at greater rates than heterosexual individuals due to this stress. Yule and colleagues (2013) found that asexual individuals do have increased mental health concerns compared to heterosexual individuals. Additionally, asexual youth tend to internalize negative social attitudes about sexual minority identities at high rates (McInroy et al., 2020).

### **Multicultural Competence with Sexual Minority Clients**

Providing culturally sensitive counseling is a cornerstone of good counseling practice. A number of guidelines have been established by counseling and psychological organizations to inform the treatment of sexual minority clients (APA, 2011; Harper et al., 2013; Logan & Barret, 2006). Historically, same-sex attraction has been classified as a psychological disorder and, although the field has moved away from this formal perspective of pathologization and toward affirmative counseling practice with sexual minority clients, counselors' attitudes toward sexual minority individuals can have profound effects on their clients (Grzanka & Miles, 2016; Israel et al., 2008).

The previously mentioned guidelines do not offer any specific recommendations for working with asexual-identified clients, despite evidence that asexual-identified individuals have unique experiences compared to other sexual minorities (Gupta, 2017a; Hille et al., 2020; MacNeela & Murphy, 2015). Without guidelines that specifically mention asexuality, clinicians

run the risk of pathologizing or microaggressing asexual clients due to lack of knowledge or awareness about asexual issues. There is argument, as well, that the existing guidelines can be applied to asexual individuals, but first clinicians need to be educated about asexuality (Pinto, 2014). Additionally, there is concern that existing guidelines lack specificity and also conflate the experiences of gay and lesbian individuals with the experiences of other sexual and gender minorities (Matthews, 2005).

Sexual minority clients are more likely to terminate therapy early or experience a negative impact as a result of treatment by an unhelpful or uneducated therapist (Liddle, 1996). Therapists' microaggressions toward sexual minority clients can weaken the therapeutic alliance, decrease the effectiveness of treatment, and increase feelings of shame, anger, and feeling misunderstood by others. For example, Spengler et al. (2016) highlight the importance of counselor awareness of, and attending to, microaggressions toward sexual minority clients and emphasize that microaggressions should be understood as clinical errors due to the impact on treatment and the client. They further emphasize the importance of counselor training to increase multicultural competence in working with sexual minority clients.

There is evidence to suggest that sexual minority individuals prefer clinicians who do not hold heteronormative attitudes and assumptions (Burckell & Goldfriend, 2006). Additionally, Burckell and Goldfried (2006) highlighted the importance of clinicians displaying LGB-affirming behaviors, having specific knowledge about the LGBT community, as well as facilitating a collaborative alliance in their work with sexual minority clients. Positively, more than two thirds of lesbian and gay participants in one study had a positive therapeutic alliance with their therapist (Kelley, 2015). However, from this same sample of lesbian and gay clients, 25% indicated their therapists lacked knowledge about LGB issues and 21% indicated their

therapists were dismissive of their sexual orientation or viewed their sexual orientation as a problem (Kelley, 2015).

Clinicians' multicultural competence is frequently measured using the Sexual Orientation Counselor Competency scale (SOCCS; Bidell, 2005). The SOCCS is a self-report measure utilizing three subscales: attitudes, knowledge, and skills. There are 29 items on a 7-point scale, with higher scores indicating higher levels of competency. Clinicians and counselors-in-training tend to rate their attitudes as higher than knowledge or skills (Bidell, 2005; O'Shaughnessy & Spokane, 2013). Additionally, the skills subscale tends to be the lowest rated of the three scales (Bidell, 2005; Farmer et al., 2013; O'Shaughnessy & Spokane, 2013). This aligns with concerns in the literature that attitudes and knowledge do not directly translate to having the skills to work with sexual minority clients (Kocarek & Pelling, 2003). To date, there are no measures of multicultural competence with asexual clients, specifically. Additionally, language in these scales can quickly become outdated. For example, the SOCCS utilizes the word "lifestyle" when referring to sexual minority clients. However, Bidell (2005) reported the following reliability estimates for attitudes, knowledge, and skills subscales, .88, .76, and .83, respectively. The overall SOCCS had a reliability estimate of .90. The SOCCS has been used in multiple studies and shows good validity and reliability indicating that it is a good measure of counselors' multicultural competence at this time (Bidell, 2005; Graham et al., 2012; Rutter et al., 2010).

### **Training Interventions**

The purpose of specific trainings in working with sexual minority clients is to decrease prejudice and increase multicultural competence (e.g. knowledge, skills, and attitudinal awareness). According to Bidell (2013), graduate courses specifically focusing on LGBT issues and provision of affirmative counseling can significantly improve counseling students'

competency and self-efficacy when working with LGB clients. It is likely that a broad multicultural course will not be sufficient training in order to work competently with LGBT clients. Thus, graduate programs need to incorporate LGB issues throughout the curriculum (Bidell; 2013; Kashubeck-West et al., 2008; Matthews, 2005). Additionally, training should focus on LGBTQ+ resilience and coping strategies versus simply focusing on distress (Vaughan & Rodriguez, 2014).

Murphy and colleagues (2002) surveyed 125 licensed psychologists and found that only 10% had a graduate course in LGB issues offered during their training and only slightly more than half of these participants actually took the course that was offered. Further, 22% indicated there were other types of graduate trainings, including modules and seminars and most participants indicated they engaged in these types of trainings. Rutter and colleagues (2008) found that counseling education students who received LGB affirming training had better scores on the SOCC, overall, and in the subscales of knowledge and skills, than did the students who did not receive the LGB affirming training.

Rock and colleagues (2010) found that increased coverage of course content on LGB affirmative therapy was predictive of counseling students' perceived competency when working with sexual minority clients. However, they also found that 60.5% of their participants had received no training on affirmative therapy practices. This gap in training is concerning as LGBT clients are very likely to be in therapists' caseloads. Therapists, themselves, have indicated a desire to receive more trainings on LGB-specific issues, including specialized training on bisexual issues as a unique sexual orientation (Murphy et al., 2002).

Satcher and Schumaker (2009) found that counselors who had not participated in training about sexual minority individuals in the past year are more likely to indicate higher levels of

modern homonegativity. However, people with higher levels of homonegativity may be less likely to seek these trainings in the first place. Therapists' religious beliefs were found to be a strong indicator of making heterosexist comments to sexual minority clients (Bowers et al., 2010). Additionally, therapists may hold specific biases that all clients are heterosexual, have a general discomfort with same-sex attraction, or could hold beliefs about parenting and intimate relationships as it relates to same-sex attraction, highlighting the importance of education in their ability to challenge their biases and provide affirming care (Eubanks-Carter et al., 2005). Further, therapist heterosexism has been linked with less empathy for sexual minority clients, and less willingness to work with sexual minority clients (Hayes & Erkis, 2000).

It is clear that the current system of training therapists to increase their multicultural competence in working with sexual and gender minority clients is in need of reform. Matthews (2005) suggested that LGBTQ+ focused training should be infused throughout the curriculum in a counselor training program. Additionally, Matthews (2005) called for utilizing formal assessments, such as the SOCCS, throughout training, engaging in multiple trainings within the department and within the local community, clearly stating and marketing the program as LGBTQ+ affirming, exploring heterosexual privilege, and confronting heterosexism and transphobia.

Training interventions aimed at raising counselors' awareness of their own values and beliefs related to heterosexuality, homosexuality, bisexuality, heterosexism, bisexism (and by extension, asexuality and anti-asexual bias) are important in increasing clinicians' multicultural competence (Dillon et al., 2004; Kashubeck-West et al., 2008). However, additional training interventions should incorporate the use of role-playing exercises to aid in the development and practice of skills in working with LGBT clients as there is evidence suggesting that positive

attitudes and increased knowledge are not enough to feel competent in actual practice with LGBTQ+ clients (Kocarek & Pelling, 2003; O'Shaughnessy & Spokane, 2013).

Regarding asexuality-specific trainings, there are currently very few continuing education training programs available for mental health professionals to learn more about asexuality. The continuing education programs that do exist are found only after specifically searching for asexual-specific programming. Asexuality is beginning to be incorporated into counseling textbooks (Ginicola & Ruggiero, 2017). However, given the above statistics on the number of clinicians who did not take a multicultural counseling course in their graduate program, or were not offered an LGBT-specific course, it is unclear how many clinicians and clinicians-in-training are actually receiving asexuality-specific training, but it can be assumed that very few clinicians are receiving asexuality-specific training.

### **Current Literature on Counseling with Asexual Clients**

Given the evidence that suggests that asexuality is a unique sexual orientation within the LGBTQ+ community, and that at least some asexual individuals are subject to experiences of discrimination related to their sexual identity, it can be assumed that asexual individuals experience minority stress. Yule and colleagues (2013) found that asexual individuals do have increased mental health concerns compared to heterosexual individuals. Additionally, asexual youth tend to internalize negative social attitudes about sexual minority identities at high rates (McInroy et al., 2020). The high rates of minority stress and mental health concerns among asexual individuals highlight the need for multicultural competence among clinicians when working with sexual minority clients.

This need was demonstrated by Flanagan and Peters' (2020) survey of 136 asexual people about their experiences with health care and mental health care professionals. They found

that most of their participants were uncomfortable disclosing their sexual identity to their providers, but they were more likely to disclose their identity to mental health professionals than medical professionals. Further, Flanagan and Peters (2020) found that clinicians who educated themselves about asexuality were experienced more positively by asexual clients than clinicians who demonstrated a lack of knowledge about asexuality or prejudiced attitudes towards asexuality. Unfortunately, between one quarter and one half of participants indicated that their health and mental health professionals pathologized their asexuality by stating that it was due to a health condition. Another troubling finding is that some participants who disclosed their sexual identity only did so because they felt pressured by their practitioner's lack of understanding of the client stating they did not engage in sexual activity. Participants strongly indicated they believed therapists have an ethical imperative to learn about asexuality and to stop trying to understand what "caused" their client's asexuality.

Foster and Scherrer (2014) qualitatively explored asexual clients' experiences in clinical settings. They found that asexual clients routinely anticipate negative interactions with their health and mental health care providers. Asexual clients reported having specific worries that therapists would attempt to "fix" the client's asexuality or would focus on their asexuality when it was not relevant. However, clinicians who responded positively to participants' identity disclosure had a positive impact on their client's wellbeing. Positive responses by clinicians were interpreted by participants as clinicians displaying their multicultural competence in working with sexual minority clients. Foster and Scherrer (2014) also provided specific recommendations for clinicians working with asexual clients, including that clinicians find ways to signal to their clients that they are affirming of LGBT and asexual identities. Additionally, they suggest that

clinicians analyze their own attitudes toward asexuality and improve their knowledge of the asexual community's experiences of pathologization and marginalization.

Gupta (2017b) also conducted a qualitative study with asexually identified people in which participants provided specific recommendations for medical and mental health professionals. Recommendations for clinicians include educating clients about HSDD, allowing clients to determine whether asexuality or HSDD (or neither, or both) are the best fit, examining their own biases about human sexuality and considering how these biases are affecting their work, and affirming clients' asexual identities. A recommendation was also provided for couples counseling that a sexual desire discrepancy between partners be viewed as a relationship issue and not as a problem of the asexual partner.

Pinto (2014) lays down a foundation for counselors' asexual ally development and emphasizes counselors' unique role in aiding in the destigmatization of asexuality. It remains unclear whether this model is being used in practice and what training opportunities there are for clinicians wanting to learn more about asexuality. Revisiting Foster and Scherrer's (2014) study, it would seem that some clinicians are affirming, but this is not necessarily the norm. Further research is needed to determine what clinicians are doing in actual practice with their asexual clients.

### **Decision-Making**

People make decisions through two types of thinking: an automatic process and a deliberate process (Evans & Stanovich, 2013). The automatic process, sometimes referred to as Type 1 processing, is generally considered the "go-to," or intuitive, process in many situations (Kahneman, 2011). Because the mind has limited resources, making decisions efficiently is important and Type 1 processing allows perceivers to do so. Taylor (1981) coined the term

cognitive miser to describe this effort to be as efficient as possible without trading off too much accuracy. Type 1 processing is aided by the use of heuristics – a set of rules that people internalize for categorizing information (Gigerenzer, 2008). However, in exchange for this efficiency, accuracy may be reduced (Payne et al., 1996).

Deliberate process, sometimes referred to as Type 2 processing, is a slower, intentional process of decision making that involves actively engaging with the information (Kahneman, 2011) utilizes working memory (Evans, 2019) and supports hypothetical thinking (Evans & Stanovich, 2013). The deliberate process takes more time and more mental resources, which may be taxing over time; however, it is likely to result in more accurate decision-making than Type 1 processing if individuals are motivated, have the relevant knowledge, and the cognitive capacity to apply Type 2 reasoning (Evans & Stanovich, 2013; Kunda & Spencer, 2003). Depending on the situation, people may be motivated to use one type of thinking over the other. In situations where accuracy is more important, individuals may utilize Type 2 processing in order to make decisions and weigh the evidence to consider what information is relevant (Kahneman, 2011; Kunda & Spender, 2003).

People make errors in judgment when they do not attend to information, or they attend to the wrong information. These errors in judgment are also referred to as cognitive biases. Cognitive biases may arise if people over-rely on heuristics, or when relevant information is not included and/or irrelevant information is included in the heuristic process (Frankish, 2010; Kahneman, 2011). For example, the availability heuristic can result in cognitive bias. The availability heuristic is a proclivity to estimate the likelihood of something based on how easily examples of it come to mind (Kahneman, 2011; Tversky & Kahneman, 1973). The availability heuristic deems the information that is most recent, frequent, or extreme as significant to make a

decision – sometimes incorrectly. For example, a person who watches the 1975 thriller “Jaws” before taking their beachside vacation may experience increased worries about shark attacks, despite shark attacks being quite rare. Schwarz and colleagues (1991) demonstrated the availability heuristic on self-assessments of people’s assertiveness. They demonstrated that it was the ease in which examples came to mind that influenced people’s self-assessment by asking participants to recall examples of assertive or unassertive behaviors and then assess their own assertiveness or unassertiveness. Participants were either asked to recall a high number of behaviors (12), which was difficult, or a low number of behaviors (6), which was easy. Those who were more easily able to produce a list of assertive behaviors assessed their own assertiveness as higher than those who had a more difficult time producing a list of assertive behaviors.

The representativeness heuristic is another example of a heuristic that can lead to cognitive bias. The representativeness heuristic refers to whether the object or subject in question is representative, or prototypical, of a group or category (Tversky & Kahneman, 1974). An example of the representativeness heuristic is when women doctors are often mistaken for nurses by their patients. This is because many people associate men with doctors and women with nurses, thus creating a representative image that they then use to inform their decision-making. Brannon and Carson (2003) demonstrated the impact of the representativeness heuristic on clinical decision-making with a sample of nurses and student nurses by asking participants to read through case descriptions and generate diagnoses for these hypothetical patients. They found that participants were less likely to diagnose patients with a physical illness when the clinical vignettes indicated extra-symptom characteristics, such as a recent job loss or the smell

of alcohol on the patient's breath, as many participants believed these characteristics were more representative of a situational explanation rather than a medical explanation.

Confirmation bias can also result in cognitive bias. Confirmation bias refers to the tendency to seek and interpret information in a manner that confirms or reinforces one's existing beliefs (Nickerson, 1998). This tendency to seek confirmatory information may be motivated or unmotivated, meaning that individuals may intentionally seek information that reinforces their own intuitive beliefs, as well as when individuals process information from a predetermined perspective. Mynatt and colleagues (1977) demonstrated the effect of confirmation bias with a sample of undergraduate students who were asked to formulate a hypothesis regarding a false research task and then choose between environments that would either allow them to make observations that might confirm their hypothesis, or that would allow them to explore alternative hypotheses. Participants overwhelmingly selected environments that would allow them to potentially confirm their hypothesis rather than to explore alternative hypotheses.

Cognitive biases may also arise from applying deliberate thinking and drawing conclusions when an underlying ideological motivation is present. Although heuristics may drive stereotypic thinking, Type 2 processing may magnify these effects if there is enough ideological motivation to maintain beliefs that align with ideological groups, such as political parties (Kahan, 2013). Evans (2019) proposed that Type 2 processing serves a dual function of rationalizing intuitive decision making and "reasoning-out" alternative decisions. Cognitive biases can arise via the automatic assumption that our intuitions are correct until proven incorrect, and our own motivation and situational factors influence how much we engage in testing our own intuition. Regarding motivation, Evans described how some individuals play chess purely based on intuition, without any integration of theory or calculating one's own

moves, or the moves of their opponent, and are quite content to play at this level, despite making numerous errors. Alternatively, players with greater motivation to improve their chess game will put in the cognitive effort; for these individuals the end goal is important.

### **Clinical Decision-Making**

Mental health clinicians need to make important decisions in their clinical work, including the provision of diagnoses, treatment planning, assessments, and interventions utilized in treatment (Spengler et al., 1995). Clinicians may maintain large caseloads and need to make quick judgments regarding their clients' care. Clinicians who bill insurance may be required to provide diagnoses after the first session, which gives them very little time to gather information about clients and their presenting concerns. Larger caseloads may also limit the amount of time clinicians are able to spend contemplating each individual client's case. Thus, clinicians are consistently working in conditions that increase the likelihood they will use heuristics to aid in decision-making; this can increase the risk of cognitive bias. Namely, these are conditions that are high in complexity (Tversky & Kahneman, 1974), with a high cognitive load (Croskerry, 2002), and made with limited time (Groopman, 2007).

Clinical judgment bias is defined as factors that influence the process and outcome of a clinical decision. A wide range of consequences can result from judgment bias in clinical decision-making, including incorrect diagnoses, overpathologization of an individual's presenting concerns (i.e., providing diagnoses for a problem that might otherwise be a normative event), and ruptures in the therapeutic alliance. These consequences might mean that clients are receiving incorrect treatment or may have negative financial implications (i.e., needing to pay for more sessions than required, insurance companies not covering care).

Cognitive biases likely contribute to misdiagnosis and substandard treatment decisions in medical and mental health treatment (Croskerry, 2002; Crumlish & Kelly, 2009; Mendel et al., 2011; McDermott, 1980). For example, McDermott (1980) asked school psychologists to review clinical case studies and provide potential diagnoses. Results showed that, regardless of their level of experience, raters showed little or no diagnostic agreement. McDermott proposed that the lack of diagnostic agreement was indicative of errors in decision-making; specifically, McDermott divided these errors into errors of inconsistency and errors of consistency. Errors of inconsistency were demonstrated by clinicians who inconsistently applied diagnostic standards and criteria, as well as inconsistent theoretical orientation within specific clinicians. Errors of consistency were demonstrated by clinicians' consistent use of overly general diagnoses, such as "emotional disturbance," or "learning disability." Similarly, psychiatrists and medical students who provided a preliminary diagnosis for a hypothetical case and then searched for new information about the case were prone to confirmation bias in their final diagnosis. As a result, they were significantly more likely to make an incorrect diagnosis and this, in turn, impacted which treatment options they prescribed (Mendel et al., 2011).

Clinicians may work with clients who share a variety of symptoms but meet criteria for different diagnoses. The availability heuristic can bias diagnostic decision-making when clinicians assume shared symptoms among clients mean shared diagnoses (Bowes et al., 2020). The representativeness heuristic also is highly applicable to mental health counselors, as diagnostic impressions of a client can be related to how representative that client's symptoms are of a particular diagnosis (Garb, 1996; Whaley & Geller, 2007). This can be a problem if clinicians stray too far from consulting diagnostic criteria as a guide as it could lead to misdiagnosis (Garb, 1996). Clinicians may neglect assessing for symptoms or experiences or

may ignore information that does not fit the prototype of a specific diagnosis or client demographic.

### ***Clinicians' Biases: Values, Attitudes, and Beliefs***

There is potential for judgment bias when clinicians work with individuals who belong to marginalized groups (Boysen, 2009; Garb, 1997; Hays et al., 2010) because clinicians' own values, attitudes, and beliefs can bias their clinical judgment (Boysen, 2009; Schlossberg & Pietrofesa, 1973; Whaley & Geller, 2007). Bias can be either explicit or implicit, with explicit bias being the conscious negative beliefs, prejudice, and stereotypes an individual holds, and implicit bias being the unconscious negative beliefs, prejudice, and stereotypes that an individual holds (Greenwald & Banaji, 1995). The phenomenon of clinicians' biases based on their own cultural values or their client's identities has also been defined as *client variable bias* (Garb, 1997; López, 1989). These biases may inform what clinical information clinicians attend to and what decisions they make regarding the course of treatment (Schlossberg & Pietrofesa, 1973).

Garb (1997) reviewed the clinical judgment literature, with a specific focus on how client variables such as race, social class, and gender, impacted clinical judgment. Biases in rates of over- or under-diagnosing individuals based on their racial, gender, and/or social class were identified. Specifically, they found that African American and Hispanic clients were more frequently misdiagnosed with schizophrenia than White clients due to clinicians' racial biases. They also found that men were more likely to be diagnosed with antisocial personality disorder than women, and women were more likely to be diagnosed with histrionic personality disorder than men due to clinicians' gender biases. Additionally, they found that referrals for therapy were more often made for middle-class clients than lower-class clients and that clinicians' social class biases affected the types of therapy recommended for people from different socioeconomic

classes. These biases against clients with marginalized social identities demonstrate the impact of clinicians' bias on their clinical decision-making and highlight the possibility that other marginalized social identities may be impacted by clinicians' bias.

López (1989) also reviewed the literature on how client-variable biases impact clinical judgment and found consistent evidence that clinicians' racial bias and gender bias impacted clinical judgment. Specifically, clients with minoritized racial identities were more likely to experience overdiagnosis and underdiagnosis than White clients, and clients who were women were more likely to have their symptoms minimized if they aligned with gender stereotypes. Hays et al. (2010) highlighted that counselors with lower levels of awareness of their cultural biases were less likely to indicate positive prognoses for their clients, instead engaging in overpathologization, which emphasizes the potential risk of implicit bias.

### *Clinicians' Countertransference*

The term countertransference is sometimes used to describe therapists' personal responses to clients and to session content. Specifically, countertransference is defined as therapists' thoughts and feelings that arise from reactions to clients; thoughts and feelings that arise in response to client characteristics that evoke reactions from others; and thoughts and feelings that are unique to the therapeutic relationship (Homqvist & Armelius, 1996). Countertransference may be elicited by client diagnoses. For example, Brody and Farber (1996) explored countertransference by therapist experience level and client diagnosis and found that clients with depression typically elicited positive countertransference reactions from therapists (e.g., compassion, empathy, nurturing feelings, and the absence of anger). They also found that clients with borderline personality disorder elicited negative countertransference reactions (e.g., feelings of anger, irritation, and frustration).

Intensity of symptoms, including suicidal ideation, may also elicit countertransference (Richards, 2000). Client suicidality was found to elicit feelings of hopelessness, frustration, and anxiety in therapists, which may result in more negative appraisals of clients with suicidal ideation (Richards, 2000). There is also some evidence that therapists who have experienced trauma within their own lives demonstrate greater countertransference reactions to clients presenting with trauma as a presenting problem (Cavanagh et al., 2015). Taken together, these studies indicate that therapists' personal reactions to a client's presenting problem may be varied and may potentially impact perceptions of client functioning.

Trauma can be particularly difficult for therapists to navigate their personal reactions, as it can increase feelings of discomfort or even elicit symptoms of vicarious trauma (Gartner, 2014). Symptoms of vicarious trauma can include anxiety, grief, a sense of helplessness, cognitive impairment, and symptoms of post-traumatic stress disorder (Beckerman, 2003; Newell & MacNeil, 2010). Difficult feelings, such as anxiety, may increase therapists' dislike toward clients (Linn-Walton & Pardasani, 2014). Therapists may avoid discussion about details of trauma or transfer clients to other clinicians to cope with these feelings (Linn-Walton & Pardasanni, 2014; Smart et al., 2022). Although therapists may have great empathy for clients who experienced trauma, therapists' countertransference can also increase the likelihood for more negative personal reactions to client trauma (Gartner, 2014).

### ***Clinicians' Biases and Client Sexual Orientation***

Clinicians' bias toward clients who hold minoritized sexual or gender identities has also been demonstrated. Clinicians who believe that being heterosexual is the norm or is desirable may also believe that sexual minority clients are in greater need of therapy or have more severe pathology; they may also conclude that the client's sexual orientation is the problem (Casas et

al., 1983; McCabe & Rubinson, 2008). Clinicians perpetuate microaggressions toward sexual minority clients (Shelton & Delgado-Romero, 2013; E. Spengler et al., 2016). Sexual minority clients who experienced microaggressions in a therapy session reported doubting the effectiveness of therapy and the therapeutic relationship (Shelton & Delgado-Romero, 2013). Further, it prompted clients to experience negative affect, such as anger, frustration, and helplessness. E. Spengler et al. (2016) proposed that microaggressions are clinical errors rooted in cognitive biases and heuristics.

Mohr and colleagues (2013) explored counselors' stereotypic beliefs about gay, bisexual, and heterosexual men and found that therapists often endorsed stereotypes that were unique to each sexual orientation. Specifically, therapists associated bisexual and gay men with feminine attributes more than heterosexual men. Additionally, bisexual men were associated with being more confused, daring, and open-minded than either gay or heterosexual men. Finally, therapists associated traits of being entertaining, intelligent, and insightful with gay men more than heterosexual and bisexual men. Mohr and colleagues (2013) noted in their discussion that it was unclear how these stereotypes may impact therapists' behavior in their clinical work.

Bowers and Bieschke (2005) surveyed counselors regarding their clinical judgment across client sexual orientation (Lesbian/Gay; Bisexual; Heterosexual) and gender (Cisgender man; Cisgender woman). Participants read a clinical vignette and responded to a series of questions regarding the prognosis, severity, and clinical conceptualization. Results showed that male clinicians demonstrated more negative attitudes towards LGB clients than did female clinicians. Specifically, male clinicians believed that LGB clients were more likely to threaten harm to someone than would heterosexual clients. Additionally, they found that female clinicians indicated a more positive prognosis for bisexual clients than for heterosexual clients. It is

interesting to consider that female clinicians saw a more positive prognosis for bisexual clients than for heterosexual clients as anti-bisexual bias is pervasive among the general population, as well as among mental health clinicians (Ferster & Zivony, 2023).

The impact of anti-bisexual bias on clinical judgment is of particular interest when considering how anti-asexual bias might impact clinical judgment. Mohr and colleagues' (2009) examined the effect of client sexual orientation on clinicians' clinical judgment. Their participants were psychotherapists who reviewed a fictitious intake summary in which client sexual orientation (heterosexual, gay, or bisexual) was manipulated. Participants rated the client's overall psychosocial functioning, their perceived salience of clinical issues (including the client's sexual orientation), their anticipated reactions to working with the fictitious client, and their awareness of their own values. Therapists were more likely to indicate that the client's bisexuality was related to the presenting problems than client heterosexuality or homosexuality. Regarding therapist factors, therapist gender, amount of graduate training in LGB issues, experience working with LGB clients, and licensure type did not contribute to the observed differences; however, therapists who indicated greater endorsement of the stereotypic beliefs that bisexual people are confused and conflicted were more likely to demonstrate bias in their clinical judgment. Additionally, Mohr et al.'s results supported the notion that therapists' self-estimated multicultural counseling competence is unrelated to their actual multicultural competence as their results remained significant and substantial even after controlling for self-efficacy for avoiding bias, social desirability, and tendency to pathologize clients.

Extrapolating from these results, it is hypothesized that a similar pattern might emerge for clinicians in their work with asexual clients, especially given the documented risk for pathologization of asexual identities and that stereotypes about asexual individuals differ from

stereotypes about gay and bisexual people. The representativeness heuristic may enhance stereotypic thinking regarding client demographics (Bowes et al., 2020). Additionally, the representativeness heuristic may be especially important for clinicians working with asexual clients due to a lack of sexual desire being representative of several diagnoses. For example, when asexual clients present to therapy with primary concerns of depression and conflict within their romantic relationship due to sexual desire discrepancies, a clinician may perceive the client's little to no sexual desire as a symptom of depression. Confirmatory hypothesis testing may also increase the risk of applying stereotypes in clinical decision-making (Mohr et al., 2009; Pfeiffer et al., 2000).

A common belief that clinicians may hold is that sexuality is central to humanity. Clinicians who hold this belief may have biases against individuals who are unpartnered, have little sexual desire, or engage in non-normative sexual practices. Such beliefs may lead clinicians to perceive that unpartnered clients are in greater distress than partnered clients. Additionally, clinicians may erroneously believe that there is a pathological cause for a client's low sexual desire, especially if they are unaware of asexual identities. Clinicians who hold this belief may attend to clinical information that highlights an individual's distress related to low sexual desire or they may assess for information they believe to be a cause of low sexual desire, such as the presence of sexual trauma, depressive symptoms, and current medications (e.g. selective-serotonin reuptake inhibitors [SSRIs]).

### ***Clinicians' Biases: Asexual Marginalization and Pathology***

There is a need for clinicians to be culturally competent when working with asexual clients, and to be aware of the experiences of asexual individuals, as well as their own biases about the nature of human sexuality. There is currently no literature exploring clinicians'

potential biases about asexuality. Counselors can hold prejudice against other sexual minority individuals (Bowers & Bieschke, 2005; Satcher & Schumacker, 2009); therefore, it stands to reason that counselors may also hold prejudice toward asexual individuals.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.; DSM-5; American Psychiatric Association, 2013) the existing boundaries that differentiate between asexuality being a disorder or an identity are typically framed around whether the experience is personally distressing to the individual; however, sexual desire discrepancies within partnered relationships and development of a sexual minority identity may be distressing to some, which blurs this line between asexuality as a disorder or an identity (Brotto & Yule, 2011; Gupta, 2017a; Steelman & Hertlein, 2016). Thus, partners receiving couples counseling in which one individual is asexual and the other is allosexual (i.e., someone who experiences sexual attraction to others) need to be distinguished from couples where one individual is experiencing low sexual desire because of a sexual disorder. This may be difficult, however, if both individuals experience marked distress as a result of the conflict surrounding one partner's low sexual desire. The extent to which clinicians consider an asexual identity as an alternative to a sexual disorder is currently unknown.

The preponderance of the evidence in the debate about whether asexuality is best conceptualized as a sexual disorder, such as hypoactive sexual desire disorder (HSDD) or as female sexual interest/arousal disorder (SIAD) points to distinct differences between individuals who meet the criteria for HSDD and those who meet the criteria for asexuality (Brotto et al., 2015; Prause & Graham, 2007; Van Houdenhove et al., 2014). Asexual individuals themselves, for the most part, strongly reject the idea that asexuality is an extreme case of a sexual desire disorder (Brotto et al., 2010; Mitchell & Hunnicutt, 2019). However, some asexual-identified

people have reported that there was something wrong with them for their lack of sexual attraction, and some asexual-identified individuals have indicated wanting to increase their sexual desire (Mitchell & Hunnicutt, 2019).

This distress may influence clinicians to pathologize an asexual individual's experience related to their identity development. Chasin (2017) indicated that this very pathologization occurs because of the fuzzy boundaries between asexuality and lifelong and acquired sexual disorders. This boundary becomes especially blurred when considering that sexual orientation has been demonstrated to have some variation over time (Chasin, 2017; Diamond, 2008) and clients may seek therapy prior to considering an asexual identity. Given the complicated relationship between asexuality and HSDD, an uneducated or biased clinician may inappropriately pathologize a person with an asexual identity.

Exploration of an asexual identity in therapy may be protective for individuals who experience little-to-no sexual attraction. Mitchell and Hunnicutt (2019) interviewed self-identified asexual people and found that most experienced a sense of relief when they learned about asexuality and adopted an asexual identity. Additionally, they found that several participants endorsed a reduction in internalized pathologization after adopting an asexual identity. Specifically, participants were able to challenge internalized beliefs that there was something wrong with them due to not experiencing sexual attraction.

### **Significant/Novel Contribution**

This study aims to fill a significant gap in the literature in identifying possible biases when working with asexual clients. Holding anti-asexual bias or sexual bias may bias clinicians' judgment when working with asexual or lesbian clients compared to heterosexual clients. These clinical judgment errors and biases could hinder therapy progress and create greater distress in

asexual and lesbian clients. These findings may have implications for training purposes in increasing clinicians' cultural responsiveness. Further, it may have implications for current conceptualization about LGBTQ+ issues in counseling psychology by means of differentiating the unique experiences of asexual individuals and their specific counseling needs.

One potential way to measure clinical judgment bias is through comparing perceptions of client functioning. Should client functioning differ across conditions of sexual orientation, it may indicate that clinicians' biases are impacting these ratings. The Global Assessment of Functioning (GAF; Hall, 1995) is a common clinical assessment of functioning that could be easily compared across conditions.

Other ways to measure clinical judgment bias could be through participants' personal reactions to hypothetical clients. This can be measured using the Therapist Personal Reaction Questionnaire (TPRQ; Davis et al., 1977) and the Feeling Thermometer (Nelson, 2008). The Feeling Thermometer (Nelson, 2008) was chosen due to the consistent links in the literature that asexual individuals are rated more coldly than heterosexual individuals and other non-asexual LGBTQ+ individuals (MacInnis & Hodson, 2012). The TPRQ (Davis et al., 1977) assesses therapists' immediate personal reactions to working with a particular client, which could identify particular biases across conditions.

Clinical judgment research frequently uses analogue studies, with participants reacting to clinical vignettes (Mohr et al., 2009; Tomko & Munley, 2013). Analogue studies simulate the counseling process and allow the researcher to manipulate some aspects of the counselor, client, and/or the counseling process (Heppner et al., 2016). Similar to Mohr and colleagues (2009), the current study will utilize fictitious intake summaries and manipulate client variables of sexual

orientation and presenting problems to explore the impact of an asexual client identity on therapists' clinical judgement.

In summary, no literature to date has examined clinicians' attitudes toward asexuality, nor their clinical judgment in working with this population. Given the overall lack of training in working with sexual minority clients, in general, it is likely that a majority of clinicians do not have specific training for working with asexual clients. Further, there are few asexuality-specific continuing education trainings currently available to mental health professionals, decreasing the likelihood that many clinicians are receiving appropriate training to work with asexual clients.

### **Questions/Hypotheses**

Hypothesis 1: There will be a main effect of client sexual orientation.

Heterosexual clients will be rated more warmly, more favorably, and as having better functioning than lesbian clients, who will be rated more favorably, more warmly, and as having better functioning than asexual clients.

Hypothesis 2: There will be a main effect of presenting problem, with clients presenting with sexual trauma being rated less favorably, more coldly, and having worse functioning than clients presenting with depression.

Hypothesis 3: There will be no interaction effect between client sexual orientation and presenting problem.

Hypothesis 4: Anti-aexual attitudes will moderate ratings on the GAF, TPRQ, and feeling thermometer. Specifically, participants with greater anti-aexual bias will rate asexual clients less favorably, colder, and as having worse functioning than heterosexual and lesbian clients. Participants with lower levels of anti-aexual bias will not rate clients differently across client sexual orientation.

Hypothesis 5: Homonegative beliefs will moderate ratings on the GAF, TPRQ, and feeling thermometer. Participants with greater modern homophobia will rate asexual and lesbian clients less favorably, colder, and as having worse functioning than heterosexual clients. Participants with lower levels of homonegativity will not rate clients differently across client sexual orientation.

## **Appendix B: Client Vignettes**

### **Depression Vignette**

Elizabeth is a 28-year-old, White, [asexual/lesbian/heterosexual], cisgender woman who has come to the community counseling center seeking help for interpersonal relationship problems related to symptoms of depression. At her intake session, she appeared to be in great distress regarding the nature of her presenting concerns. She indicated having very little support from her family in seeking help from a therapist. Additionally, she is in a monogamous relationship with her boyfriend and has a few good friends she can rely on. Elizabeth's symptoms have been present for approximately 4 months. She voiced experiencing suicidal ideation without plan or intent once a week, difficulty falling asleep and staying asleep, fatigue, unintentional weight loss of about 10 lbs, feeling sad and hopeless more days than not, loss of interest and pleasure in activities she once enjoyed, feelings of worthless and excessive guilt and shame, and difficulty concentrating. She stated she often wonders if there's "something wrong with [her]." She indicated having no sexual desire, which causes conflict between her and her partner. Elizabeth is in great distress.

### **Sexual Trauma Vignette**

Elizabeth is a 28-year-old, White, [asexual/lesbian/heterosexual], cisgender woman who has come to the community counseling center seeking help for interpersonal relationship problems following sexual trauma. At her intake session, she appeared to be in great distress regarding the nature of her presenting concerns. She indicated having very little support from her family in seeking help from a therapist. Additionally, she is in a monogamous relationship with her boyfriend and has a few good friends she can rely on. Elizabeth's symptoms have been present for approximately 4 months. She voiced experiencing intrusive thoughts and images

related to her assault, difficulty falling asleep and staying asleep, fatigue, avoidance of anything that reminds her of the assault, feeling sad and hopeless more days than not, loss of interest and pleasure in activities she once enjoyed, feelings of worthless and excessive guilt and shame, and difficulty concentrating. She stated she often wonders if there's "something wrong with [her]." She indicated having no sexual desire, which causes conflict between her and her partner. Elizabeth is in great distress.

### **Distractor Vignette**

Celia is a 32-year-old, Hispanic, heterosexual, cisgender woman who has come to a community counseling center for assistance with anxiety caused by significant life decisions. Primarily, she is concerned about a recent job opportunity that would require her to relocate across the country. She is employed as a lawyer in a small, local law firm but has been offered a position within a prestigious international law firm. One of her concerns is that she does not have the skills to manage the new position. Although she has been very successful in her current position, she is worried about her ability to attract new, high profile clients to the firm. Celia is worried about her overall performance in such a highly competitive environment.

She is also engaged to her current boyfriend, who is ambivalent about her taking the position. He owns a home and a local business, and she is concerned about his willingness to move should she decide to accept the position. Additionally, Celia has become very attached to her boyfriend's son whom she plans to adopt after she and her boyfriend marry. She is afraid that her boyfriend will decide not come with her and that she will be without any social and emotional support during this time of transition.

## Appendix C: Client Demographic Forms

Note: All client demographics include fake client data.

### Asexual Client Demographics

#### New Client Information Form

Ball State University Practicum Clinic

##### Legal Name

Elizabeth Roth

First Name Last Name

##### Preferred Name

Elizabeth Roth

First Name Last Name

##### Date of Birth

07 15 1994

Month Day Year

##### What is your gender identity?

- Man  
 Woman  
 Nonbinary  
 Prefer to self-identify (see below)

##### Prefer to self-identify gender:

##### What is your sex assigned at birth?

- Male  
 Female  
 Intersex

##### What is your race/ethnicity?

- African American/Black  
 Anglo American/White  
 Asian/Asian American/Pacific Islander  
 Biracial/Multiracial  
 Hispanic/Latine  
 Native American  
 Not listed

##### If your race is not listed, please indicate here:

##### What best describes your sexual orientation?

- Asexual  
 Bisexual  
 Gay  
 Heterosexual/Straight  
 Lesbian  
 Pansexual  
 Queer  
 Prefer to self-describe

##### If prefer to self-describe, please indicate here:

## Heterosexual Client Demographics

### New Client Information Form

Ball State University Practicum Clinic

#### Legal Name

Elizabeth Roth

First Name Last Name

#### Preferred Name

Elizabeth Roth

First Name Last Name

#### Date of Birth

07 15 1994

Month Day Year

#### What is your gender identity?

- Man
- Woman
- Nonbinary
- Prefer to self-identify (see below)

#### Prefer to self-identify gender:

#### What is your sex assigned at birth?

- Male
- Female
- Intersex

#### What is your race/ethnicity?

- African American/Black
- Anglo American/White
- Asian/Asian American/Pacific Islander
- Biracial/Multiracial
- Hispanic/Latine
- Native American
- Not listed

#### If your race is not listed, please indicate here:

#### What best describes your sexual orientation?

- Asexual
- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Pansexual
- Queer
- Prefer to self-describe

#### If prefer to self-describe, please indicate here:

## Lesbian Client Demographics

### New Client Information Form

Ball State University Practicum Clinic

#### Legal Name

Elizabeth Roth

First Name Last Name

#### Preferred Name

Elizabeth Roth

First Name Last Name

#### Date of Birth

07 15 1994

Month Day Year

#### What is your gender identity?

- Man  
 Woman  
 Nonbinary  
 Prefer to self-identify (see below)

#### Prefer to self-identify gender:

#### What is your sex assigned at birth?

- Male  
 Female  
 Intersex

#### What is your race/ethnicity?

- African American/Black  
 Anglo American/White  
 Asian/Asian American/Pacific Islander  
 Biracial/Multiracial  
 Hispanic/Latine  
 Native American  
 Not listed

#### If your race is not listed, please indicate here:

#### What best describes your sexual orientation?

- Asexual  
 Bisexual  
 Gay  
 Heterosexual/Straight  
 Lesbian  
 Pansexual  
 Queer  
 Prefer to self-describe

#### If prefer to self-describe, please indicate here:

## Distractor Demographics

### New Client Information Form

Ball State University Practicum Clinic

#### Legal Name

Celia Perez

First Name Last Name

#### Preferred Name

Celia Perez

First Name Last Name

#### Date of Birth

11 07 1989

Month Day Year

#### What is your gender identity?

- Man
- Woman
- Nonbinary
- Prefer to self-identify (see below)

#### Prefer to self-identify gender:

#### What is your sex assigned at birth?

- Male
- Female
- Intersex

#### What is your race/ethnicity?

- African American/Black
- Anglo American/White
- Asian/Asian American/Pacific Islander
- Biracial/Multiracial
- Hispanic/Latine
- Native American
- Not listed

#### If your race is not listed, please indicate here:

#### What best describes your sexual orientation?

- Asexual
- Bisexual
- Gay
- Heterosexual/Straight
- Lesbian
- Pansexual
- Queer
- Prefer to self-describe

#### If prefer to self-describe, please indicate here:

### Appendix D: Measures Used in the Study

#### Global Assessment of Functioning (GAF)

Please rate the client's overall level of functioning (0-90)

0-10 – In persistent danger of severely hurting self or others

11-20 – In some danger of hurting self or others

21-30 – Inability to function in almost all areas

31-40 – Major impairment in several areas of functioning

41-50 – Some serious symptoms or impairment in functioning

51-60 – Moderate symptoms

61-70 – Some persistent mild symptoms

71-80 – Some transient mild symptoms

81-90 – Absent or minimal symptoms

**Therapist Personal Reaction Questionnaire (TPRQ)** – Likert-type items (1 = *strongly disagree* to 5 = *strongly agree*)

1. I would like this client more than most.
2. I have a warmer, friendlier reaction to this potential client than to others I have seen.
3. I was seldom in doubt about what the client was trying to say.
4. In general, I couldn't ask for a better potential client.
5. I would find significant things to respond to in what the client said.
6. I would feel pretty ineffective with this client.
7. I think I would do a pretty competent job with this client.
8. I would disagree with this client about some basic matters.

9. I think this client is trying harder to solve her problems than most others I've seen.
10. It is hard to know how to respond to this client in a helpful way.
11. It's easier for me to see exactly how this client would feel in the situations she described than it is with other clients.
12. I am more confident that this client would work out her problems than I've been with others.
13. In comparison with other clients, I would find it hard to get involved with this client's problems.
14. I would have liked to have been able to feel more warmth toward this client than I did.
15. Sometimes I resented the client's attitude.

### **Feeling Thermometer**

Using a scale from zero to 100, please rate how warm or cold you think the client is. As you do this task, think of an imaginary thermometer. The warmer or more favorable you feel toward the client, the higher the number you should give. The colder or less favorable you feel, the lower the number. If you feel neither warm nor cold toward the client, rate them 50.

**Attitudes Towards Asexuals (ATA)** – Likert-type responses (1 = *Very strongly disagree* to 9 = *Very strongly agree*)

1. Asexual women are not real women
2. Asexual men are not real men
3. Asexuality is probably just a phase
4. A woman who claims she's "asexual" just hasn't met the right man yet

5. A man who claims he's "asexual" just hasn't met the right woman yet
6. Asexual people are sexually repressed
7. Asexuality simply represents an immature, childlike approach to life
8. People who identify as "asexual" probably just want to feel special or different
9. Asexuality is a "problem" or "defect"
10. There is nothing wrong with not having sexual attraction
11. A lot of asexual people are probably homosexual and in the closet
12. Asexuality is an inferior form of sexuality
13. You can't truly be in love with someone without feeling sexually attracted to them
14. Asexuality should not be condemned
15. Asexuals who have intimate relationships are being unfair to their partners
16. I would not be too upset if I found out my child were an asexual

**Modern Homonegativity Scale – Lesbian Version (MHS-L)** – Likert type responses (1 = *Strongly Disagree* to 5 = *Strongly Agree*)

1. Many lesbians use their sexual orientation so that they can obtain special privileges.
2. Lesbians seem to focus on the ways in which they differ from heterosexuals, and ignore the ways in which they are the same.
3. Lesbians do not have all the rights they need.
4. The notion of universities providing students with undergraduate degrees in Gay and Lesbian Studies is ridiculous.
5. Celebrations such as "Gay Pride Day" are ridiculous because they assume that an individual's sexual orientation should constitute as a source of pride.

6. Lesbians still need to protest for equal rights.
7. Lesbians should stop shoving their lifestyle down other people's throats.
8. If lesbians want to be treated like everyone else, then they need to stop making such a fuss about their sexuality/culture.
9. Lesbians who are "out of the closet" should be admired for their courage.
10. Lesbians should stop complaining about the way they are treated in society, and simply get on with their lives.
11. In today's tough economic times, Americans' tax dollars shouldn't be used to support lesbian organizations.
12. Lesbians have become far too confrontational in their demand for equal rights.

**Social Desirability Scale (MC-XX)** – True/false dichotomous responses

1. I never hesitate to go out of my way to help someone in trouble.
2. I have never intensely disliked someone.
3. I sometimes feel resentful when I don't get my way.
4. I like to gossip at times.
5. There have been times when I felt like rebelling against people in authority even though I knew they were right.
6. I can remember "playing sick" to get out of something.
7. There have been occasions when I took advantage of someone.
8. I'm always willing to admit it when I make a mistake.
9. I always try to practice what I preach.
10. I sometimes try to get even rather than forgive and forget.

11. When I don't know something I don't at all mind admitting it.
12. I am always courteous, even to people who are disagreeable.
13. At times I have really insisted on having things my own way.
14. There have been occasions when I felt like smashing things.
15. I would never think of letting someone else be punished for my wrong-doings.
16. I never resent being asked to return a favor.
17. I have never been irked when people expressed ideas very different from my own.
18. There have been times when I was quite jealous of the good fortune of others.
19. I am sometimes irritated by people who ask favors of me.
20. I have never deliberately said something that hurt someone's feelings.

### **Participant Demographic Questions**

1. What is your current level of licensure?
  - a. Licensed Masters-level Clinician (e.g., LMHC, LCSW)
  - b. Licensed Psychologist (e.g., HSPP, LP)
2. How many years have you been practicing?
3. What is your theoretical orientation? Please select all that apply.
  - a. Acceptance and Commitment Therapy (ACT)
  - b. Adlerian Therapy
  - c. Behavioral Therapy
  - d. Cognitive Behavioral Therapy (CBT)
  - e. Dialectical Behavioral Therapy (DBT)
  - f. Existentialist

- g. Feminist Multicultural Therapy
  - h. Humanistic Therapy
  - i. Interpersonal Therapy (IPT)
  - j. Psychodynamic
  - k. Relational Cultural Therapy (RCT)
  - l. Prefer to self-describe/Not listed
4. What age groups do you work with? Please select all that apply.
- a. Children
  - b. Adolescents
  - c. Young Adults
  - d. Adults
  - e. Older Adults
5. What is your primary work setting?
- a. Private Practice
  - b. University Counseling Center
  - c. Hospital
  - d. Community Mental Health/Community Health Center
  - e. Not Listed
6. Which of the following best describes your gender identity? Select all that apply.
- a. Agender
  - b. Cisgender Man
  - c. Cisgender Woman
  - d. Gender Fluid

- e. Nonbinary
  - f. Transgender Man
  - g. Transgender Woman
  - h. Prefer to self-describe
7. Which of the following best describes your sexual orientation? Select all that apply.
- a. Asexual
  - b. Bisexual
  - c. Gay
  - d. Heterosexual (straight)
  - e. Lesbian
  - f. Pansexual
  - g. Queer
  - h. Prefer not to say
  - i. Prefer to self-describe
8. Which of the following best describes your racial/ethnic identity? Select all that apply.
- a. American Arab/Middle Eastern/North African
  - b. Asian/Asian American
  - c. Black/African American
  - d. Hispanic/Latine
  - e. Native American/Indigenous American
  - f. Pacific Islander
  - g. White/European American
  - h. Multiracial

- i. Prefer to self-describe
9. What is your present age (in years)?
  10. Please indicate where you fall on the ideological continuum of conservative beliefs and liberal beliefs.