LEVEL OF HOMOPHOBIA AND GRADUATE COUNSELING STUDENTS' CLINICAL JUDGMENTS

by

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ABSTRACT

It was the purpose of this study to examine the differences in clinical judgment ratings of counselor trainees, based on a client's sexual preference, with the counselor trainee's level of homophobia. Eighty graduate counseling students participated in this study. Half of the subjects read a vignette regarding a homosexual relationship and the other half read a vignette regarding a heterosexual relationship. All subjects responded to the Index of Homophobia and the Clinical Judgment Scale. Results indicate that regardless of a client's sexual preference, a counselor trainee's level of homophobia did effect how they clinically judged a client. It is of utmost importance for counselor trainees to become informed about homosexuality, to become aware of their own beliefs and feelings regarding homosexuality, and to dispel the prejudice taught them by society.

DEDICATION

Dedicated to my parents

Marion and Anthony DiVincenzo

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Thank you,

Richard Nelson,
my advisor and for your patience with me;

Nona Tollefson,
for consenting to serve on my committee and for
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my dear and loving friend, for being there
to listen, share, and give extra-special support;

To my family, relatives, and many friends for
their encouragement and faith . . . . . .

I finally made it!

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CHAPTER I

INTRODUCTION

Homosexuality is an identity that is incomprehensible and intolerable to many. Since the American Psychiatric Association removed the "mental illness" label from homosexuality in 1974, an increasing number of psychotherapists are becoming more accepting and more understanding of the homosexual lifestyle. These therapists are willing to consider the homosexually oriented person as different, but capable of being well adjusted as are heterosexually oriented persons. However, even though they no longer see homosexuals as sick deviants who should be cured, many counselors remain relatively uninformed about the dimensions and dynamics of gay persons' lives, including the pressures which may lead them to seek counseling (Norton, 1976; Haynes, 1977).

The irrational fear and hatred of homosexuals has deep and ancient roots. Karlen (1971) states that at one time, homosexuality was sanctioned and honored, especially in the Western cultures. Both male homosexuality and lesbianism were known to exist among the general

populace and the aristocratic element. According to Karlen, the emergence and growth of the Judeo-Christian religions and cultures with their sexual and moral commandments and prohibitions caused homosexuals to fall into disfavor. They eventually became a feared, hated, and persecuted minority.

When dealing with homosexual clients, counselor trainees must be prepared to maintain the same dimensions of physical, intellectual, and emotional intimacy they would maintain with heterosexual clients. It is an ongoing responsibility for the counselor to monitor personal homophobic reactions that could be destructive to a therapeutic relationship (Thompson and Fishburn, 1977). According to Kelly (1976), the lack of human sexuality courses in training programs for social workers and counselors leaves professionals inadequately prepared to deal with sexual concerns. Finding a counselor who is open and who can give competent help may be difficult for a person with sexual concerns, Kelly notes. Storms (1979) states that both psychologists and the public still know little about the meaning and determinants of sexual orientation. Individuals will fashion self-concepts based on that uncertainty. Those self-concepts can have great effect on lifestyles, subculture memberships, and societal roles. In addition, Storms notes that those

individuals who seek psychotherapy may encounter therapists who are as uncertain and/or as uninformed as themselves.

Student participants in a study by Nuehring, Fein, & Tyler (1974) observed that mental health professionals might find it uncomfortable and personally difficult to deal with homosexual clients. The students recommended that counselors become acquainted with homosexuals away from the clinical setting so they might learn to appreciate gays as functioning persons. Other suggestions from these students included: 1) counselors should deal openly with the issue of homosexuality and help the client reveal her/his preference if that seems to be important; 2) counselors should make a special point to assure gay clients that the information they disclose will be held in confidence; 3) the use of homogeneous group therapy as a treatment modality; and 4) the use of gay students as paraprofessionals and the hiring of gay professionals.

The purpose of this study was to examine the differences in clinical judgement ratings of graduate counseling students with their level of homophobia. It is proposed that a counselor trainee's level of homophobia will effect how they clinically judge a client based on the client's sexual preference.

Definition of Terms

Clinical Judgments:	a perception a counselor trainee has of a client based on that client's sexual preference.
Sexual Orientation:	whether a person is homosexual or heterosexual; also referred to as sexual preference.
Homophobia:	the irrational fear and hatred of homosexual people, based on beliefs in myths and misconception.
Gay:	persons, both male and female, whose primary emotional and/or sexual attractions and attachments are with members of their own sex; also called homosexuals and lesbians (this term is in reference to women).

Summary

Keeping the notion of homophobia and its effect on clinical judgments in mind, counselor trainees may be better apt to help homosexual clients deal with the concerns which effect the maintenance of good mental health in a society which basically neither condones nor validates their lifestyle. Some counselors are becoming more informed about homosexuality, and aware of their own feelings and beliefs about homosexuality and how this may effect their counseling relationship with gay clients. Literature relevant to the study will be more extensively reviewed in Chapter II.

CHAPTER II

REVIEW OF THE LITERATURE

The sickness model of homosexuality is not only damaging to the self-esteem of individual gays, but encourages and perpetuates the hostility and fear of society at large toward homosexuals. Gay activists argue, in essence, that homosexuals are properly viewed as a sociological minority whose major problem is one of social discrimination rather than intrapersonal maladjustment. Alongside the ideological contention exist many testimonials that homosexuals often perceive their experience in counseling and psychotherapy as counterproductive to dealing effectively with their personal problems. Both gay students and mental health professionals concurred that one major obstacle to satisfactory exchanges in counseling and therapy was the professionals' lack of practical knowledge about homosexuality and homosexual lifestyles (Nuehring et al., 1974).

This chapter begins with some main areas of discrimination against homosexuals. As background to the discrimination of homosexuals, the etiological theories of

homosexuality and the prevalence of homophobia from the general populace, college populations and the mental health professions are discussed.

Homosexuals and Discrimination

Janeway (1971) notes that conclusions and prescriptions for proper behavior based on sex differences are common to all societies. In our society, it is assumed that men and women have different moral, social, intellectual, and physical capabilities. Different attributes and different duties and ways of living are ascribed to men and women on the basis of these assumptions.

Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970) state that it would be well for clinicians to examine their attitudes concerning sex-role stereotypes and their notions about mental health. These researchers feel that better mental health might be achieved if both men and women were encouraged to realize their maximum individual potential, rather than try to adjust to restrictive sex roles.

As O'Leary (1978) states, homosexuals encounter many legal problems in this country because the laws of our land discriminate unjustly on the basis of sexual or affectional preference. They are routinely denied government employment in many areas, turned down for

security clearances, cashiered out of the armed forces, rejected as immigrants, denied custody of their own children, taxed at higher rates, and excluded from benefits of many social programs.

Besides the various forms of legal discrimination, there is also an abundant variety of extra-legal discrimination, on the part of private individuals, that is both socially condemned and legally barred when it comes to other minorities, yet is widely sanctioned in both law and social attitudes when it comes to gays. Private discrimination against gays is not even considered a fit topic for investigation by the U.S. Civil Rights Commission, the "nation's conscience" on matters of minority rights, and in the meantime in most parts of the country employers are free to fire or refuse to hire otherwise qualified persons merely because they are gay; property owners may refuse to rent, lease, or sell to gays; and operators of public accommodations may declare their establishments off limits to "overtly" gay would-be customers.

Ironically, oppression of gay people is both mitigated and facilitated by their "invisibility". Contrary to popular stereotypes the vast majority of lesbians and gay men can very easily "pass" as "straight". But while this ability protects many of them from overt discrimina-

tion on their jobs and other areas, having to live one's life "under cover" in this way is psychologically unhealthy. Moreover, this "invisibility" hides the true extent of their oppression even from themselves, and encourages society to dismiss their problems as of concern only to some minute fringe of "kooks and queers".

Jay and Young (1977) state it is impossible to think about the oppression of lesbians and gay men without first considering that the very concept of oppression depends on the existence of power, authority, and status. That homosexuals are an "out" group in this society is obvious enough. Labels like "queer" and "pervert" illustrate the contempt in which gay people are held. Cruelty, abuse of power, and the lack of freedom have all been part of the gay experience at one time or another.

The oppressive reality of archaic laws and overt discrimination is relatively easy for all to understand, but only gay people themselves can know the damage caused by the prevailing negative attitudes and the enforced invisibility which cause so many to feel alone and unworthy. This psychological warfare waged against gay people takes a heavy toll.

Homophobia contributes to this discrimination. In turn, the theories of the causes of homosexuality have

contributed to the widespread homophobia in this society. The following section discusses those theories.

Etiological Theories of Homosexuality

Morin (1977) notes that the approach to the etiological study of homosexuality has used four major models: psychoanalytic, learning, biochemical, and ethological. According to this investigator, the attempts to discover the causes of homosexuality have often been closely tied to the techniques used in efforts to correct or prevent homosexuality. This reflects a heterosexual bias which views heterosexuality as superior and/or more natural than homosexuality.

Two considerations studied from the psychoanalytic approach are: (1) parental background and parenting styles (Evans, 1969; Kenyon, 1968), and (2) family constellations (Siegleman, 1973). In Freud's view (1957), humans are potentially bisexually responsive. However, he regarded anything less than complete heterosexual adult attraction, activity, and satisfaction as emotional and psychosexual maladjustment.

Expecting to receive negative reinforcement from the opposite sex is one attempt to explain homosexuality based on the learning model (Clark and Epstein, 1972). Freund, Langevin, Gibiri, and Zajac (1973) see homosexu-

ality as a learned phobia or aversion to the opposite sex, and Goldstein, Kant, Judd, Rice, and Green (1971) claim homosexuality is the result of experiences such as exposure to pornography as an adolescent.

Theories based on the study of genetics and biochemicals suggest that hormones (Birk, Williams, Chasin, and Rose, 1973) or other physiological differences (Evans, 1972) result in homosexual development.

The ethological model (Chevalier-Skolnikoff, 1974) observes how homosexuality naturally develops in non-human primates. This is the only model which has not engendered beliefs which promote finding prevention or cures for homosexuality (Morin, 1977).

Many of these theories come from a gender-inversion view of homosexuality; that is, male homosexuals really want to be women, and female homosexuals really want to be men. Krafft-Ebing (1922) saw homosexuals as "inverts", or people who were born predisposed to the behaviours, attitudes, and desires of the opposite sex. According to him, homosexuals were sick, not immoral. Their problem was biological and irreversible.

Freud's theory (1957) was also based on the gender-inversion concept but from a psychological viewpoint. Bieber (1962) is one proponent of this theory. He states that over-identification with the opposite-sex parent will

cause the child to take on the sexual-orientation of that parent, especially if there is under-identification with the same-sex parent.

The medical model is often used to explain homosexuality. Bullough (1974) states that until the eighteenth century, the medical community as a whole had been hostile to variant sexual behavior, but their hostility was expressed in moral rather than medical terms. In the nineteenth century, all non-procreative sexual acts were viewed as immoral and hazardous to good physical and mental health. Bullough adds that masturbation and homosexuality especially were blamed for a large variety of physical and mental disorders. Although the pathology of these "aberrant practices" was long ago disproved, it was not until 1974 that homosexuality was removed as a pathological diagnosis from the classification scheme of the American Psychiatric Association. Some psychiatrists, such as Socarides (1978) argue that the classification should not have been dropped as it really does apply to some patients and is a helpful guide to their treatment.

One theory which embraces a positive approach to sexual orientation development is that proposed by Storms (1980). In a study about sexual orientation and self perception (Storms, 1979) the results indicated that a person's erotic fantasies and impulses have more to do

with the decision they make about their sexual orientation than do their self-perceived gender characteristics. Storms purports that at puberty, when an individual's sexual urges become felt, these urges plus her/his erotic fantasies may be directed towards same-sex persons with whom she/he has previously formed affectionate bonds. Storms hypothesizes that if puberty occurs early on in one's life, there is more likelihood that an individual will develop a homosexual orientation. This may happen because there is usually more homosocial than heterosocial bonding before puberty.

Homophobia

The pervasiveness of anti-homosexual attitudes touches every person but affects gay people profoundly. These attitudes include: (1) ignornace, (2) prejudice, (3) oppression, and (4) homophobia (McWhirter and Mattison, 1982).

Morin (1977) states that studies about homosexual bias against homosexuals have mostly surveyed the general population and the mental health profession. In the first case, Levitt and Klasen (1974) surveyed a large, representative sample of adults in this country. They found that most of their respondents believed that homosexuality is sick, disgusting, and can cause the downfall

of civilization. Over half of this sample thought jobs for homosexuals should be restricted and that homosexual behavior should be outlawed.

In a follow-up study, Nyberg and Alston (1977) confirmed that research. Comparison of their data with the study mentioned above indicates strongly that public attitude had not been moderated by that time. Liberal attitudes are found only in sociodemographic "pockets", unrelated to either sex or age differences. These authors found that education proved to be an important variable in the evaluation of homosexuality. Overall, they are pessimistic in their predictions about a more liberal public attitude occurring in the near future.

Several studies have investigated the incidence of homophobia in college populations. At the University of Kansas, Storms (1978) found the gender theory to be applicable. The students surveyed disliked most the homosexual male who displayed masculine traits instead of the expected stereotypic feminine attributes. Nyberg and Alston (1977) state that 51% of the female students and 62% of the male students they surveyed felt it was wrong to be sexually attracted to a same-sex person. The students felt it was easier to identify male homosexuals than lesbians. Female homosexuality was seen as erotic while male homosexuality was labeled repugnant. Bernard

and Schwartz (1977) found that education was a factor in students' attitudes towards homosexuality, as participants in a human sexuality program were more accepting of homosexuality than were the controls.

Cox (1980) found that graduate students in the counseling program at the University of Kansas showed a negative bias toward male homosexuals.

Graduate counseling students in another study (Thompson and Fishburn, 1977) reported feeling unprepared to deal with homosexual clients, and they were unsure about the etiology of homosexuality.

The literature indicates that homosexuality remains a controversial issue among mental health professionals. Therapists' attitudes toward homosexuals in general reflect this controversy. Therapists differ as to the need and method of treatment and on recommendations for dealing with homosexual clients. Three studies used questionnaires to survey mental health professionals. Two studies (Barr and Catts, 1974; Fort, Steiner, & Conrad, 1971) found that the respondents indicated a more positive view toward homosexuals. Lief (1977) reports that his respondents displayed more negative attitudes. Barr and Catts report that 35% of their respondents agreed that homosexuality is a neurotic disorder, 52% said that as a developmental anomoly, homosexuality is not neces-

sarily or commonly connected with neurotic symptoms, and 13% called homosexuality a normal variant. These authors conclude that neurotic symptoms do not necessarily or commonly accompany homosexual feelings and behaviors. The homosexual may make a good adjustment and make a useful and creative contribution to society.

Fort, Steiner, and Conrad (1971) found similar results in their study. Ninety-seven percent of the therapists surveyed said they would work with other goals besides sexual orientation. However, their answers were more evenly divided when asked if they would treat a homosexual with the explicit goal of changing homosexual orientation: 38% said they would, 43% would not, and 19% were unable to say. Seventy-two percent reported that they would not consider a psychogenic or functional condition of homosexuality an illness or disease. These researchers state that 90% of their respondents felt the terms "illness" and "disease" result in public misunderstanding of homosexuality. Finally, 98% felt that homosexuals could function effectively in their everyday lives.

Lief (1977) reports that the majority of the 2500 psychiatrists who responded to a medical journal survey on homosexuality felt that (1) homosexuality is usually a pathological adaptation, not a normal variation, (2)

therapy can almost never help homosexuals to become heterosexuals, (3) homosexual men are less happy than others, (4) homosexual men and women are less capable of maintaning mature, loving relationships than are heterosexuals, (5) homosexuals' problems stem from personal conflicts, not stigmatization, and (6) homosexuals are generally a greater risk to hold positions of responsibility than are heterosexuals.

Ross and Talikka (1979) note that the World Health Organization (WHO) continues to classify homosexuality as a nonorganic sex anomoly, a personal pathology, and a sexual aberration. These authors urge the WHO to reconsider this classification as it ignors conclusive evidence which indicates that homosexuality is not necessarily pathological and it also adds to discrimination toward minority groups.

The use of therapy to change sexual orientation seems to be a major source of disagreement among therapists. As noted above, 72% of the sample in the study by Fort, Steiner, and Conrad (1971) said that therapy could change sexual orientation, whereas the majority of those therapists surveyed by Lief (1977) said it almost never could. Bieber and Bieber (1979), Nobler (1972), Card (1977), Socarides (1978), and Masters and Johnson (1979) contend that change of sexual orientation is a viable and

valid treatment goal. Current treatments include psychoanalysis (Bieber and Bieber, 1979), aversion therapy (Card, 1977), group therapy (Nobler, 1972), and sex therapy (Masters and Johnson, 1979).

On the other hand are those therapists who recommend working with gay clients as individual persons with individual concerns, one of which may be homosexuality. According to Haynes (1977), helping professionals sorely neglect the counseling needs of homosexuals. A client's homosexuality should be the focus of treatment only if the client and counselor agree that it is important; giving up homosexuality may not be the presenting problem. In any case, Haynes recommends that a viable treatment plan be developed.

Norton (1976) also suggests that counselors keep all options open when working with gay clients. He states that it is easier to help homosexuals accept their sexual preference than it is to change them. The client's feelings about her/his homosexuality and the issues that particular preference raises are the most important considerations. Counselors should become informed, become aware of their own beliefs and feelings about homosexuals, and they should work to dispel the prejudice taught to them by society. In Norton's view, counselors

should be the most likely group of professionals to offer gays acceptance and understanding.

This chapter has been a review of the literature pertaining to (1) the discrimination against homosexuals; (2) the etiological theories of homosexuality; and (3) the prevalence of homophobia held by the general public, college students and the mental health profession. The following chapter is an explanation of the design, procedure, and method of the present study. The results will be presented in Chapter IV; and Chapter V will include the discussion of the results and the conclusions which may be drawn from the research.

CHAPTER III

METHOD

The purpose of this study was to compare clinical judgment ratings of graduate counseling students with their level of homophobia. It was proposed that a counselor trainee's level of homophobia would effect how they clinically judged a client based on that client's sexual preference.

Subjects

The subjects were 53 female and 27 male graduate counseling students from two schools: 38 female and 16 male subjects in the School of Education from the University of Kansas; 15 female and 11 male subjects in the School of Education from Emporia State University. The participants were all included without regard to sex, age, or race. The subjects ranged in age from 22 to 52 with a mean age of 30.5 years. Their level of education was first year Master's. All subjects were of a middle class background. Personal and demographic data are presented in Tables 1-3.

TABLE 1

Age Range of Subjects

Age Range	Number
18-23	13
24-29	29
30-35	24
36-41	5
42-47	8
48-53	1
MEAN	30.5

TABLE 2

Program Level of Subjects

Program Level	Number
M.S.	80
Ph.D.	--

TABLE 3

Socioeconomic Background of Subjects

Class Level	Number
Lower Middle	15
Middle	52
Upper Middle	13

Instruments

There were three instruments utilized in this study. They were: (1) Index of Homophobia (IHP); (2) Clinical Judgment Scale (CJS); and (3) the Vignettes. The following is a description of these three instruments: (1) Index of Homophobia (IHP) designed by Wendall A. Ricketts and Walter W. Hudson (1977). The IHP was a twenty-five item summated category partition scale. Persons who have very little dread of working or associating with homosexuals tend to obtain very low scores on the IHP and those who have considerable dread or discomfort tend to obtain higher scores. Some of the items on the IHP represent positive statements about gay people and their social interactions and the remainder are negative statements. Positive and negative statements were used in order to partially eliminate or control for any response set biases. The designers of the IHP found it to be reliable (coefficient Alpha of .901) and valid. A copy of the IHP appears in Appendix A; (2) Clinical Judgment Scale (CJS) designed by the investigator of this study. All items of this scale were based on the work of Strupp (1960). This scale was made up of eleven items calling for respondents to make judgments on a five-point Likert-type scale. The eleven items were intended to represent three types of judgments assumed to be part of the clini-

cal process: (1) diagnostic judgment (e.g., "overall degree of disturbance of client"); (2) treatment judgment (e.g., "would you tend to deal with intrapsychic or interpersonal behavior with the client?"); and (3) attitudinal judgment (e.g., "how would you characterize your personal reaction to this client?") (Fischer and Miller, 1973). Counselor trainees who tend to place little or no emphasis on a client's sexual preference obtain low scores on the CJS and those who tend to place an emphasis on a client's sexual preference obtain higher scores. As in the IHP, some of the items on the CJS represent positive statements about a client and the remainder are negative statements. Positive and negative statements were used in order to partially eliminate or control for any response set biases. This instrument was designed for this study and had not been used before in any other study, therefore, there was no reliability nor validity data for its use. A copy of the CJS appears in Appendix B; and (3) Vignettes designed by the investigator of this study. There were two separate forms of this instrument utilized in order to form a control group. The vignettes were worded in exactly the same manner: Form A (Appendix C) dealt with a homosexual relationship and Form B (Appendix D) dealt with a heterosexual relationship.

Procedure

The following procedures were used in the present study. The subjects were contacted and the packets distributed through the researcher of this study from various classes in the graduate counseling programs. All subjects were handed a packet containing a consent form, instructions, a vignette (Form A or Form B), the two questionnaires (IHP and CJS), and a sheet for demographic information. The subjects were then asked to read and sign the consent form if they agreed to participate in the study (Appendix E). Also at this time, the instructions (Appendix F) were given and necessary questions answered. The participants then proceeded to complete the packet. (A copy of the sheet for demographic information can be found in Appendix G). Half of the subjects being tested were given a packet with vignette Form A and the other half of the subjects being tested were given a packet with vignette Form B. The order in which the vignettes and questionnaires were placed was varied: for both vignettes (Form A and B), twenty subjects received a packet with the IHP first, the vignette second, and the CJS third; the other twenty subjects received a packet with the vignette first, the CJS second, and the IHP third.

Statistical Analysis

The following hypotheses were analyzed using: (1) a two by two analysis of variance. In the two by two analysis of variance, the independent variables were the two levels of the IHP and the two forms of the vignette; the dependent variable was the CJS scores.

Hypotheses

$Ho:_1$ There is no difference in the mean clinical judgment ratings of groups of counselor trainees earning high and low scores on the IHP scale.

$Ho:_2$ There is no difference in the mean clinical judgment ratings of groups of counselor trainees reading vignettes describing homosexual (Form A) and heterosexual (Form B) relationships.

$Ho:_3$ There is no interaction between scores on the IHP scale and assignment to vignettes.

Summary

This chapter presented the method used in this study. It consisted of the subjects tested, the instruments, the procedures, the statistical analysis, and the

hypotheses used in this study. The results of this study will be presented in Chapter IV.

CHAPTER IV

RESULTS

The primary purpose of this study was to examine the differences in clinical judgment ratings of counselor trainees, based on a client's sexual preference, with the counselor trainees' level of homophobia. This chapter deals with the analysis of the data gathered in this study. The statistical analysis conducted and the results obtained are described below.

Analysis

In the two by two analysis of variance wherein the independent variables were the two levels (high and low) of the IHP and the two forms (A and B) of the vignette and the dependent variable was the CJS scores the following was obtained.

Table 4 gives sources of analysis in this analysis and Table 5 gives the mean scores and standard deviations of the clinical judgment scale.

For those who obtained a low score on the IHP and read vignette Form A (homosexual relationship) the mean

Table 4

Source Table for Analysis of Variance

Source of Variation	Sum of Squares	DF	Mean Square	F
Index of Homophobia	505.13	1	505.13	12.05*
Vignettes (Form A & B)	6.47	1	6.47	0.15
IHP by Vignettes	37.95	1	37.95	0.90
Within Cells	3183.61	76	41.88	

*Significant @ the .05 level

Table 5

Mean Scores and Standard Deviations
of the Clinical Judgment Scale

Variable	Mean	S.D.	N
Low Homophobia			
Vignette Form A	11.14	4.05	14
Vignette Form B	12.20	5.48	20
High Homophobia			
Vignette Form A	17.61	7.90	26
Vignette Form B	15.85	6.62	20

score on the CJS was 11.14 with a standard deviation of 4.05. Those who also obtained a low score on the IHP but read vignette Form B (heterosexual relationship) show the mean score on the CJS was 12.20 with a standard deviation of 5.48. The subjects who obtained a high score on the IHP and read vignette Form A (homosexual relationship) show the mean score on the CJS was 17.61 with a standard deviation of 7.90. Those who also obtained a high score on the IHP but read vignette Form B (heterosexual relationship) show the mean score on the CJS was 15.85 with a standard deviation of 6.62. These results indicated that regardless of whether a counselor trainee reads vignette Form A or Form B (the clients' sexual preference), when the IHP score was low so was the CJS rating, and when the IHP score was high so was the CJS rating.

$Ho:_1$ There is no difference in the mean clinical judgment ratings of groups of counselor trainees earning high and low scores on the IHP.

The results of the analysis indicate there was a significant difference in the mean clinical judgment ratings of groups of counselor trainees earning high and low scores on the IHP. Therefore, this hypothesis was rejected at the .05 level of significance.

$Ho:_2$ There is no difference in the mean clinical judgment ratings of groups of counselor trainees reading

vignettes describing homosexual (Form A) and heterosexual (Form B) relationships.

The results show there was no significant difference in the mean clinical judgment ratings of groups of counselor trainees reading vignettes describing homosexual (Form A) and heterosexual (Form B) relationships. Therefore, this hypothesis was not rejected at the .05 level of significance.

$Ho:_3$ There is no interaction between scores on the IHP and assignment to vignettes.

The results show there was not a significant interaction between scores on the IHP and assignment to vignettes. Therefore, this hypothesis was not rejected at the .05 level of significance.

A test of homogeneity of variance was also done and found to be $p = 0.05$ (Cochrans C). This implies the groups were not so different as to create problems interpreting the test of significance.

Summary

This chapter presented the results of a two by two analysis of variance between the independent variables (the two levels of the IHP and the two forms of the vignette), and the dependent variable (the CJS scores). The results indicate there is a significant difference in

the mean clinical judgment ratings of groups of counselor trainees earning high and low scores on the IHP; there is no significant difference in the mean clinical judgment ratings of groups of counselor trainees reading vignettes describing homosexual (Form A) and heterosexual (Form B) relationships; and, there was not a significant interaction between scores on the IHP and assignment to vignettes. Chapter V will consist of a discussion of these results, a summary of this study, limitations of this study, and recommendations for further research.

CHAPTER V

SUMMARY AND CONCLUSIONS

It was the purpose of this study to examine the differences in clinical judgment ratings of counselor trainees, based on a client's sexual preference, with the counselor trainees level of homophobia.

The review of the literature was divided into three sections. The first section dealt with the discrimination against homosexuals. Homosexuals have long been victims of ancient attitudes and myths. They face intolerance, misunderstanding and even hatred from a homophobic, heterosexist society. Labels such as queer and pervert illustrate the contempt in which gay people are held. This greatly affects their civil and human rights. The oppressive reality of overt discrimination is relatively easy for all to understand, but only gay people themselves can know the damage caused by the prevailing negative attitudes and the enforced invisibility which cause so many to feel alone and unworthy.

The second section of the review of the literature discussed the etiological theories of homosexuality.

Several models have been used to explain how people become homosexual. Most attempts to discover the causes of homosexuality have often been closely tied to the techniques used in efforts to cure or prevent homosexuality. The psychoanalytic theory proposes that homosexuality results from faulty or arrested emotional development. Homosexuality may also be a result of developing abnormally close ties with the same-sex parent, or a fear of the opposite-sex parent. The learning theory suggests that negative reinforcement from the opposite-sex parent or a learned phobia may contribute to homosexual orientation. The genetic and biochemical models study the effects of hormones and other physiological differences which may account for homosexuality. The gender-inversion theory holds that male homosexuals and lesbians are like the opposite sex in attitudes, behaviors, and desires. The conclusion of the medical model is that homosexuality was a sexual abberration which could lead to physical and mental disorders. Some authors suggest that homosexuals want to be that way, while others argue that homosexuals have no choice in the matter. All these theories lead to the view of homosexuals as sick, abnormal, underdeveloped, perverted, or, at best, deviant.

Storms theory (1980) suggests that homosexuality may result from early affectionate bonding with same-sex

persons. At puberty, when sexual urges are felt, awareness of desire towards same-sex person may lead to that type of sexual orientation.

The third section dealt with the prevalence of homophobia held by the general public, college students, and the mental health profession. Mental health professionals appear to disagree about the theories and about the ways to counsel gay clients. Many therapists still consider heterosexual re-orientation to be a viable treatment option. However, a growing number of therapists now consider homosexuality to be an acceptable alternative, not necessarily a pathological disturbance. They recommend that gay clients be regarded as people whose homosexuality may or may not be a presenting problem. Therapists should become informed and unbiased. They should be able to offer understanding and support to their gay clients.

In summary, the review of the literature indicates the following points to be important:

1) There is a lack of research concerning the effect of homophobia on counselor trainees clinical judgments.
2) Mental health professionals disagree about the theories and ways to counsel gay

clients, perpetuating homophobia and discrimination against homosexuals.

3) Counselors should be the most likely group of professionals to offer gays acceptance and understanding.

In the present study conducted, 80 graduate counseling students completed an index of homophobia scale and clinical judgment scale. A two by two analysis of variance was used to analyze the data. The results indicate that for this sample, if a counselor trainee's level of homophobia was high so was their rating on the clinical judgment scale and if their level of homophobia was low so was their rating on the clinical judgment scale.

Discussion

This section will discuss the results in Chapter IV and how they relate to the literature. A heterosexist, homophobic society has had a stake in maintaining a disparaging view of homosexuals. Most researchers in the past set out to "prove" that gay people are abnormal, sick, neurotic, and deviant. The other major reason for conducting research about homosexuals has been to find a way to cure them, i.e., to turn them into heterosexuals.

The literature shows that the mental health profession remains divided on the issue of homosexuality. Controversy surrounds the etiology of homosexuality and the way gay clients should be counseled. Misinformation and bias are still displayed by both professionals and students in this field, although some therapists are aware of the need to provide sensitive, unbiased, and open-minded support to gay clients. In the present study, it is apparent that a counselor trainee's level of homophobia effects how they clinically judge a client. Regardless of the client's sexual preference, when a counselor trainee's level of homophobia was high so was their clinical judgment rating and when their level of homophobia was low so was their clinical judgment rating. As was stated earlier, counselor trainees who tend to place little or no emphasis on a client's sexual preference obtain low scores on the clinical judgment scale, and those who tend to place an emphasis on a client's sexual preference obtain higher scores.

The findings from this study suggest that if a counselor chooses to work with gay clients, she/he needs to become aware of any prejudice they may hold about homosexuals, so as to not have personal homophobic reactions be counterproductive to the therapeutic process.

Some other suggestions for the counselor who chooses to work with gay clients are: (1) for counselors to deal openly with the issue of homosexuality; do not avoid or attempt to minimize the issue; (2) to keep all options open when working with gay clients. The gay client is going to come for counseling with many other personal and interpersonal problems in addition to, or quite apart from, concerns about homosexuality; (3) that counselors should become acquainted with homosexuals away from the clinical setting so they could learn to appreciate gays as functioning persons; and (4) for counselors to make a special point to assure gay clients of the confidentiality of the information they diclose.

A further suggestion is for counselor education programs to attempt to bring prejudices of counselor trainees into the open, so counselor trainees are able to control them or remove them from their counseling encounters. Perhaps incorporating the requirement of human sexuality courses into training programs for counselors would help with this goal as well as to help counselors deal adequately and competently with gay clients. Informed counselors are potential agents for dispelling stereotypic thinking in the broader culture.

A final suggestion is that mental health professionals consider conceptualizing homosexuality not as a

pathological sexual orientation, but instead as a sociological minority group. The minority group concept has greater explanatory power than the deviance concept. It redefines homosexuality as to mainly residing in prejudicial attitudes, shifting attention from the view of homosexuality being intrapersonal maladjustment to that of social discrimination. In helping counselors to understand homosexuality, a conceptual shift from the individual deviance model to a minority group perspective appears to permit a social adjustment-oriented strategy in counseling gay clients. The minority group perspective enables clearer recognition of other problems in living in which an individual, who happens to be gay, may have. In terms of problems related to homosexuality, the minority group perspective shifts the focus from defining the individual as impaired to recognizing her/his situation in terms of incompatibility with dominant social norms (Nuehring et al., 1974).

Limitations

The first limitation of this study was that one of the instruments, the CJS, was designed for this study only and had not been used in any other study, therefore, there was no reliability or validity data for its use.

Secondly, the questionnaires were self-report measures. The use of this type of measure leads to ipsative scores and problems in analyzing and interpreting scores. The openness of self-report measures permits a variety of dissimulation to occur, including faking.

Although the number of subjects tested was adequate, a larger number of subjects would have assured stronger support for the hypotheses of this study and secured a random sample. However, the sample was representative as far as age, sex, and similarity to course work for graduate counseling students. For these reasons, the results could be generalized to all graduate counseling students.

Recommendations

The following are some recommendations for further research:

1) The present study could be replicated using a larger sample.
2) Perhaps other measures and alternate means of testing subjects should be done. Most research done with self-report measures has its limitations as is mentioned in the above section.
3) Conduct a study within a training program for counselors based on modifying a counselor

trainee's level of homophobia by utilizing the index of homophobia as a pre- and post-test.

4) Further research might also be directed toward utilization of the conception of homosexuality from the minority group perspective rather than the deviance concept.

Summary

The purpose of this study was to compare clinical judgment ratings of graduate counseling students with their level of homophobia. It was proposed that a counselor trainee's level of homophobia would effect how they clinically judged a client based on that client's sexual preference. As the results indicated, regardless of the sexual preference of the client, a counselor trainee's level of homophobia did effect how they clinically judged a client.

In a society which basically neither condones nor validates a gay lifestyle, counselor trainees may be better apt, keeping the notion of homophobia and its effects on clinical judgments in mind, to help gay clients deal with concerns which effect the maintenance of good mental health. It is of utmost importance for counselor trainees to become informed about homosexuality, to become aware of their own beliefs and feelings

regarding homosexuality, and to dispel the prejudice taught to them by society. As stated earlier, mental health professionals should be the most likely group to offer gays acceptance, understanding and support.

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APPENDIX A

INDEX OF HOMOPHOBIA

INDEX OF HOMOPHOBIA (IHP)

This questionnaire is designed to measure the way you feel about working or associating with homosexuals. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 Strongly agree
2 Agree
3 Neither agree nor disagree
4 Disagree
5 Strongly disagree

Please begin.

1. I would feel comfortable working closely with a male homosexual. ____
2. I would enjoy attending social functions at which homosexuals were present. ____
3. I would feel uncomfortable if I learned that my neighbor was homosexual. ____
4. If a member of my sex made a sexual advance toward me I would feel angry. ____
5. I would feel comfortable knowing that I was attractive to members of my sex. ____
6. I would feel uncomfortable being seen in a gay bar. ____
7. I would feel comfortable if a member of my sex made an advance toward me. ____
8. I would be comfortable if I found myself attracted to a member of my sex. ____
9. I would feel disappointed if I learned that my child was homosexual. ____
10. I would feel nervous being in a group of homosexuals. ____
11. I would feel comfortable knowing that my clergyman was homosexual. ____
12. I would deny to members of my peer group that I had friends who were homosexual. ____
13. I would feel that I had failed as a parent if I learned that my child was gay. ____
14. If I saw two men holding hands in public I would feel disgusted. ____
15. If a member of my sex made an advance toward me I would be offended. ____
16. I would feel comfortable if I learned that my daughter's teacher was a lesbian. ____
17. I would feel uncomfortable if I learned that my spouse or partner was attracted to members of his or her sex. ____
18. I would like to have my parents to know that I had gay friends. ____
19. I would feel uncomfortable kissing a close friend of my sex in public. ____
20. I would like to have friends of my sex who were homosexual. ____
21. If a member of my sex made an advance toward me I would wonder if I were homosexual. ____
22. I would feel comfortable if I learned that my best friend of my sex was homosexual. ____
23. If a member of my sex made an advance toward me I would feel flattered. ____
24. I would feel uncomfortable knowing that my son's male teacher was homosexual. ____
25. I would feel comfortable working closely with a female homosexual. ____

3,4,6,9,10,12,13,14,15,17,19,21,24

APPENDIX B

CLINICAL JUDGMENT SCALE

Clinical Judgment Scale

This questionnaire is designed to measure the way a counselor clinically judges a client. It is not a test, so there are no right or wrong responses. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 Strongly agree
2 Agree
3 Neither agree nor disagree
4 Disagree
5 Strongly disagree

Please begin.

1. I would evaluate the client as emotionally mature. _____
2. I can empathize with the client's feelings. _____
3. I would find it difficult to be objective with this client. _____
4. The client is highly disturbed and needs intensive therapy. _____
5. I would have a positive reaction/attitude to this client. _____
6. If this were my client, I would focus on their sexual orientation. _____
7. The client is generally well-adjusted. _____
8. I would be uncomfortable with this client. _____
9. The client would be a poor risk for therapy. _____
10. If this were my client, I would focus on the relaship issue. _____
11. I would evaluate the client to be of above average intelligence. _____

3, 4, 6, 8, 9

APPENDIX C

VIGNETTE FORM A

HOMOSEXUAL RELATIONSHIP

Vignette

You are to read this vignette and then respond to the items on the questionnaire that follows:

An individual comes to you for counseling. This person is enrolled at the University in Graduate School in Physics and is studying on a fellowship. The individual is from a middle to upper middle class background and went to undergraduate school at the same University they currently attend. The first year at school was spent in a dorm. For the past five years, the person has lived in an apartment off campus. This person has many interests, is highly active and is currently the Director of the Gay Services program on campus.

Over the past year, this person has been living with a same-sex lover. This person describes the relationship as satisfying and involved; the two are very much a couple yet also two independent people. For the past few months, the couple has been discussing the issue of a permanent commitment to/with one another. The person who has come to see you is ready for and wants to make the commitment; their partner is neither ready nor wants to make the commitment. The two of them have had a number of discussions over the issue of a permanent relationship with one another, resolving nothing and only increasing the anger and hurt. The person who has come to see you wants help sorting out their thoughts and feelings.

APPENDIX D

VIGNETTE FORM B

HETEROSEXUAL RELATIONSHIP

Vignette

You are to read this vignette and then respond to the items on the questionnaire that follows:

An individual comes to you for counseling. This person is enrolled at the University in Graduate School in Physics and is studying on a fellowship. The individual is from a middle to upper middle class background and went to undergraduate school at the same University they currently attend. The first year at school was spent in a dorm. For the past five years, the person has lived in an apartment off campus. This person has many interests, is highly active and is currently the Director of the Graduate Student Council on campus.

Over the past year, this person has been living with a lover. This person describes the relationship as satisfying and involved; the two are very much a couple yet also two independent people. For the past few months, the couple has been discussing the issue of a permanent commitment to/with one another. The person who has come to see you is ready for and wants to make the commitment; their partner is neither ready nor wants to make the commitment. The two of them have had a number of discussions over the issue of a permanent relationship with one another, resolving nothing and only increasing the anger and hurt. The person who has come to see you wants help sorting out their thoughts and feelings.

APPENDIX E

INFORMED CONSENT FORM

The Department of Counseling at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate you are free to withdraw at any time.

> This study is concerned with the reactions of a counselor to a client. Participation in the study involves reading a vignette and filling out two clinical questionnaires in response to that vignette.

Your participation is solicited, but is strictly voluntary. If you have any questions about the study, do not hesitate to ask. Be assured that your name will not be associated in any way with the research findings. I appreciate your cooperation very much.

Sincerely,

Donna DiVincenzo
841-5844

_____

Signature of subject agreeing to participate

APPENDIX F

INSTRUCTIONS

INSTRUCTIONS

Attached are two questionnaires in which you are to respond. Both require the same type of response. You are to answer each item by placing a number in the space that proceeds it according to the following scale:

1 Strongly agree

2 Agree

3 Neither agree nor disagree

4 Disagree

5 Strongly disagree

One of the questionnaires requires you to read a vignette prior to responding to its items.

Please fill out the questionnaires carefully and truthfully.

Thank you once again.

APPENDIX G

DEMOGRAPHIC INFORMATION

AGE _____

SEX _____

RACE _____

SOCIOECONOMIC BACKGROUND _____

COURSE OF STUDY _____

LEVEL/YEAR IN SCHOOL _____