MICHIGAN STATE UNIVERSITY LIBRARIES
3 1293 01021 9685

This is to certify that the

dissertation entitled

The Heterosexual Bias Inventory (HBI): Gay, lesbian, and bisexual clients' perceptions of heterosexual bias in psychotherapy.

presented by

Julia Florence Moss

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Counseling Psychology

Linda Forrest
Major professor

Date July 28, 1994

MSU is an Affirmative Action/Equal Opportunity Institution

O-12771

LIBRARY
Michigan State
University

PLACE IN RETURN BOX to remove this checkout from your record.
TO AVOID FINES return on or before date due.

DATE DUE	DATE DUE	DATE DUE
JAN 11 [illegible]		
~~JL 230698~~ MAR 3		
~~[illegible]~~ MAR 2 [illegible]		
NOV 2 8 1999		
~~DEC 0 9 1999~~		

MSU is An Affirmative Action/Equal Opportunity Institution
c:\circ\datedue.pm3-p.1

THE HETEROSEXUAL BIAS INVENTORY (HBI): GAY, LESBIAN, AND BISEXUAL CLIENTS' PERCEPTIONS OF HETEROSEXUAL BIAS IN PSYCHOTHERAPY

Volume I

By

Julia Florence Moss

A DISSERTATION

Submitted to
Michigan State University
in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Counseling Psychology

1994

ABSTRACT

THE HETEROSEXUAL BIAS INVENTORY (HBI): GAY, LESBIAN, AND BISEXUAL CLIENTS' PERCEPTIONS OF HETEROSEXUAL BIAS IN PSYCHOTHERAPY

By

Julia Florence Moss

Gay, lesbian, and bisexual clients may be negatively impacted by the presence in psychotherapy of pervasive cultural biases against homosexuality and bisexuality. The purpose of this study was to develop a valid and reliable instrument to measure gay, lesbian, and bisexual clients' perceptions of heterosexual bias in psychotherapy. A secondary purpose was to investigate differences in the perception of heterosexual bias when client, therapist, and treatment variables varied.

To develop the instrument, an initial pool of 43 items was generated through reliance on a study conducted by the American Psychological Association Committee on Lesbian and Gay Concerns (1991). A self-administered questionnaire was completed by seventy-three gay men, one hundred and twelve lesbians, and twenty-eight bisexuals who had been in psychotherapy for one or more sessions within the past 10 years. A factor analysis of the original 43 items resulted in a single factor 15-item measure of heterosexual bias, the Heterosexual Bias Inventory (HBI). The HBI was found to be initially reliable and valid. The repeat reliability ($N=41$) was $r=.983$, $p<.0001$, and the Cronbach's alpha was .9672. Heterosexual therapists and those therapists with unknown sexual orientations were perceived to be more biased than those therapists who were known to be gay, lesbian, or bisexual ($p<.001$).

Bisexuals reported more bias than lesbians ($p < .03$). A multiple regression analysis indicated that client variables (less exclusive homosexuality, more conflict with sexual orientation), therapist variables (less perceived therapist knowledge), and treatment variables (less focus on sexual orientation issues in the therapy, less likelihood that the respondent came with a relationship difficulty, less perceived therapist empathy, less satisfaction with the treatment) each explained unique portions of the variance of perceived heterosexual bias. The final regression model explained 85% of the variance.

The results suggest the need for therapists to be sensitive to and knowledgeable about gay, lesbian, and bisexual issues in order to provide treatment that is perceived as less biased by lesbian, gay, and bisexual clients.

Copyright by

JULIA FLORENCE MOSS

1994

DEDICATION

To all those gay men, lesbians, and bisexuals whose self-esteem and positive sense of identity have suffered because of those who wanted to "help" them.

ACKNOWLEDGEMENTS

I gratefully acknowledge the participation, support, and assistance of many people who made this project possible. I thank my advisor and mentor, Dr. Linda Forrest, for her steady guidance, support, and overall availability throughout this project. I thank my committee members, Dr. Terry Stein, Dr. Gershen Kaufman, and Dr. Lee June for their teamwork, helpful critiques, and emotional support.

I am particularly grateful to my mother, Miriam Moss, whose devotion to research and whose accomplishment as a researcher have inspired me since childhood. I thank her for sharing her wisdom about research, and mostly for spending so much time with me, helping me to critically think about all aspects of this project. I also thank my father, Sidney Moss, for his love and ongoing interest in and support of my professional development. Furthermore, I would like to thank the lesbian, gay, and bisexual persons who willingly shared their experiences with me by participating in this study.

Finally, I am indebted to Mark Horwitz, whose belief in my ability has sustained me, and whose infinite devotion, patience, and support has ultimately enabled me to complete this project.

TABLE OF CONTENTS

Page

CHAPTER

I. STATEMENT OF THE PROBLEM
Introduction....1
Heterosexual Bias as a Form of Oppression: Heterosexism....2
Clinical Relevance....5
Research Relevance....8
Background of Problem. 8
Construct of Sexual Orientation....9
Prevalence of Lesbians, Gays, and Bisexuals....10
Societal Heterosexism....14
Violence....15
Legal Discrimination....17
Religious Discrimination....18
Discrimination and Its Effects....18
Need for Study....20
Assumptions of Study....23
Purpose of Study....24
Research Questions....25
Definition of Terms....25
Conclusion....28

II. LITERATURE REVIEW....30
Historical Overview....30
Changes in Policy....34
Pathological Etiology....37
Non-Pathological View of Homosexuality....39
Views of Bisexuality....40
Terminology....42
Homophobia....42
Heterosexism....43
Social Context: Psychotherapy as a Form of Social Control....45
Values and Psychotherapy....48
Clinical Theory Regarding Heterosexual Bias in Psychotherapy with Lesbians, Gay Men, and Bisexuals....49
Gay, Lesbian, Bisexual Clients Are Viewed Pathologically....50
Homosexuality as Failed Heterosexuality...51
Internalized Homophobia....53
Gay, Lesbian, Bisexual Issues Marginalized....55

Misplaced Focus on Sexual Orientation.....56
Modifying Sexual Orientation.....57
Countertransference Issues.....57
Stereotypic Pathologizing.....58
Lack of Knowledge or Expertise.....59
Therapist Attitudes Towards and Knowledge About Lesbians and Gay Men.....60
Empirical Research.....62
Survey Research-1970's.....62
Analogue Studies-1970's.....68
Survey Research-1980's.....69
Analogue Studies-1980's.....73
Survey Research-1990's.....74
Summary.....75
Lesbian, Gay, and Bisexual Client Variables..76
Prevalence Seeking Psychotherapy.....76
Reasons for Seeking Psychotherapy.....77
Gay Men's, Lesbians', and Bisexuals' Perceptions of Psychotherapy.....78
Empirical Research.....79
Client Perceptions of Psychotherapy.....89
Empathy.....91
Client Satisfaction.....93
Hypotheses.....94
Conclusion.....98

III. METHODOLOGY.....100
Sample Recruitment.....101
Characteristics of Sample.....102
Background Characteristics of Respondents.....103
Current Sexual Orientation of Respondents.....106
Mental Health/Psychiatric History of Respondents.....108
Past Therapy Experience.....108
Psychiatric History.....109
Characteristics of Therapist.....109
Characteristics of the Therapy Experience.....112
Procedures.....119
Measures.....121
Satisfaction with Psychotherapy.....121
Measure of Perceived Empathy.....123
Perceived Knowledge Measure.....125
Knowledge Index.....126
Not Knowledge Index.....126
Composite Measures.....127
Dummy Codes.....128
Hypotheses.....131
Analysis.....133

Conclusion.....136

IV. INSTRUMENT DEVELOPMENT.....137
Source of Items.....137
Themes of the Initial Pool of Bias Items....138
Pilot Testing.....142
Expert Judging.....144
Factor Analysis.....145
Criteria for Selection of Items for Heterosexual Bias Inventory (HBI).....147
Reliability of the HBI.....153
Internal Consistency.....153
Test-Retest Reliability.....154
Validity.....154
Content Validity.....155
Construct Validity.....156
Missing Data.....156
Conclusion.....157

V. RESULTS.....159
Hypothesis 1.....159
Hypothesis 2.....159
Hypothesis 3.....160
Hypothesis 4.....161
Hypothesis 5.....164
Hypothesis 6.....166
Hypothesis 7.....168
Correlations: HBI and Respondent Variables.....170
Correlations: HBI and Therapist Variables.....173
Correlations: HBI and Therapy Experience Variables.....175
Hierarchical Multiple Regression Analyses.....177
Respondent (Client) Predictors.....177
Therapist Predictors.....179
Therapy Experience Predictors.....181
Overall Predictors.....183
Final Regression Model.....185
Summary of Results from Multiple Regression.....188
Post-Hoc Analyses.....189
Therapist-Client Sex-Match.....189
Sexual Orientation of Therapist and Perceived Empathy, Knowledge, and Treatment Satisfaction.....191
Therapist Awareness of Respondent's Sexual Orientation.....193
Perceived Heterosexual Bias of Psychiatrists, Psychologists,

Social Workers, and Counselors.....194
Demographic Variables by Source of Questionnaire.....195
Prevalence of Bias on HBI.....196
Summary of Results.....201
Instrumentation Findings.....201
Client Sexual Orientation and the Perception of Heterosexual Bias.....202
Findings Related to Therapist Variables.....203
Major Predictors of Heterosexual Bias....203
Conclusion.....204

VI.DISCUSSION.....205
Summary of the Study.....205
Summary of Development of the Instrument.....205
Reliability and Validity of the Instrument.....206
External Validity.....207
Implications of the Sample Characteristics.....208
Findings Related to the Construct Validity of the HBI.....211
Implications of Validity Findings.....216
Group Differences Findings.....217
Implications of Significant Correlates of Bias.....224
Respondent Characteristics Correlated with Bias.....225
Therapist Characteristics Correlated with Bias.....227
Therapy Experience Characteristics Correlated with Perceived Bias.....229
Multiple Regression Predictors (Final model).....231
Characteristics of the Respondent.....232
Characteristics of the Therapist.....233
Characteristics of the Therapy Experience.....234
Summary of Multiple Regression Analysis.....235
Implications of Overall Findings.....236
Limitations of the Study.....237
Implications for Practice and Training.....240
Therapist Self Disclosure.....240
Importance of Perceived Therapist Knowledge and Perceived Therapist Empathy.....241
Clients Who Are Less Exclusively Gay or Lesbian.....243

Lack of Focus on Sexual Orientation Issues.....243
Therapy is Not Value Free.....244
Implications for Future Research.....244
Further Development of the Heterosexual Bias Inventory.....244
Examination of Additional Predictors of Bias.....245
Future Methodological Issues Related to Validation of the HBI.....246
Measures of Sexual Orientation.....247
Other Issues for Future Research.....248
Conclusion.....249

APPENDIX A: Instructions for Expert Judges.....250

APPENDIX B: Instructions for Subjects in Pilot Testing.....254

APPENDIX C: Recruitment Flyers.....256

APPENDIX D: Recruitment Letter.....258

APPENDIX E: Organizations from which Subjects Were Recruited.....259

APPENDIX F: Heterosexual Bias Themes, Committee on Lesbian and Gay Concerns, 1991.....267

APPENDIX G: Subject Questionnaire Packet.....269

APPENDIX H: Distribution of Responses on the 43 Bias Items.....289

APPENDIX I: The Heterosexual Bias Inventory.....295

APPENDIX J: Distribution of responses on Knowledge Measure.....297

APPENDIX K: Distribution of Responses on Satisfaction Measure.....298

APPENDIX L: Distribution of Responses on Empathy Measure.....300

APPENDIX M: One-Way Analysis of Variance: Differences Between Current Lesbian, Gay, and Bisexual Perceptions of Bias.....301

APPENDIX N: One-Way Analysis of Variance: Differences Between Lesbian, Gay, and Bisexual Perceptions of Bias At the Time They Saw Their Therapist.....307

APPENDIX O: Repeat Reliability of Empathy Measure.....312

APPENDIX P: Repeat Reliability of Satisfaction Measure.....313

APPENDIX Q: Repeat Reliability of Knowledge Measure.....314

BIBLIOGRAPHY.....315

LIST OF TABLES

TABLE 3-1 Religion of Respondents.....104

TABLE 3-2 Current Sexual Orientation of Respondents.....106

TABLE 3-3 Modified Kinsey Scale Ratings of Respondents' Sexual Orientation.....107

TABLE 3-4 Percentages of Respondents Who Are Currently "Out".....108

TABLE 3-5 Sexual Orientation of the Therapists...110

TABLE 3-6 Disciplines of the Therapists.....111

TABLE 3-7 Number of Sessions Respondent Saw Therapist in Treatment.....113

TABLE 3-8 Respondents' Sexual Orientation at Time They Saw Therapist.....114

TABLE 3-9 Sex Match Between Respondent and Their Therapist.....115

TABLE 3-10 How "Out" Respondent Was When First Saw Therapist.....117

TABLE 3-11 How Much Respondents' Therapy Experience Focused on Sexual Orientation Issues.....118

TABLE 4-1 Results of Pilot Testing - Clarity of Questions.....143

TABLE 4-2 Criteria for Selection of Items for Heterosexual Bias Inventory.....148

TABLE 4-3 Repeat Reliability of the 43 Bias Items.....150

TABLE 5-1 One-way Analysis of Variance Among Therapists with Gay, Lesbian, Bisexual, Heterosexual, or Unknown Sexual Orientations.....162

LIST OF TABLES (continued)

TABLE 5-2 One-way Analysis of Variance Among Therapists with Gay, Lesbian, Heterosexual, or Unknown Sexual Orientations.....163

TABLE 5-3 Two-sample t test: Known vs. Unknown Sexual Orientation of the Therapist.....164

TABLE 5-4 One-way Analysis of Variance: Current Sexual Orientation of Respondent x HBI.....165

TABLE 5-5 One-way Analysis of Variance: Current Sexual Orientation of Respondent x HBI.....167

TABLE 5-6 One-way Analysis of Variance: Orientation of Respondent When First Saw Therapist x HBI.....168

TABLE 5-7 Associations between Characteristics of Respondents and the HBI score.....170

TABLE 5-8 Mental Health/Psychiatric History of Respondents.....172

TABLE 5-9 Associations between the HBI and Characteristics of the Therapist..173

TABLE 5-10 Associations between the HBI and Characteristics of the Therapy Experience.....175

TABLE 5-11 Step 1- Respondents Characteristics as Predictors of Bias.....179

TABLE 5-12 Step 2-Therapist Characteristics as Predictors of HBI.....181

TABLE 5-13 Step 3- Therapy Experiences as Predictors of Bias (HBI TOT).....183

TABLE 5-14 Step 4- Overall Predictors of HBI TOT..184

LIST OF TABLES (continued)

TABLE 5-15 Final Regression Model.....185

TABLE 5-16 Correlation Matrix of Final Regression Model Variables.....187

TABLE 5-17 Sex Match and the HBI.....190

TABLE 5-18 One-way analysis of variance: Sexual Orientation of Therapist x Perceived Therapist Empathy.....191

TABLE 5-19 One-way analysis of variance: Sexual Orientation of Therapist x Satisfaction.....192

TABLE 5-20 One-way analysis of variance: Sexual Orientation of Therapist x Not Knowledge.....192

TABLE 5-21 One-way analysis of variance: Sexual Orientation of Therapist x Knowledge.....193

TABLE 5-22 One-way analysis of variance: Time at which Therapist Aware of Sexual Orientation of Respondent x HBI.....194

TABLE 5-23 One-way analysis of variance: Social workers, Psychologists, Psychiatrists, and other Counselors x HBI.....195

TABLE 5-24 Percentages of Responses on the 43 Bias Items.....199

TABLE 6-1 Correlation of Variables with Empathy and Heterosexual Bias.....213

TABLE 6-2 Correlation of Variables with Satisfaction and Heterosexual Bias.....214

TABLE 6-3 Correlation of Variables with Knowledge and Heterosexual Bias.....216

CHAPTER ONE

STATEMENT OF THE PROBLEM

Introduction

Cultural biases against homosexuality are prevalent in societal institutions, religions, laws, and attitudes. Psychotherapists and psychological theorists are not immune to prevailing social mores and attitudes (Messing, Schoenberg, & Stephens, 1984; Tievsky, 1988). This observation has been well documented in feminist and cross-cultural research (Gilbert, 1980; Prilleltensky, 1989). The result is that heterosexual bias inevitably emerges in the practice of psychotherapy (Fassinger, 1991; Morin, 1977). Lesbians, gay men, and bisexuals, as clients in psychotherapy, are at risk of receiving treatment that is negatively impacted by this bias.

Our understanding of effective psychotherapy practice with lesbians, gay men, and bisexuals has shifted over the past twenty years. The perspectives of the helping professions have become increasingly affirmative in their views towards non-heterosexual identities and same-gender sexual behavior. Homosexuality, which once fulfilled the criteria for a "sociopathic-personality disorder" (DSM I, 1952, p. 38), is no longer considered a form of pathology. Treating homosexuality as a form of mental illness violates the policies of dominant professional organizations (American Psychiatric Association, American Psychological Association, National Association of Social Workers, American College and Personnel Association). The use of aversive treatments to change an individual's sexual orientation, once a common practice, is now considered unethical. Today the use of any method to change sexual orientation

is considered a questionable psychotherapeutic practice. Therapists are encouraged by professional organizations to be knowledgeable about gay, lesbian, bisexual issues, and they are encouraged to be aware of their biases towards homosexuality in an effort to provide sensitive treatment to lesbians, gays, and bisexuals.

These changes have come in the wake of a general increase in awareness of the lesbian, gay, and bisexual presence in American culture. This increased awareness has led to an examination of heterosexual bias in psychological theory and psychotherapy practice. Despite these changes, however, therapists have not necessarily changed their attitudes or behavior towards lesbian, gay, and bisexual clients.

This chapter will first consider heterosexism as a form of oppression and then highlight the clinical and research relevance of examining this issue in psychotherapy. Following this discussion is a consideration of the prevalence of gay men, lesbians, and bisexuals in American society and an examination of the nature of societal heterosexism. Next are discussions of the need for this study, the assumptions underlying the research, and the purpose of the study. The chapter concludes with a series of research questions and a working definition of terms.

Heterosexual Bias as a Form of Oppression: Heterosexism

The Gay Liberation Movement and the Women's Movement have profoundly challenged our understanding of gender roles and sexual identity. These social movements have increased the visibility of lesbians, gay men, and bisexuals, which has resulted in a raised consciousness and awareness of ways in which lesbians, gay

men, and bisexuals are discriminated against as sexual minority group members.

Gay men, lesbians, and bisexuals have been viewed as oppressed in a similar way to other minority group members. Oppression has been defined as "the systematic subjugation of one (relatively less powerful) social group by another (relatively more powerful) social group which is sanctioned by cultural beliefs and institutional practices, the results of which benefit one group at the expense of the others" (Diversity works, 1990, p. 1).

The system of institutional oppression that subordinates lesbians, gay men, and bisexuals because of their sexual orientation has been labeled heterosexism (Herek, 1986; Iasenza, 1989; Neisen, 1990). Herek (1986) defined heterosexism as "a world view, a value system that prizes heterosexuality, assumes it is the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual" (p. 925). Iasenza (1989) described heterosexism as "an ideology that sanctifies heterosexuality as the only normal model for romantic-sexual relationships, while (sic) viewing homosexuality as criminal, sick, immoral, inferior, or insignificant" (p. 68). Like other forms of oppression, the concept of heterosexism is distinguished by its combination of power and prejudice.

Heterosexism is evidenced by discrimination in laws, employment practices, religious institutions, and family structures. Heterosexism occurs on many levels (Diversity Works, 1990). It is manifested at an individual level through personal assumptions that all people are heterosexual and at a cultural level when heterosexual relationships dominate the media and same sex relationships are represented as deviant

(Diversity Works, 1990). Heterosexism occurs at the institutional level when, for example, laws are enacted that prevent same sex couples from adopting children or becoming foster parents, and openly gay men and lesbians are banned from serving in the military.

Heterosexism in psychotherapy can also be understood by examining its manifestation on an individual, cultural, and institutional level. On an individual level, the sexual orientation of gay, lesbian, and bisexual clients may not be recognized by therapists who tend to make an assumption of heterosexuality. Lesbian, gay, and bisexual clients may be pathologized and treated insensitively by therapists who are not knowledgeable about lesbian, gay, and bisexual issues. This anti-gay sentiment may be communicated consciously or unconsciously to gay, lesbian, and bisexual clients (Rudolph, 1989; Stein, 1988). On a cultural level, clients and therapists are powerfully influenced by a society that portrays all that is not heterosexual as deviant. This contributes to the shame lesbians, gay men, and bisexuals may experience in psychotherapy, and may also impact the negative countertransference reactions of therapists. Heterosexism in psychotherapy on an institutional level is evidenced by the biases in mental health training. Biases exist in current psychological theories that inform therapy practice, in the history of the mental health professions' stance towards homosexuality, and in the academic institutions that do not support gay, lesbian, and bisexual research and faculty.

The influence of social power provides an important framework for understanding the impact of heterosexism in psychotherapy on lesbians, gay men, and

bisexuals. The psychotherapeutic relationship is marked by distinct power differences. Psychotherapists are inherently engaged in defining normality and pathology, leaving them empowered to define the mental health of the client (Halleck, 1971). Psychotherapists need to recognize the potential negative impact of biases in their work with clients who challenge societal norms of gender conformity and heterosexuality.

Therapists live in an overall culture that tends to denigrate all that is not heterosexual. Public opinion polls indicate that heterosexist attitudes continue to be prevalent. For example, a 1989 national poll (Hatfield, 1989) surveyed the views of a random sample of 3,748 non gay and 400 gay, lesbian, bisexual individuals. Of the non-gay respondents, findings indicated that 18% thought homosexuality should be illegal and 57% disapproved of gay men and lesbians living together as couples. Therapists are challenged when they attempt to reconcile professional standards that allow for acceptance of homosexuality as a normal variation of sexuality in the context of a society that reinforces heterosexism through its social mores and institutions. A review of the literature indicates that this challenge leads to conflicting views among helping professionals, and may lead to psychotherapy practices that are marked by heterosexual bias.

Clinical Relevance

Exploring the perceptions of lesbians, gay men, and bisexuals who have been in psychotherapy has significant clinical relevance both for the practice of psychotherapy and for lesbian, gay, and bisexual clients as consumers. There is considerable

literature that suggests lesbians and gay men receive biased treatment by therapists. Although limited research has specifically examined the treatment of bisexuals in therapy, it is likely that bisexuals have been included in studies of lesbians and gay men. Therefore the following research results can tentatively be applied to bisexuals.

The perception of heterosexual bias in psychotherapy has been documented in personal accounts (Duberman, 1991) and reported in survey and interview studies of lesbians and gay men (Bell & Weinberg, 1978; Jay & Young, 1977; May, 1974; Saghir & Robins, 1973). Similarly, this treatment bias has been discussed in the clinical writing of psychotherapists (Isay, 1989; Martin, 1982; Silverstein, 1991; Stein, 1988). It is also documented in large survey studies of therapists (Committee on Lesbian and Gay Concerns, 1991). Bias in psychotherapy with lesbians and gay men may largely result from prejudicial attitudes and negative countertransference reactions (Silverstein, 1991).

Understanding clients' perspectives is potentially significant in several ways. First, since the therapeutic process is a dyadic one (Luborsky, Strupp, Crits-Christoph, Mintz, & Auerbach, 1988; Strupp, Fox, & Lessler, 1969), the perspectives of both therapist and client are essential in understanding the phenomenon of heterosexism in psychotherapy. Given that the "effects of psychotherapy must be assessed along both subjective and objective dimensions" (Strupp et al., 1969), utilizing clients' perspectives would add to the subjective dimension of assessment. Examining clients' perspectives would lay the groundwork for the design of future studies that examine heterosexual bias from both therapist and

client perspectives.

Second, increased understanding of the perspective of lesbian, gay, and bisexual clients regarding their experiences of bias in psychotherapy could increase therapists' awareness of both negative and positive perceptions by gay, lesbian, or bisexual clients of their therapists. Some research has suggested that therapists may have difficulty recognizing clients' negative reactions in psychotherapy (Thompson & Hill, 1988). This may be due in part to clients' attempts to "alter their behaviors so that therapists cannot read their reactions" (Hill & Stephany, 1990). Therefore, an examination of clients' perspectives could particularly enhance our clinical understanding of problems that arise in psychotherapy with lesbian, gay, and bisexual clients.

Third, Cooley & Lajoy (1980) have suggested that it is important for all clients to perceive their therapists as making an effort at understanding their world-view. By investigating the perceptions of gay, lesbian, and bisexual clients, we draw attention to the importance of gay, lesbian, bisexual clients' views as sources of information in our developing understanding of affirmative treatment for lesbians, gay men, and bisexuals. This is particularly significant with a lesbian, gay, and bisexual client population, as their experiences more generally tend to be isolated, marginalized and unreported. Clients are the ultimate beneficiaries of psychotherapy and a consumer advocacy perspective further supports the need to consider their views. Informing the gay, lesbian, and bisexual community of the results of this study may be empowering and validating of their common experiences. Lesbians and gay men have historically

been mistreated in psychotherapy (Silverstein, 1991), and the study results could inform these clients about the nature and extent of problems recently encountered in psychotherapy.

Fourth, the results could be useful as a tool in the education and training of psychotherapists in the area of lesbian, gay, and bisexual issues. Results could aid in the development of treatment and ethical guidelines in working with lesbian, gay, and bisexual clients.

Research Relevance

One purpose of the study is to develop a reliable and valid instrument that measures lesbian, gay, and bisexual client perceptions of bias in their experiences of psychotherapy. Having a standardized instrument would be valuable for it provides a way to quantitatively measure lesbians', gays', and bisexuals' perceptions of heterosexual bias in psychotherapy. Using this instrument, the nature of correlates and predictors of heterosexual bias as reported by lesbian, gay, and bisexual clients could be examined. Such an instrument could be used in the future to measure changes in the way therapists are perceived over time. The results of this study could be used as a baseline from which to make comparisons in these future studies.

Background of Problem

Heterosexual bias in psychotherapy is one of many forms of institutionalized heterosexism. The following section first underscores the importance of this study by addressing the prevalence of gay men, lesbians, and bisexuals in society, and by briefly acknowledging other forms of societal heterosexism that are akin to

heterosexual bias in psychotherapy. The section concludes with an overview of social developments currently affecting lesbians, gay men, and bisexuals, and a consideration of the political context within which the psychotherapy experiences of lesbians, gay men, and bisexuals must be examined.

Construct of Sexual Orientation

The concept of sexual orientation is a recent development. Prior to the early 19th century individuals who engaged in same gender sexual behavior were not identified as essentially "homosexual". They simply were seen as persons who engaged in homosexual acts. Beginning in the late 18th and early 19th centuries, however, individuals began to be identified as homosexual persons based on the acts they engaged in (Boswell, 1980). Most recently theorists have moved beyond a sole focus on sexual behavior to include a focus on identity, considering such issues as self-identification and group affiliation in the development of a definition of homosexuality. It is only since the 1970's that the term homosexual has been embraced by homosexuals themselves in an effort to indicate minority group status (Cass, 1990).

Societies give labels to individuals with certain attributes in order to summarize and make meaning out of large amounts of information (Cass, 1990). The labels of homosexual, gay, lesbian, bisexual and heterosexual are all labels that are used to differentiate sexual orientation. The historic focus on identifying specific sexual behaviors has given way to an increased emphasis on exploring the qualities of persons with particular sexual orientations (Cass, 1990). An emerging controversy

dichotomizes essentialist and constructionist models of viewing sexual orientation. An essentialist model views sexual orientation as inborn and unchangeable whereas a constructionist model views orientation as changeable and as the result of socialization. Despite the increasing subtlety and complexity of the concepts of sexual identity and homosexuality, most prevalence studies, as discussed below, utilize sexual behavior as the sole criterion for determining homosexuality.

Prevalence of lesbians, gays, and bisexuals

Prevalence studies have examined same-gender sexual behavior as a method of inferring the prevalence of gay, lesbian, and bisexual persons. MacDonald (1983) has raised a concern as to "the degree to which self-identification should be considered" in measuring the prevalence of homosexuality (p. 95). Many individuals who engage in same-gender sexual behavior do not label themselves as gay, lesbian, or bisexual, and similarly some individuals who identify as gay, lesbian, or bisexual may not engage in same-gender sexual behavior. For example, in a study of bisexual women, Blumstein & Schwartz (1976) found discrepancies between womens' behaviors and their identifications as homosexual or heterosexual.

The prevalence of gay men, lesbians, and bisexuals, therefore, differs greatly depending on the definitions used. Prevalence is difficult to measure because sexual orientation is generally not operationally defined (Klein, Sepekoff, & Wolf, 1985). Problems arise regarding the inclusion of erotic same-gender feelings in measuring prevalence (MacDonald, 1983). Additionally it is difficult to measure sexual behavior that is not orgasmic in nature (Kinsey, Pomeroy, Martin, & Gebhard, 1953). Finally,

MacDonald (1983) has suggested that the results of prevalence studies of homosexuals may be inaccurate due to "the failure to recognize bisexuals as a separate group [which] has resulted in the confounding of homosexual study samples" (p. 96). Despite the potential difficulties in measuring gay, lesbian, and bisexual prevalence, several researchers have attempted to investigate the area.

Kinsey, Pomeroy, and Martin (1948) were the first to demonstrate that sexual orientation existed along a continuum and was not easily reflected in dichotomous categories. Kinsey et al. (1953) introduced a seven point measure of sexual orientation that was designed to "show what proportion of her psychologic reactions and/or overt behavior was heterosexual, and what proportion of her psychologic reactions and/or overt behavior was homosexual" (p. 469-470). Exclusive heterosexuality was at one end of the seven point (0-6) continuum, exclusive homosexuality at the other end of the continuum, and bisexuality in the middle. Kinsey et al. acknowledged that a limitation of their methodology was that it only measured ratings at a particular point in time (Kinsey et al., 1953). Therefore, Kinsey et al. (1953) recognized the impossibility of determining the number of essentially "homosexual" or "heterosexual" individuals using their methodology.

In their large scale study of same gender male behavior (Kinsey et al., 1948), results indicated that 50% of the males had a homosexual response by age 45, 37% had a homosexual experience to the point of orgasm by age 45, and 13% were found to react erotically to other men, with no overt homosexual contact after the beginning of adolescence. Kinsey et al. (1948) concluded that, "since only 50% of the [male]

population is exclusively heterosexual throughout its adult life, and since only 4% of the [male] population is exclusively homosexual throughout its life, it appears that nearly half (46%) of the [male] population engages in both heterosexual and homosexual activities, or reacts to persons of both sexes, in the course of their adult lives" (p. 656).

In a subsequent study Kinsey et al. (1953) examined the sexual behavior of women. The sample consisted of 5940 females, and results indicated that 28% had a homosexual response by age 45 (erotic arousal by same sex individual whether or not there was physical contact), 20% had an overt homosexual experience by age 45 (physical contacts of sexual nature with same sex individual whether or not they were erotically aroused), and 13% had a homosexual experience to the point of orgasm by age 45. Kinsey et al. (1953) suggested that

> there remain, however, among both females and males, a considerable number of persons who include both homosexual and heterosexual responses and/or activities in their histories. Sometimes their homosexual and heterosexual responses and contacts occur at different periods in their lives; sometimes they occur coincidentally. This group of persons is identifiable in the literature as bisexual. (p. 468)

Though Kinsey et al. (1948; 1953) and several other researchers (Blumstein & Schwartz, 1976; Klein, 1978) suggest that a very large group of men and women are bisexual, the actual prevalence has not been determined.

The results of the Kinsey studies were particularly important in documenting the wide range of sexual behavior and feelings of men and women, and in opening the door to further research in the area of human sexuality. Their research, however, has

been criticized on theoretical and methodological grounds. Although Kinsey et al. recognized that sexual behavior was fluid, potentially changing at different ages and in different circumstances, their measure of sexuality did not account for these changes. It has been suggested that the use of the Kinsey scale led to "viewing sexual orientation in a static fashion" (Klein, Sepekoff, & Wolf, 1985, p. 37). Fay, Turner, Klassen, and Gagnon (1989) have additionally criticized the Kinsey et al. (1948; 1953) methodology for utilizing an unrepresentative sample which was disproportionately drawn from college campuses and from the Midwestern region of the United States.

More recently Fay et al. (1989) conducted a secondary analysis of a national study of male-to-male sexual behavior which had originally been done in 1970 by the Kinsey Institute of Sex Research and the National Opinion Research Center (NORC). The sample consisted of 3018 U.S. adult men who were interviewed in 1970 and Fay et al. examined in greater detail 1450 men in the sample who were over 21 years old. Fay et al. (1989) found that approximately 20 percent of the adult American males had at least one homosexual experience where at least one partner reached orgasm at some point in their lives. Only 6.7 percent of these men had a homosexual experience after age 19, and 3.3 percent reported such experiences "occasionally" or "fairly often". Results of this analysis were found to be consistent with the results of a study conducted by NORC in 1988.

In a summary review of five surveys of male-to-male sexual behavior, including the two reviewed by Fay et al. (1989), Rogers and Turner (1991) reported

that 5-7 percent of men have had a homosexual experience during adulthood. However, Rogers and Turner (1991) noted that the authors in each of the studies reviewed, stated that their figures should be seen as minimum prevalence estimates due to the possibility of under-reporting. These more recent findings indicate that the prevalence of same-gender male sexual behavior may be lower than that estimated by Kinsey et al. (1948). Psychotherapists, however, remain likely to see gay, lesbian, or bisexual clients and need to be prepared to address issues related to same-gender sexual behavior.

Unlike other minority groups, lesbians, gays, and bisexuals are largely an invisible group because they are indistinguishable from heterosexual persons. The invisibility impacts psychological research conducted on lesbian, gay and bisexual issues in several ways. The stigma associated with conducting lesbian and gay research in combination with the invisibility of lesbians and gay men may lead researchers and psychotherapists to not recognize the importance and scope of the issue (Gonsiorek, 1982; Stein & Cohen, 1986). The invisibility of gay men and lesbians can lead to "a considerable underestimation of the size of the population who are to some degree homosexually oriented" (Gochros, 1984, p. 144). Invisibility also contributes to the marginalization of lesbian, gay, bisexual issues in clinical training.

Societal Heterosexism

Societal heterosexism pervades our everyday life in both conscious and unconscious ways (Herek, 1990). Referring to heterosexual bias which is manifested in social customs and institutions, Herek (1990) described the impact of what he

refers to as cultural heterosexism.

> Cultural heterosexism is like the air that we breathe: it is so ubiquitous that it is hardly noticeable. Even a cursory survey of American society reveals that homosexuality is largely hidden and, when publicly recognized, is usually condemned or stigmatized. This alternation between invisibility and condemnation is readily apparent in four major institutions: religion, the law, psychiatry and psychology, and mass media. (p. 317)

Stein (1988) further stated that "it is virtually impossible to imagine anyone - and that includes both therapist and patient - growing up in American society without experiencing some negative feelings about homosexuality" (p. 84). A brief description of societal institutional forms of heterosexism follows.

Violence

Anti-gay violence historically has been sanctioned by American culture. This is most saliently evidenced by the fact that lesbians, gay men, and bisexuals have been imprisoned, been forced to undergo psychiatric treatment, and been discharged from the military (Katz, 1976).

Anti-gay violence and hate crimes against lesbians and gays have been reported to be increasing (Herek, 1990). In 1992, the National Gay Lesbian Task Force Report on Violence indicated that an all-time high of 1,898 anti-gay incidents had been reported in five major urban areas, a 4% increase from 1991 (NGLTF, 1992). Berrill (1990) found anti-gay violence to be widespread in a review of numerous other studies. In the first national study of anti-gay violence (Berrill, 1990) conducted by the National Gay & Lesbian Task Force in 1984, 94% of a sample of 1,420 gay men and 654 lesbians indicated that they had been the target of some type of anti-gay violence (including verbal abuse, physical assault, etc.). Nineteen percent of the

sample had been physically assaulted at least once in their lives because of their sexual orientation, and 44% had been threatened with physical assault (Berrill, 1990). Similar findings have been reported in several other large scale studies of lesbians and gay men. Bell and Weinberg (1978) found that 35% of the 684 gay men and 2% of the 293 lesbians in their sample had been robbed or assaulted because of their homosexuality. Jay and Young (1977) found that 27% of their 4,400 male respondents had experienced physical abuse and 77% had experienced verbal abuse because of their homosexuality. Similarly, 14% of the 1,000 lesbians in the same study experienced physical abuse and 71% experienced verbal abuse because of their homosexuality. A study of bias crime conducted by the U.S. Department of Justice found that "homosexuals are probably the most frequent victims" of hate violence (Finn & McNeil, 1987, p. 2).

Anti-gay violence has a significant impact on society. Herek (1989) suggests that anti-gay violence creates fear among both gay and non-gay persons. For gay, lesbian, and bisexual persons, violence reinforces fears of "coming out", whereas for heterosexual persons it perpetuates maintenance of stereotypical gender roles for fear of being labeled gay, lesbian, or bisexual (Herek, 1989).

The institutionalized nature of this violence is manifest when police commit the violent acts; when gay men, lesbians, and bisexuals are afraid to report hate crimes for fear of recriminations and further victimization, leading to an under-reporting of hate crimes; when male victims of sexual assault are less likely to report than female victims; where there is a lack of uniform reporting procedures for hate crimes; when

insurance companies discriminate against individuals based on H.I.V. status; when gays, lesbians, and bisexuals are discriminated against in educational institutions and employment; and when the criminal justice system fails to prosecute incidents of anti-gay violence.

Legal Discrimination

Sodomy laws first appeared in Europe during the 13th century when sodomy became punishable by castration, torture, and death (Boswell, 1980). Executions as a punishment for engaging in sodomy were documented in New England in the mid-seventeenth century (Katz, 1976). During the Nazi era in Germany homosexuals were imprisoned and murdered. More recently, during the McCarthy era, homosexuals throughout the United States were considered security risks and were removed from service in government agencies and services (Berrill & Herek, 1990).

No federal statutes currently protect the legal rights of gays and lesbians, and same-gender behavior remains illegal in many states. Only 6 states (Wisconsin, Connecticut, Massachusetts, Hawaii, New Jersey, Vermont) have civil rights laws that protect the rights of lesbian and gay individuals (NGLTF, 1992). Sodomy laws remain in effect and the Supreme Court has held that United States citizens have no constitutional right to engage in same-gender sexual behavior (Bowers v. Hardwick, 1986). Lesbian, gay, and bisexual individuals continue to be denied equal rights with respect to housing, community recognition regarding relationships, economic benefits given to heterosexual couples, employment, military policy, immigration, child custody, taxation, and insurance coverage (Slovenko, 1980).

Religious Discrimination

Some authors have considered the impact of religious doctrine to be the most important force in the development and perpetuation of negative attitudes towards lesbians, gay men, and bisexuals. Fundamentalist doctrine and practice is aggressively anti-gay. The biblical book of Leviticus is frequently quoted to support the view that homosexuality is sinful, maintaining that "if a man lieth with another man as he lieth with a woman he would be put to death for it is an abomination" (Leviticus, chap. 11, verse 22). The assumption underlying this view is that heterosexuality is supported by God and that homosexuality is punishable by God.

Discrimination and Its Effects

Mental health professionals, as well as therapy clients and those in the general public, are powerfully influenced by these forms of societal heterosexism (Gartrell, 1984; Herek, 1990; Riddle & Sang, 1978; Stein, 1988). Heterosexual bias in psychotherapy is just one more form of this institutionalized, societal heterosexism. Though gay men, lesbians and bisexuals are a heterogeneous group who vary widely in terms of race, class, age, ethnicity, physical ability, sexual activities, and interests, the negative impact of societal discrimination on the identity formation, self-esteem, and general functioning of all gay men, lesbians, and bisexuals needs to be considered.

Recent research has begun to challenge notions about human sexuality, and has examined the ways in which assumptions about human sexuality have been marked by heterosexual bias. Human sexuality is diverse in terms of orientation, behavior, and

attractions (Berkey, Perelman, & Kurdek, 1990; Klein, Sepekoff, & Wolf, 1985). However, despite increased psychological understanding of sexuality, therapists have not necessarily changed their attitudes or behavior towards lesbian, gay, and bisexual clients. This can be explained by several factors. One is that the culture remains divided in its views towards lesbians, gays, and bisexuals. Cultural trends and mores reflect both an increased tolerance and awareness of homosexuality, and an increasingly strong conservative presence that counteracts this tolerance (Rudolph, 1990).

A wave of overtly oppressive legal initiatives have been proposed, perhaps in response to increased awareness of the existence of lesbians, gay men, and bisexuals. Several states proposed anti-gay initiatives in 1992. An initiative was proposed in Oregon which, while it was defeated at the polls, sought to label homosexuality as perverse and proposed that schools teach that homosexuality is perverse. In Colorado, however, an initiative was passed that prevents local governments from banning discrimination against lesbians and gays.

Some authors have suggested that recent societal influences have had a detrimental impact on psychotherapy with gay and lesbian individuals (Rudolph, 1989). In particular, the emergence of AIDS, the rise in political conservatism, and the increase in religious fundamentalism are cited as important influences (Rudolph, 1990). Finally, even if there were no social forces working against the improvement of psychotherapy for gays, lesbians, and bisexuals, psychotherapists, like all people, might simply have a difficult time changing attitudes and styles of practice to which

they are accustomed.

Need for Study

The need for this study is demonstrated by several factors in the literature. 1). There is a general lack of research related to the experiences of gay men, lesbians, and bisexuals in psychotherapy. The need for this study is evidenced by the lack of baseline knowledge about the experiences of gays, lesbians, and bisexuals in therapy compounded by the suggestion that psychotherapists continue to show heterosexist attitudes in their practice (Chaimowitz, 1991; Gartrell, 1984; Martin, 1982; Rudolph, 1988; Stein, 1988). Several factors account for the limited amount of available research on lesbians, gays, and bisexuals in psychotherapy. Invisibility of lesbians, gay men, and bisexuals throughout history has resulted in the accumulation of limited knowledge about most aspects of the lives of lesbian, gay, and bisexual persons. There has also been considerable confusion about the nature of sexual orientation. Iasenza (1989) has noted the confusion in the literature regarding the terms gender identity, sex-role behavior and sexual orientation, and the subsequent difficulties in conducting research in this area. It is only recently that the term "homosexual" has been used to refer to an individual's identity as opposed to an individual's behavior. Finally, negative attitudes towards different forms of sexuality and nontraditional relationships have contributed to a general lack of examination of gay, lesbian and bisexual experiences in the psychological literature in many areas, including their experiences in psychotherapy.

The paucity of lesbian, gay, and bisexual related research has resulted in few

non-clinical samples from which to form a basis of comparison in defining psychological health and illness. Martin (1982) has maintained that

> given that our understanding of a patient's psychopathology is always measured against our images of a potentially healthy individual, what happens when we have no images of healthy homosexuals, or only skeletons of images? Most probably, we will use our heterosexual models as standards, and they will serve well at times and badly at others. (p. 342)

This study contributes to a developing knowledge base that focuses on understanding the normative experiences of lesbians, gay men, and bisexuals in psychotherapy.

2). Therapists demonstrate biased attitudes towards lesbians, gays, and bisexuals.

Research indicates that therapists demonstrate heterosexist attitudes and beliefs (Garfinkle & Morin, 1978; Graham, Rawlings, Halpern, & Hermes, 1984; May, 1974; Rudolph, 1990; Wisniewski & Toomey, 1987). Many psychiatrists, psychologists, social workers, and counselors continue to believe in the inherent psychopathology of homosexuality (Graham, et al., 1984; Morin, 1977; Morin & Garfinkle, 1978). These attitudes and beliefs may directly affect both the therapeutic relationships they develop with clients and their treatment of these clients (Martin, 1982; Stein, 1988).

3). Therapists report a lack of training in and knowledge about lesbian, gay, and bisexual issues (Brown, 1991; Buhrke, 1989a; Graham et al., 1984; May, 1974; Murphy, 1992).

If the life experiences and psychotherapeutic needs of lesbian, gay, and bisexual clients are unique, and if discriminatory attitudes toward them are found throughout society, it is reasonable to assume that without training in this area psychotherapists

might tend to provide inadequate or biased services to these clients. Research indicates that therapists and counselors receive little training in the area of sexuality (Nathan, 1986), and even less in the area of sexual orientation. Survey research indicates that counselors receive little exposure to lesbian and gay issues and are inadequately trained to work with lesbian and gay clients (Graham et al., 1984; Thompson & Fishburn, 1977). These issues have been minimally incorporated into psychology training programs despite the fact that training in these areas has been demonstrated to be inadequate (Brown, 1991; Buhrke & Douce, 1991).

4). Lesbian and gay clients report dissatisfaction with their psychotherapy experiences. No study examines the satisfaction of bisexuals as a separate group in psychotherapy, though bisexuals are frequently included in studies of lesbians and gay men.

Findings suggest that many gay men and lesbians are dissatisfied with their therapists and psychotherapy experiences (Bell & Weinberg, 1978; Jay & Young, 1977; May, 1974; Saghir & Robins, 1973). Many lesbians and gay men attribute this dissatisfaction to their therapists' lack of understanding and lack of acceptance of homosexuality (Abbott & Love, 1972; Bell & Weinberg, 1978; Jay & Young, 1977; Saghir & Robins, 1973). Dissatisfaction of gay men in psychotherapy has additionally been attributed to perceived prejudice associated with H.I.V. infection and the stigma gay men face as a group at high risk of developing H.I.V. infection (Croteau & Morgan, 1989).

5). No research has fully explored heterosexual bias in psychotherapy as perceived

by lesbian, gay, and bisexual clients.

Several authors have pointed to the need for the direct investigation of gay, lesbian, and bisexual clients as a way to further understand how this population perceives biased and sensitive treatment (Fassinger, 1991; Rudolph, 1988). The results could be compared with the findings of the American Psychological Association Task Force study that outlines themes of biased and sensitive practice as reported by psychologists (Committee on Lesbian and Gay Concerns, 1991).
6). There is a need for an instrument that measures client perceptions of heterosexual bias in psychotherapy.

Heterosexual bias impacts clinical training and service delivery with gay, lesbian, and bisexual persons. No instrument has been developed that is designed to measure the perception of heterosexual bias in psychotherapy as perceived by gay men, lesbians, and bisexuals. The development and use of such an instrument would contribute to the identification and understanding of this bias.

Assumptions of Study

The foundation of this study includes several important basic assumptions. These assumptions are supported by literature written in the twenty years since the official de-pathologizing of homosexuality as a mental disorder by the American Psychiatric Association in 1973. This investigation is based on the following gay, lesbian, and bisexual affirmative assumptions.

1. Lesbian, gay, bisexual identities are not indicative of personality disorders, but rather are normative variations of human sexuality (Bell & Weinberg, 1978;

Hooker, 1957; Mitchell, 1978).

2. The etiology of homosexuality and bisexuality is complex and multifaceted. Homosexuality does not reflect an impairment of healthy functioning (Hooker, 1957, 1958; Thompson, McCandless, & Strickland, 1971).

3. Homosexual and heterosexual orientations are culturally constructed dichotomies and do not encompass the wide variations of human sexuality (Kinsey et al., 1948; 1953). Heterosexual and homosexual feelings exist along a continuum (McConaghy, 1987).

4. The influence of heterosexism affects all people in our society (Graham et al., 1984; Iasenza, 1989; Martin, 1982; Riddle & Sang, 1978; Stein, 1988).

5. All therapists should expect to see gay men, lesbians, and bisexuals in their practices (Brown, 1991; Fassinger, 1991; Murphy, 1992).

6. Heterosexist attitudes of therapists exist within a social, cultural and political context (Fassinger, 1991; Morin & Garfinkle, 1978; Neisen, 1991; Stein, 1988).

7. The biases and values of therapists affect their therapeutic relationships with their clients (Bergin, 1985; Committee on Lesbian and Gay Concerns, 1991; Martin, 1982; Rochlin, 1982).

Purpose of Study

The purpose of this study is to further the understanding of heterosexual bias in psychotherapy from the perspective of lesbian, gay, and bisexual clients. The study attempts to foster knowledge about the nature and correlates of perceived heterosexual

bias. Perceived heterosexual bias is examined as it relates to and is predicted by client variables, therapist variables, and treatment variables. The results of this study will hopefully inform therapists and facilitate the development of increasingly sensitive treatment practices with lesbian, gay, and bisexual clients.

Research Questions

Broadly stated, the research questions of the study are:

1. Are lesbian, gay, and bisexual clients' perceptions of heterosexual bias in psychotherapy associated with their satisfaction with psychotherapy, with their perception of therapists' empathy, and with their perception of therapists' knowledge about gay, lesbian, and bisexual issues?
2. Do gay, lesbian, and bisexual clients perceive gay, lesbian, and bisexual therapists as less biased than heterosexual therapists?
3. Is knowing the sexual orientation of the therapist related to less perceived bias as reported by gay, lesbian, and bisexual clients?
4. Are there differences between lesbian, gay, and bisexual clients' perceptions of heterosexual bias in psychotherapy?
5. What client variables, therapist variables and treatment variables are significantly associated with and predictive of perceived heterosexual bias in psychotherapy with lesbians, gay men, and bisexuals?

Definition of Terms

Following is a set of definitions for this research project.

Psychotherapy: The term psychotherapy is used to represent all types of counseling

and therapy provided by professionals in the disciplines of social work, psychology, psychiatry and counseling. The term therapist signifies the practitioners in each of these fields. An assumption is made that these disciplines are all involved in a similar process of helping and that common issues emerge in these psychotherapeutic relationships.

Homosexual: The term homosexual is used to describe an individual whose "fantasies, attachments and longings are predominantly for persons of the same gender, who may or may not express those longings in overt behavior, and whose orientation may or may not be accompanied by a homosexual identity" (Reiter, 1989, p. 140).

Gay Man or Lesbian: The terms "gay man" or "lesbian" are used, respectively, to describe a man or a woman whose primary affiliative, erotic, emotional, and generally sexual desires are for individuals of the same gender. The primary focus of this definition is on internal responses and feelings of affection and affiliation that endure over time, with a secondary focus on sexual behavior (Marmor, 1989; Saghir. The labels gay man or lesbian may imply a certain degree of affirmation and affiliation with a group of similar persons (Cass, 1984; Saghir & Robins, 1980). In this study lesbians and gay men are determined by their self-identification with these labels.

Bisexuals: Drawing on Zinik's (1985) definition, bisexuals are defined as those individuals who: a. are erotically or sexually aroused by both men and women; b. engage in or desire sexual involvement with men and women; and/or, c. self-identify

as bisexual (Zinik, 1985, p. 8).

Sexual orientation: The term sexual orientation is used to refer to an individual's gender preference that manifests itself in various dimensions including emotional, social, lifestyle preferences, sexual behaviors, fantasies, attractions, and self-identification (Klein, Sepekoff, & Wolf, 1985). Sexual orientation is viewed as potentially changing throughout the life cycle of an individual.

Homophobia: This term was derived from Churchill's (1967) concept of homoerotophobia, and was popularized by Weinberg (1972) to address the fear of homosexuals. It has been used to describe prejudice, hostility, or fear in response to homosexuality (Morin, 1978; Murphy, 1992; Weinberg, 1972), and encompasses both the wide spectrum of societal forms of heterosexist oppression as well as individual prejudices against homosexuality.

Heterosexism: This term derives from a racism model of oppression and suggests that power dynamics and issues related to privilege in social institutions perpetuate the oppression of non-heterosexual persons. It refers to a world-view and a belief system that denigrates all that is not heterosexual.

Heterosexual Bias: Morin (1977) first proposed the term heterosexual bias and defined it as "a belief system that values heterosexuality as superior to and/or more natural than homosexuality" (p. 629). In this study, the term is used to describe the resulting biases that emerge as a result of individual and societal forces of oppression. Adapting Betz and Fitzgerald's (1987) definition of sex bias, heterosexual bias in psychotherapy is defined in this study as including any therapist attitudes or behaviors

which favor heterosexuality and negatively evaluate homosexual or bisexual identity, behavior or relationships.

Internalized Homophobia: This term refers to the internalization of negative and hostile societal attitudes towards homosexuality. Internalized homophobia generally develops as the result of prevalent societal heterosexism, and is particularly significant to address and understand in the context of psychotherapy with lesbians, gay men, and bisexuals.

"Coming out": "Coming out" refers to a developmental process by which gay men, lesbians, and bisexuals accept their orientation as an identity and are open to others about it (Cass, 1979). It was originally described as a linear process by which gay, lesbian, and bisexual individuals progress through a series of stages of accepting feelings and integrating their identities into their lives. It has been suggested more recently that the coming out process is not linear but rather non-linear, impacted by environmental stressors and developmental life transitions (MacDonald, 1983). Woodman and Lenna (1980) suggest that the coming out process may not be marked by a single event but rather may involve a lifelong process.

Conclusion

Heterosexism pervades our social relationships and institutions, resulting in discrimination against gays, lesbians, and bisexuals. Heterosexual bias in psychotherapy is the institutionalized manifestation of this discrimination in the practice of psychotherapy. The literature indicates that, despite official mandates to end this discrimination, psychotherapy continues to be marred by heterosexual bias.

The prevalence of lesbians, gays, and bisexuals in society underscores the importance of understanding this form of treatment bias. This study of heterosexual bias in psychotherapy as experienced by the gay, lesbian, or bisexual client will provide a deeper understanding of this phenomenon and lead to the development of strategies for combatting it.

CHAPTER TWO
LITERATURE REVIEW

The purpose of this chapter is to review clinical theory and empirical research that is relevant to the exploration of heterosexual bias in psychotherapy. The areas covered include an historical review of heterosexual bias in the mental health field; a discussion of clinical theory exploring heterosexual bias in psychotherapy with lesbian, gay, and bisexual clients; a review of therapist variables related to heterosexual bias in therapy; a discussion of lesbian, gay, bisexual client variables related to the perception of heterosexual bias in therapy; and a review of literature that concerns client perceptions in evaluating therapy.

Historical Overview

Prejudice against homosexuals in Western culture has been widespread, with its roots in religion, law, and more recently psychiatry (Szasz, 1970). Homosexuality has been regarded as a sin by most religions, in particular by Christian religions (Bullough, 1979), and has been and continues to be punishable as a crime under the law. An illness model of homosexuality was adopted by the psychiatric community in the 19th century, and homosexuality was defined as a mental disorder (Morin, 1977).

Silverstein (1976/1977) has suggested that a lessened societal reliance on religion led to psychiatry being looked upon to solve social problems. Psychiatry increasingly became a profession with a dual role, to help those with mental health problems and to serve as an agent of social control. Psychiatrists therefore had the dual responsibility of helping homosexuals with their problems while also curing homosexuals of their inherent pathology.

Within this illness model persons who engaged in same-gender behavior were determined to be insane or mentally ill, and some were forced into psychiatric hospitals (Bullough, 1979). They were given a variety of treatments, including lobotomy, castration, shock treatment, and vasectomy (Katz, 1976). Homosexuality was viewed as pathological partly as the result of a moral concern about prohibiting any form of sexuality that was non-procreative (Tripp, 1975). Masturbation, therefore, as well as homosexuality was considered indicative of the presence of a mental illness and was treated as such.

This illness model was challenged by the Gay Liberation Movement. The Gay Liberation Movement gained momentum in 1969 when lesbians and gays took action against their oppression, starting with the uprising following a police raid at the Stonewall bar in New York City in 1969. One of the initial objectives of the Gay Liberation Movement was to challenge the stance of the mental health professions that homosexuality was a form of mental illness.

The influence of the Gay Liberation Movement resulted in professional mental health organizations reassessing the rationale for their pathologizing of homosexuality. The lack of sound research to substantiate the claim that homosexuals were more pathological than non-homosexuals (Hooker, 1967) led to an eventual change in the official policies of the dominant mental health associations regarding the assessment and treatment of homosexuality.

The influence of this movement also resulted in a change of the diagnosis of homosexuality. In the Diagnostic and Statistical Manual of Mental Disorders, DSM I

(1952), homosexuality was classified as a personality disorder. Specifically, the diagnosis of homosexuality was considered a "sexual deviation" under the category of "sociopathic personality disturbance" (DSM I, 1952, p. 38). In the DSM II (1968), homosexuality continued to be listed as a personality disorder, but no longer was it considered a sociopathic disturbance. It remained classified as a "sexual deviation", which was described as a "category for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or towards coitus performed under bizarre circumstances..." (DSM II, 1968, p. 44). It was not until 1973 that the American Psychiatric Association removed homosexuality per se as a mental disorder.

Despite the pathological diagnosis of homosexuality, however, there was early recognition by the American Psychiatric Association that the diagnosis of homosexuality was partially the result of nonconformity to culturally defined norms. In the DSM I (1952) homosexuality was subsumed under the criteria for a diagnosis of sociopathic personality disturbance, which is defined both as a deviation from cultural norms and as resulting from underlying personality difficulties.

> Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals. However, sociopathic reactions are very often symptomatic of severe underlying personality disorder, neurosis, or psychosis, or occur as the result of organic brain injury or disease. (DSM I, 1952, p. 38)

Although the cultural impact on homosexuality was recognized, it appears to have been largely ignored until 1973.

After 1973, homosexuality was still considered a form of pathology if the gay or

lesbian person experienced conflict accepting her or his homosexuality, and in 1980 the diagnostic category of Ego Dystonic Homosexuality was established in the DSM III. A client diagnosed with Ego Dystonic Homosexuality

> complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating and maintaining wanted heterosexual relationships. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress. (American Psychiatric Association, 1980, p. 282)

The category of "Ego Dystonic Homosexuality" was eventually removed in 1986 (DSM IIIR). What remains in the DSM IIIR is a diagnostic category of "Sexual Disorder Not Otherwise Specified" (302.90), for which the criteria include "persistent and marked distress about one's sexual orientation" (p. 169). MacDonald (1976) has observed, "ironically, it appears that before, you were sick if you liked being homosexual; now you are sick if you do not like being homosexual" (p. 29). It is important to note that these diagnostic changes were made with considerable professional debate. Despite empirical evidence to the contrary, there remained professional controversy about homosexuality and its inherent psychopathology (Stein, 1988).

Many other changes have taken place that demonstrate the increased acceptance of lesbians and gay men by the professional mental health community. The Association of Gay Psychologists was organized in 1973, and the Journal of Homosexuality was first published in 1974. In 1975, the American Psychological Association established the Society for the Psychological Study of Lesbian and Gay Issues (Division 44). The Committee on Gay Concerns was created by the American

Psychological Association in 1980, later changing its name to the Committee on Lesbian and Gay Concerns (CLGC) in 1985. Many other committees concerned with lesbian and gay issues have evolved within professional mental health organizations (i.e., Committee on Gay, Lesbian, Bisexual Issues, American Psychiatric Association; Committee on Lesbian and Gay Issues, National Association of Social Workers; Caucus of Gay, Lesbian, and Bisexual Concerns, Association of Marriage and Family Therapists).

Changes in Policy

The American Psychiatric Association developed the first affirmative policy statement regarding homosexuality in 1973, followed by the American Psychological Association (APA), the National Association of Social Workers (NASW), the Association for Counseling and Development (AACD), and the American College Personnel Association (ACPA). The American Psychological Association's statement in 1975 reflected a policy of nondiscrimination as well as a proactive stance in removing stigma towards homosexuals, stating,

> the American Psychological Association supports the action taken on the 15 December, 1973 by the American Psychiatric Association removing homosexuality from the Association's official list of mental disorders. The American Psychological Association adopts the following resolution: Homosexuality per se implies no impairment in judgement, stability, reliability, or general social or vocational capabilities; further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations. (Conger, 1975, p. 633)
>
> The American Psychological Association deplores all public and private discrimination in such areas as: employment, housing, public accommodation and licensing against those who engage in or have engaged in homosexual activities, and declares that no burden or proof of such judgment, capacity or

> reliability shall be placed upon the individuals greater than that imposed on any other persons. Further, the American Psychological Association supports and urges the enactment of civil rights legislation at the local, state and federal level that would offer citizens who engage in acts of homosexuality the same protection now guaranteed to others on the basis of race, creed, color, and so forth. The American Psychological Association urges repeal of all legislation which discriminates against persons of homosexual orientation. (Conger, 1975, p. 334)

Ethical guidelines developed by the American Psychological Association in 1981 addressed the need for training of psychologists in working with diverse groups. Though not specifically mentioned, clearly these guidelines would apply to lesbians, gay men, and bisexuals. The ethical principle stated that psychologists need to "maintain knowledge of current and professional information related to the services they render ...recognize differences among people, such as those that may be associated with age, sex, socioeconomic, and ethnic background (p. 634)." Psychologists, therefore, are mandated to be knowledgeable about diverse groups, which would include lesbians, gay men, and bisexuals.

Social worker ethical principles similarly address a policy of non-discrimination on the basis of sexual orientation. The Code of Ethics of the National Association of Social Workers (adopted in 1979), state that social workers,

> ...should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, color, sex, sexual orientation." (National Association of Social Workers, 1987, p. 964) The social worker should act to prevent and eliminate discrimination against any person or group on the basis of race, color, sex, sexual orientation. (National Association of Social Workers, 1987, p. 956)

To support this code of ethics, the Council on Social Work Education developed a curriculum policy in 1982 stating that,

> a social work curriculum, should include content on other special population groups relevant to the programs mission or location and, in particular, groups that have been consistently affected by social, economic, and legal bias or oppression. Such groups include those distinguished by age, religion, disablement, sexual orientation and culture. (National Association of Social Work, 1987, p. 961)

The American Association for Counseling and Development's Human Rights Commission developed a policy in 1987 stating that a counselor must engage in an "ongoing examination of his/her attitudes, feelings, stereotypic views, perceptions and behaviors that might have prejudicial or limiting impact on women, ethnic minorities, elderly persons, gay/lesbian persons..." (Human Rights Committee of the Association for Counseling and Development, 1987, p. 1). Ethical standards of the American Counseling and Development Association state that "through awareness of the negative impact of both racial and sexual stereotyping and discrimination, the counselor guards the individual rights and personal dignity of the client in the counseling relationship" (American Counseling Association Ethical Standards, 1988, p. 1).

In 1990, the American College Personnel Association (ACPA) developed ethical standards which addressed sexual orientation as a form of discrimination, stating that "members perform in a fashion that is not discriminatory on the basis of race, sex, national origin, affectional/sexual preference...and they work actively to modify discriminatory practices when encountered" (ACPA, 1990, p. 2).

Each of these professional organizations expresses a commitment to responsibly serve the gay and lesbian client population. What has not followed, however, is mandatory and integrated educational curricula designed to train therapists in gay and

lesbian issues, nor a significant increase in support for research designed to expand the knowledge base about gay and lesbians in psychotherapy. This may be a result of the heterosexism that is pervasive throughout the culture (Herek, 1990; Stein, 1988).

Pathological Etiology

Before the uprisings at Stonewall and the intensification of the Gay Liberation Movement, the clinical literature focused almost completely on the etiology of homosexuality (Morin, 1977). The implicit assumption of this literature was that homosexuality was an illness that demanded a cure (Krajeski, 1986). Krajeski (1986) has suggested that the treatment of gay and lesbian clients was confused with the treatment of the illness of homosexuality. He has further suggested that all problems of gay and lesbian clients were attributed to their homosexuality, with little focus on their stated presenting problems (Krajeski, 1986). Psychotherapists were naturally criticized for contributing to the psychological distress and oppression of lesbians and gay men.

This pathological view was supported by early research that was biased and unrepresentative but supported by prevalent psychoanalytic theory. Early research was biased in its assumptions of pathology, its search for a cure, and its exclusive use of psychiatric patients as subjects. For example, Bieber et al. (1962) based many of their theories about homosexuality on studies of their psychotherapy patients. Psychoanalytic theories of homosexuality were heavily influenced by the views of Freud. Freud believed that all individuals had a capacity for bisexuality and that homosexuality was not an illness. For example, in 1905 he wrote that homosexuality

"is found in people who exhibit no other serious deviations from the normal...whose efficiency is unimpaired, and who are indeed distinguished by specially high intellectual development and ethical culture" (Freud, 1905/1953, p. 135-243).

Freud, however, viewed homosexuality as a psychosexual phase through which individuals passed on the way to heterosexuality (Bayer, 1981). He believed that exclusive homosexuality was the result of an arrest in development and that it indicated a fixation at the oedipal psychosocial stage (Bayer, 1981). Followers of Freud used his theories regarding the pathological etiology of homosexuality to support the development of psychological theories of homosexuality and psychotherapy practices.

Until very recently, psychoanalytic theorists contended that homosexuality was a form of psychopathology. Homosexuality was believed to be the result of a poor relationship between parents, hostile relationships with siblings and poor peer relationships (Bieber et al., 1962). Psychoanalytic theory described homosexual behavior as a symptom of an underlying personality disorder (Kraft-Ebing, 1894), an arrest in development (Freud, 1905/1953) and a result of neurosis (Bieber et al., 1962). Lesbianism was viewed as "a form of immaturity, an ego deficit, a narcissistic condition and a denial of female genitality" (Sang, 1989, p. 92).

Considering that gays, lesbians, and bisexuals have been largely invisible throughout history (Atkinson & Hackett, 1988), it has been difficult to conduct research on non-clinical or non-institutionalized samples in order to refute these claims. The results of this research on clinical and institutional samples naturally

provided support for pathological views toward homosexuality.

Non-Pathological View of Homosexuality

There was, however, some significant early research suggesting that homosexuality was prevalent and was not inherently a form of psychopathology. Utilizing nonclinical samples, this research provided empirical evidence that demonstrated that homosexuality was a normative variation of human sexuality present in most cultures and species.

The early Kinsey et al. studies (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) demonstrated that the prevalence of homosexual behaviors was much higher than had been previously assumed. This research also suggested that sexual orientation was not dichotomous (either exclusively homosexual or heterosexual), but rather existed along a continuum (Kinsey et al., 1948; Kinsey et al., 1953). This research challenged the previously accepted notion that a non-heterosexual orientation was deviant (Atkinson & Hackett, 1988).

Around the same time several other important studies were conducted. Ford and Beach (1951) studied 76 cultures around the world and found that homosexuality was present in almost all species and in almost all cultures. Ford and Beach reported that in 64% of the cultures, homosexual behavior existed and was accepted for certain members of the society. Evelyn Hooker (1957, 1958) demonstrated that trained clinicians could not differentiate between a non-clinical sample of heterosexuals and homosexuals using projective tests. This was a landmark study in that Hooker successfully demonstrated that there were not differences in the inherent

psychopathology of heterosexuals and homosexuals.

Despite the fact that these research studies indicated both the wide prevalence of homosexual behavior and the health of homosexuals, the field of psychology ignored the research and maintained that homosexuality was a form of mental illness until the emergence of the Gay Liberation Movement. The pathological views towards homosexuality were perpetuated by cultural mores and intolerant religious views. Similar to other social movements, changes were not made by the majority culture until the minority culture organized and resisted their oppression. It appears doubtful that changes would have been made if not for the mobilization of the Gay Liberation Movement.

Views of Bisexuality

Bisexuality has also been viewed as pathological throughout history. Freud believed that humans were innately bisexual, referring to the innate biological capacity that infants have for sexual attraction to both sexes (Paul, 1985). He believed, however, that the expression of bisexual behavior was a sign of immature sexuality, and that heterosexuality was the only healthy resolution of psychosocial development (Paul, 1985).

Modern conceptualizations of bisexuality have considered two models of bisexuality, the "conflict model" and the "flexible model" (Zinik, 1985). The "conflict model" views bisexuality as "problematic, stemming from identity conflict and confusion that marks a transitional stage to a homosexual orientation" (Zinik, 1985, p. 7). Within the "conflict model" Zinik has suggested that bisexuals are seen

as: (1) conflicted or confused about their identity; (2) living in a transitional stage; or, (3) using the bisexual label to consciously or unconsciously defend against their true homosexuality (Zinik, 1985).

Other "conflict model" perspectives include the suggestion that bisexuality is an attempt to have heterosexual privilege while avoiding the stigma of homosexuality (Zinik, 1985); that bisexuality is a label used to deny one's basic homosexual identity occurring as the result of internalized homophobia (Blair, 1974); that bisexuality is associated with promiscuity and non-monogamy (Hansen & Evans, 1985); and that bisexuals are individuals with an inability to differentiate one form of sexuality from another (Cory & Leroy, 1963). These notions of bisexuality are based on a dichotomous view of sexual identity; a belief that one homosexual incident indicates homosexuality or bisexuality (the "one drop theory") (Zinik, 1985), and the idea that once homosexual behavior starts all other heterosexual behavior is viewed as "counterfeit" (Hansen & Evans, 1985, p. 3).

The "flexibility model" of bisexuality has emerged more recently. This model views bisexuality as "the coexistence of heteroeroticism and homoeroticism, as the successful integration of homosexual and heterosexual identities into a dual sexual orientation" (Zinik, 1985, p. 7). The "flexibility model" represents a less rigid and more affirming view of bisexual identity.

The experiences of bisexuals as a discrete group have most often been ignored historically. Many people, however, identify as bisexual and a growing body of literature reasons that there is utility in viewing bisexuals as a distinct group.

Considering them as either essentially homosexual or heterosexual distorts the actual characteristics of homosexuals and heterosexuals and ignores what may be the unique characteristics of bisexuals. Use of precise terminology in sexuality research is of utmost importance in regards to the exploration of bisexuality. Examining the psychotherapy experiences of bisexuals as a separate entity will enhance the accuracy and scope of this study of perceived heterosexual bias.

Terminology

The Gay Liberation Movement influenced changes in many areas, one of which was psychological terminology. The concepts of homophobia, heterosexism, and gay culture were introduced. Gay, lesbian, and bisexual persons were seen as belonging to a social group, rather than merely engaging in same-gender sexual behavior, and gay, lesbian, and bisexual identity and culture came to be considered important areas for examination.

Homophobia

Weinberg (1972) popularized the term homophobia and defined it as "the irrational fear or dread of homosexuals" (p. 22). The use of the term homophobia changed the focus of attention away from the pathology of homosexuals to the bias in societal attitudes towards homosexuals. This shift in language reflected an important change in the literature concerning homosexuality.

More recently several writers have asserted that the term homophobia is limited in its meaning (Croteau & Morgan, 1989; Herek, 1984; Hudson & Ricketts, 1980; MacDonald, 1976; Murphy, 1992; Neisen, 1990; Nungesser, 1983). Croteau and

Morgan (1989) and Murphy (1992) have maintained that homophobia is not only the irrational fear of homosexuality but also includes societal discrimination against lesbian and gay individuals. Several authors have proposed the need for the development of new terminology to distinguish between negative individual attitudes and behaviors, and the societal forces that contribute to the oppression of gay men and lesbians (Herek 1984; Neisen, 1990).

Heterosexism

Feminists (Lorde, 1984; Rosenthal, 1982) initially derived the term heterosexism from feminist theories of sexism. Heterosexism from a feminist perspective addresses the element of sexism which purports that only monogamous sexuality between married men and women should be sanctioned and considered normal. Therefore, homosexuality could not be acceptable, as it is non-procreative and not between men and women who are legally married. Herek has discussed how heterosexism stems partially from cultural negativity towards certain forms of sexuality (Herek, 1990). He quotes Rubin (1984), who stated that,

> 'normal' sexuality should ideally be heterosexual, marital, monogamous, reproductive, and non-commercial. It should be coupled, relational, within the same generation, and occur at home. It should not involve pornography, fetish toys, sex toys of any sort, or roles other than male and female. (p. 280-281, in Herek, 1990, p. 321)

Herek (1986) has defined heterosexism as "a world-view, a value system that prizes heterosexuality, assumes it is the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual" (p. 925). This definition draws on feminist theory as well as oppression theory in that it addresses

both the cultural oppression as well as the oppression of sexuality outside the acceptable norm of heterosexual married men and women. Neisen (1990) has asserted that,

> heterosexism is the continued promotion by the major institutions of society of a heterosexual lifestyle while simultaneously subordinating any other lifestyles (i.e. gay/lesbian/bisexual). Heterosexism is based on unfounded prejudices just as racism, sexism, etc., are based on unfounded prejudices. When our institutions knowingly or unknowingly perpetuate these prejudices and intentionally or unintentionally act on them, heterosexism is at work. (p. 25)

Neisen (1990) has argued that the term homophobia is comprised of two distinct constructs: heterosexism and shame due to heterosexism. Using his model, internalized homophobia is viewed as resulting from shame due to external forces. His criticism of the term homophobia is based on his belief that the term "phobia" implies that there is a fear of an objective reality and that use of the term homophobia reinforces that myth. However, it can be argued that there is some objective reality associated with the fear of a gay and lesbian lifestyle. A sense of self identity may be threatened for heterosexual persons. What was previously accepted to be the only viable lifestyle is challenged. The full validation of lesbian and gay individuals may threaten present cultural standards and mores leading to a societal change marked by tolerance and acceptance of differences among people.

The term heterosexism is particularly useful in furthering our understanding of heterosexual bias in psychotherapy with lesbian, gay, and bisexual clients. The concept of heterosexism addresses the way that discrimination and prejudice is perpetuated through social institutions. Exploring the manifestation of heterosexism

in psychotherapy is useful in that it: a) accounts for the impact on psychotherapy of the wider social context in which lesbian, gay, and bisexual clients and therapists live; b) informs an understanding of the internalized homophobia or shame due to heterosexism that lesbian, gay, and bisexual clients and their therapists may experience; c) highlights the way gay, lesbian, and bisexual oppression is maintained in conscious and unconscious ways; d) emphasizes the combination of power and prejudice that is key to understanding how biased attitudes toward and treatment of lesbians, gays, and bisexuals are reinforced; e) highlights the cultural negativity towards certain forms of sexuality, and recognizes that gay and lesbian sexuality violates rules of acceptable standards of sexuality as it is non-procreative and non-marital; f) enables us to regard lesbians, gays, and bisexuals as minority group members whose functioning and opportunities are affected by societal oppression

Heterosexual bias is maintained by a culture that reinforces heterosexism in blatant and subtle ways. The strength of these cultural reinforcers in perpetuating discrimination is evidenced by the presence of racial oppression, racist practices, and racist attitudes, which continue to exist despite the civil rights movement, affirmative action programs, and laws that prohibit discrimination on the basis of ethnicity. This study will examine the experiences of lesbians, gay men, and bisexuals in psychotherapy as influenced by a heterosexist social context.

Social Context: Psychotherapy as a Form of Social Control

Some authors have suggested that mental illness is socially constructed (Szasz, 1970) and that psychotherapy is a social institution that seeks to insure conformity to

societal values (Chesler, 1972). For example, research demonstrates that therapists have negative attitudes towards women who assume nontraditional roles (American Psychological Association Task Force, 1975; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970) and punish deviant women by labeling them sick (Chesler, 1972). Homosexuality is viewed as a threat to certain culturally sanctioned values, and therefore has been viewed as an illness. Lesbian, gay, and bisexual identities and relationships challenge rigidly defined gender roles and gender stereotyped behavior. Homosexuality challenges attitudes of sexual conservatism that only sanction sexual activity for procreative purposes. The impact of the attitudes of psychotherapists is important to examine due to the special powers of therapists to influence what constitutes normality and pathology (Halleck, 1971).

Since the 1970's there has been a shift from regarding homosexuals as mentally ill persons to viewing homosexuals as minority group members (Cambell et al., 1983; Cass, 1990). The concept of homosexuals as minority group members suggests the relevance of deviance theories to understanding homosexual experience. Lesbian and gay clients have historically been viewed as deviant by their therapists and by society at large, and a brief consideration of deviance theories provides a useful perspective for understanding homosexual experiences. Nurious (1983) has suggested that

> It is a long-standing belief in our culture that "deviant" behaviors are likely to be associated with personal and social pathologies. Those who depart from sexual attitude and experience norms tend to be particularly susceptible to the label of deviance. Typically, such labels of deviance imply negative dispositional qualities about the individual that extend beyond the non-normative orientation or behavior in question. In lay terms, the common assumption is that something is "wrong" with such individuals. (p. 119)

Szasz (1978) has stated that "...majorities usually categorize persons or groups as 'deviant' in order to set them apart as inferior beings and to justify their social control, oppression, persecution, or even complete destruction" (p. 25-26).

Labeling theory emphasizes the importance of accounting for the effect of being labeled deviant by stressing "the role of social definition in the creation and maintenance of deviance" (Moses & Hawkins, 1982, p. 10). The application of labeling theory would suggest that lesbians and gays are considered deviant not because of anything inherently destructive, but rather because society has determined homosexuality to be undesirable. The psychiatric profession has perpetuated myths and stereotypes about homosexuality by labeling lesbians and gay men as sick. The mental health professions have used their position to justify the oppression of lesbians and gays. This may have been done intentionally or with little awareness. Riddle and Sang (1978) have maintained that "because psychotherapy incorporates and perpetuates many of the biases, myths, and negative stereotypes that exist in our culture, psychotherapists may inadvertently restrict a client's options and self development" (p. 84).

Feminist ideology (Chesler, 1972), minority and cross-counseling theory (Atkinson & Hackett, 1988), and sociological literature all critique the emphasis in psychotherapy on the adjustment and intrapsychic functioning of individuals without integrating a social awareness of the cultural forces which may be impacting both therapist and client alike. An awareness of the impact of societal values on mental health practices with lesbians and gay men is of particular importance.

There remains substantial debate in the literature, however, about whether or not social context is particularly relevant to the practice of psychotherapy. Moke & Bohan (1992) have stated that "the assumption that relevant context can be eliminated in psychological research has generalized to a belief that psychology itself is free from contextual influences, that science operates in a sociohistorical vacuum" (p. 10). By denying the impact of social, political and economic forces on lesbians, gay men, and bisexuals, there has been a failure to consider how these forces have been responsible for the marginalization of lesbians, gay men and bisexuals, and how they contribute to their adjustment difficulties.

Values and Psychotherapy

Because psychological research and psychotherapy practice are embedded with values, research and practice needs to be conducted in a way that is conscious of the impact of values and biases, and the subjective nature of the processes. This is of particular import in regard to the place of gay men, lesbians, and bisexuals in society and the role of psychotherapy in maintaining that place. Moke and Bohan (1992) have maintained that

> ...if we presume that our research is value free, unbiased, and objective, if we fail to recognize how the questions asked and the answers offered are in fact shaped by context-dependent (and gendered) personal and social values, we may be seduced into believing that our "knowledge" is pure, objective, and value free. As it is in fact not pure, its hidden values may serve purposes other than those we might intend. (p. 11-12)

The importance of making values explicit as psychotherapists has been highlighted by many authors (Bergin, 1985; Grant, 1985). Martin (1982) has

discussed how values about homosexuality may influence psychotherapists and the practice of psychotherapy with lesbian clients. She has maintained that clients and therapists were raised in the same society, one in which homosexuality is devalued.

> We have all been exposed to homophobic teachings, whether we are aware of it or not, and we have all internalized those teachings. We all grew up influenced by the prevailing cultural views on homosexuality, yet we seem to expect that we can discard the old notions on a moment's notice. (Martin, 1982, p. 342)

Values also impact psychological research, which in turn can then perpetuate heterosexual bias. Some writers, however, have challenged the perpetuation of heterosexist values in psychological research and psychotherapy practice (Cohen & Stein, 1986; Martin, 1982; Riddle & Sang, 1978).

Clinical Theory Regarding Heterosexual Bias in Psychotherapy with Lesbians, Gay Men, and Bisexuals

The author defines heterosexual bias in psychotherapy as any therapist attitudes or behaviors which favor heterosexuality and negatively evaluate homosexual or bisexual identity, behavior or relationships. This is based on Betz and Fitzgerald's (1987) definition of sex bias as "any set of attitudes or behavior which favors sex role congruent behavior and negatively favors sex role incongruent behavior " (p. 83). Following is a discussion of clinical theory that guides an understanding of how heterosexual bias can be understood concretely as it emerges in the treatment of lesbians, gay men, and bisexuals in psychotherapy. These theories are based on a relatively recent body of literature that addresses new knowledge about the biological, psychological, and cultural characteristics of this population, and dispels myths about homosexuality. There is very little literature or research addressing psychotherapy

with bisexuals. An assumption is made, therefore, that an examination of theory related to psychotherapy with lesbians and gay men can inform our understanding of psychotherapy with bisexual persons. Bisexuals as a group, however, may experience bias in somewhat different ways and to varying degrees.

Gay, Lesbian, Bisexual Clients are Viewed Pathologically

Therapists continue to view homosexuals as less healthy than heterosexuals (Committee on Lesbian and Gay Concerns, 1991; Garfinkle & Morin, 1978; Lief, 1977) despite evidence to the contrary. In psychotherapy practice this may be evidenced in both overt and covert ways. A therapist may emphasize the positive qualities of a client's heterosexual relationships and dwell on the negative aspects of their homosexual relationships (Riddle & Sang, 1978). Therapists may view homosexuality as the cause of client problems, and they may have difficulty separating lifestyle concerns and stresses from psychopathology (Riddle & Sang, 1978). Coping strategies and defenses that are useful in adapting to the stresses of minority group status may be viewed as weaknesses and signs of pathology. Symptoms that accompany normal developmental stages of sexual identity formation may easily be confused with symptoms of pathology. For example, depression and alienation may be a normative response arising as a client is struggling to "come out" as gay or lesbian (Buhrke & Douce, 1991). Similarly lesbians and gay men may feel a need to distance themselves from friends and family members as a means of preserving their sense of integrity in the face of rejection. Finally, the process of

"coming out" as lesbian, gay, or bisexual may appear similar in nature to an adolescent developmental phase though generally occurring somewhat later in life (Cohen & Stein, 1986). It is important to recognize that this may be the result of the impact of societal heterosexism on the development of a lesbian, gay, or bisexual identity (Cohen & Stein, 1986; Coleman, 1982).

On the other hand, gay, lesbian, bisexual individuals are not immune from psychopathology. The presence of psychopathology must not be ignored in an attempt to be sensitive to lesbians, gay, lesbian, and bisexual issues. Though lesbians and gay men have been found to have no more inherent psychopathology than heterosexuals (Hooker, 1957, 1958; Siegleman, 1972), Martin (1982) has stated that,

> this is not to say that homosexuals do not have impairments in object relations, or arrested developments, or any of the other descriptions we have to indicate that something falls short of healthy functioning. There is no reason to assume, however, that such difficulties are any more or less prevalent in homosexuals than heterosexuals. (p. 341)

Homosexuality as Failed Heterosexuality

The etiology of homosexuality has long been a topic of intense interest and research. Therapists have generally treated homosexuality as if it occurred as the result of a failure in some area. The literature suggests that homosexuality is commonly viewed as caused by a failure in heterosexuality, a result of problems in relationships with parents, the result of an arrest in psychosexual development, or as the result of early gender non-conformity (Martin, 1982; Riddle & Sang, 1978).

Therapists may communicate their beliefs that homosexuality is a form of pathology in direct or subtle ways. Therapists may overtly encourage lesbian and gay

clients to change their sexual orientation to become heterosexual, or discourage lesbian and gay clients from "coming out" to others. In more subtle ways therapists may indicate that homosexuality is the result of problems. Therapists often collude with patients who want to explore the causes of their homosexuality (Martin, 1982). This may indicate to a client the therapist's own belief that "heterosexuality is inherently 'natural', thereby implying that homosexuality is unnatural and the result of a problem in nature" (Fassinger, 1991, p. 159). For example, DeCresenzo (1984) has asserted that therapists compare homosexuals to disabled persons, focusing on how psychotherapy can help both groups adjust to their "condition". A therapist may ask a lesbian or gay client about his or her ability to function heterosexually (Martin, 1982), subtly reinforcing the idea that homosexuality is the result of a failure in heterosexual relationships. Or, a therapist may discount a client's self definition as gay or lesbian by focusing on the capacity for heterosexual behavior or attractions. Martin (1982) recounted an example where "on learning that he [a client] had a relationship with a woman for over a year in college, the therapist said 'Then you're not really homosexual, see, you're bisexual' (p. 343)."

Similarly, therapists may attribute clients' problems to their homosexuality when the problems may be unrelated (Riddle & Sang, 1978). Therapists may focus on the lost opportunities of homosexual clients, without also helping gay, lesbian, bisexual clients to appreciate the advantages of accepting and embracing their sexual identity.

Many authors believe that psychotherapists should take a theoretical position that views homosexuality as non-pathological and normative (Cohen & Stein, 1986;

Martin, 1982; Stein, 1988). Homosexuality has been demonstrated through research to be a natural variation in human sexuality, occurring because of development which is complex and unique to each individual. The pattern may be influenced by cultural factors, social learning factors, socialization, genetic, hormonal factors, and personal variables in one's life experience. Martin (1982) has maintained that "it is important to recognize homosexuality, like heterosexuality, as a positive attraction and interest in the love object, and not to define it as a negative of something else" (p. 343). Malyon (1982) has argued that one of the objectives of affirmative psychotherapy with lesbians and gay men is to "provide corrective experiences to ameliorate the consequences of biased socialization" (p. 62). Providing a theoretical orientation that affirms that homosexuality is not the result of problems and is not inherently pathological, is essential to combatting socialization, which generally reinforces the contrary.

Internalized Homophobia

Lesbians and gay men are exposed to societal heterosexism and may internalize the heterosexist beliefs and attitudes of society at large (Messing, Schoenberg, & Stephens 1985). There is considerable evidence that lesbians and gay men are negatively influenced by their internalization of negative societal attitudes. Therapists need to be able to recognize the manifestations of internalized homophobia (Gartrell, 1984; Hanley-Hackenbruck, 1988; Malyon, 1982; Messing et al., 1985), both in themselves as well as in their clients (Gartrell, 1984). Therapists may have unrealistic expectations about how lesbian and gay clients should feel about

themselves in spite of societal stigmatization (Riddle & Sang, 1978). Many authors have maintained that lesbian's (Sophie, 1982) and gay men's (Alexander, 1986) self esteem is seriously threatened by internalized homophobia. Several writers have suggested that it is unrealistic for the self esteem of lesbians and gays not to be affected by societal heterosexism (Riddle & Sang, 1978; Sophie, 1987). When gay or lesbian clients present in therapy with concerns about their sexual identity, internalized homophobia is usually an important source of distress (Gartrell, 1984; Sophie, 1987). However, as Malyon has observed, internalized homophobia is just one of many factors that may impact the psychological adaptation of gay clients (Malyon, 1982).

Cabaj (1988) has maintained that societal heterosexism and internalized homophobia are important factors in both clients and therapists that complicate transference and countertransference in therapy. The challenge of the therapist is to communicate acceptance of homosexuality without underestimating the real or perceived difficulties involved (Sophie, 1987). Lesbians and gays can generally develop a positive lesbian or gay identity if they receive the appropriate support and affirmation (Clark, 1987).

Sophie (1987) has suggested that therapists need to help gay and lesbian clients challenge the meaning associated with their lesbian and gay identity. This may enable lesbian and gay clients to challenge internalized negative stereotypes or irrational ideas about homosexuality.

Gay, Lesbian, Bisexual Issues Marginalized

Tievsky (1988) has suggested that heterosexual bias is indicated by those therapists who believe that "sexual orientation makes absolutely no difference, thus ignoring the impact of life in a rejecting society" (p. 58). Clients may similarly fail to appreciate the extent to which their problems are impacted by external forces related to their being gay, lesbian, or bisexual, and instead they may blame themselves (Cambell et al., 1983). Subsequently, therapists may fail to fully inquire about sexual orientation issues, or fail to recognize and provide validation for the unique stresses that face a gay or lesbian person. Failure of the therapist to confront the client may reinforce the client's low self-esteem (Cambell et al., 1983). Other ways that gay and lesbian issues are marginalized occur when a therapist demonstrates more interest in heterosexual relationships as compared to homosexual relationships, and when the possibility of a homosexual identity is ignored (Riddle & Sang, 1978).

Many authors have suggested that therapists need to be thorough in their inquiry regarding a client's sexuality in initial interviews (Committee on Lesbian and Gay Concerns, 1991; Dillon, 1986). This informs the client that the therapist considers sexuality to be an important aspect of human functioning (Dulaney & Kelly, 1982). It also demonstrates that the therapist is comfortable discussing areas of sexuality, and gives the client permission to talk about sexual issues (Dillon, 1986). Dillon (1986) encourages history taking that is "as opening up as possible, and the manner of the caregiver and the nature of the questions needs inherently to suggest that anything is possible and nothing would offend or dismay" (p. 38).

Some examples that highlight marginalization of lesbian and gay issues follow. A respondent recounted in the Committee on Lesbian and Gay Concerns bias study, "[a] client told me about referring in therapy to a "lover" or "partner" and having the therapist respond with a gender-specific (term) which assumed a heterosexual relationship" (Committee on Lesbian and Gay Concerns, 1991, p. 12). Messing, et al. (1985) reported a case in which

> ...a social worker interviewed an older man regarding a discharge plan, she asked about how his wife would manage his care. When he responded that he did not have a wife, the worker immediately assumed that he lived alone. It was later that she learned of his life-long 'friend' who became his caregiver. (p. 67)

In summary, it is essential that therapists use gender non-specific language, inquire when the gender of a significant other is unknown, and address the topic of sexuality with clients.

Misplaced Focus on Sexual Orientation

Krajeski (1986) has maintained that "all too often the problems which gay men and lesbians have brought to the therapist have been viewed as emanating from the patient's homosexuality. As a result, the focus of therapy became homosexuality rather than the patient's more immediate concerns" (p. 13). A respondent recounted in the Committee on Lesbian and Gay Concerns (1991) study:

> I have seen several gay patients and in each case the person reported that, even though their previous therapist said that he or she accepted their homosexuality, the therapist continued to focus upon their being "gay" as "the problem" rather than upon what the person sought help for. (p. 12)

The therapist needs to be sensitive to the individual pathology of the client without ignoring the impact of the clients homosexuality on the presenting problem (Cambell

et al., 1983; Sophie, 1987). On the other hand, it is important for the therapist not to over-identify with the client's view that their problems are completely the result of their homosexuality, thus ignoring the possibility that the origins for their symptoms are multi-faceted. It is particularly important to understand the degree to which a client's homosexuality is an organizing principle in his or her life, and the degree to which it is related to his or her current concerns (Gagnon & Simon, 1973).

Modifying Sexual Orientation

A number of authors have suggested that therapists need to be particularly thoughtful about clients' requests to change their sexual orientation (Cambell et al., 1983; Clark, 1987; Halleck, 1976; Katz, 1976). Clark (1987) has suggested that a therapist who agrees to help clients change their sexual orientation may perpetuate the client's belief that homosexuality is pathological and undesirable. Silverstein has suggested that helping a client to change their sexual orientation may support the client's wish to be punished (Silverstein, 1977). Cambell et al. (1983) have proposed that gay and lesbian clients may test their therapist in an attempt to protect themselves from rejection by their therapist. For example, clients may state that they wish to become heterosexual or bisexual in order to see if their therapists would be pleased. Clark has stated that underlying a request to change sexual orientation may be a wish for therapist acceptance (Clark, 1987).

Countertransference Issues

There is almost no literature that addresses the countertransference issues therapists experience in their work with lesbian, gay, and bisexual clients. Krajeski

(1986) has suggested that,

> the apparent lack of introspection by therapists may reflect an automatic acceptance of the attitudes of the larger society, which views the gay man or lesbian as being imperfect and inadequate. Thus, if the therapist finds the gay or lesbian patient to be dislikable it is believed to be because the patient is truly dislikable. There is no need to look inward, nor even the recognition that one should. (p. 19)

Riddle & Sang (1978) have suggested that many therapists "believe that their views on lesbianism have no relevance to their treatment approaches. By refusing to make their value system known, these therapists prevent their clients from obtaining a context in which to evaluate the therapy relationship" (p. 92). Martin (1982) has maintained that therapists tend to become defensive at the suggestion that they hold prejudices against homosexuality and may therefore lack empathy with their lesbian and gay clients. Stein (1988) has suggested that "the absence of the ability to acknowledge negative feelings about homosexuality on the part of the therapist may indicate in some cases an unwillingness to examine one's own internalized homophobia" (p. 84).

Acceptance and affirmation of lesbian and gay clients are crucial elements in enabling clients to experience a reduction in the shame and guilt associated with their homosexuality (Clark, 1987). The lack of awareness of unconscious biases may seriously threaten the therapeutic relationship with lesbian and gay clients (Rudolph, 1988).

Stereotypic Pathologizing

Therapists might verbalize affirmative attitudes towards lesbians, gay men, and bisexuals, but in their questions, interpretations and behavior still communicate a very

different message (Riddle & Sang, 1978). These biases may be subtle and may invalidate the experiences of gays, lesbians, and bisexuals (Riddle & Sang, 1978). Stein (1988) has maintained that therapists who are unaware of their biases may give contradictory messages to their gay and lesbian clients. Rather than relying on stereotypes, Dillon (1986) has suggested that therapists need to explore what is unique about each of their lesbian and gay clients, as lesbians and gay men are a very heterogeneous group. Dillon has maintained that therapists should "be informed by the client's story rather than by stereotypes and pathology-oriented assumptions" (p. 38). Therapists need to remain open to the client's definitions and to understand that meanings are personal. Therapists need to avoid labeling a client or pushing a client to label herself as gay or lesbian (Sophie, 1987).

Lack of Knowledge or Expertise

Many authors (Dulaney & Kelly, 1982; Gartrell, 1984; Murphy, 1992) have discussed the importance of the therapist being well informed about gay and lesbian issues to effectively work with gay and lesbian clients. Therapists frequently lack awareness of the socio-political context in which lesbians and gays exist (e.g., legal, educational, employment). Therapists need to understand the potential stresses for lesbians and gay men in adapting to a hostile culture. Therapists must recognize that they as well as their clients have been affected by a heterosexist culture, and that this has affected how gay and lesbian clients and therapists understand sexual orientation.

Riddle & Sang (1978) have suggested that "...behavior which might appear as a personal problem is seen differently once it is understood as an experience

common to most lesbians" (p. 96). For example, relationships problems of gay men, lesbians, and bisexuals may be viewed differently when the unique stresses inherent in their relationships are considered. Lesbians and gay men in relationships encounter problems related to child custody, adoption, foster care, health insurance coverage, and the absence of other privileges accorded to married heterosexual couples (Berger, 1977). They lack decision-making power when partners are sick (Berger, 1977) and their grief is unrecognized when a partner dies.

Therapists need to be informed about gay or lesbian community support networks, groups and services (Gartrell, 1984; Murphy, 1992). The development of a social support network has special meaning for the lesbian and gay client as it serves to reduce the sense of social isolation prevalent among lesbians and gay men. It also provides affirmation and protection from a heterosexist society (Potter & Darty, 1981). Therapists also need to be knowledgeable about the development of gay and lesbian identity, stages in coming out, societal heterosexism, and issues related to H.I.V. infection.

Therapist Attitudes Towards and Knowledge about Lesbians and Gay Men

Following is a review of empirical research of heterosexual bias in the attitudes and knowledge of therapists, as well as in their treatment strategies. This discussion focuses on results which shed light on the clinical themes identified in the conceptual literature. Many writers have hypothesized that a relationship exists between therapists' attitudes toward and knowledge about homosexuality, and their assessment and treatment of gay and lesbian clients (Clark, 1977; Fornstein, 1988; Iasenza, 1989;

Riddle & Sang, 1978; Rudolph, 1988, Stein, 1988; Wisniewski & Toomey, 1987; Woodman & Lenna, 1980). The literature has suggested that negative attitudes towards lesbians and gay men are associated with lack of effectiveness of psychotherapy with gays and lesbians. Just as a racist therapist may not be able to be effective with African-American clients (Jones & Seagull, 1977), Rochlin (1982) has maintained that "...a homophobic or heterosexist therapist, regardless of sexual orientation, cannot be helpful to gay and lesbian clients" (p. 24). Rochlin has noted that the effects of heterosexism on psychotherapy must be considered much as the harmful effects of sexism on psychotherapy have been examined (Rochlin, 1982). The impact of heterosexual bias on the part of the therapist may have serious consequences for lesbian, gay, bisexual clients. Krajeski (1986) has suggested that therapists who believe homosexuals are disordered are "likely to bring about a diminution of self-esteem in their patients" (p. 19).

The literature points to the need for additional research that relates therapist attitudes to measurement of actual service delivery (Rudolph, 1988; Wisniewski & Toomey, 1987). Even without empirical research that establishes a sound relationship between the heterosexual bias of therapists and the lack of effectiveness in treatment, ethical guidelines have been developed which require therapists to identify and confront their attitudinal biases to adequately and ethically treat gay and lesbian clients according to professional standards of care.

Empirical Research

The empirical research has been predominantly comprised of survey studies involving the self-reports of therapists. A variety of non-standardized measures of heterosexual bias have been used, with minimal reliability and validity. Non-random samples have been utilized, therefore limiting generalizability and comparisons of results. Most studies have not differentiated between therapists' attitudes toward lesbians and gays, but instead measure attitudes towards homosexuals as a group. The studies have generally presumed that therapist respondents have a common understanding both of homosexuality and of who is homosexual. No study has looked at attitudes, knowledge, and service delivery of bisexuals as a client group. A trend in the literature suggests that attitudes are becoming increasingly accepting towards lesbians and gays. The research will be reviewed chronologically to highlight this trend.

Survey Research - 1970's

In 1971, Fort, Steiner, and Conrad surveyed a random sample of 163 psychologists, psychiatrists and social workers in private practice in the San Francisco Bay area. A self-administered questionnaire consisting of a set of close-ended items was used. The survey inquired about the attitudes, treatment strategies, and assessment of homosexual clients. The study did not distinguish between lesbian and gay clients. Thirty-eight percent of the sample reported that they would treat a homosexual with the aim of changing their sexual orientation, and seventy-two percent believed that changing a homosexual's sexual orientation was possible.

Seventy-three percent reported that all homosexuals should be diagnosed with a personality disorder based on DSM II categories and thirty-three percent believed that the diagnosis should be "sociopathic personality disturbance". Most all respondents (98%), however, believed that homosexuals could function effectively. The results of the study need to be viewed in context of the time period in which the study was done, which was several years before the change in the position statement of the American Psychiatric Association in 1973.

Morris (1973) examined the views of 103 psychiatrists and 108 general practitioners towards the etiology and treatment of homosexuality. Over two-thirds of the psychiatrists viewed homosexuality as "an aberrant behavior pattern" (69%). About a quarter (25.5%) believed that the best management of homosexuality was to try to change the person to be bisexual through the use of "behavior or aversion therapy." On the other hand, 44% believed that homosexuality was "a normal variant like left-handedness." The total percentages for items were more than 100% for which no explanation was given. Psychiatrists appeared to experience a conflict between their accepting attitudes towards homosexuality and their belief in changing individuals' homosexual orientations to bisexual ones.

Davison and Wilson (1973) surveyed 86 randomly selected members of the Association for the Advancement of Behavior Therapy and all members of the British Behavior Therapy Association. The self-administered survey, comprised of close-ended items, was designed to explore the clinical experience of the respondents, the treatment strategies used, estimates of "success" in changing homosexual behavior to

heterosexual, and knowledge of homosexual life. A positive correlation was found between trying to change the sexual orientation of a homosexual who did not want to change, refusing to help a homosexual be more at ease with her sexual orientation (phi-.48), and not believing that homosexuals can be happy and well-adjusted (phi -.60). A positive attitude toward the general mental health of homosexuals was strongly related to a willingness to deal with other client problems besides their homosexuality. Most respondents (87%) did not believe homosexuality was evidence of psychopathology. However, 13% would try to change the sexual orientation of a patient who did not want their sexual orientation changed (Davison & Wilson, 1973). The results of this study suggest that negative attitudes of therapists appear to affect the treatment strategies they employ.

In 1974, Gartrell, Kraemer, and Brodie conducted a large scale study that examined the attitudes of psychiatrists towards female homosexuality. The 355 respondents were members of the Northern California Psychiatric Association who voluntarily responded to the survey (response rate of 39%). The fifty item survey explored attitudes towards the etiology, treatment and legality of female homosexuality.

In terms of etiology, almost all of the respondents (87%) believed that "female homosexuality is a learned disorder." In addition, most (84%) believed that "homosexual women usually have as background a history of disturbed relationships with both parents, particularly in areas that specifically affect normal sexual variation." However, sixty-six percent agreed with the statement "female

homosexuality can no longer be equated only with sickness or inadequacy, but may properly be considered as a preference, orientation, or propensity for certain kinds of life styles," and 86% agreed that their "concept of mental health includes the possibility of a well adjusted homosexual woman."

In terms of treatment, sixty-six percent agreed that they "oppose the use of psychiatric labels as a way of categorizing female sexual behavior...". The results suggested that psychiatrists simultaneously believed that homosexuality is the result of problems and is a disorder, while at the same time believing that lesbians should not be discriminated against in society (i.e. most were against criminal laws which prohibit female homosexuality and believe in the equal status of lesbians in society).

May (1974) surveyed the attitudes of 38 counselor trainees in a graduate program, 79 psychologists randomly selected from the membership of the Psychotherapy Division (Division 29) of the American Psychological Association, and 125 male homosexuals who were identified through friendship networks. The focus of the survey was to compare these three groups on a measure of philosophy of human nature (Philosophies of Human Nature, PHN Scale) and on a measure of attitudes toward male homosexual behavior (Survey of Attitudes toward Deviance, SAD-Homosexuality Scale). Homosexual men were found to hold beliefs that were more favorable toward homosexual persons than psychologists ($p < .01$). Homosexual men scored significantly higher ($p < .01$) than psychologists on the variable of individual differences, suggesting that homosexual men believe to a greater extent than do psychologists "that people are different from one another in

personality and interests, that a person can change from time to time and that human nature is multiplex" (May, 1974, p. 15). Results suggest that "counselors and psychologists appear to view homosexuals quite differently from the way they view other people" (May, 1974, p. 16). The results further suggest that psychologists and counselor trainees stereotype persons more than non-professional gay men stereotype others.

In 1977 the American Psychiatric Association polled its 10,000 members and reported on the first 2,500 responses regarding their attitudes towards homosexuality (Lief, 1977). The questionnaire consisted of a set of 9 close-ended items that explored attitudes towards the pathology of homosexuals and homosexuality, the possibility of changing homosexuals to heterosexuals, and the extent to which homosexuals experience problems resulting from stigma. Results indicated that a large group of respondents believed that homosexuality was a form of pathology (69%), that homosexuals can change their sexual orientation as a result of therapy (37%), that homosexuals' problems are primarily a result of personal problems rather than societal prejudice (70%) and that homosexual men and women are less capable than heterosexuals of having mature relationships (60% and 55% respectively). This large scale study indicated that most psychiatrists continued to believe that homosexuality was inherently pathological, and that societal prejudice had minimal impact on the adjustment of homosexuals.

Thompson and Fishburn (1977) surveyed 64 counseling students who were enrolled in graduate level courses in guidance and counseling at the University of

New Mexico as well as 15 homosexual men and women on the same campus. The main purpose of the study was to explore differences between male and female counselors, and between male and female homosexuals and graduate counseling students. Questionnaires were distributed to counseling students during their class sessions. The homosexual sample consisted of lesbians and gay men who were recruited through a gay student organization. Methodology consisted of a self-administered questionnaire comprised of a set of 16 items related to attitudes towards homosexuality. Items explored attitudes about etiology, myths about homosexuality, psychopathology of homosexuals and the treatment of gays and lesbians by mental health professionals.

Results indicated that counselors in training were poorly informed about the etiology of homosexuality and felt inadequately trained to work with homosexuals. Many respondents believed that homosexuality was the result of: poor relationships with women and a dislike or fear of women (34%); seduction in adolescence by a person of the same sex (27%); and, a dominant opposite sex parent (37%). Seventeen percent believed that "homosexuality most frequently is a symptom of fear and inhibition of heterosexual expression."

Regarding the role of mental health professionals, most counseling graduate students believed that mental health professionals were inadequately trained to work with homosexuals (86%). However, only 67% indicated that "if a counselor does not view homosexuality as normal, then he or she should refer homosexual clients elsewhere."

Significant differences ($p < .05$) were found between the responses of male and female counseling graduate students, indicating that female counselors showed less biased attitudes. Significant differences ($p < .01$) were found between the homosexual subjects and the counseling students on items related to the psychopathology of homosexuals and pathological etiology of homosexuality, with homosexual subjects showing significantly less biased attitudes. A weakness of this study was that most items did not differentiate between gay males and lesbians, but rather referred to "homosexuals." Another weakness was the implicit assumption that counseling students were not also gay men or lesbians, which would have confounded the results.

Analogue Studies - 1970's

Garfinkle and Morin (1978) explored the attitudes of psychologists towards homosexual versus heterosexual clients. A sample of 40 male and 40 female psychotherapists rated both a hypothetical client and a "psychologically healthy person" on a semantic differential scale. Significant findings indicated that heterosexual clients were perceived to be more psychologically healthy than homosexual clients. No differences were found between the assessment of homosexual women and men. Male therapists evaluated all homosexual clients as less healthy than did female therapists ($p < .05$).

Treatment strategies and therapeutic goals for homosexual clients were reported to be different than for heterosexuals. Therapists tended to view "dissatisfaction with self" significantly more often for homosexual clients, and "taking increased

responsibility" as a treatment goal significantly less frequently than for heterosexuals. These differences in treatment strategies appear to indicate the existence of heterosexual bias in the treatment of lesbians and gays.

Survey Research - 1980's

DeCrescenzo (1984) surveyed 140 mental health professionals and trainees regarding their attitudes toward homosexuality. The subjects were recruited through public and private mental health organizations in Los Angeles. A homophobia measure of closed-ended items was designed to tap beliefs in commonly held myths and stereotypes of homosexuality. The instrument and the complete results were not published. The author did, however, state that the findings demonstrated that therapists had significant myths and stereotypes about homosexuality.

In 1984, Graham, Rawlings, Halpern, and Hermes surveyed 112 therapists about their attitudes toward, knowledge of, and treatment strategies for lesbian and gay clients. Subjects were identified within the departments of psychology, psychiatry, and social work at a large university in Cincinnati, as well as through city telephone book listings and through a clinic associated with the university. Methodology was a self-administered questionnaire consisting of a set of close-ended items exploring attitudes, knowledge and treatment issues with gays and lesbians.

Regarding attitudes toward pathology of homosexuals, the study found that 19% did not agreed with "the APA's current position that homosexuality is not a mental disorder"; 23% disagreed with the proposition that a homosexual person can be as well adjusted as a heterosexual; and 26% did not believe that homosexuals should be

allowed to adopt children even if they were otherwise found to be fit parents.

In terms of treatment strategies with gay and lesbian clients, findings indicated that 62% believed that it was possible to change a person's sexual orientation through therapy, and 37% would "treat a homosexual with the direct aim of changing her/his sexual orientation." Sixty-three percent reported having helped clients to be more open about their sexual orientation with significant others in their lives, however 26% believed that helping clients to self disclose about their sexual orientation was "not applicable" or "never came up".

Finally, Graham et al. (1984) examined therapists' knowledge of lesbian and gay lifestyles and therapists' treatment strategies with lesbian and gay clients. Eighty-three percent believed that special training and knowledge was needed in counseling homosexual clients. Twenty percent reported not knowing about gay social, religious, or educational groups and therefore reported that they did not refer homosexual clients. Subjects were also asked to list their three major concerns in counseling homosexuals, and their concerns were divided into 12 major categories. The three categories most frequently mentioned were: maintaining objectivity and/or countertransference difficulties (21%), lack of knowledge and/or understanding of homosexuality, (16%), and concerns regarding assessment and diagnosis (12%). These results provide more recent evidence that therapists continue to demonstrate heterosexual bias in attitudes, knowledge and treatment.

In 1986, the American Psychological Association, Committee on Lesbian and Gay Concerns established a Task Force on Psychotherapy with Lesbians and Gay

Men. This Task Force conducted a large scale study designed to gather information about biased and exemplary treatment of lesbian and gay clients as reported by psychologists (Committee on Lesbian and Gay Concerns, 1991). The sample was comprised of 2,544 psychologists who were members of the American Psychological Association. The survey included questions about the demographic and professional background of the subjects, as well as four open-ended questions inquiring about specific examples of biased and sensitive treatment of lesbian and gay clients. Subjects could choose to respond to the open-ended items in reference to their own work with clients, on the basis of an incident they heard from a colleague, or from their own experience as a client. No effort was made in this study to determine the frequencies of incidents reported, nor the percentages of incidents based on sources of information.

The results of this study were analyzed qualitatively and the responses were grouped into the following areas of bias: assessment, intervention, identity, relationships, family, and therapist expertise and education. Twenty four different forms of bias were elucidated within these six areas. Verbatim examples were provided within each area of bias. Qualitatively significant incidents of bias were reported in the recent experiences of therapists. Verbatim examples of blatant and subtle forms of bias provided rich clinical information. The results of the study are particularly relevant to the methodology and hypotheses of this current study. The themes of bias developed from the results of this study are listed in Appendix F (Committee on Lesbian and Gay Concerns, 1991). The APA Task Force also

identified twenty different ways that therapists can be sensitive to gay and lesbian clients.

Wisniewski and Toomey (1987) surveyed 77 social workers regarding their attitudes towards homosexuality. Subjects were recruited from agencies likely to offer clinical services to gay and lesbian individuals. Measures used were the Index of Homophobia (Hudson & Ricketts, 1980), as well as an authoritarianism scale. The Index of Homophobia (IHP) is an instrument consisting of 25 items that measures affective responses towards homosexuals. It does not uniformly distinguish between attitudes towards lesbians and gays, and the cut-off points for high and low homophobia scores are not empirically based. Rationally, Hudson and Ricketts had defined cut-off scores for four categories of homophobic individuals: a. non-homophobics; b. low grade non-homophobics; c. low grade homophobics; and d. high grade homophobics. Wisniewski and Toomey found that nearly one third of the subjects received scores placing them in high grade or low grade homophobic categories. Results indicated that variables of conformity and anti-intellectual attitudes accounted for a significant portion of the variance in explaining the homophobia of social workers, (r .4, $p < .01$).

Buhrke (1989a) surveyed 213 female doctoral counseling psychology students regarding the nature and extent of training in lesbian and gay issues they received in their doctoral career. Respondents came from 31 different Counseling Psychology programs. Results indicate that female counseling psychology students receive little training on lesbian and gay issues in their courses. Twenty-nine percent of the

subj

thei

con

ster

infc

pro

me

hyp

ma

rel

Sig

pr

he

wa

wi

sc

pr

hc

sa

subjects reported that lesbian and gay issues were not addressed in any course during their training and seventy percent reported that no faculty in their department was conducting gay or lesbian related research.

Analogue Studies - 1980's

Casas, Brady, and Ponterotto (1983) used analogue methodology to examine how stereotyping on the basis of gender and sexual orientation impacts the processing of information by mental health professionals. A sample of 34 mental health professionals from a medium sized California city was recruited from four different mental health agencies. Subjects were given a series of cards that identified hypothetical persons by sex and sexual preference. Stereotypic characteristics were matched with each card, and subjects were asked to make judgements about the relationship between the sex, sexual orientation and stereotypic characteristics. Significant differences were found ($p < .05$) in the ability of subjects to accurately process information when the information presented was incongruent with commonly held stereotypes about homosexual men and women. This study was limited in that it was an analogue study surmised to reflect what mental health workers actually did with homosexual men and women even though it may not adequately simulate a real scenario. The authors suggest that if the results of this study were evidenced in the practices of mental health workers, their differential diagnosis and treatment of homosexual men and women might have been biased.

Glenn and Russell (1986) explored heterosexual bias in an analogue study with a sample of 36 female counselor trainees who were enrolled in master's programs in

either counseling psychology or guidance and counseling. In this study subjects rated an audio-taped simulated intake session with a female client who referred to her partner with a woman's name, a man's name, and with a name with an unidentifiable gender. A criticism of this study is that it is not known if most subjects thought that the partner with the "unidentifiable" name was a man or a woman. No significant differences between the groups were found. During debriefing, however, participants reported a lack of training on counseling issues related to lesbian and gay clients and a need for training on confronting biases and homophobia.

Survey Research - 1990's

Rudolph (1990) surveyed the attitudes of 52 counselors and counselor trainees towards homosexuals. Measures used were the Index of Homophobia (IHP) (Hudson & Ricketts, 1980) and the Homosexuality Attitude Scale (Milham, San Miguel, & Kellog, 1976). The Homosexual Attitudes Scale is a 26-item scale measuring attitudes concerning the legality, morality and social desirability of homosexuality. Results indicated that counselors had significantly more negative attitudes ($p < .05$) towards eroticized interactions with homosexual persons as compared to noneroticized interactions.

The Committee on Lesbian and Gay Concerns of the American Psychological Association (1990) surveyed graduate psychology chairpersons regarding the inclusion of gay and lesbian related courses in curriculum. Only nine percent of 303 department chairpersons reported that their programs had training in the area of sexual orientation. Fewer than half of the programs (44%) were willing to sponsor

some gay or lesbian related doctoral research. The results of this study indicate the virtual absence of lesbian and gay related content in psychology curriculum. The results are supported by those of Buhrke (1989a) in which female graduate students reported little lesbian and gay related content in their psychology programs.

Chaimowitz (1991) surveyed 19 psychiatric residents, 31 psychiatric faculty and 22 family practice residents in a mid-sized Canadian medical school regarding their attitudes towards homosexuality and AIDS patients. The Index of Homophobia (Hudson & Ricketts, 1980) was used to measure homophobia. Thirty-three percent of the psychiatric residents and 26% of the psychiatric faculty were found to be low or high grade homophobics as measured by the IHP. Additionally, 25% of the psychiatric faculty and 11% of the psychiatric residents indicated they "feel they are prejudiced against homosexuals."

Summary

A review of the research indicates that mental health professionals appear to demonstrate heterosexual bias in their attitudes towards and treatment strategies with lesbians and gay men (Chaimowitz, 1991; Davison & Wilson, 1973; Fort et al., 1971; Garfinkle & Morin, 1978; Graham et al., 1984; Rudolph, 1988, 1989). Many therapists continue to judge gay or lesbian clients to have more psychopathology than heterosexual clients (Graham et al., 1984; Lief, 1977), describe gay and lesbian clients in stereotypic terms, and are likely to have negative attitudes about homosexual persons in eroticized contexts (Rudolph, 1990). Most of the research however, consists of survey studies of therapists, leaving the possibility of unconscious bias and

the impact of social desirability therapists' responses unknown. Those studies that have attempted to investigate less conscious bias have used analogue methodology rather than actual client counseling sessions. Generalizability of the results from analogue studies is therefore limited. No research has been conducted which addresses therapists' attitudes towards and treatment of bisexuals in psychotherapy.

A review of the literature suggests that therapists are not well equipped to work with lesbian and gay clients. Their lack of sensitivity, awareness, and knowledge may contribute to the oppression of lesbian and gay individuals. The following section will focus on the experiences and perceptions of lesbians and gay men in psychotherapy.

Lesbian, Gay, Bisexual Client Variables

Prevalence Seeking Psychotherapy

There has been little quantitative research on the prevalence of lesbians, gays, and bisexuals seeking therapy. The percentages of lesbians and gay men seeking therapy range from 32% to 83% (26% gay men, 37% lesbians, Saghir & Robins, 1973; 32% gay men, Weinberg & Williams, 1974; 58% gay caucasian men, about 66% lesbian caucasians, Bell & Weinberg, 1978; 75% lesbians, NIMH, 1987; 82% gay men and lesbians, McDermott et al., 1989). In comparing heterosexual and homosexual help seeking, the percentage of lesbians and gay men seeking therapy has been found to be higher than heterosexuals (Bell & Weinberg, 1978; Saghir & Robins 1973).

The prevalence of bisexuals seeking psychotherapy has been examined in only

one s

bisex

(Klei

for o

the b

coun

bisex

some

or sl

lesbi

hom

inter

pers

cons

psyc

one study by Klein in 1978. In this study, Klein measured the percentage of those bisexuals who "sought counseling for problems relating to [their] sexual orientation" (Klein, 1978, p. 213), thereby excluding those bisexuals who sought psychotherapy for other reasons. He found that of 127 bisexuals (92 males and 35 females), 38% of the bisexual males and 26% of the bisexual females were found to have had counseling to deal with problems related to their sexual orientation.

There are no prevalence studies that compare the help-seeking behavior of bisexuals, gay men, and lesbians. However, bisexuals may have been included in some of the studies of gay men and lesbians, confounding the results.

Reasons for Seeking Psychotherapy

The impact of societal heterosexism, and the subsequent internalized homophobia or shame due to heterosexism, may partially account for the over-representation of lesbians and gays in psychotherapy as reported in several studies. Internalized homophobia and shame due to heterosexism are terms used to refer to the internalization of hostile and negative societal attitudes towards gay and lesbian persons. An expanded definition of internalized homophobia was proposed by a consulting group, Diversity Works, as

> the process through which gay men, lesbians, and bisexuals come to accept the stereotypes, myths, and subordinate social status generated and maintained by the dominant society. This can be manifested as self put downs, living out stereotypical roles and behaviors, and not confronting the dominant system of oppression. (Diversity Works, 1990, p. 1)

Internalized homophobia has been found to be detrimental to the self-esteem, psychological adjustment, and identity development of gay men and lesbians

(Alexander, 1986; Sophie, 1987). Lesbian and gay clients, therefore, may seek therapy in higher numbers to deal with their adjustment to an antagonistic culture. A second factor is that psychotherapy may serve a unique function with lesbians and gays, since shame and secrecy are issues commonly experienced by these clients. They may seek therapy for support around "coming out", as well as for help in managing boundaries regarding their homosexuality. Brown (1989) has cautioned researchers to avoid making the assumption that the higher prevalence of gays and lesbians seeking therapy indicates a greater level of pathology, but rather has suggested the importance of examining the meaning of therapy for lesbians and gays, and the different role that therapy may play in the lives of lesbian and gay persons.

Gay Mens', Lesbians' and Bisexuals' Perceptions of Psychotherapy

Few studies have focused exclusively on exploring the perceptions of gay, lesbians, or bisexual clients in psychotherapy (Balis, 1984; Nuehring, Fein, & Tyler, 1974). Several other studies have minimally inquired about the experiences of lesbians and gay men in psychotherapy (Bell & Weinberg, 1978; Jay & Young, 1979; May, 1974; Saghir & Robins, 1973). Methodological problems, however, existed in all of these studies, including small samples, use of non-standardized measures with no validity and reliability reported, little or no information about therapist or therapy experience variables, inadequate number of questions addressing perceptions of therapy, little or no quantitative analyses of results (Balis, 1984; May, 1974; Nuehring, Fein, & Tyler, 1974; Saghir & Robins, 1973) and incomplete reporting of results (Bell & Weinberg, 1978; Jay & Young, 1979; Nuehring et al., 1974). The

research has suggested that many lesbians and gay men have been dissatisfied with their therapy experiences. This dissatisfaction has been attributed to a client perception that therapists' had a poor understanding of homosexuality and a lack of acceptance of homosexuals (Bell & Weinberg, 1978; Jay & Young, 1977; Saghir & Robins, 1973).

Empirical Research

Saghir and Robins (1973) conducted a study of 89 gay men and 57 lesbians, and 35 heterosexual men and 43 heterosexual women for comparison. Gay and lesbian respondents were recruited primarily through gay organizations in Chicago and San Francisco (Mattachine Midwest, Daughters of Bilitis, Society for Individual Rights). Heterosexual men and women were recruited from one apartment complex in St. Louis County which rented largely to single individuals with high incomes. The criteria for acceptance into the study for the heterosexual sample was exclusive heterosexuality and non-married status for at least two years. Criteria for the homosexual sample were not reported. The researchers paid the heterosexual respondents $15 for their participation, believing they would otherwise be unmotivated and unwilling to participate; whereas the homosexual respondents were not paid for their participation. Differences between the homosexual and heterosexual sample were clearly apparent and indicate evidence of bias in selection. For example, the authors stated that homosexuals and heterosexuals were matched on marital status, not taking into account the fact that lesbians and gays may have significant relationships which cannot be marital.

Methodology was primarily a structured interview format where the majority of

questions could be answered by "yes" or "no" or by a number. Some items were open-ended. Interviews lasted from 3-4 hours. Results included the finding that homosexual men reported having been in therapy in the past or currently (26%) significantly ($p. < 05$) more than the heterosexual control group (6%). Thirty-seven percent of the female homosexuals were found to have been involved in therapy at some point in their lives, as compared to 26% of the heterosexual women sample. Nine percent of the gay men and 15% of the lesbians went to therapy with the goal of changing their sexual orientation. In terms of satisfaction with their therapy experiences, "about a third" (data not provided) of the homosexual women expressed a "great deal of anger and disappointment with their therapists" (p. 272). Thirty seven percent of the homosexual male sample felt negatively about their psychotherapy experiences. The authors stated that the dissatisfaction of gay men and lesbians was frequently attributed to the perceived insensitivity of their therapist towards their sexuality. They reported that subjects frequently felt that therapy was of no value or even made things worse due to a lack of understanding by the therapist or due to the therapist's personal prejudice against homosexuality. For example, a respondent in the study stated,

> ...as far as a psychiatrist goes, maybe I just didn't get to the right one. I don't think that the psychiatrist has been of any help to me because first of all he didn't really understand the problem. He tended to put all homosexuals in the same group and I don't think you can do that. I don't think that homosexuals are alike, but some heterosexuals want to treat every homosexual the same way. They also dwell so much on the causes of homosexuality. I wonder if they are ever as concerned with the causes of heterosexuality. (Saghir & Robins, 1973, p. 112-113)

This response highlights several forms of heterosexual bias, including the therapist's

focus on stereotypic assumptions, a focus on etiology and a lack of understanding and empathy. In addition to the problem of sampling bias, a limitation of this study was that only one item was used to examine client satisfaction with treatment.

Nuehring et al. (1974) conducted a study of the gay and lesbian community in a university setting to document problems that gay and lesbian students reported with mental health services, and problems encountered with clinicians. No information about the sample characteristics or methodology was published. Problems of mental health professionals as reported by gays and lesbians included: intolerance of homosexuality; anxiety discussing homosexuality; and, the assumption that homosexual behavior has to be abandoned if the individual is to become psychologically adjusted. Mental health professionals were experienced as sympathetic but naive about homosexuality and adhering to an illness model of homosexuality. Because the methodology and analysis were not described, the results are impossible to evaluate.

May (1974) surveyed 125 gay men regarding their satisfaction with professional counseling or therapy. Respondents were recruited through snowball sampling within networks of mutual friends among gay men. Through a self-administered questionnaire comprised of closed-ended items, forty-three percent of the male homosexuals reported that they had sought professional help in order to deal with problems associated with being homosexual. Thirty-nine percent reported that the professional service they received was unsatisfactory (forced choice item, satisfactory/unsatisfactory). A weakness of the methodology was that only one item

was used to measure satisfaction with therapy, therefore there is no reliability and validity information on the measure. Reasons for dissatisfaction with therapy were not explored.

Jay and Young (1977) surveyed 4,400 gay men and 1000 lesbians regarding a wide variety of experiences. The study was extensively publicized throughout the United States and Canada, with advertising in widely circulated newspapers and magazines (PlayGuy, Blueboy, Metro Gay News, etc.), radio shows, conferences, lesbian and gay organizations, gay movie theaters, gay and lesbian religious groups, among other places. Responses came from every state in the U.S. The authors stated that "statistical analysis of the data collected in the survey showed that people...were representative of the overall adult population in the U.S. and Canada in terms of age, place of residence, and religious background" (Jay & Young, 1977, p. 10). Two questionnaires were developed, one for lesbians and another for gay men. The survey consisted of closed-ended items and open-ended items allowing for both quantitative and qualitative reporting of results. However, no data analysis was published besides percentages and raw scores.

Three questions were included regarding the psychotherapy experiences of lesbians and gays. Twelve percent of the total sample of gay men and eighteen percent of the total sample of lesbians reported that they were currently seeing a therapist, psychiatrist, or psychologist for some reason. Of those respondents who had psychotherapy experience, twenty percent of the gay men and eight percent of the lesbians reported that they had gone to a psychiatrist or counselor to be "cured" of

their homosexuality. Thirty-five percent of the gay men and 39% of the lesbians reported that they felt somewhat or very negative about their experiences in therapy with a straight therapist. Twelve percent of the gay men and 24% of the lesbians felt somewhat or very negative when they didn't know the sexuality of the therapist. Nine percent of the gay men and 4% of the lesbians felt somewhat or very negative about their experiences with a gay or lesbian therapist. The total number of gay male and lesbian respondents who had been in psychotherapy was not reported in the results. The findings suggest that a large proportion of gay men and lesbians felt negatively about their therapy experiences, and that more positive perceptions of therapy were associated with the therapist being gay or lesbian.

In 1978, Bell and Weinberg conducted a large scale study examining the sexual experiences, and social and psychological adjustment of lesbians and gay men, using a smaller comparison sample of heterosexual men and women. The sample was comprised of 686 gay men (575 caucasian, 111 African-American), 293 lesbians (229 caucasian and 64 African-American) 337 heterosexual men (284 caucasian and 53 African-American) and 140 heterosexual females (101 caucasian and 39 African-American). As differentiated from the Saghir and Robins study (1973), much attention was paid to the recruitment of a diverse and representative sample. Gay and lesbian subjects were recruited from six counties in the San Francisco Bay area using extensive publicity (e.g. public advertising, bars, gay baths, gay and lesbian organizations). From a pool of about 5000 gay men and lesbians, individuals were

divided by various categories, including educational level, age, sex and race. Attempts were made to select subjects randomly from each group. The heterosexual subjects were obtained through use of random probability sampling. Heterosexual and gay and lesbian subjects were matched on race, age, sex, and education.

Methodology consisted of structured face-to-face interviews. Among many other questions, questions about the psychotherapy experience of the respondents were asked: 1) number of times consulted a professional; 2) if ever consulted a professional to "give up" homosexuality; 3) age at first time consulted a professional; 4) reason for going to a professional; 5) number of times saw a professional (the first time); 6) how helpful the meetings with the professional were (the first time); 7) ways that contacts with professionals have been helpful; and, 8) ways that contacts with professionals have been a disappointment (Bell & Weinberg, 1978, p. 459-469).

Gay men and lesbians were found to have had contact with a professional (counselor or therapist) more than heterosexual men and women. Fifty-nine percent of the lesbians and gay men as compared with 28% of the heterosexual sample reported to have had contact with a professional. In reference to whether the respondent's first meetings with a professional were helpful, 33% of the lesbian and gay subjects reported their meetings to be "not at all helpful" as compared with 27% of the heterosexual sample. No significant differences were found between the reported dissatisfaction of lesbians and gays as compared with heterosexuals as measured on one item. The use of one item is generally not a reliable measure of a variable. It may be that additional items concerning satisfaction with different aspects

of the treatment would have yielded more significant results. No other significant differences were found between heterosexuals and gays and lesbians with regard to their experiences with professionals.

The dissertation study by Balis (1984) is one of the few studies that focused exclusively on the perceptions of lesbians regarding their psychotherapy experiences. Balis interviewed 12 lesbians about their experiences in psychotherapy in an effort to understand their perceptions of their therapists' attitudes about lesbianism and their perceptions of their therapists' "homophobic" behaviors. Methodology consisted of semi-structured interviews which were qualitatively analyzed. A checklist of 15 therapist behaviors was used to inquire about the perception of homophobic behaviors of therapists. The sample was recruited through a snowball technique. A significant finding of the study was that perceived "homophobic" behavior of therapists was related primarily to perceived empathic failures. Balis found empathic failures to be associated with five elements: 1) therapists' ignorance of what it means to be a lesbian in this society and what lesbian culture is like; 2) therapists' discomfort with the client's lesbianism; 3) therapists' ignoring, denying, or attaching little importance to the client's lesbianism; 4) therapists' persistently misconstruing and misinterpreting the client's material; and 5) therapists' blaming or pathologizing the client for being a lesbian (Balis, 1984).

Empathic successes were distinguished by three elements: 1) working through empathic failures in therapy; 2) therapists' empathic behavior; and, 3) therapists' taking initiative not only to validate but to increase the client's acceptance of her

lesbianism (Balis, 1984).

> The consequences of these empathic failures are that, lesbians blame themselves for the failures, their acquiescence to heterosexual bias, and they are denied a neutral, supportive experience in which they can safely deal with the self-hatred that was instilled in them as they grew up in a homophobic society. (Balis, 1984, p. 167)

Balis concludes that lesbians in her sample perceived therapist homophobic attitudes to be primarily related to a perceived lack of empathy by therapists.

A weakness of the study is lack of representativeness of the sample. The experiences of only 12 lesbians were explored, and there was no attempt to use a heterogeneous sample group. In addition, no quantitative analysis was conducted, so that the validity of the proposed homophobic behavior check-list was not assessed. The qualitative analysis, however, is useful in providing a conceptual framework from which to develop a quantitative measure of heterosexual bias. Many of the themes of bias and patterns of empathic failures will be measured quantitatively in the present study.

Gambrill et al. (1984) surveyed 394 lesbian and gay respondents in the San Francisco Bay area about their use of social services, and their perception of the need for social services. Subjects were recruited through distribution of surveys in gay and lesbian centers, bookstores, businesses, and through friendship networks. Of the 1632 questionnaires distributed, 127 gay men and 162 lesbians responded, a return rate of 24%. Sixty percent (n=236) reported that they had sought counseling for a problem while living in the Bay area. Those respondents who had used gay or lesbian services reported more often that their counselor was helpful (88%) as

compared to those respondents who used traditional (non-gay or lesbian) agencies (61%). The same trend was reported to be found between those respondents who saw gay or lesbian counselors as compared to those who saw heterosexual counselors (data not reported). A majority of the respondents (79%) felt that there were difficulties in using heterosexual counselors. More women (73%) as compared to men (62%) reported difficulties. Seventy-one percent of the sample (n=281) reported that in specific situations they would prefer a gay or lesbian counselor. A gay or lesbian counselor was most frequently preferred when the presenting problem "involved sexual orientation concerns" (p. 65). Twenty-five percent reported that they would prefer a lesbian or gay counselor in all situations.

In response to an open-ended question inquiring about the problems of lesbians and gay men using heterosexual counselors, the most frequent responses concerned the following: 1) a lack of information about and understanding of gay/lesbian people; 2) a lack of information on resources for gay/lesbian people; 3) prejudices against gay/lesbian people; 4) a belief that straight counselors think that gay/lesbian people are "sick"; 5) a lack of role modeling for gay/lesbian people; 6) a belief that it's an easier process for gay/lesbian people to work with gay/lesbian counselors; 7) the difficulty of straight counselors in helping gay/lesbian people feel good about themselves; and, 8) the need for special training for straight counselors.

The results of this study indicate that lesbians and gay men perceive significant problems in seeing heterosexual therapists. Concerns include lack of knowledge, fear of being pathologized, and a perception of insensitivity on the part of the heterosexual

therapist. The results of this study indicate that most lesbians and gay men, therefore, prefer to see lesbian or gay therapists, particularly when their presenting problem concerns sexual orientation issues.

McDermott, Tyndall, and Lichtenberg (1989) surveyed 36 lesbians and 47 gay men from a midwest university community to explore factors related to counselor preference. Subjects were recruited through gay and lesbian organizations and at gay and lesbian events. The Index of Homophobia (Hudson & Ricketts, 1980) was used as a measure of internalized homophobia. This is a 25 item inventory designed to measure homophobic attitudes. Additional measures used were a Counseling Concerns Scale comprised of 14 concerns regarding general counseling issues and special concerns of lesbians and gay men (i.e."coming out to friends") and the Kinsey Scale (Kinsey et al., 1953).

Results indicated that 49% of the respondents preferred to see a gay or lesbian counselor, 10% preferred to see a bisexual counselor and 39% reported that the sexual orientation of the counselor was not important. Using chi-square analysis, no significant differences were found between the preferences of gay men and lesbians. Eighty two percent of the sample reported having seen at least one counselor in the past. Greater internalized homophobia was found to be associated with discomfort discussing topics related to sexual orientation with a counselor of an unknown sexual orientation. Using a stepwise multiple regression analysis, respondents' estimates of the number of people to whom they are out was the greatest predictor of internalized homophobia (i.e. the more "out" the less internalized homophobia).

The finding that lesbians and gay men prefer to see lesbian and gay clients supports the results of other studies (Gambrill et al., 1984). The percentage of lesbians and gay men who had seen a counselor was significantly higher than the results of other studies. This may be due to the characteristics of the sample which was recruited from a university campus. The results concerning "internalized homophobia" are difficult to interpret because the IHP is of questionable utility with a lesbian and gay population. Items such as, "I would feel uncomfortable if I learned that my spouse or partner was attracted to members of his or her sex", clearly have different meaning to a gay or lesbian individual. This study does, however, raise the question of how internalized homophobia may impact clients' preferences for gay and lesbian therapists.

Client Perceptions of Psychotherapy

The importance of examining the therapeutic relationship has been cited in most approaches to therapy (Freud, 1910; Fromm-Reichman, 1960; Gurman, 1977; Strupp et al., 1969; Sullivan, 1961). It has been suggested that it is the therapeutic relationship that mediates the therapist's effectiveness (Gurman, 1977). The psychoanalytic concepts of transference and countertransference are based on the notion that the therapeutic relationship is key to understanding the nature of the therapy experience. Rogers (1957) asserted that relationship factors are of central importance in affecting treatment outcomes, regardless of the treatment techniques used.

Most of the research in this area has focused on the relationship between the

therapeutic outcome and observers' assessments of recorded therapy interactions (Gurman, 1977). The use of outside observers to rate therapy interactions is based on the premise that some clients can not accurately report on their own therapy experiences. Client perceptions were viewed by some to potentially reflect distortion and fantasies and therefore were initially believed to be of little value (Truax & Carkhuff, 1967). However, some writers (Cooley & Lajoy, 1980) have suggested that it is the perceived relationship that both client and therapist respond to in therapy, and therefore assert its validity. Gurman (1977) has observed that even if it is true that "perceptual distortions may occur with a wide variety of patients [this] does not invalidate the proposition that these therapeutic conditions must be perceived by the patient for change to occur" (p. 505).

Barrett-Lennard has maintained that "the client's experience of his therapist's responses is the primary locus of therapeutic influence in their relationship" (Barrett-Lennard, 1962, p. 2). This view represents a shift in emphasis from Roger's view (1957) that therapist variables are most important, to a view of client perceptions as most salient. Barrett-Lennard (1962) suggests that "[it] follows from this that the relationship as experienced by the client (rather than by the therapist) will be most crucially related to the outcome of therapy" (p. 2). Based on these beliefs, Barrett-Lennard (1962) explored clients' perceptions of their therapy experiences with a focus on their perceptions of the therapeutic relationship.

Recent research has suggested that both therapist and client perceptions contribute to the fullest understanding of the treatment relationships associated with

beneficial treatment outcomes (Luborsky et al., 1988). This is supported by authors who have suggested that the therapy process should be viewed from an interactional perspective within the framework of a relationship (Heatherington, 1988). Since research has shown only small or moderate correlations between client and therapist ratings of therapy (e.g., Cooley & Lajoy, 1980; Mintz, Luborsky, & Christoph, 1979; Orlinsky & Howard, 1975), client perceptions may contribute significantly to our understanding of the therapy process. The literature points to a need for further research that explores client perceptions of therapist interventions and attitudes (Hill, Helms, Spiegel, & Tichenor, 1988).

The current study explores client perceptions of heterosexual bias in the interventions, knowledge, and attitudes of therapists. While many studies have attempted to understand heterosexual bias from the point of view of therapists, few have been conducted to corroborate these findings from the lesbian, gay, bisexual clients' perspective.

Empathy

Clients' perceptions of the nature of the therapeutic relationship have been considered an important variable for examination by many authors (Barrett-Lennard, 1962; Gendlin, Jenny, & Shlien, 1960; Lorr, 1965; Parloff, 1961). Empathy, which is central to the therapeutic relationship, has been shown to be significantly related to better outcome (Luborsky et al., 1988). Accurate empathy has been defined as the "ability of the therapist to understand experiences and feelings and reflect their meanings to the client during the moment-to-moment encounter of psychotherapy"

(Rogers & Truax, 1967, p. 104).

The importance of empathy takes on particular significance for lesbian, gay, and bisexual clients. Lesbians, gay men, and bisexuals have generally not experienced early empathic mirroring related to their sexuality by parental figures and by society as a whole (Cabaj, 1988). With potentially few role models, the reactions of therapists may be viewed as representative of all significant figures as well as the larger society (Sophie, 1987). Secrecy about one's sexual orientation may additionally lend greater meaning to the reaction of the therapist, who may be one of few persons to know about the client's sexuality.

Empathy of therapists as perceived by lesbian, gay, bisexual clients is examined in this study for several reasons. First, some preliminary research indicates that a lack of perceived therapist empathy is a key variable to understanding perceived heterosexual bias in therapy (Balis, 1984) and second, it has been found to be related to the dissatisfaction of lesbian and gay clients in therapy (Committee on Lesbian and Gay Concerns, 1991). One hypothesis in this study is that the perception of empathy will be negatively associated with a perception of heterosexual bias. This significant association between the perception of empathy and the perception of heterosexual bias would provide initial construct validation for the Heterosexual Bias Instrument (HBI).

The instrument most widely used and validated as a measure of empathy is the Barrett-Lennard Relationship Inventory (1962) which was revised to a shortened form (Strong, Wambach, Lopez, & Cooper, 1979). The inventory measures client perceptions of empathic understanding, level of regard, unconditionality of regard,

congruence and willingness to be known. Only the cluster of items measuring empathy will be utilized in this study.

Client Satisfaction

Client satisfaction with treatment is an important variable to examine in order to fully understand clients' experiences in psychotherapy. Standardized client satisfaction measures of psychotherapy that are valid and reliable have yet to be developed. The use of satisfaction measures as correlates to outcome variables has been virtually absent from the literature. The satisfaction measures that are utilized have been developed for use in evaluating social services more generally, and have generally not addressed psychotherapy and psychotherapists more specifically. Satisfaction with psychotherapy has generally been measured peripherally by examining other more specific variables associated with counselor effectiveness, such as perceived therapist empathy, therapist warmth, and therapist understanding and acceptance. No standardized measures of satisfaction have been developed for use specifically with the lesbian, gay, bisexual client population. Studies that have examined the satisfaction of lesbian and gay clients have generally used measures with only a few items.

Client satisfaction is included in this current study for several reasons. First, it has been suggested in the literature that lesbians', gay mens', and bisexuals' dissatisfaction with therapy is associated with the perception of heterosexual bias (Gambrill et al., 1984). This finding would suggest that perceived heterosexual bias has serious implications related to clients dissatisfaction with therapy. Second,

the variable of client satisfaction is used in this study to provide further construct validation of the Heterosexual Bias Inventory. Finally, measures of satisfaction have generally not been correlated with other measures in order to provide validity information of a satisfaction measure. In this study, a satisfaction measure is developed, using four items of an already established and validated measure, and including three new items developed by the researcher. This satisfaction measure was expanded to include seven items in order to develop a more valid and informative measure of client satisfaction that addresses client satisfaction with the therapist, with the therapy experience and the degree to which the client experienced symptom relief and change.

Hypotheses

The following hypotheses have been generated based on the review of the literature. The first three are hypotheses related to the development of construct validity of the Heterosexual Bias Inventory. The subsequent four hypotheses are related to research questions raised in the literature.

1. Greater heterosexual bias as perceived by lesbian, gay, and bisexual clients in psychotherapy will be significantly associated with less perceived therapist empathy.

This hypothesis builds on clinical writing and empirical research that indicates that greater perceived heterosexual bias in psychotherapy is associated with less therapist empathy (Balis, 1984; Saghir & Robins, 1973). Perceived therapist empathy is particularly significant to gay, lesbian, and bisexual clients who may be more likely to experience an absence of empathy from society and significant others. Balis (1984)

found in her qualitative dissertation study of the psychotherapy experiences of lesbians that a basic element of heterosexual bias in psychotherapy as reported by lesbians themselves was the absence of perceived therapist empathy. Gay, lesbian, and bisexual clients' dissatisfaction with their psychotherapy has often been linked with their perception that their therapist lacked understanding or was not empathic (Saghir & Robins, 1973). Therefore, it is hypothesized in this study that greater perceived heterosexual bias will be significantly associated with less perceived therapist empathy.

2. Greater heterosexual bias as perceived by lesbians, gays, and bisexuals in psychotherapy will be significantly associated with less satisfaction with treatment.

The literature suggests that gay, lesbian, and bisexual clients may be dissatisfied with their psychotherapy experiences when they perceive their therapists as biased in their attitudes, interventions, or knowledge (Jay & Young, 1977; Saghir & Robins, 1973). Satisfaction with the therapy experience is explored as it is associated with the perception of heterosexual bias in order to provide construct validity for the Heterosexual Bias Inventory as well as construct validation for the satisfaction measure.

3. Greater heterosexual bias as perceived by lesbians, gays, and bisexuals in psychotherapy will be significantly associated with less perceived therapist knowledge about lesbian, gay, bisexual issues.

The literature suggests that a major problem in the counseling of gays and lesbians is therapists' lack of knowledge (DeCrescenzo, 1984; Gambrill et al., 1984;

Graham et al., 1984; Thompson & Fishburn, 1977). Lack of therapist knowledge about lesbian, gay, and bisexual issues has been considered a form of treatment bias. It has been suggested that lesbians and gay men spend too much time educating their therapists (Riddle & Sang, 1978; Rochlin, 1982). Many writers suggest that therapists need to be knowledgeable and have direct experience with gay and bisexual lifestyles in order to be effective in work with lesbian and gay clients (Woodman & Lenna, 1980). This hypothesis explores the relationship between the perception of lack of therapist knowledge and the perception of heterosexual bias in therapy.

4. Therapists known by the respondent to be gay, lesbian, or bisexual will be perceived as less biased than either those who are known to be heterosexual or those whose sexual orientation is not known.

Many writers have suggested that there are distinct advantages for gay and lesbian clients in seeing openly gay and lesbian therapists (Gartrell, 1981; Malyon, 1982; Riddle & Sang, 1978; Rochlin, 1982; Woodman & Lenna, 1980). These authors have suggested that lesbians and gay men may feel more accepted, more understood, and perceive their therapists as being more attuned to their needs, when the therapist is openly gay or lesbian. Riddle and Sang (1978) have stated that

> the discretionary use of self-disclosure can have profound healing effects since the sharing of the therapist's experiences validates the client's struggles...Not having to explain the nuances and stresses of one's life can be enormously helpful in accelerating the therapeutic process. (p. 97)

Malyon (1982) has suggested that knowing the gay sexual orientation of the therapist helps the gay male client to develop a positive gay identity.

Research studies have further suggested that lesbian and gay clients generally

pre

wh

19

see

be

5.

hete

and

bise

lesb

bise

hete

to sp

heig

whic

our t

infor

bisex

comp

6. N

report

prefer to see lesbian and gay therapists, and are more satisfied with their treatment when their therapists are openly gay or lesbian (Gambrill et al., 1984; Jay & Young, 1977; McDermott et al., 1989). In these studies, gay and lesbian clients preferred to see gay and lesbian therapists because they believed that heterosexual therapists would be less empathic, less knowledgeable, and/or less accepting.

5. Bisexuals will differ significantly from lesbians and gay men in their perception of heterosexual bias in psychotherapy.

Previous research has not examined differences between bisexuals', gay mens', and lesbians' perceptions of their psychotherapy experiences. The literature on bisexuality, however, suggests that bisexuals may be significantly different from lesbians and gay men in important ways. This may be due to the unique stressors that bisexuals face due to the lack of recognition of bisexuality from both homosexuals and heterosexuals. Paul (1985) has suggested that the marginality of bisexuality may lead to special problems and concerns of bisexuals. As a result, bisexuals may experience heightened isolation, increased identity confusion, and the lack of a subculture with which to identify (Wayson, 1988). The marginality of bisexuality and the conflicts in our theoretical understanding of bisexuality may lead to less sensitive and less informed treatment of bisexual clients in psychotherapy. This may subsequently lead bisexual clients to perceive more heterosexual bias in their therapy experiences, as compared to homosexual clients.

6. No differences will be found between the perception of heterosexual bias as reported by lesbians and gay men.

Few studies have examined differences between the perceptions of lesbians and gay men regarding their psychotherapy experiences (Bell & Weinberg, 1978; Gambrill et al., 1984). No significant differences have been found between lesbians and gay men in their perceptions of psychotherapy experiences.

7. Characteristics of respondents (clients), therapists, and the therapy experience will each be significantly associated with perceived heterosexual bias, and each will uniquely predict perceived heterosexual bias.

This study expands the scope of previous research in its examination of client variables, therapist variables, and treatment variables that inform an understanding of heterosexual bias in psychotherapy. By examining client, therapist, and treatment variables separately and in combination, it can be determined to what extent each predict unique variance of perceived heterosexual bias. Utilizing hierarchical regression analysis, both subjective variables as well as more objective variables of the client/therapist dyad and the treatment will be examined, leading to a fuller examination of perceived heterosexual bias in psychotherapy.

Conclusion

A review of the clinical and empirical literature indicates that heterosexual bias is apparent in the attitudes and knowledge of therapists, as well as in the treatment strategies they employ. Most of the studies utilized self-reports of therapists which do not allow for the possibility of unconscious biases and defensiveness about admitting socially undesirable attitudes and behavior.

The results of survey studies and anecdotal reports of lesbian and gay individuals

suggest that there is dissatisfaction with therapy in general, particularly with heterosexual therapists. Gay men and lesbians report greater satisfaction with gay or lesbian therapists as compared with heterosexual therapists (Gambrill et al., 1984; Jay & Young, 1977). Similarly, gay men and lesbians generally prefer to see gay and lesbian therapists (Gambrill et al., 1984; McDermott & Lichtenberg, 1989). There is some evidence that, for gay and lesbian clients, knowing the sexual orientation of the therapist is associated with greater satisfaction with treatment. Few details are known about the reasons for gay and lesbian clients' dissatisfaction with treatment, but both research and clinical literature suggest that it may be partially the result of heterosexual biases in treatment (Adair & Adair, 1978; Bell & Weinberg, 1978; Rudolph, 1988; Saghir & Robbins, 1973; Woodman & Lenna, 1988).

In this study, therapist and client characteristics, as well as treatment variables (objective and subjective) as reported by lesbians, gays, and bisexuals, will be examined to further understand the nature of heterosexual bias in specific psychotherapy experiences. This study addresses the need for further documentation of and elaboration on heterosexual bias as perceived by lesbian, gay, and bisexual clients. The following chapter addresses the methodology of this study.

CHAPTER THREE

METHODOLOGY

This study explored the perception of heterosexual bias in psychotherapy as reported by lesbians, gay men, and bisexuals who are or who have been in individual psychotherapy within the past ten years. A measure (the Heterosexual Bias Inventory) was developed to tap the perception of heterosexual bias in the psychotherapy experiences of lesbian, gay, and bisexual clients. Client variables, therapist variables, and treatment variables were explored as they were correlated with and predictive of perceived heterosexual bias.

Past research exploring the psychotherapy experiences of lesbians, gay men, and bisexuals has focused primarily on the self-reports of therapists. The results of this study offer an additional perspective in its direct exploration of the perceptions of lesbian, gay, and bisexual clients. The research design builds on what is known about the experiences of lesbians, gay men, and bisexuals in psychotherapy. Past research has consisted of anecdotal reports of lesbians and gay men (Abbott & Love, 1972; Adair & Adair, 1978; Committee on Lesbian and Gay Concerns, 1991; Duberman, 1991); interviews with gay and lesbian clients (Balis, 1984; Bell & Weinberg, 1978; Saghir & Robins, 1973); survey studies of gay men and lesbians in which there were one or two items inquiring about perceptions of therapy experiences (Gambrill et al., 1984; Jay & Young, 1977; May, 1974; McDermott et al., 1989; Nuehring et al., 1974); a survey study of bisexuals (Klein, 1978); and therapist self-reports (Committee on Lesbian and Gay Concerns, 1991; Graham et al., 1984). The

methodology in this study expands existing knowledge by measuring lesbian, gay, and bisexual client perceptions in a quantitative way. A fuller understanding of the nature of heterosexual bias is explored through the development of an instrument designed specifically to examine the perception of heterosexual bias as reported by lesbian, gay, and bisexual clients.

The purpose of this chapter is to present the methodology used in the study. In this chapter, a description of the sample recruitment, sample characteristics, procedures, measures, hypotheses, and analyses are presented.

Sample Recruitment

The sample was comprised of volunteer respondents who are currently gay, lesbian, or bisexual, over 18 years of age, and who have seen a therapist for one or more sessions within the past 10 years. The ten year time-span was set to gather information on the recent experiences and perceptions of lesbians, gay men, and bisexuals.

The sample of 213 respondents was recruited using several methods. One hundred diverse gay, lesbian, and bisexual organizations were contacted from all geographical regions of the United States (Appendix E). Each organization was informed of the purpose of the study and the criteria for participation (Appendix D), and were sent flyers (Appendix C) to post or duplicate. Gay pride marches were attended in Washington D.C., Boston, New York City, Philadelphia, and Northampton, Massachusetts. In order to facilitate the recruitment of subjects, placards were carried during the marches publicizing the study. Flyers were posted at

gay, lesbian, and bisexual bookstores, businesses, and organizations. Gay, lesbian, and bisexual committees of professional organizations were contacted for assistance in recruiting subjects (New England Association of Lesbian, Gay, Bisexual Psychologists; Committee on Lesbian and Gay Concerns, American Psychological Association; National Association of Social Workers, Lesbian, Gay, and Bisexual Committee). In addition, lesbian, gay, and bisexual conferences and events were attended. Finally, a network of friends and acquaintances was used, utilizing a snowball technique that encouraged respondents to refer others to the study.

Over a quarter (28.1%) of the respondents were recruited to the study through a gay pride march and over a tenth (12.2%) through a gay, lesbian or bisexual organization. The remaining 59.7% were recruited through other sources; friends (29.1%), flyers (15.5%), therapists (4.7%), a mental health or counseling service (1.9%), or other specified sources (6.6%).

Characteristics of Sample

Recruitment from a wide variety of sources was intended to reduce the possibility of a highly nonrepresentative sample. However, because this is a non-random sample, generalizations cannot be made beyond the sample surveyed. Due to the invisibility of gay, lesbian, and bisexual individuals and the stigma in identifying as lesbian, gay, and bisexual, a representative sample may not be possible (Bell & Weinberg, 1978).

Background Characteristics of the Respondents

Of the 213 respondents in the study, 65% were female and 35% were male. Most of the respondents were Caucasian (91.1%), while 3.8% were African-American, 1.4% were Latino and 3.8% of another racial identity. The mean age of respondents was 36.1 years of age, with a standard deviation of 7.9 years. Respondents' age ranged from 20 to 58 years.

About half of the respondents (49.7%) described themselves as Christian. The largest group of Christians were Protestant (27.7%), followed by Catholics (16.4%). Six percent were affiliated with another Christian religion, which included Unitarians, Universalists, Quakers, or other Christians. Fifteen percent of the respondents were Jewish, and 12% were affiliated with another non-Christian religion (Pagan, Buddhist, Humanist, New Age, Discordian, Yoruba). A large group of respondents (15.5%) reported that they had no religion, describing themselves as non-denominational, atheist, agnostic, or not affiliated.

Table 3-1

Religion of Respondents

Christian	Percentage
Protestant	27.8%
Catholic	16.4%
Ex-Catholic	1.4%
Other Christian	5.6%

Total 51.2%

Non Christian	Percentage
Jewish	15.0%
Other Non-Christian	12.2%
No religion	15.5%
Other	3.8%
No Answer	2.3%

Total 48.8%

Almost half of the respondents reported that religion or spirituality was very important in their lives (45.5%). Over a third (37.6%) reported that religion or spirituality was somewhat important. Only one in six (16.9%) believed that religion was not important. Over a third of the sample (39%) attended religious services regularly, at least 6-10 times a year (8% attended one or more times a week, 14% attended one to three times a month, and 17% attended 6-10 times a year). About one fifth of the sample (19%) attended religious services about once a year, 15%

attended less than once a year, and 27% never attended religious services.

The sample represents responses from 25 states and the District of Columbia. Over a third (36%) of the sample came from New England states, including Massachusetts (n=60), Connecticut (n=13), New Hampshire (n=3), Maine (n=1). A third (34%) of the sample came from Mid-Atlantic states, including (New York (n=27), Pennsylvania (n=14), New Jersey (n=11), Maryland (n=11), Washington D.C. (n=9), and Delaware (n=1). About a sixth (17%) of the sample came from Mid-Western states (Michigan (n=12), Wisconsin (n=9), Minnesota (n=7), Illinois (n=4), Ohio (n=3), and Iowa (n=2). Six percent of the sample (n=13) came from Western states (California (n=10), Arizona (n=1), Colorado (n=1), and Montana (n=1). The remaining 7% of the sample included respondents from Kansas (n=4), Oklahoma (n=2), Hawaii (n=1), Georgia (n=1), Florida (n=1), and North Carolina (n=1).

In terms of relationship status, 64% percent indicated that they were currently in a relationship. The sample was highly educated as a group. Almost two thirds of the sample (65%) had completed either some graduate school or a graduate degree. Another third (32%) had completed either some college or a college degree. For 1.4% of the sample the completion of high school was the highest educational attainment. Thirty six percent of the respondents reported that they were trained as a psychotherapist or counselor. A total of 24% of the respondents were trained at the Master's level, 6% at the doctoral level, and 6% at the Bachelor's level.

Participants' income was widely spread. About one fifth (21%) of the sample

reported their household income to be less than $20,000 a year, 37% reported income of $20,000-$39,999 a year, and 28% reported income of $40,000-$70,000. Only 14.6% reported a household income over $70,000. The vast majority of the sample (91%) indicated that only one or two people were supported by the reported household income.

Current Sexual Orientation of Respondents

Several measures of current sexual orientation were used. First, respondents were asked, "How do you currently identify yourself?" (question 11, section A of the questionnaire). Results of this question are reported in Table 3-2.

Table 3-2

Current Sexual Orientation of Respondents

	N	%
Lesbian	112	52.6
Gay	73	34.3
Bisexual	28	13.1
Total	213	100%

Second, using a modified Kinsey scale to measure sexual orientation (questions 12, 13, 14, section A of the questionnaire), respondents rated their current sexual behavior, current sexual feelings/fantasies, and their current self identification. Responses ranged on a scale from 0 to 6, where 0 equals exclusively heterosexual and 6 equals exclusively homosexual.

Table 3-3

Modified Kinsey Scale Ratings of Respondents' Sexual Orientation

	EXCLUSIVELY HETEROSEXUAL					EXCLUSIVELY HOMOSEXUAL		
	0	1	2	3	4	5	6	MS*
SEXUAL BEHAVIOR	.9%	2.3%	1.9%	.9%	2.8%	7.0%	82.2%	1.9
SEXUAL FEELINGS/ FANTASIES	.5%	3.3%	10.8%	20.2%	28.2%	36.6%	.5%	
SELF-IDENTIFI-CATION	.5%	-	8.5%	6.1%	16.0%	68.1%	.9%	

*MS = missing values

Sexual Behavior	Mean 5.58, S.D. 1.16
Sexual Feelings/Fantasies	Mean 4.83, S.D. 1.16
Self-Identification	Mean 5.43, S.D. .99

A majority of the respondents considered themselves to be predominantly homosexual based on their sexual behavior, sexual feelings, and self-identification. However, a much greater percentage of respondents considered themselves to be exclusively homosexual regarding sexual behavior (82.2%), as compared with exclusively homosexual in terms of sexual feelings/fantasies (36.6%) and in terms of their self-identification (68.1%).

Another measure of current sexual orientation inquired about how "out" respondents are to others regarding their sexual orientation. Respondents were asked

to respond to a measure of how "out" they were currently (questions 15, 16, 17, section A). Three-quarters of the sample (75%) reported that they were "out" to most or all of their close family, 90% were "out" to most or all of their friends, and 60% were out to most or all of their co-workers.

Table 3-4

Percentages of Respondents Who Are Currently "Out"

	NONE	SOME	MOST	ALL	MISSING
CLOSE FAMILY	8.5%	16.0%	16.4%	58.7%	.5%
FRIENDS	.5%	8.9%	23.9%	66.2%	.5%
CO-WORKERS	10.3%	28.2%	25.8%	34.3%	1.4%

A final item explored respondents' comfort with their current sexual orientation (question 18, section A). Most all respondents reported that they were very (79%) or somewhat (16%) comfortable with their current sexual orientation. Only 5% indicated that they were somewhat (3.8%) or very (1.4%) conflicted about their current sexual orientation.

Mental Health/Psychiatric History of Respondents

Past Therapy Experience

Over the last ten years, 27% of the respondents had seen one therapist or counselor, 29% had seen two, 36% had seen three to five, and 7% had seen more

than five therapists. Fifty eight percent of the respondents were currently seeing a therapist (not necessarily the therapist they reported on for the primary data in this study).

Psychiatric History

Over half of the respondents (58%) were aware of having been given a psychiatric diagnosis. For the sample as a whole the diagnoses most frequently reported were major depression (15%), anxiety disorder (15%), adjustment disorder (16%), and substance use disorder (6%). Other less frequently reported diagnoses included bipolar disorder (2.8%), eating disorder (3.3%), and identity disorder (.5%). No respondents reported that they had been diagnosed with schizophrenia or a psychotic disorder. A small percentage of the respondents (15.5%) reported more than one diagnosis. Sixteen percent of the respondents reported current use of medication for a psychiatric condition. Thirteen percent reported that they had been hospitalized for psychiatric reasons. Twenty percent reported that they had tried to commit suicide.

Characteristics of Therapist

Respondents were asked to choose the therapy experience within the past ten years in which they felt treated least sensitively or least appropriately as a lesbian, gay, or bisexual person. Respondents were then asked to describe in detail this particular therapist and this therapy experience, providing the bulk of the data of this study.

About two thirds (66.2%) of the therapists described were female and a third

(3

rer

rac

age

we

sex

Ta

Sex

—

G
L
H
B
D
T

Abo

(21

lest

sect

that

(33.8%) were male. Most of the therapists were Caucasian (94%), with the remaining therapists identified as African-American (1%), Latino (1%) and of another racial identity (4%). Over three-quarters of the therapists (80%) were between the ages of 30 and 49 years of age. Sixteen percent were 50 years or older, and 4% were younger than 30 years of age.

Over three quarters of the respondents reported that they were aware of the sexual orientation of their therapist (78.4%).

Table 3-5

Sexual Orientation of the Therapists

	N	%
Gay	15	7.0
Lesbian	27	12.7
Heterosexual	118	55.4
Bisexual	7	3.3
Don't Know	46	21.6
Total	213	100%

Over half of the respondents reported their therapist to be heterosexual (55.4%). About a fifth of the respondents did not know the sexual orientation of their therapist (21.6%). Twenty three percent of the respondents reported their therapist to be gay, lesbian, or bisexual.

Respondents were asked how they came to know this information (question 5, section B). Fifty one percent reported that their therapist told them directly, 9% said that someone else told them, and 18% reported that they made an assumption about

the sexual orientation of their therapist. This question did not apply to the 21.6% of the respondents who did not know the sexual orientation of their therapist.

Therapists represented several disciplines, with social workers and psychologists most prevalent.

Table 3-6

Disciplines of the Therapists

	N	%
Social Worker	74	34.7
Psychologist	66	31.0
Psychiatrist	24	11.3
Counselor	26	12.2
Religious/pastoral counselor	7	3.3
Other	8	3.8
Don't Know	7	3.3
Missing	1	.5
Total	213	100%

Respondents were asked about their perception of the experience level of their therapists, both generally and specifically with lesbian, gay, and bisexual clients. In response to the question, "Generally, what impression do (did) you have of the level of experience of your therapist?" (question 7, section B), 54% reported that their therapist was very experienced and 38% reported that their therapist was moderately experienced, while 8% reported that their therapist had little experience. When the

respondents were asked, "What impression do (did) you have of the level of experience of your therapist specifically working with lesbian, gay, bisexual clients?" (question 8, section B), 27% reported that their therapist was very experienced, 37% reported their therapist was moderately experienced, and 36% reported their therapist to have little experience. Clearly a greater percentage of therapists were perceived to have little experience working specifically with lesbian, gay, and bisexual clients, as compared to general experience as psychotherapists.

Characteristics of the Therapy Experience

Almost three quarters (73%) of the respondents saw their therapist in a private practice. About one in ten (11%) saw their therapist through a mental health service, 5% through a gay/lesbian mental health or health service, 3% through a college or university counseling service, 1% through a hospital in-patient setting, and 6% in another setting.

The vast majority (94%) of the sample saw their therapist for six or more sessions. One third of the respondents (33%, N=71) saw their therapist for more than 100 sessions.

Table 3-7

Number of Sessions Respondent Saw Therapist in Treatment

# of sessions	N	%
1	2	.9
2-5	11	5.2
6-12	25	11.7
13-26	37	17.4
27-52	27	12.7
53-100	38	17.8
>100	71	33.3
Missing	2	.9
Total	213	100%

The age at which respondents first saw their therapists ranged from age 10-51. The average age was 30.7 years, with a standard deviation of 7.9 years. Almost a third of the respondents (30%) were currently seeing their therapists. For those respondents who were not currently seeing their therapists, the average amount of time since last seeing their therapist was 3 years (35.2 months) with a standard deviation of 31 months.

The most commonly cited problems that led respondents to seek therapy were relationship difficulties (49%), depression (42%), anxiety (33%), family problems (30%) and career/work issues (26%). Less frequently mentioned presenting problems were concern about sexual orientation (15%), problems with "coming out" (14%),

sexual difficulties (9%), drug or alcohol problems (9%), concern about HIV/AIDS (5%), eating problems (5%), major mental illness (1%), and/or other problem (24%). Note that respondents may have indicated more than one main problem area, so that the total exceeds 100%.

At the time that the respondents first saw their therapist, 30% identified as a gay man, 41% as lesbian, 10% as bisexual, 8% as heterosexual, and 12% did not identify themselves.

Table 3-8

Respondents' Sexual Orientation at Time They Saw Therapist

	N	%
Gay	63	29.6
Lesbian	88	41.3
Bisexual	21	9.9
Heterosexual	16	7.5
Did Not identify	25	11.7
Total	213	100%

The approximated length of time that respondents had identified as such was an average of 10 years, with a standard deviation of 8 years. There were significant changes in the reported sexual orientation of respondents between when respondents first saw their therapist and when they completed the survey. Of the 73 currently identified gay men, 62 were gay at the time they saw their therapist, 5 were bisexual,

1 was heterosexual, and 4 did not identify. Of the 112 currently identified lesbians, 87 were lesbian at the time they saw their therapist, 3 were bisexual, 10 were heterosexual and 12 did not identify. Of the 28 currently identified bisexuals, 1 was lesbian at the time she saw his or her therapist, 13 were bisexual, 5 were heterosexual, and 9 did not identify.

The sex match of respondents and therapists was as follows: fifteen percent of the respondents who saw women therapists were male, twenty five percent of the respondents who saw male therapists were women, seventy two percent of the men saw male therapists, and eighty seven percent of the women saw female therapists.

Table 3-9

Sex Match Between Respondent and Their Therapist

Respondent	Therapist	Frequency	Percent
F	F	120	56.3
M	F	21	9.9
F	M	18	8.5
M	M	54	25.3
Total		213	100%

Thirteen percent of the respondents saw lesbian therapists, seven percent saw gay therapists, and three percent saw bisexual therapists. Of the 63 respondents who were gay at the time they saw they saw their therapist, 19% saw gay therapists, 4% saw lesbian therapists, 3% saw bisexual therapists, 41% saw heterosexual therapists, and

26% did not know the sexual orientation of their therapist. Of the 88 respondents who were lesbian at the time they saw their therapist, 22% saw lesbian therapists, 3% saw gay therapists, 3% saw bisexual therapists, 59% saw heterosexual therapists, and 13% did not know the sexual orientation of their therapist. None of the 21 respondents who were bisexual at the time they saw their therapist reported that they saw bisexual or gay therapists, while 9% saw lesbian therapists, 57% saw heterosexual therapists, and 33% did not know the sexual orientation of their therapist.

Respondents were asked how "out" they were at the time that they first saw their therapist. Half (50%) of the respondents were out to most (16%) or all (34%) of their close family, and about two thirds (65%) were out to most (21%) or all (40.4%) of their friends. Respondents were less "out" at the time that they saw their therapist as compared to the present time when they completed the survey.

Table 3-10

How "Out" Respondent Was When First Saw Therapist

"When you first saw your therapist, who had you told about your sexual orientation? (Question 15, 16, 17, Section B)

	NONE	SOME	MOST	ALL	MS*
MY CLOSE FAMILY	26.8%	19.2%	16.4%	34.3%	3.3%
MY FRIENDS	12.7%	23.9%	21.1%	40.4%	1.9%
MY CO-WORKERS	32.9%	26.8%	14.1%	23.0%	3.3%

*MS = missing values N=213

In response to the question (question 18, section B), "How comfortable were you with your sexual orientation when you first saw your therapist?", 45% felt very comfortable with their sexual orientation, 23% felt somewhat comfortable, 20% felt somewhat conflicted and 12% felt very conflicted.

Respondents were asked a series of questions that inquired about the extent to which issues related to their sexual orientation were a focus of the treatment. Almost a third (32%) of the respondents discussed issues related to their sexual orientation with their therapist a great deal, over a third (38%) discussed these issues somewhat, 23% very little, and 7% not at all.

Specifically, respondents were asked to describe the extent to which they focused on each of five issues central to their sexual orientation with their therapist. Fifty

percent of the respondents reported that they discussed "their family and their sexual orientation" very much (18%) or somewhat (32%). Societal discrimination as a gay, lesbian, or bisexual person was the next most frequently discussed issue, with 44% reporting that they discussed it very much (9%) or somewhat (35%). "Coming out" to others followed, with 36% reporting that they discussed it very much (12%) or somewhat (24%).

Table 3-11

How Much Respondents' Therapy Experience Focused on Sexual Orientation Issues

"How much did you focus on the following issues with your therapist?"
(Questions 20-24, Section B)

	very much	some-what	very little	not at all	MS*
"coming out" to myself	11.3	19.7	28.2	39.4	1.4
"coming out" to others	12.2	23.5	29.1	34.7	.5
my family (i.e.) parents and my sexual orientation	18.3	31.9	23.5	25.8	.5
my conflicts or fears about being lesbian, gay, or bisexual	10.8	23.0	30.5	34.7	.9
societal discrimination as a gay, lesbian, bisexual person	8.5	35.2	32.9	23.0	.5

MS* = missing values

Three-quarters of the respondents told their therapist about their sexual orientation (or same sex attractions, feelings, or behavior) during their first or second

session. Twenty percent told their therapist after this point (6% between sessions 3-10, and 13% after session 10). For only 5% of the respondents was the therapist never aware of their sexual orientation or same-sex feelings.

Twenty seven percent strongly (11%) or somewhat agreed (16%) with the statement, "I ended therapy because I felt my therapist was not sensitive to my needs as a lesbian, gay, or bisexual person". Forty three percent strongly (35%) or somewhat (8%) disagreed with this statement. Forty four percent of the respondents had seen other therapists since they ended with their therapist, and twenty five percent had not. Over a third (36%) of the respondents had seen 1 or 2 other therapists, 3.8% had seen 3 other therapists, 1.9% had seen 4 therapists, and 2.3% had seen between 5-7 other therapists. For 30% of the respondents these questions did not apply because they were currently seeing their therapist.

Procedures

Potential respondents were informed that the researcher was investigating the perceptions of lesbians, gay men, and bisexuals regarding their psychotherapy experiences. They were informed that their responses would be anonymous and kept strictly confidential, and that their participation was voluntary. Subjects who agreed to participate were given a self-administered questionnaire packet consisting of:

I. Face sheet to determine whether or not each participant met the criteria for eligibility. The eligibility criteria were:

a) gay, lesbian, or bisexual;

b) experience(s) in psychotherapy within past 10 years;

c) 18 years of age or over

II. Consent form. The cover page informed respondents of the voluntary nature of their participation and the anonymity and confidentiality of their responses.

III. Self-Administered Questionnaire which included:

Section A). Demographic items. These items included questions about age, race, religion, current sexual orientation, current relationship status, socio-economic level, city of current residence, psychiatric history, and general information about current and past psychotherapy experience.

Section B). Description of one psychotherapy or counseling experience in which the respondent felt treated least sensitively or least appropriately as a lesbian, gay, or bisexual person. The respondent was asked to describe the therapist characteristics, when and where the respondent saw the therapist, the focus and duration of the treatment, and the nature of the sexual orientation of the respondent and therapist.

Section C). Primary data for the study included a set of 43 items using a Likert response format inquiring about the respondent's perception of heterosexual bias in their selected therapy experience (or in their only therapy experience).

Section D). Knowledge Measure - a 13-item scale designed to measure the perception of therapist knowledgeability about issues related to lesbian, gays, and bisexuals.

Section E). Measure of Client Satisfaction - a 7-item measure of client satisfaction that included 4 items from a Client Change subscale as developed by

Strupp et al., (1969), and three items developed for this study.

Section F). Measure of Therapist Empathy - an 8-item measure of perceived therapist empathy (Revised Barrett-Lennard Empathy Subscale, Strong et al., 1979).

Section G). Two open-ended qualitative items, similar to those in the American Psychological Association Task Force study (Committee on Lesbian and Gay Concerns, 1991). Open-ended items inquired about respondents' experiences in which a therapist was insensitive, lacked understanding, and/or was not helpful, and those experiences in which a therapist was particularly sensitive, understanding, and/or helpful to the respondent as a gay, lesbian, or bisexual client.

IV). Included with each packet of materials was a return stamped envelope (addressed to the author's post office box). In addition, a self-addressed postcard was included to be completed and mailed separately if the respondent was willing to complete a section of the questionnaire again.

Measures

Satisfaction with Psychotherapy

The measure of client satisfaction in this study was comprised of 7 items. Four of the items were drawn from a subscale of Strupp et al. (1969) that was developed to measure the amount of change experienced by the patient, as well as patient satisfaction. The subscale included the following items:

1). How much have you benefitted from this therapy experience?

2). Everything considered, how satisfied are you with the results of this therapy experience?

3). How much do you feel you have changed as a result of this therapy experience? 4). To what extent have your complaints or symptoms that brought you to therapy changed as a result of the therapy experience.

Three additional items were developed by the author to reflect client satisfaction with the therapist as a helping person, as differentiated from satisfaction with the overall therapy experience. The subscale of client satisfaction and client change (Strupp et al., 1969) was developed through its initial use in two studies. Strupp et al. (1969) utilized a cluster analysis in analyzing the data from the two studies. Item clusters were constructed through examining intercorrelations of items. Clusters were formed partially on an empirical basis and partially on a rational basis. The goal was to develop clusters that were internally consistent as well as highly differentiated from one another. Item pairs (with correlations of .70 to .80) were found and new items that correlated highly with these pairs were added. Correlation coefficients of less than .50 were not included in clusters. The cluster designed to measure client satisfaction and amount of change (Cluster 2, Strupp et al., 1969) was used in this study. Strupp et al. (1969) has described this cluster, stating that it

> represents a global estimate of the degree of benefit the patient felt he derived from therapy, the extent to which he experienced change, and the degree of symptomatic improvement, as well as his over-all satisfaction with the experience. Scores based on this cluster represent the key measure of therapeutic success as experienced by the patient (p. 193).

Some of the seven items were reflected so that a high score equaled more satisfaction. Each item was also z scored to allow for subsequent summing of the 7 item scores to obtain the Satisfaction Scale. (See Appendix K for actual distribution of

responses) Reliability of this measure was determined through repeat and alpha reliability. Correlations between item scores for the 43 persons who completed the scale twice ranged from .78 to .92, $p<.0001$. The repeated r Time1 x Time2 for the 41 respondents $r = .949$, $p<.0001$. (See Appendix P) The alpha reliability for the satisfaction scale was .9601.

Measure of Perceived Empathy

The Revised G. T. Barrett-Lennard empathy subscale (Strong et al., 1979) was utilized in this study. The subscale was comprised of 8-items designed to measure empathic understanding. The original Barrett-Lennard Relationship Inventory has been used with many different populations, and has been demonstrated to be a valid and reliable measure (Barrett-Lennard, 1962).

The Barrett-Lennard Relationship Inventory was initially developed to measure the variables of empathic understanding, level of regard, unconditionality of regard, willingness to be known, and congruence as reported by both client and therapist (Barrett-Lennard, 1962). The variables of empathic understanding and congruence of therapist were based on the writing of Rogers (1957). Items were operationalized drawing on Roger's ideas regarding the necessary conditions for therapy (Rogers, 1957) and Brown's Relationship Sort (Brown, 1954). No initial item-analysis data were reported, but one of the original scales was eliminated (willingness to be known) and the original 74 items were reduced to 64 items. Item development involved theoretical analysis of concepts and revision utilizing feedback from other professionals.

Content validity of the Barrett-Lennard Inventory was supported using the input of five judges who were client-centered counselors. They classified each item as either positive, negative, or neutral regarding the variable it was designed to measure. Judges also rated the positive items on a scale of +1 to +5 and the negative items on a scale from -1 to -5 in terms of each item's strength in indicating the variable. Items for which there was not perfect agreement were eliminated. Construct validity of this empathy measure has been demonstrated through its wide use in research, including its use in treatment outcome studies. The Barrett-Lennard Inventory has been found to be a highly reliable measure. The test-retest reliability coefficient reported for the original Empathic Understanding scale of 15 items was .89.

The revised Barrett-Lennard Inventory (Strong et al., 1979) reduced the length of the inventory from 64 items to 36 items. Each subscale was reduced to 8 items. The revised subscale of Empathic Understanding (8 items) was found to be internally consistent, with a Cronbach alpha reliability of .61 (Strong et al., 1979).

Response categories range on a Likert scale from mostly agree (1) to mostly disagree (7). In this study the empathy scale score was calculated to be the sum of scores of the 8 items, with a theoretical and actual range of 8-56. (See Appendix L for actual distribution of responses). Two items were reflected (item 4 and item 7) so that higher scores consistently indicated more empathy. The empathy subscale was found to be internally consistent with an Cronbach alpha reliability of .90.

The measure was administered twice to 41 respondents. The correlations between the time one (T1) and time two (T2) scores on the overall empathy scale

equaled $r = .92$, $p < .0001$. Correlations between item scores for the 43 persons who completed the scale twice ranged from Pearson r correlation coefficients of .66 - .88, $p < .0001$. (See Appendix O)

Perceived Knowledge Measure

The perceived knowledge measure is a 13 item measure developed for this study in order to examine clients perceptions of therapist knowledge. The measure was formed by reviewing literature addressing areas of therapist knowledge that are of special import to lesbians, gay men, and bisexuals in therapy. The literature suggests that a wide spectrum of issues are likely to bring a gay, lesbian, or bisexual individual to therapy, and therapists therefore need to be knowledgeable about each of these issues. In this study, thirteen areas of knowledge were determined to be most salient for therapists of gay, lesbian, and bisexual clients. Respondents were asked to rate their therapist's knowledge about each issue as it related to lesbian, gay, and bisexual clients. Respondents were asked, "How knowledgeable do you think your therapist" is (was) about the following issues as they relate to lesbians, gays, and bisexuals?". The response categories included, (1) very knowledgeable, (2) somewhat knowledgeable, (3) not knowledgeable, and (4) "don't know." The measure was found to be reliable, with repeat reliability (N=41) Pearson r Correlations for each item ranging from $r = .71$ to .94, $p < .0001$.

Using the perceived knowledge measure, two distinct indices of therapist knowledge were developed to determine if it is the perception of lack of knowledge or the perception of more knowledge that is correlated with and predictive of the

perception of heterosexual bias.

Knowledge Index

The knowledge index was developed by the researcher to measure respondents' perceptions of how knowledgeable their therapists were. The scores of "somewhat" or "very" knowledgeable on each item were summed to create a total score. The knowledge index was computed such that high scores indicated more perceived knowledge. Responses were re-coded so that 0 = not knowledgeable, 1 = somewhat knowledgeable, and 2 = very knowledgeable. The range of responses on the knowledge measure was from 0 to 26. The responses of those who indicated that they "didn't know" how knowledgeable their therapist was about an issue were not counted.

Lack of Knowledge Index

An index was developed to measure the degree to which therapists were perceived as being not knowledgeable about lesbian, gay, and bisexual issues. The index was developed by counting the number of items in which the respondent perceived the therapist to be not knowledgeable about a topic (i.e. response category #3). The range or responses in this index spread from 0 to 13.

Fifty one percent of the respondents never rated their therapists "not knowledgeable" on any topic. Twenty six percent judged their therapist to be "not knowledgeable" on one to five topics. Twenty three percent judged their therapist to be "not knowledgeable" on at least 6 and at most thirteen of the items. Four percent judged their therapist "not knowledgeable" on all items. (See Appendix J for

distribution of responses on knowledge measure)

Composite Measures

Composite measures were developed in order to facilitate further analyses of the results. There were several variables that were measured by a cluster of items that addressed different aspects of the same variable. In each of these cases a summary score was used. The composite measures were then utilized in the correlational and multiple regression analysis. Each composite measure will be listed and described below.

Total focus on sexual orientation issues in the therapy experience (FOCUSTOT) - This summary score reflects the extent to which the respondent focused on five issues related to sexual orientation with their therapist. The issues were: "coming out to myself", "coming out to others", "my family (i.e. parents) and my sexual orientation", "my conflicts or fears about lesbian, gay, or bisexual", and "societal discrimination as a gay, lesbian, bisexual person." The measure was calculated by summing the 4 point Likert scores (from (1) very much to (4) not at all on the five items (question numbers 20-24, section B). The range was 6 to 20, the mean was 14.02, and standard deviation was 3.80. A high score indicates less focus on issues related to sexual orientation.

Current sexual orientation based on revised Kinsey scale (ORTOT)- This composite score measures where the respondent lies between exclusively heterosexual and exclusively homosexual in terms of sexual behavior, sexual feelings/fantasies and self identification. The three items with response categories ranging from 0 (exclusively

heterosexual) to 6 (exclusively homosexual) were summed to create a composite score (questions 12-14, section A). The range was 5-18, the mean was 15.85, and the standard deviation was 2.77. A higher score indicates that the respondent is more exclusively homosexual.

Extent to which respondent is currently "out" to others (TELLTOT)- This composite score measures the degree of how "out" the respondent was to others at the time the questionnaire was completed. It measures the degree to which respondents are out to their family (TELLFAM), to their friends (TELLFRND), and to their co-workers (TELLWORK). Each item is measured on a four point scale from none (1) to all (4), (questions 15-17, section A). The range of the measure is from 3-12, the mean is 9.68, and the standard deviation is 2.14. A high score signifies more "out" to others.

Extent to which respondents were "out" when they saw their therapist YTTELTOT- This composite score parallels the above measure, differing from it only in the respect to which it measures how "out" the person was at the time they saw their therapist. (questions 15, 16, 17, section B). The range was 3-12, the mean was 7.79 and the standard deviation was 3.08.

Total score on the HBI (HBITOT)- This measure is the dependent variable used in each of the hypotheses. It is the sum of the response codes (1-4) to the final 15 items in the Heterosexual Bias Inventory (HBI). The theoretical range and actual range of the measure was 15 to 60.

Dummy Variable Codes

For the multiple regression analysis, dummy variable codes needed to be

developed in order to create variables whose amounts could be measured with interval variables. Through the use of dummy variable codes, non-interval variables were made into dichotomous variables so they could be entered into the regression equation as an interval variable with two values (Lewis-Beck, 1980). The following non-interval variables were made into dichotomous variables.

Race of therapist (YTRACEWH)- As 94% of the therapists described were caucasian, a dichotomous variable was created to compare Caucasian therapists with non-Caucasian therapists. A dummy code was developed in which Caucasian equals 1, all others equal 0.

Race of respondents (RACEWH)- As 91% of the respondents were caucasian, a dichotomous variable was created to compare Caucasian respondents with non-Caucasian respondents. A dummy code was developed in which Caucasian equals 1, and all others equal 0.

Current bisexuals vs current gays and lesbians (BISEXNOW)- This dummy variable was developed to differentiate those respondents who were currently bisexual from currently gay and lesbian respondents. Current bisexuals were coded 1 and all others were coded 0. (Question 11, section A)

Sexual orientation of respondents at the time they saw their therapist (YTRGLBR) This measure was developed to separate those respondents who were gay, lesbian, or bisexual at the time they saw their therapists, from those respondents who were heterosexual or who did not identify. The dummy variable was coded Gay, lesbian, bisexual =1, Else =0. (Question 13, section B)

Perceived therapist knowledge of client's sexual orientation (YTAWARER)- This dummy variable is a dichotomy which distinguishes between those therapists who were aware of the respondents' lesbian, bisexual, or gay identity (or same sex attractions) on the first or second session (Code=1) as compared with those who were aware later or not at all (Code=0). (Question 25, section B)

Professional discipline of therapists (PSYCHIAT)- In this study psychiatrists were found to be significantly more biased than social workers, psychologists and counselors. Therefore, a dummy variable was created to compare psychiatrists and therapists from all other disciplines, Psychiatrists (Code = 1), others (Code= 0). (Question 6, section B)

Therapists' sexual orientation (YTNOTGLB)- This variable was made into a dichotomy that distinguishes between those therapists who were known to be gay, lesbian, or bisexual (23%) and those who were not known to be gay, lesbian, or bisexual (e.g. heterosexual therapists or those with unknown sexual orientations, 77%). A dummy code was developed in which known gay, lesbian, bisexual therapists were Code= 1, and Others=0). (Question 4, section B)

Therapists' sexual orientation known (YTDKGLB)- This is a dichotomy that distinguishes between those respondents who did not know the sexual orientation of their therapist, (Code=1) and those who did know their therapist's sexual orientation, (Code=0). (Question 4, section B)

Hypotheses

Below are the hypotheses for this study, and the measures that are used to test each hypothesis. The instrument that was developed in this study, the Heterosexual Bias Inventory (HBI), was used as the dependent variable of perceived heterosexual bias. The total scale score of the Heterosexual Bias Inventory (HBITOT) was used as the measure of perceived heterosexual bias.

The first three hypotheses are related to the development of construct validity of the Heterosexual Bias Inventory, and the subsequent four hypotheses address research questions.

Hypothesis 1: Greater heterosexual bias as perceived by lesbian, gay, and bisexual clients in psychotherapy will be significantly associated with less perceived therapist empathy.

Measure: The measure of empathy was an 8 item empathy subscale, the Revised Barrett & Lennard Relationship Inventory developed by Strong et al. (1979).

Hypothesis 2: Greater heterosexual bias as perceived by lesbians, gay men, and bisexuals in psychotherapy will be significantly associated with less satisfaction with treatment.

Measure: The measure of satisfaction was a 7 item scale measuring client satisfaction with therapy. Four items were from a subscale developed by Strupp et al. (1969) and three items were developed by the researcher.

Hypothesis 3: Greater heterosexual bias as perceived by lesbians, gays, and bisexuals in psychotherapy will be significantly associated with less perceived therapist

knowledge about lesbian, gay, and bisexual issues.

Measure: The measure of knowledge was a 13 item measure developed by the researcher. Using this measure, a knowledge Index and lack of knowledge index was further delineated by the researcher.

Hypothesis 4: Therapists known by the respondent to be gay, lesbian or bisexual will be perceived as less biased than either those who are known to be heterosexual or whose sexual orientation is not known.

Measure: A dichotomous variable (YTNOTGLB) was used to distinguish between those therapists who were known to be gay, lesbian, or bisexual and those who were not. An additional dichotomous variable (YTDKGLB) was used to distinguish between those respondents who did not know the sexual orientation of their therapist and those who did know.

Hypothesis 5: Bisexuals will differ significantly from lesbians and gay men in their perception of heterosexual bias in psychotherapy.

Measures: A dichotomous variable (BISEXNOW) was used in order to differentiate current bisexual respondents from current gay or lesbian respondents. An additional dichotomous variable (YTRGLBR) was used to distinguish between those who identified as gay, lesbian, or bisexual at the time they first saw their therapist, and those who identified as heterosexual or who did not identify with a sexual orientation label.

Hypothesis 6: No differences will be found between the perception of heterosexual bias as reported by lesbians and gay men.

Measures: Current sexual orientation was measured by question 11, section A, "How do you currently identify yourself?" (gay, lesbian, or bisexual). The sexual orientation of respondent when they first saw their therapist was measured by question 13, section B, "When you first saw your therapist did you see yourself as...(gay, lesbian, bisexual, heterosexual, did not identify)?"

Hypothesis 7: Characteristics of respondents, therapists, and the therapy experience will each be associated with heterosexual bias, and each will have variables that will predict unique pieces of bias.

Measures: Those characteristics of the client, therapist, and treatment that were significantly associated with perceived bias or of theoretical interest were used as the independent variables in the multiple regression analysis.

Analysis

The quantitative data was analyzed in several ways.

Hypothesis 1

Analysis: The Pearson correlation coefficient r was examined between the measure of empathy and the measure of heterosexual bias.

Hypothesis 2

Analysis: The Pearson correlation coefficient r was examined between the measure of client satisfaction and the measure of heterosexual bias.

Hypothesis 3

Analysis: The Pearson R correlation coefficient was examined between the measure of knowledge and the measure of heterosexual bias.

Hypothesis 4

Analysis: Two t tests were conducted comparing the level of perceived heterosexual bias for gay/lesbian/bisexual therapists as compared with non-gay therapists. In addition, two one-way analyses of variance were done to examine differences between three groups: gay, lesbian, bisexual therapists; heterosexual therapists; and those therapists with unknown sexual orientations.

Hypothesis 5

Analysis: A t test was done comparing the level of perceived heterosexual bias for those respondents who were currently bisexual and those who were currently gay or lesbian. A one-way analysis of variance was done to compare the level of perceived heterosexual bias between those respondents who were; gay, lesbian, bisexual, heterosexual, and those who did not identify with a sexual orientation label at the time they saw their therapist.

Hypothesis 6

Analysis: A t test was done comparing the level of perceived heterosexual bias by current gay men versus current lesbians. A second t test was done to compare the level of perceived heterosexual bias as reported by those respondents who were gay men at the time they first saw their therapist, and those who were lesbian at the time they first saw their therapist. In addition t tests were conducted to examine differences between the perceptions of lesbians and gay men on each of the 43 items.

Hypothesis 7

Analysis: Through examining a correlation matrix of all variables, associations of

each variable with the HBI were determined. The correlations among the independent variables were examined for multicollinearity, which is considered a problem when the independent variables are correlated beyond the .8 level (Lewis-Beck, 1980). No variables were correlated beyond the .8 level, therefore, multicollinearity was not considered a problem. Hierarchical regression analysis was used, as it is considered an appropriate strategy when there is an apriori rationale for how the independent variables are to be entered (Cohen, 1968; Wampold & Freund, 1987). Three initial sets of regressions were conducted which separately explored client variables, therapist variables, and treatment variables.

Through backward regressions, the unique pieces of variance explained by each of these sets of predictors were examined. In the final model, predictors were entered into the regression model based on a proposed theory. Characteristics of the respondent were entered first, therapist characteristics were added to the respondent characteristics, therapy experience characteristics were added third, and finally, the perception of empathy and satisfaction with treatment was added last. The theoretical rationale underlying this model was that first client and therapist variables which were generally more objective in nature (age, race, income, educational level, etc.) should be accounted for and only after these variables were accounted for, should the more subjective variables be examined. The sample size of 213 subjects was considered adequate for the multiple regression analyses, considering the requirement that ten to twenty subjects per independent variable are needed for each regression (Cohen & Cohen, 1975). Adequacy of the sample size is further supported by Kerlinger and

Pedhazur (1973) who have stated that, "Any multiple regression analysis and especially those with many independent variables, should have at least 100 subjects, preferably 200 or more" (p. 446-447). In this study, each set of multiple regression analyses had a total of 8 variables, such that the sample size was sufficient for the number of independent variables.

Conclusion

A sample of 213 respondents was recruited through extensive community outreach. Respondents completed a self-administered questionnaire and the data was analyzed through the use of bivariate correlations, *t* tests, one way analyses of variance, and hierarchical multiple regression analysis. Composite measures were developed and non-interval variables were transformed into dichotomous variables in order to complete the multiple regression analysis. The following chapter will address steps leading to the development of the Heterosexual Bias Inventory (HBI).

CHAPTER FOUR
INSTRUMENT DEVELOPMENT

The major purpose of this study was the development of a reliable and valid measure of lesbian, gay, and bisexual client perceptions of heterosexual bias in psychotherapy. In this chapter the following issues are addressed: 1) source of the items; 2) pilot testing; 3) expert judging; 4) factor analysis; 5) criteria for selection of items of the HBI; and 6) reliability and validity of the HBI.

Source of Items

In order to develop the instrument an initial pool of items was developed on which pilot testing and expert judging took place. The primary source of the items was a study conducted by the American Psychological Association Committee on Lesbian and Gay Concerns (1991). In this study, the authors quantitatively analyzed 1481 psychologist reports of incidents reflecting biased, inadequate, or inappropriate care to gay or lesbian clients in psychotherapy and incidents demonstrating special sensitivity to gay or lesbian clients.

Themes of heterosexual bias and guidelines for exemplary practice were derived from these responses. Themes of bias were described in the following areas: Assessment, Intervention, Identity, Intimate Relationships, Family, Expertise and Education (Committee on Lesbian and Gay Concerns, 1991). Within each theme, specific areas of bias were illustrated (See Appendix F). Use of these themes provided an empirically based framework from which the 43 bias items were developed. In addition, a review of the clinical and research literature addressing heterosexual bias in psychotherapy with lesbians, gay men, and bisexuals was

examined.

Themes of the Initial Pool of Bias Items

Items were generated to reflect specific areas of bias described within the themes described below. The items designed to tap each bias theme are listed by their actual number in the questionnaire.

1 - SOCIETAL DISCRIMINATION

Therapist does not recognize the impact of societal discrimination on lesbians, gay men, and bisexuals (e.g., on the development of positive lesbian, gay, bisexual identity, self esteem, and relationships).

28. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may affect my intimate same sex relationships.

33. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may contribute to my personal problems.

39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.

40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.

2 - PATHOLOGICAL ETIOLOGY

Therapist believes in the pathological etiology of homosexuality.

Homosexuality is viewed by the therapist as failed heterosexuality.

16. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems with my mother and/or father.

19. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems in my childhood.

34. My therapist focused too much on the cause of my homosexuality, bisexuality, or same sex attractions.

38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex.

3 - HOMOSEXUALITY AS PATHOLOGY OR PROBLEM

Therapist believes that the presence of homosexuality is indicative of pathology or immorality. Therapist focuses on lesbian and gay identity as the problem.

7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality.

8. Although there was nothing that my therapist said directly to indicate it, I had the sense that she or he felt negatively about a lesbian, gay, or bisexual lifestyle.

10. My therapist respected me as a lesbian, gay, or bisexual person.

14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.

25. My therapist seemed to think that homosexuality or bisexuality was immoral or sinful.

23. My therapist seemed to think that being lesbian, gay, or bisexual was a symptom of mental illness.

22. My therapist treated my homosexuality or bisexuality as only one of many important parts of me.

35. My therapist seemed to think that if I resolved personal problems, I would become heterosexual.

41. How often did your therapist make overtly negative statements that indicated that s/he believed that homosexuality was a problem?

4 - HOMOSEXUALITY TO CHANGE

Therapist focuses on changing the sexual orientation of the gay, lesbian, or bisexual to heterosexuality. Therapist tries to modify the client's sexual orientation.

26. My therapist encouraged me to become heterosexual.

27. My therapist seemed supportive of my developing or having romantic same sex relationships.

37. My therapist indicated that she or he would only work with me if I were willing to try to become heterosexual.

42. How often did your therapist encourage you to date persons of the opposite sex?

43. How often did your therapist suggest that you try to change your sexual attractions to heterosexual ones?

5 - ACCEPTANCE OF ORIENTATION

Therapist is not accepting of homosexuality or bisexuality. Therapist is not accepting and supportive of clients' homosexuality or bisexuality. Therapist does not help lesbian and gay clients to increase their own self-acceptance and decrease their internalized homophobia.

6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized.

9. My therapist was supportive of my being lesbian, gay, or bisexual.

4. My therapist let me know that being lesbian, gay, or bisexual was okay for me.

11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.

18. My therapist did not believe that I am lesbian, gay, or bisexual.

15. My therapist helped me to feel good about my sexual orientation.

21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.

29. My therapist questioned whether I was really lesbian, gay, or bisexual.

32. My therapist discouraged me from being lesbian, gay, or bisexual.

36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.

6 - SUBTLE BIAS, AVOIDANCE, INQUIRY

Subtle forms of bias are manifested in the psychotherapy experiences of lesbians and gay men. Gay, lesbian, and bisexual issues are marginalized, and the therapist avoids the topic of homosexuality, and/or fails to inquire adequately.

1. I felt satisfied with the questions my therapist asked me about my sexuality.

2. There were subtle things about the way my therapist responded to me that made me feel that she or he was <u>not</u> supportive of my being lesbian, gay, or bisexual.

3. My therapist seemed to have stereotyped notions about gay, lesbian, or bisexual lifestyles.

5. My therapist understood how problems in same sex relationships may be different than problems in heterosexual relationships.

12. In my therapy, I felt welcomed to talk about my sexuality.

13. My therapist asked too little about my sexuality.

17. I felt satisfied with how much my therapist inquired about my sexual orientation.

20. I felt that my therapist avoided discussing my same sex behavior.

24. My therapist relied on me too heavily for information about lesbian, gay or bisexual lifestyles.

30. My therapist was interested in understanding what my sexuality meant to me.

31. I felt that my therapist avoided discussing my same sex attractions.

Subjects were asked to report on one psychotherapy experience in which they felt treated the least sensitively as a lesbian, gay or bisexual client. Items were responded to on a Likert scale from 1 to 4, (where 1=strongly agree, 2=somewhat agree, 3=somewhat disagree, and 4=strongly disagree). For three of the items (#41, #42, #43) the Likert scale ranged from 1 to 3 (where 1=very often, 2=a few times, and 3=never).

Pilot-testing

Pilot-testing of an initial pool of 47 items helped determine the content validity of the 43 items. Pilot testing was done using a sample of ten lesbian, gay, and bisexual individuals who met the criteria for participation in the study (gay, lesbian, or bisexual; 18 years of age or over; past or present experience in psychotherapy for one or more sessions within the past 10 years). The ten subjects were asked to complete the questionnaire and provide written feedback. Specifically, they were asked to rate the survey as excellent, good, fair, or poor on the following criteria: clarity of questions, relevance of questions to their experience, comfort with language used in survey, and clarity of instructions. (See Appendix B for instructions for subjects in pilot testing). The results of the pre-testing process are summarized below.

Table 4-1

Results of Pilot Testing

Clarity of Questions

N=10

Excellent	7
Good	3
Fair	0
Poor	0

Respondent's Comfort with Language Used in Survey

N=10

Excellent	4
Good	5
Fair	1
Poor	0

Clarity of Instructions

N=10

Excellent	6
Good	4
Fair	0
Poor	0

(table continues)

Table 4-1 (continued)

Results of Pilot Testing

Relevance of Questions to Respondent's Experience

N=10

Excellent	3
Good	6
Fair	0
Poor	1

The average reported length of time to complete the questionnaire (N=9) was 39 minutes. Feedback was incorporated and changes on the survey were made based on suggestions provided.

Expert Judging

To further facilitate the development of a pool of items designed to measure heterosexual bias, ten mental health professionals, most with extensive clinical experience working with lesbian, gay, and bisexual clients were used as expert judges. These professionals were asked to evaluate the questionnaire for clarity, comprehensiveness, and relevance of items. (See Appendix A for expert instructions). In addition, they were asked to evaluate each bias item as to whether in their professional judgement the item was or was not a measure of heterosexual bias in psychotherapy.

Nine of the ten experts were practicing psychotherapists with an average of 15.5 years of clinical experience (range 6-35 years). Seven of the experts were master's

level clinicians (five Social Workers, two Counselors). Two were doctoral level clinicians with doctorates in Clinical Psychology. One of the experts was a social researcher with expertise in research and survey design (M.A. Sociologist). Six of the clinicians were lesbian or bisexual women, two were heterosexual women, and two were heterosexual men. The nine practicing therapists had treated an average of 45 gay men, 69 lesbians, and 19 bisexuals. The range of gay men treated was 1-150, the range of lesbians treated was 1-300, and the range of bisexuals treated was 1-50.

The ten experts were asked to evaluate each of the heterosexual bias items by responding to the question, "Is this item a measure of heterosexual bias?." Eight of the ten experts rated all items as measures of heterosexual bias. Only two experts raised questions about any items and these items were subsequently modified or dropped from the survey.

Several changes were made in the survey as a result of pilot testing and the expert judge review process. Instructions and questions were modified to provide additional clarity. Many bias items were modified or dropped from the initial pool of 47 items and new items were added, resulting in a revised pool of 43 heterosexual bias items. This set of 43 items was used to collect the data for the study using the responses of the 213 sample subjects. Subsequent analyses were conducted on the primary data of this study to further develop the instrument.

Factor Analysis

The next major step in the development of the instrument was to determine whether there were multiple dimensions of heterosexual bias (which could be

measured independently by separate subscales), or whether there was an overriding heterosexual bias factor that emerged from the 43 items. The sample size of 213 subjects for a 43 item scale was adequate for this factor analysis (Comrey, 1973; Tinsley & Tinsley, 1987). A ratio of 5-10 subjects per item is considered adequate according to Tinsley and Tinsley (1987). Similarly, according to Comrey (1988) a sample size of 200 is generally considered adequate with a scale of 40 items or less.

A series of factor analyses using varimax rotation were undertaken. They included analyses seeking 1 factor, 2 factor, 3 factor, 4 factor, 5 factor, 6 factor, and 7 factor solutions. The criteria used for the inclusion of a factor in each analysis was an eigen value equal to or greater than 1. The single factor solution explained 54.3% of the variance and none of the subsequent factors added more than 8%. The loadings of the individual items on the single factor were very high: twelve were in excess of .80, 17 were between .70 and .79, eight were between .60 and .69; four between .50 and .59; and the remaining two items had loading of .42 and .35 on the single factor. The factor structure beyond the single factor solution was complex with many single items having significant loadings on more than one factor (e.g. 19 of the 43 items in the two factor solution had a factor loading of greater than .40 on both factors). This was also true of 16 of the 43 items in the 3 factor solution. Thus, using these variables, it was difficult to develop orthogonal subscales to measure heterosexual bias.

As a result of the factor analyses and the extremely high intercorrelations between the items (see Table 4-2), it was decided that the best representation of heterosexual

bias was a single scale, rather than multiple subscales.

Criteria for Selection of Items for Heterosexual Bias Inventory

Based on the finding that a single scale represented the construct of heterosexual bias, the next task was the selection of the final items to be included in the Heterosexual Bias Inventory. The use of multiple criteria was determined and each were considered in the selection process of the final 15 items. The criteria included:

1. Item loadings on the single factor solution. Higher loadings on the single factor solution were considered important in selecting items.

2. The degree of intercorrelations with other items. Items were selected that significantly correlated with a greater number of other items ($\underline{r}$ significant to $p < .001$).

3. Poor response splits (where $\geq$ 70% of the responses were in one category). Items which had poor response splits were generally not selected.

4. The proportion of missing values (not applicable responses). Those items with a greater number of missing values or "not applicable" (NA) responses were considered less useful measures of bias.

5. Repeat reliability, Pearson $\underline{R}$ correlation coefficient, $p < .001$, ($N = 41$). Those items that were more reliable, as measured by the repeat reliability Pearson R correlation coefficient were selected.

6. The extent to which the item discriminated between lesbians, gay men, and bisexuals (currently, and at the time that the respondent saw their therapist). Items were selected that discriminated between respondents' sexual orientation

Table 4-2 Criteria for Selection of Items for Heterosexual Bias Inventory

Item #	Item Loadings on single factor solution	Item inter-correlations (#items with r signif $<.001$	poor response splits $\geq 70\%$ in one category	% does not apply	Repeat reliability (r) (N=41) all signif $p<.001$	Item Discrimi-nates a*
1*	.82	40		2	.75	
2*	.83	41		1	.86	
3	.76	40		3	.78	
4	.79	42		4	.84	P
5	.68	40		8	.83	
6*	.83	40		3	.92	
7*	.88	42		4	.94	
8	.85	42		3	.90	
9	.88	42		3	.93	P, N
10	.85	42		2	.88	N
11*	.77	42		5	.90	N
12*	.79	41		0	.84	N
13	.53	36		2	.71	
14*	.80	42	72%	4	.93	
15*	.84	42		8	.79	P, N
16	.65	40		6	.85	
17	.74	40		3	.75	
18	.63	40	72%	7	.95	P
19	.67	40		6	.83	
20	.71	39		3	.78	
21*	.92	42		1	.94	
22	.75	42		4	.80	P, N
23	.77	42	78%	4	.85	
24	.53	38		6	.83	

(table continues)

Table 4-2 (continued)

Criteria for Item Selection for Heterosexual Bias Inventory

Item #	Item Loadings on single factor solution	Item inter-correlations (#items with r signif <.001)	poor response splits ≥70% in one category	% does not apply	Repeat reliability (r) N=41) all signif p<.001	Item discrimi-nates a*
25	.71	41	83%	3	.87	
26	.66	41	77%	3	.89	
27	.85	42		7	.89	
28	.76	41		5	.68	
29	.60	40		4	.85	P
30*	.71	41		1	.90	
31	.72	41		3	.72	
32*	.79	42	72%	2	.92	P
33	.64	40		3	.80	
34	.65	41	76%	4	.81	P
35	.79	42	71%	6	.89	P
36*	.89	42		2	.90	
37	.42	31	90%	6	.89	
38*	.72	42		8	.80	P
39*	.81	42		8	.88	
40*	.72	40		6	.81	
41	.65	42	84%	0	.80	
42	.35	26	89%	1	.80	
43	.52	38	91%	0	.83	

a* =Ability of item to discriminate between the responses of gay men, lesbians and bisexuals.
P=discriminates between respondents' sexual orientation when saw therapist
N=discriminates between respondents' orientation now
Items selected for the HBI are noted by asterisk after the item number.

Table 4-3

Repeat Reliability of the 43 Bias Items (N=41)

Item #	# both legit. responses	% Identical	% +/- 1 point diff.	Total within 1 point (%)	Pearson r correlates Time 1, Time 2
1*	40	60	38	98	.75***
2*	41	80	15	95	.86***
3	39	64	31	95	.78***
4	39	79	21	100	.84***
5	39	62	38	100	.83***
6*	40	75	25	100	.92***
7*	38	82	18	100	.94***
8	41	78	20	98	.90***
9	40	80	20	100	.93***
10	41	80	17	97	.88***
11*	39	82	18	100	.90***
12*	41	63	37	100	.84***
13	40	70	23	93	.71***
14*	41	83	17	100	.93***
15*	39	67	28	95	.79***
16	40	70	28	98	.85***
17	41	54	41	95	.75***
18	37	89	11	100	.95***
19	39	69	28	97	.83***
20	40	68	28	96	.78***
21*	41	80	20	100	.94***
22	41	68	31	99	.80***
23	40	83	15	98	.85***
24	39	74	18	92	.83***
25	39	85	15	100	.87***



Table 4-3 (continued)

Repeat Reliability of the 43 Bias Items (N=41)

Item #	# both legit. responses	% Identical	%+/- 1 point diff.	Total within 1 point	Pearson r correlates Time 1, Time 2
26	40	83	15	98	.89***
27	37	76	22	98	.89***
28	39	62	26	88	.68***
29	39	79	18	97	.85***
30*	41	76	23	99	.90***
31	41	73	17	90	.72***
32*	41	83	17	100	.92***
33	41	66	27	93	.80***
34	39	79	18	97	.81***
35	39	90	05	91	.89***
36*	41	76	27	100	.90***
37	38	87	11	100	.89***
38*	39	69	28	97	.80***
39*	39	72	28	100	.88***
40*	41	71	22	93	.81***
41	41	88	12	100	.80***
42	41	95	02	95	.80***
43	41	93	07	100	.83***

Items 41, 42, and 43 had 3 response categories, all others had 4 response categories. All correlations were significant to the $p < .001$ level (***). Items selected for the HBI are noted by an asterisk after the item number.

After carefully reviewing each item based on the criteria described, the following

items were selected for inclusion in the Heterosexual Bias Inventory.

32. My therapist discouraged me from being lesbian, gay, or bisexual.

39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.

38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex.

14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.

7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality.

36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.

21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.

11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.

6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized.

15. My therapist helped me to feel good about my sexual orientation.

1. I felt satisfied with the questions my therapist asked me about my sexuality.

2. There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay, or bisexual.

12. In my therapy I felt welcomed to talk about my sexuality.

30. My therapist was interested in understanding what my sexuality meant to me.

40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.

Reliability of the Heterosexual Bias Inventory

The next step in developing the Heterosexual Bias Inventory was to determine the reliability and validity of the measure. Reliability refers to the extent to which responses are due to measurement error, that is, what extent of the variance measured is due to true variance. Reliability was determined by examining the degree to which the individual items of the measure were consistent with each other (internal consistency) and through determining whether scores were stable over time (test-retest reliability) (Corcoran & Fisher, 1987). Internal consistency was measured by Cronbach's coefficient alpha, and repeat reliability was measured through examining the Pearson r correlation coefficients for the 41 repeat responses.

Internal Consistency

After the factor analysis, Cronbach's alpha, a measure that reflects the average inter-correlations between items, was calculated to measure the internal consistency of the instrument. The Cronbach's coefficient alpha for the instrument was .9672 indicating a high level of internal consistency. The item-total correlations are reported below.

Item-Total Correlations

HBI 32R	.726
HBI 39	.819
HBI 38R	.670
HBI 14R	.789
HBI 7R	.858
HBI 36	.886
HBI 21	.918
HBI 11R	.760
HBI 6R	.853
HBI 15	.877
HBI 1	.812
HBI 2R	.845
HBI 12	.769
HBI 30	.718
HBI 40	.721

Test-Retest Reliability

Forty one respondents completed the heterosexual bias measure twice. All time1 - time2 item correlations were significant to the $p < .0001$ level. The repeat reliability of the Heterosexual Bias Inventory was .983, $p < .0001$.

Validity

Validity refers to how well the instrument measures what it was designed to measure (Corcoran & Fisher, 1987). Two approaches to validity were used in this study: content validity and construct validity. Criterion validity, evidenced by the extent to which a measure is associated with or predictive of an outcome variable was not used in this study, as the Heterosexual Bias Inventory was the only outcome measure in the study.

Content Validity

Content validity refers to the degree to which the sample of items are representative of the construct to be measured. Content validity assesses whether the instrument items cover a representative sample of the domain it was designed to measure (Anastasi, 1982; Corcoran & Fisher, 1987; DeVillis, 1991). In order to determine content validity, the domain to be measured must be systematically analyzed to ensure that all important aspects are included in the measure.

Content validity was determined in this study through generation of a large group items that were evaluated by experts for relevance to the content domain. The expert judging was provided by ten clinical experts who reviewed the instrument. Their feedback was elicited regarding the content validity of the bias items. In addition, they were encouraged to provide suggestions for additional items and additional content areas.

There was high agreement among the expert judges and only those items that were uniformly rated as good heterosexual bias items were included in the study. Content validity was also determined through examination of conceptual frameworks and empirical data addressing the concept of heterosexual bias. Finally, the items of the instrument were also derivative of those themes judged as indicative of heterosexual bias by experts in the field (Committee on Lesbian and Gay Concerns, 1991), providing further evidence of content validity.

Construct Validity

Construct validity, a term developed by Cronbach and Meehl (1955), concerns the extent to which a measure is related to another variable based on a theoretical relationship. Construct validity is evidenced when a construct behaves in relation to other constructs as it is hypothesized (DeVillis, 1991). Based on a review of the literature, it was hypothesized that greater perceived heterosexual bias in psychotherapy would be significantly associated with less perceived therapist empathy, less satisfaction with treatment, and less perceived therapist knowledge. These proposed theoretical relationships were tested by examining the correlations between these variables. Significant correlations were found between the heterosexual bias measure and the empathy, satisfaction, and knowledge measures, providing support for the construct validity of the measure.

An additional element of construct validity is discriminatory power, which is defined as "the ability of a test to produce a spread of scores" (Kline, 1993, p. 28) Therefore, a criteria for inclusion in the Heterosexual Bias Inventory was an item's ability to exhibit a representative spread of response scores. No items in the Heterosexual Bias Inventory were found to have more than 72% of the responses in one category.

Missing Data

Once the 15 items for the Heterosexual Bias Inventory were selected, decisions were made about how to compute a total score for each respondent for further analyses. Items were reflected so that a high score for each item indicated more

heterosexual bias. Total scores were calculated to be equal to the sum of the response codes to the 15 individual items. Thus, the theoretical range was 15 to 60, and this was the actual range as well.

Although seventy four percent of the respondents answered each of the fifteen items, for 26% of the respondents one or more items was either reported as not applicable or was not answered. Specifically, 29 persons failed to respond to one item, 10 respondents did not respond to two items, 8 did not respond to three items, and 8 did not respond to 4 or more items. To generate a full HBI score for each respondent, the following method was utilized. The scores for all of the items that a respondent completed were summed, and a mean was computed on the basis of that sum. That mean was inserted to replace the missing values for that respondent. In this way, all 213 respondents were included in the subsequent analyses of the HBI. The overall mean of the HBI scores for the 213 respondents was 28.5, standard deviation, 13.4. Cohen (1968) has suggested that use of means is superior to excluding subjects with missing data. Cohen (1968) has stated that the "practice of excluding cases lacking some of the data has the undesirable properties of analyzing a residual sample which is unrepresentative to an unknown degree of the population originally sampled, as well as the loss of information (viz., the fact of data being missing) which may be criterion relevant" (p. 438).

Conclusion

The initial item pool was developed by operationalizing bias themes identified in the Committee on Lesbian and Gay Concerns study (1991) and drawing on the clinical

literature. The pool was subsequently reviewed by ten experts, and pilot tested by ten potential subjects. Analysis of the original 43 items resulted in the development of a 15 item measure of heterosexual bias in psychotherapy. The instrument was found to be reliable based on a Cronbach's coefficient alpha of .9672 and a repeat reliability score of $\underline{r} = .983$, $p < .0001$.


MICHIGAN STATE UNIV. LIBRARIES
31293010219685

MICHIGAN STATE UNIVERSITY LIBRARIES
3 1293 01021 9669

LIBRARY
Michigan State
University

PLACE IN RETURN BOX to remove this checkout from your record.
TO AVOID FINES return on or before date due.

DATE DUE	DATE DUE	DATE DUE
JUN 1 1 1996		
IC:2309048 (100 2) MAR 3 [illegible]		
(X) 6287223 MAR 2 0 199[illegible]		

MSU Is An Affirmative Action/Equal Opportunity Institution

c:\circ\duedue.pm3-p.1

THE HETEROSEXUAL BIAS INVENTORY (HBI): GAY, LESBIAN, AND BISEXUAL CLIENTS' PERCEPTIONS OF HETEROSEXUAL BIAS IN PSYCHOTHERAPY

Volume II

By

Julia Florence Moss

A DISSERTATION

Submitted to
Michigan State University
in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Counseling Psychology

1994

CHAPTER FIVE

RESULTS

The results of the study are presented in this chapter. Each of the seven hypotheses are examined and relevant findings are explored. First the three hypotheses concerning the construct validity of the instrument are examined, following which the four hypotheses concerning the research questions are discussed. The dependent variable for each of these hypotheses is the total scale score of the 15 item Heterosexual Bias Inventory (HBI).

Hypothesis 1

Greater heterosexual bias as perceived by lesbian, gay, and bisexual clients in psychotherapy will be significantly associated with less perceived therapist empathy.

The perception of heterosexual bias as measured by the Heterosexual Bias Inventory (HBI) was found to be significantly negatively correlated with the perception of therapist empathy, as indicated by a Pearson correlation coefficient of $r = -.78$, $p < .0001$. High scores on the HBI correlated with low scores on the empathy measure. The significant negative correlation between the perceived heterosexual bias measure (HBI) developed by the researcher and a previously established and validated measure of empathy provides support for the construct validity of the Heterosexual Bias Inventory (HBI).

Hypothesis 2

Greater heterosexual bias as perceived by lesbians, gay men, and bisexuals in psychotherapy will be significantly associated with less satisfaction with the

psychotherapy experience.

The perception of heterosexual bias as measured by the Heterosexual Bias Inventory (HBI) was found to be significantly negatively correlated with satisfaction with treatment, as indicated by a Pearson r correlation coefficient of $r = -.80$, $p < .0001$. Higher scores on the HBI indicating greater perceived heterosexual bias were associated with lower scores on the satisfaction measure indicating less satisfaction with therapy. This result provides further evidence of construct validity of the Heterosexual Bias Inventory.

Hypothesis 3

Greater heterosexual bias as perceived by lesbians, gay men, and bisexuals in psychotherapy will be significantly associated with less perceived therapist knowledge about lesbian, gay, and bisexual issues.

Using the knowledge measure developed by the research, two indices were used to evaluate perceived knowledgeability of the therapist (Knowledge index and Lack of Knowledge Index). The HBI score was significantly correlated with both of these indices. High scores on the Knowledge measure indicated more perceived knowledge of the therapist, and high scores on the Lack of Knowledge measure indicated more areas of a lack of knowledge. A significant negative correlation was found between the HBI score and perceived therapist knowledge, $r = -.72$, $p < .0001$. A significant positive correlation was found between the HBI and perceived therapist lack of knowledge, $r = .78$, $p < .0001$. Therefore this hypothesis was supported. Greater perceived heterosexual bias of therapists was found to be associated with less

perceived therapist knowledge and more areas of perceived lack of knowledge.

Hypothesis 4

Therapists known by the respondent to be gay, lesbian, or bisexual will be perceived as significantly less biased as measured by the HBI than those who are known to be heterosexual or whose sexual orientation is not known.

A one way analysis of variance was conducted that compared three groups: gay, lesbian, and bisexual therapists (Group 1); heterosexual therapists (Group 2); and therapists whose sexual orientation was unknown (Group 3).

Table 5-1

One-way Analysis of Variance Among Therapists with Gay, Lesbian, Bisexual, Heterosexual, or Unknown Sexual Orientations.

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	2	6331.3490	3165.6745	20.7414	.0001
Within groups	210	32051.503	152.6262		
Total	212	38382.851			

	Freq.	Mean	Group Differences
Group 1: Gay,lesbian, bisexual therapists	49	19.11	
Group 2: Hetero therapists	118	30.00	2 > 1
Group 3: Therapists with unknown sexual orientation	46	34.66	3 > 1
Total	213		

Heterosexual therapists and therapists with unknown sexual orientations were perceived as significantly more biased as compared to gay, lesbian, and bisexual therapists.

In an additional one-way analysis of variance (See Table 5-2), both heterosexual

therapists and those with unknown sexual orientations were found to be significantly more biased than gay therapists independently and lesbian therapists independently. Bisexual therapists as a group were not examined separately as there were only seven bisexual therapists (3.3%) in the sample.

Table 5-2

One Way Analysis of Variance Among Therapists with Gay, Lesbian, Heterosexual, or Unknown Sexual Orientations.

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	3	6468.31	2156.10	14.17	.0001
Within groups	202	30747.23	152.21		
Total	205	37215.54			

	Freq.	Means	Group Diffs.
Group 1 Gay	15	18.32	
Group 2 Lesbian	27	18.12	
Group 3 Hetero	118	30.00	3>2, 3>1
Group 4 Unknown	46	34.66	4>2, 4>1
Total	206		

A two sample t test was done to compare the mean scores on the HBI for respondents whose therapists' sexual orientation was known (regardless of the sexual orientation of the therapist) and those whose sexual orientation was unknown. Significant differences were found between the groups. Those therapists with a known sexual orientation were perceived as significantly less biased than therapists

with an unknown sexual orientation.

Table 5-3

Two-sample t test: Known vs. Unknown Sexual Orientation of the Therapist

	Freqs	Mean	S.D.	S.E.
Group 1- Those therapists with known sexual orientations	167	26.803	12.55	.971
Group 2- Those therapists with unknown sexual orientations.	46	34.657	14.93	2.20

t= -3.60 p= <.001

Hypothesis 5

Bisexuals will differ significantly from lesbians and gay men in their perception of heterosexual bias.

Differences between bisexuals and gay men and lesbians were examined on the HBI. Results indicated that current bisexuals perceived significantly more heterosexual bias than current lesbians (F-ratio 3.32; F-probability .038). No significant differences were found between current bisexuals and current gay men, although it appears the mean differences between these groups approached significance (see Table 5-4).

Table 5-4

One-way Analysis of Variance: Current Sexual Orientation of Respondent x HBI

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	2	1177.4708	588.7254	3.323	.0379
Within groups	210	37205.381	177.1685		
Total	212	38382.852			

	Mean	Group Differences
Group 1 Gay Man	27.99	
Group 2 Lesbian	27.33	
Group 3 Bisexual	34.50	3>2

In an additional one-way analysis of variance, no significant differences were found on the HBI between those respondents who identified as bisexual at the time they saw their therapist and those who identified as lesbian or gay. Significant differences were found, however, between those who identified as heterosexual and those who identified as gay men; between heterosexuals and lesbians; and between those who did not identify, and both gay men, and lesbians.

To determine if the differences found between bisexuals, lesbians and gay men, and those who didn't identify, were related to gender differences, two tail t-tests were done to compare the responses of men and women on each item of the original pool of 43 items. No significant differences were found on any items which distinguished

between the responses between men and women.

Hypothesis 6

No significant differences will be found between lesbians and gay men in their perceptions of heterosexual bias.

A one-way analysis of variance was conducted to examine differences between the HBI scores of currently gay men, lesbians, and bisexuals. An additional analysis of variance examined differences between the HBI score of those subjects who identified as gay men, lesbians, bisexuals, and those who did not identify at the time they saw their therapist. No differences were found between both currently identified lesbians and gay men, and those who identified as gay men or lesbians at the time they first saw their therapist (see Tables 5-5 and 5-6).

Table 5-5

One-way Analysis of Variance: Current Sexual Orientation of Respondent x HBI

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	2	1177.4708	588.7254	3.3230	.0379
Within groups	210	37205.381	177.1685		
Total	212	38382.852			

	Mean	Group Differences
Group 1 Gay Man	27.99	
Group 2 Lesbian	27.33	
Group 3 Bisexual	34.50	3>2

Table 5-6

One-way Analysis of Variance: Orientation of Respondent When First Saw Therapist x HBI

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	4	3346.46	836.6141	4.97	.0008
Within groups	208	35036.40	168.44		
Total	212	38382.8519			

		Frequencies	Means	Group Diffs.
Group 1	Gay men	63	25.99	
Group 2	Lesbians	88	26.00	
Group 3	Bisexuals	21	33.08	
Group 4	Heterosexuals	16	36.20	4>1, 4>2
Group 5	Didn't identify	25	34.85	5>1, 5>2

Hypothesis 7

Characteristics of the respondents, characteristics of the therapists, and characteristics of the therapy experience will each be significantly correlated with perceived heterosexual bias, and each will have variables that will predict unique pieces of variance.

The findings related to this hypothesis will be reported in three steps. First, the associations between the HBI and characteristics of respondents, therapists and the therapy experience will be examined. Second, within the three preliminary regressions, those variables with significant correlations will be inspected. Finally, a

final regression model combining those variables that explain unique pieces of the variance will be introduced.

After examining the zero order correlations and the t tests between the heterosexual bias measure and characteristics of the respondents, therapists, and the therapy experience, those variables from each category that were significantly associated with heterosexual bias, or had theoretical significance, were selected. Using hierarchical regression analysis, they were then entered into a multiple regression to determine which characteristics of the client, the therapist, and the treatment predicted a significant amount of variance in the heterosexual bias measure.

Using this analysis, the degree to which client, therapist, and treatment characteristics (e.g. objective and subjective), explained unique aspects of the variance in the dependent variable of heterosexual bias was examined.

Correlations: HBI and Respondent Variables

Table 5-7

Associations between Characteristics of Respondents and the HBI score

	t	r
Gender	.31 ns	
Current Age		.08 ns
Age when first saw therapist		-.15 ns
Race (Caucasian vs else)	-.14	
Education		.09 ns
Professional Therapist	-.19 ns	
Income		.08 ns
Protestant	-.9 ns	
Catholic	1.48 ns	
Jewish	-.18 ns	
No Religion	.64 ns	
Importance of Religion or Spirituality		-.03 ns
Attendance of religious services		-.10 ns
Found out about study through a gay pride march or other source	-.41 ns	

*=p<.05
**=p<.01
***=p<.001

None of the 14 general background variables of the respondent were found to be significantly associated with the perception of heterosexual bias as measured by the HBI.

Table 5-7 (Continued)

Associations between Characteristics of the Respondents and HBI score

	t	r
Current sexual behavior (heterosexual vs homosexual)		-.14*
Current sexual feelings/ fantasies (heterosexual vs homosexual)		-.18**
Current self-identification (heterosexual vs homosexual)		-.17**
Composite measure of degree of current homosexuality in relation to sexual behavior, feelings, self-identification (ORTOT)		-.19**
Bisexual Currently (BISEXNOW)	-2.56**	
Composite score of how currently out to close family, friends, and co-workers (TELLTOT)		-.17**
Degree to which currently comfortable or conflicted with sexual orientation (COMFORT)		.13*
Respondent was gay, lesbian, or bisexual when first saw therapist (YTRGLBR)	-.25**	
How comfortable respondent was with sexual orientation at time first saw therapist (YTCOMFORT)		.24***
How out to family, friends, and co-workers at the time saw therapist (YTTELLTOT)		-.12*

*=p<.05
**=p<.01
***=p<.001

Significant associations were found between each of the ten variables measuring respondent sexual orientation and perceived heterosexual bias. Respondents who reported more bias were currently less exclusively homosexual in terms of sexual behavior, sexual feelings, fantasies, attractions, and self-identification. They were more significantly more conflicted about their sexual orientation when they first saw their therapist, and currently more conflicted. They were currently less "out" to family, friends, and co-workers, and were less "out" when they first saw their therapist. Those respondents who were currently bisexual reported more bias than lesbians and gay men. Those respondents who did not identify as gay, lesbian, or bisexual at the time they saw their therapist (i.e. identified as heterosexual or did not label themselves) reported more heterosexual bias.

Table 5-8

Mental Health/Psychiatric History of Respondents

	t	r
Total number of therapists seen (THERNUM)		.43***
History of psychiatric hospitalization (HOSP)	3.57***	
Current medication for psychiatric reasons	1.23 ns	
History of Suicide Attempt	1.56 ns	

*=p<.05
**= p<.01
***=p<.001

Greater bias was significantly correlated with respondents having been hospitalized for psychiatric reasons. Respondents reporting more bias were also significantly more likely to have seen a greater number of therapists within the past 10 years. Current use of psychiatric medication and past attempted suicide were not found to be related to the perception of heterosexual bias.

Correlations: HBI and Therapist Variables

Table 5-9

Associations between the HBI and Characteristics of the Therapist

	t	r
Therapist Age		.04 ns
Therapist Race (Caucasian vs. other)	.61 ns	
Therapist Gender	-1.87	
Extent of therapist knowledge of lesbian, gay, bisexual issues (KNOWLEDG)		-.72***
Number of Issues therapist was not knowledgeable about (NOTKNOWLG)		-.78***
Psychiatrist vs other professional (PSYCHIAT)	-3.68***	
Therapist experience generally (YTEXPGEN)		-.32***
Therapist was not gay, lesbian, or bisexual (YTNOTGLB)	-8.25***	
Therapists' sexual orientation unknown (YTDKGLB)	-3.60***	
Therapist experience with lesbian, gay, bisexual clients (YTEXPGLB)	-.61***	

*=p<.05 **=p<.01 ***=p<.001

Therapists' race, age and gender were not significantly associated with greater perceived heterosexual bias. Greater perceived heterosexual bias was significantly correlated with a belief that the therapist was less experienced generally, and a belief that the therapist was less experienced specifically with lesbian, gay, and bisexual clients. Those respondents who reported more bias, perceived their therapists to be less knowledgeable about gay, lesbian, and bisexual issues. Psychiatrists were perceived to be significantly more biased than other mental health professionals. Significantly more bias was reported when the therapist was not gay, lesbian, or bisexual, and when the therapists' sexual orientation was unknown to the respondent.

Correlations: HBI and Therapy Experience Variables

Table 5-10

Associations between the HBI and Characteristics of the Therapy Experience

	t	r
Therapist aware of respondents' sexual orientation in first or second session vs later or not at all (YTAWARER)	4.19***	
Presenting problem: "concern about your sexual orientation" (PROB1)	-.75 ns	
Presenting problem: "problems with "coming out"" (PROB2)	1.80	
Presenting problem: "depression" (PROB4)	-.79 ns	
Presenting problem: anxiety (PROB5)	1.14 ns	
Presenting problem: relationship (PROB6) difficulties	3.03**	
Presenting problem: sexual difficulties (PROB7)	.18 ns	
Presenting problem: family problems (PROB8)	-.61 ns	
Presenting problem: drug or alcohol problem (PROB9)	.89 ns	
Presenting problem: career/work issues (PROB12)	.50 ns	
Empathy		-.78***
Satisfaction		-.80***
Seeing therapist now vs terminated (YTNOW)	-10.04***	

* $p < .05$
** $p < .01$
*** $p < .001$

Table 5-10 (continued) Associations between the HBI and Characteristics of the Therapy Experience

	t	r
Private Practice vs. other setting	1.24 ns	
Length of time since respondent last saw therapist (YTMOSAGO)		.32***
How respondent knew the sexual orientation of therapist (YTHOWKNOW)	2.90**	
Number of times respondent saw therapist (YTSESS)		-.42***
How much focused on "'coming out' to self" (YTFOCUS1)		.22***
How much focused on "'coming out' to others" (YTFOCUS2)		.38***
How much focused on, "my family and my sexual orientation" (YTFOCUS3)		.37***
How much focused on "my conflicts or fears about being gay, lesbian, bisexual person" (YTFOCUS4)		.18**
How much focused on "societal discrimination as a gay, lesbian, bisexual person" (YTFOCUS5)		.30***
Summary score of focus on issues related to sexual orientation (FOCUSTOT)		.38***
Amount respondent discussed issues related to sexual orientation (YTTALK)		.19*
If saw other therapists since respondent saw their therapist (YTOTHERS)	4.78***	

Those respondents who reported more bias perceived their therapists as significantly less empathic and were significantly less satisfied with their overall treatment. Respondents reporting more bias were significantly more likely to have seen their therapists less recently and for fewer sessions, and were less likely to be seeing their therapist currently.

Those respondents who experienced more bias were significantly less likely to focus on a variety of issues related to sexual orientation and they talked less in their therapy about their sexual orientation in general. Respondents were less likely to seek help for relationship difficulties, and were more likely to know the sexual orientation of their therapists from a source other than their therapists (i.e. their therapists were significantly less likely to have told them directly about their sexual orientation). Finally, those respondents who perceived more bias were more likely to have seen other therapists since they saw their therapist.

Hierarchical Multiple Regression Analyses

Respondent (Client) Predictors

Three preliminary regressions were computed in order to reduce the complexity of a final regression model. First, the HBI was regressed upon respondent characteristics. Second, the HBI was regressed upon therapist characteristics. And third, the HBI was regressed upon the characteristics of the therapy experience. In each of the hierarchical regressions reported below, predictors that did not explain a unique piece of variance of the HBI were eliminated through backward regressions. The final, fourth model includes items from each of these three preliminary

regressions.

First the HBI score was regressed upon a set of 8 respondent characteristics:

1. The degree to which the respondent was conflicted about sexual orientation at the onset of the therapy experience. (YTCOMFOR)

2. The number of therapists seen by the respondent in the last 10 years. (THERNUM)

3. Whether or not the respondent had ever been hospitalized for psychiatric reasons. (HOSP)

4. The degree to which the respondent currently has a homosexual orientation in terms of behavior, feelings/fantasies, and self-identification. (ORTOT)

5. Age of respondent at the time he/she saw the therapist. (YTRAGE)

6. Whether at the time of seeing the therapist the respondent identified as gay, lesbian, or bisexual. (YTRGLBR)

7. Whether or not the respondent considers him/herself bisexual now. (BISEXNOW)

8. The degree to which the respondent was out to friends, family and co-workers at the time of seeing the therapist (YTTELLTOT)

The 8 respondent variables predicted 26% of the variance. Subsequently a backwards regression was performed to remove those respondent characteristics which explained no significant unique variance of the HBI. A backwards regression is used in order to remove those variables that fail to explain a unique portion of the variance (Polkosnik & Wisenbaker, 1986). The multiple regression coefficients used for this analysis were Beta weights, as they are standardized coefficients that are "unaffected by differences in the standard deviations of the predictor variables" (Polkosnik & Wisenbaker, 1986, p. 170).

As a result of the backwards regression (see Table 5-11), 4 significant respondent predictors remained in the model: heterosexual bias was predicted by

respondents' less comfort and more conflict about their sexual orientation at the time of initially seeing the therapist (YTCOMFOR), respondents having seen more therapists in the past 10 years (THERNUM), respondents being more likely to have been hospitalized for psychiatric reasons (HOSP), and respondents being currently less exclusively homosexual in behavior, feelings and identifications (ORTOT). Thus, items 5-8 were eliminated from the original model.

Table 5-11

Step 1- Respondents Characteristics as Predictors of Bias

Respondent Characteristics	Beta
Conflicted about sexual orientation when first saw therapist (YTCOMFOR)	.187
Number of therapists seen in last 10 years (THERNUM)	.370
Less hospitalized for psychiatric reasons (HOSP)	-.123
More exclusively homosexual currently (ORTOT)	-.147
$F=17.82$, $p<.001$	$R^2=.26$

Therapist Predictors

Next the HBI score was regressed upon a set of 8 characteristics of the therapist.

1. Whether or not the therapist was gay, lesbian, or bisexual. (YTNOTGLB)

2. The number of issues that the therapist was not knowledgeable about. (NOTKNOWL).

3. The degree to which the therapist was perceived to be knowledgeable. (KNOWLEDG)

4. Gender of the therapist. (YTGENDER) (*This variable was included because its correlation to heterosexual bias approached significance).

5. Whether the respondent did or did not know the sexual orientation of the therapist. (YTDKGLB)

6. The degree to which the therapist was perceived to be experienced generally. (YTEXPGEN)

7. The degree to which the therapist was perceived to be experienced in working with lesbian, gay, bisexual clients. (YTEXPGLB)

8. Whether the therapist was a psychiatrist or not. (PSYCHIAT)

With the therapist characteristics added, the model explained 70% of the variance of the HBI. Through a backwards regression, those therapist characteristics which explained no significant unique variance of the HBI were eliminated. Five variables were removed, leaving three predictors of unique variance. Bias was predicted by: the respondents' knowledge that their therapist was not lesbian, gay, or bisexual; the therapist being perceived as less knowledgeable about gay, lesbian, and bisexual issues; and by the therapist being perceived as not at all knowledgeable about a greater number of issues.

Table 5-12

Step 2-Therapist Characteristics as Predictors of HBI

	Beta
Therapist is not gay, lesbian or bisexual (YTNOTGLB)	.098
Number of areas therapist is not knowledgeable about GLBI issues (NOTKNOWL)	.530
Therapist more knowledgeable about gay, lesbian, bisexual issues (KNOWLEDG)	-.442
$F=161.50$, $p<.001$	$R^2=.703$

Therapy Experience Predictors

The third set of regressions involved the characteristics of the therapy experience as predictors of heterosexual bias (as measured by the HBI). Because the variables satisfaction and empathy were so highly correlated with the HBI, forward and backwards regressions were conducted twice. First, the set of variables below were examined with satisfaction but not empathy, and subsequently the set was examined without satisfaction but with empathy. The characteristics of therapy that were examined included the following variables.

1. The summary score reflecting the total amount that the respondent focused on five issues related to sexual orientation (FOCUSTOT)

2. Whether or not the respondent came to therapy with a problem of relationship difficulties (PROB6)

3. Whether or not the therapist was aware of the respondent's lesbian, gay, bisexual identity or same sex attractions in the first or second session (YTAWARER)

4. Whether or not the respondent was currently seeing his/her therapist. (YTNOW)

5. Whether or not the respondent came with a problem of "coming out" (PROB2) - (Note, this variable was included as its correlation approached significance).

6. The number of sessions that the respondent saw his/her therapist. (YTSESS)

7. The degree to which the respondent was satisfied with his/her therapy experience. (SATISF)

8. The degree to which the respondent reported the therapist to be empathic. (EMPATHY)

Through backwards regression, the variables five and six above (PROB2 and YTSESS) were removed. When satisfaction was included in the model (see Table 5-13), 70% of the variance is explained. Without satisfaction in the model, the characteristics of the therapy experience explain only 43% of the variance of HBI (R^2= .426). A similar regression analysis was conducted that included empathy instead of satisfaction, with similar results. Thus, greater bias is predicted by 5 independent variables: (1) less focus on gay, lesbian, and bisexual issues in therapy; (2) less likelihood client presents with relationship difficulties; (3) therapists were not aware of the respondent's sexual orientation or same sex attractions in the first two therapy sessions; (4) the respondent having terminated therapy; and (5) the respondent being less satisfied with the therapy.

Table 5-13

Step 3- Therapy Experiences as Predictors of Bias (HBI TOT)

	Beta
Amount therapy focused on issues related to sexual orientation (FOCUSTOT)	.103
Whether or not respondent came to therapy with relationship difficulties (PROB6)	-.112
Whether or not the therapist was aware of the respondent's lesbian, gay, bisexual identity, or same-sex attractions in the first or second session (YTAWARER)	.158
Whether or not the respondent was currently seeing the therapist (YTNOW)	.076
The degree to which the respondent is satisfied with the therapy experience (SATISF)	-.691
$F = 95.799$, $p < .001$	$R^2 = .701$

Overall Predictors

Finally, the unique predictors in each of the three regressions in Tables 5-11, 5-12, and 5-13, were combined in a single hierarchical regression to ascertain the degree to which each set predicted unique pieces of variance of bias. The three sets were characteristics of the respondent, characteristics of the therapist, and characteristics of the therapy experience. Empathy and satisfaction were placed were at the end of the model so that it could be determined what additional variance these

two variables explained.

As presented in Table 5-14, the characteristics of the respondent predicted 26% of the variance of bias, the characteristics of the therapist explained an additional 48% of the variance and the characteristics of the therapy experience further explained an additional 11% of the variance.

Table 5-14

Step 4- Overall Predictors of HBI TOT

	R^2
Characteristics of the Respondent	
Exclusively homosexual currently (ORTOT)	
Hospitalized for psychiatric reasons (HOSP)	
Conflicted about sexual orientation when first saw therapist (YTCOMFOR)	
Number of therapists seen in last 10 years (THERNUM)	.26
Characteristics of the Therapist	
Therapist was not gay, lesbian, or bisexual (YTNOTGLB)	
More g/l/b issues therapist was not knowledgeable about (NOTKNOWL)	
Therapist was less knowledgeable about g/l/b issues (KNOWLEDG)	.74

Characteristics of the Therapy Experience	R^2
Amount of focus in therapy on sexual orientation issues (FOCUSTOT)	
Likelihood that respondent cited relationship difficulties as main problem (PROB6)	
Therapist aware of respondent's sexual orientation within first two sessions (YTAWARER)	
Respondent seeing their therapist currently (YTNOW)	
Perceived therapist empathy (EMPATHY)	
Treatment Satisfaction (SAT)	.85

To further simplify the model a backward regression was done again, as a final step in the process, eliminating 5 of the items on Table 5-14 (HOSP, THERNUM, YTNOTGLB, YTAWARER, YTNOW).

Final Regression Model

Table 5-15

Final Regression Model

Final Model	Beta
Characteristics of Respondent	
Exclusively homosexual currently (ORTOT)	-.049
Conflicted about sexual orientation when first saw therapist (YTCOMFOR)	.067

Characteristics of Therapists	
More g/l/b issues therapist was not knowledgeable about (NOTKNOWL)	.290
Therapist was less knowledgeable about g/l/b issues (KNOWLEDG)	-.184
Therapy Characteristics	
Amount of focus in therapy on sexual orientation issues (FOCUSTOT)	.086
Likelihood that respondent cited relationship difficulties as main problem (PROB6)	.067
Subjective Characteristics	
Perceived therapist empathy (EMPATHY)	-.265
Treatment Satisfaction (SATISF)	.245
$F=133.411$, $p<.001$	$R^2=.84$

The final scaled down set of 8 predictors explain 85% of the variance of HBI (Table 5-15). Greater heterosexual bias is predicted by respondents who were less exclusively homosexual in terms of sexual behavior, feelings, and self-identification, by those who were more conflicted about their sexual orientation at the time they saw their therapist, by those who perceived their therapist as less knowledgeable about gay, lesbian and bisexual issues, by those who reported that during their therapy there was less focus on gay lesbian or bisexual issues, by those who were less likely to cite relationship issues as a main problem, and by respondents who reported that their

therapist was less empathic and who were less satisfied with their therapy.

In order to assess signs of multicollinearity, a correlation matrix of all the predictor variables used in the final multiple regression analysis was examined. Multicollinearity is considered a problem if independent variables are found to be highly correlated with one another (.80 or above) (Lewis-Beck, 1980). As Table 5-16 demonstrates no predictor variables are correlated at the .80 level or above.

Table 5-16

Correlation Matrix of Final Regression Model Variables

	ORTOT	YTCOMFOR	NOTKNOWL	KNOWLEDG	FOCUSTOT	PROB6	EMP	SAT
ORTOT	1.00	-.085	-.09	.16	-.13	.11	.16	.10
YTCOMFOR	-.085	1.00	.28**	-.20*	-.29**	-.04	-.14	-.13
NOTKNOWL	-.09	.28**	1.00	-.66**	-.27**	-.15	-.65**	-.63**
KNOWLEDG	.16	-.20*	-.66**	1.00	-.36**	.06	.56**	.59**
FOCUSTOT	-.13	-.29**	.27**	-.36**	1.00	-.12	-.27**	-.33**
PROB6	.11	-.04	-.15	.06	-.12	1.00	.16*	.08
EMPATHY	.16	-.14	-.65**	.56**	-.27	.16*	1.00	.77**
SATISF	.10	-.13	-.63**	.59**	-.33	.08	.77**	1.00

Summary of Results from Multiple Regression Analysis

The characteristics of the respondent that predicted unique aspects of heterosexual bias were comfort with sexual orientation and the degree of homosexual identification. These two characteristics of the respondent were more salient than whether the respondent was hospitalized for psychiatric reasons or how many therapists the respondent had seen within the past ten years. Over and above how respondent characteristics predicted bias, therapist characteristics which predicted bias were examined. The perceived lack of knowledge by the therapist was more important in predicting bias than whether or not the therapist was gay, lesbian, or bisexual. Additional variance was predicted by characteristics of respondents' therapy experiences. In examining the respondents' therapy experiences, the less focus on gay, lesbian, bisexual issues, or on relationship issues in general, the more heterosexual bias was predicted. Therapists who were perceived as gay, lesbian, or bisexual were perceived as more knowledgeable ($\underline{r}$ =.67). However, knowing whether or not a therapist is gay, lesbian, or bisexual did not add to our understanding of bias beyond that which was predicted by therapists' knowledge. Although the zero order correlations between YTNOW, YTAWARER and HBI were significant (r=.25, and -.31 respectively), these two variables did not add any explanation of unique pieces of variance of perceived bias in the model.

The two dimensions of knowledge (KNOWLEDG and NOTKNOWLEDG) were highly correlated r= .66, yet they each explained different pieces of the variance of the HBI. Finally, empathy and satisfaction were highly correlated with each other

(r=.77), and each is highly correlated with the HBI total score (EMP r=-.78, and SAT r=-.80). It is most important to note that empathy and satisfaction each predicted a significant and unique piece of the variance of bias even after all the other variables had been accounted for.

Post Hoc Analyses

Therapist-Client Sex Match

Differences were examined between those respondents who saw a therapist of the same sex and those who saw a therapist of a different sex. One-way analyses of variance were conducted to examine sex match differences on the heterosexual bias inventory, and sex match differences on the empathy, knowledge, and satisfaction measures.

No significant differences were found in the perception of heterosexual bias between those respondents who saw same sex therapists and those who saw opposite sex therapists. There was, however, a trend towards significance suggesting that female clients seeing male therapists perceived greater heterosexual bias.

Table 5-17

Sex Match and the HBI

Group	Frequency	Mean	Standard Error
Female respondent/ Female therapist	120	27.63	13.18
Male respondent/ Male therapist	21	25.22	12.21
Female respondent/ Male therapist	18	35.89	16.29
Male respondent/ Male therapist	54	29.23	12.96
Total	213		

F-Ratio= 2.50, F-Probability .06

Empathy was found not to differ by sex match at the p=.05 level (F-ratio .8580; F probability .464). Satisfaction did not differ by sex match at (F ratio .564; F probability .639). The perception of therapist as knowledgeable did not differ by sex match (F-ratio 1.238; F-probability .296). Finally, the perception of the therapist as not knowledgeable about more lesbian, gay, and bisexual issues did not differ by sex match, (F-ratio 2.45; F probability .06); nor was the perception of the therapist as less knowledgeable about gay, lesbian, bisexual issues related to sex match (F -ratio .564; F-probability .6394).

Sexual Orientation of Therapist and Perceived Empathy, Knowledge, and Treatment Satisfaction

In addition to the finding that gay, lesbian, bisexual therapists were perceived as significantly less biased than heterosexual therapists and than those therapists whose sexual orientation was unknown, significant group differences were found between gay, lesbian, bisexual and heterosexual therapists, and those therapists with unknown sexual orientations on the measures of empathy, knowledge, and satisfaction.

Table 5-18

One-way analysis of variance: Sexual orientation of Therapist x Perceived Therapist Empathy

Group 1	Group 2	Group 3		
Gay, lesbian, bisexual therapists	Heterosexual therapists	Therapists with unknown sexual orientation	F Ratio	Group Differences
43.90	37.11	35.07	7.19***	1>2, 1>3

p=<.05 significance level

Gay, lesbian, bisexual therapists were perceived to be significantly more empathic than heterosexual therapists and those therapists whose sexual orientation was not known.

Table 5-19

One-way analysis of variance: Sexual Orientation of Therapist x Satisfaction

Group 1	Group 2	Group 3		
Gay, lesbian, bisexual therapists	Heterosexual therapists	Therapists with unknown sexual orientations	F-ratio	Group Differences
2.11	-.34	-2.42	9.50***	1>3, 1>2

p=<.05 significance level

Respondents were significantly more satisfied with their therapist and therapy experiences when their therapist was gay, lesbian, or bisexual.

Table 5-20

One-way analysis of variance: Sexual Orientation of Therapist x Not Knowledge

Group 1	Group 2	Group 3		
Gay, lesbian, bisexual therapists	Heterosexual therapists	Therapists with unknown sexual orientations	F-ratio	Group Differences
.31	3.50	4.48	16.75***	1>2, 1>3

p=<.05 significance level

Table 5-21

One-way analysis of variance: Sexual Orientation of Therapist x Knowledge

Group 1	Group 2	Group 3		
Gay, lesbian, bisexual therapists	Heterosexual therapists	Therapists with unknown sexual orientations	F-ratio	Group Differences
19.49	8.03	6.30	89.08***	1>3, 1>2

p=<.05 significance level

Gay, lesbian, bisexual therapists were perceived to be more knowledgeable, and to have fewer areas of no knowledge on issues related to gay men, lesbians, and bisexuals.

Therapist Awareness of Respondent's Sexual Orientation

The time at which a therapist became aware of the client's gay, lesbian, or bisexual orientation, or same-gender feelings was examined as it was associated with perceived heterosexual bias.

As Table 5-22 demonstrates, the sooner that a therapist was aware of respondents' gay, lesbian, bisexual identity, or the respondents' same sex attractions, feelings, or behavior, the less bias was perceived by the client.

Table 5-22

One-way analysis of variance: Time at which Therapist Aware of Sexual Orientation of Respondent x HBI

Source	D.F	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	3	5832.926	1944.309	12.495	.0001
Within groups	208	32366.83	155.610		
Total	211	38199.75			

	Means	Group Differences
Group 1-first or second session	26.15	
Group 2-between sessions 3-10	31.94	
Group 3-after session 10	33.72	3>1
Group 4-therapist was never aware	48.57	4>1, 4>2, 4>3

Perceived Heterosexual Bias of Psychiatrists, Psychologists, Social Workers and Counselors

Differences were examined in the perceived heterosexual bias of psychiatrists, psychologists, social workers, and counselors, as reported by gay, lesbian, bisexual clients. As Table 5-23 indicates, psychiatrists were found to be perceived as significantly more biased than social workers, psychologists, and counselors.

Table 5-23

One-way analysis of variance: Social workers, Psychologists, Psychiatrists, and other Counselors x HBI

Source	D.F.	Sum of Squares	Mean Squares	F Ratio	F Prob.
Between groups	3	2484.6	828.18	4.975	.002
Within groups	186	30965.7	166.48		
Total	189	33450.3			

	Freqs.		Means	Group Differences
Group 1	74	Social workers	26.81	
Group 2	66	Psychologists	26.90	
Group 3	24	Psychiatrists	37.75	3>1, 3>2, 3>4
Group 4	26	Counselors	26.93	
Total	190			

Demographic Variables by Source of Questionnaire

Differences were examined between those respondents who found out about the survey through a gay pride march, through a lesbian, gay, or bisexual organization, or through some other source (i.e. through a friend, current therapist, flyer, or other). One-way analyses of variance and Chi-Square analyses were conducted to examine differences on demographic variables by source. No differences between the three groups were found in respondent age, education, income, comfort with sexual orientation, gender, previous psychiatric hospitalizations, previous suicide attempts,

whether the respondent was a professional therapist, or whether the respondent was gay, lesbian, or bisexual. Differences were found on two variables, use of medications for psychiatric reasons, and a summary score of how currently "out" the respondent reported to be. In a Chi-Square analysis comparing the three groups, those who acquired the survey through a gay pride march were significantly more likely to currently use medication for psychiatric reasons (Chi-Square 6.99; Significance .03). In a one-way analysis of variance comparing the three groups, those who found out about the survey through a gay pride march were significantly more "out" to family, friends, and co-workers (F Ratio 3.71; F Prob .03). When analyses were conducted on two groups (those who found out about the survey through a gay pride march and all others) the similar results were found.

Prevalence of Bias on HBI

The frequencies of the responses for each of the 15 items in the HBI were examined. Items are listed below by number, in order from most perceived bias to least perceived bias. By each item the percentage of respondents who strongly or somewhat agreed or disagreed with the statement is reported.

1. "I felt satisfied with how much my therapist inquired about my sexual orientation" (42% disagreed)

6. "I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized" (37% agreed)

15. "My therapist helped me to feel good about my sexual orientation" (35%

disagreed)

21. "I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client" (33% disagreed)

30. "My therapist was interested in understanding what my sexuality meant to me" (34% disagreed)

2. "There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay, or bisexual" (31% agreed)

39. "My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person" (30% disagreed)

12. In my therapy, I felt welcomed to talk about my sexuality" (27% disagreed)

40. "My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself" (27% disagreed)

7. "My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality" (27% agreed)

36. "My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person" (24% disagreed)

38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex" (19% agreed)

38. "My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex" (19% agreed)

36. "My therapist discouraged me from being lesbian, gay, or bisexual" (16% agreed)

11. "My therapist made me feel worse about my same sex attractions, fantasies, or behavior that I felt when I entered therapy" (13% agreed)

Subtle forms of bias were perceived more frequently than blatant forms of bias. For example, lack of therapist inquiry about sexuality, and a perception that the therapist was less accepting than she or he realized were the most common forms of perceived bias. The perception that the therapist believed in one of several pathological views of the etiology of homosexuality, and made the respondent feel worse than when they entered therapy were least common. (See Table 5-24 for complete response frequencies of the HBI items).

Table 5-24

Percentages of Responses on the 43 Bias Items

1=strongly agree 2=somewhat agree 3=somewhat disagree 4=strongly agree

	1	2	3	4	N/A	MS	Mean	SD
1. I felt satisfied with the questions my therapist asked me about me sexuality.	37%	26%	22%	13%	2%	---	2.11	1.06
2. There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay or bisexual.	17%	14%	9%	58%	15%	.5%	1.91	1.20
6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized.	19%	18%	10%	50%	3%	___	2.05	1.22
11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.	6%	7%	11%	71%	5%	___	1.45	.88
12. In my therapy, I felt welcomed to talk about my sexuality.	54%	19%	14%	13%	--	--	3.09	1.20
14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.	5%	12%	8%	72%	3%	.5%	1.48	.91
7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality. *	12%	15%	8%	61%	4%	.5%	1.77	1.12

(table continues)

Table 5-24 (continued)
Percentages of Responses on the 43 Bias Items

	1	2	3	4	N/A	MS	Mean	S.D.
21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.	47%	18%	17%	16%	1%	--	2.02	1.15
30. My therapist was interested in understanding what my sexuality meant to me.	38%	27%	18%	16%	1%	.5%	2.13	1.10
32. My therapist discouraged me from being lesbian, gay, or bisexual.	7%	9%	10%	72%	2%	1%	1.49	.92
36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.	50%	24%	14%	10%	2%	.5%	1.85	1.03
38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex.	5%	14%	12%	62%	6%	1%	1.59	.94
39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.	34%	28%	15%	15%	8%	.5%	2.11	1.09
15. My therapist helped me to feel good about my sexual orientation.	35%	23%	18%	17%	8%	--	2.19	1.14
40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.	34%	34%	11%	16%	6%	5%	2.08	1.06

Summary of Results

Instrumentation Findings

The perception of heterosexual bias in psychotherapy as measured by the HBI was found to be significantly correlated with the perception of empathy ($r=-.78$; $p<.001$), as measured by the Revised Barrett-Lennard Empathy Measure. Greater perceived heterosexual bias was correlated with less perceived therapist empathy. However, despite the significant correlation between the variables, there were variables that were found to be correlated significantly with heterosexual bias that were not correlated with empathy. Variables related to the sexual orientation of the respondent were significantly associated with perceived bias but not with perceived empathy.

The perception of heterosexual bias in psychotherapy as measured by the HBI was found to be significantly correlated with satisfaction with treatment ($r=-80$; $p<.001$). Greater perceived heterosexual bias was associated with less overall satisfaction with treatment. Despite the significant correlation between satisfaction and the HBI, there were variables that were found to be differentially associated with each, suggesting their unique properties. Again, the Heterosexual Bias Inventory was found to be correlated with variables that concerned the respondent's sexual orientation, whereas the satisfaction measure was for the most part not correlated with these variables.

Greater perceived heterosexual bias in psychotherapy was found to be

significantly correlated with a perception of less therapist knowledge of lesbian, gay, bisexual issues. Heterosexual bias was correlated with perceived knowledge indicated by a Pearson correlation coefficient of r=-.72, and with a lack of knowledge indicated by a Pearson correlation coefficient of r =.78. Perceived heterosexual bias was additionally found to be distinct from perceived therapist knowledge and lack of therapist knowledge. Respondents' homosexual orientation was associated with the perception of heterosexual bias but not with the perception of therapist knowledge.

Client Sexual Orientation

and the Perception of Heterosexual Bias

Currently identified bisexual respondents were found to perceive significantly more heterosexual bias than currently identified lesbians, but not significantly more bias than currently identified gay men. No differences were found between bisexuals (at the time they saw their therapist) and lesbians and gay men (at the time they saw their therapist). Respondents who didn't identify with a sexual orientation label or who identified as heterosexual at the time they first saw their therapist, reported significantly more bias than those who identified as gay men, lesbians, or bisexuals at the time they saw their therapist.

No differences were found between the perceptions of heterosexual bias as reported by currently identified gay men and lesbians, and between those who identified as gay or lesbian at the time they saw their therapist.

Findings Related to Therapist Variables

Gay, lesbian, bisexual therapists were perceived as less biased than heterosexual therapists, and less biased than those therapists whose sexual orientations were unknown. Therapists with known sexual orientations (regardless of whether they were lesbian, gay, bisexual, or heterosexual) were perceived as less biased by their lesbian, gay, or bisexual clients than those therapists whose sexual orientation was not known. Psychiatrists were seen as more biased than other mental health professionals.

Major Predictors of Heterosexual Bias

The characteristics of the client which were found to be the greatest predictors of heterosexual bias were less exclusive current homosexuality and less comfort with one's sexual orientation at the time the client saw his or her therapist. The characteristics of the therapist that were found to be the greatest predictors of heterosexual bias were therapists' lack of knowledge of lesbian, gay, bisexual issues. The characteristics of the therapy experience that were found to be the greatest predictors of bias were less focus on gay, lesbian, bisexual issues and less likelihood that the respondent presented with relationship difficulties. Over and above what these characteristics predicted, the perception of less therapist empathy and less client satisfaction with treatment predicted even more of the variance.

Conclusion

The results of this study highlight the importance of therapist knowledge and therapist self-disclosure in working with lesbian, gay, and bisexual clients. Knowledge was found to be the single greatest therapist predictor of perceived heterosexual bias. The findings suggest that it is not enough to be empathic with lesbian, gay, and bisexual clients, but that the therapist needs to be knowledgeable about gay, lesbian, bisexual issues. The results challenge a tendency to universalize the helping capabilities of professional therapists.

The findings additionally point to the need for therapists' increased understanding and acceptance of the complexity of sexual orientation. Clients who did not identify with a sexual orientation label perceived significantly more bias than other groups. Additionally, for clients, a less exclusive homosexual orientation and greater conflict about sexual orientation was the greatest predictor of bias. Some of the differences may be accounted for by client projection or transference. However, knowing the lack of training that most therapists receive in the area of sexuality and sexual orientation, it appears highly likely that some of this perceived bias reflects actual therapist bias, ignorance, and inexperience with the concerns of those individuals struggling with sexual orientation issues.

CHAPTER SIX

DISCUSSION

In this chapter the development of the instrument is summarized and implications of the sample characteristics and findings are discussed. Following is a consideration of limitations of the study, and implications for practice, training, and future research.

Summary of the Study

The major purpose of this study was to develop a valid and reliable instrument to measure gay, lesbian, and bisexual clients' perceptions of heterosexual bias in psychotherapy. A secondary purpose was to utilize this instrument to test hypotheses concerning the correlates of, predictors of, and group differences in the perception of heterosexual bias.

Summary of Development of the Instrument

The procedures used to develop the Heterosexual Bias Inventory (HBI) included initial generation of 43 bias items developed from a review of the literature. The primary source for the development of these items was a study conducted by the American Psychological Association Committee on Lesbian and Gay Concerns (1991). Two hundred and thirteen subjects responded to the 43 bias items using a four point Likert scale. Forty-one respondents completed the instrument twice for repeat reliability purposes.

A factor analysis of the bias items demonstrated that the construct of heterosexual bias was best represented by a single measure. Using multiple criteria, the 43 bias items were reduced to a set of 15 items which comprised the Heterosexual Bias

Inventory (HBI). The Heterosexual Bias Inventory reflected five bias themes including: 1) therapist lack of recognition of the impact of societal discrimination on gay men, lesbians, and bisexuals; 2) therapist belief in the pathological etiology of homosexuality; 3) therapist belief that homosexuality is indicative of pathology; 4) therapist lack of acceptance of clients' homosexuality; and, 5) subtle forms of bias exhibited by therapist (i.e., lack of, or unsatisfactory inquiry about sexuality, and devaluing or marginalizing of gay, lesbian, and bisexual experiences).

Reliability and Validity of the Instrument

The Heterosexual Bias Inventory was found to be a reliable and internally consistent measure. Cronbach's coefficient alpha, a measure of internal consistency, was found to be .9672, indicating a high degree of internal consistency. The repeat reliability score, indicated by a Pearson r correlation coefficient, was also found to be extremely high ($r=.983$, $p>.0001$). The high internal consistency and repeat reliability of the HBI may be partially explained by both the high intercorrelations among the items and the length of the measure. Because of the high intercorrelations of the items, a shortened version of the measure might have been adequate for reliability purposes, though with fewer items the range of conceptual areas of interest would not have been explored.

Content validity was established through the generation of items from areas of bias identified by the American Psychological Association Committee on Lesbian and Gay Concerns (1991). The reliance on those bias themes generated by the APA study is clearly an improvement over past research in which researchers have simply

generated items without the use of past empirical findings. Content validity was further determined through the use of expert judges.

Construct validity of the HBI was determined by testing theory that suggested that perceived heterosexual bias would be significantly correlated with other related constructs. Initial construct validity of the HBI was supported through the findings that the perception of heterosexual bias was significantly correlated with perceived therapist empathy (-.783, $p < .0001$ one-tailed), client satisfaction with therapy (-.796, $p < .0001$, one-tailed) and perceived therapist knowledge of gay, lesbian, and bisexual issues (-.724, $p < .0001$, one-tailed). Construct validity was further evidenced by the discriminatory power of the items (e.g., there was good variability in response spreads).

External Validity

To address external validity, recruitment procedures targeted a heterogeneous gay, lesbian, and bisexual population. Geographically the sample respondents were diverse, representing 26 states, primarily from New England, the Mid-Atlantic, and the Midwestern region of the United States. The sample was additionally varied in terms of age, income, religion, and religiosity. The sample, however, was homogeneous in terms of both race (91% caucasian) and highest educational attainment (51% had completed a graduate degree). A large proportion of the respondents were professionally trained as psychotherapists or counselors (37%). The study included more lesbians (52%, N=112) than gay men (34%, N=73), and the bisexuals sampled (12%, N=26) were primarily bisexual women (N=24).

Over a quarter of the sample (28%) was recruited through gay pride marches. About two thirds (64%) of the respondents saw their therapist (the therapist described in the study) for an extended period of time (27-100+ sessions), and the large majority of respondents saw their therapist in private practice (73%).

Implications of the Sample Characteristics

Because over a quarter of the respondents were recruited through gay pride marches, group differences were examined between those respondents who found out about the survey through a gay pride march and those who found out through another source. One-way analyses of variance and Chi-square analyses indicated few significant differences on demographic variables between these groups. One significant difference, however, was that respondents who found out about the survey through a gay pride march reported that they were currently more "out" to friends, family and co-workers (F Ratio 3.71; F Probability $< .03$).

Another significant difference was that respondents who found out about the survey through a gay pride march were significantly more likely to be taking medication for a psychiatric condition ($p < .03$). However, these same individuals were not significantly more likely to have been hospitalized for psychiatric reasons, were not more likely to have made a suicide attempt, had not seen more therapists over the past ten years, and did not report more conflict with their sexual orientation. Therefore, it does not appear that they had more overall psychiatric or adjustment difficulties. Additionally, the variable of current medication use was not found to be significantly correlated with perceived heterosexual bias.

A large proportion of the respondents were themselves counselors or therapists (36%). This was most likely due to the recruitment efforts within a school for social work and within professional gay, lesbian, and bisexual therapist organizations. The large proportion of the sample who were counselors or therapists themselves may have impacted the results of the study in a variety of ways. It may be that therapist respondents were less likely to see a biased therapist and therefore that they reported less bias. On the other hand, it may be that therapist respondents were more likely to perceive heterosexual bias in their psychotherapy experiences, due to their sensitivity and psychological sophistication as therapists themselves.

There were significantly more lesbians (112) in the sample than gay men (73), which may reflect the finding that women seek therapy at higher rates than men (Chesler, 1972). Lesbians may also be more likely to respond to and participate in a study conducted by a woman researcher. The large majority of the bisexuals were women, therefore results cannot be generalized to bisexual men. Greater numbers of bisexual women as compared to bisexual men in the sample may also be related to women's greater representation in psychotherapy. However, it may also be due to the more extensive recruitment efforts made in the women's community, or other factors related to differences between bisexual men and women.

Ethnic minorities were under-represented in the sample. Recruitment methods may have been more likely to reach gay, lesbian, and bisexual persons who were more open about their sexual identities, due to reliance on public events and community organizations. The multiple sources of oppression faced by minority

group members may leave them less open about their sexual identities and consequently less apt to respond to a survey. Greater attention is needed regarding the recruitment of gay, lesbian, and bisexual minority group subjects in order to better understand how the results of this study relate to other than caucasian individuals.

The high educational level of subjects in this study may be due to sampling bias resulting from the recruitment of subjects through professional associations and networks of highly educated individuals. The finding may also reflect the high educational level of psychotherapy clients who are seen in private practice, where the majority of subjects in this study were seen (73%). However, high education level of the subjects was not indicative of their high socio-economic status. Subjects reported a wide spread of household income, with 39% of the sample reporting a moderate income of less than $30,000 a year.

The large proportion of the respondents who saw their therapist in a private practice setting may suggest that respondents personally chose their therapist as opposed to having been assigned a therapist in a clinic setting. It may be that choosing one's therapist is related to less perceived bias. The finding that almost two-thirds (63%) of the respondents saw their therapist for between 27-100 sessions suggests that respondents had sufficient time working with their therapist to enable them to evaluate their therapy experience for perceived heterosexual bias.

It is important to recognize that the results of this study cannot be generalized beyond the sample characteristics. A random sample of lesbian, gay, and bisexual

clients, however, may be impossible to recruit both considering the stigma associated with being gay, lesbian, and bisexual (Bell & Weinberg, 1978) and due to the confidentiality required in the service of psychotherapy. Therefore, it is not possible to know how representative this sample is of the general population.

In the next section, each hypothesis will be addressed and the implications of the findings will be examined. First, the implications of findings related to the validity of the HBI will be reviewed. Next the implications of the findings addressing research questions will be explored.

Findings Related to the Construct Validity of the HBI

Finding 1: A negative association between the perception of therapist empathy and the perception of heterosexual bias as reported by gay, lesbian, and bisexual clients was found to be significant (Pearson correlation, -.78, $p > .0001$).

Because one of the elements of heterosexual bias in psychotherapy has been described in the literature to be related to the extent to which a gay, lesbian, or bisexual client feels accepted by, attuned to, and understood by their therapist, it was predicted that perceived therapist empathy and perceived heterosexual bias would be significantly negatively associated. In addition, several items in the HBI were directly related to perceived therapist empathy specifically with gay, lesbian, and bisexual clients. These items included the following: "My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person", "My therapist was interested in understanding what my sexuality meant to me", and "There were subtle things about the way my therapist responded to me that made me feel that she or he was <u>not</u>

supportive of my being lesbian, gay, or bisexual". The significant negative correlation of the HBI with the Revised Barrett Lennard Empathy measure, a well validated instrument, provides a good construct validity indicator.

The perception of empathy and the perception of heterosexual bias, although similar, were found to be distinct in some ways. Through an examination of a correlation matrix many variables were found to be significantly associated with both empathy and heterosexual bias, yet there were some variables that were significantly correlated with heterosexual bias but not significantly correlated with empathy. The variables were primarily those concerned with the sexual orientation of the respondent. These variables included: whether the respondent was gay, lesbian, or bisexual; respondent comfort with his or her sexual orientation; and the respondent's less exclusive homosexual orientation. Therefore it appears that the perception of heterosexual bias, but not the perception of empathy, is impacted by sexual orientation differences of respondents. This provides further confirmation of the need for the establishment of a heterosexual bias measure, as the empathy measure is not sensitive to differences in the sexual orientation of respondents. The high correlation between perceived empathy and perceived heterosexual bias, however, warrants further investigation to distinguish between the two variables.

supportive of my being lesbian, gay, or bisexual". The significant negative correlation of the HBI with the Revised Barrett Lennard Empathy measure, a well validated instrument, provides a good construct validity indicator.

The perception of empathy and the perception of heterosexual bias, although similar, were found to be distinct in some ways. Through an examination of a correlation matrix many variables were found to be significantly associated with both empathy and heterosexual bias, yet there were some variables that were significantly correlated with heterosexual bias but not significantly correlated with empathy. The variables were primarily those concerned with the sexual orientation of the respondent. These variables included: whether the respondent was gay, lesbian, or bisexual; respondent comfort with his or her sexual orientation; and the respondent's less exclusive homosexual orientation. Therefore it appears that the perception of heterosexual bias, but not the perception of empathy, is impacted by sexual orientation differences of respondents. This provides further confirmation of the need for the establishment of a heterosexual bias measure, as the empathy measure is not sensitive to differences in the sexual orientation of respondents. The high correlation between perceived empathy and perceived heterosexual bias, however, warrants further investigation to distinguish between the two variables.

Through an examination of a correlation matrix, satisfaction was found to be somewhat distinct from the perception of heterosexual bias. Similar to the relationship between perceived empathy and perceived heterosexual bias, those variables concerning the sexual orientation of the respondent were not significantly correlated with satisfaction, but were significantly correlated with perceived heterosexual bias. This finding further indicates the need for a measure of heterosexual bias that is sensitive to differences in the sexual orientation of the respondent.

Table 6-2

Correlation of Variables with Satisfaction and Heterosexual Bias

	SATISFACTION	HBI
R was g/l/b at time they saw therapist	NS	**
R was more conflicted re: sexual orient.	NS	**
R was bisexual currently	NS	*
R was less exclusively homosexual	NS	*
R less likely to present w/relat. diff.	NS	*

*p=<.05
**p=<.01
R=respondent

Finding 3: Greater perceived heterosexual bias was found to be associated with less perceived therapist knowledge (.72, one-tailed $p < .001$) and a perception that the

therapist was not at all knowledgeable in more areas (.78, one-tailed $p < .001$).

Many authors have suggested that it is the lack of therapist knowledge that is particularly salient in understanding both the ineffective treatment of lesbians, gay men, and bisexuals, and the dissatisfaction of lesbian, gay, and bisexual clients. Therefore, it was hypothesized that greater perceived heterosexual bias would be related to less perceived therapist knowledge. One explanation for the findings is that the perception that a therapist is not knowledgeable may lead to the perception that the therapist is not expert and competent, and it may be this perceived lack of expertise that links a lack of perceived knowledge to a perception of bias.

Clients may perceive their therapists to lack knowledge for many reasons. First, a therapist may actually lack knowledge about lesbian, gay, or bisexual issues, and the client may be able to detect this lack of knowledge. Second, a lack of knowledge may be perceived due to the therapist's theoretical orientation and subsequent treatment style. For example, it may be that some therapists do not believe that it is useful to directly impart information to their clients (sharing resources, etc.). Finally, clients' perceptions that their therapists lack knowledge may reflect clients' distortion resulting from projection or transference.

This finding provides support for the construct validity of the HBI measure. The perception of therapist knowledge was found, however, to be distinct from the perception of heterosexual bias, as many variables were associated with each differently. Therefore the finding supports the need for the development of a separate instrument measuring heterosexual bias.

Table 6-3

Correlation of Variables with Knowledge and Heterosexual Bias

Variable	Knowledge	HBI
R was more out to family, friends, co-workers	*	NS
R had past psychiatric hospitalizations	NS	**
R was bisexual currently	NS	*
R was less exclusively homosexual	NS	*
R less likely to present w/relat. diff.	NS	*
R was currently seeing therapist	NS	**

*p=<.05

**p=<.01

R=respondent

Implications of Validity Findings

The measure of perceived heterosexual bias was found to be related to other measures as hypothesized. Greater perceived bias was significantly correlated with less perceived empathy, less client satisfaction, and less perceived therapist knowledge. The high correlations between perceived bias and these variables however, may be partially due to the way that the data were gathered (i.e., measures were self-report and were administered at the same time). DeVillis (1991) has suggested that "...because of procedural similarities, data of one type...may be correlated to a degree with other data gathered in the same way; that is, some of the

covariation between two variables may be due to measurement similarity rather than construct validity" (p. 48). The use of other methods of measurement would be valuable to further demonstrate the construct validity of the HBI. For example, assessing the constructs by additional methods (i.e., using outside observers or an interview format) would allow for the possibility of comparing the results obtained by different means of measurement. Furthermore, longitudinal studies would be useful in order to determine the effect of completing the measures at different times. It may be that clients differentially perceive bias, empathy, satisfaction, or knowledge based on when they complete the measure. Construct validity of the HBI could be further established by examining the relationship between perceived heterosexual bias and other constructs where a non-significant correlation was hypothesized, thereby establishing discriminant validity.

Group Differences Findings

Finding 4a: Heterosexual therapists were found to be perceived as significantly more biased than gay, lesbian, or bisexual therapists, as measured by the HBI.

This finding is supported by clinical writing and research that indicates that gay and lesbian clients are more satisfied with gay and lesbian therapists (Gartrell, 1981; Malyon, 1982; Riddle & Sang, 1978; Rochlin, 1982; Woodman & Lenna, 1980). The results are also supported by literature that suggests that therapist characteristics have a significant impact on the effectiveness of treatment.

Psychotherapy outcome research has demonstrated that greater client-therapist similarity on various attributes is associated with better outcome. Luborsky et al.

(1988) reported that, in 20 of 29 studies, client-therapist similarity was significantly associated with better outcome. Smith and Glass (1977), in their meta-analysis of 50 studies, found that the largest correlations with successful treatment outcome were the similarity of therapists and clients, $r = .19$, $p < .01$. One explanation for this finding is that similarities foster close relationships. Luborsky et al. (1988) has suggested that

> The presence of similarities furthers the formation of a helping relationship because the patient and the therapist can see each other as having a shared background, as being alike, and thus as able to understand each other. In turn, the better relationship that forms helps the patient achieve the goals through the treatment. (p. 297)

Preliminary past research has suggested that therapist/client similarity on the variable of sexual orientation leads to more successful outcomes (Liljestrand, Gerling, & Saliba, 1978). Client-therapist similarity may be particularly important for gay, lesbian, and bisexual clients. Clients who are gay, lesbian, and bisexual may have a greater need to feel understood and accepted. There may be critical elements of the gay, lesbian, bisexual experience (isolation and marginalization, religious and legal oppression) that are perceived to be better understood by gay, lesbian, or bisexual therapists.

Heterosexual therapists may be perceived as more biased partially because they are perceived to be less knowledgeable and less empathic than gay, lesbian, and bisexual therapists. It may also be that heterosexual therapists have less experience working with lesbian, gay, bisexual clients, and that this actual lack of experience leads clients to view them as more biased. It is important to note that the sexual

orientations of the therapists were determined in this study using client reports, and may not be completely accurate. However, most respondents learned of their therapists' sexual orientation directly, lending credibility to their reports.

Despite the significance of the sexual orientation of the therapist, it is interesting to note that in the multiple regression analysis the variable of perceived therapist knowledge remained in the final equation as a predictor, whereas the variable of therapist sexual orientation was removed. This might suggest that whereas clients' perceptions of the sexual orientation of therapists is an important variable, their perception of therapists' lack knowledge may well be the more salient feature.

Finding 4b: Those therapists whose sexual orientation was not known by the respondent were perceived as significantly more biased than those therapists whose sexual orientation was known, regardless of the sexual orientation of the therapist.

Clients' knowledge of the sexual orientation of the therapist, whether it is homosexual, bisexual, or heterosexual, may increase their perception of safety within the therapeutic relationship. For example, when a therapist discloses his or her homosexuality or bisexuality, the gay, lesbian, or bisexual client is able to benefit from working with a therapist who is openly similar to him or herself on an important variable. With this information, the client may then evaluate, question, and recognize the strengths and potential limitations of the therapist.

"Coming out" to clients as a gay, lesbian, or bisexual therapist brings the issue of self disclosure of sexual orientation to the fore. Self disclosure is generally an

important issue for gay men, lesbians, and bisexuals, who frequently deal with problems related to societal invisibility, being "closeted," and "passing" for heterosexual (Cohen & Stein, 1986). Within this context, being "out" to clients as a gay, lesbian, or bisexual therapist takes on greater significance than perhaps other therapist disclosures and may well impact a client's perception of a therapist more profoundly.

Another explanation for this finding is that clients' knowledge of therapists' sexual orientation may be related to clients' greater knowledge of their therapists' values in general. It may be that therapists who are open about their sexual orientation with their clients are more open with their clients about other areas of their lives. Therefore, greater therapist self-disclosure in and of itself may reduce a client's perception of therapist heterosexual bias. In addition, therapists who disclose their sexual orientation may be distinctly different in their theoretical orientation and therefore their use of self in treatment, and this may directly or indirectly affect client perceptions of bias. Therapists who disclose their sexual orientation may generally be more sensitive to similarities and differences between themselves and their clients, and this greater attunement may account for the perception of less bias.

Therapists whose sexual orientation is unknown to their clients may also be more likely to be heterosexual. If heterosexual therapists are perceived to be more biased, it would then follow that therapists with unknown orientations would be more likely to be perceived as more biased. Finally, it may be that therapists who do not disclose their sexual orientation are perceived to be less comfortable with their sexual

orientation. For example, several respondents mentioned that their therapists who "came out" as gay, lesbian, or bisexual, served as role models which immediately enhanced trust and a sense of safety in the therapy relationship. Similarly, when therapists disclosed their heterosexuality, some clients felt that their therapists were not afraid of acknowledging differences, leaving the client with a further sense of confidence in the therapist's ability to acknowledge what they did not know about being gay, lesbian, or bisexual.

Finding 5: No significant differences were found between lesbian and gay clients' perceptions of heterosexual bias in psychotherapy.

This finding suggests that heterosexual bias in psychotherapy with gay men and lesbians is related less to the client's gender than to their non-heterosexual orientation. It may be that the common experience of societal oppression is so pervasive for gay men and lesbians that it overrides gender differences such that gay men and lesbians perceive heterosexual bias similarly. This idea is supported by the existence of societal prejudice that fuels heterosexual bias in the psychotherapy of both lesbians and gay men.

Past research examining gender differences in psychotherapy has been inconclusive (Orlinsky & Howard, 1976). One would expect that differences between the perceptions of lesbians and gay men would follow a similar pattern of results as those between men and women. However, it may be that lesbians perceive more bias considering the double stigma that they face both as women, and then as lesbians.

No differences between lesbians and gay men might have been found partly due

to the lack of sensitivity of the HBI measure to gender differences. Differences might have been found if the measure was designed more specifically to examine differences between the perceptions of lesbians and gay men. Finally, no differences may have been found because of characteristics unique to this sample, or due to the uneven distribution of lesbians and gay men in the study. Differences between the perceptions of lesbians and gay men need further exploration.

Finding 6: Current bisexuals were found to perceive significantly more heterosexual bias in psychotherapy than current lesbians as measured by the HBI. Current bisexuals did not report significantly more bias than gay men. No differences were found between respondents who reported that they were bisexual at the time they saw their therapist, as compared to those who were gay or lesbian at the time.

Considering that 26 of the 28 current bisexuals were bisexual women, the significant differences more accurately reflect differences between lesbians and bisexual women. The fact that differences were not found between those respondents who identified as bisexual and those who identified as gay and lesbian at the time they saw their therapists can be explained by the fact that many of the current bisexuals were the same individuals who did not identify with a sexual orientation label at the time they saw their therapist. Differences were found on the HBI between those respondents who did not identify with a sexual orientation label, or identified as heterosexual at the time they first saw their therapist, and those who were gay and lesbian. Of the 28 current bisexuals, 9 did not identify with a sexual orientation label at the time they saw their therapist, and 5 identified as heterosexual at that time.

Greater heterosexual bias perceived by current bisexuals as compared with current lesbians supports the idea that bisexuals are a unique group, and need to be investigated separately. The findings may reflect the notion that therapists might be more at ease or more proficient when working with clients who can be categorized as being at either end of a heterosexuality-to-homosexuality continuum. The subtleties required to address less dichotomous experiences of sexuality might challenge the skill or comfort levels of psychotherapists, resulting in bisexual client perceptions of greater bias. For heterosexual therapists, the client who acknowledges a range of same and opposite sex feelings and attractions may challenge therapists' more rigid definitions of sexual orientation. For gay or lesbian therapists, clients who are not exclusively homosexual may be threatening to their own sense of personal and group identity. Gay, lesbian, or bisexual therapists might overly identify with clients, thus making it difficult for the therapist to adequately differentiate his or her own "coming out" process from that of the client. In this way, therapists who are out as gay or lesbian might view bisexual clients as fleeing a lesbian or gay identity. Whether therapists are gay, lesbian, or heterosexual, the greater experience of perceived bias by less exclusively homosexual clients might simply be related to the way in which less competent therapists address ambiguity in their clients' lives generally. Finally, it is not known whether a larger sample of bisexuals and one that included a more equal distribution of bisexual men and bisexual women would have yielded different findings.

Finding 7: Characteristics of the respondents, characteristics of the therapists, and

characteristics of the therapy experience were found to correlate significantly with perceived heterosexual bias and each were found to be unique predictors of heterosexual bias. This was an exploratory hypothesis developed to test a theoretical model which proposed that subjective characteristics of the client, therapist, and treatment would predict heterosexual bias over and above more objective characteristics. To test the model, a hierarchical regression model was used. Characteristics of each category were regressed separately, and those variables which survived as unique predictors were regressed together in a final model. This hypothesis was based on past psychotherapy research which has suggested that therapist and client demographic variables are less important than therapeutic relationship characteristics in predicting successful treatment outcome.

Implications of Significant Correlates of Bias

A correlation matrix was examined to determine the significant correlations among the independent variables and to examine the correlations between the independent variables and the dependent variable, the HBI. Due to the exploratory nature of the analysis and in order to prevent over inflation of significant results, the bivariate correlations were reported using two-tailed probability levels. This provides a more conservative approach to reporting results when there is not a theoretical basis for each comparison, thereby reducing the risk of Type I error. In an area where little is known, the examination of large numbers of potential correlates provides important preliminary data regarding associations between variables of interest. Significant correlates of heterosexual bias that were of interest and did not remain as

predictors in the final regression model will each be discussed in the following section. Those correlates that remained in the final regression model will be examined in the subsequent section.

Respondent Characteristics Correlated with Bias

General background variables of the respondent (sex, age, race, education, professional status as a therapist, income, religion, importance of religion or spirituality, attendance of religious services, and whether the respondent found out about this study through a Gay Pride March) were not found to be significantly associated with the perception of heterosexual bias. Characteristics of the respondents that were found to be significantly associated with the perception of bias were variables concerning respondents' psychiatric and therapy history, and respondents' sexual orientation.

Past psychiatric hospitalization was found to be associated with greater perceived heterosexual bias ($p < .001$). This may indicate that respondents with more serious pathology perceived greater heterosexual bias. It may also be that the respondent's past biased treatment may have more often occurred as the result of prior psychiatric treatment. Individuals who have been hospitalized may be generally more stigmatized, and therefore may be more sensitive to other stigma such as heterosexual bias in psychotherapy. Psychiatric patients may in fact elicit more biased reactions, or subjectively, regardless of what the therapist does, those with more psychopathology may feel more judged and be more sensitive to the judgement. Finally, it may be that therapists are less supportive of clients' choices (i.e. their

homosexuality) when the clients are functioning less well in their lives.

Having seen more therapists during the past 10 years was found to be significantly associated with greater perceived heterosexual bias ($p < .001$). This may be the result of several possible factors. Seeing more therapists may enable clients to be able to detect heterosexual bias when it occurs, as they have seen more different therapeutic styles and are better able to identify problematic therapists. In addition, if a client sees more therapists, statistically he or she may be more likely to see a biased therapist. Furthermore, clients who see more therapists may be more likely to see negative aspects of their therapists and therefore terminate and find new therapists. On the other hand, they may believe more in the effectiveness of therapy (having sought it on several occasions) and may expect more from therapy, thus increasing their sensitivity to shortcomings in their therapists.

Respondents who were less likely to have identified as gay, lesbian, or bisexual at the time they saw their therapist perceived more bias ($p < .001$). These respondents included those who identified as heterosexual and those who did not label their sexual orientation at all. This finding may be due to the clients' presentation of a more ambiguous and complex picture, or it may be due to a projection of their conflicts onto their therapists. Not identifying oneself, however, was not found to be significantly correlated with greater conflict with one's sexual orientation.

Those respondents who were less "out" to family members, friends, and co-workers currently and at the time they saw their therapist perceived significantly more bias ($p < .05$). Being less "out" has been found to be associated with lower self-

esteem and less self acceptance, and it may be that these variables are related to perceived bias.

The variables addressing respondents' degree of current homosexuality in terms of behavior, feelings/fantasies, and self identification, and the extent of their conflict or comfort with their sexuality at the time they saw their therapist, remained in the final multiple regression. A discussion of the implications of these findings will be explored in the subsequent section describing final predictors.

Therapist Characteristics Correlated with Bias

Therapist demographic variables (age, sex, and race) were not found to be significantly associated with perceived heterosexual bias. However, respondents' perceptions of their therapists' experience level, their perceptions of their therapists' knowledge, their reported knowledge that their therapist was a psychiatrist, their lack of awareness of their therapists' sexual orientation, and their reported knowledge that their therapist was not gay, lesbian, or bisexual, were all significantly associated with perceived heterosexual bias.

Those therapists who were perceived to be less experienced, both generally ($p < .001$) and with lesbian, gay, bisexual clients in particular ($p < .001$), were perceived to be more biased. This finding is congruent with other research findings that have demonstrated that a key element of successful psychotherapy is the perception of the therapist as an expert.

There are several explanations for the finding that psychiatrists were perceived to be more significantly biased than psychologists, social workers, and counselors

($p < .001$). It may be that homosexuality is viewed more pathologically by psychiatrists because the discipline of psychiatry is based on a medical model that has historically pathologized homosexuality. The traditional training of psychiatrists has generally been informed more strongly by psychoanalytic theory than other disciplines, which may also lead to this result. Additionally, it may be that psychiatrists receive less training in cultural issues.

Second, clients may feel more judged by psychiatrists for various reasons, in part due to the increased issues of power and authority that may arise when the therapist is a medical doctor, leading a client to be more sensitive to being judged within the relationship. It may also be that clients who see psychiatrists have more serious psychopathology. This pathology might cause their therapists to have less respect for the clients' decisions, thus increasing the likelihood that heterosexual bias would be perceived in the treatment relationship. Conversely, the increased perception of heterosexual bias in these relationships might be caused by the seriousness of the client's pathology, and the potential for their relations with others to be marked by paranoia, and not by the psychiatric training of their therapists.

Greater perceived heterosexual bias was found to be significantly correlated with less perceived therapist knowledge, and more areas of no knowledge. These two variables remained in the final regression equation, and the implications of these findings will be discussed later.

Therapy Experience Characteristics Correlated with Perceived Bias

Many characteristics of the therapy experience were found to be significantly correlated with the perception of bias, yet a few were not. Those variables that were not associated with the perception of bias were: (1) the presenting problem of the respondent (with one exception being a presenting problem of relationship difficulties); (2) the therapy setting; and (3) whether the respondent had seen other therapists since he or she last saw the therapist.

Characteristics of the therapy experience that were significantly correlated with greater perceived heterosexual bias were: (1) the therapist lacked awareness of the sexual orientation of the respondent within the first or second session; (2) the respondent was not currently seeing the therapist; (3) the therapy experience was less recent; (4) the respondent found out the sexual orientation of the therapist from a source other than the therapist; (5) there was less focus in the therapy on gay, lesbian, bisexual issues, (6) the respondent discussed issues related to sexual orientation less; (7) the respondent was less likely to cite relationship difficulties as a main problem; (8) the respondent perceived less therapist empathy; and, (9) the respondent was less satisfied with the therapy experience.

Explanations for some of the significant correlations that do not remain in the final regression model are discussed below. One important finding was that clients who report their therapist not to be aware of their sexual orientation within the first one or two sessions perceive greater bias ($p < .001$) suggesting that client disclosure of sexual orientation is important early on in the treatment. Clients' perceptions that

their therapists lacked awareness of their sexual orientation in the first one or two sessions however, was found to be significantly correlated ($p < .001$) with clients' discomfort with their sexual orientation. This would suggest that client discomfort is related to clients' disclosure of sexual orientation. It is not possible to determine the cause and effect relationship between these variables. It may be that clients who are less comfortable with their sexual orientation do not come out right away in therapy, and being closeted within therapy subsequently leads to a perception of bias. Or, it may be that when clients sense that their therapists are biased, they then decide not to come out quickly to their therapists.

The finding that respondents who are currently seeing their therapist report less bias may be due to several factors. It may be that client perceptions of psychotherapy generally differ depending on whether the therapy is ongoing. Clients who report on their ongoing therapy may be more likely to idealize the therapy or the therapist, therefore inhibiting either a perception or the reporting of a perception of bias. Furthermore, clients who report on their current therapy experiences may feel less able to judge their therapy considering the unfinished nature of the treatment.

A related finding was that clients who saw their therapists less recently reported less bias. This may be due to actual changes in therapists over the last 10 years. For example, there may be an increase in affirmative attitudes and behavior towards lesbian, gay, and bisexual clients. Or, it may be that there is less dissonance for clients in reporting negative perceptions of their therapy experiences in the more distant past. The finding that greater bias was perceived by those respondents who

became aware of the sexual orientation of their therapist from a source other than the therapist is further related to the issue of therapist self-disclosure. It suggests that it is not only client knowledge of the sexual orientation of the therapist that leads to less perceived bias, but that the manner in which clients discover this information also effects perceived bias. Variables related to therapist self-disclosure of sexual orientation is an area in need of further exploration.

Clients' perception of empathy, their satisfaction with treatment, their focus on sexual orientation issues in therapy, and their presentation with relationship difficulties will be discussed further in the discussion of the final regression model. In the next section, the findings in the final regression model are examined, and the meaning of the predictors found in each set of categories are explored.

Multiple Regression Predictors (Final model)

PREDICTORS

Characteristics of Respondent

Less exclusively homosexual sexual orientation

Less comfort with sexual orientation at time respondent saw therapist

Characteristics of the Therapist

More perceived areas of no knowledge

Less perceived knowledge of lesbian, gay, bisexual issues

Therapy Experience Characteristics

Less overall focus on sexual orientation issues in the therapy

Less likelihood that client presents with relationship difficulties

Greater client perceived empathy of therapist

Less client satisfaction with therapy

Characteristics of the Respondent

Respondent characteristics that were found to be the major predictors of perceived heterosexual bias included less exclusive homosexuality of clients (in terms of sexual behavior, feelings and fantasies, and self-identification) and less comfort with sexual orientation at the time clients saw their therapist. The combination of these variables may predict the perception of heterosexual bias for several reasons. This finding may be explained by therapist variables and client variables, and each will be discussed below.

The client's presentation of conflict regarding sexual identity may be an invitation for the therapist to suggest that the client is therefore able to choose a sexual orientation, thus pushing the client to make a choice he or she does not feel the need to make. A client's conflict may additionally suggest to a therapist that the client's sexuality is ego dystonic, leading to a therapist intervention that encourages the client to alter her or his sexual orientation.

Clients who present as less exclusively homosexual and who are conflicted about their sexual orientation might project their fears and conflicts onto their therapists. Thus the client's own ambivalence regarding sexual identity might be attributed to the therapist and then experienced by the client as heterosexual bias. A less skilled

therapist might be unable to help the client sort out the way he or she projects his or her conflicts. This is yet another dynamic which might be attributed to the general skill level of the therapist and not to factors which specifically relate to bias regarding gay, lesbian, and bisexual clients.

What these results suggest is that it is not so much how the client labels him or herself, but it is more about his or her internal feelings and experiences. It is the more subjective client variables that have been found to predict the perception of heterosexual bias. For example, feeling conflicted about one's sexuality, and reporting that one's feelings and behavior are not exclusively homosexual, was found to be more significant in predicting bias than whether one labels oneself gay, lesbian, or bisexual. Clients' reports of comfort versus conflict regarding their sexuality, and their ratings of the degree of their sexual orientation are very subjective measures, and perhaps better measure what is another subjective measure, the perception of heterosexual bias. This suggests that for client characteristics, subjective dimensions may best predict the perception of bias.

Characteristics of the Therapist

Therapist characteristics that were found to be the major predictors of perceived heterosexual bias were less perceived therapist knowledge of lesbian, gay, and bisexual issues, and more perceived areas in which the respondent perceived the therapist to have no knowledge. The perception of therapist knowledgeability was found to predict unique pieces of the variance over and above the bias explained by the clients' characteristics.

The extent to which a client sees a therapist as knowledgeable about lesbian and gay issues and the number of issues that the therapist is perceived to have no knowledge about were highly correlated ($r = -6635$, $p < .001$), yet each explained unique pieces of the variance. This finding suggests that no matter how much a therapist knows about some gay, lesbian, bisexual issues, if there are areas that the therapist has no knowledge about, then he or she is more likely to be perceived as biased. Therapists thus need to be knowledgeable about all important gay, lesbian, bisexual issues, to be perceived by their clients as unbiased.

Characteristics of the Therapy Experience

Characteristics of the therapy experience that were found to be the major predictors of heterosexual bias were less focus on gay, lesbian, and bisexual issues in the treatment, less likelihood that the respondent came to his/her therapist with a problem of relationship difficulties, and less perceived therapist empathy and less respondent satisfaction with treatment.

These characteristics of the therapy experience accounted for a unique portion of the variance of heterosexual bias even after client and therapist variables were accounted for. Greater perceived heterosexual bias was perceived by those respondents who focused less on lesbian, gay, and bisexual issues in treatment. The findings suggest that facilitation of discussion about sexual orientation issues may be particularly important for gay, lesbian, and bisexual clients. It may also be that discussion of sexuality is an essential component of treatment for clients in general. The ability to discuss sexual orientation issues with a therapist may be of critical

importance for the gay, lesbian, or bisexual client who may have limited opportunities to discuss these issues. It may be that clients who do not openly discuss issues related to their sexual orientation with their therapists remain convinced of their therapists' heterosexual bias without giving the therapist an opportunity to disconfirm their negative predictions. Or, conversely, it may be that because clients perceive their therapists to be biased, they choose not to focus on lesbian, gay, bisexual issues.

After all other variables were accounted for in the multiple regression analyses, perceived empathy and satisfaction with treatment still explained additional variance. This is an important finding as it suggests the critical nature of perceived empathy and satisfaction in predicting bias. It suggests the need for a further understanding of perceived therapist empathy and satisfaction, particularly as it relates to bias.

Summary of Multiple Regression Analysis

In interpreting the reliability of the results of the multiple regression analysis it is important to note that multiple regression coefficients tend to change with different samples and with different numbers of independent variables (Kerlinger & Pedhazur, 1973). It is only through replication of the study that the results can be confirmed. For example, ordering of the regression variables can lead to differing results (Pedazur, 1982). Pedhazur (1982) has stated that

> Because predictors in the various blocks tend to be intercorrelated, it is clear that whether or not a predictor is entered into the equation depends, in part, on the order of entry assigned to the block to which it belongs. Generally speaking, variables belonging to blocks assigned to an earlier order of entry stand a better chance to be selected than those belonging to blocks assigned a later order of entry. (p. 165)

Pedazur's observation thus supports the importance of the finding that client

satisfaction and client perception of therapist empathy explained a significant and unique portion of the variance even after all other client, therapist, and treatment variables were accounted for. However, it is important to consider the possibility that variables that did not remain in the final regression model may actually remain important in the prediction and understanding of perceived heterosexual bias. It may that because variables were somewhat correlated with one another that an important variable fell out of the equation despite its true importance in explaining the perception of bias.

Implications of Overall Findings

In this study multiple tests were conducted, thereby increasing the risk of Type I error. Fletcher, Daw, and Young (1989) have stated that multiple testing may create a "compound probability problem whereby essentially the more opportunities allowed for error, the greater the probability that at least one error will occur" (p. 102). However, the major concern about controlling for Type I error has been related to the use of univariate statistics with multiple dependent variables (Leary & Altmaier, 1980), whereby some researchers (Leary & Altmaier, 1980) have proposed the use of multivariate analysis (MANOVA). In this study, however, only one dependent variable was used (the HBI) such that this problem was avoided. The efforts that were made in this study to control for Type I error included: the use of alpha level at $p < .05$; the use of two-tailed probability levels when there were no apiori hypotheses; the use of an overall F test in one-way analyses of variance (ANOVA) rather than multiple *t* tests; and use of a large sample (N=213). Other potential methods for

controlling for Type I error rate when conducting multiple tests include the Bonferroni multiple comparisons procedure, the Holm's procedure and Shaffer's procedure (Holland & Copenhaver, 1988). However, because of the exploratory nature of the study, and the subsequent reduction in power that occurs through the use of these methods, their use was not determined to be necessary. Replication of the study using another sample should be conducted in order to further examine the possibility of significant chance relationships found in this study.

Limitations of the Study

There are several important limitations of this study. One primary limitation is that client perceptions are the sole focus of the study. Although client perceptions represent an important source of unique information (Luborsky, et al., 1988; Strupp, et al., 1969), therapist perceptions are also a key factor in fully understanding the nature of the therapy experience. Research demonstrates low agreement between client and therapist perceptions of therapy, further suggesting the need for exploration of both client and therapist perceptions (Cooley & Lajoy, 1980). Despite this limitation, the study does address client perceptions of both objective and subjective attributes of the therapist, client, and the treatment relationship.

Reliance on client perceptions can be limiting in several ways. One problem is that dissonance may surface for clients as they examine their therapy experience. Dissonance arises when therapists are believed to be objective and bias free on the one hand, and insensitive, not knowledgeable, and not empathic on the other hand. How clients manage this potential dissonance may result in inaccurate reporting. For

example, clients may feel protective of their therapists, and they may not want to blame their therapists for their dissatisfaction. Conversely, clients who are disappointed in the results of their therapy experiences may be prone to over-report heterosexual bias as a means of maintaining a consonant view of their therapy experience as inadequate.

Transference and projection might further influence client reports of their psychotherapy experiences. Psychoanalytic theory suggests that the therapeutic relationship is characterized by a transference relationship which develops between the client and therapist. Whereas transference may contribute to the vitality and potency of therapy, its presence also suggests that client perceptions of therapists are based at least partially on re-experiencing elements of previous relationships. The presence of transference thus could serve to distort the client's perception of the therapist and the therapeutic relationship. Inasmuch as transference could distort client perceptions by attributing characteristics of important figures in a client's life to the therapists, projection could have a similar effect by attributing a client's own thoughts, feelings or characteristics to a therapist.

A second limitation in this study is the extent to which causal relationships can be inferred. Correlational analyses and multiple regression only permit the researcher to make statements about the relationship between variables. For example, although a large proportion of the variance was explained by client, respondent, and therapist characteristics, it is not known whether these variables reflect a causal relationship or whether other variables may mediate the effect of these independent variables on the

dependent variable (Darlington, 1967). The experiences of clients in psychotherapy are complex, and their perceptions may be related to a host of factors, including those examined in this study, as well as many others (i.e., personality traits such as locus of control, self-esteem, and affective states). Experimental research is needed in order to make statements of causality about the effects of therapist, client, and treatment characteristics on perceived heterosexual bias.

A third limitation in this study is the use of a non-random sampling method which does not ensure a representative group of lesbian, gay, and bisexual subjects. Despite an attempt to recruit a varied lesbian, gay, bisexual population, it is not possible to determine if the results would be similar using a random population. Furthermore, no study has examined the perception of heterosexual bias utilizing a random sample of gay men, lesbians, and bisexuals, so that the results of this study cannot be compared with the findings of a random sample.

A fourth limitation is the fact that the sample is skewed, with lesbians and bisexual women over-represented. Considering that there were only two bisexual men in the study, generalizations can not be made to this group. In addition, the large percentage of therapists in the study (39%) make comparisons to a more heterogeneous group impossible.

A fifth limitation of this study concerns the retrospective nature of client responses. Deficiencies in memory and recall may have potentially effected these results. In this study therapy experiences that occurred farther in the past were perceived as significantly more biased than more recent experiences. Similarly,

clients who were currently seeing their therapist reported their therapist to be significantly less biased. It may be that respondents were more able to acknowledge perceived bias in those therapy experiences in the more distant past, and that they experienced more dissonance in reporting their more recent therapists to be biased. This finding may also indicate that therapists are actually becoming less biased.

Finally, there are limitations related to developing an instrument in a study, and then using this instrument to examine variables of interest. The instrument needs to be further validated through its use in other studies using other populations. Larger and more representative samples need to be used in order to increase the generalizability of the results.

Implications for Practice and Training

The results of this study have many implications for clinical practice and training. Exploration of therapist disclosure of sexual orientation, the need for increased therapist empathy towards and knowledge of lesbian, gay, and bisexual clients, increasing effectiveness in working with clients who do not identify with a sexual orientation label, and an examination of the impact of therapist biases on treatment are salient clinical issues raised by this study.

Therapist Self Disclosure

The results of this study suggest that when gay, lesbian, and bisexual clients are aware of the sexual orientation of their therapist they are significantly less likely to see their therapist as biased regardless of the therapist's sexual orientation. Findings also suggest that clients assume their therapists to be heterosexual unless they are told

otherwise (i.e. 18% of the respondents assumed their therapist was heterosexual and only 1% assumed their therapist was gay or lesbian). Therapists' lack of disclosure regarding their sexual orientation is thus associated both with increased perceived bias per se and the likelihood that a therapist will be assumed to be heterosexual, which in itself is associated with bias. This finding is supported by previous psychotherapy research which has suggested that moderate therapist disclosure generally leads both to more positive client reactions and to client disclosures which are associated with successful treatment (Mann & Murphy, 1975).

The issue of self-disclosure is both important and complicated in psychotherapeutic theory and practice. The dynamics involved in such disclosures might vary dependent on whether client and therapist are gay, lesbian, bisexual or heterosexual. The impact of the disclosure may vary dependent on the way the disclosure is made and how it is processed by the client. Despite these mediating variables, results of the current study support the further exploration of therapist disclosure in limiting gay, lesbian, and bisexual clients' perception of bias in psychotherapy. Training programs should strive to assist trainees in addressing the issue of self-disclosure of sexual orientation, which could include addressing personal issues or dissonance between the desired disclosure and particular theoretical frameworks utilized.

Importance of Perceived Therapist Knowledge and Perceived Therapist Empathy

The perception of the therapist as knowledgeable about gay, lesbian, and bisexual issues was found to be a key variable in the perception of therapist bias. Both

increasing knowledge and eliminating areas of no knowledge were found to be important. This finding suggests that therapists need both to become aware of those areas in which they lack knowledge and then to acquire knowledge in these areas. Even if therapists attempt to increase their knowledge base they may inevitably encounter situations where their knowledge is lacking, indicating the constant need to remain aware of the possibility of lacking a sufficient knowledge base regarding gay, lesbian, and bisexual clients.

Therapists were perceived by gay, lesbian, and bisexual clients most frequently to have no knowledge about community resources for gays, lesbians, and bisexuals (32%); gay or lesbian sex (29%); lesbian or gay lifestyles and cultures (28%), bisexual lifestyles and cultures (26%); and, gay or lesbian couples (25%). It appears that therapists are perceived to be more knowledgeable about more general issues such as "coming out", societal discrimination, and dealing with one's sexual orientation and one's family. This finding would suggest the need for training that introduces therapists to the diverse lifestyles of gay men, lesbians, and bisexuals, as well as to the cultural identities of lesbian, gay, and bisexual individuals. Therapists need to recognize that knowledge about lesbian, gay, and bisexual issues is important in working with gay, lesbian, and bisexual clients, and then need to become knowledgeable, without completing relying on clients for this knowledge. Finally, if therapists are aware of the negative effect of their lack of knowledge they may be able to acknowledge these lapses in a more sensitive way which may limit any resultant perceived bias.

Perceived therapist empathy was also found to be significantly associated with perceived heterosexual bias. This finding could serve to encourage therapists to increase the quality of their empathic responses with gay, lesbian, and bisexual clients.

Clients Who Are Less Exclusively Gay or Lesbian

The findings of this study provide evidence that bisexuals, those who do not identify with a specific sexual orientation label, and those who are less exclusively homosexual in terms of their sexual behavior, feelings/fantasies and self-identification are more vulnerable to perceiving heterosexual bias than lesbians and gay men. Therapists may require training in normative views of bisexuality to increase their sensitivity to and effectiveness with these clients. This training may well conflict with a therapist's theoretical views or personal beliefs, and such conflicts should be addressed openly. Therapists might also need to examine their own comfort level in dealing with ambiguity and uncertainty related to sexuality if they are to be effective with clients who do not identify exclusively as gay, lesbian, or heterosexual.

Lack of Focus on Sexual Orientation Issues

Those respondents who reported that they focused less on sexual orientation issues in their therapy perceived greater heterosexual bias. This would suggest that therapists need to be particularly sensitive both to what clients talk about and what they do not talk about. Clients who present with struggles related to their sexual orientation should be invited to discuss their feelings about it with their therapist, and therapists should pursue the possibility that clients who do not initially present with

these conflicts might with support, choose to address them.

Therapy is Not Value Free

This study highlights issues relevant to perceived therapist bias and the potential impact of this bias on gay, lesbian, and bisexual clients' perceptions of their therapy experiences. Findings of perceived bias indicate the importance of examining the ways in which therapists may perpetuate heterosexism. Therapist training needs to include a broader examination of human sexuality, which addresses homosexuality, bisexuality and the wide range of normative sexual behavior and orientations. Inclusion of cross-cultural theory, with it's emphasis on the impact of social context, might be useful in designing therapist training that acknowledges the forces of oppression which serve to disempower and marginalize non-dominant groups.

Implications for Future Research

This study highlights the need for future research in several areas, including (1) further development of the validity of the HBI; (2) examination of additional variables as they are related to the HBI; (3) future use of the HBI with larger and more diverse populations; (4) measures of sexual orientation; and (5) other issues for future research.

Further Development of the Heterosexual Bias Inventory

The HBI is the first such instrument to be developed to measure gay, lesbian, bisexual clients' perceptions of bias in psychotherapy, giving it important utility as a research tool. The instrument's validity could be further established in a number of ways. Further analysis of the initial 43 items could be conducted with larger samples

to confirm whether or not the Heterosexual Bias Inventory remains best described by a single measure. In addition, the HBI could be compared with a variety of standardized measures.

Future research could also use the Heterosexual Bias Inventory as a predictor of outcome variables, such as perceived therapist empathy, satisfaction with therapy, and treatment effectiveness. Use of outside observers and behavioral measures would be particularly useful. This would further our understanding of the effects of perceived heterosexual bias on clients' treatment experiences, and provide further rationale for the training of therapists in lesbian, gay, and bisexual issues. Finally, a qualitative analysis could be conducted based on client generated examples of biased and sensitive treatment in psychotherapy with lesbians, gays, and bisexuals. Through the reliance on similar methodology to that used in the APA Committee on Lesbian and Gay Concerns study, validation of those bias themes generated by therapists could be further supported by those generated by clients. Bias items developed for the HBI could then be compared with those generated by clients, providing further validation. This phenomenon might also be examined through the use of focus groups of lesbians, gay men, and bisexuals who have been in psychotherapy.

Examination of Additional Predictors of Bias

One issue that is raised by this study concerns the impact of internalized homophobia on the perception of bias. Future studies could use a measure of internalized homophobia to help determine if internalized homophobia is a confounding variable in the perception of heterosexual bias. The finding in this study

that respondents' greater conflict with their sexual orientation was a significant predictor of perceived heterosexual bias suggests the importance of examining the variable of internalized homophobia.

An additional area for exploration concerns the extent to which client motivation and client expectations of treatment predicted perceived bias. It would be important to know whether those clients who perceived significantly more heterosexual bias had lower expectations and were generally less motivated for treatment.

Future Methodological Issues Related to Validation of the HBI

Special attention should be placed on the recruitment of a more random sample. Future studies utilizing the HBI should attempt to identify a more diverse participant population, with greater ethnic diversity, less education, and more subjects recruited through means other than gay pride marches. Identification of a larger sample of bisexuals with a more even distribution of bisexual men and women is needed. More bisexual therapists also should be included in future uses of the HBI.

Consideration might also be given to targeting clients who are currently in therapy, allowing them to evaluate an on-going therapist. This would avoid the disadvantages posed by a retrospective study, though it would also raise the question of how accurately clients can recognize bias in an on-going therapy relationship. Future research might examine client and therapist dyads to address the limitation inherent in solely examining client perceptions. The potential problems of client projection and client transference could be addressed by surveying both parties in the therapy relationship.

Measures of Sexual Orientation

One area for future research concerns the measurement of sexual orientation, which has posed many difficulties for researchers in this area (e.g., Nurious, 1983). Sexual orientation has been measured by self-reported identity as well as by frequency of sexual behaviors and erotic attractions. In this study several measures were used, including a modified Kinsey scale and a self-report measure.

There has been substantial criticism of the Kinsey scale (Klein et al., 1985). The Kinsey scale is based on a heterosexual-homosexual continuum that may not be applicable to all individuals. The Kinsey scale measures an individual's sexual orientation at one point in time, and does not account for past and present sexual orientations. Several other measures of sexual orientation have been developed that account for both the multidimensional aspect of sexual orientation and it's fluidity. For example, Klein (1985) developed the Klein Sexual Orientation Grid which measures a respondent's sexual orientation based on their past, present, and ideal sexual attraction, sexual behavior, sexual fantasies, emotional preference, social preference, self-identification, and hetero/homo lifestyle, past, present, and ideal. Building on the typologies developed by Klein, Sepekoff, and Wolf (1985), Coleman (1987) developed a sexual orientation assessment tool, Assessment of Sexual Orientation, that measures a respondent's current and future ideal physical identity, gender identity, sex-role identity, and sexual orientation identity. Future research might these other measures of sexual orientation in order to compare gay, lesbian, and bisexual client perceptions of psychotherapy.

Other Issues for Future Research

An additional area for further research would be an examination of how differential client responses to perceived heterosexual bias in psychotherapy may mediate its impact. For example, some of the participants in this study indicated that when they confronted their therapists with their perception of bias, they felt less dissatisfied and reported less bias. Thus, the extent to which a client can address these issues with a therapist may reduce the perception of bias.

It would also be useful in future studies to examine the differential impact of how and when therapists disclose their sexual orientation to clients. While such disclosures may lessen perceived bias it would be important to consider the variable impact of these therapist disclosures on other aspects of treatment across a variety of client populations.

Conclusion

This study operationalized themes of heterosexual bias which have been identified in the literature. The results of the study indicate that an examination of client, therapist, and treatment variables are essential in understanding and predicting perceived bias. The study begins a process of critically examining these three unique predictors of heterosexual bias. Further qualitative and quantitative studies are needed to more fully understand the nature and prevalence of heterosexual bias in psychotherapy.

The primary purpose of this study was the development of an instrument to measure perceived heterosexual bias. The Heterosexual Bias Inventory was developed

and found to be highly reliable, with indications of good construct validity. The results of the study indicate the need both for further investigation of heterosexual bias and for training designed to eliminate heterosexual bias in the practice of psychotherapy.

APPENDIX A
Instructions for Expert Judges

APPENDIX A
Instructions for Expert Judges

Dear Colleague,

I am developing an instrument to measure the perception of heterosexual bias as reported by gay, lesbian, and bisexual persons who have been in individual therapy or counseling within the past 10 years. I am asking experts to provide feedback on the content, clarity, comprehensiveness, and relevance of the items.

The items were generated from several different sources. The primary source was the American Psychological Association's Task Force on Psychotherapy with Lesbians and Gay Men, which thematically analyzed examples of bias as reported by a large sample of psychologists. In developing the instrument, I have also relied on clinical writing by experts in the field, and on my own clinical experience as a therapist with lesbian, gay, and bisexual clients. The instrument items address heterosexual bias as perceived by clients in the attitudes, interventions and knowledge of their therapists. It seeks to tap the perception of both manifest and subtle forms of heterosexual bias in psychotherapy.

As an expert judge, your task is the following:

1. Please complete the cover page which is the Background Questionnaire for Experts.

2. For the rest of the questionnaire, I do not want you to answer the questions. I want you to evaluate the content, clarity, comprehensiveness, and relevance of the survey items. Please write your comments in the margins as you review the survey. Feel free to include suggestions regarding items which you believe need to added, removed, or modified.

3. Section C, the Heterosexual Bias Inventory (HBI), is where I want you to pay particular attention. Please evaluate each item of the Heterosexual Bias Inventory as to whether in your professional judgement each item is or is not a measure of heterosexual bias in psychotherapy.

4. Provide additional feedback as needed on the Expert Evaluation Form.

To assure anonymity of your responses, please do not write your name anywhere on this packet of materials. This study is part of a doctoral dissertation in Counseling Psychology at Michigan State University. If you have any questions or concerns about this project, please contact, Julia Moss, Psychotherapy Project, Box 1114,

Northampton, MA 01061, phone # (413) 596-4631; or Dr. Linda Forrest, Department of Counseling, Educational Psychology and Special Education, College of Education, Michigan State University, 447 Erickson Hall, East Lansing, MI. 48824. You indicate your voluntary agreement to participate in evaluating this instrument by returning the survey with your feedback. Thank you very much for your help.

Sincerely,

Julia Moss, MSW

Background Questionnaire for Expert Judges

1. Are you :
   Female.....1
   Male.....2

2. Age _____

3. Race
   Caucasian.....1
   African-American....2
   Latino.....3
   Asian.....4
   Native American.....5
   Other [Specify].....6 _____

4. What is your professional degree and in what field?

   _____

5. Do you practice psychotherapy or counseling?

   Yes.....1
   No.....2

6. If yes, how long have you been practicing psychotherapy or counseling?

   _____

7. Approximately how many gay clients, lesbian clients, and bisexual clients have you worked with in psychotherapy or counseling?

   # of gay male clients_____
   # of lesbian clients _____
   # of bisexual clients_____

Expert Evaluation Form

Feel free to write here any further comments that you have about each aspect of the questionnaire.

Please be as specific as you can.

BACKGROUND QUESTIONS (Sections A and B)

HETEROSEXUAL BIAS INVENTORY (Section C)

KNOWLEDGE MEASURE (Section D)

OPEN-ENDED ITEMS (Section E)

Are there additional areas of heterosexual bias in psychotherapy which you believe should be included in this survey? If yes, please elaborate. (Use back as necessary)

THANK YOU VERY MUCH FOR YOUR HELP.

APPENDIX B
Instructions for Subjects in Pilot Testing

APPENDIX B
Instructions for Subjects in Pilot Testing

Dear Friend:

As part of a doctoral dissertation in Counseling Psychology at Michigan State University, I am conducting research on lesbians', gay mens', and bisexuals' perceptions of their psychotherapy or counseling experiences within the past 10 years. I am currently in the process of pilot-testing the final instrument. I am asking you, as a lesbian, gay, or bisexual person who has been in therapy within the past 10 years, to complete the survey and provide feedback. Your feedback will be useful in the development of the final survey.

Your task is the following:

1. Complete the entire questionnaire using the instructions provided.

2. Keep track of the time it took for you to complete the survey.

3. As you complete the survey, indicate any questions or instructions that are unclear, ambiguous, or confusing to you. Write your comments in the margin next to the questions or instructions which are unclear. Feel free to make any suggestions for improvement.

4. Upon completion of the survey, complete a brief feedback form.

To ensure anonymity of responses, please do not write your name anywhere on the survey.

Thank you very much for your help.

Sincerely,

Julia Moss

Feedback Form

1. How long did you take to complete the survey?

2. Please rate the following aspects of the survey:

Clarity of Questions: (circle one)

Excellent Good Fair Poor

Relevance of Questions to your experience: (circle one)

Excellent Good Fair Poor

Comfort with language used in survey: (circle one)

Excellent Good Fair Poor

Clarity of Instructions: (circle one)

Excellent Good Fair Poor

THANK YOU FOR YOUR HELP.

APPENDIX C
Recruitment Flyers

APPENDIX C
Recruitment Flyers

RESEARCH STUDY EXPLORING

PSYCHOTHERAPY EXPERIENCES OF LESBIANS, GAY MENS, AND BISEXUALS

Are you lesbian, gay, or bisexual?

Have you seen a therapist within the past 10 years?

Are you over 18?

If you answered yes to these three questions, you are eligible to participate in this study. This study is part of a doctoral dissertation which explores the experiences of lesbians, gay men, and bisexuals who are currently in therapy or who have been in therapy within the past 10 years. Participants will complete a survey which takes less than 30 minutes to complete. All responses are anonymous.

To participate in this study, use the tear-off sheet below to request questionnaires by mail.

Please send _____copies of the survey exploring the perceptions of lesbians, gay males, and bisexuals of their psychotherapy experiences.

Name (optional)_____

Street address or PO Box_____

City, State, Zip Code_____

Send this form to:

Psychotherapy Project
Box 1114
Northampton, MA 01060

Or call: Julia Moss
(413) 586-4631

RESEARCH STUDY EXPLORING

PSYCHOTHERAPY EXPERIENCES OF LESBIANS AND GAY MEN

Are you a therapist or counselor who sees lesbian or gay clients?

Would you be willing to give a survey to any of your lesbian, or gay, or bisexual, clients?

This study is part of a doctoral dissertation which explores the perceptions of lesbians, gay men, and bisexuals who are currently in therapy or who have been in therapy within the past 10 years. Participants will complete a self-administered survey which takes less than 30 minutes to complete. All responses are anonymous. If you are willing to give a questionnaire to a client, please contact:
Psychotherapy Project
Box 1114
Northampton, MA 01060
Or call: Julia Moss
(413) 586-4631

APPENDIX D
Recruitment Letter

APPENDIX D
Recruitment Letter

June 23, 1993

Dear _____,

I am a doctoral candidate in Counseling Psychology at Michigan State University, and am conducting research on the perceptions of lesbian, gay, and bisexual clients about their psychotherapy and counseling experiences.

As a practicing psychotherapist, I am concerned about heterosexism and homophobia on the part of mental health professionals and the way that this is perceived by lesbian, gay, and bisexual clients. Research in this area is particularly important as there has been no large scale study which has inquired about the psychotherapy experiences of lesbians, gay males, and bisexuals. I plan to publish the results of this study in both mainstream counseling and psychology journals, as well as gay, lesbian, and bisexual journals. My hope is that this research can lead to improved training for mental health providers and ultimately will lead to more sensitive and better informed treatment of lesbian, gay and bisexual persons.

I am attempting to survey a heterogeneous sample of lesbian, gay, and bisexual persons who have been in therapy or counseling within the past ten years. I am writing to you to ask for your assistance in publicizing this study. I am enclosing flyers for you to distribute, and one survey for you to review, (and hopefully pass on to someone to complete). If you would be willing to distribute additional surveys or flyers, feel free to contact me at (413) 586-4631 or write:

Psychotherapy Project
Box 1114
Northampton, MA 01060

I appreciate your help.

Sincerely,

Julia Moss, MSW

APPENDIX E
Organizations from which Subjects Were Recruited

APPENDIX E
Organizations from which Subjects Were Recruited

ARIZONA
Arizona AIDS Project Inc., 919 N. 1rst St., Phoenix, AZ 85004-1902

University of Arizona, Lesbian, Bisexual & Gay Union, Tuscon, AZ 85720

CALIFORNIA
Asian & Pacific Islander Gay/BI Men's Support Group, c/o Pacific Center, 2712 Telegraph Av., Berkeley CA 94705

University of California, Santa Barbara, Lesbian, Gay & Bisexual Alliance, Campus Activities Center, Santa Barbara, CA 93106

Pomona College, Lesbian, Gay & Bisexual Student Union
Women's Union, Walker, Claremont, CA 91711

Occidental College, Bisexual, Gay & Lesbian Association
OC Box 5, 1600 Campus Road, Los Angeles, CA 90041

Stanford University, Lesbian Gay & Bisexual Community Center
P.O. Box 8265, Stanford, CA 94309

Mills College, Bisexual Lesbian Union, 5000 MacArthur Blvd.
Oakland, CA 94613

San Francisco State University, Lesbian/Gay/Bisexual Alliance
Room 100A, Student Union Building, 1600 Holloway, San Francisco California 94132

Sonoma State University, Gay, Lesbian, Bisexual Student Union
Rohert Park, California 94928

University of California, Berkeley, Multicultural Bisexual Lesbian Gay Alliance, 415 Eshelman Hall, Berkeley, CA 94720

The Center, 2017 E. 4th Street, Long Beach, CA 90814

California State University, Fresno, Gay, Lesbian, Bisexual,
Straight Alliance, 5280 N. Jackson, Fresno, CA 93740-0036

California State University, Long Beach, Lesbian, Gay, Bisexual Resource Center, F04 Room 165, 1250 Bellflower Blvd., Long Beach, CA 90804

San Jose State University, Gay, Lesbian, Bisexual Alliance
Box 55 SAS, San Jose, CA 95192-0038

University of California, Irvine, Gay, Lesbian, Bisexual Student Union, Irvine, California 92717

University of California, Riverside, Union of Lesbians, Gays & Bisexuals, c/o Commons Main Desk, Riverside, CA 92502

University of California, San Diego, Lesbian, Gay, Bisexual Association, 9500 Gilman Drive 0077-B18, La Jolla, California 92093

University of California, Santa Cruz, Lesbian, Gay, Bisexual, Network Resource Center, Santa Cruz, CA 95064

University of Redlands, Gay, Lesbian & Bisexual Student Union, c/o Student Life, Redlands, CA 92373

COLORADO
Gay & Lesbian Community Center, 1245 E. Colfax Ave., Denver, CO 80218

Colorado State University, Gay, Lesbian & Bisexual Alliance, Box 206, Lory Student Center, Fort Collins, CO 80523

University of Colorado, Lesbian, Bisexual, Gay Community Alliance, UMC 28, Boulder, CO 80309

Colorado College, Gay, Lesbian, Bisexual Alliance, 902 N. Cascade
Colorado Springs, CO 80946

CONNECTICUT
Project 100/Gay, Lesbian, Bisexual Community Center, 1841 Broad Street, Hartford, Connecticut 06114

Women's Liberation Center, 614 Orange Street, New Haven,
Connecticut

DELAWARE
Lesbian, Gay & Bisexual Student Union at the University of
Delaware, Room 201 Student Center, Academy St., Newark, Delaware 19716

WASHINGTON DC
George Washington University, Gay, Lesbian, Bisexual Alliance
800 21rst St., NW, Box 16, Rm. 419, Washington, DC 20057

FLORIDA
Orlando Bisexual Support Group, 750 W. Colonial Drive, PO Box 533446, Orlando, Florida 32853-3446

Gay & Lesbian Student Union, Box 48, GWRU, University of Florida
Gainesville, Florida 32611

GEORGIA
Gay, Lesbian & Bisexual Veterans of America, PO Box 512
Duluth, Georgia 30136

University of Georgia, Lesbian, Gay & Bisexual Student Union
Box 2438, Athens, Georgia 30612-0438

Agnes Scott College, Lesbian & Bisexual Alliance, Box 501
Decatur, Georgia 30030

HAWAII
Gay Community Center, 1820 University Ave
Honolulu, Hawaii 96822

Gay, Bi, Lesbian Community Organization, PO Box 5042
Kahului, Maui, Hawaii 96732

ILLINOIS
Dignity-Chicago, 909 W. Belmont Av. , #205, Chicago, Illinois 60657-4408

Gay, Lesbian & Bisexual Veterans of America-Chicago
PO Box 29317, Chicago, Illinois 60629

Lesbian, Gay & Bisexual United Employees of AT&T (LEAGUE)
200 Park Plaza, Naperville IL 60566

INDIANA
Earlham College, Lesbian, Gay, Bisexual People's Union
Richmond, Indiana 47374

Indiana University, Gay, Lesbian & Bisexual Student Union, Indiana Memorial Union
48L-M, Bloomington, Indiana 47405

IOWA
Grinnell College, Stonewall Resource Center, PO Box S-6, Grinnell, Iowa 50112

Iowa State University, Lesbian/Gay/Bisexual Alliance, 39 Memorial Union Ames, Iowa 50011

University of Iowa, Gay, Lesbian & Bisexual People's Union, c/o Student Activities Center, Iowa Memorial Union, Iowa City, Iowa 52242

MAINE
Unitarian Universalists Bisexual Network, P.O. Box 10818
Portland, Maine 04104

MARYLAND
The BiNETWORK of the Virginia, Maryland, Washington DC Area
P.O. Box 3646, Langley Park, MD 20787

Gay/Lesbian Community Center, 241 W. Chase St., P.O. Box 22575
Baltimore, Maryland 21203

MASSACHUSETTS
East Coast Bisexual Network, 95 Berkeley St. #613, Boston, MA 02115

Alliance of Massachusetts Lesbians and Gays, P.O. Box 543
Prudential Station, Boston 02199

Clark University Lesbian and Gay Alliance, 950 Main St. Box B5, Worcester, MA 01610

MICHIGAN
SAPAC, 580 Union Drive. Room 107, Ann Arbor, Michigan 48109

Lesbian and Gay Male Program Office, 3116 Michigan Union
University of Michigan, Ann Arbor, Michigan 48109

MONTANA
Montana Lesbian Coalition, MLC, POB 1283, Helena, Montana 59624

Out in Montana, POB 8661, Missoula, Montana 59807-8661

Montana Women's Resource Center, UL 119, University of Montana, Missoula, Montana 59812

NEBRASKA
Lincoln Legion of Lesbians, POB 84245
Lincoln, Nebraska 68501

University of Nebraska-Lincoln, Gay/Lesbian Student Association
Nebraska Union 14th & R, Room 342, Lincoln, Nebraska, 68588

NEVADA
Southern Nevada Association of Pride (SNAP), POB 70807
Las Vegas, Nevada 89170

Women United of Nevada, POB 12956, Las Vegas, Nevada 89112-0956

NEW HAMPSHIRE
Seacoast Area Lesbian Feminist Alliance (SALFA), POB 1651
Portsmouth, New Hampshire 03802-1651

Dartmouth Gay & Lesbian Organization, Dartmouth College, HB 5057, Hanover, New Hampshire 03755

Gay Community Counseling, POB 1124, Keene, New Hampshire 03431

Gay & Lesbian Student Union, POB 100 Student Union Bldg., Room 215, University of New Mexico, Albuquerque, New Mexico 87131

Common Bond Gay and Lesbian Information line, POB 26836
Albuquerque, New Mexico 87125

NEW YORK
Capital District Lesbian & Gay Community Center, POB 131
Albany, New York 12201-0131

Lesbian Gay Bisexual Alliance, CC16 1400
SUNY Albany, Albany, New York, 12222

The S.P.A.C.E., 213 State St.
Binghampton, New York 13902

Bisexual Information and Counseling Service, 599 West End Ave, #1-A, New York City, New York 10024

Community Counseling Center, 115 Washington Place #4, New York City, NY 10014

Gay Counseling Center of Long Island, Box 1133, Massapequa, Long Island, New York 11758

Lesbian and Gay Community Services, 208 W. 13th Street, NYC, NY 10011

The Loft: Lesbian and Gay Community Services Center, Inc.
POB 1513, White Plains, New York 10602

NORTH CAROLINA
Southern Appalachia Lesbian and Gay Alliance (SALGA), POB 197, Asheville, North Carolina 28802

Alternative Resources of the Triad, POB 4442, Greensboro, North Carolina 27404

Gay, Lesbian & Bisexual Veterans Association, 130-C N. Walnut Circle, Greensboro, North Carolina 27409

OHIO
Stonewall Community Center, POB 10814, Columbus, Ohio 43201

Ohio State University, Gay, Lesbian, Bisexual Alliance, 340 Ohio Union, 1739 High Street, Columbus, Ohio 43210

OKLAHOMA
Herland Sister Resources, Inc., 2312 NW 39th Street
Oklahoma City, Oklahoma 73112

Oasis Community Center, 2135 NW 39th Street
Oklahoma City, Oklahoma 73112

Oklahoma University, Gay, Lesbian & Bisexual Alliance
303 Ellison Hall, 633 Elm Ave., Norman, Oklahoma City, Oklahoma 73019-0350

OREGON
Lambda Eastern Oregon Association, POB 382, Baker City, Oregon 97814

Gay and Lesbian Outreach Network, Box 4212, Coos Bay, Oregon 97420

Lesbian Community Project, POB 5931, Portland, Oregon 97228

Gays and Lesbians of Reading and Allentown, POB 4502,
Reading, PA 19606

TEXAS
Coalition of Lesbian/Gay Student Groups, Inc., POB 190712
Dallas, Texas 75219

Gay Service Network, POB 2585, Austin, Texas 78768

UTAH
Gay and Lesbian Community Council of Utah, POB 3832, Salt Lake City, Utah 84110-3832

VERMONT
Middlebury Gay/Lesbian/Bisexual Alliance, Drawer 8, Middlebury College, Middlebury, Vt. 05753

Greater Central Vermont Gay Men's Support/Social Network, P.O. Box 301, Montpelier, Vermont 05602

Gay, Lesbian, Bisexual Alliance, Goddard College, Plainfield, Vermont 05667

VIRGINIA
Lesbian and Gay Student Union at the University of Virginia, POB 525 Newcomb Hall Stn
Charlottesville, Virginia 22904

Counseling Center, 415 Harrison St., Lynchburg, Virginia 24504

WASHINGTON
Lesbian/Gay Resource Center, CAB 305, Evergreen State College
Olympia, Washington 98505

Women's Resource and Research Center, Washington State University, Pullman, Washington 99164

Central Seattle Recovery Center, 1401 E. Jefferson #300
Seattle, Washington 98122

Seattle Counseling Service, 200 W. Mercer St #300
Seattle, Washington 98119

Seattle Institute for Sex Therapy Education & Research, 100 NE 56th Street, Seattle, Washington 98105

North Central Washington Gay & Lesbian Alliance, POB 234
Wenatchee, Washington 98807

WISCONSIN
Madison Gay and Lesbian Resource Center, POB 1722, Madison, Wisconsin 53701

WYOMING
United Gays and Lesbians of Wyoming, POB 2037, Laramie, Wyoming 82070

ALASKA
Anchorage Lesbian Families Alliance, c/o Alaska Woman's Cultural Center, 2440 E. Tudor, Box 304, Anchorage, Alaska 99507

Alaska Women's Resource Center, 111 W. 9th Ave, Anchorage, Alaska 99501

S.E. Alaska Gay/Lesbian Alliance, POB 211371, Auke Bay, Juneau, Alaska 99821

APPENDIX F

Heterosexual Bias Themes Reported in Qualitative Analysis of responses, Committee on Lesbian and Gay Concerns, 1991

APPENDIX F
Heterosexual Bias Themes, Committee on Lesbian and Gay Concerns, 1991

ASSESSMENT

1). A therapist believes that homosexuality per se is a form of psychopathology, developmental arrest, or other psychological disorder.
2). A therapist automatically attributes a client's problem to her or his sexual orientation without evidence that this is so.
3). A therapist fails to recognize that a client's psychological symptoms or distress can be influenced by the client's own negative attitudes or ideas about homosexuality.
4). A therapist automatically assumes a client is heterosexual or discounts a client's self-identification as gay or lesbian.

INTERVENTION

5). A therapist focuses on sexual orientation as a therapeutic issue when it is not relevant.
6). A therapist discourages a client from having or adopting a lesbian or gay orientation
7). When not requested, a therapist seeks to change the sexual orientation of a client, for example by prescribing heterosexual behavior.
8). A therapist expresses beliefs which trivialize and/or demean homosexuality and gay/lesbian experience.
9). Upon disclosure of homosexuality, a therapist abruptly terminates a client without the provision of appropriate referrals to the client or assistance with the emotional difficulties associated with the termination.
10). A therapist makes renouncing one's homosexuality a condition of treatment.
11). A therapist discloses the client's sexual orientation inappropriately.

IDENTITY

12). A therapist lacks understanding of the nature of gay and lesbian identity development by considering a gay male or lesbian identity possible only for adults, by viewing lesbian or gay male identity solely in terms of sexual behavior, or by interpreting a client's gay male or lesbian identity as a "phase" that will be outgrown.
13). A therapist does not sufficiently take into account the extent to which lesbian or gay male identity development is complicated by the client's own negative attitudes toward homosexuality.
14). A therapist underestimates the possible consequences of a client's disclosure of his/her homosexuality to others.

INTIMATE RELATIONSHIPS

15). A therapist minimizes, trivializes, or underestimates the importance of intimate relationships for lesbians and gay men.
16). A therapist is insensitive to the nature and diversity of gay male and lesbian relationships and inappropriately uses a heterosexual frame of reference.
17). A therapist is unsupportive of the maintenance of or encourages dissolution of a client's lesbian or gay relationship solely because it is a homosexual relationship.
18). A therapist does not provide or recommend couples and/or family therapy to a gay male or lesbian client when it would be the more appropriate intervention.

FAMILY

19). A therapist presumes a client is a poor or inappropriate parent solely on the basis of a gay male or lesbian sexual orientation, for example by automatically attributing a child's problems to his/her parent(s) being lesbian or gay without evidence that this is so or by opposing child custody to such parent(s) on the grounds that their sexual orientation in and of itself makes them unfit.
20). A therapist is insensitive to or underestimates the effects of prejudice and discrimination on gay and lesbian parents and their children.
21). A therapist is insensitive to or unsupportive of assisting lesbian or gay male clients in disclosing their sexual orientation to their family of origin.

THERAPIST EXPERTISE AND EDUCATION

22). A therapist provides services to gay male or lesbian clients despite lacking knowledge or expertise in the following areas:
a). gay/lesbian community or culture
b). gay/lesbian identity
c). problems due to societal prejudice and discrimination
d). gay/lesbian relationships
e). appropriate psychological resources and referral for gay men and lesbians
23). A therapist relies unduly on a client to education the therapist about gay and lesbian issues.
24). In an educational setting, a therapist teaches information about gay men or lesbians that is inaccurate or prejudiced
25). In the role of educator, a therapist actively discriminates against gay male and lesbian students or colleagues.

APPENDIX G
Subject Questionnaire Packet

APPENDIX G
Subject Questionnaire Packet

Dear Participant,

Thank you for your interest in completing a survey regarding your experiences in psychotherapy as a lesbian, gay, or bisexual client. The results of this study will be used to better understand the needs and concerns of lesbian, gay, bisexual clients, and to enable therapists and counselors to better serve lesbians, gay males, and bisexuals.

Your participation in this study is completely voluntary. You may chose not to participate and you have the right to refuse to answer any question. We would, however, appreciate it if you would answer all questions to enable us to gain as much information as possible in this area where little is known.

All questions in this survey concern your feelings, perceptions, and experiences. There are no right or wrong answers. Please answer the questions one by one in the order that they appear. Please read each question carefully.

The entire survey will take about 30 minutes to complete. All responses are completely anonymous.

Please do not write your name anywhere on this survey.

This study is part of a doctoral dissertation in Counseling Psychology at Michigan State University, East Lansing, Michigan. If you have any questions or concerns about this project, please contact Julia Moss at (413) 586-4631, Psychotherapy Project, Box 1114, Northampton, MA 01061 or Dr. Linda Forrest, Department of Counseling, Educational Psychology and Special Education, College of Education, Michigan State University, 447 Erickson Hall, East Lansing, Michigan, 48824.

You indicate your voluntary agreement to participate by completing and returning the questionnaire.

<u>Please mail the survey back in the enclosed self-addressed stamped envelope</u>.

Thank you very much for your participation.

Sincerely,

Julia Moss, MSW

ELIGIBILITY CRITERIA

This research study explores the perceptions of lesbians, gay males, and bisexuals about their psychotherapy experiences within the past 10 years.

You are eligible for this study

IF YOU ARE:
-LESBIAN, GAY, OR BISEXUAL

-AT LEAST 18 YEARS OLD

-AND HAVE SEEN A PSYCHOTHERAPIST OR COUNSELOR IN THE PAST 10 YEARS

PLEASE ANSWER THE 3 QUESTIONS IN BOX

==========

1. Are you lesbian, gay, or bisexual? Yes...1 No...2

2. What is your age? _____

3. Have you had one or more individual sessions with a psychotherapist or counselor in the past 10 years?

Yes...1 No...2

==========

[If you are NOT eligible for this study, please pass the questionnaire on to someone who may be eligible. Thank you for your help.]

IF YOU ARE ELIGIBLE FOR THIS STUDY, please continue on the following page (page 1).

Please do not write your name anywhere on this survey.

SECTION A

Date_____ _ _ _ _

How did you find out about this survey? (Circle main source)
March in Washington D.C. April 25, 1993.....1
friend, lover, or acquaintance.....2
gay, lesbian, or bisexual organization.....3
mental health or counseling service.....4

my current therapist.....5
flyer.....6
other [please specify].....7
_____

First some background about you...

1. Are you: Female.....1 Male.....2

2. Age _____

3. Race
Caucasian.....1
African-American....2
Latino.....3
Asian.....4
Native American.....5
Other [Specify].....6 _____

4. Religion
Protestant.....1
Catholic.....2
Jewish.....3
Other [Specify].....4 _____

5. How important is religion or spirituality in your life?
Very important.....1
Somewhat important....2
Not important.....3

6. How often do you attend religious services?
One or more times a week.....1
One to three times a month.....2
Six to ten times a year.....3
About once a year.....4
Less than once a year.....5
Never.....6

7. Where do you currently live?
City _____
State_____

8. Education (CIRCLE Highest that Applies)
   Some High school.....1
   High School Graduate.....2
   Some College.....3
   College Graduate.....4
   Some Graduate School.....5
   Graduate Degree Completed..6

9. Household Income
   Under $10,000.....1
   $10,000 -$19,999.....2
   $20,000 -$29,999.....3
   $30,000 -$39,999.....4
   $40,000 -$49,999.....5
   $50,000 -$69,999.....6
   Over $70,000.....7

10. How many people live on this income? _____

11. How do you currently identify yourself?
    Gay Male....1 Lesbian....2 Bisexual....3

The following three questions ask you to rate your **CURRENT SEXUAL ORIENTATION** from 0 - 6 using the following categories.

0 exclusively heterosexual
1 mainly heterosexual with a small degree of homosexuality
2 mainly heterosexual with a substantial degree of homosexuality
3 equally heterosexual and homosexual
4 mainly homosexual with a substantial degree of heterosexuality
5 mainly homosexual with a small degree of heterosexuality
6 exclusively homosexual

Please rate yourself in terms of YOUR SEXUAL BEHAVIOR, YOUR SEXUAL FEELINGS/FANTASIES and YOUR SELF-IDENTIFICATION.

CIRCLE BEST NUMBER FOR EACH CATEGORY.

	EXCLUSIVELY HETEROSEXUAL						EXCLUSIVELY HOMOSEXUAL
12. SEXUAL BEHAVIOR	0	1	2	3	4	5	6
13. SEXUAL FEELINGS/ FANTASIES	0	1	2	3	4	5	6
14. SELF-IDENTIFICATION	0	1	2	3	4	5	6

Who have you told about your sexual orientation?

	NONE	SOME	MOST	ALL
15. MY CLOSE FAMILY	1	2	3	4
16. MY FRIENDS	1	2	3	4
17. MY CO-WORKERS	1	2	3	4

18. How comfortable are you with your current sexual orientation?
very comfortable.....1
somewhat comfortable.....2
somewhat conflicted.....3
very conflicted.....4

19. Are you currently: (Circle one)
in a relationship with one or more partners....1
in no relationship.....2

20. Over the last 10 years, approximately how many psychotherapists or counselors have you seen individually?
one 1
two 2
three to five.....3
six to ten.....4
more than ten.....5

21. Are you currently seeing a therapist?
Yes...1 [If Yes, skip to question 23]
No....2

22. If NOT CURRENTLY seeing a therapist, how long since you saw last therapist?
Number of years____
If less than one year, approximate number of months____

23. In your therapy experience(s) are you aware of having been given a psychiatric diagnosis?
Yes.....1 No.....2 [If No, skip to question 25]

24. If YES, what was the diagnosis?
Major depression.....1
Bipolar Disorder.....2
Schizophrenia.....3
Anxiety Disorder.....4
Psychotic Disorder.....5
Adjustment Disorder.....6
Eating Disorder.....7
Substance Use Disorder.....8
Identity Disorder.....9
Other [Please specify].....10_____

25. Are you currently taking medication for a psychiatric condition? Yes....1 No....2

26. Have you ever been hospitalized for psychiatric reasons?
Yes.....1 No.....2

27. Have you ever tried to commit suicide?
Yes.....1 No.....2

28. Are you professionally trained as a psychotherapist or counselor?
Yes.....1 No.....2 [If No, skip next question]

29. If Yes, what is your degree? _____

SECTION B

In Section B, you are asked to describe your experience with one psychotherapist or counselor during the past **ten years.**

IF YOU HAVE BEEN IN THERAPY WITH ONLY ONE THERAPIST, PLEASE COMPLETE THIS QUESTIONNAIRE ABOUT YOUR EXPERIENCE WITH THAT THERAPIST.

IF YOU HAVE HAD MORE THAN ONE THERAPIST, PLEASE CHOOSE THE THERAPY EXPERIENCE IN WHICH YOU FELT TREATED LEAST SENSITIVELY OR LEAST APPROPRIATELY AS A LESBIAN, GAY, OR BISEXUAL PERSON.

NOW THAT YOU HAVE SELECTED ONE THERAPIST, PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT THIS THERAPIST WHO WILL BE REFERRED TO AS "YOUR THERAPIST".

PLEASE DESCRIBE YOUR THERAPIST OR COUNSELOR.

1. Is (was) your therapist:
   Female.....1 Male.....1

2. What is (was) the race of your therapist?
   Caucasian.....1
   African-American.....2
   Latino.....3
   Asian.....4
   Native American.....5
   Other [Specify].....6_____

3. What was the approximate age of your therapist when you first saw her or him?
   20 - 29.....1
   30 - 39.....2
   40 - 49.....3
   50 - 59.....4
   60 or over.....5

4. Is (was) your therapist:
   Gay.....1
   Lesbian.....2
   Heterosexual...3
   Bisexual.....4
   Don't Know.....5 [If you don't know, skip to question 6]

5. If you know the sexual orientation of your therapist, how do you know?
   My therapist told me.....1
   Someone else told me.....2
   Other [Please specify].....3_____

6. Is (was) your therapist a: (Circle primary one)
   social worker.....1
   psychologist.....2
   psychiatrist.....3
   counselor.....4
   religious/pastoral counselor...5
   other [specify].....6_____
   don't know.....7

7. Generally, what impression do (did) you have of the level of experience of your therapist?
   little experience.....1
   moderate experience....2
   very experienced.....3

8. What impression do (did) you have of the level of experience of your therapist specifically working with lesbian, gay, bisexual clients?
   little experience.....1
   moderate experience....2
   very experienced.....3

9. Where do (did) you see your therapist? (Circle one)
   Private Practice.....1
   Gay/Lesbian Mental Health or Health Service.....2
   College or University Counseling Service.....3
   Other Mental Health Center.....4
   Hospital (in-patient).....5
   Other [SPECIFY TYPE]_____6

10. About how many times did you see [have you seen] your therapist?

1	2-5	6-12	13-26	27-52	53-100	more than 100 sessions
___	___	___	___	___	___	___

11. How old were you when you **first** saw your therapist?

12. What was the main problem you were having that led you to go to your therapist? (Circle all that apply)
   concerns about your sexual orientation....1
   problems with "coming out".....2
   concern about HIV/AIDS.....3
   depression.....4
   anxiety.....5
   relationship difficulties.....6
   sexual difficulties.....7
   family problems.....8
   drug or alcohol problem.....9
   major mental illness.....10
   eating problem.....11
   career/work issues.....12
   other [please specify].....13

13. When you first saw your therapist did you see yourself as a: (Circle one)
    gay male.....1
    lesbian.....2
    bisexual.....3
    heterosexual.....4
    I did not identify myself....5

14. How long had you identified yourself this way before you saw your therapist? _____

When you first saw your therapist, who had you told about your sexual orientation? [If you did not identify yourself, who had you told about not identifying yourself?] (Circle best number for each question)

	NONE	SOME	MOST	ALL
15. MY CLOSE FAMILY	1	2	3	4
16. MY FRIENDS	1	2	3	4
17. MY CO-WORKERS	1	2	3	4

18. How comfortable were you with your sexual orientation when you first saw your therapist?
    very comfortable.....1
    somewhat comfortable.....2
    somewhat conflicted.....3
    very conflicted.....4

19. How much did you discuss issues related to your sexual orientation with your therapist?
    a great deal.....1
    somewhat.....2
    very little.....3
    not at all.....4

How much did you focus on the following issues with your therapist? [Please circle best number for each question].

	very much	some-what	very little	not at all
20. "coming out" to myself	1	2	3	4
21. "coming out" to others	1	2	3	4
22. my family (i.e. parents) and my sexual orientation	1	2	3	4
23. my conflicts or fears about being lesbian, gay, or bisexual	1	2	3	4
24. societal discrimination as a gay, lesbian, bisexual person	1	2	3	4

25. At approximately what point in the therapy did your therapist become aware of your lesbian, gay, bisexual identity, or your same sex attractions, feelings or behavior.
    first or second session.....1
    between sessions 3-10.....2
    after session 10.....3
    my therapist was never aware.....4

26. Are you currently seeing your therapist?
    Yes....1 No.....2

If YOU ARE CURRENTLY SEEING YOUR THERAPIST, SKIP TO SECTION C (PAGE 8). If NOT CURRENTLY seeing your therapist, please answer the following questions.

27. How long ago did you last see your therapist
    _____years _____weeks

28. I ended therapy because I felt my therapist was not sensitive to my needs as a lesbian, gay, or bisexual person.
    strongly agree.....1
    somewhat agree.....2
    somewhat disagree....3
    strongly disagree....4

29. Have you seen any other therapists since you saw your therapist?
    Yes....1 No....2 [If No, skip next question]

30. If Yes, how many?_____

SECTION C

The following questions focus on your experience as a lesbian, gay, or bisexual client in psychotherapy or counseling. Please respond about your experiences with "your therapist", the one therapist you just described.
Please answer questions thoughtfully and quickly. If you are not sure, choose the best response. DO NOT USE N/A (Not Applicable) UNLESS IT IS IMPOSSIBLE TO ANSWER OTHERWISE.
Please rate the following statements from 1 to 4 by circling the best response.

strongly agree.....1
somewhat agree.....2
somewhat disagree.....3
strongly disagree.....4
Not applicable.....N/A

	strongly agree	somewhat agree	somewhat disagree	strongly disagree	
1. I felt satisfied with the questions my therapist asked me about my sexuality.	1	2	3	4	N/A
2. There were subtle things about the way my therapist responded to me that made me feel that she or he was <u>not</u> supportive of my being lesbian, gay, or bisexual.	1	2	3	4	N/A
3. My therapist seemed to have stereotyped notions about gay, lesbian, or bisexual lifestyles.	1	2	3	4	N/A
4. My therapist let me know that being lesbian, gay, or bisexual was okay for me.	1	2	3	4	N/A
5. My therapist understood how problems in same sex relationships may be different than problems in heterosexual relationships.	1	2	3	4	N/A
6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized.	1	2	3	4	N/A

	strongly agree	somewhat agree	somewhat disagree	strongly disagree	
7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality.	1	2	3	4	N/A
8. Although there was nothing that my therapist said directly to indicate it, I had the sense that she or he felt negatively about a lesbian, gay, or bisexual lifestyle.	1	2	3	4	N/A
9. My therapist was supportive of my being lesbian, gay, or bisexual.	1	2	3	4	N/A
10. My therapist respected me as a lesbian, gay, or bisexual person.	1	2	3	4	N/A
11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.	1	2	3	4	N/A
12. In my therapy, I felt welcomed to talk about my sexuality.	1	2	3	4	N/A
13. My therapist asked too little about my sexuality.	1	2	3	4	N/A
14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.	1	2	3	4	N/A
15. My therapist helped me to feel good about my sexual orientation.	1	2	3	4	N/A
16. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems with my mother and/or father.	1	2	3	4	N/A

	strongly agree	somewhat agree	somewhat disagree	strongly disagree	
17. I felt satisfied with how much my therapist inquired about my sexual orientation.	1	2	3	4	N/A
18. My therapist did not believe that I am lesbian, gay, or bisexual.	1	2	3	4	N/A
19. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems in my childhood.	1	2	3	4	N/A
20. I felt that my therapist avoided discussing my same sex behavior.	1	2	3	4	N/A
21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.	1	2	3	4	N/A
22. My therapist treated my homosexuality or bisexuality as only one of many important parts of me.	1	2	3	4	N/A
23. My therapist seemed to think that being lesbian, gay, or bisexual was a symptom of mental illness.	1	2	3	4	N/A
24. My therapist relied on me too heavily for information about lesbian, gay or bisexual lifestyles.	1	2	3	4	N/A
25. My therapist seemed to think that homosexuality or bisexuality was immoral or sinful.	1	2	3	4	N/A
26. My therapist encouraged me to become heterosexual.	1	2	3	4	N/A
27. My therapist seemed supportive of my developing or having romantic same sex relationships.	1	2	3	4	N/A

	strongly agree	somewhat agree	somewhat disagree	strongly disagree	
28. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may affect my intimate same sex relationships.	1	2	3	4	N/A
29. My therapist questioned whether I was really lesbian, gay, or bisexual.	1	2	3	4	N/A
30. My therapist was interested in understanding what my sexuality meant to me.	1	2	3	4	N/A
31. I felt that my therapist avoided discussing my same sex attractions.	1	2	3	4	N/A
32. My therapist discouraged me from being lesbian, gay, or bisexual.	1	2	3	4	N/A
33. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may contribute to my personal problems.	1	2	3	4	N/A
34. My therapist focused too much on the cause of my homosexuality, bisexuality, or same sex attractions.	1	2	3	4	N/A
35. My therapist seemed to think that if I resolved personal problems, I would become heterosexual.	1	2	3	4	N/A
36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.	1	2	3	4	N/A
37. My therapist indicated that she or he would only work with me if I were willing to try to become heterosexual.	1	2	3	4	N/A

	strongly agree	somewhat agree	somewhat disagree	strongly disagree	
38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex.	1	2	3	4	N/A
39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.	1	2	3	4	N/A
40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.	1	2	3	4	N/A

41. How often did your therapist make overtly negative statements that indicated that s/he believed that homosexuality was a problem?

Very often....1 A few times.....2 Never....3

42. How often did your therapist encourage you to date persons of the opposite sex?

Very often....1 A few times.....2 Never....3

43. How often did your therapist suggest that you try to change your sexual attractions to heterosexual ones?

Very often....1 A few times.....2 Never....3

SECTION D
How knowledgeable do you think "your therapist" is (was) about the following issues as they relate to LESBIANS, GAYS, AND BISEXUALS?

1...very knowledgeable
2...somewhat knowledgeable
3...not knowledgeable
4...don't know

	Very	Somewhat	Not	Don't know
1. Stages of "coming out" to self and to others	1	2	3	4
2. Dealing with family (i.e. parents) and being gay, lesbian, or bisexual	1	2	3	4
3. HIV and AIDS	1	2	3	4
4. Societal discrimination of lesbians, gays, and bisexuals	1	2	3	4
5. Gay or Lesbian couples	1	2	3	4
6. Gay or Lesbian sex	1	2	3	4
7. Lesbian or Gay lifestyle and culture	1	2	3	4
8. Bisexual lifestyle and culture	1	2	3	4
9. Work/career issues for lesbians, gays, and bisexuals	1	2	3	4
10. Minority, racial, ethnic issues for lesbians, gays, and bisexuals	1	2	3	4
11. Lesbian and Gay parenting	1	2	3	4
12. Religious conflicts for lesbians, gays, and bisexuals	1	2	3	4
13. Community resources for gays, lesbians, bisexuals	1	2	3	4

SECTION E These are more questions about your therapist. The questions in this section are about your **overall experience** with "your therapist".

1. How satisfied are you with the help you got from your therapist?
   very satisfied.....1
   somewhat satisfied.....2
   somewhat dissatisfied..3
   very dissatisfied.....4

2. Overall I would say that my therapist was...
   very helpful.....1
   somewhat helpful....2
   not at all helpful..3

3. I would recommend my therapist to others.
   strongly agree.....1
   somewhat agree.....2
   somewhat disagree.....3
   strongly disagree.....4

4. How much have you benefitted from this therapy experience?
   A great deal.....1
   A fair amount.....2
   To some extent....3
   Very little.....4
   Not at all.....5

5. Everything considered, how satisfied are you with the results of this therapy experience?
   Extremely satisfied.....1
   Highly satisfied.....2
   Moderately satisfied.....3
   Fairly satisfied.....4
   Fairly dissatisfied.....5
   Moderately dissatisfied.....6
   Extremely dissatisfied.....7

6. How much do you feel you have changed as a result of this therapy experience?
   A great deal....1
   A fair amount...2
   Somewhat.....3
   Very little.....4
   Not at all.....5

7. To what extent have your complaints or symptoms that brought you to therapy changed as a result of the therapy experience?
   Completely disappeared.....1
   Very greatly improved.....2
   Considerably improved.....3
   Somewhat improved.....4
   Not at all improved.....5
   Got worse.....6

SECTION F

Please answer the following items about "your therapist". For each item, please circle the number which best describes how much you agree or disagree with the item.

Mostly Agree.....1
Moderately Agree.....2
Slightly Agree.....3
Neither Agree or Disagree....4
Slightly Disagree.....5
Moderately Disagree.....6
Mostly Disagree.....7

	Mostly Agree						Mostly Disagree
1. My therapist did not realize how sensitive I was about some of the things we discussed.	1	2	3	4	5	6	7
2. My therapist may have understood my words, but did not see the way I felt.	1	2	3	4	5	6	7
3. Sometimes my therapist thought that I felt a certain way, because that's the way she or he felt.	1	2	3	4	5	6	7
4. My therapist realized what I meant even when I had difficulty in saying it.	1	2	3	4	5	6	7
5. At times my therapist thought that I felt a lot more strongly about a particular thing than I really did.	1	2	3	4	5	6	7
6. At times I sensed that my therapist was not aware of what she or he was really feeling with me.	1	2	3	4	5	6	7
7. My therapist wanted to understand how I saw things.	1	2	3	4	5	6	7
8. My therapist just took no notice of some things that I thought or felt.	1	2	3	4	5	6	7

SECTION G

Finally, we are interested in examples of your experiences in psychotherapy as a lesbian, gay, or bisexual client. Thinking about all experiences you have had in psychotherapy within the past 10 years (including the therapy experience you have already described) please answer the following questions.

1). Describe any experiences where a therapist was insensitive, lacked understanding and/or was not helpful to you as a lesbian, gay, or bisexual client. Describe as fully as you can.

2. Describe any experiences where a therapist was particularly sensitive, understanding, and/or helpful to you as a lesbian, gay, or bisexual client. Describe as fully as you can.

This is the end of the questionnaire.
Thank you very much for completing this questionnaire.
Please mail the questionnaire in the enclosed self-addressed envelope.

APPENDIX H
Distribution of Responses on the 43 Bias Items

APPENDIX H
Distribution of Responses on the 43 Bias Items

Items that are starred* are in the Heterosexual Bias Inventory.
1=strongly agree 2=somewhat agree 3=somewhat disagree 4=strongly agree

	1	2	3	4	N/A	MS	Mean	SD
1. I felt satisfied with the questions my therapist asked me about me sexuality. *	37%	26%	22%	13%	2%	---	2.11	1.06
2. There were subtle things about the way my therapist responded to me that made me feel that she or he was <u>not</u> supportive of my being lesbian, gay or bisexual.*	17%	14%	9%	58%	15%	.5%	1.91	1.20
3. My therapist seemed to have stereotyped notions about gay, lesbian, or bisexual lifestyles.	11%	18%	12%	56%	3%	___	1.83	1.09
4. My therapist let me know that being lesbian, gay, or bisexual was okay for me.	53%	20%	11%	13%	4%	___	1.83	1.08
5. My therapist understood how problems in same sex relationships may be different than problems in heterosexual relationships.	27%	27%	21%	17%	8%	.5%	2.31	1.08
6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized. *	19%	18%	10%	50%	3%	___	2.05	1.22
7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality. *	12%	15%	8%	61%	4%	.5%	1.77	1.12

	1	2	3	4	N/A	MS	Mean	SD
8. Although there was nothing that my therapist said directly to indicate it, I had the sense that she or he felt negatively about a lesbian, gay, or bisexual lifestyle.	11%	17%	9%	59%	2%	1%	1.79	1.10
9. My therapist was supportive of my being lesbian, gay, or bisexual.	55%	17%	13%	12%	3%	___	1.81	1.08
10. My therapist respected me as a lesbian, gay, or bisexual person.	60%	20%	8%	10%	2%	___	1.68	1.01
11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy. *	6%	7%	11%	71%	5%	__	1.45	.88
12. In my therapy, I felt welcomed to talk about my sexuality. *	54%	19%	14%	13%	___	___	3.09	1.20
13. My therapist asked too little about my sexuality.	17%	25%	20%	35%	2%	___	2.25	1.12
14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity. *	5%	12%	8%	72%	3%	.5%	1.48	.91
15. My therapist helped me to feel good about my sexual orientation. *	35%	23%	18%	17%	8%	___	2.19	1.14
16. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems with my mother and/or father.	7%	16%	10%	61%	6%	___	1.66	1.00

	1	2	3	4	N/A	MS	Mean	SD
17. I felt satisfied with how much my therapist inquired about my sexual orientation.	32%	23%	28%	14%	3%	.5%	2.24	1.07
18. My therapist did not believe that I am lesbian, gay, or bisexual	5%	8%	9%	72%	7%	.5%	1.40	.84
19. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems in my childhood.	7%	16%	9%	62%	6%	___	1.66	1.01
20. I felt that my therapist avoided discussing my same sex behavior.	12%	20%	10%	55%	3%	___	1.89	1.13
21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.*	47%	18%	17%	16%	1%	___	2.02	1.15
22. My therapist treated my homosexuality or bisexuality as only one of many important parts of me.	63%	21%	5%	7%	4%	___	1.55	.89
23. My therapist seemed to think that being lesbian, gay, or bisexual was symptom of mental illness.	3%	5%	10%	78%	4%	___	1.30	.70

	1	2	3	4	N/A	MS	Mean	SD
24. My therapist relied on me too heavily for information about lesbian, gay, or bisexual lifestyles.	10%	16%	14%	55%	6%	___	1.79	1.06
25. My therapist seemed to think that homosexuality or bisexuality was immoral or sinful.	3%	5%	6%	83%	3%	___	1.26	.70
26. My therapist encouraged me to become heterosexual.	6%	7%	8%	77%	3%	___	1.40	.86
27. My therapist seemed supportive of my developing or having romantic same sex relationships.	49%	17%	14%	14%	7%	___	1.91	1.12
28. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may affect my intimate same sex relationships.	33%	27%	20%	16%	4%	.5%	2.19	1.08
29. My therapist questioned whether I was really lesbian, gay, or bisexual.	7%	10%	12%	68%	4%	___	1.54	.94
30. My therapist was interested in understanding what my sexuality meant to me. *	38%	27%	18%	16%	1%	.5%	2.13	1.10

	1	2	3	4	N/A	MS	Mean	SD
31. I felt that my therapist avoided discussing my same sex attractions.	10%	18%	12%	57%	3%	___	1.82	1.08
32. My therapist discouraged me from being lesbian, gay, or bisexual. *	7%	9%	10%	72%	2%	1%	1.49	.92
33. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may contribute to my personal problems.	25%	35%	16%	21%	3%	___	2.34	1.09
34. My therapist focused too much on the cause of my homosexuality, bisexuality, or same sex attractions.	4%	8%	9%	76%	4%	___	1.38	.81
35. My therapist seemed to think that if I resolved personal problems, I would become heterosexual.	5%	9%	9%	71%	5%	.5%	1.45	.88
36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.*	50%	24%	14%	10%	2%	.5%	1.85	1.03
37. My therapist indicated that she or he would only work with me if I were willing to try to become heterosexual.	1%	1%	2%	90%	6%	.5%	1.06	.35

	1	2	3	4	N/A	MS	Mean	SD
38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex. *	5%	14%	12%	62%	6%	1%	1.59	.94
39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person. *	34%	28%	15%	15%	8%	.5%	2.11	1.09
40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself. *	34%	34%	11%	16%	6%	.5%	2.08	1.06

For items 41-43 the response categories are:
1= very often 2=a few times 3=never

	1	2	3	MS	Mean	SD
41. How often did your therapist make overtly negative statements that indicated that s/he believed that homosexuality was a problem.	1%	15%	84%	___	1.17	.42
42. How often did your therapist encourage you to date persons of the opposite sex?	3%	7%	89%	1%	1.14	.43
43. How often did your therapist suggest that you try to change your sexual attractions to heterosexual ones?	1%	8%	91%	___	1.10	.35

APPENDIX I
The Heterosexual Bias Inventory

APPENDIX I
The Heterosexual Bias Inventory

32. My therapist discouraged me from being lesbian, gay, or bisexual.

39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.

38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex.

14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.

7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality.

36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.

21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.

11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.

6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized.

15. My therapist helped me to feel good about my sexual orientation.

1. I felt satisfied with the questions my therapist asked me about my sexuality.

2. There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay, or bisexual.

12. In my therapy I felt welcomed to talk about my sexuality.

30. My therapist was interested in understanding what my sexuality meant to me.

40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.

APPENDIX J
Distribution of responses on Knowledge Measure

APPENDIX J
Distribution of responses on Knowledge Measure

How knowledgeable do you think "your therapist" is (was) about the following issues as they relate to LESBIANS, GAYS, AND BISEXUALS?
1...very knowledgeable
2...somewhat knowledgeable
3...not knowledgeable
4...don't know

	N=213 Very 1	Somewhat 2	Not 3	Don't Know 4	MS*
1. Stages of "coming out" to self and to others	27.2	38.5	23.9	10.3	
2. Dealing with family (i.e. parents) and being gay, lesbian, or bisexual	34.3	40.8	17.8	7.0	
3. HIV and AIDS	25.8	28.2	12.2	32.9	
4. Societal discrimination of lesbians, gays, and bisexuals	34.3	43.2	16.9	5.6	
5. Gay or Lesbian couples	31.9	31.9	25.4	10.8	
6. Gay or Lesbian sex	22.1	30.0	29.1	18.8	
7. Lesbian or Gay lifestyle and culture	23.5	40.4	27.7	8.0	.5
8. Bisexual lifestyle and culture	7.5	24.9	25.8	40.4	1.4
9. Work/career issues for lesbians, gays, and bisexuals	26.8	38.0	22.1	13.1	
10. Minority, racial, ethnic issues for lesbians, gays, and bisexuals	15.0	26.8	20.7	37.1	.5
11. Lesbian and Gay parenting	10.3	22.5	23.9	43.2	
12. Religious conflicts for lesbians, gays, and bisexuals	19.7	26.8	20.7	32.4	
13. Community resources for gays, lesbians, bisexuals	27.2	26.3	31.5	14.6	.5

APPENDIX K
Distribution of Responses on Satisfaction Measure

APPENDIX K
Distribution of Responses on Satisfaction Measure

N=213

1. How satisfied are you with the help you got from your therapist?

very satisfied	1	42.7%
somewhat satisfied	2	25.8%
somewhat dissatisfied	3	16.4%
very dissatisfied	4	15.0%

mean = 2.03

2. Overall I would say that my therapist was...

very helpful	1	51.6%
somewhat helpful	2	36.6%
not at all helpful	3	11.7%

mean = 1.60

3. I would recommend my therapist to others.

strongly agree	1	41.8%
somewhat agree	2	22.5%
somewhat disagree	3	15.5%
strongly disagree	4	20.2%

mean = 2.14

4. How much have you benefitted from this therapy experience?

A great deal	1	44.6%
A fair amount	2	17.4%
To some extent	3	21.6%
Very little	4	9.4%
Not at all	5	7.0%

mean = 2.17

5. Everything considered, how satisfied are you with the results of this therapy experience?

Extremely satisfied	1	28.6%
Highly satisfied	2	22.5%
Moderately satisfied	3	14.1%
Fairly satisfied	4	9.4%
Fairly dissatisfied	5	8.9%
Moderately dissatisfied	6	3.8%
Extremely dissatisfied	7	12.7%

mean= 3.09

6. How much do you feel you have changed as a result of this therapy experience?

A great deal	1	40.4%
A fair amount	2	24.9%
Somewhat	3	21.1%
Very little	4	9.9%
Not at all	5	3.8%

mean = 2.21

7. To what extent have your complaints or symptoms that brought you to therapy changed as a result of the therapy experience?

Completely disappeared	1	1.9%
Very greatly improved	2	34.3%
Considerably improved	3	27.7%
Somewhat improved	4	22.1%
Not at all improved	5	9.4%
Got worse	6	4.2%
Missing		.5%

mean = 3.16

APPENDIX L
Distribution of Responses on Empathy Measure

APPENDIX L
Distribution of Responses on Empathy Measure

	Mostly Agree						Mostly Disagree
	1	2	3	4	5	6	7
1. My therapist did not realize how sensitive I was about some of the things we discussed. **Mean= 4.35**	15.5	13.6	15.5	7.0	3.8	13.6	31.0
2. My therapist may have understood my words, but did not see that way I felt. **Mean= 4.57**	10.8	17.4	14.1	3.8	5.2	13.6	35.2
3. Sometimes my therapist thought that I felt a certain way, because that's the way she or he felt. **Mean= 4.80**	9.4	10.3	11.3	12.7	7.5	13.6	35.2
4. My therapist realized what I meant even when I had difficulty in saying it. **Mean= 4.66**	18.8	23.5	14.1	15.0	12.2	8.5	7.5 MS*=.5
5. At times my therapist thought that I felt a lot more strongly about a particular thing than I really did. **Mean= 4.34**	6.6	10.8	17.8	16.9	10.3	19.2	17.8 MS*=.5
6. At times I sensed that my therapist was not aware of what she or her was really feeling with me. **Mean= 4.42**	11.7	11.7	14.1	14.1	6.1	15.5	25.8 MS*=.9
7. My therapist wanted to understand how I saw things. **Mean=5.72**	48.8	19.2	11.3	5.2	7.5	4.7	2.8 MS*=.5
8. My therapist just took no notice of some things that I thought or felt. **Mean= 5.28**	5.6	7.5	11.7	7.0	7.0	17.8	42.7 MS*=.5

APPENDIX M

One-Way Analysis of Variance: Differences between current lesbian, gay, bisexual perceptions of bias

APPENDIX M

One-Way Analysis of Variance: Differences between current lesbian, gay, bisexual perceptions of bias

Item	Mean Differences Gay 1	Lesbian 2	Bi 3	F-Ratio	Group Diffs
1. I felt satisfied with the questions my therapist asked about my sexuality.				2.11 ns	
2. There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay or bisexual. (R)				2.54 ns	
3. My therapist seemed to have stereotyped notions about gay, lesbian, or bisexual lifestyles. (R)				1.45 ns	
4. My therapist let me know that being lesbian, gay, or bisexual was okay for me.				2.54 ns	
5. My therapist understood how problems in same sex relationships may be different than problems in heterosexual relationships.				.679 ns	
6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized. (R)				1.36 ns	
7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality. (R)				2.10 ns	

F probability is marked by *. *-.05, ** =.01, ***=.001

An (R) beside the item indicates that the item was reflected in further analysis.

Items	Mean Differences 1	2	3	F-Ratio	Group Diffs
8. Although there was nothing that my therapist said directly to indicate it, I had the sense that she or he felt negatively about a lesbian, gay, or bisexual lifestyle. (R)				1.10 ns	
9. My therapist was supportive of my being lesbian, gay, or bisexual.	1.74	1.72	2.37	4.27*	3>2, 3>1
10. My therapist respected me as a lesbian, gay, or bisexual person.	1.61	1.62	2.15	3.32*	3>1, 3>2
11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy. (R)	3.51	3.68	3.19	3.34*	2>3
12. In my therapy, I felt welcomed to talk about my sexuality.	1.77	1.79	2.39	3.91*	3>1, 3>2
13. My therapist asked too little about my sexuality. (R)				3.72 ns	
14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity. (R)				1.32 ns	
15. My therapist helped me to feel good about my sexual orientation.	2.19	2.06	2.70	3.51*	3>2
16. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems with my mother and/or father. (R)				1.33 ns	

Mean Differences

Items	1	2	3	F-Ratio	Group Diffs
17. I felt satisfied with how much my therapist inquired about my sexual orientation.				1.83 ns	
18. My therapist did not believe that I am lesbian, gay, or bisexual. (R)				.481 ns	
19. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems in my childhood. (R)				.009 ns	
20. I felt that my therapist avoided discussing my same sex behavior (R)				1.33 ns	
21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.				2.11 ns	
22. My therapist treated my homosexuality or bisexuality as only one of many important parts of me.	1.58	1.43	2.0	4.47 **	3>2
23. My therapist seemed to think that being lesbian, gay, or bisexual was symptom of mental illness. (R)				3.29 ns	

Items	Mean Differences 1	2	3	F-Ratio	Group Diffs
24. My therapist relied on me too heavily for information about lesbian, gay, or bisexual lifestyles. (R)				.013 ns	
25. My therapist seemed to think that homosexuality or bisexuality was immoral or sinful. (R)				2.72*	
26. My therapist encouraged me to become heterosexual. (R)				.764 ns	
27. My therapist seemed supportive of my developing or having romantic same sex relationships.				1.22 ns	
28. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may affect my intimate same sex relationships.				.640 ns	
29. My therapist questioned whether I was really lesbian, gay, or bisexual. (R)				2.63 ns	
30. My therapist was interested in understanding what my sexuality meant to me.				.286 ns	

Items	Mean Differences 1	2	3	F-Ratio	Group Diffs
31. I felt that my therapist avoided discussing my same sex attractions. (R)				.394 ns	
32. My therapist discouraged me from being lesbian, gay, or bisexual. (R)	3.51	3.61	3.11	3.37*	2>3
33. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may contribute to my personal problems.				1.67 ns	
34. My therapist focused too much on the cause of my homosexuality, bisexuality, or same sex attractions. (R)				1.31 ns	
35. My therapist seemed to think that if I resolved personal problems, I would become heterosexual. (R)				2.48 ns	
36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.				2.55 ns	
37. My therapist indicated that she or he would only work with me if I were willing to try to become heterosexual. (R)				.432 ns	

Items	Mean Differences 1	2	3	F-Ratio	Group Diffs
38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex. (R)				1.11 ns	
39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.				.287 ns	
40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.				1.32 ns	
41. How often did your therapist make overtly negative statements that indicated that s/he believed that homosexuality was a problem? (R)				1.20 ns	
42. How often did your therapist encourage you to date persons of the opposite sex? (R)				1.33 ns	
43. How often did your therapist suggest that you try to change your sexual attractions to heterosexual ones? (R)				1.78 ns	

APPENDIX N

One-Way Analysis of Variance (ANOVA) Differences Between Lesbian, Gay, and Bisexual perceptions of bias at the time they saw their therapist

APPENDIX N

One-way Analysis of Variance : Differences Between The Responses of Lesbians, Gay Men, and Bisexuals at the time they saw their therapist

The significance level for the pairwise differences is p= < .05.
F probability is marked by *. *=.05, ** =.01, ***=.001
An (R) indicates that item was reflected for further analysis.

	Gay	Lesbian	Bi	Didn't Identify	F-Ratio	Group Diffs
1. I felt satisfied with the questions my therapist asked me about me sexuality.	1.93	1.95	2.28	2.64	4.91**	4>1, 4>2
2. There were subtle things about the way my therapist responded to me that made me feel that she or he was not supportive of my being lesbian, gay or bisexual.(R)					3.30*	
3. My therapist seemed to have stereotyped notions about gay, lesbian, or bisexual lifestyles.(R)					1.74ns	
4. My therapist let me know that being lesbian, gay, or bisexual was okay for me.	1.70	1.60	2.40	2.30	5.59***	3>2, 4>2
5. My therapist understood how problems in same sex relationships may be different than problems in heterosexual relationships.					1.30ns	
6. I felt that my therapist was less accepting of lesbian, gay, or bisexual lifestyles than she or he realized. (R)	3.16	3.09	2.57	2.49	3.73**	1>4, 2>4
7. My therapist seemed to think that heterosexuality was more healthy than homosexuality or bisexuality. (R)	3.30	3.48	2.86	2.80	4.43**	2>4

One-way Analysis of Variance : Differences Between The Responses of Lesbians, Gay Men, and Bisexuals at the time they saw their therapist

	Gay	Lesbian	Bi	Didn't Identify	F-Ratio	Group Diffs
8. Although there was nothing that my therapist said directly to indicate it, I had the sense that she or he felt negatively about a lesbian, gay, or bisexual lifestyle.(R)					2.07ns	
9. My therapist was supportive of my being lesbian, gay, or bisexual.	1.58	1.66	2.29		5.33**	3>1, 4>1, 4>2
10. My therapist respected me as a lesbian, gay, or bisexual person.	1.47	1.52	2.05	2.21	6.50***	4>1, 4>2
11. My therapist made me feel worse about my same sex attractions, fantasies, or behavior than I felt when I entered therapy.(R)	3.62	3.76	3.45	3.00	7.20***	1>4, 2>4
12. In my therapy, I felt welcomed to talk about my sexuality.	1.65	1.72	2.19	2.31	4.55**	4>1, 4>2
13. My therapist asked too little about my sexuality. (R)	2.90	2.88	2.74	2.28	3.23*	2>4, 1>4
14. My therapist seemed to think that being gay, lesbian, or bisexual was a symptom of immaturity.(R)					2.92*	
15. My therapist helped me to feel good about my sexual orientation.	2.02	2.01	2.75	2.53	4.05**	3>2
16. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems with my mother and/or father. (R)					1.65ns	

One-way Analysis of Variance : Differences Between The Responses of Lesbians, Gay Men, and Bisexuals at the time they saw their therapist

	Gay	Lesbian	Bi	Didn't Identify	F-Ratio	Group Diffs
17. I felt satisfied with how much my therapist inquired about my sexual orientation.	2.08	2.03	2.48	2.79	5.72**	4>1 4>2
18. My therapist did not believe that I am lesbian, gay, or bisexual. (R)	3.72	3.78	3.11	3.18	7.17***	1>3 1>4 2>3 2>4
19. My therapist seemed to think that my being lesbian, gay, or bisexual was the result of problems in my childhood. (R)					.442ns	
20. I felt that my therapist avoided discussing my same sex behavior. (R)	3.30	3.22	2.79	2.68	3.30*	1>4
21. I felt pleased with the way my therapist treated me as a lesbian, gay, or bisexual client.	1.79	1.84	2.48	2.55	5.86***	4>1 4>2
22. My therapist treated my homosexuality or bisexuality as only one of many important parts of me.	1.51	1.36	2.00	1.82	4.46**	4>2 3>2
23. My therapist seemed to think that being lesbian, gay, or bisexual was symptom of mental illness.(R)					2.22ns	
24. My therapist relied on me too heavily for information about lesbian, gay, or bisexual lifestyles.(R)					.037ns	
25. My therapist seemed to think that homosexuality or bisexuality was immoral or sinful. (R)	3.77	3.86	3.75	3.42	3.66**	2>4
26. My therapist encouraged me to become heterosexual. (R)	3.66	3.79	3.43	3.16	5.46***	1>4 2>4

One-way Analysis of Variance : Differences Between The Responses of Lesbians, Gay Men, and Bisexuals at the time they saw their therapist

	Gay	Lesbian	Bi	Didn't Identify	F-Ratio	Group Diffs
27. My therapist seemed supportive of my developing or having same sex relationships.	1.77	1.72	2.16	2.41	4.24**	4>2 4>1
28. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may affect my intimate same sex relationships.					1.49ns	
29. My therapist questioned whether I was really lesbian, gay, or bisexual. (R)	3.61	3.68	2.86	3.03	8.35***	1>3 1>4 2>3 2>4
30. My therapist was interested in understanding what my sexuality meant to me.					.371 ns	
31. I felt that my therapist avoided discussing my same sex attractions. (R)					2.48ns	
32. My therapist discouraged me from being lesbian, gay, or bisexual. (R)	3.62	3.78	3.14	2.92	10.35***	1>4 2>4 2>3
33. My therapist seemed to recognize how societal discrimination against lesbians, gays, and bisexuals may contribute to my personal problems.					1.83ns	
34. My therapist focused too much on the cause of my homosexuality, bisexuality, or same sex attractions. (R)	3.69	3.78	3.21	3.33	4.66**	2>3 2>4
35. My therapist seemed to think that if I resolved personal problems, I would become heterosexual. (R)	3.66	3.75	3.05	3.14	7.24***	1>3 1>4 2>3 2>4
36. My therapist showed sensitivity to my concerns as a lesbian, gay, or bisexual person.	1.63	1.75	2.24	2.22	3.95**	4>1

One-way Analysis of Variance : Differences Between The Responses of Lesbians, Gay Men, and Bisexuals at the time they saw their therapist

MEANS

	Gay	Lesbian	Bi	Didn't Identify	F-Ratio	Group Diffs
37. My therapist indicated that she or he would only work with me if I were willing to try to become heterosexual. (R)					1.80 ns	
38. My therapist thought that my being lesbian, gay, or bisexual was caused by negative experiences with people of the opposite sex. (R)	3.60	3.44	2.95	3.25		1>3
39. My therapist seemed to understand my experiences of societal discrimination as a lesbian, gay, or bisexual person.					1.22ns	
40. My therapist recognized how societal discrimination against lesbians, gays, and bisexuals may affect my feelings about myself.					1.23ns	
41. How often did your therapist make overtly negative statements that indicated that s/he believed that homosexuality was a problem? (R)	2.81	2.92	2.71	2.71	3.27*	2>4
42. How often did your therapist encourage you to date persons of the opposite sex? (R)					2.54ns	
43. How often did your therapist suggest that you try to change your sexual attractions to heterosexual ones? (R)					2.24ns	

The means describe the original scores, not the reflected scores. The differences describe the degree of bias, as measured by each item and thus account for the fact that items were reflected.

APPENDIX 0
Repeat Reliability of Empathy Measure

APPENDIX O
Repeat Reliability of Empathy Measure

ITEMS (N=41)	Pearson R	Significance
1. My therapist did not realize how sensitive I was about some of the things we discussed.	.685	.0001
2. My therapist may have understood my words, but did not see the way I felt.	.831	.0001
3. Sometimes my therapist thought that I felt a certain way, because that's the way she or he felt.	.753	.0001
4.(R) My therapist realized what I meant even when I had difficulty in saying it.	.841	.0001
5. At times my therapist thought that I felt a lot more strongly about a particular thing than I really did.	.658	.0001
6. At times I sensed that my therapist was not aware of what she or he was really feeling with me.	.740	.0001
7. (R) My therapist wanted to understand how I saw things.	.884	.0001
8. My therapist just took no notice of some things that I thought or felt.	.809	.0001
Repeat Reliability of Empathy Index	.923	.0001

(R) indicates that item was reflected so that higher scores indicated more empathy.

APPENDIX P
Repeat Reliability of Satisfaction Measure

APPENDIX P

Repeat Reliability of Satisfaction Measure

(N=41)

ITEMS	Pearson R	Significance
1. How satisfied are you with the help you got from your therapist?	.911	.0001
2. Overall I would say that my therapist was...	.908	.0001
3. I would recommend my therapist to others.	.923	.0001
4. How much have you benefitted from this therapy experience?	.826	.0001
5. Everything considered, how satisfied are you with the results of this therapy experience?	.925	.0001
6. How much do you feel you have changed as a result of this therapy experience?	.777	.0001
7. To what extent have your complaints or symptoms that brought you to therapy changed as a result of this therapy experience?	.889	.0001
Total Satisfaction Index	.949	.0001

APPENDIX Q
Repeat Reliability of Knowledge Measure

APPENDIX Q
Repeat Reliability of Knowledge Measure
(N=41)

ITEMS		Pearson R	Significance
1.	Stages of "coming out" to self and to others	.750	.0001
2.	Dealing with family (i.e. parents) and being gay, lesbian, or bisexual	.857	.0001
3.	HIV and AIDS	.776	.0001
4.	Societal discrimination of lesbians, gays, and bisexuals	.842	.0001
5.	Gay or Lesbian couples	.826	.0001
6.	Gay or Lesbian sex	.920	.0001
7.	Lesbian or Gay lifestyle and culture	.943	.0001
8.	Bisexual lifestyle and culture	.896	.0001
9.	Work/career issues for lesbians, gays, and bisexuals	.932	.0001
10.	Minority, racial, ethnic issues for lesbians, gays, and bisexuals	.877	.0001
11.	Lesbian and Gay parenting	.903	.0001
12.	Religious conflicts for lesbians, gays, and bisexuals	.844	.0001
13.	Community resources for gays, lesbians, bisexuals	.710	.0001

BIBLIOGRAPHY

BIBLIOGRAPHY

Abbott, S., & Love, B. (1972). Sappho was a right on women. New York: Stern & Day.

Adair, N., & Adair, C. (1978). Word is out: Stories of some of our lives. New York: New Glide/Delta.

Alexander, R.A. (1986). The relationship between internalized homophobia and depression and low self-esteem in gay men. Unpublished doctoral dissertation, University of California, Santa Barbara.

American Association for Counseling and Development. (1981). Ethical standards (rev.ed.). Washington, DC: Author.

American College Personnel Association. (1990). Ethical standards. Journal of Student Development (College), 31, 197-202.

American Counseling Association. (1988). Ethical Standards. Alexandria, VA: Author.

American Psychiatric Association. (1952). Diagnostic and statistical manual for mental disorders (DSM I). Washington, DC: Author.

American Psychiatric Association. (1968). Diagnostic and statistical manual for mental disorders (DSM II). Washington, DC: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (DSM III). Washington, DC: Author.

American Psychiatric Association. (1986). Diagnostic and statistical manual of mental disorders (DSM IIIR). Washington. DC: Author.

American Psychological Association. (1979). Criteria for accreditation of doctoral training programs and internships in professional psychology. Washington, DC: Author.

American Psychological Association. (1981). Ethical principles of psychologists (revised). American Psychologist, 36, 633-638.

American Psychological Association Committee on Professional Standards. (1989). Casebook for providers of psychological service. American Psychologist, 41, 689-691.

American Psychological Association Task Force. (1975). Report of the task force on sex bias and sex-role stereotyping in psychotherapeutic practice. American Psychologist, 30, 1169-1175.

Anastasi, A. (1982). Psychological Testing. New York: MacMillan.

Atkinson, D. R., Brady, S., and Casas, M. J. (1981). Sexual preference similarity, attitude similarity, and perceived counselor credibility and attractiveness. Journal of Counseling Psychology, 28, 504-509.

Atkinson, D.R., & Hackett, C. (1988). Counseling non-ethnic American minorities. Springfield, IL: Charles C Thomas.

Balis, E. J. (1984). Lesbian experiences in psychotherapy. Unpublished doctoral dissertation, Boston University, School of Education, Boston, MA.

Barrett-Lennard, G.T. (1962). Dimensions of therapist response as causal factors in therapeutic change. Psychological Monographs, 76, 1-33.

Bayer, R. (1981). Homosexuality and American Psychiatry. New York: Basic.

Bell, A.P., & Weinberg, M.S. (1978). Homosexualities: A study of diversity among men and women. New York: Simon & Schuster.

Berger, R. M. (1977). An advocate model for intervention with homosexuals. Social Work, 22, 280-283.

Berger, R. M. (1982). The unseen minority: older gays and lesbians. Social Work, 27, 236-241.

Bergin, A. E. (1985). Proposed values for guiding and evaluating counseling and psychotherapy. Counseling and Values, 29, 99-116.

Berkey, B. R., Perelman-Hall, T. & Kurdek, L. A. (1990). The multidimensional scale of sexuality. Journal of Homosexuality, 19, 67-87.

Berrill, K. T. (1990). Anti-gay violence and victimization in the United States. Journal of Interpersonal Violence, 5, 274-294.

Berrill, K. T. & Herek, G. M. (1990). Violence against lesbians and gay men. Journal of Interpersonal Violence, 5, 269-273.

Betz, N. E., & Fitzgerald, L. F. (1987). The career psychology of women. New York: Academic Press.

Bieber, I., Dain, H.J., Dince, P.R., Drellich, M.G., Grand, H.G., Gundlach, R.H., Kremer, M.W., Rifkin, A.H., Wilbur, C.B., & Bieber, T.B. (1962). Homosexuality: A psychoanalytic study. New York: Basic Books, Inc.

Blair, R. (1974). Counseling concerns and bisexual behavior. The Homosexual Counseling Journal, 1, 26-30.

Blumstein, P. W. & Schwartz, P. (1976). Bisexuality in women. Archives of Sexual Behavior, 5, 171-181.

Boswell, J. (1980). Christianity, social tolerance, and homosexuality. Chicago: University of Chicago Press.

Bowers v. Hardwick, 478 U.S. 186 (1986)

Brooks, V. R. (1981). Sex and sexual orientation as variables in therapists' biases and therapy outcomes. Clinical Social Work Journal, 9, 198-210.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., & Vogel, S. (1970). Sex-role stereotypes and clinical judgements of mental health. Journal of Consulting and Clinical Psychology, 34, 1-7.

Brown, L.S. (1989). New voices, new visions: Toward a lesbian/gay paradigm for psychology. Psychology of Women Quarterly, 13, 445-458.

Brown, L. S. (1991). Commentary on the special issues of The Counseling Psychologist: Counseling with lesbians and gay men. The Counseling Psychologist, 19, 235-238.

Brown, O. H. (1954). An investigation of therapeutic relationship in client-centered psychotherapy. Unpublished doctoral dissertation, University of Chicago, Chicago, Illinois.

Buhrke, R.A. (1989a). Female student perspectives on training in lesbian and gay issues. The Counseling Psychologist, 17, 629-636.

Buhrke, R.A. (1989b). Incorporating lesbian and gay issues into counselor training: A resource guide. Journal of Counseling and Development, 68, 77-80.

Buhrke, R.A. & Douce, L.A. (1991). Training issues for counseling psychologists in working with lesbian women and gay men. The Counseling Psychologist, 19, 216-234.

Bullough, V.L. (1979). Homosexuality: A history. New York: New American Library.

Bullough, V. (1984). Weighing the shift from sexual identity to sexual relationships. Journal of Homosexuality, 10, 3-5.

Cabaj, R.P. (1988). Homosexuality and neurosis: Considerations for psychotherapy. Journal of Homosexuality, 15, 13-23.

Cambell, H. D., Hinkle, D. O., Sandlin, P., & Moffic, H. S. (1983). A sexual minority: Homosexuality and mental care. The American Journal of Social Psychiatry, 2, 26-35.

Casas, J.M., Brady, S., and Ponterotto, J.G. (1983). Sexual preference biases in counseling: An information processing approach. Journal of Counseling Psychology, 30, 139-145.

Cass, V.C. (1979). Homosexual identity formation: A theoretical model. Journal of Homosexuality, 4, 219-235.

Cass, V.C. (1984). Homosexual identity: A concept in need of redefinition. Journal of Homosexuality, 10, 105-127.

Cass, V. (1990). The implications of homosexual identity formation for the Kinsey model and scale of sexual preference. In D.S. McWhirter, S.A. Sanders, and J.M. Teinisch (Eds.), Homosexuality/heterosexuality: Concepts of sexual orientation (pp. 239-266). New York: Oxford University Press.

Chaimowitz, G.A. (1991). Homophobia among psychiatric residents, family practice residents and psychiatric faculty. Canadian Journal of Psychiatry, 36, 206-209.

Chesler, R. (1972). Women and Madness. New York: Avon Books.

Churchill, W. (1967). Homosexual behaviors among males: A cross-cultural and cross species investigation. New York: Hawthorn.

Clark, D. (1977). Loving someone gay. New York: New American Library.

Clark, D. (1987). The new loving someone gay (2nd ed.). Berkeley, CA: Celestial Arts.

Cohen, J. (1968). Multiple regression as a general data-analytic system. Psychological Bulletin, 70, 426-433.

Cohen, J., & Cohen, P. (1975). Applied multiple regression/correlation analysis for the behavioral sciences. Hillsdale, N.J.: Lawrence Erlbaum.

Cohen, C. J. & Stein, T. S. (1986). Reconceptualizing individual psychotherapy with gay men and lesbians. In T. S. Stein & C. J. Cohen (Eds.), Contemporary perspectives on psychotherapy with lesbians and gay men (pp. 27-54). New York: Plenum.

Coleman, E. (1982). Developmental stages of the coming out process. In J.C. Gonsiorek (Ed.), Homosexuality and Psychotherapy (pp. 27-54). New York: Plenum.

Coleman, E. (1987). Assessment of sexual orientation. Journal of Homosexuality, 14, 9-24.

Committee on Lesbian and Gay Concerns. (1991). Final report of the task force on bias in psychotherapy with lesbian women and gay men. Washington, DC: Author.

Comrey, A. L. (1988). Factor analytic methods of scale development in personality and clinical psychology. Journal of Consulting and Clinical Psychology, 56, 754-761.

Conger, J. (1975). Proceedings of the American Psychological Association, incorporated for the year 1974: Minutes of the annual meeting of the council of representatives. American Psychologist, 30, 620-651.

Cooley, E. J. & Lajoy, R. (1980). Therapeutic relationship and improvement as perceived by clients and therapists. Journal of Clinical Psychology, 36, 562-570.

Corcoran, K., & Fisher, J. (1987). Measures for clinical practice. New York: Macmillan Inc.

Cory, D. W., & LeRoy, J. P. (1963). The homosexual and his society: A view from within. New York: Oxford University Press.

Council on Social Work Education, (1982) Curriculum policy for the masters degree and baccalaureate degree programs in social work education. New York. Author.

Cronbach, L. J., & Meehl, P. E. (1955). Construct validity in psychological tests. Psychological Bulletin, 52, 281-302.

Croteau, J. M. and Morgan, S. (1989). Combating homophobia in AIDS education. Journal of Counseling and Development, 68, 86-91.

Darlington, R. B. (1967). Multiple regression in research and practice. Psychological Bulletin, 69, 161-182.

Davison, G.C., & Wilson, G.T. (1973). Attitudes of behavior therapists toward homosexuality. Behavior Therapy, 4, 686-696.

Decker, B. (1984). Counseling Gay and Lesbian Couples. In R. Schoenberg, R. S. Goldberg, & D. A. Shore (Eds.), With compassion toward some: Homosexuality and social work in America (pp. 39-52). New York: Harrington Park Press.

De Crescenzo, T. A. (1984). Homophobia: A study of the attitudes of mental Health professionals toward homosexuality. In R. Schoenberg, R. S. Goldberg, & D. A. Shore (Eds.), With compassion toward some: Homosexuality and social work in America (pp. 115-137). New York: Harrington Park Press.

de Monteflores, C. (1986). Notes on the management of difference. In T. Stein & C. Cohen (Eds.), Contemporary perspectives on psychotherapy with lesbians and gay men (pp.73-101). New York: Plenum Publishing.

DeVillis, R. F. (1991). Scale development: Theory and applications. Newbury Park: Sage Publications.

Dillon, C. (1986). Preparing college health professionals to deliver gay-affirmative services. Journal of College Health, 35, 36-40.

Diversity Works (1990). Resources for gay, lesbian and bisexual concerns. Pelham, MA: Author. (Unpublished manuscript)

Douglas, C. J., Kalman, C. M., Kalman, T. P. (1985). Homophobia among physicians and nurses: An empirical study. Hospital and Community Psychiatry, 36, 1309-1311.

Dulaney, D. D. & Kelly, J. (1982). Improving services to gay and lesbian clients. Social Work, 27, 178-183

Falco, K. L. (1991). Psychotherapy with lesbian clients. New York: Brunner/Mazel.

Fassinger, R.E. (1991). The hidden minority: Issues and challenges in working with lesbian women and gay men. The Counseling Psychologist, 19, 157-176.

Fay, R. E., Turner, C.F., Klassen, A. D., & Gagnon, J. H. (1989). Prevalence and patterns of same-gender sexual contact among men. Science, 243, 338-348.

Finn, P., & McNeil, T. (1987). The response of the criminal justice system to bias crime: An exploratory review. Washington, DC: U.S. Department of Justice, National Institute of Justice.

Fletcher, H. J., Daw, H., & Young, J. (1989). Controlling multiple F test errors with an overall F test. The Journal of Applied Behavioral Science, 25, 101-108.

Ford, C., & Beach, F. (1951). Patterns of sexual behavior. New York: Harper & Row.

Fornstein, M. (1988). Homophobia: An overview. Psychiatric Annals, 18, 33-36.

Fort, J., Steiner, C. M., & Conrad, F. (1971). Attitudes of mental health professionals toward homosexuality and its treatment. Psychological Reports, 29, 347-350.

Freud, S. (1905/1953). Three essays on the theory of sexuality. In J.Strachev (Ed. and Trans.), The standard edition of the complete psychological works of Sigmond Freud, (Vol. 7, pp. 135-243). London: Hogarth Press. (Original work published 1905).

Freud, S. (1910). Three contributions to sexual theory. New York Journal of Nervous and Mental Disorders, 7, 472-474.

Fromm-Reichman, F. (1960). Principles of intensive psychotherapy. Chicago: Phoenix.

Fyfe, B. (1983). Homophobia or homosexual bias reconsidered. Archives of sexual behavior, 12, 549-554.

Gagnon, J. (1977). Human sexualities. Glenville: Scott, Foresman.

Gagnon, J.H., & Simon, W. (1973). Sexual conduct: The social sources of human sexuality. Chicago: Aldine, 1973.

Gambrill, E.D., Stein, T.J., & Brown, C.E. (1984). Social services use and need among gay/lesbian residents of the San Francisco Bay area. Journal of Social Work and Human Sexuality, 3, 51-69.

Garfinkle, E. M., & Morin, S. F. (1978). Psychologists' attitudes toward homosexual psychotherapy clients. Journal of Social Issues, 34, 101-112.

Gartrell, N. (1984). Combatting homophobia in the psychotherapy of lesbians. Women and Therapy, 3, 13-29.

Gartrell, N., Kraemer, H. & Brodie, K. (1974). Psychiatrists' attitudes toward female homosexuality. The Journal of Nervous and Mental Disease, 159, 141-144.

Geller, T. (Ed.). (1990). Bisexuality: A reader and sourcebook. Hadley, MA: Common Wealth Publishing.

Gendlin, E. T. , Jenny, R. H., & Shlien, J. (1960). Counselor ratings of process and outcomes in client-centered therapy. Journal of Clinical Psychology, 44, 888-897.

Gilbert, L. (1980). Feminist therapy. In A. Brodsky & R. Hare-Mustin (Eds.), Women and psychotherapy: An assessment of research and practice. New York: Guilford Press.

Glenn, A. A. & Russell, R. K. (1986). Heterosexual bias among counselor trainees. Counselor Education and Supervision, 26, 222-229.

Gochros, H. (1984). Teaching social workers to meet the needs of the homosexually oriented. Journal of Social Work and Human Sexuality, 2, 137-156.

Goldstein, A.P. (1973). Psychotherapeutic attraction. New York: Pergamon Press.

Gonsiorek, J. (1982). Homosexuality and Psychotherapy. New York: Haworth Press.

Graham, D. L. R., Rawlings, E.I., Halpern, H.S. & Hermes, J. (1984). Therapists' needs for training in counseling lesbians and gay men. Professional Psychology: Research and Practice, 15, 482-296.

Grant, B. (1985). The moral nature of psychotherapy. Counseling and Values, 29, 141-150.

Gurman, A. S. (1977). The patient's perception of the therapeutic relationship. In A.S. Gurman & A.M. Razin (Eds.), Effective Psychotherapy (pp. 503- 537). New York: Pergamon Press.

Halleck, S. L. (1971). The politics of therapy. New York: Science House.

Halleck, S. L. (1976). Another response to "Homosexuality: the ethical challenge". Journal of Consulting and Clinical Psychology, 44, 167-170.

Hanley-Hackenbruck, P. (1988). "Coming out" and psychotherapy. Psychiatric Annals, 18, 29-32.

Hansen, C.E. & Evans, A. (1985). Bisexuality Reconsidered: An idea in pursuit of a definition. In Klein, F. & Wolf, T.J. (Eds.), Two lives to lead: Bisexuality in men and women (pp. 1-6). New York: Harrington Park Press.

Hatfield, L. D. (1989, June). New Poll: How U.S. views gays. (In reprint of published series) San Francisco Examiner.

Heatherington, L. (1988). Coding relational communication control in counseling: Criterion validity. Journal of Counseling Psychology, 35, 41-46.

Hencken, J. D. (1984). Conceptualizations of homosexual behavior which preclude homosexual self-labeling. Journal of Homosexuality, 10, 53-63.

Herek, G. M. (1984). Beyond "homophobia": A social psychological perspective on attitudes toward lesbians and gay men. Journal of Homosexuality, 10, 1-21.

Herek, G. (1986). The social psychology of homophobia: Toward a practical theory. Review of Law and Social Change, 14, 923-934.

Herek, G. (1989). Hate crimes against lesbians and gay men. American Psychologist, 44, 948-955.

Herek, G. M. (1990). The context of anti-gay violence. Journal of Interpersonal Violence, 5, 316-333

Hill, C.E., Helms, J.E., Speigel, S.B. & Tichenor, V. (1988). Development of a system for categorizing client reactions to therapist interventions. Journal of Counseling Psychology, 35, 27-36.

Hill, C. E., & Stephany, A. (1990). Relation of nonverbal behavior to client reactions. Journal of Counseling Psychology, 37, 22-26.

Holland, B. S., & Copenhaver, M. D. (1988). Improved bonferroni-type multiple testing procedures. Psychological Bulletin, 104, 145-149.

Hooker, E. (1957). The adjustment of the male homosexual. Journal of Projective Techniques, 21, 18-31.

Hooker, E. (1958). Male homosexuality in the Rorschach. Journal of Projective Techniques, 22, 33-54.

Hooker, E. (1967). The homosexual community. In J.H. Gagnon & W. Simon (Eds.), Sexual deviance (pp. 167-196). New York: Harper & Row.

Hooker, E. (1969). Parental relations and male homosexuality in patient and non-patient samples. Journal of Counseling and Clinical Psychology, 33, 141-142.

Howard, K., & Orlinsky, D. (1972). Psychotherapeutic processes. In P. Mussen & M. Rosenzweig (Eds.), Annual Review of Psychology, 23 (pp. 615-668). Palo Alto, Ca.:Annual Reviews.

Howard, K., Orlinsky, D., & Hill, J. (1970). Patient's satisfaction in psychotherapy as a function of patient-therapist pairings. Psychotherapy: Theory, Research and Practice, 7, 130-134.

Hudson, W.W. & Ricketts, W. A. (1980). A strategy for the measurement of homophobia. Journal of Homosexuality, 5, 357-371.

Human Rights Committee (1987). Position paper of the human rights committee of the American Association for Counseling and Development. Alexandria, VA: Author.

Humphreys, G. E. (1983). Inclusion of content on homosexuality in the social work curriculum. Journal of Education for Social Work, 19, 55-60.

Iasenza, S. (1989). Some challenges of integrating sexual orientations into counselor training and research. Journal of Counseling and Development, 68, 73-76.

Iasenza, S. (1990). A training program to diminish prejudicial attitudes in student leaders. Journal of College Student Development, 31, 83-84.

Isay, R.A. (1989). Being homosexual: Gay men and their development. New York: Giroux.

Jay, K., & Young, A. (1977). The gay report: Lesbians and gay men speak out about sexual experiences and lifestyles. New York: Summit.

Jones, A. & Seagull, A.A. (1977). Dimensions of the relationship between the black client and the white therapist. American Psychologist, 32, 850-855.

Kaplan, G. T. and Rogers, L. J. (1984). Breaking out of the dominant paradigm: A new look at sexual attraction. Journal of Homosexuality, 10, 71-75.

Katz, J. (1976). Gay american history. New York: Avon.

Katz, J. (1979). Gay american history: lesbians and gay men in the U.S.A.: A documentary. New York: Avon.

Kerlinger, F. N. & Pedhazur, E. J. (1973). Multiple regression in behavioral research. New York: Holt, Rinehart, & Winston.

Kinsey, A.C., Pomeroy, W.B., & Martin, C.E. (1948). Sexual behavior in the human male. Philadelphia: Saunders.

Kinsey, A.C., Pomeroy, W.B., Martin, C.E., & Gebhard, P.H. (1953). Sexual behavior in the human female. Philadelphia: W.B. Saunders Co.

Klein, F. (1978). The Bisexual Option. New York: Arbor House.

Klein, F., Sepekoff, B., & Wolf, T. (1985). Sexual orientation: A multi-variable dynamic process. In F. Klein & T. Wolf (Eds.), Two lives to lead: Bisexuality in men and women (pp. 35-50). New York: Harrington Park.

Kline, P. (1993). The handbook of psychologial testing. London: Routeledge.

Kraft-Ebing, R. von. (1894). Psychopathia sexualis (C. H. Chaddock, Trans.). Philadelphia: F.A. Davis.

Krajeski, J.P. (1986) Psychotherapy with gay men and lesbians. In T.S. Stein & C. J. Cohen (Eds.), Contemporary perspectives on psychotherapy with lesbians and gays men (pp. 9-25). New York: Plenum.

Leary, M. R. & Altmaier, E. M. (1980). Type I error in counseling research: A plea for multivariate analysis. Journal of Counseling Psychology, 27, 611-615.

Levitt, E. E. & Klassen, A.D. (1974). Public attitudes toward homosexuality: Part of the 1970 national survey by the institute for sex research. Journal of Homosexuality, 1, 29-43.

Lewis-Beck, Michael. (1980). Applied Regression: An Introduction. Beverly Hills: Sage Publications.

Lief, H. I. (1977). Sexual survey #4: Current thinking on homosexuality. Medical Aspects of Human Sexuality, 11, 110-111.

Lord, A. (1984). Sister outsider. Trumansburg, NY: Crossing Press.

Lorr, M. (1965). Client perceptions of therapists. Journal of Consulting Psychology, 29, 146-149.

Lourea, D. N. (1985). Psycho-social issues related to counseling bisexuals. Journal of Homosexuality, 11, 51-62.

Luborsky, L., Strupp, H., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). Who will benefit from psychotherapy?: Predicting therapeutic outcomes. New York: Basic Books.

MacDonald, A. P. (1976). Homophobia: Its roots and meanings. Homosexual Counseling Journal, 3, 23-33.

MacDonald, A. P. (1981). Bisexuality: Some comments on research and theory. Journal of Homosexuality. 11, 51-62.

MacDonald, A.P. (1983). A little bit of lavender goes a long way: A critique of research on sexual orientation. The Journal of Sex Research, 19, 94-100.

MacDonald, A. P. (1984). Reactions to issues concerning sexual orientations, identities, preferences, and choices. Journal of Homosexuality, 10, 23-124.

Malyon, A. (1982). Psychotherapeutic implications of internalized homophobia in gay men. Journal of Homosexuality, 7, 59-69.

Mann, B. & Murphy, K. C. (1975). Timing of self-disclosure, reciprocity of self-disclosure, and reactins to an initial interview. Journal of Counseling Psychology, 22, 304-308.

Marmor, J. (Ed.). (1980) Homosexual behavior. New York: Basic.

Martin, A. (1982). Some issues in the treatment of gay and lesbian patients. Psychotherapy: Theory, Research and Practice, 19, 341-348.

May, E. P. (1974). Counselors', psychologists', and homosexuals' philosophies of human nature and attitudes toward homosexual behavior. The Homosexual Counseling Journal, 1, 3-25.

McConaghy, N. (1987). Heterosexuality/homosexuality: Dichotomy or continuum. Archives of Sexual Behavior, 16, 411-424.

McDermott, D., Tyndall, L. and Lichtenberg, J. W. (1989). Factors related to counselor preference among gays and lesbians. Journal of Counseling and Development, 68, 31-35

Melton, G. (1989). Public policy and private prejudice. American Psychologist. 44, 933-940.

Messing, A. E., Schoenberg, R., & Stephens, R. K. (1985). Confronting homophobia in health care settings: Guidelines for social work practice. In R. Schoenberg, R.S. Goldberg, D. A. Shore (Eds.), With compassion toward some: Homosexuality and social work in america (pp. 65-74). New York: Harrington Park Press.

Mintz, J., Luborsky, L., & Christoph, P. (1979). Measuring the outcomes of psychotherapy: Findings of the Penn psychotherapy project. Journal of Consulting and Clinical Psychology, 47, 319-334.

Miranda, J., & Storms, M. (1989). Psychological adjustment of lesbians and gay men. Journal of Counseling and Development, 68, 41-45.

Mitchell, S. (1978). Psychodynamics, homosexuality, and the question of pathology. Psychiatry, 41, 251-263.

Moke, P., & Bohan, J.S. (1992). Reconstructing curriculum: Psychology's paradigm and the virtues of iconoclasm. Women's Studies Quarterly, 1 & 2, 7-27.

Morin, S. (1977). Heterosexual bias in psychological research on lesbianism and male homosexuality. American Psychologist, 32, 629-637.

Morin, S. (1978). Psychology and the gay community: An overview. Journal of Social Issues, 34, 1-27.

Morin, S. & Garfinkle, E. M. (1978). Male homophobia. Journal of Social Issues, 34, 29-47.

Morris, P. A. (1973). Doctors' attitudes to homosexuality. British Journal of Psychiatry, 122, 435-436.

Moses, A. E. & Hawkins, R. O. (1982). Positive intervention with gay clients: a summation and conclusion. In, Counseling lesbian women and gay men: A life issues approach. St. Louis: C.V. Mosby Co.

Murphy, B.C. (1992). Educating mental health professionals about gay and lesbian issues. In K. M. Harbeck (Ed.), Coming out of the classroom closet: gay and lesbian students, teachers, and curriculula (pp. 229-246). New York: Haworth Press.

Nathan, S. (1986). Are clinical psychology graduate students being taught enough about sexuality? A survey of doctoral programs. Journal of Sex Research, 22, 220-224.

National Association of Social Workers. (1987). Code of ethics of the National Association of Social Workers. In Encyclopedia of social work, (Vol. 2, 18th ed.). (pp. 951-964). Silver Spring, Maryland: Author.

National Gay & Lesbian Task Force (NGLTF). (1984). Anti-gay/lesbian victimization: A study by the National Gay Task Force in cooperation with gay and lesbian organizations in eight U.S. cities. Washington DC: Author.

National Gay & Lesbian Task Force (NGLTF). (1992). Lesbian and gay civil rights. Washington, DC: Author.

National Gay & Lesbian Task Force (NGLTF). (1992). Anti-gay violence and victimization in 1992. Washington, DC: Author.

National Institute of Mental Health (NIMH). (1987). National lesbian health care survey. (Contract No. 86MO19832201D). Washington, DC: DHHS Publication.

Neisen, J. H. (1990). Heterosexism: Redefining homophobia for the 1990s. Journal of Gay and Lesbian Psychotherapy, 1, 21-36.

Norton, J.L. (1982). Integrating gay issues into counselor education. Counselor Education and Supervision, 21, 208-212.

Nuehring, E., Fein, S., & Tyler, M. (1974). The gay college student: Perspectives for mental health professionals. The Counseling Psychologist, 4, 64-72.

Nungesser, L. (1983). Homosexual acts, actors, and identities. New York: Praeger Publishers.

Nurious, P.S. (1983). Mental health implications of sexual orientation. Journal of Sex research, 19, 119-136.

Orlinsky, D. E. & Howard, K. I. (1975). The therapist experience of psychotherapy. In A.S. Gurman & A.M. Razin (Eds.), Effective psychotherapy: A handbook of research (pp. 566-590). New York: Pergamon Press.

Parloff, M.B. (1961). Therapist-patient relationships and outcome of psychotherapy. Journal of Consulting Psychology, 25, 29-38.

Paul, J. (1985) Bisexuality: Reassessing our Paradigms of Sexuality. In F. Klein & T. Wolf (Eds.), Two lives to lead: Bisexuality in men and women (pp. 35-50). New York: Harrington Park.

Pedhazur, E.J. (1982). Multiple regression in behavioral research. New York: Holt, Rinehart, & Winston.

Polkosnik, M. C. & Wisenbaker, J. M. (1986). Multiple regression research methods: A primer for student affairs professionals. Journal of College Student Personnel, 27, 166-172.

Potter, S. J. & Darty, T. E. (1981). Social work and the invisible minority: An exploration of lesbianism. Social Work, 26, 187-192.

Prilleltensky. I. (1989). Psychology and the status quo. American Psychologist, 44, 795-802.

Reiter, L. (1989). Sexual orientation, sexual identity, and the question of choice. Clinical Social Work Journal, 17, 138-150.

Reiter, L. (1991). Developmental origins of anti-homosexual prejudice in heterosexual men and women. Clinical Social Work Journal, 19, 163-175.

Rich, A. (1980). Compulsory heterosexuality and lesbian experience. Signs, 5, 631-660.

Richardson, D. (1984). The dilemma of essentiality in homosexual theory. Journal of Homosexuality, 10, 79-90.

Riddle, D.I., & Sang, B. (1978). Psychotherapy with lesbians. Journal of Social Issues, 34, 84-100.

Rochlin, M. (1982). Sexual orientation of the therapist and therapeutic effectiveness with gay clients. Journal of Homosexuality, 7, 21-29.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. Journal of Consulting Psychology, 21, 95-103.

Rogers, C. R., & Truax, C.B. (1967). The therapeutic conditions antecedent to change: A theoretical view. In C.R. Rogers (Ed.), The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics (pp. 97-108). Madison, Wisconsin: University of Wisconsin Press.

Rogers, S. M. & Turner, C.F. (1991). Male-male sexual contact in the U.S.A.: Findings from five sample surveys, 1970-1990. The Journal of Sex Research, 28, 491-519.

Roman, M., Charles, E., & Karasu, T.B. (1978). The value systems of psychotherapists and changing mores. Psychotherapy: Theory, research, & Practice, 15, 409-415.

Rubin, G. G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In C.S. Vance (Ed.), Pleasure and danger: Exploring female sexuality (pp. 267-319). Boston: Routledge & Kegan Paul.

Rudolph, J. (1988). Counselors' attitudes toward homosexuality: A selective review of the literature. Journal of Counseling and Development, 67, 165-168.

Rudolph, J. (1989). Effects of a workshop on mental health practitioners' attitudes toward homosexuality and counseling effectiveness. Journal of Counseling and Development, 68, 81-85.

Rudolph, J. (1990). Counselors' attitudes toward homosexualtiy: Some tentative findings. Psychological Reports, 66, 1352-1354.

Saghir, M.T., & Robins, E. (1973). Male and female homosexuality: A comprehensive investigation. Baltimore: Williams & Wilkins.

Saghir, M. T. & Robins, E. (1980). Clinical aspects of female homosexuality. In J. Marmor (Ed.), Homosexual Behavior (pp. 280-295). New York: Basic Books.

Sang, B. (1989). New directions in lesbian research, theory and education. Journal of Counseling and Development, 68, 92-96.

Scher, M. (1975). Verbal activity, sex, counselor experience and success in counseling. Journal of Counseling Psychology, 22, 97-101.

Shannon, J. W. & Woods, W.J. (1991). Affirmative psychotherapy for gay men. The Counseling Psychologist, 19, 197-215.

Siegelman, M. (1972). Adjustment of male homosexuals and heterosexuals. Archives of Sexual Behavior, 2, 9-25.

Silverstein, C. (1976/77). Even psychiatry can profit from its past mistakes. Journal of Homosexuality, 2, 153-158.

Silverstein, C. (Ed.). (1991). Gays, lesbians, and their therapists: Studies in psychotherapy. New York: Norton.

Slovenko, R. (1980). Homosexuality and the law: From condemnation to celebration. In J. Marmor (Ed.), Homosexual Behavior (pp. 194-218). New York: Basic.

Smith, M. L. & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. American Psychologist, 32, 752-760.

Sophie, J. (1982). Counseling lesbians. The Personnel and Guidance Journal, 60, 341-345.

Sophie, J. (1987). Internalized homophobia and lesbian identity. Journal of Homosexuality, 14, 53-65.

Stein, T. (1988). Theoretical considerations in psychotherapy with gay men and lesbians. Journal of Homosexuality, 15, 75-95.

Stein, T.S., & Cohen, C. (Eds.). (1986). Contemporary perspectives on psychotherapy with lesbians and gay men. New York: Plenum.

Strong, S.R., Wambach, C.A., Lopez, F.G., & Cooper, R.K. (1979). Motivational and equipping functions of interpretation in counseling. Journal of Counseling Psychology, 26, 98-107.

Strupp, H.H., Fox, R.E., & Lessler, K. (1969). Patients view their psychotherapy. Baltimore: John Hopkins Press.

Sullivan, H.S. (1961). The psychiatric interview. New York: Norton.

Szasz, T. (1970). The manufacture of madness. New York: Harper Row.

Szasz, T. (1978). The Myth of Psychotherapy. New York: Syracuse University Press.

Thompson, G. H. & Fishburn, W. R. (1977). Attitudes toward homosexuality among graduate counseling students. Counselor Education and Supervision, 17, 121-130.

Thompson, B. J., & Hill, C. E. (1988, June). Therapist perceptions of client reactions. Paper presented at the Society for Psychotherapy Research, Evanston, IL.

Thompson, C., McCandless, B.R., & Strickland, B.R. (1971). Personal adjustment of male and female homosexuals and heterosexuals. Journal of Abnormal Psychology, 78, 237-240.

Tievsky, D. L. (1988). Homosexual clients and homophobic social workers. Journal of Independent Social Work, 2, 51-62.

Tinsley, H.E.A., & Tinsley, D.J. (1987). Uses of factor analysis in counseling psychology research. Journal of Counseling Psychology, 34, 414-424.

Tripp, C.A. (1975). The Homosexual Matrix. New York: McGraw Hill.

Troiden, R. R. (1984). Self, self-concept, identity, and homosexual identity: Constructs in need of definition and differentiation. Journal of Homosexuality, 10, 97-109.

Truax, C.B., & Carkuff, R.R. (1967). Toward effective counseling and psychotherapy: training and practice. Chicago: Aldine.

Van Wyk, P. H. & Geist, C. S. (1984). Psychosocial development of heterosexual, bisexual and homosexual behavior. Archives of Sexual Behavior, 13, 505-544.

Vargo, S. (1987) The effects of women's socialization on lesbian couples. In Boston Lesbian Psychologies Collective (Eds.), Lesbian Psychologies (pp. 161-174). Chicago: University of Illinois Press.

Wampold, B. E. & Feund, R. D. (1987). Use of multiple regression in Counseling Psychology research: A flexible data-analytic strategy. Journal of Counseling Psychology, 34, 372-382.

Weinberg, G. (1972). Society and the healthy homosexual. New York: Anchor.

Wisniewski, J.J., & Toomey, B.G. (1987). Are social workers homophobic? Social Work, 32, 454-455.

Woodman, N.J., & Lenna, H.R. (1980). Counseling with gay men and women. San Francisco: Jossey-Bass.

Zinik, G. (1985). Identity conflict or adaptive flexibility? Bisexuality reconsidered. In, Klein, F. & Wolf, T.J. (Eds.), Two Lives to Lead: Bisexuality in Men and Women (pp. 7-19). New York: Harrington Park Press.

MICHIGAN STATE UNIV. LIBRARIES
31293010219669