Counseling Trainees' Attitudes Toward Homosexuality and Conversion Therapy C Tiffany Cannon.

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ABSTRACT

Research on conversion therapy, counselor training and therapy concerning issues of sexual orientation, and correlates with attitudes toward homosexuality are reviewed. Fifty-three master's level counselor trainees participated in a study of the relationship between one's willingness to consider conversion therapy a viable and ethical treatment modality and their attitudes toward homosexuality. In addition, a fictional case-description was used to examine the kinds of therapeutic goals, issues, and concerns trainees would have when working with a gay male client requesting conversion therapy. Results suggest that there was a significant difference between mean scores on an assessment of attitudes toward homosexuality between those who said conversion therapy was possible or ethical versus those who said it was not. It is argued that results suggest implications for training and therapy concerning issues of sexual orientation.
CHAPTER 1
INTRODUCTION

The purpose of this thesis is to examine the relationship between counselor trainees' willingness to engage in conversion therapy and their attitudes toward homosexuals. Sexual orientation is defined as being inclusive of one's sexual experiences, feelings, and attractions (Nevid, Fichner-Rathus, & Rathus, 1995). Conversion therapy is any intervention designed to assist clients in changing their sexual orientation. The ethics and utility of this practice have been explored by many authors (Davison, 1991; Gonsiorek, 1991; Haldeman, 1991; Murphy, 1992; Nicolosi, 1993; Weinberg, 1973), and the willingness of some practicing professionals to pathologize homosexuality is well established (DeCrescenzo, 1984; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Nicolosi, 1993; Weinberg, 1973). While there is research concerning the biases, attitudes and training deficits of counselor trainees regarding gay, lesbian, and bisexual clients, there is little research examining the willingness of this population to consider conversion therapy as an ethical and viable treatment modality.

A variety of participants' attitudes toward homosexuality have been measured in relation to several variables, including: gender, religious orientation, belief systems, racial identity, and interpersonal contact (Herek, 1987, 1988; Herek &

While it has been suggested that there is a relationship between counselors' attitudes toward homosexuals and the quality of therapy (Betz & Fitzgerald, 1993; Garnets et al., 1991), it is not known if one's attitudes can be correlated with one's willingness to use conversion therapy as a treatment modality.

The research presented will examine the types of issues, goals, and concerns a master's level counseling trainee might conceptualize when faced with a client requesting conversion therapy. Additionally, the correlation between a trainee's tendency to conceptualize conversion as a viable goal and their attitudes toward homosexuality will be investigated. This information will expand on the literature concerning counselor trainees and their attitudes and goals when working with gay, lesbian, or bisexual clients.
CHAPTER 2

REVIEW OF THE LITERATURE

Conversion Therapy

In 1975, the American Psychological Association (APA) urged “mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations” (p.633). In its Code of Ethics and Standards of Practice, the American Counseling Association (1996) warns against discrimination based on sexual orientation. Betz and Fitzgerald (1993) claim that changes in the field of psychology have occurred since the American Psychiatric Association officially dropped homosexuality from their list of mental disorders in 1973, particularly in the reduction of research efforts to find causality and cures. Despite these changes, the APA continues to debate its stance on conversion therapy, or interventions designed to change a client’s sexual orientation (Edwards, 1996). A resolution was proposed by members of the APA which would officially discourage professionals from engaging in conversion therapy, citing lack of effectiveness as an intervention and the implications of pathology associated with this modality as justifications (Edwards, 1996). The APA responded at its 1997 annual meeting in Chicago with a resolution on therapeutic responses to sexual orientation (Sleek, 1997). While the resolution highlights previous APA principles regarding
discrimination and therapy with gay, lesbian, or bisexual clients, it does not specifically condemn or discourage conversion therapy (Sleek, 1997).

There is a difference of opinion among mental health practitioners and researchers regarding the effectiveness and appropriateness of conversion therapy. Joseph Nicolosi (1993), executive director of the National Association for Research and Therapy of Homosexuality (NARTH), claims that there are over 500 mental health professionals who hold membership in this organization. The goals of NARTH are to continue research on conversion therapy and to defend the rights of homosexuals to receive therapy when seeking a change in their orientation. In his book, Healing Homosexuality, Nicolosi (1993) has written case studies of eight men he claims representative of the “personalities” he has encountered while successfully treating over 200 gay men. Although Nicolosi claims that developmental issues are the root of homosexuality, he provides no new research and cites only nine sources for his book.

Socarides (1978) also supports the psychoanalytic view that homosexuality is caused by developmental fixation and regression resulting in a fear of women. He explained that homosexuality is a result of difficulties during the separation-individuation phase of early childhood, resulting in difficulties in gender identification and the formation of a healthy sexual identity. Kaplan (1983) distinguished between the appropriateness of treatment for those content with their “preference” versus those who are not, and she claims that distressed homosexuals deserve the opportunity to have a “normal family life” (p. 252).
The pathologizing of homosexuality and the practice of conversion therapy are not acceptable to everyone, for many contend that it is not ethical to “cure” if there is no disease (Davison, 1991; Gonsiorek, 1991; Haldeman, 1991; Silverstein, 1991; Weinberg, 1973). Silverstein (1991) claimed that previous decisions made by the APA regarding the diagnosis of homosexuals as sick and the continuing efforts of some psychologists to change sexual orientation and find the source of homosexuality is reflective of a social climate that is intolerant. An historic approach is used to demonstrate instances in which psychiatric diagnosis is used as a method of control against feared groups (Silverstein, 1991). The tendency in diagnosis is to treat those who suffer, yet the suffering is often caused by current societal norms which stigmatize certain behaviors and label particular groups as deviant (Silverstein, 1991). Stein (1988) points out that attempts to convert are not the only source of stigma, for the lack of effectiveness inherent in this treatment ensures that the client will carry the burden of failing in therapy, as well. Many authors argued that the willingness to conceptualize conversion therapy as a viable treatment modality further reinforces the societal stigmatization and self-hate which leads many clients to request help (Davison, 1991; Haldeman, 1991).

Reviews of the literature in support of conversion therapy point to bias and methodological flaws. For instance, Ferguson (1994) argued against the psychoanalytic conceptualization of homosexuality and claimed that Socarides (1978) and others interpret theory in a subjective and narrow way in order to label homosexuality as pathology. The concepts of “fixation” and “regression” are
explored in an attempt to demonstrate that their modern application to homosexuality is based on bias as opposed to scientific research (Ferguson, 1994). Haldeman (1991) evaluates the literature describing psychotherapeutic and religious methods of conversion therapy and concludes that they are scientifically flawed in terms of theory, methodology, and outcomes. In addition to ethical concerns surrounding the lack of effectiveness, conversion therapy is criticized for treating homosexuality as an illness and reinforcing prejudice against homosexuals (Haldeman, 1991). Murphy (1992) reviews techniques and justifications used for therapy designed to redirect sexual orientation. He concludes that despite evidence that justifications have changed from using the language of pathology to claiming that therapeutic change is the personal choice of clients, an implied moral devaluation of homosexuality remains (Murphy, 1992). In a review of research, Gonsiorek (1991) demonstrates that studies which endorse conversion suffer from methodological and sampling problems. For example, few studies have obtained a representative sample despite evidence that homosexual behavior spans across social, economic, racial-ethnic, religious, and other variables (Gonsiorek, 1991). It is suggested that the energy invested in employing treatments that have little or no evidence of effectiveness to cure a disease that does not exist would be better spent doing gay-affirmative therapy with the goal of assisting gay and lesbian clients in the acceptance of their orientation (Davison, 1991; Silverstein, 1991; Weinberg, 1973).
Homosexuality and Therapy

Research indicates a tendency for practitioners to see gay and lesbian clients through a lens of stereotype and pathology. In a survey of 86 behavior therapists, Davison and Wilson (1973) found a tendency to frequently employ aversive procedures in their treatment of gay clients and to see homosexuality as less rational than heterosexuality. The therapists studied were not likely, however, to attempt to change the orientation of a client who did not wish to do so. In a study of 80 psychotherapists, Garfinkle and Morin (1978) found that the perceived health of a hypothetical client differed as a function of their sexual orientation and the gender of the therapist. Homosexual clients were assessed as significantly less healthy than heterosexual clients on a measure of female stereotyped characteristics. The authors concluded that the therapists’ bias was based on the assumption that homosexuality represents a violation of “normal” sex role behaviors. Casas, Brady, and Ponterotto (1983) used an illusory paradigm with 34 mental health professionals and found that participants were more likely to correctly process information when it was congruent with sexual orientation stereotypes or attributed to heterosexual men and women. The authors concluded that the interference of stereotype in information processing is detrimental to the therapists’ ability to adequately serve this population, yet the study was limited by a lack of data regarding the participants’ sexual orientation and familiarity with homosexuality. A 20-page questionnaire administered to 140 mental health professionals regarding attitudes toward homosexuality revealed homophobic
attitudes among various disciplines (DeCrescenzo, 1984). DeCrescenzo (1984) found that social workers achieved the highest homophobic scores, while interpersonal contact, stereotypical beliefs about gay men and lesbians, and the sexual orientation of the participant impacted the correlations between disciplines and attitudes. Graham, Rawlings, Halpern, and Hermes (1984) surveyed 112 therapists in the greater Cincinatti area regarding their attitudes, knowledge, and concerns about counseling gay and lesbian clients. Results indicate that despite positive attitudes toward homosexuality in general, therapists acknowledged a lack of information regarding gay and lesbian lifestyles and resources available in their community. The most frequent responses to an open-ended question requesting major concerns in counseling homosexuals were: difficulty with countertransference and a lack of objectivity (21%); a lack of knowledge about the population (16%); and difficulties with assessment and diagnosis (12%). The authors conclude that clinicians serving the gay and lesbian community lack the training and knowledge to do so. In 1984, the APA Committee on Lesbian and Gay Concerns formed a task force to investigate the types of bias involved in therapy with lesbians and gay men. In the committees' 1986 survey of 2,544 psychologists, Garnets, Hancock, Cochran, Goodchilds, and Peplau (1991) found that 58% of practitioners knew of incidents where lesbian and gay clients were defined as "sick" and in need of a change in their sexual orientation. They conclude that the adherence of professionals to the guidelines for unbiased practice with this population is highly inconsistent.
The attitudes of practitioners toward their clients are an important consideration, particularly when one’s values affect treatment goals (Morin & Charsles, 1983). Morin and Charsles (1983) argued that bias ranging from the attempted conversion of clients not wishing to change to the subtle use of language which implies heterosexism creates a system where gay, lesbian, and bisexual clients are jeopardized. In a study of counselor comfort with HIV-infected patients, Hayes & Gelso (1991) found that participants’ discomfort with gay clients was related to their measured level of homophobia.

Cabaj (1988) claims that internalized homophobia in the therapist or the client often leads to difficulties in therapy for gay and lesbian clients, including inaccurate diagnosis and inappropriate treatment. For instance, internalized homophobia resulting in self-hatred may be manipulated by the therapist who is convinced that homosexuality is harmful, rather than treated and addressed with regard to the clients unique needs (Cabaj, 1988). In contrast, the therapist who too quickly accepts a client as gay or lesbian without being comfortable with the doubts and uncertainty inherent in the coming out process can be harmful, as well (Cabaj, 1988). As with any other therapeutic issue, the client must have the freedom to explore feelings and experience growth at their own pace.

McHenry and Johnson (1993) suggested that homophobia and heterosexism are present in every clinician and client in varying degrees. If the therapist does not acknowledge or address these biases, a collusion may exist in the therapeutic relationship resulting in negative treatment outcomes. For example, a psychologist
may collude with a client’s internalized homophobia and claim that their sexual
orientation is merely a “phase” they are going through (McHenry & Johnson, 1993).

Heterosexual bias does not begin at graduation, for several studies have
investigated the training deficits and attitudes of counselor trainees regarding gay,
lesbian, and bisexual clients (Buhrke, 1989; Davison & Friedman, 1981; Glenn &
students with case description of hypothetical clients that differed only in their sexual
orientation and asked for a diagnosis. They found that the client described as having
homosexual experiences were more likely to have his psychological problems
attributed to his sexuality. In a study of 36 female counseling trainees, Glenn &
Russell (1986) found that 83% of participants demonstrated heterosexual bias when
presented with a client whose orientation was ambiguous and unidentifiable. Finally,
Buhrke (1989) surveyed 213 female counseling psychology students and discovered
that they received little exposure to gay and lesbian concerns from faculty, clients, or
research. In fact, almost 30% of doctoral students had not received any training
regarding working with gay and lesbian clients (Buhrke, 1989).

Attitudes Toward Homosexuality and Correlates

There have been several correlates investigated in relation to attitudes toward
lesbians and gay men (Herek, 1987, 1988; Herek & Capitanio, 1995; Herek & Glunt,
1993; Kite, 1984, 1992a). Gender differences in attitudes toward homosexuals were
found by Herek (1988), with men having more hostile attitudes than women. Several
variables were found to underlie one’s attitudes including: religion, adherence to
traditional ideologies of family and gender, perceptions of friends agreement with attitudes, and past interactions. In a meta-analytic review, Kite (1984) found a small mean effect indicating that males had more negative attitudes than females, but it decreased as sample size became larger. Kite (1988) furthered her research of men's attitudes and found that the men studied held more negative views of gay men than they did of lesbians, but these views did not necessarily affect their affective reactions. In a study of 126 heterosexual students, Herek found that the conservatism of one's religious beliefs was a more important factor than one's religious orientation. In a phone survey of 391 black heterosexual adults, Herek and Capitanio (1995) observed no greater presence of negative attitudes among black heterosexuals than among whites. Finally, Herek and Glunt (1993) found in a survey of 937 adults that interpersonal contact was the single greatest predictor of positive attitudes towards homosexual men.

Research Questions

It is well documented that there is a difference of opinion among mental health professionals regarding conversion therapy. While there are investigations of the attitudes and training deficits of counselor trainees regarding homosexual and bisexual clients, there is little research which considers the willingness of this population to see conversion therapy as a viable treatment modality. It is also unknown if the attitudes of trainees toward homosexuality are related to their attitudes regarding conversion therapy.

This study will examine the following questions and phenomena:
1. Responses to a fictional case-description will be analyzed in order to explore the kinds of issues, treatment goals, and concerns that a master's level counselor trainee would identify when faced with a male client requesting conversion therapy.

2. The HAS (Kite & Deaux, 1986) and open-ended questions will be used to compare the attitudes toward homosexuality of trainees who consider conversion therapy a viable treatment modality versus those who do not.

3. The HAS (Kite & Deaux, 1986) and open-ended questions will be used to compare the attitudes toward homosexuality of trainees who consider conversion therapy an ethical treatment modality versus those who do not.
CHAPTER 3

METHODOLOGY

Participants

Fifty-four (11 males, 43 females) master’s level counselor trainees from Loyola University Chicago participated in the study during class time. Data collected from the demographic questionnaire indicate that the participants ranged in age from 21-years-old to 50-years-old ($M=25.2$, $SD=5.4$). Table 1 describes the participants in terms of their school program, racial/ethnic background, and sexual orientation.
TABLE 1

Demographic Information

<table>
<thead>
<tr>
<th>School Program</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Counseling</td>
<td>43</td>
<td>79.6</td>
</tr>
<tr>
<td>School Counseling</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Family Studies</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Non-Responses</td>
<td>2</td>
<td>3.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Racial/Ethnic Background</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>42</td>
<td>77.8</td>
</tr>
<tr>
<td>African-American</td>
<td>5</td>
<td>9.3</td>
</tr>
<tr>
<td>Hispanic/Latino(a)</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Asian-American</td>
<td>2</td>
<td>3.7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>52</td>
<td>96.3</td>
</tr>
<tr>
<td>Bisexual</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Gay Male/Lesbian</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.9</td>
</tr>
</tbody>
</table>

As Table 1 demonstrates, the majority of students participating in the study were white heterosexuals enrolled in the Community Counseling program. In addition to describing their sexual orientation, students were asked about how they experience their sexuality. On a 7-point Likert-type scale ranging from zero (exclusively heterosexual) to seven (exclusively gay/lesbian), 79.6% (n=43) of the sample circled zero, 7.4% (n=4) circled one, 7.4% (n=4) circled two, 1.9% (n=1) circled three, and 1.9% (n=1) circled four. One participant did not respond to this question. The participants vary in terms of their number of semester hours in their program, their educational experiences regarding gay male, lesbian, or bisexual clients, and their interpersonal contacts with these populations. The number of
semester hours completed by the students (including current enrollment) ranged from one to fifty ($M = 20.5$, $SD = 15.6$), with a mode of nine. Table 2 shows the previous education and interpersonal contact of the participants with gay men, lesbians or bisexuals. Ninety-four percent of the sample have known someone who is gay, lesbian, or bisexual.
TABLE 2

Previous Experiences and Interpersonal Relationships with Gay Males, Lesbians, or Bisexuals (G/L/B)

<table>
<thead>
<tr>
<th>Experience</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course in counseling special populations</td>
<td>26</td>
<td>48.1</td>
</tr>
<tr>
<td>Professional ethics course</td>
<td>23</td>
<td>42.6</td>
</tr>
<tr>
<td>Clinical supervision when working with G/L/B client</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Other education</td>
<td>16</td>
<td>29.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpersonal Relationships</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>39</td>
<td>72.2</td>
</tr>
<tr>
<td>Clients</td>
<td>11</td>
<td>20.4</td>
</tr>
<tr>
<td>Supervisor/Professor</td>
<td>10</td>
<td>18.5</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>27.8</td>
</tr>
</tbody>
</table>

Finally, participants were asked to complete the Homosexuality Attitude Scale (HAS, Kite & Deaux, 1986) as an assessment of their attitudes toward homosexuals. The highest possible score on the measure is 105, with higher scores indicating a more positive attitude toward homosexuals. Scores for the entire sample ranged from 44 to 105 ($M = 92.12$, $SD = 11.77$), with a median score of 95 and a mode of 103. Two participants did not complete the scale ($N = 52$).

Procedure

Participants were asked to complete the measures during class time in the middle of their Fall semester. The requirements of participation were described prior to
administration, and students were informed that participation was completely voluntary and that they could withdraw from the study at any time. Those who wished to participate were asked to complete an informed consent form and confidentiality was clearly explained by the test administrator. A copy of the informed consent is available in Appendix A.

Participants were asked to complete a numbered “Packet 1” containing a case-description of a fictional client and three open-ended questions regarding initial treatment goals, issues and concerns for the client based on this description. Upon completion of the initial packet, participants turned in the packet face down, and picked up a “Packet 2”. Participants were asked to write the number from the initial packet on the second packet for the purpose of correlation.

“Packet 2” consists of a demographic questionnaire, two yes/no questions regarding beliefs about conversion therapy, and the HAS (Kite & Deaux, 1986). A copy of the HAS is available in Appendix D. Due to the emphasis on sexual orientation issues and conversion therapy in the second packet, the measures were separated in an attempt to reduce participant bias. Participants were also asked not to discuss the nature of the study with students outside of class. Upon completion of the second packet, participants were asked if they had any questions, and were reminded of who to contact with any further concerns.
Pilot Study

The study was piloted with five master's level counselor trainees. In addition to the procedures previously described, pilot-study participants were asked for feedback regarding the clarity of the measure. Responses dictated changes in the wording of questions in the first packet and a correction of spelling errors. A copy of the final measure is available in Appendix B. Due to the minimal changes resulting from the pilot study, the data obtained from this phase was included in the results from the study.

Measures

Case-Description and Questions. The fictional case-description in the first packet describes a male client exhibiting depressive symptoms and requesting assistance in changing his sexual orientation. (See Appendix B for a copy of the case-description and questions). The case-description was developed by the author in an attempt to describe a client requesting conversion therapy while presenting additional issues and symptoms that would be of concern in a counseling assessment.

Following the fictional description, participants were asked to list the top three therapeutic issues in order of importance that they would identify based on the information provided. This question was asked in order to describe the issues that students would list when faced with a fictional client requesting conversion therapy. The second question asked for three initial treatment goals for the client listed in order of importance. Treatment goals were requested so that the trainees would illustrate how the issues they had identified would be translated into treatment. Finally, participants top three concerns regarding their ability to effectively work with the client were requested. It
was hoped that this question would elicit responses that described the kind of fears or
difficulties the participants would imagine having when faced with a client requesting a
change in his sexual orientation.

Content analysis was used to evaluate the open-ended questions following the
case-description. Categories were created by sorting common answers into nine to eleven
main categories for each question. A team of three judges were assembled to help reduce
the categories further into five to six main response sets. Finally, three judges were asked
to sort 16 randomly selected responses each into the resulting categories. This validity
check of the qualitative categories resulted in 91% agreement.

**Demographic Questionnaire.** Several demographic questions were asked in Packet
2 in an attempt to further describe the participants. Following the demographic questions,
participants were asked two yes/no questions regarding their views of conversion therapy
as a viable treatment modality and reasons and circumstances for their answers. (See
Appendix C for a copy of the demographic questions and the yes/no questions.)

**Homosexuality Attitude Scale.** The Homosexuality Attitude Scale (HAS, Kite &
Deaux, 1986) is the final measure completed in the second packet. The HAS (Kite &
Deaux, 1986) is a single-factor scale demonstrating a favorable or unfavorable view of
homosexuality. The measure is a 21-item Likert scale on which ratings are made ranging
from strong agreement (1) to strong disagreement (5). Items on the scale are statements
concerning stereotypes, attitudes, and fears regarding homosexuals. Scores are obtained
by reverse scoring certain items according to directions provided by the author (Kite,
1992b), and summing the responses. A higher score indicates a more positive attitude toward homosexuality.

The authors' (Kite & Deaux, 1986) initial presentation of the HAS includes reports of one major factor (Coefficient alpha = .93), high internal consistency (alpha = .93), and good test-retest reliability (r = .71). Three later studies (Kite, 1992b) were conducted with data from 838 introductory psychology students and a sample from a gay and lesbian rights group in order to further document the reliability and validity of the measure. Results in the study demonstrated a high internal consistency similar to previous studies, correlation's with other measures of constructs previously found to be related to attitudes toward homosexuals, and no evidence of influence from the desire to be socially acceptable (Kite, 1992b).
CHAPTER 4

RESULTS

Results from Analysis of the Case-Description

The case-description (See Appendix B) in the initial packet was followed by three open-ended questions which called for the listing of three responses in order of importance. Content analysis was employed to evaluate the responses and determine the kinds of issues, treatment goals, and concerns the participants would describe when faced with a gay male client requesting a change in his sexual orientation through therapy.

Content analysis was used to evaluate the open-ended questions following the case-description. Categories were created by sorting common answers into nine to eleven main categories for each question. A team of three judges were assembled to help reduce the categories further into five to six main response sets. Finally, three judges were asked to sort 16 randomly selected responses each into the resulting categories. This validity check of the qualitative categories resulted in 91% agreement.

Therapeutic Issues. Table 3 shows the frequencies of the five categories of client issues based on the fictional case description. Respondents were asked to list three issues in order of importance. The table indicates the frequencies of the first, second, and third most important issue (Issue 1, Issue 2, and Issue 3, respectively)
followed by the total number of responses in bold numbers (Frequency). There were three non-responses to this question.
TABLE 3

Frequencies of Client Issues Based on the Fictional Case-Description

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Issue 1</th>
<th>Issue 2</th>
<th>Issue 3</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexuality/Sexual Orientation</td>
<td>25</td>
<td>18</td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>Depression/Suicide</td>
<td>16</td>
<td>12</td>
<td>15</td>
<td>43</td>
</tr>
<tr>
<td>Self in Relation to Others</td>
<td>2</td>
<td>13</td>
<td>24</td>
<td>39</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Adjustment</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

* Numbers shown indicate frequency of responses to each category.

As demonstrated by Table 3, five categories surfaced in result to the question regarding focus of treatment for the fictional client. The most common responses centered around the issues of the client’s Sexuality/Sexual Orientation. Answers placed in this category ranged from those which emphasized affirming the client’s sexual orientation (i.e., “Homosexuality is O.K.”), to exploring the clients sexual orientation and his desire to become heterosexual:

"Discovering the client’s true sexual orientation."
"Exploring the client’s desire to become heterosexual."
"Sexual feelings when he was younger. What exactly does he mean by ‘his problem’?"

The second most commonly cited issue falls under the heading of Depression/Suicide. These responses concerned the depressive symptoms in the case
description or explicitly mention an assessment of the client's suicidality. Responses focused on the client's stated feelings of desperation, shame, loss, and guilt were also included in this category. Examples of this category include:

"Depressed mood, sleeplessness, and loss of energy."
"Targeting ways to improve sleep patterns to increase energy."
"Assessment of suicidality"

A fourth identified response set is **Self in Relation to Others**. While many responses were focused on the process of coming out (i.e., "The process of coming out as a gay person"), others were more generally focused on relating to and communicating with others. All answers reflected a concern for the client in relation to friends, family, his fiancee, and others as indicated by the following examples:

"Talking about his family and friends' opinions or potential reactions to the idea of him being gay."
"The break-up with his fiancee"
"Relationship skills."
"Up-front and honest communication."

The **Self-Esteem** category included those answers which speak of addressing or increasing the client's self esteem, identity, awareness, or acceptance without mentioning the client's sexual orientation:

"Work on client accepting himself."
"Self-esteem."
"Perception of self-identity"

Finally, **Adjustment** responses are issues of coping, increasing functioning, and reducing anxiety. Answers in this category are focused on the client's performance in activities of daily living:

"How can he change in order to function in a healthy manner in his everyday life?"
“Anxiety reduction/ coping mechanisms.”
“Deal with the issues affecting his everyday functioning.”

**Treatment Goals.** The content analysis of responses pertaining to initial goals in terms of treatment also resulted in the identification of five categories. Table 4 shows the frequencies of the five treatment goal categories based on the fictional case-description. Participants were asked to list three initial treatment goals in order of importance for the client. Table 4 shows the frequencies for the first, second, and third most important treatment goal (Tx Goal 1, Tx Goal 2, and Tx Goal 3, respectively) followed by the total number of responses in bold numbers (Frequency). There were seven non-responses to this question.
### TABLE 4

Frequencies of Treatment Goals Based on the Fictional Case-Description

<table>
<thead>
<tr>
<th>Tx Goal Category</th>
<th>Tx Goal 1 (f=53)</th>
<th>Tx Goal 2 (f=52)</th>
<th>Tx Goal 3 (f=50)</th>
<th>Frequency (F=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexuality/ Sexual Orientation</td>
<td>29</td>
<td>18</td>
<td>13</td>
<td>60</td>
</tr>
<tr>
<td>Depression/ Suicide/Anxiety</td>
<td>12</td>
<td>14</td>
<td>11</td>
<td>37</td>
</tr>
<tr>
<td>Self in Relation to Others</td>
<td>2</td>
<td>11</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

* Numbers shown indicate frequency of responses to each category.

Similar to the responses for issues, the most common treatment goals cited focused on the client's **Sexuality/ Sexual Orientation**. Some respondents were concerned with determining or choosing an orientation:

"To choose between two lifestyles: a gay or heterosexual lifestyle."
"Figure out his own sexual preference"

Other responses in this category showed a concern for the client accepting his orientation or exploring his desire to change:

"Accepting his natural/biological sexual orientation."
"Address desire to change sexual orientation, why does he want to change?"

**Depression/Suicide/Anxiety** includes responses centered around addressing the client's depression, depressive symptoms, and suicidal ideation. "Deal with depressive
episodes,” and “decrease depression” are examples of responses which specifically mention depression, while others were concerned with specific feelings or symptoms:

“Alleviating desperation and shame.”
“Work through sense of hopelessness and guilt.”

Other responses in this category focused on suicide:

“Assuring client’s safety.”
“Assess suicidality”

The third response set, Self in Relation to Others, includes those responses which are concerned with the client and his relationships with friends, family, his fiancee, and the world. Responses centered around “coming out” to family and friends, expressing feelings, and communicating with others are also included. The following are examples of this category:

“Formulate reactions others would have and how to present them the information.”
“Help him to learn how to talk to his family and friends.”
“Deal with separation issues with his girlfriend, maybe it’s a good thing.”

Self-Esteem describes data which focuses on the client’s “self”, whether it be reflection, acceptance, expression, or exploration. Responses are concerned with self-examination, yet they are not explicit about sexual orientation:

“Acceptance of individuality.”
“Improved self-esteem.”
“To love and accept himself with who he is.”

“Acceptance of self, whatever ‘self’ is.” is an example of a response which may be interpreted as a reference to the client’s sexual orientation, yet it is included in this category because no overt reference to the client’s sexuality or sexual orientation is made.
Finally, **Other** includes responses that are reflective of general treatment goals of psychotherapy and answers not fitting in other categories. The following are examples of responses fitting into this category:

"**Commit to treatment with therapist on a regular basis.**"

"**Get the client to evaluate realistic future goals.**"

"**A goal he may bring up?**"

**Concerns.** The third and final question following the case description asked participants to list concerns they would have in regards to their ability to effectively work with the client. Table 5 summarizes the frequencies of six content categories of participant concerns when working with the fictional client. The category frequencies are divided into the first, second, and third most important concerns (Concern 1, Concern 2, and Concern 3, respectively) stated by participants followed by the total frequency (Frequency) in bold-faced numbers. There were twenty non-responses for this category.
TABLE 5

Frequencies of Therapists’ Concerns Based on the Fictional Case-Description

<table>
<thead>
<tr>
<th>Concern Category</th>
<th>Concern 1 (f=54)</th>
<th>Concern 2 (f=48)</th>
<th>Concern 3 (f=40)</th>
<th>Frequency (F=142)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy w/ Population</td>
<td>13</td>
<td>11</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Discomfort w/ Clients</td>
<td>16</td>
<td>11</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Request for Conversion Therapy</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>General Therapist Efficacy</td>
<td>12</td>
<td>8</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td>General Client Concerns</td>
<td>2</td>
<td>6</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Countertransference</td>
<td>4</td>
<td>8</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>View of Homosexuality</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>13</td>
</tr>
</tbody>
</table>

*Numbers shown indicate frequency of responses to each category.

**Efficacy with Population** includes responses in which participants expressed a lack of knowledge, experience, or the ability to relate with clients in terms of working with a gay, lesbian, or bisexual person:

“Little past experience with homosexuals or bisexual individuals.”

“Understanding the gay community, since I am not familiar with too many people.”

Other responses were focused on the participants inability to understand the client’s world-view:

“Inability to fully understand the situation from his point of view.”

“My lack of knowledge of what it’s like to be gay - or caught in between.”
The final types of concerns regarding efficacy with the population were related to a lack of knowledge regarding unique therapeutic issues:

"Lack of knowledge bio/env issues in homosexuality."
"Do I have enough experience/ info to help him acknowledge his sexual orientation?"
"Entering into a new orientation."

Discomfort with Clients Request for Conversion Therapy are answers which reflect the respondents’ concerns about the clients request to change his sexual orientation:

"I do not believe I would (or any therapist) be able to change someone’s sexuality."
"I don’t know how to assist someone in changing his sexual orientation."

Other responses in this category were centered on the trainee’s “bias” that there is nothing wrong with homosexuality:

"Might my commitment to being gay-affirming bias or otherwise complicate my work with this client?"
"He thinks homosexuality is an illness."

A third popular response category is General Therapist Efficacy. This category includes any concerns about the participant working with the client that are not centered on his sexual orientation:

"Lack of knowledge on DSM IV disorders."
"Lack of counseling experience."

Other responses in this set reflected a perceived inability to handle the client’s depressive symptoms effectively:

"His depression that may be suicidal."
"Pressure that the outcome is life or death."
General Client Concerns are those answers which reflect a concern for the client not linked to the therapist’s efficacy or views and that are not concerned with the client’s sexual orientation. This category was created to catch a wide variety of responses that are focused primarily on the client and his experiences in therapy and the world:

“*He is frightened of the therapeutic process*”
“*That the client will not take responsibility for therapy outcome.*”
“*No/lack of family support.*”

Countertransference are responses that suggest the participant is projecting their feelings or values onto the client in the case description:

“*Personal experience with spouse/fiancée being unfaithful.*”
“*Have my biases and values show when helping the client*”
“*The feeling that I want to save his girlfriend and help him the best way I can.*”

Due to their placement in other categories, responses concerned with the client’s sexual orientation or conversion therapy were not included.

Views of Homosexuality is the sixth and final category of participant concerns. These answers are focused on the trainees’ discomfort, bias, and views regarding homosexuals:

“*Personal views of homosexuality.*”
“*Personal bias toward gays.*”

The following responses are included in this category because they reflect a concern based on the sexual orientation of the client without making reference to their efficacy with the population or the client’s request for conversion therapy:

“*Homosexual nature.*”
“*Homosexual tendencies.*”
Possibility of Conversion Therapy and Attitudes Toward Homosexuals

Table 6 provides a comparison of the mean HAS score for those who claim conversion is possible versus those who say it is not possible.

<table>
<thead>
<tr>
<th>Possible</th>
<th>84.4</th>
<th>17.5</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Possible</td>
<td>93.9</td>
<td>9.3</td>
<td>42</td>
</tr>
</tbody>
</table>

TABLE 6
Mean Ratings of Attitudes Toward Homosexuals:
Conversion Therapy is Possible Vs. Not Possible

* Higher numbers indicate a more positive attitude toward homosexuals.

Ten students said it was possible to change one’s sexual orientation through therapeutic interventions versus 42 who said it was not possible. The mean difference in HAS scores between the two groups is 9.55. The Levene’s Test for Equality of Variance was run indicating a significant difference between the mean HAS scores of those saying conversion therapy is possible versus those who say that it is not ($F = 5.46, p = .02$).

Participants were asked to list three circumstances or reasons in order of importance under which they thought that conversion of a client’s sexual orientation through therapy was possible or not possible. Table 7 provides a summary of the circumstances provided by those who believe that it is possible to change a client’s
sexual orientation through therapeutic interventions. Categories, frequencies, and response examples are provided.
TABLE 7

Frequencies and Examples of Circumstances Under Which Successful Conversion Therapy is Possible

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion is the goal of the client.</td>
<td>8</td>
<td>“Personal desire to change.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“A person must want to change.”</td>
</tr>
<tr>
<td>Specific interventions.</td>
<td>4</td>
<td>“Support group involvement (12-step etc.).”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Discovery of tendencies that led client to that lifestyle (family of origin, child sexual abuse, etc.).”</td>
</tr>
<tr>
<td>Characteristics of client’s sexual orientation.</td>
<td>3</td>
<td>“If they are bisexual.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“If a client is acting heterosexual/homosexual for specific reasons, therapy may discover this.”</td>
</tr>
<tr>
<td>Intentions of the therapist.</td>
<td>3</td>
<td>“Brainwashing counselor.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Prejudiced counselor.”</td>
</tr>
</tbody>
</table>

Table 8 provides a summary of the kinds of reasons given by those participants stating that successful conversion therapy is not possible. Categories, frequencies and response examples are provided.
### TABLE 8

Frequencies and Examples of Reasons Why Successful Conversion Therapy is Not Possible

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Nature of sexual orientation.         | 59        | "They are born that way."  
"Biological evidence on hormone level." |
| Therapist ethics/judgments.           | 15        | "If it aint broke, don't fix it."  
"I feel it is unethical." |
| *Not possible, unless...              | 8         | "The individual has to want to change."  
"It really depends on one's religion." |
| Societal pressure/internalized homophobia.. | 6        | "If a person is just doing this for form or fashion, you can help them become aware of this."  
"Society teaches that "gay is bad, you must change who you are' \
" |

* This category includes responses that indicate conversion therapy is possible under specific circumstances, yet the participant checked “no” when asked if successful conversion therapy is possible.

**Ethics of Conversion Therapy and Attitudes Toward Homosexuals**

Table 9 demonstrates a comparison of the mean HAS scores for those who claim conversion therapy is an ethical treatment modality versus those who say it is not ethical.
TABLE 9

Mean Ratings of Attitudes Toward Homosexuals:

Conversion Therapy is Ethical Vs. Not Ethical

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical</td>
<td>87.9</td>
<td>19.6</td>
<td>9</td>
</tr>
<tr>
<td>Not Ethical</td>
<td>93.0</td>
<td>9.5</td>
<td>43</td>
</tr>
</tbody>
</table>

* Higher numbers indicate a more positive attitude toward homosexuals.

Nine students said it was ethical to attempt conversion therapy versus 43 who claimed it was not ethical. The mean difference in HAS scores between the two groups is 5.11. The Levene’s Test for Equality of Variance was run indicating a significant difference between the mean HAS scores of those saying conversion therapy is possible versus those who say that it is not \( (F = 5.84, p = .02) \).

Table 10 provides a summary of the circumstances provided by those who believe that it is ethical to change a client’s sexual orientation through therapeutic interventions. Categories, frequencies, and response examples are provided.


<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversion is the goal of the client.</td>
<td>16</td>
<td>&quot;If it would honestly make the client happier.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;You are responsible to your client.&quot;</td>
</tr>
<tr>
<td>Characteristics of the therapist/therapy.</td>
<td>4</td>
<td>&quot;If studies indicate it is effective in some cases.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Therapist is trained/ experienced in sexual orientation therapy.&quot;</td>
</tr>
<tr>
<td>If a client makes decision without negative view of homosexuality.</td>
<td>4</td>
<td>&quot;That self-acceptance is the first and foremost goal.&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;They have completely explored the position that they are homosexual and realize that it is not necessarily wrong.&quot;</td>
</tr>
<tr>
<td>Characteristics of client’s sexual orientation.</td>
<td>1</td>
<td>&quot;They are mixed on their emotions and feelings (they also have heterosexual feelings).&quot;</td>
</tr>
</tbody>
</table>
Table 11 provides a summary of the kinds of reasons given by those participants stating that successful conversion therapy is not possible. Categories, frequencies and response examples are provided.
**TABLE 11**

Frequencies and Examples of Reasons Why Conversion Therapy is Not Ethical

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violates client’s rights/ ethical goals of treatment.</td>
<td>51</td>
<td>“It is possible that it may harm, rather than help the person.” “We are not allowed, nor should we, impose our views, stereotypes, personal norms on anyone.”</td>
</tr>
<tr>
<td>Reinforcing societal / internalized homophobia</td>
<td>13</td>
<td>“Changing them is somehow saying that a person can’t live a ‘normal’ happy life gay.” “It imposes societies values on an individual.”</td>
</tr>
<tr>
<td>Biological nature of sexual orientation.</td>
<td>10</td>
<td>“I don’t think you should work against nature.” “A therapist can’t change a genetic structure through therapy.”</td>
</tr>
<tr>
<td>*Not ethical, unless...</td>
<td>5</td>
<td>“Only address this topic if it is of concern to the client.” “The answer is dependent on the client’s personal acceptance of his orientation.”</td>
</tr>
</tbody>
</table>

* This category includes responses that indicate conversion therapy is ethical under specific circumstances, yet the participant checked “no” when asked if conversion therapy is ethical.
Discussion of Findings from the Case-Description

Participants responses to the open-ended question following the case-description indicate that the participants were attentive to the sexual orientation issues presented by the client. The client’s sexuality or sexual orientation was the most commonly cited client issue, followed by depression and suicide, the self in relation to others, self-esteem and adjustment. The question regarding treatment goals drew similar results, for clarification and exploration of sexual orientation issues was the primary goal followed by addressing the client’s depression and suicide, exploring the self in relation to others, and improving self-esteem.

The priority of certain goals and issues is also evident, for trainees were asked to list their top three responses in order of importance. Despite the mention of depressive symptoms and suicidal ideation in the case-description, issues and goals related to the client’s sexual orientation ranked first in both categories. Depression and suicide ranked second. Several respondents did not mention suicide or depression in any of their responses. This could be explained by the respondents belief that the clients depression would be eased by addressing his internalized homophobia and his crisis regarding his relationship with his fiancee.
Trainees’ concerns regarding their ability to effectively work with the client also resulted in a variety of responses. While the most commonly cited concern was focused on working with a gay client, almost the same number of responses were about working with clients in general. This perceived lack of counseling efficacy may be due to the inexperience of the sample as reflected by their reported number of semester hours completed. Responses about sexual orientation indicated a discomfort with working with a gay client and concerns about the appropriate response to a client requesting sexual orientation conversion therapy. Finally, the remaining responses reflected a discomfort with the client’s request for conversion therapy, general countertransference issues and concerns about how the trainees personal views regarding homosexuality would affect their ability to work effectively with the client.

The responses of the counselor trainees in this portion of the study adds to previous literature regarding conversion therapy and therapeutic responses to gay, lesbian, and bisexual clients. In a study of psychology students, Davis and Friedman (1981) reported that the psychological problems of a fictional client were more likely to be attributed to sexuality when a client reported having homosexual experiences. In the case-description of the current study, the client’s depressive symptoms actually were centered around his internalized homophobia and his fear of coming out to others. While a number of students focused on the client’s sexual orientation when listing issues and treatment goals, the second most popular response in each category was concerned with depression and suicide. Although there was a link between the client’s struggle with his sexuality and his depressive symptoms in the responses, this was a logical reflection of the issues
presented by the client in the case description. In contrast to the previous study, many students appeared to be able to explore issues of sexuality while remaining aware of other clinical issues.

A number of the initial issues and goals focused on the client’s sexuality were about being gay-affirmative or assisting the client in accepting his sexual orientation and coming out. There appears to be a temptation to focus on the supporting the client’s homosexuality prior to addressing his depression and uncertainty. This finding is consistent with Cabaj’s (1988) assertion that therapists may deny clients the opportunity to experience growth at their own rate in an attempt to be gay-affirmative.

The concerns of counselor trainees’ when faced with the gay male client in the case-description were similar to the major concerns listed by practicing therapists in a survey conducted by Graham et al. (1984). Countertransference, lack of objectivity and knowledge, and difficulties with assessment of gay clients were concerns shared by the two samples (Graham et al., 1984). Another common element in the two studies was the acknowledged lack of information regarding gay and lesbian lifestyles and resources despite positive attitudes toward homosexuals in general (Graham et al., 1984). The apparent lack of comfort when working with this population appeared to be present whether one is in training or working in the field.

Concerns listed by participants demonstrated an agreement with the link between conversion therapy and anti-homosexual attitudes suggested by Haldeman (1991). The second most common concern reported by participants was a discomfort with the client’s request for conversion therapy. Students stated that attempts to change one’s sexual
orientation through therapy would imply that homosexuality was wrong. The responses in this category reflected a perceived conflict between gay affirmative views and the practice of conversion therapy. Many trainees' appeared to equate attempts to change a client's sexual orientation through therapy with bias against homosexuality.

**Discussion of Quantitative Questions**

The results of the quantitative portion of the study suggest that there was a significant difference between the mean HAS scores of those who believe that it is possible to change one's sexual orientation through therapy versus those who do not. Students saying that successful conversion therapy was not possible had a higher mean score suggesting more positive attitudes towards homosexuals.

The majority of participants said that they did not think that conversion therapy was possible. Their primary reason for this belief was the biological nature of sexual orientation. Ethical reasons and the belief that conversion therapy reinforces societal homophobia were less popular responses. Of the ten students who stated that conversion therapy was possible, the most popular justification was the stated wishes of the client. In addition to a client who really wants to change, the remaining factors were a motivated therapist or the use of special interventions.

There was also a significant difference between the mean HAS score of those stating that conversion therapy was ethical versus those who said it was not ethical. Nine students claimed that it was ethical to attempt to change a client's sexual orientation through therapy versus 43 who said was not. Those who said it was unethical cited a violation of client's rights and the ethical goals of treatment as their primary reasons.
Some respondents felt that conversion therapy is unethical because it is based on stigma and societal homophobia. Other answers drew a connection between the ethical goals of therapy and their belief that sexual orientation can not be altered. They expressed discomfort with attempting a therapeutic goal which they saw as impossible.

The justifications for ethical conversion therapy are similar to those given for why it is possible. The primary circumstance cited is that attempting to change a client's sexual orientation is fine if it is the client's goal to do so. In addition to claiming that the customer is always right, some students emphasized the training of the therapist and the proven effectiveness of the treatment were of primary importance. Others held the view that conversion therapy is O.K., as long as the therapist makes sure that the client chooses heterosexuality while feeling good about homosexuality.

Murphy's (1992) review of techniques and justifications used to convert clients' sexual orientation is supported by the results and justifications found in this study. It is suggested in the review that a change has occurred in the justifications of those who support conversion therapy. While conversion was once justified because homosexuality was discussed overtly as pathology, it is now argued that therapeutic change is the choice of the client (Murphy, 1992). Despite this change in language, it is suggested that bias toward homosexual clients still remains. The most popular circumstance under which the participants in the present study would consider conversion therapy ethical or possible is when the client truly wants to change or would be happier as a heterosexual, supporting the assertion that this is currently the popular justification for this practice. Furthermore, the lower HAS scores found by the trainees who say that conversion therapy is possible or
ethical supports Murphy's (1992) view that the switch in justifications is merely a mask for negative attitudes toward this population. It is important to note, however, that there was a small number of participants who were willing to justify the practice of conversion therapy under any circumstances. Perhaps there continues to be progress in the removal of stigma for clients dealing with issues of sexual orientation as suggested by Betz & Fitzgerald (1993).

The reasons cited by those who said that conversion is not ethical or possible is also supported by the literature. Many respondents claim that the biological nature of homosexuality makes it unethical to practice conversion therapy. Stein (1988) agrees with this view, stating that attempts to change a client's orientation is harmful because it sets a therapeutic goal which is guaranteed to fail. Others agreed with Davis’ (1991) and Haldeman’s (1991) views that agreeing to help a client to change their sexual orientation is reinforcing the societal stigmatization that probably lead the client to seek help in the first place.

Implications of the Study

The present study has several implications for counselor trainees, the field of psychology, and our understanding of how issues of sexual orientation are treated in therapy. As demonstrated by their stated concerns and issues, masters level counselor trainees appear to need additional training in working with gay males, lesbians, and bisexual clients. The uncertainty seemed to be compounded by the client’s request for conversion therapy. Training should include an exploration of issues of gay, lesbian and
bisexual identity development, gay-affirmative therapy, and conversion therapy. Ideally, experience working with this issue in practicum or role plays should be included.

A related implication is the quality of care for clients dealing with issues of sexual orientation. Participants demonstrated an openness to explore their beliefs, knowledge, and biases regarding homosexuality. While this is an important first step in working effectively with topics of sexual orientation in therapy, it is also necessary that students take the additional steps of receiving adequate training and supervision regarding these issues. A positive attitude toward homosexuality is not enough for adequate treatment. While many participants were concerned with doing “gay-affirmative” therapy, an overzealous therapist could overlook a potentially dangerous situation or deny the client the right to explore their issues at their own pace.

A final implication regarding trainees and the quality of treatment is the question of how our values affect the treatment of gay, lesbian, and bisexual clients. Homosexuality is unique in its ability to elicit “beliefs” rather than “opinions”. Many people see their attitudes toward homosexuality as an unalterable part of who they are rather than a malleable view influenced by bias. This study demonstrated that the students willing to consider conversion therapy a viable or ethical treatment modality obtained a lower mean score on a measure of attitudes toward homosexuality. This supports the implication that there is a link between values and the treatment options considered for clients struggling with issues of sexual orientation.

The recent resolution by the APA states that when working with gay males, lesbians, or bisexuals it is important to avoid discrimination and respect different values
and opinions. The APA justifies its decision not to directly condemn or discourage conversion therapy in the resolution because there is no evidence that this type of therapy is harmful to the client (Sleek, 1997). The current study may influence policy, for it is evident that the belief that conversion therapy is a viable and ethical treatment modality is linked to more negative attitudes toward homosexuality. It follows that the decision to engage in this type of treatment may be based on the type of discrimination and bias that the APA proclaims therapists should avoid. If practicing conversion therapy is influenced personal bias, it is unethical according to current APA principles. In addition, the current study indicates that a large majority of respondents were unwilling to consider this treatment option as ethical or viable under any circumstances.

**Strengths and Limitations of the Study and Recommendations for Future Research**

The primary limitations in terms of the design and internal validity of the study are linked to the qualitative nature of the case-description and open-ended questions used to describe the population. The case involved a specific situation with a gay male client which limits the generalizability of responses to lesbian or bisexual populations. Future research should use different types of clients in the case examples in order to compare differences in responses. While this portion of the study is limited in terms of its generalizability, it was helpful in eliciting a variety of responses which served to describe the issues, goals, and concerns of the participants when faced with a client requesting conversion therapy. Validity is difficult to establish in the analysis of qualitative data, yet a validity check of the content categories resulted in a high level of agreement (91%). A second limitation in terms of the design of the study is a lack of specific information
regarding trainees' experiences and interpersonal contact with gay males, lesbians, and bisexuals. It is not known the depth or level of experiences and contacts the participants have had with this population, and it has been established that this variable is strongly related to one's attitudes toward homosexuals (Herek & Glunt, 1993). Future research in this area could more thoroughly describe the sample in terms of demographic information and look for correlation's between various variables and one's views of conversion therapy.

The sample is limited to volunteers from a private, midwestern university which limits the external validity of the findings. The sample is primarily composed of white, heterosexual, women which limits generalizability. Future research should utilize a more diverse subject pool to investigate whether the subjects background affects their views of conversion therapy. The sample is also limited by the low number of hours completed by the sample, for the mode for number of hours was nine. Some students may not have had the minimal training necessary in order to understand ethical and treatment issues in therapy. Continued research which utilizes a pre-test and a post-test to examine the effects of training would be helpful in examining the influence of this variable. The views of those already seeing clients in the field are also important, therefore it would be helpful to study the attitudes of experienced clinicians toward conversion therapy. A final limitation is the influence of social desirability responses in the study. Although the measures were separated and participants were asked not to discuss the nature of the study with others, it is possible that participant bias and the self-report method influenced responses. For instance, it is possible that the word "ethical" elicited a desirable response
from participants who were drawn primarily from classes in counseling special population and therapeutic ethics. A future study which used a behavioral measure and a counseling vignette with a client who brings up conversion therapy would help to further eliminate participant bias. Finally, another approach would involve analyzing written or verbal responses in terms of subtle language cues suggesting heterosexual bias as a measure of one's attitudes.

This research revealed that the issues of sexual orientation and conversion in therapy were difficult to sort out for the students in the sample. It was also found that these decisions can be linked to attitudes toward homosexuality. It is hoped that this information will inform future research on the important issue of conversion therapy and affect policy regarding how gay, lesbian, and bisexual clients are treated in therapy.
APPENDIX A
INFORMED CONSENT
APPENDIX A
Informed Consent

The purpose of this study is to gain a better understanding of the kinds of professional decisions Master's level counseling students are likely to make when working with a client. Participation in this research involves reading a case description of a fictional client and identifying issues, concerns, and treatment goals based on this description. Additionally, you will be asked to complete a questionnaire and a Likert-scale instrument. Information obtained from you will be number coded and kept completely confidential, and no names will be used at any time.

Your participation is completely voluntary and you are free to halt participation at any time without penalty.

If you have any questions or concerns about your participation, please feel free to contact Dr. London at (847) 853-3347.

I, _____________________________, acknowledge that: I am aware of the requirements involved with participation in this research; I may withdraw from participation at any time without prejudice; I am free to ask questions regarding procedures to be followed; and I will be given a copy of this consent form.

I freely and voluntarily consent to my participation in this research project.

________________________________________________________________________
(Signature of Participant) (Date)

________________________________________________________________________
(Signature of Researcher) (Date)

If you would like to receive a copy of the findings of this study, please print your address below:
APPENDIX B
CASE DESCRIPTION
APPENDIX B

Case Description

The client is a 29-year-old single white male who has come to therapy complaining of depressed mood, sleeplessness, and a loss of energy that is interfering with his functioning at work. Initially, the client revealed that his problems began three months ago when his engagement with his fiancee of two years was suddenly broken. Later in the intake, the client described with much agitation the events leading up to their separation. The client was discovered leaving a local gay bar by a mutual friend who then reported this occurrence to the client's fiancee. She consequently discovered that he frequented the bar and often left with different men. The client conveyed a sense of helplessness and guilt as he described these events and proclaimed his love for his fiancee.

The client reports that he and his fiancee decided to wait until marriage to have sexual intercourse. His fantasy life and desires are focused on men, and he has been aware of "feelings of being different" since he was very young. He expressed feelings of desperation and shame and stated that the successful outcome of treatment is a matter of life and death.

The client reported no history of mental illness, yet he expressed relief that he was "finally seeking help for his problem." The client expressed anxiety about what he is going to tell friends and family and fear that others would find out. The client is requesting assistance in changing his sexual orientation so that he can "acquire the
capacity to truly love a woman, experience and enjoy heterosexual gratification, and participate in normal family life."

Based on the case description, please list three issues (in order of importance) that would be your focus of treatment for this client:

1.
2.
3.

Given these three issues, list three initial goals (in order of importance) in terms of treatment:

1.
2.
3.

List 3 concerns (in order of importance) you would have in regards to your ability to effectively work with this client:

1.
2.
3.
APPENDIX C

DEMOGRAPHIC INFORMATION
APPENDIX C

Demographic Information

Gender: ___ Female ___ Male

Age:

Please indicate your racial or ethnic background:

___ African American ___ Asian American ___ Hispanic/Latino(a)
___ Native American ___ Caucasian ___ Other

Program:

How many semester hours (including current enrollment) have you completed?

Which of the following best describes your sexual orientation?

___ gay/lesbian
___ bisexual
___ heterosexual
___ other

How do you experience your sexuality? (Indicate by circling the appropriate number.)

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>exclusively heterosexual</td>
<td>exclusively gay / lesbian</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Please check any previous education you have had regarding gay/lesbian/bisexual clients?

___ professional ethics course
___ course in counseling special populations
___ clinical supervision when working with clients
___ other

Have you ever known anyone who is gay/lesbian/bisexual?

___ yes ___ no
If yes, in what capacity?

____ family member
____ friend
____ client
____ supervisor or professor    ____ other

Do you think that it is possible to change one's sexual orientation through therapeutic interventions?

____ Yes    ____ No

If "Yes", under what circumstances? If "No", why not? (Please list the top three circumstances or reasons in order of importance.)

1. 
2. 
3.

Do you think that it is ethical to attempt to change a client's sexual orientation through therapeutic interventions?

____ Yes    ____ No

If "Yes", under what circumstances? If "No", why not? (Please list the top three circumstances or reasons in order of importance.)

1. 
2. 
3. 
APPENDIX D
HOMOSEXUALITY ATTITUDE SCALE
APPENDIX D
HOMOSEXUALITY ATTITUDE SCALE

Please indicate your level of agreement with the items below using the following scale:

1 2 3 4 5
Strongly Agree Neutral Strongly Disagree

1. I would not mind having a homosexual friend.
2. Finding out that an artist was gay would have no effect on my appreciation of his/her work.
3. I won’t associate with known homosexuals if I can help it.
4. I would look for a new place to live if I found out my roommate was gay.
5. Homosexuality is a mental illness.
6. I would not be afraid for my child to have a homosexual teacher.
7. Gays dislike members of the opposite sex.
8. I do not really find the thought of homosexual acts disgusting.
9. Homosexuals are more likely to commit deviant sexual acts, such as child molestation, rape, and voyeurism (Peeping Toms), than are heterosexuals.
10. Homosexuals should be kept separate from the rest of society (i.e., separate housing, restricted employment).
11. Two individuals of the same sex holding hands or displaying affection in public is revolting.
12. The love between two males or two females is quite different from the love between two persons of the opposite sex.
13. I see the gay movement as a positive thing.
14. Homosexuality, as far as I’m concerned, is not sinful.
15. I would not mind being employed by a homosexual.
16. Homosexuals should be forced to have psychological treatment.
17. The increasing acceptance of homosexuality in our society is aiding in the deterioration of morals.
18. I would not decline membership in an organization just because it had homosexual members.
19. I would vote for a homosexual in an election for public office.
20. If I knew someone was gay, I would still go ahead and form a friendship with that individual.
21. If I were a parent, I could accept my son or daughter being gay.

REFERENCES


VITA

The author, Tiffany Cannon, was born in Fort Worth, Texas.

In August, 1989, Ms. Cannon entered the University of North Texas, receiving a Bachelor of Arts in Psychology, Cum Laude in December, 1993. Studies at the University of North Texas included participation in an honors program entitled the Classic Learning Core. This program ended with a Capstone Seminar in Europe during the Summer of 1993.

In addition to her studies, Ms. Cannon volunteered for a local counseling agency, Denton County Friends of the Family, from May, 1993 to August, 1995. She completed a forty hour training for certification as a rape crisis counselor in May, 1993 and received an “Excellence in Advocacy” award from the Texas Association Against Sexual Assault in March 1994. In addition, Ms. Cannon served as intern for the agency’s Sexual Assault Program in the Fall of 1993 and was a partner’s advocate in the Batterer’s Intervention Program for two years.

Following graduation, the author worked for Denton County Friends of the Family as a Family Advocate from February, 1994 to August, 1995. Duties included helping families to meet the requirements of their service plans from Child Protective Services including parenting training, case management, homemaking training, and providing supervised visitation with children removed from the home.
In 1995, Ms. Cannon entered Loyola University Chicago as a master's student in the Community Counseling program. During her studies at Loyola, Ms. Cannon served as a member of two research teams. The first team led by Dr. Suzette Speight and Dr. Liz Vera focused on the underlying factors of a client's perception of counselor competence. The second team led by Dr. Al Agresti explored the issues of multiculturalism and counseling supervision. She was also a co-presenter of a poster at Loyola University on a study of the portrayal of gender roles in the media. The author's thesis research focused on counselor trainees' attitudes toward homosexuality and conversion therapy.

In addition to participation in research projects, Ms. Cannon gained experience in clinical settings and extra-curricular activities. She completed her practicum at Community Counseling Centers of Chicago from September of 1996 through June of 1997. In this position she provided assessment and counseling services for a diverse population of children and families. She was also a member of the Committee for Multicultural Education and participated on a team which created a violence prevention program with parents, teachers and children in a Chicago Public School. She is a student affiliate of the American Psychological Association.

The author is currently working at Youth Organization Umbrella in Evanston, Illinois as a Youth Caseworker doing crisis, family, and individual counseling, outreach, and prevention work with a diverse population of clients. She started the position in August of 1997.
THESIS APPROVAL SHEET

The thesis submitted by Tiffany Cannon has been read and approved by the following committee:

Dr. Lorna London
Professor of Counseling Psychology
Loyola University Chicago

Dr. Suzette Speight
Professor of Counseling Psychology
Loyola University Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

[Signature]
Director’s Signature

11/24/97
Date