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Counseling Professionals' Attitudes toward Transgender People and Responses to Transgender Clients

Emily A. Nisley
Western Michigan University

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COUNSELING PROFESSIONALS' ATTITUDES TOWARD TRANSGENDER
PEOPLE AND RESPONSES TO TRANSGENDER CLIENTS

by

Emily A. Nisley

A Dissertation
Submitted to the
Faculty of The Graduate College
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Advisor: Kelly A. McDonnell, Ph.D.

Western Michigan University
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COUNSELING PROFESSIONALS' ATTITUDES TOWARD TRANSGENDER PEOPLE AND RESPONSES TO TRANSGENDER CLIENTS

Emily A. Nisley, Ph.D.

Western Michigan University, 2010

The multicultural counseling movement emphasizes the critical nature of counselor attitudes in providing culturally competent service (e.g., Sue, 2001; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue & Sue, 2003). Until recently, however, the counseling professions have paid little attention toward transgender people as a cultural minority group. The purpose of this study was to conduct the first assessment of counseling professionals' attitudes toward transgender people and to examine relationships between such attitudes and responses to a transgender client.

A national convenience sample of 138 master's and doctoral level counselors and counseling psychologists, recruited via electronic mailing lists, participated in this web-based study. Participants read one of two written descriptions of a fictional client, a transgender-identified, gender-variant person, described as either biologically male or female. Participants assessed the client using the Global Assessment of Functioning scale (American Psychiatric Association, 2000) and assigned adjectives from the Adjective Check List (Gough & Heilbrun, 1983) expressing their favorable and unfavorable perceptions of the client. Participants completed the Genderism and Transphobia Scale (Hill & Willoughby, 2005), the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), an adapted measure of

training and experience (Tomko, 2008) with additional items to assess beliefs regarding transgender etiology and personal familiarity with transgender people, and a demographic questionnaire.

Overall, the level of anti-trans attitudes in this sample was very low. Men, those with less personal familiarity with transgender people, less training and experience in counseling and assessment with transgender clients, and less perceived multicultural counseling competence expressed greater anti-trans attitudes. Neither anti-trans attitudes nor client sex were significantly correlated with, or predictive of, assessments of psychosocial functioning. Participants with greater anti-trans attitudes expressed fewer favorable perceptions of the client and more unfavorable perceptions. After controlling for education level, extent of training and experience in counseling and assessment with transgender people, and years of counseling experience, neither anti-trans attitudes nor client sex predicted favorable perceptions of the client, while greater anti-trans attitudes, but not client sex, predicted more unfavorable perceptions. Findings, implications, and limitations are discussed and suggestions are made for future research.

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CHAPTER I

INTRODUCTION

The term *transgender* describes “people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their birth sex” (American Psychological Association, 2006, para. 1). Such identities can include those of “transsexuals, cross-dressers, masculine-identified females, feminine-identified males, ...transmen, transgendered women, intersexed, and other differently gendered people” (Lev, 2004, p. 399). The term is often abbreviated in popular and social scientific literature to refer simply to *trans* people, identities, or expressions (used hereafter except when referring more specifically to transsexual people).

There are documented examples of gender variance in a wide variety of cultures throughout recorded history and in contemporary times (APA Task Force on Gender Identity and Gender Variance, 2008; Ettner, 1999; Feinberg, 1996; Herdt, 1994; Nanda, 1999). Serious attention to trans expressions and identities in the United States is a relatively recent phenomenon, however. Along with “the emergent consciousness and political activism emanating from the transgender community” (Carroll & Gilroy, 2002, p. 240), attention from popular media and the legal and social science communities have highlighted trans people’s stories of resilience and achievement, as well as their all-too-many experiences as victims of violence, ridicule, and discrimination within American society (APA Task Force on Gender Identity and Gender Variance; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Currah, Juang, & Minter, 2006; Gender Public Advocacy Coalition, 2006; Koken, Bimbi, & Parsons, 2009;

Lombardi, Wilchins, Priesing, & Malouf, 2001; National Coalition of Anti-Violence Programs, 2006, 2007, 2008, 2009; Nuttbrock et al., 2010).

As of this writing, no federal laws prohibit discrimination on the basis of gender identity or expression with regard to matters of employment, healthcare, housing, or public accommodations. This often leaves trans people without legal recourse when such discrimination occurs, and it does occur. In a survey of over 400 trans people, more than a third (37.1%) of the participants reported experiencing some form of economic discrimination such as “being fired, not being hired, [being] demoted, losing promotions, or being unfairly disciplined” due to their status as trans people (Lombardi et al., 2001, p. 92). That survey also documented high rates of harassment and violence suffered by trans people. Nearly 60% of the participants reported being verbally harassed at some point in their lives for being trans, and one third (33.6%) reported experiencing such harassment within the previous year. Over a quarter (26.6%) reported being violently assaulted, including over 20% of the transsexual participants who reported being the victims of rape and/or attempted rape (Lombardi et al.). Nuttbrock and colleagues (2010) interviewed and surveyed over 500 male-to-female transgender people in the New York metropolitan area and found that approximately half of the participants experienced gender-related physical abuse at some point in their lives, and that nearly 80% experienced gender-related psychological abuse at some point in their lives. Reports issued by the Gender Public Advocacy Coalition (2006) and the National Coalition of Anti-Violence Programs (2006, 2007, 2008, 2009) also documented violence against gender-variant people, including more than 60 murders since 1995.

Acts of harassment, discrimination, and violence against trans people may be evidence of anti-trans social stigma and prejudice. As would be consistent with the minority stress model proposed by Meyer (2003), the stresses of social stigma and prejudice may be major factors in the relatively high incidence of mental health problems within trans populations (APA Task Force on Gender Identity and Gender Variance, 2008; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Clements-Noelle, Marx, & Katz, 2006; Lev, 2004; Lombardi et al., 2001; Mathy, 2002; Nuttbrock et al., 2010). Nuttbrock and colleagues determined that this was indeed the case among their study participants, for whom gender-related physical and psychological abuse impacted major depression and suicidality across the lifespan of male-to-female trans people. They found rates of lifetime major depression (54.3%) and suicidal ideation (53.5%) that were nearly three times that estimated for the general population, and a rate of lifetime suicide attempts (27.9%) which was 10 times that estimated in the general population.

As members of a population made vulnerable by oppressive social conditions, many trans people might be helped through the services and advocacy of counseling professionals (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Carroll & Gilroy, 2002; Koken et al., 2009). Research suggests that many do avail themselves of such services. In a survey of 130 trans people recruited at an annual trans conference, 37% of the participants reported using mental health services in the previous year (Shipherd, Green, & Abramovitz, 2010). Mathy (2001) also surveyed a non-clinical sample of trans people and found that they were more likely to have

participated in psychotherapy than were random or psychosocially matched samples of non-trans men and women.

Counseling professionals, though, are members of the same society that evidences anti-trans attitudes through the stigmatization and oppression of trans people. It is possible, therefore, that some counselors themselves hold anti-trans attitudes, and that such attitudes could negatively impact their work with trans clients (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Carroll & Gilroy, 2002), potentially even harming those seeking help and/or resulting in would-be clients' avoidance of counseling despite potential need for services. Over half (52%) of the trans participants in Shipherd and colleagues' (2010) trans conference study demonstrated current need for mental health services, but had not utilized such services in the previous year. One of the treatment barriers they endorsed most frequently, second only to concerns about the cost of mental health services, was that "somebody I know or heard about had a bad experience with mental health services" (p. 102). The authors noted that the nature of the "bad experience" was not ascertained, but suggested that "provider insensitivity" (p. 103) was a potential explanation. The present study was designed to assess anti-trans attitudes among counseling professionals and to investigate potential relationships between those attitudes and counselors' responses to trans clients.

Statement of the Problem

The multicultural movement within the counseling professions emphasizes the critical nature of counselor attitudes and beliefs, as well as knowledge and skills, in providing culturally competent service (e.g., Sue, 2001; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue & Sue, 2003). Culturally incompetent counselors may not be

aware of their biased attitudes. Their attitudes may cause them to feel uncomfortable with demographic or cultural differences between themselves and their clients, and they may not make any effort to challenge their assumptions about minority clients or to develop “nonoppressive and nonexploitative” attitudes (Sue & Sue, p. 19).

Research has shown that some counseling professionals have negatively biased attitudes regarding client factors such as gender, minority race, and/or minority sexual orientation (e.g., Barratt, 2008; Barrett & McWhirter, 2002; Mohr, Israel, & Sedlacek, 2001; Roach, 2005). In some cases, those negative attitudes were associated with negative reactions to clients and/or biased clinical assessments. Examples from that research will be described in the next chapter. Such forms of multicultural incompetence may harm clients, hinder the development of therapeutic relationships, contribute to client dropout, or lead to inappropriate treatments for members of socially-marginalized populations.

The multicultural movement in the counseling professions spurred increased attention to diversity and social biases, but issues of gender identity and expression have, until recently, been largely overlooked in those efforts (Carroll & Gilroy, 2002; Carroll, Gilroy, & Ryan, 2002). Given the dearth of literature and training regarding trans people as counseling clients, Carroll and colleagues concluded that most mental health practitioners are unprepared to work effectively with transgender clients. The American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (2008) agreed that few psychologists or psychology students are highly knowledgeable regarding trans issues. They emphasized the need for greater education and training regarding trans issues in the interest of cultural competence.

Multicultural counseling practice, training, and supervision are informed by the professions' awareness of negatively biased social attitudes and the detrimental impacts such attitudes can have on counseling. Just as research regarding counselor attitudes about race or sexual orientation contributes to improved counseling services for members of racial and sexual orientation minority groups, similar research regarding attitudes toward trans people might be helpful toward identifying and addressing counseling training needs and, thus, providing more competent counseling services to trans clients. However, no previous studies have investigated attitudes held by counseling professionals regarding trans people or how those attitudes may relate to counseling professionals' work with trans clients.

While no previous studies have investigated counseling professionals' attitudes toward trans people, several examined other populations' attitudes regarding trans people. Those populations included health professionals, college students, and the general populations of particular geographic regions. Nearly all of that research actually focused specifically on attitudes regarding transsexual people, rather than transgender people more broadly. Transsexuals are one category of transgender people, those who believe that "their physiological bodies do not represent their true sex" and who typically desire sex reassignment surgery (Lev, 2004, p. 400) and to live as members of the sex considered "opposite" to their birth sex.

Previous studies of attitudes toward trans people (again, mainly regarding transsexual people) documented that individual and group differences exist in those attitudes, running the gamut from unfavorable to favorable, conservative to liberal, etc. They also revealed that attitudes can vary by participants' gender (Antoszewski,

Kasielska, Jedrzejczak, & Kruk-Jeromin, 2007; Harvey, 2002; Hill & Willoughby, 2005; Landen & Innala, 2000; Leitenberg & Slavin, 1983; Nagoshi et al., 2008; Rye & Elmslie, 2001, June; Winter, Webster, & Cheung, 2008), age (Harvey; Landen & Innala), personal familiarity with transsexuals (Hill & Willoughby; Rye & Elmslie), professional specialty among health professionals (Franzini & Casinelli, 1986; Green, Stoller, & MacAndrew, 1966), etiology beliefs regarding transsexuality (Antozsewski et al.; Landen & Innala), and a variety of other attitudes and beliefs such as homophobia, religious fundamentalism, and right-wing authoritarianism (Hill & Willoughby; Nagoshi et al.; Rye & Elmslie).

Attitudes regarding trans people, as expressed through stated beliefs, affective reactions, and anticipated responses to trans people, do not always appear consistent in the research literature. For example, many physician participants in one early study, Green et al. (1966), expressed negative attitudes toward transsexuals through judgments of their mental health and morality, yet the vast majority supported legal recognition, marriage, and adoption rights for post-operative transsexuals. Physicians and clinical psychologists in a later study expressed far more favorable attitudes regarding transsexuals' mental health and morality, yet would not want to be professional colleagues with transsexuals (Franzini & Casinelli, 1986). Thus, an attitude assessment alone would not provide sufficient information to determine how counseling professionals might respond to trans clients. Responses to clients, such as assessments of a client's personal characteristics and level of psychosocial function or dysfunction, are quite important, since they may serve as a basis for case conceptualization and treatment

planning. It would also be important, therefore, to examine particular responses to trans clients and to determine whether those are associated with attitudes toward trans people.

A shortcoming of most of the previous studies of attitudes toward trans people was that they did not employ psychometrically-sound attitude measures, and instead used questionnaires written for each study without assessing validity or reliability. Rye and Elmslie (2001, June), Hill and Willoughby (2005), and Nagoshi et al. (2008) each addressed this gap with the development of more psychometrically-sound measures, the Transgender Belief Questionnaire (TBQ), the Genderism and Transphobia Scale (GTS), and the Transphobia Scale, respectively. As Hill and Willoughby suggested regarding the GTS, such measures could be used “to explore causal and correlative factors of anti-trans sentiments and behaviors” (p. 542). The authors of the TBQ and GTS recommended that their measures be tested with additional populations, but neither of those measures, nor the Transphobia Scale, has yet been used to assess the attitudes of counseling professionals.

In summary, within a multicultural counseling framework, attention to social attitudes is important, but until recently, little attention has been paid in the counseling professions to attitudes toward trans people as a cultural minority group. Given evidence of the oppression of trans people in American society at large, it is possible that some counseling professionals hold negative attitudes toward trans clients and thus could potentially harm those seeking help and/or cause some trans people to avoid counseling when in need. Such attitudes have never before been assessed among counseling professionals. Learning about those attitudes could help shape much needed education and supervision efforts aimed at increasing counseling students’ and professionals’

competence in working with trans clients. Studies of other populations' attitudes toward trans people identified a variety of participant variables (e.g., gender and personal familiarity with trans people) which may be relevant to counseling professionals' attitudes toward trans people as well. Those studies also revealed apparent inconsistencies between particular beliefs and responses regarding trans people, suggesting that a link between counseling professionals' attitudes towards trans people and their responses to trans clients cannot be assumed, but should be investigated. Finally, most of the previous research regarding attitudes toward trans people was conducted without the use of formal attitude measures. Several more psychometrically-sound measures are now available, but none have been utilized yet to assess counseling professionals' attitudes toward trans people.

Purpose of the Study

The purpose of this counseling analogue study is to assess counseling professionals' attitudes regarding trans people and to determine whether relationships exist between such attitudes and counselors' responses to trans clients. Participants responded to one of two written descriptions of a fictional client, a transgender-identified, gender-variant person, also described as either biologically male or biologically female. Participants assessed the overall psychosocial functioning of the client using the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 2000). Participants also indicated their positive and negative perceptions of the client by assigning favorable and unfavorable adjectives from the Adjective Check List (ACL; Gough & Heilbrun, 1983). Attitudes toward trans people, more specifically anti-trans

attitudes, were measured by the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005).

This study also sought to replicate the findings of previous studies of attitudes toward trans people by investigating relationships between those attitudes and a variety of participant variables. Those variables included gender, personal familiarity with trans people, age, and beliefs regarding transgender etiology. Two participant variables previously unexamined in studies of attitudes regarding trans people were also considered in the present study: the extent of participants' training and experience in counseling and assessment with trans clients, and their perceived multicultural counseling competence as measured by the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Riger, & Austin, 2002).

This study was designed to contribute to the literature on attitudes and counseling, and especially to the small but growing body of literature regarding trans people as counseling clients. The APA Task Force on Gender Identity and Variance (2008) called for research to "strengthen the evidence base for transgender issues" (p. 71), and specifically suggested research regarding "social stigma" (p. 84) against trans people. The present study responded to critiques of the lack of attention to trans issues within the multicultural counseling movement (Carroll & Gilroy, 2002; Carroll et al., 2002). By assessing attitudes as well as responses relevant to clinical conceptualization and treatment planning, the present study also sought to inform future research regarding attitude-behavior prediction in general (Eagly & Chaiken, 2005) and, more specifically, the prediction of anti-trans behaviors via anti-trans attitudes (Hill & Willoughby, 2005).

The present study was expected to identify the extent to which counseling professionals hold anti-trans attitudes and how those may relate to particular responses to trans clients. This study also sought to identify which counselor characteristics may be most associated with anti-trans attitudes and responses to trans clients. The results may reveal important education and training needs regarding counseling and advocacy work with trans populations, and inform efforts to address those needs.

Research Questions and Null Hypotheses

The following research questions and hypotheses were investigated in this study.

1. Previous research investigated the extent of anti-trans attitudes among a variety of populations, but such attitudes have not been examined among counseling professionals. The first research question for the present study asked, to what extent do counseling professionals hold anti-trans attitudes? In addition to addressing this question by measuring counseling professionals' anti-trans attitudes, the following null hypothesis was tested to examine the extent of counseling professionals' anti-trans attitudes relative to other populations:

Null hypothesis 1: Levels of anti-trans attitudes among counseling professionals are not significantly different from those of undergraduate and graduate students as measured in previous studies (i.e., Hill & Willoughby, 2005; Winter et al., 2008).

2. Previous research indicated that the variables of gender, personal familiarity with trans people, beliefs regarding transgender etiology, and age were related to attitudes toward trans people. It is possible that, among counseling professionals, attitudes toward trans people might also be related to training and experience in counseling and assessment with trans clients, and to multicultural counseling competence. In order to

replicate the earlier findings with a sample of counseling professionals, and to investigate the previously unexamined training and experience and multicultural counseling competence variables, the following research question was asked: To what extent do gender, extent of personal familiarity with trans people, beliefs regarding transgender etiology, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence relate to counseling professionals' anti-trans attitudes?

Null hypothesis 2a: Among counseling professionals, men's levels of anti-trans attitudes do not differ significantly from those of women.

Null hypothesis 2b: Levels of anti-trans attitudes among counseling professionals who report being personally familiar with one or more trans individuals do not differ significantly from those of counseling professionals who report having no personal familiarity with trans individuals.

Null hypothesis 2c: Counseling professionals' anti-trans attitudes are not significantly related to the extent of their personal familiarity with trans individuals.

Null hypothesis 2d: Levels of anti-trans attitudes do not vary significantly between counseling professionals who hold different beliefs regarding transgender etiology.

Null hypothesis 2e: Counseling professionals' anti-trans attitudes are not significantly related to their age.

Null hypothesis 2f: Counseling professionals' anti-trans attitudes are not significantly related to the extent of their training and experience regarding counseling and assessment with trans clients.

Null hypothesis 2g: Counseling professionals' anti-trans attitudes are not significantly related to their perceived multicultural counseling competence.

Null hypothesis 2h. The variables of participant gender, extent of personal familiarity with trans people, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence will not contribute unique significant variance to the prediction of counseling professionals' anti-trans attitudes.

3. Previous research revealed inconsistencies between particular attitudes and responses regarding trans people, suggesting that knowledge of the extent of anti-trans attitudes among counseling professionals would not necessarily indicate how counseling professionals might tend to respond to trans clients. Potential attitude-response relationships can be explored by also examining responses such as assessments of a trans client's psychosocial functioning. Some past research suggested that individuals may respond differently to a trans person depending on whether the trans person is perceived to be male or female (Winter et al., 2008). Furthermore, evidence suggested that the accuracy of clinical judgments, such as evaluations of psychosocial functioning, is positively influenced by experience, whether clinical or educational (Spengler et al., 2009). The following research question and null hypothesis was investigated with those points in mind: To what extent do anti-trans attitudes and client sex relate to counseling professionals' assessments of a trans client's overall level of psychosocial functioning?

Null hypothesis 3: After controlling for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique

significant variance to the prediction of ratings of a trans client's overall level of psychosocial functioning.

4. Following the same line of reasoning as that behind research question 3, the next research question was examined: To what extent do anti-trans attitudes and client sex relate to counseling professionals' favorable perceptions of a trans client?

Null hypothesis 4: After controlling for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique significant variance to the prediction of counseling professionals' favorable perceptions of a trans client.

5. Following the same line of reasoning as that behind research questions 3 and 4, this final research question was examined: To what extent do anti-trans attitudes and client sex relate to counseling professionals' unfavorable perceptions of a trans client?

Null hypothesis 5: After controlling for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique significant variance to the prediction of counseling professionals' unfavorable perceptions of a trans client.

Definition of Key Terms

Anti-trans Attitudes: Broadly, the term anti-trans attitudes refers to negative attitudes regarding trans people. Negative attitudes toward a group, commonly referred to as "prejudice" (Eagly & Chaiken, 2005), are presumed to underlie negative feelings, beliefs, and behaviors regarding that group. Hill and Willoughby (2005) conceptualized

anti-trans attitudes more specifically as being comprised of transphobia, genderism, and gender-bashing dimensions. “Transphobia is an emotional disgust toward individuals who do not conform to society’s gender expectations” (p. 533). Genderism refers to belief in the superiority of, or preference for, typical gender identities and expressions over gender-variant ones. It is “an ideology that reinforces the negative evaluation of gender non-conformity or an incongruence between sex and gender” (p. 534). Gender-bashing is harassment and/or violence against gender non-conformists.

Attitude: Eagly and Chaiken (1993) defined attitude as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (p.1). As a psychological construct, an attitude cannot be directly observed (Krosnick, Judd, & Wittenbrink, 2005), but may be inferred from stated beliefs, affective responses, and overt behavior which particular attitudes are presumed to underlie (Albarracin, Zanna, Johnson, & Kumkale, 2005).

Counseling Professionals: For the purpose of this study, counseling professionals are defined as individuals who hold master’s and/or doctoral degrees in counseling and/or counseling psychology.

Counselor Responses: Counseling professionals respond to their clients in many ways, including affectively, cognitively, and behaviorally. Multicultural counseling theory suggests that biased attitudes impact counselors’ responses to clients, including through negative affective reactions, biased assumptions and clinical judgments, and/or inappropriate interventions or other behaviors. The counseling responses to be examined in the present study include two examined in previous studies of counselor bias: counseling professionals’ favorable and unfavorable perceptions of clients’

characteristics (e.g., Barrett & McWhirter, 2002) and counseling professionals' judgments of clients' overall levels of psychosocial functioning (e.g., Mohr et al., 2001).

Homophobia: Weinberg (1972) coined the term homophobia to refer to “the dread of being in close quarters with homosexuals” (p. 4). A more common, contemporary definition refers to homophobia as “fear of or contempt for lesbians and gay men” or “behavior based on such a feeling” (Homophobia, n.d.). Wright, Adams, and Bernat (1999) further conceptualized homophobia as a construct involving negative cognitions, negative affect, and aggressive and/or avoidant behaviors regarding homosexuality or lesbians and gay men.

Transgender: This term describes “people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their birth sex” (American Psychological Association, 2006, para. 1). It is an umbrella term which can apply to people who express many types of gender variance, including “transsexuals, cross-dressers, masculine-identified females, feminine-identified males, MTFs [male-to-female transsexuals], FTMs [female-to-male transsexuals], transmen, transgendered women, intersexed [referring to a variety of disorders of sexual development, involving genetically-, hormonally-, and/or physiologically-atypical conditions], and other differently gendered people” (Lev, 2004, p. 399). Individuals identifying with one or more of the particular categories above may or may not also identify with the broader transgender term. The term transgender does not refer to any particular sexual orientation. “Transgenderist is a term used by some cross-dressers who feel they are more than cross-dressers, but not quite transsexuals” (Lev, p. 399). In

contemporary popular and social scientific literature, the term transgender is sometimes shortened to *trans*.

Transsexual: Transsexuals are people who identify and desire to live as members of the gender considered “opposite” to their birth sex. Many transsexual people seek to alter their bodies through hormonal, surgical, and/or other sex-reassignment procedures in order to make their physical appearance and/or functioning more congruent with their gender identities.

Overview of Remaining Chapters

Chapter II includes a review of literature regarding attitudes and counseling, and expands upon the review of research regarding attitudes toward trans people noted briefly in Chapter I. The research methods used in this study are described in Chapter III. The results are reported in Chapter IV. The research findings, limitations, implications, and suggestions for further research are discussed in Chapter V.

CHAPTER II

LITERATURE REVIEW

The purpose of this study is to assess anti-trans attitudes among counseling professionals and to examine the potential relationships between those attitudes and particular responses to trans clients. This chapter presents a review of literature pertinent to the study. It begins with an examination of attitudes and counseling, including the relevance of attitudes to the provision of culturally competent counseling, research regarding clinical bias, and a sampling of findings regarding counselors' social attitudes and their impacts. The remainder of Chapter II provides a critical review of the research regarding various populations' attitudes toward trans people and related issues.

Attitudes and Counseling

As noted in Chapter I, attitude is most conventionally defined in psychology as “a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor” (Eagly & Chaiken, 1993, p.1). The evaluative component can be considered the essence of attitude, involving reactions such as “approval or disapproval, favor or disfavor, liking or disliking, approach or avoidance, attraction or aversion” (Eagly & Chaiken, 1993, p. 3). When the evaluation object is a minority group, the associated attitudes, especially if negative, may be referred to as *prejudice* (Eagly & Chaiken, 1993, 2005). As a psychological construct, an attitude cannot be directly observed (Krosnick et al., 2005), but may be inferred from stated beliefs, affective responses, and overt behaviors which particular attitudes are presumed to underlie (Albarracin et al., 2005). While some attitudes may be inherent, most attitudes examined in the social sciences, including attitudes toward minority groups, are considered to be

learned (Eagly & Chaiken, 1993) and subject to change as the result of new experiences which are not compatible with existing attitudes (LaFleur, Rowe, & Leach, 2002).

There are many avenues of attitude research relevant to psychology, but an area of particular concern for counseling psychology and other counseling professions is the potential impact of attitudes on counseling processes and outcomes via counselor and client beliefs, affective responses, and behaviors. In their text on the field of counseling psychology, Gelso and Fretz (1992) wrote that it is client and counselor attitudes toward one another and the expression of such attitudes which essentially define the therapeutic relationship. The therapeutic relationship, in turn, is known to account for approximately 30% of improvement in counseling clients, second only to extratherapeutic factors at 40% and greater than expectancy/placebo and technique effects, accounting for 15% each (Asay & Lambert, 1999). Research regarding common factors in therapy strongly supports the importance of the therapeutic relationship as a necessary aspect of all models of therapy, “and that its overall quality influences the final outcome of therapy” (Bachelor & Horvath, 1999, p. 138).

The importance of attitudes to counseling is also reflected in models of multicultural counseling competency (e.g., Arredondo et al., 1996; Sue, 2001). Multicultural counseling experts emphasize that, even if unconscious, subtle expressions of a counselor’s prejudice against a client can hamper or preclude the development of an effective therapeutic relationship and cause the client great psychological distress, resulting in a situation of harm where help was sought (Sue & Capodilupo, 2008; Sue et al., 2008). The development of attitudes as a dimension of multicultural competence will be discussed next.

Attitudes and Multicultural Counseling Competence

Frequently referred to as the “fourth force” (Pederson, 1990) in psychology, multiculturalism is a significant factor shaping the counseling professions today. One major impetus for the fields of counseling and counseling psychology to attend to multicultural issues and to develop multicultural counseling competencies was the assertion that, as a mirror of society at-large, the social sciences reflect the biased attitudes of the dominant culture against minority cultural groups (Sue et al., 1992; Sue & Sue, 1990). In counseling and psychology, historically, this was evidenced through general inattention to minority mental health issues or, when they were addressed, by the perspective taken that minority groups were biologically and/or culturally-deficient, -disadvantaged, and/or -deprived (Robinson & Morris, 2000; Sue, 2001; Sue et al., 1992; Sue et al., 1982). This resulted in the development of counseling and therapy perspectives and practices which were “White, male, Euro-centric, and middle class in origin and practice” (Ivey, 1995, p. 55), and “inherently biased against racial/ethnic minorities, women, gays/lesbians, and other culturally different groups” (Sue et al., 1998, p. 15).

Not only may practitioners be influenced by those biases built into the profession, but they also experience the same types of “cultural conditioning” (Sue & Capodilupo, 2008, p. 122) that shape all Americans to hold a variety of prejudices regarding race, ethnicity, gender, sexual orientation, and other cultural categories. Whether consciously or otherwise, counseling professionals bring such biased attitudes to their relationships with clients. This important point will be explored later in this chapter in the “attitudes and clinical bias” section.

To begin remedying the inherent biases of the counseling professions and those of individual professionals, and thereby more appropriately serve diverse clientele, Sue and colleagues (Sue et al., 1982) developed a three-part framework of multicultural counseling competencies. They identified counselors' awareness of their own attitudes and beliefs as the first dimension of their framework. Along with knowledge and skills dimensions of the framework, the attitude/beliefs dimension continues to be used by "most multicultural specialists" (Sue & Sue, 2003, p. 26) to define multicultural competency. The attitudes and beliefs dimension refers to the importance of counselors gaining awareness of their attitudes and beliefs about their own cultures and those of minority groups, examining and checking the biases and stereotypes they hold, understanding the impacts their attitudes and beliefs can have on clients and the counseling process, and developing an affirmative perspective regarding multiculturalism (Sue et al., 1992).

Transgender Issues as Matters of Multicultural Competency

While some in the counseling fields use the term multicultural to refer exclusively to issues of race and ethnicity, many counseling professionals have come to view the multicultural movement from an increasingly inclusive perspective, encompassing not only issues of race and ethnicity, but also many other cultural dimensions such as sexual orientation, gender, physical disability, and socioeconomic status (Fuentes, Bartolomeo, & Nichols, 2001; Sue, 2001; Sue & Sue, 2008). Such an inclusive perspective recognizes that these dimensions can all influence the worldviews of counseling professionals and clients. In terms of multicultural counseling competence, this expansion means that

counseling professionals and trainees should develop awareness, knowledge, and skills relevant to many different cultural dimensions.

While much greater attention should be paid to all of the various cultural dimensions and populations, trans issues and clients have been particularly invisible in the literature and training efforts of the counseling professions, including within the multicultural movement (Carroll & Gilroy, 2002; Carroll et al., 2002). Carroll and colleagues noted that, “For the most part, mental health practitioners’ views about transsexuals, transvestites or cross-dressers, and others with transgender status have ‘not been informed by objective empirical research’ (Fox, 1996, p. 31)” (p. 131). Without education and training to counter the gender stereotypes and biases evident in the stigma, discrimination, and violence experienced by many transgender people (APA Task Force on Gender Identity and Gender Variance, 2008; Currah et al., 2006; Gender Public Advocacy Coalition, 2006; Koken et al., 2009; Lombardi et al., 2001; National Coalition of Anti-Violence Programs, 2006, 2007, 2008, 2009; Nuttbrock et al., 2010; Shipherd et al., 2010), counseling professionals and trainees are unprepared to work with trans clients in a culturally competent manner (Carroll & Gilroy; Carroll et al.).

Recently, however, with the growing sociopolitical visibility of trans communities (Carroll & Gilroy, 2002; Ettner, 1999; Lev, 2007), counselors and psychologists are beginning to recognize and address trans populations as cultural minority groups. For example, in an article in *Counselor Education & Supervision*, Carroll and Gilroy described cultural competencies for counselors regarding trans issues. These were framed in terms of exploring transphobic attitudes and raising consciousness regarding gender identities and expressions, acquiring knowledge and understanding of the experiences of

trans people, and developing “trans-positive” approaches and skills. Attention to these issues was also evident in a major publication, that of the second edition of the *Handbook for Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients* (Bieschke, Perez, & DeBord, 2007), which included transgender in the title and contents, both for the first time. Two chapters in the *Handbook* focus specifically on trans issues and clients, and four other chapters incorporate trans content to some extent.

Even more significant recognition of trans people as a cultural minority group occurred at the national organization level in both counseling and psychology. The American Psychological Association (APA) formed a Task Force on Gender Identity and Gender Variance (2008). Included in the Task Force’s report to the APA was the recommendation that researchers investigate trans issues so as to increase evidence-based knowledge regarding this population and thereby enhance psychologists’ cultural competence in their work with trans people. The Task Force also advised the Association to develop guidelines for working with transgender and gender variant clients. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (2009) took on a similar task and produced the *Competencies for Counseling with Transgender Clients*, which were recently approved by the American Counseling Association Governing Council. The competencies were built around the multicultural counseling competencies framework described earlier in this chapter (i.e., awareness, knowledge, and skills; Sue et al., 1982), and also upon the perspectives of a “wellness (e.g., Myers & Sweeney, 2005), resilience (Singh, Hays, & Watson, in press), and strength-based approach (e.g., Bockting, Knudson, & Goldberg, 2007; Carroll, 2010; Lev, 2004; Vanderburgh, 2007)” (p. 2) for working with trans individuals and groups. The authors

stated their intention that the competencies should serve just as a base for working with competently with trans clients, and that counselors should further expand their knowledge.

Attitudes and Clinical Bias

As noted in Chapter I, no previous studies have examined counseling professionals' attitudes toward trans people, nor their responses to trans clients. Research regarding counselors' and trainees' attitudes toward other marginalized populations, and biases in their responses to clients from those populations, can inform the present topic. An examination of select works from that large body of literature, beginning with a review article (i.e., López, 1989), provides evidence of bias in clinical assessments in regard to particular client variables. Studies to be noted in this section of the chapter also provide support for the idea that biased social attitudes can be associated with biased responses from counselors.

López (1989) conducted a review of studies of clinical bias. He identified limitations in previous conceptualizations of clinical bias, including that those studies considered all types of clinical judgments equally and ignored minimization or underdiagnosis as examples of bias. First, López suggested that because different types of clinical judgments (e.g., diagnoses, evaluations of symptom severity, and ratings of client likeability) may involve different cognitive processes and relate differently to treatment, they should be considered separately, rather than being conflated. Because of the importance of diagnoses and assessments of symptom severity as parts of clinical evaluations (with obvious implications for treatment), as well as their frequent use in

research, López limited his review to studies which examined diagnostic and symptom severity judgments.

López (1989) identified the use of too-narrow criteria for bias as a second limitation in prior conceptualizations of clinical bias. He explained that past research often involved the assumption that only overpathologizing symptoms and/or overdiagnosing particular disorders were reflective of bias, ignoring that minimizing symptoms and/or underdiagnosing disorders could also result from bias. He reexamined the studies he reviewed for evidence of bias in either direction. In cases where the correct judgments of diagnosis or symptom severity were available, López defined biased judgments as those which “deviated” (p. 186) from those standards. For example, in his review of a study in which both Black and White clients met the criteria for an alcoholism diagnosis, but in which Black clients were more often diagnosed accordingly (Luepnitz, Randolph, & Gutsch, 1982 as cited in López), López categorized the case as one of underdiagnosis of the White clients. In cases for which correct judgments were not defined, López identified the direction of bias (i.e., overdiagnosis of one group vs. underdiagnosis of the other) by assuming “that the bias was directed against the patient from groups that historically have been the recipients of societal prejudices: women, Blacks, the elderly, and lower social class members” (p. 187).

López (1989) reviewed studies examining clinical bias regarding client variables including race, ethnicity, sex, age, social class, mental retardation, religion, weight, and/or suburban vs. rural residency. Using the bi-directional definition of bias described above, López found almost twice as many cases of bias than had been identified previously. He identified biased judgments of symptom severity in 44% of the 73 cases

which involved severity judgments. He identified biased diagnostic judgments in 60% of the 30 cases which involved diagnostic judgments. López found evidence of bias regarding each patient variable listed above, except for religion. Bias was identified regarding mental retardation (identified in 100% of the seven cases examined), social class (identified in 75% of the 20 cases examined), race (identified in 48% of the 21 cases examined), and gender (identified in 28% of the 36 cases examined).

López (1989) posited that most instances of clinical judgment bias were not due to prejudicial attitudes on the part of clinicians, but rather due to errors in their adjustment of clinical judgments to account for differences in group norms. As evidence of that, he cited research findings that bias is sometimes specific to particular symptoms or disorders and has been found in judgments of non-marginalized as well as marginalized populations. If bias was due to clinicians' social attitudes, he suggested, it should not be problem-specific or have an impact on groups who have not traditionally experienced discrimination. Based on this conceptualization, López suggested that the focus of clinical bias studies should be on the ways clinicians process client information, rather than on their social attitudes. López suggested that if further support for this model was found, then training efforts to minimize biased clinical judgments should also focus on information processing and not on changing trainees' social attitudes.

López's (1989) review is a useful source of evidence of clinical judgment bias regarding a variety of client cultural variables. However, his suggestion that clinicians were not exhibiting any prejudicial attitudes in their biased clinical judgments is at odds with basic premises of the multicultural counseling movement, which argue that the counseling professions and their practitioners do reflect the biased attitudes of society,

through means including biased assessments of minority clients. Researchers have since examined a wide variety of social attitudes among counseling professionals and trainees, and found evidence that some counselors and trainees do hold negatively biased attitudes regarding particular populations, contrary to López's position. And, while the effects of such biases were not examined in all of those studies, some studies identified negative impacts of counselors' attitudes on counseling process/outcome-related variables. The following three examples illustrate these types of findings.

Barratt (2008) surveyed dyads of formerly paired clients of Color and White counselors. Amongst other variables, Barratt assessed the counselors' White racial identity attitudes and asked the former clients to rate their counselors' multicultural counseling competence. She found that, compared to counselors who expressed more positive attitudes regarding racial difference, counselors with "conflicted and ambivalent" attitudes were perceived by their clients as less multiculturally competent.

Another example of biased attitudes and their potential to affect counseling processes comes from Barrett and McWhirter's (2002) study of counselor trainees' perceptions of clients based on client sexual orientation. Participants read descriptions of a heterosexual man, heterosexual woman, gay man, or lesbian, and responded by assigning favorable and unfavorable adjectives to the client using The Adjective Checklist (ACL; Gough & Heilbrun, 1983). The participants also completed a homophobia measure. Barrett and McWhirter found that responses to the client descriptions varied by the described sexual orientation of the client, such that fewer unfavorable adjectives were assigned to a client described as a gay man or lesbian than to those described as heterosexual. The authors suggested that participants may have

avoided assigning unfavorable adjectives to the gay or lesbian client due to concerns about appearing negatively biased. Homophobia scores significantly predicted the assignment of unfavorable adjectives, regardless of client sexual orientation, $F(1, 160) = 4.28, p < .05$, but were significantly correlated with the assignment of unfavorable adjectives, $r = .31, p < .05$, only when participants responded to a description of a lesbian client.

Barrett and McWhirter (2002) suggested that the assignment of favorable adjectives might have been less susceptible to social desirability concerns “because it represented ‘omission’ rather than ‘commission’” (p. 228). They found that participants “with higher homophobia scores assigned significantly fewer favorable adjectives to gay male and lesbian clients and significantly more favorable adjectives to heterosexual clients than did their counterparts with lower homophobia scores” (p. 228). Given the format of the ACL (Gough & Heilbrun, 1983) in which favorable and unfavorable perceptions were assessed as separate dimensions rather than a single, bipolar dimension, the assignment of a greater number of favorable adjectives did not indicate correspondingly fewer unfavorable perceptions. Barrett and McWhirter concluded that, while counselor trainees did not perceive gay or lesbian clients more unfavorably than heterosexual clients, the trainees did perceive gay and lesbian clients significantly less favorably than heterosexual clients.

A third example of counselor bias and its impact can be found in Mohr and colleagues’ (2001) study of counselors’ attitudes regarding bisexuality as a predictor of their clinical responses to bisexual clients. Like Barrett and McWhirter (2002) and many others examining counselor bias, these researchers used a counseling analogue format.

They presented a description of a bisexual female client and assessed the participants' responses, asking them to rate the client's psychosocial functioning using the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 2000), identify client problems on a checklist, and complete a measure of their personal reactions to the client. Then participants completed a measure of self-presentation concerns and a measure of attitudes regarding bisexuality. Mohr and colleagues found that "counselors with the most negative attitudes regarding bisexuality were more likely than others to have negative reactions to the client, anticipate responding to the client in a biased and judgmental manner, believe the client had problems in areas related to bisexual stereotypes, and rate the client as having a low level of psychosocial functioning" (p. 212).

These examples demonstrate that there are relationships between counseling professionals' and trainees' social attitudes and counseling responses to particular client populations, as well as relationships between particular social attitudes and clients' perceptions of counselors with those attitudes. It is plausible that there could also be relationships between counseling professionals' attitudes regarding trans people and particular responses to trans clients. The remainder of this chapter will review studies of attitudes regarding trans people and related issues.

Attitudes toward Trans People

Despite increasing sociopolitical attention to trans issues and populations in recent years, including regarding the stigma faced by this minority group (APA Task Force on Gender Identity and Gender Variance, 2008; Carroll & Gilroy, 2002; Ettner, 1999; Lev, 2004, 2007), such attention is hardly reflected in counseling literature (Carroll & Gilroy;

Carroll et al., 2002). Rather, most psychological research regarding transgender issues has been “strongly clinical and positivistic” (APA Task Force on Gender Identity and Gender Variance, p. 33), focused mainly on “the clinical implications of transsexual transitioning as well as associated physiological concerns” (Rye & Elmslie, 2001, June, p. 1). Studies regarding attitudes toward trans people are quite sparse. An extensive literature search revealed just ten studies focused on the attitudes of various populations toward trans people (most of those focused more narrowly on transsexual people), including three describing the development of attitude measures. Each of those studies will be examined here in depth. This portion of the literature review will first consider studies regarding health professionals’ attitudes (i.e., Franzini & Casinelli, 1986; Green et al., 1966), then those of college students (i.e., Antoszewski et al., 2007; Hill & Willoughby, 2005; Leitenberg & Slavin, 1983; Nagoshi et al., 2008; Rye & Elmslie; Winter et al., 2008), and finally, those of two general populations in specific geographic regions (i.e., Harvey, 2002; Landen & Innala, 2000).

Health Professionals’ Attitudes toward Transsexuals

This section of the literature review begins with an examination of two studies of health professionals’ attitudes toward transsexuals. The earliest study to investigate attitudes toward transsexuals was that of Green et al. (1966). Given their awareness of “the intensity of the feelings” (p. 178) experienced by physicians in response to transsexual patients’ requests for sex reassignment surgeries, the authors sought to document associated attitudes. They surveyed a national sample of urologists, gynecologists, general practitioners, and psychiatrists, as well as a sexual minority sample comprised of heterosexual male cross-dressers (referred to as “transvestites” by

the authors), gay men, and lesbian women (referred to as “male and female homosexuals,” respectively, by the authors). Green and colleagues did not provide a rationale for including the sexual minority sample, which they referred to as “the deviant groups,” but did compare responses between those participants and the physicians.

Green et al. (1966) conducted “statistical purification” (p. 178) by excluding surveys from physicians who indicated that they were “practicing homosexuals” (p. 178), cross-dressers, or frequently desired to be the other sex, along with those who left the corresponding questions unanswered, leaving a final physician sample of 51 urologists, 43 gynecologists, 93 general practitioners, and 168 psychiatrists. The authors also excluded surveys from cross-dressing participants who indicated that they engaged in same-sex sexual activity and from gay men and lesbian participants who indicated that they engaged in cross-dressing. The remaining sexual minority sample included 83 heterosexual male cross-dressers, 169 gay men, and 115 lesbians. The authors did not provide any other demographic information regarding the participants.

Green and colleagues (1966) stated that their questionnaire included 128 items “concerning attitudes toward sex transformation procedures, transvestism, homosexuality, etc.” (p. 178), a vignette describing an individual seeking sex reassignment surgery, and 40 items collecting biographical data. The authors did not describe the item or response format, nor did they provide verbatim item examples or report on the reliability or validity of their survey as an attitude measure.

Data analysis in Green et al. (1966) consisted of descriptive statistics, specifically the percentage of each group who selected particular responses. The first set of results concerned participants’ judgments regarding transsexuals’ mental health. The authors

reported that most of the physicians (81% of the psychiatrists, 86% of the urologists and gynecologists combined as “surgeons,” and 80% of the general practitioners), given no case information beyond that sex reassignment surgery was requested, thought that a male transsexual was “severely neurotic.” A smaller majority of the sexual minority group participants (68% of the gay men, 70% of the lesbians, and 49% of the cross-dressers) agreed with the “severely neurotic” characterization. Green and colleagues reported that 17% of the psychiatrists, 14% of the surgeons, and 15% of the general practitioners judged a transsexual patient to be “psychotic.” Fewer than 2% of the sexual minority participants agreed with the “psychotic” characterization.

The next set of results concerned participants’ beliefs regarding the “moral status” of someone requesting sex reassignment surgery. Green et al. (1966) reported that 14% of the surgeons and general practitioners considered a transsexual to be “morally depraved,” while only 2% of the psychiatrists and 3% of the sexual minority participants concurred. A similar pattern was found in response to a question asking participants whether they thought that a transsexual person is a “threat to society.” Nineteen percent of the surgeons, 11% of the general practitioners, and only 6% of the psychiatrists and 2% of the sexual minority participants agreed with the statement. It appeared that many of the physicians, but especially the psychiatrists, believed transsexuals were mentally ill, but not depraved or a threat to society.

The third set of results concerned judgments regarding what degree of intervention transsexuals should receive. Green and colleagues (1966) reported that “over 85% of all groups thought that such people should be given outpatient psychiatric treatment” (p. 179). Eleven percent of surgeons and 9% of the general practitioners

agreed that transsexuals should be institutionalized, while only 3% of the psychiatrists and 1% of the sexual minority participants thought so. The authors reported that no participants believed that transsexuals should be imprisoned.

Green et al. (1966) also presented participants with the following brief case history:

Since early childhood, this 30-year-old biological male has been very effeminate in his mannerisms, interests, and daydreams. His sexual desires have always been directed toward other males. He would like to be able to dress exclusively in women's clothes. This person feels inwardly and insists to the world that he is a female trapped in a male body. He is convinced he can only be happy if he is operated on to make his body look like that of a woman. Specifically, he requests the removal of both testes, his penis, and the creation of an artificial vagina (all of which can, in fact, be done surgically). He also requests that his breasts be made to appear like a woman's, either surgically or by the use of hormones (this, too, is medically possible). (pp. 179-180)

Following the vignette, participants were asked to indicate whether they would approve the patient's request for sex reassignment surgery. Just 3% of the surgeons, 6% of the general practitioners, and 9% of the psychiatrists indicated that they would approve the request, while 50% of the cross-dressers, 37% of the lesbians, and 34% of the gay men indicated approval. Participants were asked again about granting approval following each of three additional stipulations: (a) that the patient had been assessed by a psychiatrist as not psychotic or severely mentally ill, (b) that the patient also had "two years of psychiatric treatment, still desired the procedure, and was believed by the psychiatrist to

be reasonable and responsible in all other respects” (p. 180), and (c) that after the two years of psychiatric treatment “the treating psychiatrist *also* believed that the operation was indicated” (p. 180). The percentage of participants indicating approval increased in each group with each additional stipulation. Even following the final stipulation, however, only 37% of the surgeons, 41% of the general practitioners, and 45% of the psychiatrists indicated that they would approve the request for sex reassignment surgery, while over 80% of the sexual minority participants indicated that they would grant approval. A quarter of the physicians indicated their belief that sex reassignment surgery would “definitely be harmful” (p. 181) to the patient’s mental health, while half thought that surgery had “as much chance of helping as harming” (p. 181). The remaining quarter of physicians indicated their belief that the patient’s mental health would likely improve following surgery. The authors did not report the responses of the sexual minority participants for this latter section of results, nor did they differentiate responses for the various physician categories.

Despite what Green and colleagues (1966) referred to as the physicians’ “overwhelming conservatism” (p. 181) regarding granting approval for sex reassignment surgery, the study suggested a “paradoxical liberalism” (p. 181) toward patients who have undergone such surgery. Seventy-five percent of the physicians agreed that patients should be legally identified as a member of the other sex following sex reassignment surgery and allowed to change legal documents to reflect that. Eighty percent agreed that those patients should also be allowed to marry as a member of their post-operative sex and 50% agreed that they should be allowed to adopt children. Again, the authors did not

report the responses of the sexual minority participants for this section of results, nor did they differentiate responses for the various physician categories.

The Green et al. (1966) study established the existence of individual and group differences in attitudes toward transsexuals and sex reassignment surgery, at least among physicians and sexual minority groups. Their findings suggested that most physicians at that time would not grant approval for sex reassignment surgery for transsexual patients and considered transsexual individuals to be at least severely neurotic, if not psychotic. Psychiatrists appeared to be just slightly less conservative than other physicians regarding sex reassignment surgery, but expressed far more favorable attitudes through their beliefs regarding transsexuals' morality. Gay men, lesbians, and male cross-dressers appeared to hold far more positive attitudes than physicians as expressed through their approval of sex reassignment surgery, their beliefs about transsexuals' morality, and their judgments of transsexuals' mental health. Surprisingly, given the discovery of unfavorable judgments regarding transsexuals' mental health and the conservative positions identified regarding sex reassignment surgery, Green and colleagues' findings suggested that most physicians supported particular civil rights for post-operative transsexuals.

Because the authors included psychiatrists in their sample, Green and colleagues' (1966) work may provide some indication of counseling professionals' attitudes regarding transsexuals. However, Green et al. did not include counselors, psychologists, or other non-physician mental health professionals in their sample, and the results might not be generalizable to these or other professions. Furthermore, given a dynamic social context, it seems unreasonable to rely on this study from the 1960s to characterize

contemporary attitudes or their possible relationship to counseling professionals' responses to trans clients.

Twenty years after the Green et al. (1966) study, Franzini and Casinelli (1986) conducted a similar study, assessing health professionals' knowledge and attitudes regarding transsexual patients and sex reassignment surgery. In their introduction, the authors suggested that there was a lack of awareness and knowledge among health professionals regarding gender issues and transsexuality, as well as negative attitudes held by health professionals toward transsexual patients and sex reassignment surgery, and controversy regarding appropriate treatment for individuals diagnosed with transsexualism (as defined in the *Diagnostic and Statistical Manual of Mental Disorders, 3rd ed.*, American Psychiatric Association, 1980). Franzini and Casinelli suggested that such attitudes and lack of knowledge likely "directly affect physicians' practice behaviors" (p. 535) contributing perhaps to "blatant discrimination" (p. 535) and/or inappropriate treatment of transsexual patients. The authors described their study as the first to assess health professionals' knowledge regarding transsexual patients and sex reassignment surgery. They also partially replicated the Green et al. study in order to compare the 1966 findings to their own.

Like Green and colleagues (1966), Franzini and Casinelli (1986) surveyed health professionals, including general practitioners ($n = 23$), obstetrician-gynecologists (OB-GYN, $n = 17$), urologists ($n = 30$), and psychiatrists ($n = 42$). Unlike Green et al., they also included clinical psychologists ($n = 90$) in their sample. By practitioner group, survey response rates ranged from 3.4% of the OB-GYN sampled to 18% of the clinical psychologists sampled. The total sample size represented a response rate of just 8.2%, so

the authors urged caution in interpreting their findings. They reported demographic data regarding participants' gender, age, race, religion, religious involvement, community type (e.g., metropolitan-urban, rural, etc.) and work settings (e.g., individual private practice, large group or clinic, etc.). The vast majority of the participants were White (94%). Eighty-three percent were men. A majority (60%) did not attend religious services, and 34% attended one to four times per month. Their mean age was approximately 50 years and the majority worked in metropolitan-urban (44%) or suburban (29%) communities.

Franzini and Casinelli (1986) surveyed participants with a three-part questionnaire. Part one (Knowledge) consisted of 24 statements representing factual information about transsexuality drawn from professional literature and judged by the authors to be undisputed in the scientific community at that time. Participants responded with "yes" or "no" to the statements, which were counterbalanced with regard to the correct response. Correct responses were summed to generate a factual knowledge score for each participant, with greater scores indicating a greater degree of knowledge regarding transsexuality. Part two (Attitudes) was made up of 23 items which "advocat[ed] a clear position or value" (p. 536) regarding transsexual patients and sex reassignment surgery. Participants indicated their degree of agreement or disagreement using a 5-point Likert-type scale. Response scores were summed to generate a favorability rating for each participant, with greater scores indicating more favorable attitudes toward transsexuals and sex reassignment surgery. Part three (Replication) consisted of 30 questions from the Green et al. (1966) study.

Franzini and Casinelli (1986) used ANOVA to compare knowledge scores across practitioner categories and found that each demonstrated an equivalent degree of

knowledge regarding transsexuality. They reported that the entire sample responded correctly 64.3% of the time, representing what they referred to as “a relatively high degree of accurate knowledge” (p. 538).

Franzini and Casinelli (1986) used ANOVA and chi-square analyses to compare the five professional groups by their favorability ratings from the attitudes portion (part two) of the questionnaire. They found that the clinical psychologists’ favorability scores were significantly greater than the other four participant groups, indicating a “less psychopathological perspective of the syndrome and greater social acceptance” (p. 535) of transsexuals, $M(\text{psychologists}) = 80.63$, $M(\text{OB-GYN}) = 73.28$, $M(\text{psychiatrists}) = 71.79$, $M(\text{urologists}) = 64.45$, and $M(\text{general practitioners}) = 62.01$.

Franzini and Casinelli (1986) reported several additional trends in the data from the attitudes portion of the survey. They stated that “the greatest agreement among all respondents appeared in their support of continued scientific study of transsexualism; yet there was major opposition to increasing federal research funds and federally supported loans to transsexual patients” (p. 537). A large majority (82%) agreed that civil rights and anti-discrimination legislation should be passed to protect transsexuals. Over 85% agreed that transsexuals should be allowed in teaching professions and the military. Despite the favorable positions, “most respondents indicated that transsexuals would not be desirable professional colleagues and that establishing close personal relationships with them could be very difficult” (p. 537). Responses to items regarding sex reassignment surgery also revealed “contradictory” (p. 537) attitudes. The authors stated that many responses indicated “highly favorable” (p. 537) attitudes regarding surgery, but they also provided several examples of items to which the majority of the participants responded

unfavorably, such as finding that over half (54%) believed that sex reassignment surgery “ultimately would be harmful to mental health” (p. 537). That particular response was shared by 74% of the general practitioners and just 44% of the clinical psychologists.

Results of the replication section revealed that, consistent with those in the Green et al. (1966) study, most of the physicians in the Franzini and Casinelli (1986) study were “unlikely to recommend [sex reassignment] surgery based merely on the transsexual patient’s case history and request” (p. 537). Also like the participants in the earlier study, but to a significantly greater degree, the physicians in the later study were more favorable toward recommending surgery with each of three additional positive stipulations. Clinical psychologists were not included in the earlier Green et al. (1966) study, but their responses to the replicated questions were consistent with the physicians’ in terms of becoming more favorable with the addition of positive stipulations. The psychologists’ responses were also significantly more favorable than any of the physician groups’ in the 1966 and 1986 studies. Following the final stipulation, 92% of the psychologists indicated a willingness to grant approval for sex reassignment surgery.

While over 80% of the physicians in the Green et al. (1966) study judged transsexuals to be severely neurotic, Franzini and Casinelli (1986) reported that a smaller percentage of the 1986 participants agreed with that judgment (the authors did not report specific percentages). Franzini and Casinelli also noted that a smaller percentage of their participants than those in Green et al. believed transsexual people were a threat to society (again, specific percentages were not reported by Franzini and Casinelli, but 19% of the surgeons, 11% of the GPs, and 6% of the psychiatrists in Green et al. agreed with the societal threat characterization). Franzini and Casinelli reported consistency in the

percentage of participants in their study who considered transsexuals to be psychotic with the percentage who made the same judgment in Green and colleagues' (1966) study (i.e., 17% of psychiatrists, 14% of surgeons, and 15% of GPs in Green et al.). They also reported consistency in the percentage of participants who believed transsexuals were morally depraved (i.e., 14% of surgeons and GPs, and 2% of psychiatrists in Green et al.).

Franzini and Casinelli's (1986) final replication section concerned beliefs regarding the likely outcome of sex reassignment surgery; such beliefs appeared to be far more optimistic than the results from 1966. Fifty-two percent of the physicians in the 1986 study expressed the belief that sex reassignment surgery would improve the mental health of the transsexual patient, 36% believed it could help as much as harm, and 12% believed it would definitely be harmful (vs. 25%, 50%, and 25%, respectively, in Green et al., 1966). Again, clinical psychologists were not included in the earlier Green et al. study, but Franzini and Casinelli reported that fewer than 2% of the clinical psychologists in their sample believed that sex reassignment surgery would definitely be harmful to a transsexual patient's mental health.

As noted by Franzini and Casinelli (1986), the low response rate to their survey necessitated that their findings be considered as preliminary only. It appears that at the time of the study, clinical psychologists were as knowledgeable regarding transsexuality as other health care providers likely to encounter transsexual patients, but judged transsexuals to be far less psychopathological than did physicians. Compared to physicians, clinical psychologists also appeared to hold less conservative social perspectives regarding transsexuals. There also appeared to be a trend between 1966 and

1986 toward less psychopathological and conservative social perspectives regarding transsexuals and sex reassignment surgery, with some exceptions. Nonetheless, negative attitudes toward transsexuals and sex reassignment surgery were evident among the participants even in the later study. Though Franzini and Casinelli suggested that such negative attitudes were likely to have a direct impact on professional practice with transsexuals, their study did not examine potential relationships between items that might have tapped into general attitudes regarding transsexuals (e.g., questions about their morality) and items directly related to clinical practice with transsexuals (e.g., judgments of their mental health). Nor have any others done so.

The two studies just reviewed both focused on attitudes of health professionals toward transsexuals and sex reassignment surgery. The first, Green et al. (1966), also included sexual minority participants. The second, Franzini and Casinelli (1986), also included clinical psychologist participants. No other studies to date have assessed health care providers' attitudes toward trans people, and none at all have assessed the attitudes of professional counselors or counseling psychologists toward trans people. There have been efforts, however, to assess the attitudes of college students and general populations toward trans people; these will be reviewed next.

College Students' Attitudes toward Trans People

This section of the literature review considers six studies which examined college students' attitudes toward trans people. The first two studies, like those reviewed in the section on health professionals' attitudes, did not use formal attitude measures. The remaining four involved the development and/or use of such measures.

Leitenberg and Slavin (1983) conducted the earliest study of college students' attitudes toward transsexuality. As a premise for their study, the authors suggested that homophobia and "homosexual denial, fear, or repulsion" (p. 338) may be a factor in the motivation for sex transformation procedures. That is, they theorized that some people experience same-sex sexual attractions, find those unacceptable, and so rationalize that they are the other sex in order to redefine their sexual orientation as heterosexual.

Leitenberg and Slavin wrote,

In purely statistical terms, transsexuality is by far a more socially 'deviant' response pattern. Could it nevertheless be that transsexuality carries with it less of a moral and social stigma than homosexuality, not only in the minds of many transsexuals but for general society as well? (pp. 339-340)

The authors surveyed 318 university students and compared their attitudes regarding transsexuality and homosexuality. Participants were students in an introductory psychology course at a state university in New England. They included 106 men and 212 women. Nearly all indicated that they were single (97%) and heterosexual (99%). The authors also reported participants' class standings (i.e., freshmen, sophomores, etc.), but provided no other demographic descriptions.

According to Leitenberg and Slavin (1983), each participant completed two 5-item questionnaires, one regarding transsexuality and one regarding homosexuality, presented in counterbalanced order. The former provided participants with a definition of transsexuality. The authors stated that their questionnaire items were drawn from "the most well-known surveys of attitudes toward homosexuality (Glenn and Weaver, 1979, Levitt and Klassen, 1974)" (p. 340). One question on each survey assessed general

attitudes regarding transsexuality or homosexuality, one addressed adoption rights (“conceived as a more subtle or more indirect gauge than the first question of general attitudes toward homosexuality and transsexuality,” p. 341), two addressed job discrimination, and one assessed beliefs regarding biological causality of transsexuality or homosexuality.

The authors found significant order effects; participants who completed the homosexuality questionnaire first expressed more negative attitudes regarding transsexuality than those who completed the transsexuality questionnaire first. No order effects were found in the results of the homosexuality questionnaire. Data from just the first questionnaires completed by each participant were used in the subsequent analyses.

Regarding general attitudes toward homosexuality and transsexuality, Leitenberg and Slavin (1983) found that a significantly greater percentage of participants considered homosexuality to be “always wrong” (30% of women and 31% of men) than considered transsexuality to be “always wrong” (18% of women and 26% of men), $\chi^2 = 4.28$, $p < .05$. More participants were in favor of post-operative transsexuals being allowed to adopt children (51% of women and 39% of men) than were in favor of adoption rights for gay men or lesbians (37% of women and 32% of men), $\chi^2 = 4.64$, $p < .05$. Responses to the adoption questions did not differ according to whether the question referred to transsexual men or transsexual women.

Regarding job discrimination, the questionnaires asked participants whether transsexual women, transsexual men, gay men, or lesbians should be allowed to work in any of five particular occupations (i.e., judge, teacher, minister, doctor, or government official). Women indicated nearly equal support for transsexual men and women, gay

men, and lesbians in each occupation and were significantly more favorable regarding transsexuals' employment than were men for all the occupations except for minister. Men indicated greater support for gay men and lesbians than for transsexuals in the five occupations. Again, responses did not differ according to whether the question referred to transsexual women or transsexual men. While the authors stated that two of the survey questions addressed job discrimination, only this one was noted in the results section.

The final survey question asked participants to select a response to indicate "for how many homosexuals (transsexuals) did they think the following statement was true: 'Are they born that way?'" (Leitenberg & Slavin, 1983, p. 342). Fewer than 10% of participants responded with "all or almost all" regarding transsexuals or gay men and lesbians. Only a quarter (25.2%) of the participants responded with "few or none" regarding transsexuals, while nearly half (47%) of participants endorsed that response regarding lesbians and gay men. Twice as many participants selected "don't know" regarding transsexuality (43%) than for homosexuality (20%). The authors did not provide descriptions of any other response options for this item.

Leitenberg and Slavin (1983) concluded that the participating college students held more negative attitudes regarding homosexuality than transsexuality. Such attitudes did not necessarily correspond to "judgments about civil or legal rights" (p. 345) since women were not less in favor of employment in specific occupations for gay men or lesbians than for transsexuals, and men expressed greater support regarding employment for gay men and lesbians than for transsexuals. This finding is somewhat similar to that of Green et al. (1966), in which the physician participants tended to hold conservative views about sex reassignment surgery and considered transsexuals to be mentally ill, but

nonetheless tended to be supportive of particular civil rights for transsexuals. Leitenberg and Slavin suggested that “different values seem to govern decisions labeling a behavior ‘wrong’ as compared to decisions denying or affirming equal job opportunity to a person exhibiting this behavior” (p. 345).

Though Leitenberg and Slavin (1983) did not reference the identified gender differences in their discussion, such differences were apparent in all of the results, except that nearly the same percentage of men and women considered homosexuality to be “always wrong.” A greater percentage of men than women considered transsexuality to be “always wrong.” A greater percentage of women than men were in favor of adoption rights for transsexuals. A greater percentage of women than men were supportive of employment for transsexuals in each occupation participants were asked about. Overall, it appears that women held more favorable attitudes toward transsexuals than men did.

Leitenberg and Slavin (1983) acknowledged that their college student participants did not represent the general population and likely held more favorable attitudes than the general population toward gay men, lesbians, and transsexual people (a hypothesis based on a comparison of their findings with previous surveys of attitudes toward homosexuality). Even if that is so, they suggested, “there is no reason to believe that the direction or magnitude of the differences...*between* expressed attitudes toward transsexuals and homosexuals would be altered in a more representative sample” (p. 344).

One additional study, Antoszewski et al. (2007), examined college students’ attitudes toward trans people without using a formal attitude measure. Antoszewski and colleagues noted the scarcity of publications addressing social awareness of and attitudes

toward transsexual people. They referred to social acceptance as “a vital prognostic factor in the treatment of people with gender identity disorders” (p. 30) and stated that “the rights granted to transsexuals [*sic*] persons are the result of knowledge and tolerance of communities toward them” (p. 30). Antoszewski and colleagues surveyed 300 students from three universities in Lodz, Poland to assess participants’ knowledge of and attitudes regarding transsexuality. Participants were in their third-year or more of college, with a median age of 23 years. Fifty-one percent were men and 49% were women. Sixty-one percent were born in a “big city” (with a population of 100,000 or more), 27% in a “smaller town,” and 12% in a “village” (p. 31). The authors noted that all participants “were free of gender identity disorders” (p. 31).

Participants each completed a 30-item questionnaire. In addition to demographic items, the questionnaire included items asking about the definition and etiology of transsexualism, whether participants could befriend and/or work with a transsexual person, and whether transsexuals should have particular treatment and civil rights. The definition question asked participants to select the correct definition of “transsexualism” from amongst five other definitions (e.g., “synonym of homosexuality,” or “synonym of transvestitism,” p. 32). Response options for the questions about the etiology of transsexuality, relationships with transsexual people, and rights for transsexuals were: “definitely yes” and “rather yes” (collapsed as “yes” for analysis), “rather no” and “definitely no” (collapsed as “no” for analysis), and “I do not have an opinion” (p. 31). The authors did not present any reliability or validity data.

Twelve students (4%) indicated that they knew a transsexual person. The authors noted, however, that only four of those students selected the correct response to the

question regarding the definition of transsexualism. Just over half of the participants (54%) did select the correct definition. The same percentage agreed that transsexualism has a genetic basis, while 22% disagreed, and 20% had no opinion. Twenty five percent of participants agreed that transsexualism has an environmental basis, while 55% disagreed, and 20% had no opinion. Asked whether it could depend on upbringing, 46% answered, “no,” 39% answered, “yes,” and 15% answered, “I do not have an opinion.” Sixty-two percent indicated that they could be friends with a transsexual person and 75% indicated that they could work with a transsexual person. Antoszewski et al. (2007) used chi-square analyses ($p < .05$) to identify significant differences in responses between participants grouped by various demographic characteristics. Women responded significantly more favorably than men. Participants from big cities responded significantly more favorably than those from small towns and villages.

Regarding rights for transsexual people, a majority of students supported the opportunities for transsexual people to change their names (67%), obtain hormone treatments (70%), and undergo sex reassignment surgery (65%). Women, those who selected the correct definition of transsexualism, and those from small towns and big cities were more likely than others to support sex reassignment surgery rights. Forty-three percent supported the right of transsexual people to marry, while 26% did not, and 32% had no opinion. Just 23% of participants supported adoption rights for transsexuals, while 55% did not, and 22% had no opinion. Women indicated greater support than men for all of these rights. Forty-two percent of students indicated that transsexuals should not have the right to work with children in schools, 29% did support such a right, and 29% had no opinion. A majority of participants were opposed to social insurance coverage of

hormone treatment (63%) and sex reassignment surgery (66%). Those who agreed with a genetic explanation of transsexualism were more supportive of such coverage than others.

Antoszewski and colleagues (2007) concluded that college students in Lodz, Poland held knowledge regarding the definition of transsexualism comparable to that of medical students in another study (Sanchez et al., 2006, cited in Antoszewski et al.). They characterized students' attitudes regarding "legal and surgical sex change" (p. 34) as positive, but noted a lack of support for social insurance coverage. Finally, consistent with the previously reviewed study of college students' attitudes regarding transsexuals (i.e., Leitenberg & Slavin, 1983), as well as those to be reviewed later in this chapter (i.e., Hill & Willoughby, 2005; Nagoshi et al., 2008; Rye & Elmslie, 2001, June; Winter et al., 2008), the authors concluded that women expressed "a more liberal attitude" (p. 34) regarding transsexual people than did men.

Neither the two studies of health professionals' attitudes toward transsexuals, nor the two studies reviewed thus far in this section on college students' attitudes utilized a psychometrically-developed attitude measure, assessed for adequate reliability and validity. Based on a sample of college students, Rye and Elmslie (2001, June) developed the first such measure regarding attitudes toward trans people, and they shared their work in a conference poster presentation.

Rye and Elmslie (2001, June) theorized that, like attitudes toward gay, lesbian, and bisexual people, attitudes toward transsexual and non-transsexual transgender people, may be based on perceptions of "deviant sexuality" (p. 1). They suggested that negative attitudes may also result from the "ambiguous nature" (p. 1) of trans people. Against a social backdrop of violence and discrimination, and given the dearth of studies on

attitudes toward this population, the authors sought to develop a reliable and valid measure of beliefs regarding transsexual and transgender people.

Participants were 157 introductory psychology students at a university in Ontario, Canada. They included 61 men and 96 women. No other demographic descriptions were provided in the authors' handout. After reading a vignette describing a transsexual, transgender, or "homosexual" person (the authors did not state whether the third description was of a gay man or lesbian), participants completed "a series of measures that assessed respondents' reactions/attitudes/beliefs" (p. 3) regarding the person described in the vignette. Then participants completed a measure the authors titled the Transgender Belief Questionnaire (TBQ). The TBQ included 22 items developed through a review of literature regarding prejudice against trans people, as well as a review of measures of attitudes toward gay, lesbian, and bisexual people. In their handout, the authors listed brief statements revealing item content, but did not provide verbatim items or describe the response options. Participants also completed "a battery of sexuality and personality individual difference scales" (p. 1).

Rye and Elmslie (2001, June) reported that the TBQ (with the deletion of two problematic items) had adequate internal consistency ($\alpha = .92$). They identified three factors (labeled "acceptance/rejection," "morality/civil rights," and "sexual aspects," p. 2) through exploratory factor analysis. Those factors accounted for 52% of the scale variance. The TBQ was significantly correlated with the measures regarding reactions to the vignette characters. The authors reported strong correlations between the TBQ and measures of attitudes toward gay men ($r = .86, p < .001$) and lesbians ($r = .78, p < .001$), and moderate correlations between the TBQ and measures of attitudes toward women (r

= .53, $p < .001$), erotophobia-erotophilia (i.e., “the disposition to respond to sexual cues along a negative-positive dimension of affect and evaluation,” Fisher, Byrne, White, & Kelley, 1988, p. 123; $r = .48$, $p < .001$), number of sexual minority acquaintances ($r = .27$, $p < .05$), quality of experiences with sexual minority acquaintances ($r = .45$, $p < .001$), self-identified sexual orientation ($r = .27$, $p < .05$), orientation of desire/interest ($r = .29$, $p < .001$), right-wing authoritarianism ($r = .59$, $p < .001$), religious fundamentalism ($r = .63$, $p < .001$), religiosity ($r = .39$, $p < .001$), and tolerance for ambiguity ($r = .4$, $p < .001$). It was weakly correlated with a measure of personal boundaries ($r = .25$, $p < .05$) and was not correlated with the measures of gender role conformity ($r = .06$, *ns*) or social desirability ($r = .06$, *ns*).

Rye and Elmslie (2001, June) found that participants who received a vignette describing a transsexual person responded similarly on the TBQ to those who received a vignette describing a transgender person, while those who received a vignette describing a homosexual person responded slightly more negatively. This result is consistent with Leitenberg and Slavin’s (1983) finding of more negative attitudes regarding homosexuality than transsexuality. Rye and Elmslie reported that women expressed more favorable attitudes than men on the TBQ, consistent with all the studies reviewed here in which gender differences in attitudes toward trans people were examined.

Hill and Willoughby (2005) also developed a formal measure of attitudes toward trans people and assessed those attitudes in college students. In their introduction, the authors discussed evidence of “anti-trans sentiments” (p. 531) through examples of violence and discrimination against trans people. They cited the scarcity of research on

the topic of attitudes toward trans people and critiqued the rigor of prior studies, also arguing that:

Ideally, studies of anti-trans reactions should be more covert and able to tap into both overt reactions and more subtle values and ideology that underlie intolerance of gender boundary transgressions. Thus, it is critical to develop an instrument that measures values, ideology, and beliefs that might underlie hatred of gender non-conformists....It is important, then, to design a multi-item instrument with psychometric properties that can identify people who have strong negative attitudes toward a wide range of gender non-conforming people and behaviors. (p. 533)

Hill and Willoughby's article described three studies conducted in Montreal, Quebec, Canada, conducted with the goal of developing "a short psychometric questionnaire to assess negative attitudes toward trans persons" (p. 534).

Hill and Willoughby's (2005) first study was used for initial scale development, and involved 227 undergraduate college student participants, including 87 men and 140 women. Participants ranged in age from 18 to 50 years ($M = 22$, $SD = 4.6$). Most (94%) identified as heterosexual, while 4% identified as bisexual, and 2% identified as lesbian or gay. Race and ethnicity were not reported. Hill and Willoughby's conceptualization of anti-trans attitudes, drawn from previous work of the first author, included three dimensions: genderism, transphobia, and gender-bashing. Drawing from literature regarding anti-trans attitudes and the problems faced by trans people, the authors developed over 100 statements with potential for assessing cognitive, behavioral, and affective manifestations of anti-trans attitudes, consistent with the three dimensions.

Students responded by rating their agreement with the statements on a 7-point Likert-type scale, from 1 (*strongly agree*) to 7 (*strongly disagree*).

Hill and Willoughby (2005) reported that they eliminated items for which the average response was very high or very low (indicating a floor or ceiling effect), and also eliminated items which correlated at .50 or less with the total or corresponding subscale scores. They then selected the 10 strongest correlating items for each of the three subscales from the remaining items. Hill and Willoughby noted that “in two cases, the items were similarly correlated, thus 32 items in total were selected” (p. 535). The resulting product was the 32-item Genderism and Transphobia Scale (GTS), with three, strongly correlated subscales: genderism, transphobia, and gender-bashing. The scales had an overall coefficient alpha of .95. Greater total scores indicated more intolerant attitudes. Consistent with the findings of the studies reviewed previously in this chapter (Antoszewski et al., 2007; Leitenberg & Slavin, 1983; Rye & Elmslie, 2001, June), women’s scores on the GTS indicated less genderism, transphobia, and gender-bashing than men’s, $ts(225) = 5.37, 6.30, \text{ and } 7.36$, respectively, $p = .0001$.

The purpose of Hill and Willoughby’s (2005) second study was to further assess the reliability and validity of the GTS with a sample of 52 parents. (While this study did not use a college student sample, it is described in this section for the sake of continuity.) The parents included 34 women and 18 men. They ranged in age from 28 to 74 years ($M = 45$, SD not reported), and most (71%) were married. A third of the participants (33%) had bachelor’s degrees, 21% had graduate degrees, and 17% had completed at least one year of college. Half of the participants (50%) were Catholic and 14% were Jewish. No other demographic data were reported. The parents responded to a vignette, describing

either a gender-conforming or gender-variant child, by rating the happiness and mental health of the child, and by rating their concern about the child. Greater scores indicated greater intolerance for the child. The parents then completed measures of homophobia and gender role beliefs, and then the GTS. Parents' responses to the gender-variant child were more negative than to the gender-conforming child. The authors used regression analyses to check the predictive validity of the GTS and found that it moderately predicted parents' reactions to the gender-variant child, $R^2 = .50$, $\beta = .71$, $F(1, 27) = 26.9$, $p = .0001$. The GTS had an overall coefficient alpha of .88 for the second study. It was significantly correlated with the measures of homophobia ($r = .87$, $p = .0001$) and gender role beliefs ($r = .65$, $p = .0001$).

The third study described in Hill and Willoughby (2005) was designed to test and norm the GTS with a larger and more diverse sample. Participants were 180 undergraduate and graduate students from a variety of university academic departments, and included 81 men, 98 women, and 1 person of unknown gender. They ranged in age from 18 to 73 years ($M = 25$, SD not reported). The majority of participants were single (72%), while 24% were married, and 4% were widowed or divorced. In terms of highest level of education, 4% had graduate degrees, 31% had bachelor's degrees, and 66% were high school graduates. In addition to the demographic questionnaire, participants indicated whether they knew a cross-dresser, transsexual, or transgender person, and completed the GTS and measures of homophobia, gender role beliefs, self-esteem, gender orientation, social-desirability, and a modified version of Herek's (1987, as cited in Hill & Willoughby) Attitudes Toward Lesbians and Gays scale, in which, according to Hill

and Willoughby, “the term ‘gays’ was replaced with ‘gender non-conformists,’” (p. 539). They termed the modified scale the Attitude Function Index (AFI).

The third study again indicated that the scale had strong internal consistency ($\alpha = .96$). A principle components factor analysis revealed that a two-factor solution (genderism/transphobia and gender-bashing) was more reasonable than the three-factor solution (genderism, transphobia, and gender-bashing), and explained 60% of the variance. This led to Hill and Willoughby’s (2005) conclusion that the GTS was likely measuring a single, anti-trans attitude construct with two dimensions. The overall GTS mean was greater for the third study sample than the first two, “indicating slightly more intolerance for gender non-conformity in this diverse sample of participants” (p. 540). The GTS was moderately correlated with the measures of homophobia ($r = .34, p = .01$), gender role beliefs ($r = .39, p = .01$), and the AFI ($r = .55, p = .01$), supporting convergent validity. GTS scores were poorly correlated with measures of self-esteem ($r = .11, ns$), gender orientation (masculinity, $r = -.06, ns$; femininity, $r = -.09, ns$), and social desirability ($r = .23, p = .01$), supporting discriminant validity. GTS scores discriminated between those who had or had not been acquainted with a transsexual, transgender, or cross-dressing person, such that those who had these acquaintances had significantly lower GTS scores (i.e., more positive attitudes) than those who did not.

Hill and Willoughby (2005) concluded that the GTS demonstrated adequate reliability and validity, and “represent[ed] an advance in the study of discrimination and prejudice against gender non-conformists, especially transsexuals, transgenderists, and cross-dressers” (p. 542). The authors noted that they found a wide range of responses to GTS items, including “extremely intolerant attitudes” (p. 542). Hill and Willoughby

recommended that the GTS be tested with other populations and larger samples. They suggested that the GTS could be used “to explore causal and correlative factors of anti-trans sentiments and behaviors” (p. 542).

Winter and colleagues (2008) followed up on the work of Hill and Willoughby (2005) by testing the GTS with a sample of undergraduate students in Hong Kong. In addition to checking the measure’s suitability for use in a culture outside the one in which it was developed, Winter and colleagues sought to examine gender differences in GTS responses and also to determine whether responses varied by the gender referred to in particular GTS items. They utilized data from 203 undergraduate students, including 82 men and 121 women, from one of three courses at the University of Hong Kong. Participants ranged in age from 18 to 25 years ($M = 21$, SD not reported), came from all ten divisions of the university, and “represented all three years of its curriculum” (p. 674). Ninety two percent of participants identified as heterosexual, 5% as bisexual, and 0.5% as gay or lesbian. The authors stated that the majority of participants were ethnic Chinese.

Participants completed a Chinese translation of the GTS which was produced through several stages of translation and back-translation. Winter and colleagues (2008) added the following item to Hill and Willoughby’s (2005) original GTS, “In nature there are two sexes and two sexes only” (Winter et al., p. 681). This was done in order to supplement one of the original items which referred to God creating two sexes only, because, according to the authors, approximately 70% of the population in Hong Kong does not associate with a religion. The response and scoring formats were consistent with the original GTS, with higher scores indicating more negative attitudes.

Winter and colleagues (2008) conducted a factor analysis of the scale. They removed item 8 (“Children should be encouraged to explore their masculinity and femininity”) because it was weakly correlated (i.e., less than .3) with the other items. They removed item 26 (“I would go to a bar that was frequented by females who used to be males”) because it did not load on any factors, which the authors suggested might be because it is not typical in Hong Kong for college students to go to bars. Finally, they removed item 16 (“I would avoid talking to a woman if I knew she had a surgically created penis and testicles”) because it “did not load on any factor that made any contextual sense” (p. 675). Winter et al. identified five factors in the GTS scale, which they termed *Anti Sissy Prejudice* (9 items), *Anti Trans Violence* (4 items), *Trans Unnaturalness* (6 items), *Trans Immorality* (2 items), and *Background Genderism* (9 items). The authors stated that the items from the first and last factors consisted of many of the same items from Hill and Willoughby’s (2005) collapsed Transphobia and Genderism factor. Winter and colleagues noted that their third and fourth factors consisted entirely of items from the Transphobia and Genderism factor. The anti trans violence factor included some items from Hill and Willoughby’s Gender-bashing factor.

Together, the factors Winter and colleagues (2008) identified explained 53.96% of the total variance. Alpha coefficients for the factors ranged from .789 to .807, $p = .01$, and the mean correlations for each factor with all the other factors ranged from .216 to .404. The authors interpreted this data to mean that each factor was unidimensional and, while correlated with the others, measured a different underlying characteristic. In comparison, Hill and Willoughby (2005) determined that a two-factor solution best fit the data they collected from Canadian college students, so Winter and colleagues concluded

that “the factor structure underlying GTS data can vary across samples drawn from two different cultures” (p. 677) as gender non-conformity may have different meanings and ramifications depending on the values (religious, philosophical, etc.) of the culture of interest. Thus, a particular factor structure should not be assumed when using the GTS with populations from other cultures, nor, as Winter and colleagues cautioned, even with different populations from the same culture.

Regarding overall levels of transphobia, Winter and colleagues (2008) reported finding a wide variation in their sample. The mean GTS score of the sample was 107.89 ($SD = 23.15$). They used a *t*-test to compare that mean with the mean of 100.4 ($SD = 37.7$) reported by Hill and Willoughby (2005) for their final sample. The result was significant ($t = 4.28, p < .05$) and Winter et al. concluded that the students in the Hong Kong sample “seemed more transphobic” (p. 674) than those in the Canadian sample. They noted, however, that in both samples, the mean GTS item score was toward the more tolerant end of the scoring range, M (Hong Kong sample) = 3.37, M (Canadian sample) = 3.14. Winter et al. described the Hong Kong sample of participants as “mildly transphobic” (p. 677).

The authors found no effects of participants’ year of study on their GTS scores. Consistent with all the previous studies which examined gender differences in attitudes toward trans people, Winter and colleagues (2008) concluded that men ($M = 3.46, SD = .82$) were more transphobic than women ($M = 3.16, SD = .79$) in their sample, $t = 2.65, p = .009$. In addition to the gender differences at the level of overall GTS scores, they found corresponding difference on two factor scores (i.e., Anti Trans Violence and

Background Genderism), and nine individual GTS items, most of which referred to violence or teasing against trans people.

Winter and colleagues (2008) reported one additional main finding. They examined response variations based on the gender of the person being referred to in particular GTS items. In each of three pairs of GTS items (i.e., items 2 and 20, 6 and 13, and 25 and 29), the item content is the same except for the gender and/or gender expression of the person described. For example, item 6 reads, “I have teased a man because of his feminine appearance or behavior,” while item 13 reads, “I have teased a woman because of her masculine appearance or behavior” (p. 680). The authors used the Wilcoxon-Signed Ranks Test to determine that “on all three pairs participants expressed a significantly less tolerant view ($p = .000$) towards gender variant males than to gender variant females” (p. 675). Thus, as the authors noted, men are more likely than women to be intolerant of trans people, and trans people perceived to be men are most likely to be the targets of such intolerance. Winter and colleagues recommended that the GTS be studied further with general populations, with attention to the “invariance (or otherwise)” (p. 680) of the instrument’s factor structure.

The final study to be reviewed in this section on college students’ attitudes toward trans people is by Nagoshi et al. (2008). They developed a third measure of negative attitudes toward trans people, also with data from a college student sample. Nagoshi and colleagues lauded Hill and Willoughby’s (2005) contribution of the GTS as ground breaking, but critiqued the construct validity of the scale, and the discriminant validity of the genderism, transphobia, and gender bashing subscales. The authors noted that Hill and Willoughby’s initial use of those three constructs (i.e., genderism, transphobia, and

gender bashing) to conceptualize anti-trans attitudes was not based on any factor-analyses. The very high intercorrelations among the subscales led Nagoshi et al. to suggest that a briefer scale could just as well “capture all of the relevant variance” (p. 523) of Hill and Willoughby’s Genderism and Transphobia Scale.

Rather than attempting to assess emotions, cognitions, and behaviors through which anti-trans attitudes may be expressed, as was done by Hill and Willoughby (2005), Nagoshi and colleagues (2008) focused more narrowly on the emotional, or transphobic, component of anti-trans attitudes. Based on the work of Bornstein (1994, 1998 as cited in Nagoshi et al.), the nine items of Nagoshi and colleagues’ Transphobia Scale were intended to “assess a person’s degree of discomfort when encountering individuals who don’t conform to conventional gender norms” (p. 523). Items included, for example, “When I meet someone, it is important for me to be able to identify them as a man or a woman” (p. 530). Responses were made on a Likert-type scale from 1 (*completely disagree*) to 7 (*completely agree*).

Nagoshi et al. (2008) gathered data from questionnaires completed by undergraduate college student participants from introductory psychology courses at a university in the southwestern United States. The sample included 153 women and 157 men. The mean age was just over 19 years for both men and women. The reported ethnicity was 75% White, 12% Hispanic, 5% Asian, 2% African American, 2% Native American, and 4% other. Religious identification was reported as 35% Catholic, 32% Protestant or “other Christian,” 5% Jewish, 3% Mormon, 14% atheist or agnostic, and 12% other. The authors stated that most of the participants identified their sexual

orientation as “straight,” while two each identified as gay or lesbian, bisexual, or “other” (p. 525).

Nagoshi and colleagues (2008) examined the Transphobia Scale’s construct validity through its correlation with theoretically- and literature-derived predictors including participants’ own masculinity-femininity, ambivalent sexism (including hostile sexism, referring to bias against women and their rights, and benevolent sexism, referring to “a positive view of women only as they fit into traditional gender roles,” p. 526), sexual restrictiveness vs. sexual permissiveness/promiscuity, rape myth acceptance (i.e., beliefs that victims of sexual assault, rather than perpetrators, are to blame for such violence), hypermasculinity, right-wing authoritarianism, and religious fundamentalism. They also examined whether the Transphobia Scale correlated with theoretically irrelevant constructs including impulsivity and sensation seeking, neuroticism, self-esteem and social dominance, locus of control, and self-monitoring. The authors assessed the scale’s discriminant validity in relation to a homophobia measure.

Nagoshi and colleagues (2008) looked for gender differences in all the correlates, and expected that men would have higher scores than women for transphobia and homophobia. Their first hypothesis was that transphobia and homophobia would both be positively correlated with right-wing authoritarianism, religious fundamentalism, sexism, rape myth acceptance, and sexual restrictiveness. Their second hypothesis was that for men, but not women, hypermasculinity (as measured by aggression proneness) and hostile sexism would be correlated with homophobia and transphobia. The authors’ third hypothesis was that “transphobia would be more correlated with measures of beliefs in traditional gender roles and identity (benevolent sexism and rape myth acceptance) than

would be the case for homophobia” (p. 525). Finally, Nagoshi and colleagues’ fourth hypothesis was that the particular constructs which may underlie transphobia and homophobia would be different for women and men (e.g., they expected that “beliefs in traditional gender roles...beyond their effects on homophobia, would be more correlated with transphobia in women compared to men,” p. 525).

Nagoshi and colleagues (2008) reported that the Transphobia Scale had high internal consistency ($\alpha = .82$), which, along with the results of principal components analyses (in which all items but one loaded on a single factor), indicated that the scale items tapped into a single, unidimensional construct. The Transphobia Scale was significantly correlated ($r = .56, p < .001$) with the measure of homophobia (i.e., the Homophobia Scale; Wright et al., 1999). Regarding the measures theoretically irrelevant to transphobia and homophobia, Nagoshi et al. stated that those “for the most part, did not correlate” (p. 526) with transphobia or homophobia, supporting the Transphobia Scale’s divergent validity. The authors reported a test-retest stability correlation of .88.

Using MANOVA, Nagoshi et al. (2008) found, as they had expected, that men’s scores were significantly higher than women’s on the Transphobia Scale and the Homophobia Scale (Wright et al., 1999). As hypothesized (Hypothesis 1), the authors found that transphobia and homophobia were both significantly positively correlated with right-wing authoritarianism, religious fundamentalism, and hostile sexism. Rape myth acceptance was correlated with homophobia for both men and women, but with transphobia only in women. Benevolent sexism was correlated with transphobia in women and men, but with homophobia only in women. Sexual restrictiveness (vs. sexual

permissiveness/promiscuity) was not correlated with transphobia, and only correlated with homophobia in women.

The results related to the authors' second hypothesis were mixed. Nagoshi and colleagues (2008) found that transphobia and homophobia were, as expected, both correlated with aggression proneness in men only. However, hostile sexism was correlated with homophobia and transphobia for both men and women. Consistent with hypothesis three, the authors found that benevolent sexism was more strongly positively correlated with transphobia than homophobia, especially for women. Rape myth acceptance was correlated with homophobia for both men and women, but was correlated with transphobia only for women, and more strongly with transphobia than homophobia for women.

Nagoshi et al. (2008) also examined the correlates of transphobia with the influence of homophobia partialled out. For men, with homophobia controlled for, transphobia remained correlated only with benevolent sexism. For women, with homophobia controlled for, the correlates of transphobia remained largely unchanged, except for hostile sexism, which was no longer correlated with transphobia. Those results support the authors' fourth hypothesis and suggest that, for men, homophobia and transphobia are "driven by the same causal factors" (p 527), while, for women, the factors underlying transphobia are "somewhat different" (p. 527) from those underlying homophobia.

Through hierarchical regression analyses, Nagoshi and colleagues (2008) found that authoritarianism and religious fundamentalism were strong predictors of transphobia and homophobia for men and women. Beyond the variance explained by those factors,

aggression proneness significantly predicted homophobia and transphobia for men only. They also found that “over and above [those] effects...rape myth acceptance and benevolent sexism were significantly predictive of transphobia but not homophobia, with the effects being a little stronger for women than for men” (p. 528-529).

Nagoshi and colleagues (2008) concluded that their Transphobia Scale demonstrated adequate reliability and validity. The scale’s pattern of relationships with other measures led to the authors’ interpretation that both transphobia and homophobia may be motivated largely by “socialization experiences emphasizing ‘traditional,’ ‘conservative’ social values” (p. 527). They found that traditional gender role beliefs, in particular, are associated with transphobia in women. Additionally, they determined that homophobia and transphobia are associated with aggression proneness in men. Nagoshi and colleagues recommended “further research on transphobia and homophobia to clearly differentiate between the threats to heteronormative identity posed by deviations in gender roles vs. gender identity vs. sexual orientation” (p. 529). The authors acknowledged that their findings were limited by their Western cultural context and college-student sample.

While the bulk of the extant research on attitudes toward trans people was conducted with college student populations, the two remaining studies examined those attitudes among general populations. These studies will be reviewed next.

General Populations’ Attitudes toward Transsexuals

Landen and Innala (2000) surveyed a sample of the general population of Sweden, a country where, since 1972, the cost of sex reassignment surgery has been covered by the national health care system and post-operative transsexuals have been

allowed all of the civil rights and responsibilities of their post-operative sex. The authors noted that, despite support from the law, sex reassignment surgery and related issues remain controversial in Sweden. They claimed that “people’s attitudes toward transsexuals and whether transsexuals encounter prejudices and discrimination in society are of importance for the transsexuals’ quality of life” (p. 376). Landen and Innala aimed to assess attitudes toward transsexuals and perspectives on sex reassignment surgery. They also investigated whether attitudes differed according to whether participants endorsed biological or psychosocial explanations of transsexuality (a question based on findings from studies of attitudes regarding homosexuality), or by participant age or gender.

Landen and Innala (2000) used a national registry to randomly sample 992 Swedish residents, aged 18-70 years. Those selected received a questionnaire along with a letter which included a definition of transsexualism and described how it differs from transvestitism. Surveys were returned by 668 participants (a response rate far greater than that achieved by Franzini & Casinelli, 1986 or Green et al., 1966). The authors presented national registry data regarding the sex, age, marital status, and income of those who did and those who did not return surveys. They found no significant differences between the two groups, except that more women ($n = 352$) returned their surveys than did men ($n = 316$).

Participants completed a 13-item questionnaire (some items had multiple parts, for a sum of 18 responses). In their report, Landen and Innala (2000) provided the text of each item, the response options, and the percentage of responses each option received. They did not provide information about how items were selected for use, nor on the

reliability or validity of their questionnaire as an attitude measure. Questionnaire items addressed beliefs about the etiology and prevalence of transsexualism, about freedom of opportunity for transsexuals to undergo social and physical gender transitions (i.e., name change, hormone treatment, etc.), about who should cover the expense of sex reassignment surgery, and about rights for post-operative transsexuals to marry, adopt children, and work with children. Other items assessed whether participants knew any transsexuals and if they could accept an openly transsexual co-worker, friend, or romantic partner. Most items had response options of “Yes,” “No,” or “Have no opinion/Have not thought about it.”

Landen and Innala (2000) reported finding generally “positive and tolerant” (p. 380) attitudes toward transsexual people, though 91% of participants indicated that they did not know any transsexual people. Over half of the participants (56%) expressed support for the rights of post-operative transsexuals to marry “in their new sex” (p. 379) and to work with children (61%). These findings appear far more supportive than those reported by Antoszewski and colleagues (2007). The majority of participants in the Landen and Innala study also supported transsexuals’ rights to legally change their names (64%) and undergo physical gender transition through hormone treatment (53%) and genital surgery (56%), findings that were slightly less supportive than those found by Antoszewski et al. The majority of participants in the Landen and Innala study also indicated that they would accept an openly transsexual co-worker (71%) or friend (60%). Those results are consistent with Antoszewski et al., and both studies appear to have found more favorable attitudes regarding such relationships than Franzini and Casinelli (1986), in which most of the health professionals “indicated that transsexuals would not

be desirable professional colleagues and that establishing close personal relationships with them could be very difficult” (p. 537).

Unfavorable attitudes were, however, also expressed in the Landen and Innala (2000) study. Only 2% of participants indicated that they thought they could accept an openly transsexual person as a romantic partner. Only 29% of participants expressed support for the right of post-operative transsexuals to adopt and raise children as single parents; 43% supported such rights for married post-operative transsexuals. In surprising contrast, 50% of the physicians surveyed by Green et al. (1966) indicated support for the right of post-operative transsexuals to adopt children and 80% supported post-operative marriage rights.

Landen and Innala (2000) found that over half of the participants believed that transsexuals are “born that way” (53%), but did not consider transsexualism a disease to be treated (52%). The authors suggested that the latter perspective may account for why most participants (63%) indicated that the transsexual individual, rather than the state, should cover the expense of sex reassignment surgery, consistent with Antoszewski et al. (2007).

While 52% of participants endorsed the biological explanation of transsexualism (i.e., “You are born that way”), 29% selected responses representing psychosocial explanations (i.e., “You choose to be that way,” “You learn to be that way,” or “It is due to different experiences during childhood”). Landen and Innala (2000) used chi-square tests ($p < .005$) to determine the significance of differences between the identified participant categories. Those who endorsed the biological explanation held significantly less restrictive views regarding sex reassignment surgery (consistent with Antoszewski et

al., 2007), civil rights for post-operative transsexuals, and personal relationships with transsexuals. Similarly, women expressed less restrictive views than men, consistent with all the studies reviewed here in which gender differences were examined. Younger participants (aged 44 years or younger) expressed significantly less restrictive views regarding sex reassignment than older participants (aged 45 years or older, $p < .0001$), but older participants expressed significantly greater support than younger participants for public funding of sex reassignment surgery (17% vs. 13%, respectively, $p < .0005$).

Landen and Innala (2000) acknowledged that their participants might have, as a group, held less restrictive views than non-respondents, but stated that their findings are likely “to be reasonably representative for the population as a whole” (p. 386). The study could not answer, however, whether the findings would be similar in a contemporary general or specific population in another country, such as the United States. The authors recommended that future studies should identify cultural differences in attitudes and examine how such attitudes change over time.

The final study to be reviewed in this section, Harvey’s (2002) doctoral dissertation, was the first which aimed to assess attitudes toward transsexuals in an American general population. Harvey sought to “help to create a better understanding toward transsexuals for professionals who work with transsexuals, the general population, as well as transsexuals themselves” (p. 10). To develop specific research questions and the content for a questionnaire, Harvey drew from previous studies of attitudes toward transsexuals, studies of attitudes toward gay and lesbian people, and a focus group he convened of 10 pre- and post-operative transsexuals (5 female-to-male [FTM] and 5

male-to-female [MTF]). Harvey hypothesized that attitudes toward transsexuals would differ by participant sex and age.

Harvey (2002) recruited a stratified sample of 57 men and 61 women, aged 18-88 years, from Los Angeles, CA. He reported information regarding participants' race, income, education level, religion, and degree of religious involvement. Participants completed a 16-item questionnaire (some items had multiple parts, so participants provided over 20 responses). The questionnaire began with a definition of transsexuality and included items regarding participants' exposure to transsexual people through personal contact and media, along with ratings of their degree of acceptance and impressions of the media. Seven items presented scenarios and asked participants to respond by identifying their attitude on a 5-point scale, from *non-accepting* to *accepting* (e.g., "Imagine you have been introduced to a masculine-looking woman. A friend tells you that she is a transsexual and used to live as a man. What would your attitude be toward this person?"). Two questions asked participants about whether transsexual people (MTF and FTM) should have the right to marry men, women, either, or neither, and another two asked whether transsexual people (MTF and FTM) would be attracted to men, women, both/either, neither, or other transsexual people. One question assessed participants' beliefs about the main reason why a person would be transsexual, with a choice of one of five reasons or "other." A series of questions with "yes," "no," and "have no opinion/have not thought about it" response options asked participants about their expected ability to interact with a transsexual person, their willingness to shop at a store with a transsexual employee, whether they thought transsexuality was increasing in prevalence, whether health insurance should cover the cost of sex reassignment surgery,

whether their consciousness was raised through the questionnaire, and whether they might want to learn more about transsexuality sometime in the future. The final item asked participants to describe any attitudes they held toward transsexual people that were not covered by the survey instrument. Harvey did not provide any reliability or validity data regarding the survey instrument as an attitude measure.

Harvey (2002) concluded that, overall, participants' responses indicated that they held accepting attitudes toward transsexual people. He reported that many of the questions with response options on a continuum from *non-accepting* to *accepting* had average responses representing *somewhat accepting* (though responses did include the full range of options). Consistent with previous research, he found significant differences between men's and women's responses, and concluded that women held more accepting attitudes toward transsexuals than did men, except with regard to transsexuals in the workplace (about which both men and women were "somewhat accepting"). Responses differed significantly by participant age for just one question, that regarding beliefs about the cause of transsexuality. Harvey reported that the mean age of those who selected the "the person decides to be that way" response was 36.50 ($SD = 14.34$), the mean age of those who selected the "the person learns to be that way" response was 45.79 ($SD = 15.78$), and the mean age of those who selected the "the person is born that way" response was 40.23 ($SD = 13.79$).

Like the participants in Landen and Innala's (2000) Swedish study and Antoszewski and colleagues' (2007) Polish study, most participants in Harvey's (2002) study indicated that they did not know a transsexual person (74%). Most indicated that they had seen portrayals of transsexual people on television or in movies (82%), thought

they would be able to interact socially with a transsexual person (80%), and would shop at a store which had a transsexual employee (94%). Over half (59%) thought that the incidence of transsexuality had increased in the U.S. in the past 25 years. The majority of participants also indicated their belief that MTF and FTM transsexual people should have the right to marry either men or women (regarding MTFs, 70%; regarding FTMs, 71%) and would be attracted to both or either gender (regarding MTFs, 59%; regarding FTMs, 53%) . When asked for the main reason why a person would be transsexual, the top four responses were: “The person is born that way” (49%), “The person decides to be that way” (19%), “Other” (17%), and “It is the result of certain experiences in the person’s childhood” (11%).

Asked whether medical insurance should cover the expense of sex reassignment surgery, 39% of participants responded “No,” 33% responded “Yes,” and 27% responded “Have no opinion/Have not thought about it.” This contrasts with the results of Landen and Innala (2000) and Antoszewski et al. (2007), in which over 60% of the participants in each study thought that social insurance should not cover the cost of sex reassignment surgery. Regarding whether Harvey’s (2002) questionnaire increased participants’ consciousness of transsexual people, 47% responded “No,” 38% responded “Yes,” and 15% responded “Have no opinion/Have not thought about it.” Thirty-eight percent of participants indicated that they could not see themselves wanting to know more about transsexuality in the future, while 36% indicated that they could and 26% indicated that they had no opinion or had not thought about it.

Harvey (2002) acknowledged that his findings were limited by the facts that all participants were recruited from one city (Los Angeles, CA) and self-selected to

complete the survey. He noted that potential participants with negative attitudes may have been more likely to decline to participate. Harvey recommended that the study be replicated on a national level and suggested that attitudes may vary geographically.

Summary of Research Regarding Attitudes toward Trans People

Despite the dearth of literature on this topic, the studies reviewed in this chapter provide some insight into attitudes regarding trans people. Such attitudes appear to have become, generally, more favorable since first investigated in the 1960s, at least among physicians (Franzini & Casinelli, 1986). The authors of relatively recent investigations characterized participants' attitudes as generally positive, accepting, or tolerant (Antoszewski et al., 2007; Harvey, 2002; Landen & Innala, 2000; Winter et al., 2008). Two studies which compared participants' attitudes toward trans people with attitudes toward lesbians and gay men found that attitudes toward trans people tended to be more favorable than those toward lesbians and gay men (Leitenberg & Slavin, 1983; Rye & Elmslie, 2001, June). All of these findings would seem to be at odds with the contemporary evidence of violence and discrimination against trans people presented in the introductory chapter, except that the extant attitude research revealed a full range of attitudes held regarding trans people, including not only the fairly positive attitudes found on average, but quite negative and hostile attitudes as well.

Many of the studies reviewed here compared responses by participant gender; those that did found consistently that women tended to express more favorable attitudes regarding trans people than did men (Antoszewski, 2007; Harvey, 2002; Hill & Willoughby, 2005; Landen & Innala, 2000; Leitenberg & Slavin, 1983; Nagoshi et al., 2008; Rye & Elmslie, 2001, June; Winter et al., 2008). The same type of gender

difference has been found regarding attitudes toward lesbian and gay people (Herek, 1994) and, to a lesser extent, bisexual people (Herek, 2002).

Another participant variable found to be relevant to attitudes toward trans people is personal familiarity with trans people. While several studies inquired about participants' familiarity with trans people through personal acquaintanceships, relationships, and/or media exposure, only two, Hill and Willoughby (2005) and Rye and Elmslie (2001, June) compared other responses by this variable. Hill and Willoughby asked participants whether they had personally met a transgender, transsexual, or cross-dressing person. Rye and Elmslie inquired about acquaintanceship with "sexual minorities," which, presumably, included not just trans people, but also lesbian, gay, and bisexual individuals (this was not clarified in their handout). In both studies, participants who indicated such familiarity tended to express more favorable attitudes than those who did not.

Findings regarding age differences in attitudes toward trans people have been limited and mixed. Only two studies, Landen and Innala (2000) and Harvey (2002), examined variation in attitudes by age. Landen and Innala found significant differences between the responses of older and younger participants only regarding opinions about opportunities for sex reassignment (younger participants expressed less restrictiveness than older participants) and about who should cover the expense of sex reassignment surgery (older participants were more supportive of coverage through public funds than younger participants). Harvey found age differences only in response to his question about the main reason why a person would be transsexual. When he compared the mean

ages of participants who selected the three most chosen responses, though, Harvey found no significant differences.

Participant responses in studies of attitudes toward trans people have been found to vary by one additional demographic variable, professional specialty among health care professionals. This was assessed and revealed in both Green et al. (1966) and Franzini and Casinelli (1986). The results of both studies also suggested that mental health professionals may hold more favorable attitudes than physical health professionals.

Several studies asked participants about their views on the cause of transsexuality, but only two, Antoszewski et al. (2007) and Landen and Innala (2000) compared this variable to other responses. Both identified significant relationships. Landen and Innala found that those who endorsed a biological explanation of transsexuality expressed less restrictive views than others regarding sex reassignment, and expressed greater support for marriage rights for transsexuals and for transsexuals' rights to adopt and work with children. Antoszewski et al. and Landen and Innala both found that those who endorsed a biological explanation were more supportive than others of insurance coverage for sex reassignment procedures. Across the four studies that asked participants about their beliefs about the cause of transsexuality, the percentage of participants who agreed with a biological explanation ranged from fewer than 10% in Leitenberg and Slavin's (1983) study to 49% in Harvey's (2002) study to 54% in Antoszewski and colleagues' study to nearly 65% in Landen and Innala's (2000) study.

Three studies reviewed in this chapter, Hill and Willoughby (2005), Nagoshi et al. (2008), and Rye and Elmslie (2001, June), reported on the development and validation of formal measures of attitudes toward trans people. Each found evidence of relationships

between such attitudes and several socially-conservative attitudes and beliefs, suggesting, as Nagoshi and colleagues wrote, “that a large part of what drives these prejudices are possibly socialization experiences emphasizing ‘traditional,’ ‘conservative’ social values” (p. 527). The most consistent finding, documented in all three studies, was that attitudes toward lesbian and gay people and attitudes toward trans people were highly related, with correlation coefficients of .87 ($p = .0001$) and .34 ($p = .01$) reported by Hill and Willoughby, .56 ($p < .001$) reported by Nagoshi et al., and .86 (attitudes toward gay men; $p < .001$) and .78 (attitudes toward lesbians; $p < .001$) reported by Rye and Elmslie.

Several other variables regarding socially-conservative attitudes and beliefs were examined in the instrument-development studies, but two stood out due to the strength of their correlations with attitudes toward trans people: religious fundamentalism and right-wing authoritarianism. Nagoshi and colleagues (2008) and Rye and Elmslie (2001, June) both measured participants’ religious fundamentalism, which “reflects adherence to a centralized religious belief system that is fundamental for existence, represents a special relationship with God, and must be strictly adhered to in opposition to the forces of evil” (Nagoshi et al., p. 525-526). Nagoshi et al. reported correlation coefficients for religious fundamentalism and the Transphobia Scale of .54 ($p < .001$) for women and .28 ($p < .001$) for men. Rye and Elmslie reported a correlation of .63 ($p < .001$) between religious fundamentalism and the Transgender Belief Questionnaire. The same two studies also both measured participants’ right-wing authoritarianism, which “reflects a belief in submission to authority, the legitimacy of aggressive actions by authority, and conventional social norms” (Nagoshi et al., p. 525). Nagoshi and colleagues reported correlations between right-wing authoritarianism and the Transphobia Scale of .49 ($p <$

.001) for women and .42 ($p < .001$) for men. Rye and Elmslie reported a correlation of .59 ($p < .001$) between right-wing authoritarianism and the Transgender Belief Questionnaire. Hill and Willoughby (2005) did not assess religious fundamentalism or right-wing authoritarianism. Several other measures were uncorrelated or weakly correlated with anti-trans attitudes, including measures of masculinity and femininity, self-esteem, hostility, and the tendency to present oneself in a positive light.

The various expressions of attitudes toward trans people through beliefs, feelings, and anticipated behaviors did not always appear consistent in the studies reviewed. For example, many physician participants in the earliest study reviewed, Green et al. (1966), expressed negative attitudes toward transsexuals' through judgments of their mental health and morality, yet the vast majority supported legal recognition, marriage, and adoption rights for post-operative transsexuals. Physicians and clinical psychologists in a later study expressed far more favorable attitudes regarding transsexuals' mental health and morality, yet would not want to be professional colleagues with transsexuals (Franzini & Casinelli, 1986). Hill and Willoughby (2005) did find a relationship between parents' anti-trans attitudes and their responses to a gender-non-conforming child such that more negative attitudes predicted greater intolerance of the child. Rye and Elmslie (2001, June) found that scores on their Transgender Belief Questionnaire were highly correlated with measures of reactions to a trans person (i.e., positive reactions, negative reactions, attitude toward the target, individual beliefs about the target, and personality judgments). No previous research has investigated the relationship between attitudes toward trans people and counselors' responses to trans clients.

Chapter II Summary

This chapter reviewed literature pertinent to the examination of counseling professionals' anti-trans attitudes and the potential relationship between those attitudes and responses to trans clients. The literature review included a brief overview of the relevance of attitudes to multiculturally competent counseling. It also included a review of select studies that provided empirical support for the existence of biased social attitudes among counseling professionals and trainees, and the relationship between such attitudes and counseling-relevant variables including client perceptions of counselors or counselors' perceptions and assessments of clients. The remainder of the chapter provided a thorough review of studies of attitudes toward trans people, most focused more specifically on attitudes regarding transsexual people.

Gaps revealed in the literature include the dearth of attention and research on transgender people as a cultural minority or as counseling clients, the lack of research regarding counseling professionals' attitudes toward trans people, and the infrequent use of psychometrically-sound attitude measures in previous studies of attitudes toward trans people. The present study addressed those gaps. The research methods are described in the next chapter.

CHAPTER III

METHODS

This chapter describes the methods used in this counseling analogue study. The first section describes the research participants and their selection. The data collection process is described in the procedures section. The next section, materials and instrumentation, includes a description of the fictional client material presented to participants, followed by descriptions of the research measures and their psychometric properties. Finally, the statistical analyses used to address the research questions are described in the data analysis section.

Participants

Counselors and counseling psychologists were recruited via electronic mailing lists and direct email messages to participate in this study. Eligibility criteria included (a) being 18 years of age or older; (b) holding a masters and/or doctoral degree in counseling and/or counseling psychology; (c) being enrolled as a doctoral student in counseling or counseling psychology, and/or working as a practicing professional providing counseling, training, and/or counseling supervision services; and d) having previous training in the use of the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 2000). A total of 176 people completed at least the first item of the online survey. Data was not used from 22 participants who dropped out before reaching the end of the survey, or from 16 others whose responses indicated that they did not meet one or more of the inclusionary criteria. The eliminations left a final sample size of 138 participants.

Participants ranged in age from 24 to 66 years, ($M = 39.63$, $SD = 11.194$). They included 110 women (79.7%), 26 men (18.8%), one person who identified as transgender (0.7%), and one person who identified as “mostly female” (0.7%). The majority of participants (90.6%) identified their race/ethnicity as White/European American ($n = 125$). Six participants (4.3%) identified their race/ethnicity as Bi/Multi-racial, four (2.9%) as Black/African American, four (2.9%) as Hispanic/Latino(a)/Chicano(a), and one (0.7%) as Asian/Asian American. Two participants marked both the Hispanic/Latino(a)/Chicano(a) and the White/European American response options (included in the percentages reported above). No participants selected the response options of “Native American or Alaskan Native” or “Other (please specify).”

Most participants (82.6%) identified as heterosexual ($n = 114$), while 16 participants (11.6%) identified as bisexual, four (2.9%) as lesbian or woman-loving women, three (2.2%) as gay men or man-loving men, and three (2.2%) as queer. Four participants (2.9%) selected “Other (please specify)” as a response; one specified having a “mostly heterosexual” orientation, another indicated having a “pansexual” orientation, a third wrote that she “prefer[red] not to say,” and one participant who selected “Other” did not specify his sexual orientation. Four participants selected more than one response (included in the percentages above).

Over half of the participants (60.1%) indicated that the Midwest U.S. was their region of primary residence ($n = 83$). Another 25.4% of participants reported being from the Southern U.S. ($n = 35$), while 7.2% were from the Northeast U.S. ($n = 10$), and 6.5% were from the Western/Pacific U.S. ($n = 9$). No participants selected the response options

of “U.S. Territory” or “Outside the U.S. and its Territories.” One participant (0.7%) did not indicate her region of primary residence.

A total of 96 participants (69.6%) indicated that their most advanced degree in counseling or counseling psychology was the master’s degree. Two participants (1.4%) reported having an educational specialist degree in counseling psychology (collapsed with master’s degree for data analysis). Forty participants (29.0%) reported having a doctoral degree in counseling or counseling psychology. Participants’ reported years of counseling experience (including practica, externships, internships, employment, etc.) ranged from one to 30 years ($M = 10.51$, $SD = 8.203$).

When asked about the program type of their most advanced degree in counseling or counseling psychology, the most frequent responses were counseling psychology (34.1%, $n = 47$), and community counseling (21.0%, $n = 29$). Other participants reported earning their most advanced degrees in counseling or counseling psychology in the following program types: counselor education and supervision (11.6%, $n = 16$); mental health counseling (10.9%, $n = 15$); school counseling (5.8%, $n = 8$); marital, couple, and family counseling/therapy (3.6%, $n = 5$); college counseling (2.9%, $n = 4$); rehabilitation counseling (2.2%, $n = 3$); and student affairs (1.49%, $n = 2$). Other participants specified their program types as: counseling (1.49%, $n = 2$), clinical psychology (1.49%, $n = 2$), educational psychology-counseling focus (.72%, $n = 1$), general psychology with a focus on mental health counseling (.72%, $n = 1$), art therapy, (.72%, $n = 1$), and counselor education and counseling and marriage and family therapy (.72%, $n = 1$).

The majority of participants (68.1%) indicated that they were not enrolled in a doctoral program at the time of the survey ($n = 94$), while 17.4% indicated that they were

enrolled in a counseling psychology doctoral program ($n = 24$), and 10.1% indicated that they were enrolled in a counselor education and supervision doctoral program ($n = 14$). One participant (0.72%) indicated that he had completed all requirements but the dissertation for a counseling psychology program, but it was not clear whether he was actively enrolled in that program at the time of the survey. The remaining five participants (3.6%) reported being enrolled in a variety of other doctoral programs (i.e., marriage and family therapy, research and measurement, general psychology with a focus on counseling psychology, counseling, counseling studies, and applied ecopsychology). See Appendix H for the demographics questionnaire.

Procedure

Participants were recruited through a research invitation (see Appendix A) distributed through professional and graduate student electronic mailing lists, including those of the American Psychological Association Division 17, the Society of Counseling Psychology (DIV17DISCUSS); the American College Counseling Association (ACCA-L); the Counselor Education and Supervision Network (CESNET-L); the Association for Specialists in Group Work (ASGWALL); the Michigan Counseling Association (MCA-L); the Michigan Psychological Association (MPALISTSERV); COUNSGRADS (primarily serving graduate students in counseling and counselor education programs); and Counselortalk (primarily serving school counselors). The original invitation was also distributed by email to current doctoral students in counselor education and counseling psychology at a large, public Midwestern university, as well as graduates of the doctoral programs in counselor education and counseling psychology at that university. The research invitation was also distributed by email to counseling psychology doctoral

program training directors as listed on their colleges' or universities' websites or in the online directory of the Council of Counseling Psychology Training Programs (an organization of training directors). The email sent to training directors was prefaced with a request that the training directors forward the invitation to eligible faculty and doctoral students in their departments (see Appendix B). Finally, the original research invitation was followed by a reminder invitation (Appendix C) sent between two and eight weeks after the first invitation to the electronic mailing lists named above.

The research invitation (see Appendices A-C) included a brief description of the purpose of the study, the participation criteria, a statement indicating that participants would have the opportunity to enter a drawing to win a \$100 Visa gift card (with entry data kept separate from research data in order to maintain confidentiality), a link to the online survey, and a request that recipients forward the posting to other potential participants. Due to concerns that participants' survey responses might be influenced by an awareness of the study's specific focus on anti-trans attitudes, the purpose of the study was described broadly as a survey of counseling professionals' clinical impressions and attitudes regarding gender issues.

When individuals who chose to click on the survey link did so, they were presented with an informed consent webpage (see Appendix D) describing the purpose of the study, inclusion criteria, anticipated duration, procedures, and anticipated risks and benefits. The consent page also described the voluntary nature of the study and the optional prize drawing, and provided assurance of the confidentiality of participants' responses through encryption technology and other means. A statement at the bottom of the consent page indicated that potential participants could close the web browser (or

otherwise navigate away from the webpage) to decline participation at any point, and that they could click “continue” to indicate their consent to participate. Those who chose to continue then accessed the first page of the online survey instrument.

The survey was built and hosted online using the commercial survey company PsychData (<https://www.psychdata.com/>). To ensure the security of participants’ electronic responses, PsychData uses technology that prevents use of a web browser’s “back” button or “history” to view completed survey pages. When the survey window is closed, the temporary history files associated with the survey are deleted from the computer used by a participant. Both of those measures prevent subsequent users of the computer from viewing participants’ survey responses. Survey responses were transmitted to PsychData into a password-protected database accessible to the researcher. To protect participant privacy during transmission, the survey questions and responses were encrypted using 128-bit Secure Socket Layer technology.

The survey began with instructions asking participants to read a fictional client intake summary which would be followed by questions about their impressions of the client. The instructions were followed by one of two versions of a client intake summary describing a transgender-identified person, either male or female (see Appendix E). The version presented to a participant was randomly assigned and recorded through the survey web host, PsychData (<https://www.psychdata.com/>). The intake summary was followed by two client response measures with instructions. First, participants rated the fictional client’s overall level of psychosocial functioning using the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 2000). Second, participants selected adjectives to describe the client from a list of adjectives which

comprise the combined “Number of Favorable Items Checked” and “Number of Unfavorable Items Checked” scales of the Adjective Check List (ACL; Gough & Heilbrun, 1983). All responses were made and recorded electronically.

After reading the fictional intake summary and completing the two client response measures, participants completed the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005) and the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002). Participants were then presented with a definition of the term *transgender* and descriptions of a variety of trans identities quoted from an American Psychological Association (2006) brochure, *Answers to your questions about transgender individuals and gender identity* (see Appendix F). Following the definition and descriptions, participants rated their degree of training and experience in counseling and assessment with trans people using a scale (see Appendix G) adapted from one developed by Tomko (2008). They also rated their degree of personal familiarity with trans people on a scaled item and indicated their beliefs regarding transgender etiology by selecting one of five response options.

Finally, participants completed a demographic questionnaire (see Appendix H). The questionnaire included items requesting information regarding participants’ age, gender, race/ethnicity, sexual orientation, level of education/degrees earned in counseling or counseling psychology, enrollment in a doctoral program in counseling or counseling psychology, years of counseling experience, and previous training in the use of the GAF scale (American Psychiatric Association, 2000).

Upon completion of the survey, participants were thanked for their participation and offered the option to enter their email address in a drawing for a \$100 Visa gift card.

Participants were informed that their email addresses would be kept confidential and saved separately from their survey responses (see Appendix I). Participants who indicated that, “Yes,” they would like to enter the drawing were then presented with a new web page where they could type their email address into a text box and click to submit (see Appendix J). When they did so, the next page again thanked them for their participation and instructed them to close their web browser for maximum confidentiality (see Appendix K). Participants who indicated that, “No,” they did not want to enter the drawing were taken directly to that final thank you page with the instruction regarding closing their web browser.

The fictional intake summary will be described in the next section, followed by descriptions of all of the research measures and their psychometric properties.

Materials and Instrumentation

Fictional Intake Summary

The present author composed two versions of a brief intake summary describing a fictional client, “Jamie,” with multiple presenting concerns (see Appendix E). Consistent with previous written counseling analogue studies investigating counselor bias (e.g., Barrett & McWhirter, 2002; Mohr et al., 2001; Mohr, Weiner, Chopp, & Wong, 2009), the fictional client’s presenting issues did not include concerns specifically regarding the client characteristic of interest. That is, the client described in the summary did not present with concerns regarding gender identity. Rather, the presenting concerns involved (a) discord with a work supervisor resulting in anxiety and impaired occupational functioning, (b) grief regarding the death of a family member, and (c) indecision regarding whether or not to relocate to be closer to family. The description of the conflict

with the work supervisor was centered on criticism regarding the client's work and appearance, leaving open the possibility that the criticism was related to the client's gender-variant appearance, but not specifying or confirming that possibility.

The two versions of the intake summary varied by the client's sex and gender expression, with one version describing a male, feminine, transgender person and the other version describing a female, masculine, transgender person. Those variations were included due to evidence that reactions to trans people may vary according to whether they are perceived as gender variant men or women (Winter et al., 2008). Each version of the intake summary included brief descriptive statements regarding the client's sex and appearance (e.g., hairstyle and clothing) to indicate a feminine appearance (e.g., long hair, makeup, wearing a blouse) or masculine appearance (e.g., short hair, wearing a button-down shirt and tie). The intake summary versions also included statements noting that the client indicated a transgender identity on a counseling intake form, that the client thinks of himself or herself "in some ways as a man, and in some ways as a woman," and that the client prefers the masculine or feminine pronouns consistent with his or her biological male or female sex. The two versions were otherwise identical, with no differences in the presentation of the client's psychological, social, or occupational functioning. The version presented to a participant was randomly assigned and recorded through the survey web host, PsychData (<https://www.psychdata.com/>).

Global Assessment of Functioning Scale

Participants were asked to rate the fictional client on the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 2000). The GAF is used by mental health professionals to rate an individual's overall psychological, social, and

occupational functioning. Such ratings are “useful in planning treatment and measuring its impact, and in predicting outcome” (p. 32). As one component of the multiaxial diagnostic system described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR*; American Psychiatric Association), the GAF scale is a very widely used measure among mental health professionals. Due to its widespread use in clinical assessments of clients, and its use as a response measure in previous studies of counselor attitudes and biased responses to clients (e.g., Mohr et al., 2001; Mohr et al., 2009), the GAF was selected as one measure of participants’ responses to the fictional client presented in the present study.

The GAF scale consists of a continuum of scores, from 0 to 100, with 0 indicating insufficient information and 1 to 100 representing the lowest to highest levels of psychosocial functioning, respectively. Descriptive anchors are provided for each 10-point interval. For example, the 1- to 10-point interval is labeled: “Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death” (p. 34). The 91- to 100-point interval is labeled: “Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms” (p. 34).

The GAF scale was introduced in the *DSM-Third Edition-Revised (DSM-III-R*, American Psychiatric Association, 1987), and was based on a measure called the Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976, as cited in American Psychiatric Association, 2000). The current *DSM-IV-TR* does not include information regarding the psychometric properties of the GAF. Loevdahl and Friis (1996) presented

evidence to suggest that GAF ratings are significantly more reliable with raters trained in GAF use than with untrained raters. For that reason, one of the participation inclusion criteria for the present study was that participants had previous training in the use of the GAF. There is also evidence to suggest that GAF ratings are susceptible to rater biases. Landers (2008) studied the GAF's inter-rater reliability with manipulated client variables including gender, marital status, educational level, and ethnicity. She found the corresponding GAF ratings to be unreliable across time and the manipulated variables. In clinical applications, that kind of susceptibility to rater bias may be an argument against use of the GAF. In a research context, however, it could be useful if the cognitive processes involved in determining a GAF rating may be influenced by attitudes regarding particular client characteristics, perhaps including transgender identity.

Participants were asked to determine and assign a GAF score from 1 to 100 to represent their assessment of the fictional client's current overall level of psychological, social, and occupational functioning. As per the standard GAF instructions, participants were instructed to not include impairment due to physical or environmental limitations. Participants were asked to type their numerical GAF rating in a data entry box on the survey webpage.

Spengler and colleagues (2009) noted that many studies of clinical judgment did not include a standard to assess judgment accuracy. Such studies identified client variables that may impact clinical judgment, but could not provide information on the degree of accuracy of those judgments. In order to avoid such a limitation in the present study, participants were instructed to provide a GAF score for the client in the fictional intake summary, which was compared to an expert determined GAF score utilized as a

standard of rating accuracy. Four licensed psychologists who regularly use the GAF as part of their clinical practice and who had experience instructing others in the use of the GAF served as expert raters. Each version of the intake summary was reviewed by two of the licensed psychologists.

The two psychologists who reviewed the intake summary version describing a feminine, male-bodied, transgender client both rated the client's psychosocial functioning as a 70 on the GAF scale. Of the two psychologists who reviewed the intake summary version describing a masculine, female-bodied, transgender client, one rated the client's psychosocial functioning as a 65 on the GAF scale, and the other gave a rating of 68. All of the ratings fell within the same 10-point interval of the GAF scale, a range with the following description: "Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships" (American Psychiatric Association, 2000, p. 34). The GAF scores obtained in the present study were compared against this standard to describe whether they fell within the accurate GAF interval, below the accurate interval (indicating overpathologizing the client), or above the accurate interval (indicating underpathologizing the fictional trans client).

Adjective Check List

The Adjective Check List (ACL; Gough & Heilbrun, 1983) was used as a second response measure regarding the fictional client described in the intake summary. The ACL was selected to assess participants' favorable and unfavorable perceptions of the client. Based on a variety of personality theories, the ACL, in its entirety, consists of 300

adjectives and short descriptive phrases, listed in alphabetical order, which can describe the personal attributes of self or others. Any number of items may be endorsed, and responses can be scored along 37 subscales (e.g., Achievement, Dominance, Nurturance, and Deference). Only two subscales, Number of Favorable Items Checked (henceforth referred to as *Favorable*) and Number of Unfavorable Items Checked (henceforth referred to as *Unfavorable*), were used in the present study. This is consistent with previous studies of counselors' biased perceptions (e.g., Barrett & McWhirter, 2002; O'Connor, 2005), including Barrett and McWhirter's study of counselor trainees' perceptions of clients based on client sexual orientation, which was discussed in the previous chapter. Gough and Heilbrun noted that the ACL instructions are easily adapted to fit a variety of purposes. For the present study, the standard ACL directions were altered to refer to the fewer number of items administered for this study and to the measure's purpose in describing the client from the fictional intake summary.

Participants were instructed to review a list of 150 adjectives from the combined, alphabetized Favorable and Unfavorable scales (75 items each) and to click to mark a box next to those which they believed characterized the fictional client. Examples of favorable items included "adaptable," "healthy," and "insightful." Examples of unfavorable items included "apathetic" and "hostile." Participants were instructed to mark as many or as few adjectives as they believed characterized the fictional client. The Favorable scale score is the total number of favorable items checked by a participant, while the Unfavorable scale score is the total number of unfavorable items checked by a participant.

Gough and Heilbrun (1983) reported alpha reliability coefficients for the ACL scales based on samples of 591 men and 588 women. Alpha coefficients for the Favorable scale were .95 for men and .94 for women. Alpha coefficients for the Unfavorable scale were .92 for men and .91 for women. They reported test-retest coefficients of .62 and .60 for men and women, respectively, for the Favorable scale. For the Unfavorable scale, they reported test-retest coefficients of .65 and .76 for men and women, respectively. The intercorrelation among the Favorable and Unfavorable scales was -.68 for the combined samples of men and women. Thus, the Favorable and Unfavorable scales each appeared to be adequately reliable and measuring somewhat polar constructs. Alpha coefficients for the present sample of counseling professionals were .95 for the Favorable scale and .74 for the Unfavorable scale.

Genderism and Transphobia Scale

As described in Chapter II, the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005) is a measure of anti-trans attitudes. It was used in the present study to examine the extent of counseling professionals' anti-trans attitudes. The GTS authors conceptualized anti-trans attitudes as being expressed through genderist beliefs, transphobic feelings, and gender-bashing behaviors. The original GTS was comprised of 32 statements reflecting such cognitive, affective, and behavioral expressions. Item examples include, "Sex change operations are morally wrong," "Masculine women make me uncomfortable," and "I have beat up men who act like sissies" (p. 543). Winter and colleagues (2008) added one item to the scale, "In nature there are two sexes and two sexes only" (p. 681) as a supplement to an original GTS item referring to God creating two sexes only. The additional question may be a more appropriate way to tap into

essentialist beliefs about sex and gender held by participants who do not subscribe to monotheistic religious beliefs. The additional item was included in the present study for a total of 33 items.

Respondents indicate their agreement or disagreement with each GTS item through ratings on a Likert-type scale from 1 (*Strongly agree*) to 7 (*Strongly disagree*), with a middle point of 4 (*Neutral*). In the present study with online administration of the GTS, participants indicated their degree of agreement or disagreement with each of the 33 GTS items by clicking to mark one of the points along the Likert-type scale. All but four items are reverse-scored. Greater scores indicate more negative attitudes toward trans people.

Hill and Willoughby (2005) initially planned for the GTS to have three subscales: genderism, transphobia, and gender-bashing. They tested the measure with Canadian samples and found the three subscales to be highly correlated. Following factor analysis, Hill and Willoughby concluded that the GTS was likely measuring a single, anti-trans attitude construct with genderism/transphobia and gender-bashing dimensions which accounted for 60% of the total variance. Winter and colleagues (2008) tested the GTS with a sample of college students in Hong Kong. Their factor analysis identified a five-factor solution (i.e., anti sissy prejudice, anti trans violence, trans unnaturalness, trans immorality, and background genderism), accounting for approximately 54% of the total variance. Given their finding of a different set of factors, Winter and colleagues cautioned against assuming that a factor structure identified with a sample from one population would apply to a sample from another population. Total GTS scores were used in the present study. For the full GTS scale, Hill and Willoughby reported alpha

reliability coefficients of .95, .88, and .96 for the three studies described in their report. Winter et al. did not report reliability statistics for the full GTS scale. Alpha reliability coefficients for the present sample of counseling professionals were .929 for the original 32 items and .932 with the additional item from Winter et al.

Hill and Willoughby (2005) reported convergent validity for the GTS with theoretically-related measures of homophobia ($r = .34, p = .01$) and gender role beliefs ($r = .39, p = .01$), and a measure of attitudes toward gay men and lesbians, modified to assess attitudes toward gender non-conformists ($r = .55, p = .01$). Their assessment of the GTS' discriminative validity revealed non-significant correlations between the GTS and theoretically-unrelated measures of self-reported self-esteem ($r = .11, ns$), masculinity ($r = -.06, ns$), and femininity ($r = -.09, ns$), and weak correlations with tendencies toward positive self-presentation ($r = .23, p = .01$). The GTS also demonstrated predictive validity in terms of being able to discriminate between those who had or had not been acquainted with a transsexual, transgender, or cross-dressing person, such that those who had these acquaintances had significantly lower GTS scores (i.e., more positive attitudes) than those who did not. In the present study, the GTS' predictive validity was examined in terms of being able to predict participants' responses to the trans clients presented in the fictional intake summaries.

Multicultural Counseling Knowledge and Awareness Scale

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002) is a self-report measure of multicultural counseling competence, and is a revision of the Multicultural Counseling Awareness Scale (Ponterotto et al., 1996). The 32-item scale assesses competence in terms of multicultural awareness and

knowledge, which, along with a skills dimension, comprise the framework most commonly used to define multicultural counseling competency (Sue & Sue, 2003, p. 26).

Each MCKAS item is a statement referring to the respondent's awareness, knowledge, or beliefs regarding a multicultural counseling issue. For example, one item states, "I believe all clients should maintain direct eye contact during counseling" (Ponterotto et al., 2002, p. 178). Another states, "I am aware some research indicates that minority clients are more likely to be diagnosed with mental illness than are majority clients" (p. 179). Respondents rate the truth of each statement, as it applies to them, on a 7-point, Likert-type scale, from 1 (*not at all true*) to 7 (*totally true*), with a middle point of 4 (*somewhat true*). The scale includes 20 Knowledge subscale items assessing general multicultural knowledge, with greater scores indicating greater perceived knowledge. The scale also includes 12 Awareness subscale items "tapping a subtle Eurocentric worldview bias of the counseling relationship and therapeutic goals" (p. 156). Ten of the Awareness items are negatively worded and reverse-scored, with greater scores indicating greater awareness. Total MCKAS scores were used for analyses in the present study.

Ponterotto and colleagues (2002) used confirmatory factor analysis to establish the construct validity of the MCKAS, with results supporting the use of the two-factor (Knowledge and Awareness) model. They reported alpha coefficients of .85 for each subscale. The authors checked convergent validity for the MCKAS against related measures and found significant correlations between the MCKAS Knowledge subscale and the Knowledge ($r = .49$), Skill ($r = .43$), and Awareness ($r = .44$) subscales of the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994), and between the Awareness subscale and the MCI Counseling Relationship subscale ($r =$

.74). Criterion validity was supported by significant correlation of the MCKAS Knowledge subscale with the Ethnic Identity subscale of the Multigroup Ethnic Identity Measure (Phinney, 1992; $r = .31$). Ponterotto and colleagues reported adequate internal consistency reliability coefficients for the MCKAS Awareness and Knowledge subscales of .85 each. The reliability coefficient for the entire MCKAS scale with the present sample of counseling professionals was .91.

Transgender Definition and Identities Material

Given the lack of attention to transgender issues in the education and training of counseling professions (APA Task Force on Gender Identity and Gender Variance, 2008; Carroll & Gilroy, 2002; Carroll et al., 2002), it could not be assumed that participants would know the definition of the term transgender or be aware of various transgender expressions or identities (e.g., transsexuals, cross-dressers, etc.). Because accurate responses to subsequent survey questions regarding training, experience, and familiarity with transgender issues and people required such awareness, a definition of the term *transgender* and explanations regarding categories of transgender people was presented to participants (see Appendix F). That material was quoted directly from an American Psychological Association (2006) brochure, *Answers to your questions about transgender individuals and gender identity*.

Training, Experience, and Familiarity Questionnaire

In order to measure participants' training and clinical experience regarding transgender issues and clients, the researcher adapted a training and experience questionnaire (TEQ) developed by Tomko (2008). Tomko designed the questionnaire to assess counseling psychologists' perceived levels of pre-doctoral training (e.g.,

coursework, practica, internships), and post-doctoral training (e.g., workshops, conferences, fellowships) and clinical experience (i.e., counseling, psychotherapy, and assessment) regarding multicultural issues and racial/ethnic minority clients, and also regarding aging issues and older adults. Each topic (i.e., multicultural issues and aging issues) was addressed in a separate 7-item scale, with three items referring to pre-doctoral training and four items referring to post-doctoral clinical experience. Items included, for example, “Please rate the extent of your pre-doctoral practicum and internship training in counseling and psychotherapy with racially/ethnically diverse clients [older adults],” and “Please rate the extent of your post-doctoral training in multiculturalism [aging issues and working with older adults] (e.g., workshops, conferences, post-doctoral fellowship, etc.).” For all but one item for each scale, respondents indicated the extent of their training or experience referred to in each item by marking a point along a Likert-type scale from 1 (*None*) to 7 (*Very extensive*), with a middle point of 4. The one item with a different set of response options asked “Approximately what percentage of your post-doctoral client caseload has consisted of older adults [racially/ethnically diverse clients]?” with responses again along a 7-point scale, from 1 (0%) to 7 (*more than 80%*) with a middle point of 4 (36-50%). Responses for each scale were summed, with greater scores indicating greater perceived training and experience with multicultural issues and minority clients or aging issues and older adults. Tomko utilized just the scale regarding aging and older adults in her own analyses and reported alpha reliability coefficients of .87 for the three items regarding training and .90 for the four items regarding clinical experience.

For the present study, items from Tomko's (2008) scale were altered to refer to training and experience regarding transgender issues and clients. The scale was also altered to refer to graduate and post-graduate training and experience rather than pre- and post-doctoral training and experience in order to be relevant for the masters-level as well as doctoral-level counselors and counseling psychologists who participated in the present study.

For six of the scale items, respondents rated the extent of their graduate and then post-graduate training and clinical experience (including assessment and counseling) regarding transgender issues and clients on a 7-point Likert-scale from 1 (*None*) to 7 (*Very extensive*). For the seventh item, respondents selected a point along another 7-point Likert-scale from 1 (*0%*) to 7 (*more than 25%*), with a middle point of 4 (*11-15%*) to approximate the percentage of their client caseload to date which has consisted of transgender individuals. A shortened percentage range was selected for the present study because, especially compared with the populations of ethnic/racial minority individuals and older adults, trans people are an extremely small population, expected to make up a small percentage of client caseloads for most counseling professionals. The alpha reliability coefficient for the 7-item TEQ scale with the present sample of counseling professionals was .88.

Past research suggests that people who are personally familiar with transgender individuals (Hill & Willoughby, 2005; Rye & Elmslie, 2001, June) and people who hold biological explanations of transgenderism (Antoszewski et al., 2007; Landen & Innala, 2000) tend to express more favorable attitudes than others regarding trans people. In order to investigate those relationships with the present sample, two items were added to

the training and experience portion of the research survey. The two additional items, however, were not scored with the TEQ scale described above. Participants indicated the extent of their personal familiarity with trans individuals (e.g., friends, family members, colleagues, acquaintances) using a 7-point Likert-scale from 1 (*Not at all personally familiar with transgender individuals*) to 7 (*Very familiar, e.g., you identify as transgender and/or you have a close relationship with one or more transgender individuals*), with a middle point of 4 (*Somewhat familiar, e.g., you know one or more transgender individuals, but do not have close relationships with them*). To investigate respondents' beliefs regarding why some people are trans, the final questionnaire item asked participants to select a multiple-choice response to the question "What do you think causes some people to be transgender?" Response options included (a) biological causes (e.g., genetics, prenatal hormone levels), (b) psychosocial causes (e.g., early childhood experiences, other social forces), (c) a combination of biological and psychosocial causes, (d) unsure, and (e) other (please specify).

Demographic Questionnaire

Participants were asked to complete a demographic questionnaire (see Appendix H). The questionnaire included items requesting information regarding participant age, gender, race/ethnicity, sexual orientation, level of education/degrees earned in counseling or counseling psychology, years of counseling experience, and training in the use of the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 2000).

Data Analyses

PASW Statistics 18 (Release 18.0.2) was used to run all statistical analyses of the data. Descriptive statistics and Pearson r correlations were calculated for all of the

variables. To examine the first research question, “to what extent do counseling professionals hold anti-trans attitudes?” descriptive statistics for the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005) were calculated, including the sample mean and standard deviation. Those statistics were also computed for GTS scores with item 33 removed to allow for direct comparison with the 32-item sample means reported by Winter et al. (2008) for their study and that of Hill and Willoughby (2005). In order to test null hypothesis 1, two 1-sample *t*-tests were conducted using the corrected GTS scores. One compared the corrected GTS mean for the present sample with the mean for the Canadian undergraduate and graduate students surveyed by Hill and Willoughby. The other compared the corrected GTS mean for the present sample with the corrected mean for Hong Kong undergraduate students surveyed by Winter et al.

The second research question asked, to what extent do gender, extent of personal familiarity with trans people, beliefs regarding transgender etiology, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence relate to counseling professionals’ anti-trans attitudes? To examine that question and to test null hypotheses 2a, an independent samples *t*-test was conducted to compare anti-trans attitudes between women and men. To test null hypothesis 2b, an independent samples *t*-test was conducted to compare anti-trans attitudes between participants grouped according to whether they reported having any or no personal familiarity with one or more trans individuals (i.e., the personal familiarity variable was collapsed into those two categories). Correlation analyses were used to test null hypotheses 2c, 2e, 2f, and 2g. Pearson *r* correlations were computed between the variables of extent of personal familiarity with trans people (not collapsed),

age, extent of training and experience regarding counseling and assessment with trans people, and perceived multicultural counseling competence with the criterion variable of anti-trans attitudes. Null hypothesis 2d was tested using a one-way between-subjects ANOVA, with beliefs regarding transgender etiology as the independent variable and anti-trans attitudes as the dependent variable. Null hypothesis 2h was tested using simultaneous multiple regression analysis. The predictor variables were gender, extent of personal familiarity with trans people, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence, and the criterion variable was anti-trans attitudes.

The third research question asked, to what extent do anti-trans attitudes and client sex relate to counseling professionals' assessments of a trans client's overall level of psychosocial functioning? To examine that question and to test null hypothesis 3, a hierarchical multiple regression analysis was conducted with the assessment of the client's psychosocial functioning as the criterion variable. To control for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, those variables were entered together as a block in the first model. The variables of anti-trans attitudes and client sex were then entered together as a block in the second model.

The fourth research question asked, to what extent do anti-trans attitudes and client sex relate to counseling professionals' favorable perceptions of a trans client? To examine that question and to test null hypothesis 4 a second hierarchical multiple regression analysis was performed. The criterion variable was favorable perceptions of the trans client. The predictor variables used in this analysis were identical to those used

to test null hypothesis 3. To control for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, those variables were entered together as a block in the first model. The variables of anti-trans attitudes and client sex were then entered together as a block in the second model.

The fifth and final research question asked, to what extent do anti-trans attitudes and client sex relate to counseling professionals' favorable perceptions of a trans client? To examine that question and test null hypothesis 5, a third hierarchical multiple regression analysis was performed. The criterion variable was unfavorable perceptions of the trans client. The predictor variables used in this analysis were identical to those used to test null hypotheses 3 and 4. To control for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, those variables were entered together as a block in the first model. The variables of anti-trans attitudes and client sex were then entered together as a block in the second model.

Chapter III Summary

This chapter provided information regarding the methods employed for this analogue study, including the selection and recruitment of participants, the materials and instruments utilized, the study procedures, and the data analyses. The results will be presented in Chapter IV.

CHAPTER IV

RESULTS

Chapter IV presents the research findings of this study. First, descriptive statistics of the data and correlations among the variables are reported. Then, results of the main statistical analyses for each research question are presented.

Descriptive Statistics and Correlations Among the Variables

PASW Statistics 18 (Release 18.0.2) was used to run all statistical analyses of the data. Pearson r correlations were calculated for all of the main variables. The correlation matrix is presented in Table 1. Ratings on the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 2000), through which participants provided their assessments of the fictional trans client's overall level of psychosocial functioning, ranged from 51 to 90 ($M = 67.95$, $SD = 6.674$, $n = 138$). The mean GAF score fell within the 10-point GAF interval (61-70) determined by the expert raters. More participants rated the client accurately (i.e., within the 61-70 GAF interval; $n = 89$) than inaccurately ($n = 49$). All but three of the inaccurate ratings were within one scoring range above ($n = 31$) or below ($n = 15$) the accurate range. The remaining three ratings fell two intervals above the accurate interval. Scores on the Favorable scale (FAV) of the Adjective Check List (ACL; Gough & Heilbrun, 1983), through which participants indicated their favorable perceptions of the fictional client, ranged from 1 to 64 ($M = 21.67$, $SD = 14.217$, $n = 138$). Scores on the Unfavorable scale (UNFAV) of the ACL, through which participants indicated their unfavorable perceptions of the fictional client, ranged from 0 to 15 ($M = 1.16$, $SD = 1.16$, $n = 138$).

Table 1

Correlations Among the Criterion and Predictor Variables

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Gender	--										
2. Age	-.068	--									
3. EdLevel	.027	.198*	--								
4. CounExp	-.054	.659***	.331***	--							
5. TEQ	.011	.320***	.286**	.268**	--						
6. Familiar	.122	.195*	.069	.148	.443***	--					
7. CltSex	.036	-.142	.027	-.088	-.068	-.057	--				
8. GAF	-.147	.011	-.060	.089	.001	.123	-.044	--			
9. FAV	.122	.027	-.161	-.079	.113	.215*	-.058	.084	--		
10. UNFAV	-.127	-.108	-.099	-.084	-.153	-.143	-.029	-.180*	-.006	--	
11. GTS	-.187*	-.075	-.017	-.065	-.194*	-.410***	.089	-.056	-.176*	.229**	--
12. MCKAS	.127	.101	.032	.055	.154	.431***	-.074	.091	.064	-.153	-.543***

Note. Gender coded as man = 0, woman = 1; EdLevel = Education level coded as master's degree = 0, doctoral degree = 1; CounExp = Years of counseling experience; TEQ = Training and Experience Questionnaire; Familiar = Extent of personal familiarity with trans people; CltSex = Intake summary client sex coded as male = 0, female = 1; GAF = Global Assessment of Functioning Scale; FAV = Adjective Check List Number of Favorable Items Checked Subscale; UNFAV = Adjective Check List Number of Unfavorable Items Checked Subscale; GTS = Genderism and Transphobia Scale; MCKAS = Multicultural Counseling Knowledge and Awareness Scale. *p < .05. **p < .01. ***p < .001.

Scores on the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005; including the additional item from Winter et al., 2008), which measured anti-trans attitudes, ranged from 33 to 172 ($M = 59.36$, $SD = 22.451$, $n = 138$). Scores on the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), which measured participants' perceived multicultural counseling competence, ranged from 115 to 219 ($M = 183.95$, $SD = 20.739$, $n = 138$). Scores on the Training and Experience Questionnaire (TEQ), by which participants reported the extent of their training and experience regarding counseling and assessment with trans clients, ranged from 7 to 38 ($M = 14.73$, $SD = 7.209$, $n = 138$). The TEQ mean corresponds to an item mean of 2.104, which represents very little training or experience with regard to counseling and assessment with trans clients. Over half (54.3%, $n = 75$) of the participants indicated that trans clients had made up just one to five percent of their caseloads up to the date of the survey, while 39.9% ($n = 55$) of the participants indicated that their caseloads had not included any trans clients, and just 5.8% ($n = 8$) of the participants indicated that trans clients had made up more than 5% of their caseloads. Scores on the personal familiarity item, by which participants reported the extent of their personal familiarity with trans people, ranged from 1 to 7 ($M = 3.59$, $SD = 1.737$, $n = 138$). The mean personal familiarity score was near the scale midpoint of 4, labeled "somewhat familiar (e.g., you know one or more transgender individuals, but do not have close relationships with them)."

When participants were asked, "What do you think causes some people to be transgender?," the frequency of responses were as follows (from most to least frequent): a combination of biological and psychosocial causes (58.7%, $n = 81$), biological causes

(e.g., genetics, prenatal hormone levels; 23.2%, $n = 32$), unsure (10.1%, $n = 14$), other (please specify; 6.5%, $n = 9$), and psychosocial causes (e.g., early childhood experiences, other social forces; 1.4%, $n = 2$). The individual responses of participants who selected the “other” response are listed below:

- Biological causes, psychosocial causes and “that’s the way God made them.”
- I don’t know that there is necessarily a “cause” some people are as they are.
- Combination of biological and psychological causes, as well as political structures, media and societal influences and promotion of a strictly binary gender categorization and reinforcement.
- I am not thrilled with the use of the word “causes” as it seems to suggest that something is wrong with the individual. I actually think that there is something wrong with the system. I suppose without getting bogged down in symantics [*sic*] I believe in both a combination of reasons a person may not feel comfortable idenfying [*sic*] as one of the two genders our society has chosen to endorse.
- Spiritual causes.
- It doesn’t matter.
- I think primarily biological with the social factors that push gender binary as keeping folks from expressing themselves as how they see themselves. I probably struggle with the language of “transgender” since I do not

believe gender is a binary, so it is hard for me to see the label [*sic*] as being accurate.

- I think there are many “causes” both within and externally that contribute to how one views themselves. I also believe the “causes” vary by individual much as any individual forms a personal identity and each client has the right to be viewed as an individual and tell their story without being pigeonholed into a specific label.
- Either biological causes or a combination of biological and social causes.

The combined percentage of participants in the present study who endorsed the biopsychosocial explanation (i.e., the “combination of biological and psychosocial causes”), or the biological explanation, or who specified their own, alternate explanation which included a biological component was 84.8% ($n = 117$).

As noted in the previous chapter, 96 participants (69.6%) indicated that their most advanced degree in counseling or counseling psychology was the master’s degree. Two participants (1.4%) reported having an educational specialist degree in counseling psychology (collapsed with master’s degree for data analysis). Forty participants (29.0%) reported having a doctoral degree in counseling or counseling psychology. Participants’ reported years of counseling experience (including practica, externships, internships, employment, etc.) ranged from one to 30 years ($M = 10.51$, $SD = 8.203$). Doctoral-level participants tended to report a greater number of years of counseling experience ($M = 14.75$, $SD = 8.47$) than masters-level participants ($M = 8.79$, $SD = 7.47$), $t(136) = -4.09$, $p < .0001$.

Research Questions and Null Hypotheses

Research Question 1

To what extent do counseling professionals hold anti-trans attitudes?

Null hypothesis 1: Levels of anti-trans attitudes among counseling professionals are not significantly different from those of undergraduate and graduate students as measured in previous studies (i.e., Hill & Willoughby, 2005; Winter et al., 2008).

To examine the first research question, descriptive statistics for the Genderism and Transphobia Scale (GTS; Hill & Willoughby, 2005) were calculated. As noted in the previous section, GTS scores (including the additional item from Winter et al., 2008), ranged from 33 to 172 ($M = 59.36$, $SD = 22.451$, $n = 138$). The mean GTS score corresponds to an item mean of 1.80, which is on the favorable side of the scale midpoint of 4, indicating very little anti-trans sentiment in the sample overall. The participant scores at the lowest end of the scoring range suggest completely tolerant attitudes (corresponding to an item mean of 1), while those at the highest end of the scoring range (corresponding to an item mean of 5.21) fall on the intolerant side of the scale midpoint of 4.

Without the additional GTS item from Winter and colleagues (2008), GTS scores ranged from 32 to 165 ($M = 56.93$, $SD = 21.181$, $n = 138$). To test null hypothesis 1, that 32-item GTS mean was first compared through a 1-sample *t*-test with the sample mean reported for the Canadian undergraduate and graduate students surveyed by Hill and Willoughby ($M = 100.4$, $SD = 37.7$, $n = 180$), and then compared through a second 1-sample *t*-test with the 32-item sample mean reported for the Hong Kong undergraduate students surveyed by Winter and colleagues ($M = 107.89$, $SD = 23.15$, $n = 203$). The

mean for the present study was significantly lower than the Canadian undergraduate sample, $t(137) = -24.11, p < .0001$, and the Hong Kong sample, $t(137) = -28.26, p < .0001$, indicating that the counseling professional participants demonstrated more favorable attitudes regarding trans people than did participants in the undergraduate samples. Thus, null hypothesis 1 was rejected.

To further explore the results for the GTS (Hill & Willoughby, 2005), subscale scores were computed based on the genderism/transphobia and gender-bashing factors identified through factor analysis by the scale authors. As with the total GTS scale, higher subscale scores indicated more unfavorable attitudes. The genderism/transphobia subscale has a possible range of 25 to 175. The range for the sample in the present study was 25 to 139 ($M = 47.25, SD = 19.27, n = 138$). The gender-bashing subscale has a possible range of 7 to 49. The range for the sample in the present study was 7 to 35 ($M = 9.68, SD = 3.77, n = 138$). The item means for each subscale were compared using a paired-samples t -test. The item mean for the gender-bashing subscale ($M = 1.38, SD = .54$) was significantly lower than the item mean for the genderism/transphobia subscale ($M = 1.89, SD = .77$), $t(137) = -8.24, p < .0001$, suggesting that the counseling professionals in this sample expressed less of the gender-bashing dimension of anti-trans attitudes as compared to the genderism/transphobia dimension. Hill and Willoughby did not report the 2-factor subscale scores for their samples, so a comparison with the present sample is not possible. Given Winter et al.'s (2008) finding of an alternate factor structure, only total GTS scores, not subscale scores, were used in the previous and remaining main analyses.

Research Question 2

To what extent do gender, extent of personal familiarity with trans people, beliefs regarding transgender etiology, age, extent of training and experience regarding counseling and assessment with trans people, and perceived multicultural counseling competence relate to counseling professionals' anti-trans attitudes?

Null hypothesis 2a: Among counseling professionals, men's levels of anti-trans attitudes do not differ significantly from those of women.

To examine research question 2 and to test null hypothesis 2a, an independent samples *t*-test was conducted to compare anti-trans attitudes (GTS; Hill & Willoughby, 2005) for women and men. Data from the two participants who indicated a gender other than woman or man were not included in this analysis. Men's GTS scores ($M = 68.23$, $SD = 28.62$, $n = 26$) were significantly higher at the $p < .05$ level than women's ($M = 57.59$, $SD = 20.44$, $n = 110$), $t(134) = 2.20$, $p = .030$, indicating greater anti-trans attitudes among men than among women. Thus, null hypothesis 2a was rejected.

Null hypothesis 2b: Levels of anti-trans attitudes among counseling professionals who report being personally familiar with one or more trans individuals do not differ significantly from those of counseling professionals who report having no personal familiarity with trans individuals.

To test null hypothesis 2b, an independent samples *t*-test was conducted to compare anti-trans attitudes (GTS; Hill & Willoughby, 2005) between participants grouped according to whether they reported having any or no personal familiarity with one or more trans individuals (i.e., the personal familiarity was collapsed into those two categories). Participants who were not personally familiar with trans individuals had

significantly higher GTS scores ($M = 77.78$, $SD = 29.39$, $n = 27$) than those who indicated that they were personally familiar with one or more trans individuals ($M = 54.88$, $SD = 17.89$, $n = 111$), $t(136) = 5.18$, $p < .0001$, indicating greater anti-trans attitudes among those not personally familiar with trans people. Thus, null hypothesis 2b was rejected.

Null hypothesis 2c: Counseling professionals' anti-trans attitudes are not significantly related to the extent of their personal familiarity with trans individuals.

To test null hypothesis 2c, a Pearson product-moment correlation coefficient was computed to assess the relationship between anti-trans attitudes (GTS; Hill & Willoughby, 2005) and reported extent of personal familiarity with trans individuals. In this analysis, the personal familiarity variable was not collapsed as was done to test null hypothesis 2b. There was a significant negative correlation between the two variables, $r = -.410$, $p < .0001$, $n = 138$, indicating that participants with greater personal familiarity with trans people demonstrated lower levels of anti-trans attitudes. Thus, null hypothesis 2c was rejected.

Null hypothesis 2d: Levels of anti-trans attitudes do not vary significantly between counseling professionals who hold different beliefs regarding transgender etiology.

To test null hypothesis 2d, a one-way between subjects ANOVA was conducted to compare anti-trans attitudes (GTS; Hill & Willoughby, 2005) between participants grouped by their reported beliefs regarding transgender etiology: biological explanations, psychosocial explanations, biopsychosocial explanations, unsure of transgender etiology, or other explanations specified by participants. There was a significant effect of etiology

beliefs on GTS scores at the $p < .05$ level for the five belief categories, $F(4, 133) = 3.24$, $p = .014$. Thus, null hypothesis 2d was rejected.

Post hoc comparisons using the Tukey HSD test specified that the mean GTS (Hill & Willoughby, 2005) score for those who indicated that they were unsure about transgender etiology ($M = 73.14$, $SD = 15.00$, $n = 14$) was significantly greater than that of participants who endorsed a biological explanation of transgender etiology ($M = 53.25$, $SD = 18.54$, $n = 32$) and that of participants who indicated their belief in other, individually-specified explanations of transgender etiology ($M = 44.78$, $SD = 14.85$, $n = 9$). The mean GTS scores of participants who endorsed a psychosocial explanation ($M = 69.50$, $SD = 24.75$, $n = 2$) or a biopsychosocial explanation ($M = 60.77$, $SD = 24.23$, $n = 81$) did not significantly differ from each other or from those who endorsed any of the other explanations.

Null hypothesis 2e: Counseling professionals' anti-trans attitudes are not significantly related to their age.

To test null hypothesis 2e, a Pearson product-moment correlation coefficient was computed to assess the relationship between anti-trans attitudes (GTS, Hill & Willoughby, 2005) and participant age. There was no significant correlation between the two variables, $r = -.075$, $p = .38$, $n = 136$. Thus, null hypothesis 2e failed to be rejected.

Null hypothesis 2f: Counseling professionals' anti-trans attitudes are not significantly related to the extent of their training and experience regarding counseling and assessment with trans clients.

To test null hypothesis 2f, a Pearson product-moment correlation coefficient was computed to assess the relationship between anti-trans attitudes (GTS; Hill &

Willoughby, 2005) and reported extent of training and experience in counseling and assessment with trans clients (TEQ). There was a significant negative correlation at the $p < .05$ level between the two variables, $r = -.194$, $n = 138$, $p = .022$, indicating that participants with more extensive training and experience regarding counseling and assessment with trans clients demonstrated lower levels of anti-trans attitudes. Thus, null hypothesis 2f was rejected.

Null hypothesis 2g: Counseling professionals' anti-trans attitudes are not significantly related to their perceived multicultural counseling competence.

To test null hypothesis 2g, a Pearson product-moment correlation coefficient was computed to assess the relationship between anti-trans attitudes (GTS; Hill & Willoughby, 2005) and perceived multicultural counseling competence (MCKAS; Ponterotto et al., 2002). There was a significant negative correlation between the two variables, $r = -.543$, $p < .0001$, $n = 138$, indicating that participants with greater perceived multicultural counseling competence demonstrated lower levels of anti-trans attitudes. Thus, null hypothesis 2g was rejected.

Null hypothesis 2h: The variables of participant gender, extent of personal familiarity with trans people, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence will not contribute unique significant variance to the prediction of counseling professionals' anti-trans attitudes.

To test null hypothesis 2h, a simultaneous multiple regression analysis was conducted with anti-trans attitudes (GTS; Hill & Willoughby, 2005) as the criterion variable, and gender, reported extent of personal familiarity with trans people, age,

reported extent of training and experience regarding counseling and assessment with trans people (TEQ), and perceived multicultural counseling competence (MCKAS; Ponterotto et al., 2002) as predictor variables. Data from the two participants who indicated a gender other than woman or man, and data from two participants who did not report their ages were not included in this analysis. Influential case analysis identified two outlier cases (i.e., those with standardized DfFit values greater than 1.0) which were also removed from analysis. The outlier cases included the two highest GTS scores (i.e., 172 and 140). The regression model accounted for 28.3% of the variance in GTS scores, Multiple $R = .532$, $R^2 = .283$, Adjusted $R^2 = .255$, $F(5, 126) = 9.967$, $p < .0001$. Thus, null hypothesis 2h was rejected. Only personal familiarity ($t = -2.07$, $p = .041$) and perceived multicultural counseling competency ($t = -4.39$, $p < .0001$) emerged as significant unique predictors of anti-trans attitudes at the $p < .05$ level. Those results indicate that more extensive personal familiarity with trans people and greater perceived multicultural counseling competency predicted lower levels of anti-trans attitudes. The results of this analysis are presented in Table 2.

Research Question 3

To what extent do anti-trans attitudes and client sex relate to counseling professionals' assessments of a trans client's overall level of psychosocial functioning?

Null hypothesis 3: After controlling for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique significant variance to the prediction of ratings of a trans client's overall level of psychosocial functioning.

Table 2

Results of Simultaneous Multiple Regression Analysis on GTS Scores

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
Constant	135.379	14.481		9.349	< .0001
Age	.045	.134	.027	.339	.735
Gender	-4.222	3.671	-.088	-1.150	.252
Personal familiarity	-2.103	1.018	-.190	-2.066	.041
MCKAS	-.349	.080	-.366	-4.386	< .0001
TEQ	-.254	.230	-.098	-1.104	.272

Note. $N = 132$. GTS = Genderism and Transphobia Scale; Gender coded as man = 0, woman = 1; Personal familiarity = Extent of personal familiarity with trans people; MCKAS = Multicultural Counseling Knowledge and Awareness Scale; TEQ = Training and Experience Questionnaire. Multiple $R = .532$; $R^2 = .283$; Adjusted $R^2 = .255$; $F(5, 126) = 9.967$; $p < .0001$.

To examine research question 3 and to test null hypothesis 3, a hierarchical multiple regression analysis was conducted with Global Assessment of Functioning (GAF; American Psychiatric Association, 2000) ratings as the criterion variable, and extent of training and experience in counseling and assessment with trans clients (TEQ), education level (masters or doctoral), years of counseling experience, anti-trans attitudes (GTS; Hill & Willoughby, 2005), and client sex (male or female) as predictor variables. To control for extent of training and experience in counseling and assessment with trans people, education level, and years of counseling experience, those variables were entered together as a block in the first model. The linear combination of those variables was not significantly related to GAF ratings, Multiple $R = .130$, $R^2 = .017$, Adjusted $R^2 = -.005$, $F_{\text{Change}}(3, 134) = .764$, $p = .516$, and none of those variables were significant unique predictors of GAF ratings. The variables of anti-trans attitudes and client sex were then

entered together as a block in the second model and did not account for any significant additional variance in GAF ratings, Multiple $R = .142$, $R^2 = .020$, Adjusted $R^2 = -.017$, $\Delta R^2 = .003$, $F_{\text{Change}}(2, 132) = .227$, $p = .797$. Neither GTS scores ($t = -.568$, $p = .571$) nor client sex ($t = -.320$, $p = .749$) were significant unique predictors of GAF ratings. Thus, null hypothesis 3 failed to be rejected. The results of these analyses are presented in Table 3.

Research Question 4

To what extent do anti-trans attitudes and client sex relate to counseling professionals' favorable perceptions of a trans client?

Null hypothesis 4: After controlling for extent of training and experience in counseling and assessment with trans clients, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique significant variance to the prediction of counseling professionals' favorable perceptions of a trans client.

To examine research question 4 and test null hypothesis 4, a second hierarchical multiple regression analysis was performed. The criterion variable was favorable perceptions of the trans client (ACL Favorable scale; Gough & Heilbrun, 1983). The predictor variables used in this analysis were identical to those used to test null hypothesis 3. The variables of extent of training and experience in counseling and assessment with trans clients (TEQ), education level (master's or doctoral degree), and years of counseling experience, were entered together as a block in the first model and accounted for 5.7% of the variance in favorable perceptions of the client, Multiple $R = .238$, $R^2 = .057$, Adjusted $R^2 = .036$, $F_{\text{Change}}(3, 134) = 2.692$, $p = .049$. Training and

Table 3

Results of Hierarchical Multiple Regression Analyses on Counseling Professionals' GAF Ratings of a Trans Client

Model	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
1	Constant	67.370	1.374		49.027	< .0001
	TEQ	-.003	.084	-.003	-.037	.971
	Ed level	-1.459	1.363	-.100	-1.071	.286
	Counseling exp	.100	.075	.122	1.324	.188
2	Constant	68.627	2.344		29.282	< .0001
	TEQ	-.014	.086	-.015	-.163	.871
	Ed level	-1.391	1.376	-.095	-1.011	.314
	Counseling exp	.096	.076	.118	1.268	.207
	GTS	-.015	.026	-.050	-.568	.571
	Client sex	-.372	1.160	-.028	-.320	.749

Note. *N* = 138. GAF = Global Assessment of Functioning Scale; TEQ = Training and Experience Questionnaire; Ed level = Education level coded as master's degree = 0, doctoral degree = 1; Counseling exp = Years of counseling experience; GTS = Genderism and Transphobia Scale; Client sex coded as male = 0, female = 1.

Model 1: Multiple *R* = .130, *R*² = .017, Adjusted *R*² = -.005, *F*_{Change} (3, 134) = .764, *p* = .516

Model 2: Multiple *R* = .142, *R*² = .020, Adjusted *R*² = -.017, ΔR^2 = .003, *F*_{Change} (2, 132) = .227, *p* = .797, *F*(5, 132) = .544, *p* = .743.

experience in counseling and assessment with trans clients (*t* = 2.073, *p* = .040) and education level (*t* = -2.11, *p* = .036) emerged as significant unique predictors of favorable perceptions of a trans client at the *p* < .05 level, indicating that more extensive training and education regarding trans clients predicted the endorsement of a greater number of

favorable descriptors of the trans client, and that having a doctoral degree (rather than only a master's degree) in counseling or counseling psychology predicted the endorsement of fewer favorable descriptors. In this analysis, years of counseling experience may have functioned as a suppressor variable in that it was significantly correlated with both TEQ and education level, but not with the criterion variable, favorable perceptions of the trans client. It appears that, with the variance shared between years of experience and the other two predictors partialled out, the relationships between favorable perceptions of the client and both TEQ and education level, which appeared insignificant on their own, were strengthened to become significant.

The variables of anti-trans attitudes (GTS; Hill & Willoughby, 2005) and client sex were then entered together as a block in the second model and did not account for significant additional variance in favorable perceptions of a trans client, Multiple $R = .284$, $R^2 = .081$, Adjusted $R^2 = .046$, $\Delta R^2 = .024$, $F_{\text{Change}}(2, 132) = 1.720$, $p = .183$. Neither anti-trans attitudes ($t = -1.77$, $p = .079$) nor client sex ($t = -.42$, $p = .672$) were significant predictors of favorable perceptions. Thus, null hypothesis 4 failed to be rejected. In the full model, training and experience in counseling and assessment with trans clients was no longer a significant predictor of favorable perceptions ($t = 1.68$, $p = .095$), leaving just education level as a significant predictor at the $p < .05$ level ($t = -2.00$, $p = .047$). The results of this analysis are presented in Table 4.

Research Question 5

To what extent do anti-trans attitudes and client sex relate to counseling professionals' unfavorable perceptions of a trans client?

Null hypothesis 5: After controlling for extent of training and experience in counseling

Table 4

Results of Hierarchical Multiple Regression Analyses on Counseling Professionals' Favorable Perceptions of a Trans Client

Model	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
1	Constant	19.210	2.867		6.700	< .0001
	TEQ	.365	.176	.185	2.073	.040
	Ed level	-6.009	2.844	-.192	-2.113	.036
	Counseling exp	-.112	.157	-.064	-.712	.478
2	Constant	26.423	4.836		5.464	< .0001
	TEQ	.300	.178	.152	1.682	.095
	Ed level	-5.687	2.839	-.182	-2.004	.047
	Counseling exp	-.125	.157	-.072	-.796	.427
	GTS	-.096	.054	-.151	-1.769	.079
	Client sex	-1.014	2.393	-.036	-.424	.672

Note. *N* = 138. Favorable Perceptions = Number of Adjective Check List favorable items checked; TEQ = Training and Experience Questionnaire; Ed level = Education level coded as master's degree = 0, doctoral degree = 1; Counseling exp = Years of counseling experience; GTS = Genderism and Transphobia Scale; Client sex coded as male = 0, female = 1.

Model 1: Multiple *R* = .238, *R*² = .057, Adjusted *R*² = .036, *F*_{Change} (3, 134) = 2.692, *p* = .049

Model 2: Multiple *R* = .284, *R*² = .081, Adjusted *R*² = .046, ΔR^2 = .024, *F*_{Change} (2, 132) = 1.720, *p* = .183, *F*(5, 132) = 2.321, *p* = .047.

and assessment with trans people, education level, and years of counseling experience, the variables of anti-trans attitudes and client sex will not contribute unique significant

variance to the prediction of counseling professionals' unfavorable perceptions of a trans client.

To examine research question 5 and test null hypothesis 5, a third hierarchical multiple regression analysis was performed. The criterion variable was unfavorable perceptions of the trans client (ACL Unfavorable scale; Gough & Heilbrun, 1983). The predictor variables used in this analysis were identical to those used to test null hypotheses 3 and 4. Influential case analysis identified one outlier case (i.e., with a standardized DfFit value greater than 1.0) which was removed from analysis. The outlier case included the highest score of all the participants on the Unfavorable scale (i.e., 15).

The variables of extent of training and experience in counseling and assessment with trans clients (TEQ), education level (master's or doctoral degree), and years of counseling experience, were entered together as a block in the first model. The linear combination of those variables was not significantly related to unfavorable perceptions, Multiple $R = .138$, $R^2 = .019$, Adjusted $R^2 = -.003$, $F_{\text{Change}}(3, 133) = .859$, $p = .464$, and none of those variables were significant unique predictors of unfavorable perceptions of a trans client.

The variables of anti-trans attitudes (GTS; Hill & Willoughby, 2005) and client sex were then entered together as a block in the second model which accounted for 7.7% of the variance in unfavorable perceptions, significantly more than the first model, Multiple $R = .277$, $R^2 = .077$, Adjusted $R^2 = .041$, $\Delta R^2 = .058$, $F_{\text{Change}}(2, 131) = 4.088$, $p = .019$. Thus, null hypothesis 5 was rejected. Anti-trans attitudes ($t = 2.52$, $p = .013$), but not client sex ($t = -1.528$, $p = .129$), were identified as a significant unique predictor of unfavorable perceptions of a trans client at the $p < .05$ level, indicating that higher levels

of anti-trans attitudes predicted the endorsement of a greater number of unfavorable descriptors of the trans client. Overall, however, the linear combination of variables included in the second model was not significantly related to unfavorable perceptions, $F(5, 131) = 2.175, p = .061$. Confidence in the results of this analysis must be tempered by the fact that not all of the assumptions for multiple regression analysis, namely homoscedasticity, were met. The results of this analysis are presented in Table 5.

Chapter IV Summary

This chapter presented the results of the present study, including descriptive statistics and the results of correlational analyses, *t*-tests, ANOVA, and multiple regression analyses. On the basis of those results, null hypotheses 1, 2a, 2b, 2c, 2d, 2f, 2g, and 5 were rejected, while null hypotheses 2e, 3, and 4 failed to be rejected. The results presented in Chapter IV are discussed in Chapter V, along with the practical implications and limitations of the findings, and suggestions for future research.

Table 5

Results of Hierarchical Multiple Regression Analyses on Counseling Professionals' Unfavorable Perceptions of a Trans Client

Model	Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>
1	Constant	1.463	.295		4.963	< .0001
	TEQ	-.020	.018	-.102	-1.115	.267
	Ed level	-.130	.291	-.042	-.449	.654
	Counseling exp	-.007	.016	-.038	-.409	.683
2	Constant	.757	.485		1.560	.121
	TEQ	-.013	.018	-.067	-.738	.462
	Ed level	-.133	.285	-.043	-.468	.640
	Counseling exp	-.008	.016	-.045	-.490	.625
	GTS	.014	.005	.216	2.516	.013
	Client sex	-.368	.241	-.129	-1.528	.129

Note. $N = 137$. Unfavorable Perceptions = Number of Adjective Check List unfavorable items checked; TEQ = Training and Experience Questionnaire; Ed level = Education level coded as master's degree = 0, doctoral degree = 1; Counseling exp = Years of counseling experience; GTS = Genderism and Transphobia Scale; Client sex coded as male = 0, female = 1.

Model 1: Multiple $R = .138$, $R^2 = .019$, Adjusted $R^2 = -.003$, $F_{\text{Change}}(3, 133) = .859$, $p = .464$

Model 2: Multiple $R = .277$, $R^2 = .077$, Adjusted $R^2 = .041$, $\Delta R^2 = .058$, $F_{\text{Change}}(2, 131) = 4.088$, $p = .019$, $F(5, 131) = 2.175$, $p = .061$.

CHAPTER V

DISCUSSION

The research findings for the present study are discussed in this chapter, following a brief review of the purpose for the study. Findings regarding the extent of anti-trans attitudes among counseling professionals are discussed, followed by a discussion of the correlates and predictors of anti-trans attitudes among counseling professionals, and then a discussion of the relationships between anti-trans attitudes and counselor responses to a trans client. Suggestions for future research are included and implications of the study for practice and training are also discussed. Finally, several limitations of this study are noted.

The purpose of this study was to assess counseling professionals' attitudes regarding trans people and to determine whether relationships exist between those attitudes and counselors' responses to trans clients. Despite increasing attention to trans people as a cultural minority group (APA Task Force on Gender Identity and Gender Variance, 2008; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Carroll & Gilroy, 2002) and the movement for greater multicultural counseling competence with diverse client populations (Carroll & Gilroy; Sue, 2001; Sue et al., 1992; Sue et al., 1982; Sue & Sue, 2003), such attitudes have never before been assessed among counseling professionals.

Previous studies of attitudes toward trans people identified several related participant variables including gender, personal familiarity with trans people, age, and etiology beliefs regarding transsexuality. The present study examined those variables for counseling professionals, while addressing a shortcoming of all but some of the most

recent studies (i.e., Hill & Willoughby, 2005; Nagoshi et al., 2008; Rye & Elmslie, 2001, June; Winter et al., 2008) by utilizing a psychometrically developed measure of attitudes. The present study also investigated two participant variables not previously examined in studies of attitudes regarding trans people, the extent of participants' training and experience in counseling and assessment with trans people and their perceived multicultural counseling competence. The counselor responses examined in the present study included assessments of the trans client's overall psychosocial functioning and the participants' favorable and unfavorable perceptions of the client.

Extent of Anti-Trans Attitudes among Counseling Professionals

Overall, the level of anti-trans attitudes among the counseling professionals in this sample was very low. Put more positively, participants appeared to generally hold very tolerant attitudes toward trans people, a finding consistent with several relatively recent investigations which characterized participants' attitudes as generally positive, accepting, or tolerant (Antoszewski et al., 2007; Harvey, 2002; Landen & Innala, 2000; Winter et al., 2008). The range of expressed attitudes in the present sample included completely tolerant attitudes at one extreme and only moderately intolerant attitudes at the other. In terms of Hill and Willoughby's (2005) conceptualization of the genderism, transphobia, and gender-bashing dimensions of anti-trans attitudes, counseling professionals in the present study appeared to disavow expressions of gender-bashing more so than expressions of genderism/transphobia. It is not surprising that this highly educated sample of helping professionals would more strongly reject outright violence and harassment against trans people than negative emotional or cognitive reactions to trans people and issues of gender-variance.

The level of anti-trans attitudes among counseling professionals in this study was significantly lower than those among Canadian undergraduate and graduate students (Hill & Willoughby, 2005) and Hong Kong undergraduate students (Winter et al., 2008) sampled in previous studies. The present study did not examine which characteristics of the samples may explain the finding of more favorable attitudes among counseling professionals, but one possible explanation could be an effect of the counseling professional sample being more educated than the undergraduate students. While an education effect was not evident in the present study, which only examined education level in terms of master's and doctoral degrees, perhaps it would be more apparent with a wider range of education levels, consistent with research regarding anti-gay attitudes (Herek, 1994). There may also be some other quality of counseling professionals' which contributes to more favorable attitudes toward trans people, even among similarly highly educated samples. Recall, for example, that the results of Green and colleagues' (1966) and Franzini and Casinelli's (1986) studies suggested that mental health professionals held more favorable attitudes than physical health professionals toward trans people. Future studies could explore possibilities such as a stronger multicultural orientation or universal diverse orientation (see Miville, Carlozzi, Gushue, Schara, & Ueda, 2006), or simply more empathy, among counseling professionals as compared to other specific populations. The possibility should also be considered that counseling professionals' attitudes toward trans people may have appeared more favorable than they may actually be due to the self-report nature of the anti-trans attitude measure used and the possibility of socially desirable responding, which was not controlled for in the present study.

Correlates and Predictors of Anti-Trans Attitudes Among Counseling Professionals

Findings from the present study revealed the extent to which counseling professionals' anti-trans attitudes were related to their gender, extent of personal familiarity with trans people, beliefs regarding transgender etiology, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence. The results regarding each of those variables are discussed under the corresponding headings below.

Gender

In the present study, women expressed significantly more favorable attitudes than men. This finding is consistent with previous research regarding attitudes toward trans people (Antoszewski, 2007; Harvey, 2002; Hill & Willoughby, 2005; Landen & Innala, 2000; Leitenberg & Slavin, 1983; Nagoshi et al., 2008; Rye & Elmslie, 2001, June; Winter et al., 2008). The same type of gender difference has been found regarding attitudes toward lesbian and gay people (Herek, 1994; Leitenberg & Slavin, 1983; Nagoshi et al., 2008) and bisexual people (Herek, 2002).

Despite the significant correlation between gender and anti-trans attitudes, when gender was considered alongside the variables of age, extent of personal familiarity with trans people, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence, only the personal familiarity and multicultural competency variables were significant unique predictors of anti-trans attitudes. So, while gender has been one of the most consistently reported correlates of attitudes toward trans people, including in the present study, its strength as a predictor of anti-trans attitudes appeared to be overshadowed by other factors in the present sample of

counseling professionals. Nagoshi and colleagues (2008) examined the relationships between transphobia and a wide variety of beliefs and personal attributes (e.g., religious fundamentalism, benevolent sexism, and aggression proneness) and found those relationships differed between women and men. Future studies could investigate those factors and/or other characteristics (e.g., education, multicultural competence, universal diverse orientation, and/or empathy) among men and women counseling professionals to examine which of these might directly or indirectly mediate the effect of gender on anti-trans attitudes among counseling professionals.

Personal Familiarity with Trans People

There was a wide range in the reported extent of personal familiarity with trans people (e.g., friends, family members, colleagues, and acquaintances) among the counseling professionals in the present study, from being not at all personally familiar with trans people to being very familiar with trans people (i.e., they identified as transgender and/or they had close relationships with one or more trans persons). On average, participants indicated that they were somewhat personally familiar with trans people (i.e., they knew one or more transgender individuals, but did not have close relationships with them). Less than one fifth of participants (19.56%) in the present study indicated that they had no personal familiarity with trans people. In comparison, all of the previous studies which reported participants' familiarity with trans people found considerably greater percentages of participants who were unfamiliar with trans people: 96% of participants in Antoszewski and colleagues' (2007) study, 92% of participants in Landen and Innala's (2000) study, and 73.7% of participants in Harvey's (2002) study were unfamiliar or had no contact with trans people. The relatively high percentage of

participants in the present study who were personally familiar with trans people may reflect a sampling bias, or it may be an effect of the increasing social visibility of trans people. The latter explanation would support the assertion that “many if not most psychologists and students of psychology can expect to encounter transgender people among their clients, colleagues, and trainees” (APA Task Force on Gender Identity and Gender Variance, 2008).

Consistent with previous research (Rye & Elmslie, 2001, June), participants who reported less personal familiarity with trans people tended to express significantly more negative attitudes regarding trans people. Also consistent with previous research (Hill & Willoughby, 2005), when participants were grouped according to whether they had any or no personal familiarity with trans people, those who reported no personal familiarity with trans people expressed significantly greater anti-trans attitudes than participants who reported familiarity to any extent. Consistent with the significant correlational findings regarding personal familiarity and anti-trans attitudes, being less personally familiar with trans people also significantly predicted more intolerant attitudes toward trans people, when personal familiarity was considered alongside the variables of gender, age, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence.

The findings regarding the negative relationship between anti-trans attitudes and personal familiarity with trans people are consistent with research regarding the relationship between anti-gay attitudes and interpersonal contact with gay, lesbian, and bisexual people (Barrett & McWhirter, 2002; Herek, 1994, 2002; Herek & Capitanio, 1996). According to Allport's (1954) contact theory, interpersonal contact with members

of a target group reduces prejudice against that group, but a causal relationship such as that cannot be confirmed for the present study due to the study's correlational design. Another plausible explanation of this relationship may be drawn from Herek's (1994) clarification that, while interpersonal contact with gay men and lesbians can improve attitudes toward gay men and lesbians, positive attitudes toward gay and lesbian people can also precede greater contact with them. The greater likelihood of contact may arise due to other factors associated with more positive attitudes toward gay and lesbian people, including "being in an environment where lesbians and gay men are visible, such as a college campus" (p. 219) and because gay men and lesbians may be more likely to disclose their sexual orientation to those whom they perceive to be accepting. While not investigated in the present study, future studies could examine whether the same explanations might apply to contact with, and attitudes toward, trans people.

Transgender Etiology Beliefs

Counseling professionals in this study were asked about their beliefs in an explanation for why some people are transgender. Given response options of biological explanations, psychosocial explanations, biopsychosocial explanations, and uncertainty regarding an explanation, along with the option to specify an alternate explanation, over half (58.7%) of the participants selected the biopsychosocial explanation. That explanation is consistent with research which identified significant biological and psychosocial correlates of gender-variant identities (Veale, Clarke, & Lomax, 2010). Veale and colleagues concluded that biological factors are involved in the development of gender-variant identities, while psychosocial factors may be involved in that development or may result from it. The latter explanation is consistent with the current

study's second most frequently endorsed etiology explanation, biological reasons (23.2% of participants), in that the biological explanation includes biological factors but rejects psychosocial ones as causal. Only 1.4% of participants endorsed the psychosocial explanation, which rejects the contribution of biological factors. Several participants (6.5%) specified their own, alternate explanations, such as "spiritual causes," "I don't know that there is necessarily a 'cause' some people are as they are," and "I think primarily biological with the social factors that push gender binary as keeping folks from expressing themselves as how they see themselves. I probably struggle with the language of 'transgender' since I do not believe gender is a binary, so it is hard for me to see the label [*sic*] as being accurate." A tenth (10.1%) of the participants indicated that they were unsure about why some people are transgender.

The combined percentage of participants in the present study who endorsed the biopsychosocial or biological explanation, or who specified their own, alternate explanation which included a biological component was 84.8%. Across the four previous studies that investigated participants' beliefs about what would cause transsexuality, the percentage of participants who agreed with a biological explanation ranged from fewer than 10% in Leitenberg and Slavin's (1983) study to 49% in Harvey's (2002) study to 54% in Antoszewski and colleagues' (2007) study to nearly 65% in Landen and Innala's (2000) study. It appears that the majority of counseling professionals in this sample, more so than previously sampled groups, believed that biological factors at least contribute to the phenomena of trans identities and expressions. Possible explanations for that finding include the high level of education in the present sample and the increasing social visibility of trans people and issues. Either or both of those factors might have

contributed to a more informed perspective on trans etiology that was consistent with recent research on the matter. Also, increases over the years in the percentage of people who endorse a biological explanation, along with decreases in the percentage of people who endorse psychosocial explanations, would be consistent with research regarding the general public's changing views on the etiology of same-sex sexual orientations (see Sheldon, Pfeffer, Jayaratne, Feldbaum, & Petty, 2007 for a review).

The anti-trans attitudes of counseling professionals in the present study were compared by etiology beliefs and a significant effect was found. Specifically, participants who endorsed the biological explanation expressed significantly more favorable attitudes than those who indicated that they were unsure about the reasons why some people are transgender. Participants who indicated their beliefs in other, individually-specified explanations also expressed significantly more favorable attitudes than those who were unsure about transgender etiology. Only two previous studies compared participants' beliefs regarding transgender etiology with other responses regarding trans people. Landen and Innala (2000) found that participants who endorsed biological explanations responded more favorably regarding trans issues than those who endorsed psychological explanations. Antoszewski and colleagues (2007) and Landen and Innala found that participants who endorsed biological explanations were more supportive of insurance coverage for the cost of sex reassignment than those who endorsed psychological explanations. In the present study, comparisons involving the psychosocial explanation were not significant, but were very likely limited by the very small number of participants who endorsed that explanation ($n = 2$), and the wide variation in their Genderism and Transphobia Scale (Hill & Willoughby, 2005) scores (i.e., 52 and 87).

Offering potential explanations for why participants who endorsed the “other” category had significantly more favorable attitudes is complicated because the specified responses were not homogenous. However, some themes were apparent. As previously noted, four of the “other” explanations included a biological component (e.g., “either biological causes or a combination of biological and social causes”), which is expected to be associated with more favorable attitudes. Two of those four responses, plus an additional two expressed a negative perspective on the gender binary system or forced labeling of identities (e.g., “I am not thrilled with the use of the word ‘causes’ as it seems to suggest that something is wrong with the individual. I actually think that there is something wrong with the system. I suppose without getting bogged down in symantics [*sic*] I believe in both a combination of reasons a person may not feel comfortable identifying [*sic*] as one of the two genders our society has chosen to endorse”). Nagoshi and colleagues (2008) confirmed that socially conservative attitudes, including acceptance of traditional gender roles, are highly correlated with transphobia. Those four participants, in contrast, seem to express very progressive perspectives regarding gender, so their more favorable attitudes regarding trans people are not surprising. The relationships between the remaining responses and attitudes toward trans people are more challenging to explain. One participant referred to “spiritual causes” while another included, “that’s the way God made them.” Two others expressed the position that “it doesn’t matter” why some people are transgender or that there is not “necessarily a ‘cause’ some people are as they are.” Further research may clarify the relationship between these types of perspectives and attitudes regarding trans people.

Compared to those in all the other response categories, participants who endorsed the unsure option expressed the most unfavorable attitudes regarding trans people. Notably, however, the average level of anti-trans attitudes for that group still fell on the more tolerant side of the attitude scale midpoint. Landen and Innala (2000) did not offer participants a similar response option to their etiology question and, though Antoszewski and colleagues (2007) included the option of “I do not have an opinion,” they did not report on attitudes related to that response. Without past research against which the unsure responses could be directly compared, and because the present study did not further investigate responses of uncertainty regarding trans etiology, possible explanations for the finding of more unfavorable attitudes associated with the unsure response option are not readily apparent. However, Krosnick et al. (2005) offered several explanations for “don’t know” or “no opinion” types of survey responses which may be relevant to that problem. While some people may have chosen the unsure response because they lacked information needed to select a more definitive response or were concerned that they were not informed enough to make a decision, others may have held ambivalent beliefs, making it difficult to select another response. Ambivalent beliefs could be associated with ambivalent attitudes, keeping those participants’ responses to the attitude measure from being as favorable as the sample average. Other participants may have actually held a specific belief about trans etiology, but may have been concerned that their belief was not socially desirable, and so they may have selected the unsure option instead. For example, if participants believed in psychosocial explanations of trans etiology (which past research suggests would be associated with more unfavorable attitudes regarding trans people), but were aware that the currently more

popular perspectives accept biological or biopsychosocial explanations, they may have selected the unsure response to avoid providing a socially undesirable response. That highly speculative scenario could explain the more unfavorable attitudes found among participants who selected the unsure response. Further research could investigate possible motivators for expressing uncertainty regarding trans etiology beliefs and how those may relate to anti-trans attitudes.

Age

Age was not significantly correlated with anti-trans attitudes in the present study. When considered alongside the variables of gender, extent of personal familiarity with trans people, extent of training and experience in counseling and assessment with trans clients, and perceived multicultural counseling competence, age was not a significant unique predictor of anti-trans attitudes.

Few studies have investigated the possible relationship between age and attitudes toward trans people and their findings have been mixed. Direct comparisons with those studies are not possible due to differences in how attitudes toward trans people were assessed, but the current finding could be considered consistent with Harvey's (2002) finding that age was not significantly related to the acceptance of transsexual people. And while Landen and Innala (1983) found that younger participants expressed significantly less restrictiveness regarding opportunities for sex reassignment than did older participants, and that older participants were more supportive of public insurance coverage for the cost of sex reassignment than were younger participants, they also found no significant differences between the older and younger age groups regarding beliefs about civil rights for transsexual people or about the possibility of having relationships

(i.e., co-worker, friend, or romantic partner) with an openly transsexual person. Though, intuitively, one might expect younger people to be responsible for ushering in the trend of increasingly more favorable attitudes regarding trans people, and though previous studies suggest that age may relate to some particular beliefs regarding trans people and issues (Landen & Innala), the present study is consistent with research such as Harvey's which found no evidence that age is related to anti-trans attitudes on the whole. It is possible that this finding may have been limited by the very low levels of anti-trans attitudes among the present sample of counseling professionals. Furthermore, given findings that anti-trans attitudes and anti-gay attitudes tend to be strongly correlated (Hill & Willoughby, 2005; Nagoshi et al., 2008; Rye & Elmslie, 2001, June), that younger people are more likely to have contact with gay men and lesbians, which in turn is associated with more favorable attitudes (Herek, 1994), and that older people tend to have more negative attitudes regarding bisexual people (Herek, 2002), researchers should continue to explore possible relationships between age and attitudes toward trans people.

Training and Experience in Counseling and Assessment with Trans Clients

Counseling professionals in this study varied somewhat in their reported degree of training and experience in counseling and assessment with trans clients, from none at all to moderately extensive. On average, though, they reported very little training and experience in this area, which is consistent with one of the findings of the APA Task Force on Gender Identity and Gender Variance (2008), that "many psychologists and students of psychology currently receive little or no exposure to transgender issues in their education and training" (p. 72). The Task Force also noted, though, that the APA included in its accreditation guidelines, effective in 2008, the expectation that issues of

gender identity be included in the curricula of psychology training programs.

Consequently, should future research investigate education and training regarding trans issues, it is reasonable to expect that psychologists will report increasingly more extensive training. The same trend may be found for counselors given advancements such as the American Counseling Association Governing Council's 2009 approval of the *Competencies for Counseling with Transgender Clients* (The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009).

Counseling professionals in this study who reported having more extensive training and experience in counseling and assessment with trans clients tended to express more favorable attitudes toward trans people. This finding does not specify whether or not such training and experience contributes to the development of more favorable attitudes, but it provides tentative support for the provision of such training for counseling professionals and trainees in the interest of developing greater cultural competency in working with trans clients and colleagues. Future studies using experimental designs could examine the potential impact of such training and experience on attitudes toward trans people.

When the extent of training and experience in counseling and assessment with trans clients was considered alongside the variables of gender, age, extent of personal familiarity with trans people, and perceived multicultural counseling competence, the personal familiarity and multicultural competency variables, but not the training and experience variable, were significant unique predictors of anti-trans attitudes. If training regarding trans clients indeed becomes part of the curricula of counseling and psychology training programs, and some future research participants, therefore, report

more extensive training in this area, perhaps the strength of the relationship between training and attitudes will increase. If so, the utility of the training and experience variable in predicting attitudes toward trans people might also increase.

Perceived Multicultural Counseling Competence

On average, counseling professionals in this study expressed moderately high levels of perceived multicultural counseling competence. Of all the independent variables examined, perceived multicultural counseling competence was the most strongly correlated with anti-trans attitudes among counseling professionals in this study. Participants with lower levels of perceived multicultural counseling competency expressed more intolerant attitudes toward trans people.

When considered alongside the variables of gender, age, extent of personal familiarity with trans people, and extent of training and experience in counseling and assessment with trans clients, perceived multicultural counseling competence was the best predictor of anti-trans attitudes, with higher levels of perceived multicultural counseling competence predicting lower levels of anti-trans attitudes.

These findings support the perspective taken in this dissertation and elsewhere (e.g., APA Task Force on Gender Identity and Gender Variance, 2008; Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009; Carroll & Gilroy, 2002) that awareness, knowledge, and skills regarding trans issues and clients should be attended to as matters of multicultural counseling competency. While training and experience in counseling and assessment with trans clients was significantly positively correlated with perceived multicultural counseling competence, the present study did not investigate the extent of participants' multicultural counseling training, nor to what extent

such training included issues regarding gender identity and expression. So, it cannot be assumed that education and training in multicultural counseling without attention to trans issues and clients is sufficient for the development of trans-affirmative attitudes. It may be the case, however, that the attitudes fostered in the development of multicultural counseling competence positively influence attitudes regarding trans people.

Alternatively, perhaps counseling professionals who already hold positive attitudes regarding diversity, including the diversity of gender identity and expression, are more likely than others to work toward becoming more multiculturally competent. Conversely, just as anti-trans attitudes are positively correlated with anti-gay attitudes (Hill & Willoughby, 2005; Nagoshi et al., 2008; Rye & Elmslie, 2001, June), the results of the present study may suggest that anti-trans attitudes are similarly related to perspectives which reject the value of multicultural counseling competency.

Anti-Trans Attitudes and Responses to Trans Clients

To investigate possible relationships between anti-trans attitudes and counselor responses to trans clients, three client response measures were used: the GAF scale (American Psychiatric Association, 2000), through which participants assessed the fictional client's overall psychosocial functioning, and the Favorable and Unfavorable scales of the Adjective Check List (Gough & Heilbrun, 1983), through which participants expressed their favorable and unfavorable perceptions of the client's personal characteristics. Given Winter and colleagues' (2008) finding that their participants tended to respond more unfavorably to a trans person perceived to be male than to a trans person perceived to be female, client sex was included with anti-trans attitudes as a predictor variable for the response measures in order to assess this. Also, because evidence

suggested that the accuracy of clinical judgments is positively influenced by experience, whether clinical or educational (Spengler et al., 2009), regression analyses controlled for the variables of educational degree level, years of counseling experience, and extent of training and experience in counseling and assessment with trans clients. Findings related to each response measure are discussed under the corresponding headings below.

Global Assessment of Functioning

Overall, counseling professionals in the present study accurately assessed the overall psychosocial functioning of the fictional trans client using the GAF scale (American Psychiatric Association, 2000). The mean GAF rating fell within the 10-point interval (61-70) determined by the expert raters. Inaccurate assessments more frequently rated the client at a higher level of psychosocial functioning rather than a lower level. The skew of inaccurate assessments could have been an indication of the type of minimization of severity that López (1989) noted may also be a sign of clinical bias (vs. only considering overpathologization or overdiagnosing as signs of bias). However, anti-trans attitudes were not significantly correlated with GAF ratings in the present study. Alternate possible explanations may be that many of the participants in this sample happened to be prone to underpathologizing clients in general, or might have rated the trans client at a higher level of psychosocial functioning in an effort to avoid appearing biased against the trans client. The tendency to minimize the severity of client concerns or symptoms could be examined in future studies by using a warm-up GAF rating and then controlling for a tendency to over- or underpathologize clients as was done by Mohr et al. (2009) in their study of clinical judgment bias regarding bisexuality.

Neither education level, nor years of counseling experience, nor extent of training and experience in counseling and assessment with trans clients were significantly correlated with GAF ratings (American Psychiatric Association, 2000) of the trans client, and none of those variables were significant unique predictors of GAF ratings. This stands in contrast to Spengler and colleagues' (2009) meta-analysis of clinical judgment research, through which the authors found that educational and clinical experience contribute to clinical judgment accuracy, with a "small but reliable effect" (p. 350). Spengler et al. noted that they examined a variety of types of clinical judgments, including clients' problems, symptoms, and diagnoses; the severity of clients' problems; treatment recommendations; and prognoses. They did not specify the particular measures of those judgment types, however, so it is possible that none of the analyzed studies used the GAF scale. If not, it may be that Spengler and colleagues' findings do not apply to clinical judgments made via the GAF scale.

Additionally, the nonsignificant findings for this aspect of the present study may indicate limitations in how the education, training, and experience variables were measured. The education level variable, for example, might have been improved by increasing the number of levels examined (e.g., masters, predoctoral internship, doctoral, and postdoctoral). The variable of training and experience in counseling and assessment with trans clients was assessed via retrospective report on a scale which did not include points denoting specific, objective standards of the extent of training (e.g., number of courses, seminars, etc.). Specifying the scale points more objectively might have improved that measure. The nonsignificant finding regarding a relationship between GAF ratings (American Psychiatric Association, 2000) of a trans client and the variable of

training and experience in counseling and assessment with trans clients might also be a result of how little training and experience in that area was reported overall by the counseling professionals in the present study. Furthermore, years of counseling experience may have been too broad a measure of clinical experience in relation to the specific task of psychosocial functioning assessment via the GAF scale. Perhaps a measure of counseling experience that incorporated experience in psychosocial functioning assessment or, more specifically, the extent of experience using the GAF scale, would have been more relevant to the GAF rating task in the present study. It may also have been useful to assess participants' clinical experience with gay men, lesbians, and bisexual people, which would likely be more extensive than the very little experience with trans clients reported in the present study, and evaluate whether this contributes to clinical judgment accuracy with trans clients.

Client sex and anti-trans attitudes were not correlated with the assessment of the trans client's psychosocial functioning via the GAF scale (American Psychiatric Association, 2000). After controlling for the education and experience variables discussed above, neither client sex nor anti-trans attitudes were significant unique predictors of GAF ratings. The finding of no significant relationship between the sex of the fictional client and ratings of the client's psychosocial functioning contrasts with Winter and colleagues' (2008) finding that trans people who were perceived to be male tended to be responded to more negatively than those perceived to be female. Instead, this finding of the present study is consistent with that of Leitenberg and Slavin (1983) who found no differences in responses to items depending on whether they described a transsexual woman or a transsexual man.

In both of the previous studies noted (i.e., Leitenberg & Slavin, 1983; Winter et al., 2008), the evaluation of differential responding depending on a trans person's sex was based on participants' responses to survey items not referring to any specific trans person, while that evaluation in this part of the present study was done on the basis of participants' responses to specific, albeit fictional, trans clients. Perhaps the client information supplied in the intake summary was of sufficient detail such that participants were less likely to rely on stereotypic beliefs about trans people and assumed responses to trans people they perceive as male or female than they might if asked without a particular trans person in mind. Further research may clarify the validity of a pattern of differential responses according to the perceived sex of a trans person.

No previous studies have investigated the potential relationship between anti-trans attitudes and assessment of a trans client's psychosocial functioning, but the nonsignificant findings in the present study do differ from those of Mohr et al. (2001), who found that participants with more negative attitudes regarding bisexuality rated a bisexual client's psychosocial functioning as lower via GAF scale ratings (American Psychiatric Association, 2000). There are several possible explanations for the nonsignificant findings regarding anti-trans attitudes and the assessment of psychosocial functioning via GAF ratings in the present study. It may be that, unlike the effect bisexuality attitudes appeared to have on the overall psychosocial assessment of a bisexual client (Mohr et al., 2009), attitudes regarding trans people and gender variance were not involved in the cognitive task of using the GAF scale to assess a trans client's psychosocial functioning. This may have been particularly so because the participants in the present study were counseling professionals who reported having training in the use

of the GAF scale, and GAF training is associated with more reliable ratings (Loevdahl & Friis, 1996). The participants in Mohr and colleagues' (2009) study, in contrast, included counselor trainees who may or may not have had training in GAF use, which may have caused their ratings to be more susceptible to bias. Another possibility is that the presentation of the client in a written format only (vs. a visual or in vivo presentation) in the present study was not a vivid enough stimulus to elicit stereotypic beliefs or affective responses which might influence GAF ratings. Finally, it is possible that any effects of anti-trans attitudes on GAF ratings were limited by the very low levels of anti-trans attitudes apparent in the present sample.

Favorable Perceptions

Counseling professionals in this study tended to endorse far more favorable than unfavorable adjectives from the Adjective Check List (ACL; Gough & Heilbrun, 1983), to describe the fictional trans client. This may have been partly a result of how the client and presenting issues were described in the intake summary, and/or may have reflected a tendency in the present sample of counseling professionals to focus on favorable client characteristics and/or minimize unfavorable characteristics or issues, but was certainly in part explainable by participants' anti-trans attitudes. Participants who expressed lower levels of anti-trans attitudes tended to endorse a significantly greater number of favorable adjectives to describe the trans client, as well as significantly fewer unfavorable adjectives. These findings are similar to previous research which found that higher homophobia scores were associated with the assignment of "significantly fewer favorable adjectives to gay male and lesbian clients and significantly more favorable adjectives to heterosexual clients" (Barrett & McWhirter, 2002, p. 228). Unlike in the Barrett and

McWhirter study, and despite the significant correlation found between anti-trans attitudes and favorable perceptions of the trans client, the present study did not find attitudes to be a significant unique predictor of favorable perceptions of the client. The findings regarding prediction of favorable perceptions are discussed next.

When considered alongside the variable of years of counseling experience, education level and the extent of training and experience in counseling and assessment with trans clients were significant unique predictors of favorable perceptions of the trans client. The lower level of education (i.e., master's degree) and more extensive training and experience predicted more favorable perceptions of the trans client. However, when considered on their own, neither the education variable nor the training and experience variable was significantly correlated with favorable perceptions of the trans client. The training and experience variable may have emerged as a significant unique predictor of favorable perceptions as a consequence of its significant correlation with anti-trans attitudes, a variable which was significantly correlated with favorable perceptions. When client sex and anti-trans attitudes were considered alongside the education, training, and experience variables, the variable of training and experience in counseling and assessment with trans clients was no longer a significant unique predictor of favorable perceptions. Though anti-trans attitudes were significantly negatively correlated with favorable perceptions of the trans client, neither client sex nor anti-trans attitudes were significant unique predictors of favorable perceptions. Only education level remained as a significant unique predictor of favorable perceptions of the trans client, with the doctoral degree predicting less favorable perceptions

Because education level was not significantly correlated with anti-trans attitudes in the present study, the finding that education level did predict favorable perceptions was unexpected. It should be noted that the endorsement of fewer favorable descriptors as predicted by doctoral education level does not indicate more unfavorable perceptions of trans clients, just less favorable ones. That is, given the nature of the measures of those responses as two separate scales, rather than a bipolar, unidimensional scale, participants' endorsements of favorable descriptors of the client did not preclude them from endorsing any number of unfavorable descriptors. Thus, the adjectives selected by participants could indicate little favorability in their perceptions of the client while also indicating little unfavorability, for example, in their perceptions of the client, which could be interpreted as neutrality in their perceptions overall.

Explanations for the finding of education level as a significant predictor of favorable perceptions are not readily apparent. One explanation considered was that perhaps doctoral level counseling professionals simply checked fewer adjectives overall (favorable and unfavorable) compared to master's level counseling professionals. However, this was not the case, as both doctoral and master's level participants endorsed very few unfavorable adjectives. Given that doctoral-level participants tended to report a greater number of years of counseling experience than masters-level participants, another possible explanation may be that the doctoral-level participants completed their education longer ago and, if so, perhaps their education was less likely to include training in multicultural counseling or other diversity issues. Future studies in this area could specifically examine such variables along with education level (perhaps with a greater

number of levels as suggested earlier in this chapter), and look for evidence of relationships between those variables and favorable perceptions of clients.

Unfavorable Perceptions

As noted in the previous section, counseling professionals in this study tended to endorse far more favorable than unfavorable adjectives from the Adjective Check List (ACL; Gough & Heilbrun, 1983), to describe the fictional trans client. In fact, 44.2% of the participants did not endorse any unfavorable adjectives at all. Possible explanations for this pattern were discussed in the previous section. Participants who expressed more unfavorable attitudes toward trans people tended to endorse a greater number of unfavorable descriptors of the trans client. Those who endorsed a greater number of unfavorable descriptors of the trans client also tended to rate the trans client's psychosocial functioning as lower.

Unfavorable perceptions of the trans client were not significantly related to, or significantly predicted by, any of the education, training, or experience variables. Anti-trans attitudes, but not client sex, was a significant unique predictor of unfavorable perceptions. While Barrett and McWhirter (2002) did not control for education, training, or experience variables, they found, similarly, that the negative attitudes of homophobia significantly predicted the assignment of unfavorable adjectives to gay and lesbian clients. Overall, however, in the present study, the full set of training, experience, anti-trans attitudes, and client sex variables did not explain a significant proportion of the variance in unfavorable perceptions of the trans client. Confidence in this finding is somewhat limited due to the violated assumption of homoscedasticity in the multiple

regression analysis, along with the very low frequency of unfavorable perceptions of the client.

Implications

The present study revealed the extent to which counseling professionals hold anti-trans attitudes. While the level of anti-trans attitudes was very low in this sample overall, there was evidence that some counseling professionals held moderately intolerant attitudes toward trans people. In terms of practice implications, these findings support the position that counseling professionals and students have the potential to hold biased attitudes similar to those of the general population (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 1990) and thus, should examine their own attitudes regarding trans people for signs of intolerance (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009). Though counseling professionals in this sample appeared less likely to express anti-trans attitudes via obvious harassment or violence against trans people than via negative affective or cognitive reactions, it is possible such affective or cognitive reactions could be perceived by trans clients as harmful microaggressions (see Sue, 2010). Additionally, counseling professionals should be aware that the trans clients with whom they work may have encountered anti-trans attitudes in interactions with other counseling professionals and that such experiences may impact the later therapeutic relationship. In terms of training implications, these findings indicate that some trainees may hold intolerant attitudes toward trans people and, therefore, that instructors and clinical supervisors should address attitudes toward trans people as a matter of cultural competency and should monitor trainees for signs of intolerance in their work with gender-variant clients and peers.

The present study also replicated the findings of previous investigations of attitudes toward trans people in terms of identifying relationships between those attitudes and other variables including gender, personal familiarity with trans people, and trans etiology beliefs. The present study also expanded research in this area by identifying relationships between anti-trans attitudes and training and experience in counseling and assessment with trans clients, as well as between anti-trans attitudes and perceived multicultural counseling competence. These findings may assist practitioners as they seek to enhance their competency for working with trans clients and colleagues. For example, reading about current research into the etiology of gender-variant identities and expressions, as well as seeking opportunities to become more personally familiar with trans people, may help counseling professionals develop more affirming attitudes toward trans people.

In terms of training implications, the relationship between anti-trans attitudes and training and experience in counseling and assessment with trans clients supports the expansion of opportunities for such training. While it may be that some people who choose to participate in that type of training already hold more favorable attitudes toward trans people, this first exploration of the matter suggests at least the possibility that such training could help in the development of trans-affirmative attitudes. Facilitating contact experiences for students in counseling and counseling psychology may be particularly beneficial toward the development of trans-affirmative attitudes. Future research could explore the efficacy of training in this area and could also examine how such training may also contribute to the development of knowledge and skills for working with trans clients.

Though perceived multicultural counseling competency was associated with attitudes toward trans people, practitioners and educators should be careful to not assume that multicultural counseling competency with a particular client population necessarily indicates competency with another, such as trans clients. Future research is needed to determine the training needs of counseling professionals and students regarding the development of knowledge and skills for culturally competent work with trans people. The knowledge and skills competencies outlined in the *Competencies for Counseling with Transgender Clients* (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2009) could provide a basis for further research in this area.

The present study also investigated relationships between anti-trans attitudes and counselor responses to trans clients, with mixed findings. No relationships were found between anti-trans attitudes and ratings of a trans client's psychosocial functioning via the GAF scale (American Psychiatric Association, 2000). Anti-trans attitudes were found to be related to favorable and unfavorable perceptions of a trans client. None of the counselor responses examined in the present study were significantly predicted by anti-trans attitudes, results which may reflect the complex nature of counselor/client responses and, more generally, the difficulties of attitude-behavior prediction (Ajzen & Fishbein, 2005). Practitioners, educators, and clinical supervisors should be aware, however, that their tendencies to perceive favorable and unfavorable characteristics of trans clients, may be influenced by anti-trans attitudes, whether those attitudes are more favorable or more unfavorable.

Limitations

There were several limitations to the present study. First, while the use of web-based sampling aimed to reach a diverse, national sample of counseling professionals, it was not random and the sample of participants was not diverse in terms of race and ethnicity or sexual orientation. Both of those issues may limit the generalizability of the findings to the population of counseling professionals at large and/or to subsets comprised of racial, ethnic, and sexual orientation minority members. Future studies using random sampling, perhaps with additional targeted recruitment to obtain a more diverse sample of participants, may help address this issue.

Second, the analogue design of the study contributed to the study's internal validity in terms of consistent stimuli materials and response options, but as with all counseling analogue studies, this was at the expense of realism and, therefore may limit the generalizability of the findings to actual clinical practice and training scenarios (Heppner, Kivlighan, & Wampold, 1999). Heppner and colleagues suggested that one way to evaluate the generalizability of analogue studies is to consider how similar the analogue is to actual counseling in terms of variables related to the client, the counselor, and the counseling process and setting. The written presentation of the client, the presentation of just a brief intake summary, and the restricted range of response options (i.e., a GAF rating and the assignment of adjectives to describe the client) all lessened the similarity of the analogue in the present study to a real life counseling situation. In an effort to address issues of generalizability, future research could ask participants to respond to images or videos depicting trans clients, the presented client information could be more detailed and representative of that available to a counseling professional through

several sessions with a client, and/or they could utilize a wider range of response options. As an alternative to an analogue design, researchers could investigate counseling professionals' actual clinical responses to actual trans clients (e.g., via observations of counseling sessions, practitioners' and/or trans clients' recollections, or reviews of clinical records), and look for patterns in those responses which may reveal negative or positive biases.

A third limitation also concerns the design of the present study. Given that the design of this study was correlational, determination of causal relationships was not possible. For example, though more extensive training and experience in counseling and assessment with trans clients was associated with lower levels of anti-trans attitudes, it cannot be said that the training and experience caused the more favorable attitudes, or vice versa. Future studies using an experimental design could evaluate causality. For example, researchers could provide participants with training in counseling and assessment with trans clients and then examine the effect that training may have on anti-trans attitudes.

A fourth area of limitations is in regard to statistical analysis issues. As previously noted, the model examined through hierarchical multiple regression to investigate the prediction of unfavorable perceptions of clients was found to violate the assumption of homoscedasticity. While "moderate violations of these assumptions tend not to be very problematic" (Licht, 1995, p. 49), the combination of heteroscedasticity and the pattern of participants' very low response frequency on the measure of unfavorable perceptions suggests that the result for that particular analysis should be interpreted cautiously.

Finally, some findings of the present study may be limited due to measurement issues. Several possible problems with measurement were already discussed in this chapter, including the use of self-report measures, some retrospective measures of training and experience, and failure to control for possible socially desirable response patterns. Additional measurement limitations include the use of single-item measures of trans etiology beliefs and personal familiarity with trans people. Psychometrically developed, multi-item measures may enhance the utility of those variables in future research. Also, the present study only assessed personal familiarity with trans people, but did not consider whether there might also be a relationship between anti-trans attitudes and indirect contact with trans people through media exposure, known as parasocial contact (Schiappa, Gregg, & Hewes, 2005). Future studies could inquire about counseling professionals' parasocial contact with trans people via television, movies, the internet, etc., using a psychometrically developed measure. Additionally, experimental studies could expose counseling professionals or trainees to parasocial contact with trans people and then examine effects on attitudes toward trans people. Finally, the present study only measured counselor responses in terms of psychosocial assessments and favorable and unfavorable perceptions of the trans client. A wide range of other response types could be considered in future examinations of responses to trans clients. For example, affective reactions to trans clients, identification of presenting issues and/or diagnoses of trans clients, or ratings of interest or efficacy in working with trans clients could be investigated.

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Appendix A
Research Invitation

Dear fellow [listserv name] member, (for professional organization electronic mailing lists)

OR

Dear colleagues, (for all other invitations)

Dr. Kelly McDonnell and I cordially invite counselors and counseling psychologists to participate in a survey of counseling professionals' clinical impressions and attitudes regarding gender issues. We value the perspective you could contribute to this research and hope you'll take a moment to consider participating. This study has been approved by the Western Michigan University Human Subjects Institutional Review Board.

You are eligible to participate in this study if you meet all of the following criteria:

- 1) You are 18 years of age or older *and*
- 2) You have earned a masters and/or doctoral degree in counseling and/or counseling psychology *and*
- 3) You are a practicing professional providing counseling, training, and/or counseling supervision services, *and/or* you are a doctoral student in counseling or counseling psychology *and*
- 4) You have previously been instructed in how to use the Global Assessment of Functioning (GAF) Scale (i.e., the scale used as Axis V of the multiaxial diagnostic system described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR). This may include instruction as part of course, a seminar, in clinical supervision, or in other academic or clinical training situations.

Participation involves responding to a brief, fictional client intake summary, and completing questionnaires regarding issues related to gender, multicultural competencies, training and clinical experience, and a demographic questionnaire. Survey completion will take place entirely online and is expected to take approximately 20-30 minutes.

Upon completion of the survey, participants will have the opportunity to enter a drawing to win a \$100 VISA gift card.

If you are interested in learning more about participating, please click on the link below (or cut and paste the URL into your web browser) and you will be directed to the participant consent document for this study:

<https://www.psychdata.com/s.asp?SID=129065>

Please consider forwarding this invitation to eligible doctoral students and/or professional colleagues who may be interested in participating in our study. Feel free to contact us if you have any questions or concerns regarding this study.

Sincerely,

Emily A. Nisley, M.A., LLPC

Kelly A. McDonnell, Ph.D.

Student Investigator
Western Michigan University
emily.nisley@wmich.edu

Associate Professor and Principal Investigator
Dept. of Counselor Education &
Counseling Psychology
Western Michigan University
kelly.mcdonnell@wmich.edu
(269) 387-5107

Appendix B
Request to Training Directors

Dear Training Directors,

Dr. Kelly McDonnell and I are seeking counselors, counseling psychologists, and doctoral students in counseling and counseling psychology to participate in our survey of counseling professionals' clinical impressions and attitudes regarding gender issues. Our participant invitation is pasted below. Would you please forward the invitation to eligible doctoral students, graduates, and faculty members of your department? Thank you for your time and consideration.

Sincerely,

Emily A. Nisley, M.A., LPC (Student Investigator)
 Kelly A. McDonnell, Ph.D. (Principle Investigator)
 Dept. of Counselor Education & Counseling Psychology
 Western Michigan University

 Dr. Kelly McDonnell and I cordially invite counselors and counseling psychologists to participate in a survey of counseling professionals' clinical impressions and attitudes regarding gender issues. We value the perspective you could contribute to this research and hope you'll take a moment to consider participating. This study has been approved by the Western Michigan University Human Subjects Institutional Review Board.

You are eligible to participate in this study if you meet all of the following criteria:

- 1) You are 18 years of age or older *and*
- 2) You have earned a masters and/or doctoral degree in counseling and/or counseling psychology *and*
- 3) You are a practicing professional providing counseling, training, and/or counseling supervision services, *and/or* you are a doctoral student in counseling or counseling psychology *and*
- 4) You have previously been instructed in how to use the Global Assessment of Functioning (GAF) Scale (i.e., the scale used as Axis V of the multiaxial diagnostic system described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR). This may include instruction as part of course, a seminar, in clinical supervision, or in other academic or clinical training situations.

Participation involves responding to a brief, fictional client intake summary, and completing questionnaires regarding issues related to gender, multicultural competencies, training and clinical experience, and a demographic questionnaire. Survey completion will take place entirely online and is expected to take approximately 20-30 minutes.

Upon completion of the survey, participants will have the opportunity to enter a drawing to win a \$100 VISA gift card.

If you are interested in learning more about participating, please click on the link below (or cut and paste the URL into your web browser) and you will be directed to the

participant consent document for this study:

<https://www.psychdata.com/s.asp?SID=129065>

Please consider forwarding this invitation to eligible doctoral students and/or professional colleagues who may be interested in participating in our study. Feel free to contact us if you have any questions or concerns regarding this study.

Sincerely,

Emily A. Nisley, M.A., LLPC
Student Investigator
Western Michigan University
emily.nisley@wmich.edu

Kelly A. McDonnell, Ph.D.
Associate Professor and Principal Investigator
Dept. of Counselor Education &
Counseling Psychology
Western Michigan University
kelly.mcdonnell@wmich.edu
(269) 387-5107

Appendix C
Reminder Invitation

Dear fellow [listserv name] members,

Thank you to those of you who have already participated in our survey regarding counseling professionals' clinical impressions and attitudes regarding gender issues. In case others of you may still be interested in learning more about participating, our original invitation is posted below. Thanks again for your consideration.

Dr. Kelly McDonnell and I cordially invite counselors and counseling psychologists to participate in a survey of counseling professionals' clinical impressions and attitudes regarding gender issues. We value the perspective you could contribute to this research and hope you'll take a moment to consider participating. This study has been approved by the Western Michigan University Human Subjects Institutional Review Board.

You are eligible to participate in this study if you meet all of the following criteria:

- 5) You are 18 years of age or older *and*
- 6) You have earned a masters and/or doctoral degree in counseling and/or counseling psychology *and*
- 7) You are a practicing professional providing counseling, training, and/or counseling supervision services, *and/or* you are a doctoral student in counseling or counseling psychology *and*
- 8) You have previously been instructed in how to use the Global Assessment of Functioning (GAF) Scale (i.e., the scale used as Axis V of the multiaxial diagnostic system described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR). This may include instruction as part of course, a seminar, in clinical supervision, or in other academic or clinical training situations.

Participation involves responding to a brief, fictional client intake summary, and completing questionnaires regarding issues related to gender, multicultural competencies, training and clinical experience, and a demographic questionnaire. Survey completion will take place entirely online and is expected to take approximately 20-30 minutes.

Upon completion of the survey, participants will have the opportunity to enter a drawing to win a \$100 VISA gift card.

If you are interested in learning more about participating, please click on the link below (or cut and paste the URL into your web browser) and you will be directed to the participant consent document for this study:

<https://www.psychdata.com/s.asp?SID=129065>

Please consider forwarding this invitation to eligible doctoral students and/or professional colleagues who may be interested in participating in our study. Feel free to contact us if you have any questions or concerns regarding this study.

Sincerely,

Emily A. Nisley, M.A., LLPC
Student Investigator
Western Michigan University
emily.nisley@wmich.edu

Kelly A. McDonnell, Ph.D.
Associate Professor and Principal Investigator
Dept. of Counselor Education &
Counseling Psychology
Western Michigan University
kelly.mcdonnell@wmich.edu
(269) 387-5107

Appendix D
Informed Consent Document

Western Michigan University
Department of Counselor Education & Counseling Psychology

Principal Investigator: Kelly A. McDonnell, Ph.D.

Student Investigator: Emily A. Nisley, M.A.

Title of Study: Counseling Professionals' Clinical Impressions and Attitudes Regarding Gender

You have been invited to participate in a research project titled "Counseling Professionals' Clinical Impressions and Attitudes Regarding Gender." This project will serve as Ms. Nisley's dissertation for the requirements of the Ph.D. in counseling psychology. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study and the risks and benefits of participating in this research project. Please read this consent form carefully and completely, and use the contact information provided below to ask questions if you need more clarification.

What are we trying to find out in this study?

The purpose of this study is to gather information about counseling professionals' clinical assessments of particular client populations and about attitudes that counseling professionals' may hold regarding gender issues. This information may clarify our professional understanding of the relationships between such assessments and attitudes, neither of which have been previously investigated among counseling professionals. The results may reveal important education and training needs regarding counseling work with particular client populations, and inform efforts to address those needs.

Who can participate in this study?

You are eligible to participate in this study if you meet **all** of the following criteria:

- 1) **You are 18 years of age or older** *and*
- 2) You have **earned a masters and/or doctoral degree in counseling and/or counseling psychology** *and*
- 3) You are a **practicing professional providing counseling, training, and/or counseling supervision services, and/or you are a doctoral student in counseling or counseling psychology** *and*
- 4) You have **previously been instructed in how to use the Global Assessment of Functioning (GAF) Scale** (i.e., the scale used as Axis V of the multiaxial diagnostic system described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR). This may include instruction as part of a course, a seminar, in clinical supervision, or in other academic or clinical training situations.

Where will this study take place?

This study will take place entirely online through the PsychData survey web host.

What is the time commitment for participating in this study?

Completion of the study is expected to take approximately 20-30 minutes.

What will you be asked to do if you choose to participate in this study?

You will be asked to read a brief intake summary for a fictional counseling client. Then you will be asked to rate the client's overall level of psychosocial functioning using the Global Assessment of Functioning (GAF) scale and then to use another scale to provide your impressions of the client's positive and negative characteristics. You will then be asked to complete a series of four questionnaires regarding gender issues, multicultural counseling issues, your counseling and assessment training and experience, and your personal familiarity with particular populations. Finally, you will be asked to provide some demographic information.

What are the risks of participating in this study and how will these risks be minimized?

Potential risks of participating in this study include mild emotional discomfort as you are asked to respond to a variety of potentially socially-charged statements regarding gender and multicultural counseling issues and, perhaps, as you recall and report on your familiarity with particular populations. Any discomfort is expected to be mild and no more than what an individual could expect to encounter as part of their counseling training, education, and/or practice.

What are the benefits of participating in this study?

Potential benefits of participating in this study include having the opportunity to reflect on your attitudes regarding social and counseling issues and contributing to a study that has the potential to impact the education and training of counseling professionals.

Are there any costs associated with participating in this study?

There are no costs associated with participating in this study.

Is there any compensation for participating in this study?

Upon completion of the survey, you will have the option to enter a drawing to win a \$100 VISA gift card. If you choose to enter the drawing, you will be asked to provide your email address to serve as your entry and as a means to contact you should you win. Your email address will be kept confidential and will not be saved with, or linked to, your survey responses in any way. The researchers will randomly select a winner within one week of the conclusion of data collection, contact the winner by email, and request a mailing address where the gift card can be sent.

Who will have access to the information collected during the study?

All information collected from you will be anonymous. Your name will not be requested at any time during the survey. To protect your privacy during data collection, the survey web host uses technology to prevent subsequent users of the computer you utilize from viewing your survey responses. Survey responses are encrypted and transmitted to the survey web host into a password-protected database, accessible only by the researchers. Published and/or presented findings from this research will be in aggregate form and will not include personal identifying information.

What if you want to stop participating in this study?

Your participation in this study is voluntary. You can choose to stop participating in the study at any time for any reason, without penalty. You may close your web browser or otherwise navigate away from the survey webpage to decline participation or to stop participating at any time. If you decide to stop participating before completing the survey, any responses you have already provided will be considered incomplete data and removed from analysis. Because your responses are anonymous, we cannot identify your individual responses or remove them from analysis once you have completed the entire survey.

Should you have any questions prior to or during the study, you can contact the student investigator, Emily Nisley, at (269) 267-8430 or emily.nisley@wmich.edu, or the principal investigator, Dr. Kelly McDonnell at (269) 387-5107 or kelly.mcdonnell@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) on January 20, 2010. Do not participate in this study after January 20, 2011. You may print a copy of this consent document for your records.

To indicate that 1) you have read this informed consent document, 2) the risks and benefits have been explained to you, 3) you meet the participation criteria, and 4) you agree to take part in this study, please click "Continue to Next Page" below.

Appendix E

Fictional Client Intake Summary Versions

Please read the following fictitious intake summary. After reading the summary, you will be asked to share your impressions of the client.

Version 1: Female [label not presented to participants]

Jamie presented for counseling appearing neatly groomed, with a closely-cropped haircut, and wearing pressed slacks with a button-down shirt and tie. On the intake form, Jamie indicated having a transgender identity. Upon inquiry, Jamie noted that she thinks of herself in some ways as a man, and in some ways as a woman, but prefers to be referred to by the feminine pronouns, she and her, associated with her biological female sex. She appeared tense and visibly anxious initially as she explained why she was seeking counseling. Jamie reported feeling very “stressed” about her job and complained that her supervisor constantly critiques her work and, recently, her appearance. Jamie described this as confusing and frustrating, given that previous managers praised her work and that her appearance is within the bounds of the office dress code. She noted that she gets along well with everyone else in the office and enjoys socializing after work with some of them on a regular basis. Jamie stated that she feels intimidated by her supervisor and finds herself spending increasingly more of her work time thinking and worrying about their next interaction, even when trying to focus instead on her work tasks. Jamie acknowledged that her work performance has begun to suffer noticeably over the past couple of weeks and she is now worried that her supervisor’s critiques will eventually become justified and she will lose her job.

Jamie criticized her own inability to cope better with the work situation and shared how “everything” feels more challenging to handle since the death of her mother a year ago. Jamie shared that she often thinks about her mother and feels sad and also guilty that she wasn’t there when her mother died. She reported that she frequently wonders if she’d feel better if she moved back to her hometown to be closer to her family, with whom she described having supportive relationships. Jamie noted that she just can’t seem to think through her options clearly right now in regards to a move. She stated that she’s brought the issue up within her close knit group of friends, and that’s when one of them encouraged her to seek counseling. During the intake, Jamie was open and cooperative, and appeared to relax over the course of the session. She reported some difficulty falling asleep at night over the past two weeks, but no other sleep or appetite disturbances. Jamie denied suicidal ideation.

Version 2: Male [label not presented to participants]

Jamie presented for counseling appearing neatly groomed, with shoulder length hair, well-applied makeup and polished nails, wearing slacks and a silk blouse. On the intake form, Jamie indicated having a transgender identity. Upon inquiry, Jamie noted that he thinks of himself in some ways as a man, and in some ways as a woman, but prefers to be referred to by the masculine pronouns, he and his, associated with his biological male sex. He appeared tense and visibly anxious initially as he explained why he was seeking counseling. Jamie reported feeling very “stressed” about his job and complained that his supervisor constantly critiques his work and, recently, his

appearance. Jamie described this as confusing and frustrating, given that previous managers praised his work and that his appearance is within the bounds of the office dress code. He noted that he gets along well with everyone else in the office and enjoys socializing after work with some of them on a regular basis. Jamie stated that he feels intimidated by his supervisor and finds himself spending increasingly more of his work time thinking and worrying about their next interaction, even when trying to focus instead on his work tasks. Jamie acknowledged that his work performance has begun to suffer noticeably over the past couple of weeks and he is now worried that his supervisor's critiques will eventually become justified and he will lose his job.

Jamie criticized his own inability to cope better with the work situation and shared how "everything" feels more challenging to handle since the death of his mother a year ago. Jamie shared that he often thinks about his mother and feels sad and also guilty that he wasn't there when his mother died. He reported that he frequently wonders if he'd feel better if he moved back to his hometown to be closer to his family, with whom he described having supportive relationships. Jamie noted that he just can't seem to think through his options clearly right now in regards to a move. He stated that he's brought the issue up within his close knit group of friends, and that's when one of them encouraged him to seek counseling. During the intake, Jamie was open and cooperative, and appeared to relax over the course of the session. He reported some difficulty falling asleep at night over the past two weeks, but no other sleep or appetite disturbances. Jamie denied suicidal ideation.

Appendix F

Transgender Definition and Identities Material

The next set of questions refers to your training and experience regarding transgender issues and your personal familiarity with transgender people. In answering those questions, please refer to the following definitions and information about transgender individuals from the American Psychological Association (2006; <http://www.apa.org/topics/transgender.html>):

What does transgender mean?

Transgender is an umbrella term used to describe people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their birth sex. Many transgender people live part-time or full-time as members of the other gender. Broadly speaking, anyone whose identity, appearance, or behavior falls outside of conventional gender norms can be described as transgender. However, not everyone whose appearance or behavior is gender-atypical will identify as a transgender person.

What are some categories or types of transgender people?

Transsexuals are transgender people who live or wish to live full time as members of the gender opposite to their birth sex. Biological females who wish to live and be recognized as men are called female-to-male (FTM) transsexuals or transsexual men. Biological males who wish to live and be recognized as women are called male-to-female (MTF) transsexuals or transsexual women. Transsexuals usually seek medical interventions, such as hormones and surgery, to make their bodies as congruent as possible with their preferred gender. The process of transitioning from one gender to the other is called sex reassignment or gender reassignment.

Cross-dressers or transvestites comprise the most numerous transgender group. Cross-dressers wear the clothing of the other sex. They vary in how completely they dress (from one article of clothing to fully cross-dressing) as well as in their motives for doing so. Some cross-dress to express cross-gender feelings or identities; others cross-dress for fun, for emotional comfort, or for sexual arousal. The great majority of cross-dressers are biological males, most of whom are sexually attracted to women.

Drag queens and drag kings are, respectively, biological males and females who present part-time as members of the other sex primarily to perform or entertain. Their performances may include singing, lip-syncing, or dancing. Drag performers may or may not identify as transgender. Many drag queens and kings identify as gay, lesbian, or bisexual.

Other categories of transgender people include androgynous, bigendered, and gender queer people. Exact definitions of these terms vary from person to person, but often include a sense of blending or alternating genders. Some people who use these terms to describe themselves see traditional concepts of gender as restrictive.

Appendix G

Training, Experience, and Familiarity Questionnaire

Training, Experience, and Familiarity Questionnaire

The following questionnaire is designed to assess to your graduate and post-graduate training and clinical experience regarding transgender issues and clients. It also inquires about your personal familiarity with transgender people and your beliefs about why some people are transgender. Please refer to the definitions and information regarding transgender individuals provided above when responding to the items.

Click to mark the response that best fits your experience using the scale included below each item:

1. Please rate the extent of your GRADUATE COURSEWORK on transgender issues and working with transgender individuals.

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

2. Please rate the extent of your GRADUATE practica and internship training in COUNSELING and/or PSYCHOTHERAPY with transgender individuals.

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

3. Please rate the extent of your GRADUATE practica and internship training in ASSESSMENT with transgender individuals.

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

4. Please rate the extent of your POST-GRADUATE TRAINING in transgender issues and working with transgender individuals (e.g., workshops, conferences, post-doctoral fellowships, etc.).

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

5. Please rate the extent of your POST-GRADUATE experience in COUNSELING and/or PSYCHOTHERAPY with transgender individuals.

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

6. Please rate the extent of your POST-GRADUATE experience in ASSESSMENT with transgender individuals.

° 1	° 2	° 3	° 4	° 5	° 6	° 7
						Very Extensive

7. Approximately what percentage of your client caseload to date has consisted of transgender individuals?

° 1	° 2	° 3	° 4	° 5	° 6	° 7
0%	1-5%	6-10%	11-15%	16-20%	21-25%	more than 25%

8. Please rate the extent of your personal familiarity with transgender individuals (e.g., friends, family members, colleagues, acquaintances)

- ° 1 Not at all personally familiar with transgender individuals
- ° 2
- ° 3
- ° 4 Somewhat familiar (e.g., you know one or more transgender individuals, but do not have close relationships with them)
- ° 5
- ° 6
- ° 7 Very familiar (e.g., you identify as transgender and/or you have a close relationship with one or more transgender individuals)

9. What do you think causes some people to be transgender?

- ° Biological causes (e.g., genetics, prenatal hormone levels)
- ° Psychosocial causes (e.g., early childhood experiences, other social forces)
- ° A combination of biological and psychosocial causes
- ° Unsure
- ° Other (Please specify)

Appendix H
Demographic Questionnaire

Demographic Questionnaire

Please respond to the following items regarding your demographic characteristics and other background information.

1. What is your age? (Please enter your age in years):

2. Please indicate your gender:

- Woman
- Man
- Transgender
- Other (Please specify)

3. Please indicate your race/ethnicity. Check all that apply:

- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ Hispanic/Latino(a)/Chicano(a)
- ☐ Native American or Alaskan Native
- ☐ White/European American
- ☐ Bi/Multi-racial
- ☐ Other (Please specify)

4. Please indicate your sexual orientation. Check all that apply:

- ☐ Bisexual
- ☐ Gay man or man-loving man
- ☐ Heterosexual
- ☐ Lesbian or woman-loving woman
- ☐ Queer
- ☐ Other (Please specify)

5. Please indicate the region of your primary residence:

- Northeast U.S. (CT, MA, ME, NH, NJ, NY, PA, RI, VT)
- Midwest U.S. (IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI)
- Southern U.S. (AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)
- Western/Pacific U.S. (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY)
- U.S. Territory (e.g., Guam, Puerto Rico, U.S. Virgin Islands)
- Outside the United States and its territories

6. Please indicate the highest degree level you've completed thus far in counseling or counseling psychology:

- Master's degree
- Doctoral degree
- None
- Other (Please specify)

7. Please indicate the type of program from which you earned your highest degree thus far in counseling or counseling psychology:

- Counseling Psychology
- Career Counseling
- College Counseling
- Community Counseling
- Counselor Education & Supervision
- Gerontological Counseling
- Marital, Couple, and Family Counseling/Therapy
- Mental Health Counseling
- School Counseling
- Student Affairs
- Other (Please specify)

8. Please indicate if you are currently enrolled in a doctoral program in:

- Counselor Education & Supervision
- Counseling Psychology
- I am not currently enrolled in a doctoral program
- Other (Please specify)

9. Approximately how many total years of experience providing counseling have you had, including practica, externships, internships, employment, etc.? (Please enter the number of years in digits, rather than words)

10. Please indicate whether you've completed training in the use of the Global Assessment of Functioning (GAF) Scale (i.e., the scale used as Axis V of the multiaxial diagnostic system described in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR)

- Yes, I have completed training in the use of the GAF scale.
- No, I have not completed training in the use of the GAF scale

Appendix I
Incentive Drawing Invitation

Thank you for your participation in this study.

If you would like to enter a drawing for a \$100 VISA gift card, please click “Yes” below, and then “Continue to Next Page.” Your web browser will be directed to a separate survey page where you can enter your email address. The email address will serve as your entry and as a means to contact you should you win the drawing. The winner will be selected at random within one week of the conclusion of data collection. The researcher will contact the winner by email and request a mailing address to which the gift card can be mailed. Your email address will be transmitted and saved in the same confidential and secure conditions as your survey responses, BUT will be saved separately from your other responses and will not be linked to them in any way.

If you do not wish to participate in the drawing, please click "No" below, then “Continue to Next Page,” or simply close your web browser or otherwise navigate away from this webpage. Thank you again for your participation in this study.

Would you like to enter a drawing for a \$100 VISA gift card?

- Yes
- No

Appendix J
Incentive Drawing Entry Form

Incentive Drawing

Thank you for your participation in this research project.

If you would like to enter a drawing for a \$100 VISA gift card, please carefully type your email address in the text box below and then click on "Continue to Next Page." Your email address will be kept confidential and will not be linked to your survey responses in any way.

Appendix K
Survey Conclusion Text

Thank you for your participation.

For maximum confidentiality: Close this browser.

Appendix L

Human Subjects Institutional Review Board Approval Letter

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: January 20, 2010

To: Kelly McDonnell, Principal Investigator
Emily Nisley, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair *Amy Naugle*

Re: HSIRB Project Number: 09-12-09

This letter will serve as confirmation that your research project titled "Counseling Professionals' Clinical Impressions and Attitudes Regarding Gender" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 20, 2011

Appendix M

Permission to Use the Adjective Check List

For use by Emily Nisley only. Received from Mind Garden, Inc. on January 26, 2010

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: *The Adjective Checklist*

Author: *Harrison G. Gough*

Copyright: *1965, 1980, 1983, 1984, 2006, 2007 by CPP, Inc.*

for his/her thesis research.

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com