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The Insidious Effects of Sexual Stereotypes in Clinical Practice

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The present study investigated the influence of sexual stereotyping on the diagnostic impressions and treatment expectations of gay and straight male patients. Italian male, straight, licensed psychotherapists (N = 152) were presented with clinical vignettes that described a gay (versus straight) male patient reporting either a straight-stereotypical disorder (i.e., rage dyscontrol) or a gay-stereotypical disorder (i.e., sexual compulsivity). Results revealed that treatment efficacy expectations were influenced by the patient's sexual orientation and the stereotypicality of the disorder. Specifically, psychotherapists anticipated fewer benefits from psychotherapy when gay patients reported a sexual disorder rather than a rage disorder. Furthermore, explicit and implicit levels of sexual prejudice did not play any role in driving such results. Taken together, these findings reveal that sexual stereotyping might exert its subtle effects among clinicians by influencing their clinical evaluations.

When we are immersed in the social context, social categorization—the automatic ability to sort different persons into meaningful groups and categories (Fiske, Haslam, & Fiske, 1991; Fiske & Taylor, 1991; Taylor, Fiske, Etcoff, & Ruderman, 1978)—helps us cope with the overwhelming complexity of our milieu and drives our social judgments. Thus, people spontaneously partition their social world into discrete and internally homogeneous units based on criteria such as gender, age, ethnicity, religion, profession, and sexual orientation. Moreover, these social categories are strictly associated with typical attributes (i.e., stereotypes; Hamilton & Sherman, 1996) that concern personal characteristics, values, knowledge, and behaviors. Because social categorization and stereotyping are automatic and involuntary cognitive processes (e.g., Taylor et al., 1978), psychotherapists and counselors might not be immune to their effects. Based on such sociocognitive literature, the present research aimed at exploring the consequences of social categorization based on sexual orientation and sexual stereotyping on diagnostic impressions and treatment expectations among male licensed psychotherapists treating fictitious gay (versus straight) male patients.

Sexual Stereotypes Among Clinicians

In the past decade, a growing body of research has investigated attitudes toward lesbian, gay, transgender, and bisexual (LGTB) individuals in large samples of psychotherapists and related them to demographic characteristics (e.g., age, gender),

educational background, theoretical models, and psychoanalytic society memberships (for a review, see Boysen, 2009). For example, an Italian study revealed that both educational and theoretical backgrounds influence analysts' attitudes toward sexual minorities more so than demographic characteristics (Lingiardi & Capozzi, 2004). In particular, having a medical degree as opposed to having a degree in psychology, and being a member of the International Psychoanalytical Association as opposed to being Jungian, were associated with higher levels of sexual prejudice.

In line with these findings, a second set of studies has more directly investigated the effects of sexual prejudice in everyday clinical practice (e.g., Barrett & McWhirter, 2002; Biaggio, Roades, Staffelbach, Cardinali, & Duffy, 2000; Bowers & Bieschke, 2005; Eubanks-Carter & Goldfried, 2006). However, the results of these studies have been mixed. In a review, Boysen (2009) concluded that, overall, explicit prejudice appears to be uncommon among counselors and psychotherapists, even if it might exert an influence on clinical impressions. For example, in the study by Bowers and Bieschke (2005), female psychologists (who reported low levels of sexual prejudice) were found to have more positive attitudes toward and treatment expectations for lesbian, gay, and bisexual (LGB) clients than did male psychologists (who reported higher levels of sexual prejudice than female psychologists). More specifically, male psychologists rated LGB clients to be more pathological and more threatening to others (i.e., more likely to harm someone) than heterosexual clients. Eubanks-Carter and Goldfried (2006) found that only male clients, when they were perceived as likely to be gay or bisexual or when they presented with partners of an unspecified gender, were more likely to be diagnosed with borderline personality disorder.

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However, other studies found that, when compared to straight patients, lesbian and gay male patients were assessed as exhibiting higher levels of functioning in relationships and higher degrees of motivation for therapy (Boysen, 2009). Moreover, these patients were given more positive prognoses, were awarded more respect, and were less likely to be described by negative adjectives. As a case in point, in a study by Biaggio and colleagues (2000), patient gender and sexual orientation had no effect on the clinician's diagnosis of depression, although gay and lesbian patients were evaluated as being more motivated to engage in therapy and in greater need of medication. Taken together, all these findings suggest that patients' sexual orientation is likely to influence clinical evaluation and practice (Boysen, 2009).

Importantly, most of these studies considered the influence of sexual prejudice, overlooking the role played by stereotypes that follow social categorization in driving clinical practice. However, research has shown that sexual stereotypes and sexual prejudice are two distinct constructs that might operate differently (for a review, see Herek & McLemore, 2013). Indeed, it has been shown that people (including mental health professionals) ascribe stereotypes to social targets based on their sexual orientation; as such, people believe that gay men and lesbians possess characteristics of the opposite sex and that they are mentally ill or perverted (Boysen, Fisher, DeJesus, Vogel, & Madon, 2011; Boysen, Vogel, Madon, & Wester, 2006; Burke & LaFrance, 2016; Eubanks-Carter & Goldfried, 2006; Mohr, Chopp, & Wong, 2013). Stereotypes are fixed and overgeneralized beliefs about people fostered by their membership in a particular social category (for a review, see Hilton & von Hippel, 1996). Previous research has widely demonstrated that trait concepts and stereotypes, which are generally shared within a community and stable over time, are automatically activated in the presence of relevant behavior or stereotyped-group features (Devine, 1989; Devine & Elliot, 1995; Macrae & Bodenhausen, 2000). Given their pervasiveness, most people internalize stereotypes in the course of normal socialization. Consequently, stereotypes may exert their effects on social perception and elicit stereotype-consistent behavioral responses whenever the social category becomes salient, independent of the individual's values and personal levels of prejudice toward that social group (Devine, 1989; Devine & Elliot, 1995; Macrae & Bodenhausen, 2000). In other words, extensive research revealed that stereotypes and prejudice are dissociable constructs that do not necessarily covary. Hence, as revealed by prior studies, stereotyping may be equally active in social perceivers with high and low levels of prejudice (for a review, see Macrae & Bodenhausen, 2000). As members of a wider society, clinicians do not represent an exception (Boysen et al., 2011; Boysen et al., 2006; Burke & LaFrance, 2016; Mohr et al., 2013).

The Present Research

The present study sought to extend the prior research in two ways. First, from a clinical psychology perspective, it aimed to

explore the effects of sexual stereotypes during the clinical evaluation of both nonheterosexual and heterosexual patients, moving beyond the overall and undifferentiated influence of sexual prejudice. Second, from a social psychology perspective, the study aimed to determine whether stereotypes and cognitive schemata associated with nonheterosexual (versus heterosexual) individuals include not only traits and behaviors but also specific psychosocial difficulties and symptoms.

Our main hypothesis was that psychotherapists might be affected by a patient's sexual orientation while forming diagnostic impressions and treatment expectations, which is consistent with prior research evidence (Boysen, 2009). However, we expected patients' sexual orientation to have different effects on clinical evaluations depending on the stereotypicality of their symptoms and/or mental disorders. More specifically, we hypothesized that information on sexual orientation influences practitioners only when the symptoms referred by the patient fit the symptoms included in the sexual stereotype. This hypothesis would be consistent with the robust line of research in social psychology (Hilton & Von Hippel, 1996) that shows that as soon as a social category (i.e., the sexual category in this case) is activated, the social stereotypes become cognitively salient, driving the impression-formation process and the subsequent judgment on the social target, even independently from the perceiver's level of prejudice (Devine, 1989). The social labels by themselves are likely to create expectancy that may alter the impact of evidence on other people's dispositions, capabilities, and behaviors (Darley & Gross, 1983).

To test this, we manipulated the sexual orientation (straight versus gay) and the type of psychological disorder of a fictitious male patient. More specifically, based on the literature (Levitt & Klassen, 1974; Madon, 1997) and on a preliminary study described in the following section, we considered rage dyscontrol and sexual compulsivity as types of impulse-control disorders stereotypically associated with straight men and gay men, respectively. Diagnostic impressions and treatment expectations were then assessed, as were the explicit and implicit levels of prejudice toward sexual minorities.

The present research was conducted in Italy, a country that is well behind in its recognition of fundamental civil rights for lesbians, gay men, and other sexual minorities (Worthen, Lingardi, & Caristo, 2016). Importantly, the attitude toward sexual minorities in Italy has been dominated by ambivalence, switching between pathologization (i.e., considering it a deviation from normal psychosexual development) and tolerance (Worthen et al., 2016). Against this background, Italian psychotherapists seem to be an interesting sample for the study of sexual stereotypes.

Preliminary Studies

To ensure that the clinical vignettes we used in the main study were comparable in terms of severity and that they were perceived as two examples of the same diagnostic category, we conducted a pretest. Thus, 15 expert

heterosexual clinicians were asked to read a clinical vignette describing a male patient affected by either rage dyscontrol or sexual compulsivity. Clinicians were asked to answer questions regarding the patient's severity using a Likert scale ranging from 1 (*Not at all severe*) to 10 (*Extremely severe*). Then, participants assigned a Global Assessment of Functioning (GAF) score to the patient. The GAF consists of nine behavioral descriptors ranging from "Absent or minimal symptoms (e.g., mild anxiety before an exam) [...] no more than everyday problems" to "Persistent danger of severely hurting self or others [...] or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death" (APA Task Force, 2009). Patients were rated between 0 (*Most severe*) and 100 (*Least severe*), with each descriptor having a 9-point range. The GAF has shown good interrater reliability in studies involving mental health professionals (with different educational backgrounds) rating written clinical vignettes (Söderberg, Tungström, & Armelius, 2005).

Clinicians were further asked to indicate whether the clinical scenario was plausible on a scale ranging from 1 (*Not at all plausible*) to 7 (*Extremely plausible*). Finally, they indicated the diagnostic category of the disorder described in the vignette by selecting one diagnostic category among six different diagnostic categories (i.e., personality disorder, anxiety disorder, impulse control disorder, depressive disorder, psychotic disorder, dissociative disorder).

Results showed that the rage dyscontrol scenario ($M = 6.57$, $SD = 1.27$) and the sexual compulsivity scenario ($M = 6.28$, $SD = 1.38$) did not differ in terms of severity as measured by a single item on a Likert scale, $t(12) = .40$, $p = .69$. Similar findings emerged when severity was measured in terms of the GAF score, $t(12) = .46$, $p = .65$. Moreover, the rage dyscontrol scenario ($M = 6.25$, $SD = 1.75$) and the sexual compulsivity scenario ($M = 5.43$, $SD = 2.76$) were perceived as equally plausible, $t(12) = .70$, $p = .50$. Finally, both scenarios were perceived as referring to impulse-control disorders, $\chi^2(2) = 1.38$, $p = .50$. Thus, as intended, the two scenarios were comparable in terms of plausibility, severity, and diagnostic categorization.

Next, we tested the stereotypicality of the disorders (i.e., rage dyscontrol and sexual compulsivity) in relation to the two social categories (i.e., straight male patients; gay men patients). Hence, we asked a sample of 94 master's-level students enrolled in an advanced course in clinical psychology at the University of Milan-Bicocca to complete a brief questionnaire. Ten participants were excluded because they reported not being heterosexual; thus, the final sample comprised 84 participants (age: $M = 24.92$, $SD = 5.88$). Master's students were recruited because prior studies showed that college students and therapist trainees endorsed the same mental health stereotypes in terms of content and strength about gay men (Boysen et al., 2006). Half of the sample ($n = 43$) were asked to imagine a male straight patient; the other half ($n = 41$) were asked to think about a male gay patient. Participants were randomly assigned to one of the two conditions. Then, they had to estimate how likely a rage dyscontrol disorder and a sexual compulsive disorder could affect

that patient. Participants answered the questions on a 7-point scale ranging from 1 (*Very unlikely*) to 7 (*Very likely*). Next, a 2 (clinical condition: rage dyscontrol versus sexual compulsivity) \times 2 (patient's sexual orientation: straight versus gay) analysis of variance (ANOVA) was carried out. The analysis showed a significant interaction effect between clinical condition and patient's sexual orientation, $F(1, 82) = 15.28$, $p < .001$, $\eta_p^2 = .16$. In line with our assumptions, as revealed by the post hoc test (least significant difference [LSD] test), male straight patients were perceived as more likely to suffer from rage dyscontrol ($M = 4.42$, $SD = 1.42$) than from sexual compulsivity ($M = 3.84$, $SD = 1.45$), $p = .004$; by contrast, male gay patients were perceived as more likely to suffer from sexual compulsivity ($M = 4.07$, $SD = 1.03$) than from rage dyscontrol ($M = 3.56$, $SD = 1.12$), $p = .01$. The ANOVA did not yield the main effect of clinical condition, $F(1, 82) = .06$, $p = .80$, and of patient's sexual orientation, $F(1, 82) = 1.68$, $p = .20$. Therefore, in line with our assumptions, the results supported the idea that straight male individuals are perceived more likely to suffer from rage dyscontrol than from sexual compulsivity, whereas gay male individuals from sexual compulsivity than from rage dyscontrol.

Method

Participants

An a priori power analysis was conducted for sample size estimation using G*Power 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007). The power analysis (alpha = .05, power = .80, medium effect size = .25) suggested a sample size of approximately $N = 128$ for a between-participants ANOVA with four groups. Thus, a total of 152 heterosexual, male, licensed psychotherapists aged 29 to 71 years ($M = 46.04$; $SD = 11.26$) participated in the experiment. To avoid the large effects of respondents' gender and sexual orientation observed in previous studies (e.g., Steffens & Wagner, 2004), female and nonheterosexual psychotherapists were excluded from the study. All participants were White Italian citizens. The sample characteristics are reported in Table 1.

This study was approved by the ethics committee at the University of Milan-Bicocca in accordance with the Helsinki Declaration and the Oviedo Convention.

Measures and Procedure

Psychotherapists were voluntarily recruited through an online survey administered via SurveyMonkey and advertised by contacting the boards of psychologists and psychiatrists throughout the country.

Following completion of informed consent, participants were asked about their sexual orientation using the Heterosexual–Homosexual Kinsey Rating Scale (Kinsey, Pomeroy, & Martin, 1948). Nonexclusive heterosexual psychotherapists were excluded from the survey.

Table 1. *Sample Characteristics* (N = 152)

Characteristics	Percentage	M	SD
Geographical distribution			
Northern Italy	83.6		
Central Italy	11.1		
Southern Italy	5.3		
Political orientation			
Left	44.1		
Central left	28.3		
Center	4.6		
Central right	7.9		
Right	3.9		
Apolitical	11.2		
Religion			
Believers	9.9		
Nonpracticing believers	23		
Nonbelievers	67.1		
Educational background			
Degree in psychology	68.4		
Degree in medicine	30.3		
Other degree	1.3		
Theoretical orientation			
Psychodynamic/analytic	45		
Cognitive/cognitive-behavioral	14		
Systemic	14		
Eclectic	11		
Client centered	7		
Others	12		
Clinical experience			
Years in clinical practice		13.03	11.30
Hours of clinical practice per week		22.44	12.73
Prejudice			
ATG scale (explicit prejudice)		2.25	.89
IAT (implicit prejudice)		.64 (D score)	.56
Age (range: 29–71)		46.04	11.26

Note. ATG = Attitudes Toward Gay Men (response scale: 1 = *Totally disagree* to 7 = *Totally agree*). IAT = Implicit Association Test (high levels of D score indicate high levels of prejudice).

Participants included in the sample were asked to read a clinical vignette and form a clinical impression of the patient described in the scenario. The vignette was a case description of a 42-year-old employee with a stable romantic relationship who exhibited impulse-control disorder symptomatology (for the full text of the manipulations, see the Appendix). Participants read one of four versions of this vignette, which was approximately 35 lines and varied by the patient's sexual orientation (straight versus gay) and by symptoms (rage dyscontrol versus sexual compulsivity). Given that we aimed at describing a patient whose symptoms were unrelated to a sexual identity crisis, the patient's sexual orientation was only subtly suggested by the gender of the patient's romantic partners (male versus female).

We used a 2 (patient's sexual orientation: straight versus gay) × 2 (clinical condition: stereotypical of straight men versus stereotypical of gay men) between-participants design. As such, the stereotypical-straight clinical case corresponded to rage dyscontrol, and the stereotypical-gay clinical case corresponded to sexual compulsivity.

Participants were randomly exposed to one of the four experimental conditions.

After reading the vignette, to assess the diagnostic impression, participants were asked to rate the psychopathological severity of the patient using a 10-point scale ranging from 1 (*Not at all severe*) to 10 (*Extremely severe*). Psychopathology severity was further measured by rating the patient's current level of overall functioning by using the GAF score. Thus, as in the preliminary study, patients were rated between 0 (*Most severe*) and 100 (*Least severe*), with each descriptor having a 9-point range.

Next, participants were asked to indicate the relevance of the information regarding the patient's sexual orientation to define the diagnostic impression using a 7-point scale ranging from 1 (*Totally irrelevant*) to 7 (*Extremely relevant*). Then, participants were asked to report the extent to which the disorder described in the vignette was likely to be classified in six different diagnostic categories (i.e., personality disorder, anxiety disorder, impulse-control disorder, depressive disorder, psychotic disorder, dissociative disorder), using a 7-point scale ranging from 1 (*Very unlikely*) to 7 (*Very likely*). Moreover, to explore the effect of the manipulation on treatment expectations, participants were asked to estimate how likely psychotherapy could be effective for the patient described in the vignette by measuring the patient's amenability to psychotherapy on a 10-point scale ranging from 1 (*Minimum amenability*) to 10 (*Maximum amenability*).

Given that prior research has shown that sexual prejudice impacts clinical evaluations of nonheterosexual patients (Boysen, 2009), we tested whether the hypothesized effects were moderated by the levels of participants' sexual prejudice. Thus, participants reported their prejudice toward gay men on a 10-item Attitudes Toward Gay Men (ATG) scale developed by Herek (1988; e.g., "Male homosexuality is disgusting"; Cronbach's alpha = .77) using a 7-point scale ranging from 1 (*I totally disagree*) to 7 (*I totally agree*). Participants were then asked about their sociodemographic data (age, gender, nationality), their professional experiences (e.g., degree, theoretical orientation, type of practice, time of practice, number of years in clinical practice), and their political orientation (on 5-point scale ranging from *Extreme left* to *Extreme right*) and their religious orientations (on 3-point scale listing *Believer*, *Nonpracticing believer*, and *Nonbeliever*). At the end of this first phase, participants were presented with an implicit measure of prejudice toward gay men, namely, a gay-straight Implicit Association Test (IAT) administered via computer using the Inquisit web program (Costa, Bandeira, & Nardi, 2013). The IAT (Greenwald, McGhee, & Schwartz, 1998) measures the relative strength of the association between pairs of concepts by comparing response times. Thus, the core of the method is a timed semantic discrimination task. Participants were presented with a target stimulus (pictures

of gay or straight partners) in the center of the computer screen and instructed to classify it into one of two categories (e.g., straight versus gay) by pressing, as quickly as possible, the designated response keys on the keyboard. It is possible to assess implicit attitudes toward homosexuality and heterosexuality by combining the target concept discrimination task with an attribute discrimination task (i.e., *Pleasant/Unpleasant*). Individuals with implicit prejudice against gay men should react more slowly when pictures of gay men and pleasant attributes share the same response key compared to the reverse configuration (*Gay + Unpleasant*). The response time difference, or the IAT effect, essentially constitutes an estimate of the strength of the subject's implicit attitude. Stimuli used in the current study were six positive words (e.g., *happiness, paradise*), six negative words (e.g., *disaster, pain*), five photographic images of two men engaged in an embrace or romantic pose, and five photographic images of a man and a woman engaged in an embrace or romantic pose (for validity and reliability of the IAT toward homosexuality, see Banse, Seise, & Zerbes, 2001). At the end, participants were thanked and debriefed.

Results

Preliminary Analysis

As revealed by the first pretest, the symptoms described in the clinical scenarios proved to belong to the same diagnostic category. To ascertain that the vignettes describing rage dyscontrol and sexual compulsivity were perceived as homogeneous also in the main experiment, the participants, assigned to one of the four experimental conditions, were asked to rate on a 7-point scale the extent to which the disorder was likely to be classified in six different diagnostic categories (i.e., personality disorder, anxiety disorder, impulse-control disorder, depressive disorder, psychotic disorder, dissociative disorder). A 2 (patient's sexual orientation: straight versus gay) \times 2 (clinical condition: stereotypical of straight men versus stereotypical of gay men) \times 6 (type of disorder: personality, anxiety, impulse control, depressive, psychotic, dissociative disorder) ANOVA was carried out, with the first two factors varied between participants and the last one varied within participants. The analysis yielded only a main effect of type of disorder, $F(1, 148) = 333.62, p < .001, \eta_p^2 = .70$, revealing that the clinical vignettes were more often ascribed to impulse-control disorders ($M = 5.62, SD = .12$) than to personality disorders ($M = 4.36, SD = .16$), anxiety ($M = 3.17, SD = .14$), depression ($M = 3.09, SD = .14$), psychosis ($M = 1.63, SD = .09$), or dissociative disorder ($M = 2.75, SD = .15$). Crucially, the ANOVA did not show any other effects, $F_s(1, 148) = 2.37, p_s > .12, \eta_p^2 < .016$. Thus, this finding suggested that the clinical vignettes were properly balanced for type of disorder and allowed us to exclude alternative explanations for the main findings.

Exploring descriptive analyses on sample characteristics (see Table 1), it is noteworthy that, although measures of implicit and explicit prejudice proved to be positively correlated ($r = .36; p < .001$), the average score of explicit prejudice measured with the ATG scale was quite low ($M = 2.25; SD = .89$), whereas the score of implicit prejudice (D score of the IAT; Greenwald, Nosek, & Banaji, 2003) suggested high prejudice among our participants ($M = .64; SD = .56$). As such, according to Nosek, Greenwald, and Banaji's (2005) analysis, an IAT index (i.e., D score) greater than .65 would indicate a strong association between gay men and unpleasant concepts. Moreover, the correlation analysis revealed a positive relationship between religiosity ($M = 1.87; SD = .56$) and ATG ($r = .26; p < .001$), and between political orientation ($M = 1.87; SD = 1.14$) and ATG ($r = .30; p < .001$). Therefore, in line with prior research evidence (Hebl, Law, & King, 2010), right-wing political orientation and religiosity are associated with a higher level of prejudice toward nonheterosexual people.

The Influence of Categorization and Stereotypicality on Diagnosis

We submitted the psychopathological severity of the patient scores measured by the Likert scale to a 2 (patient's sexual orientation: straight versus gay) \times 2 (clinical condition: stereotypical of straight men versus stereotypical of gay men) between-participants ANOVA. Results did not yield any significant effect. Indeed, in line with the pretest, we did not find a main effect of disorder type, $F(1, 148) = .24, p = .62$, indicating that therapists judged the rage dyscontrol scenario ($M = 6.23, SD = 1.61$) and the sexual compulsivity scenario ($M = 6.06, SD = 1.95$) as equally severe. Moreover, we found neither a main effect of the patient's sexual orientation, $F(1, 148) = 1.78, p = .19; \eta_p^2 = .01$, nor an interaction effect between the two factors, $F(1, 148) = 1.27, p = .26, \eta_p^2 = .009$. We found the same findings using the GAF score as an index of severity, all $F_s(1, 148) < 2.45, p_s > .12, \eta_p^2 < .01$. Moreover, the two measures proved to be highly correlated ($r = .51, p < .001$).

Thus, these findings seem to suggest that patients' sexual orientation and type of symptoms did not affect participants' perception of severity.

The Relevance of Patients' Sexual Orientation

To assess the impact of the patient's sexual orientation in formulating the diagnosis, a 2 (patient's sexual orientation: straight versus gay) \times 2 (clinical condition: stereotypical of straight men versus stereotypical of gay men) ANOVA was carried out on participants' judgment of the relevance of patient's sexual orientation for the purposes of the diagnosis. As shown in Figure 1, the analysis revealed a significant interaction effect between the two factors, $F(1, 148) = 6.55, p = .01, \eta_p^2 = .04$. Thus, for gay male patients, the sexual orientation of the patient was rated as a more relevant piece of

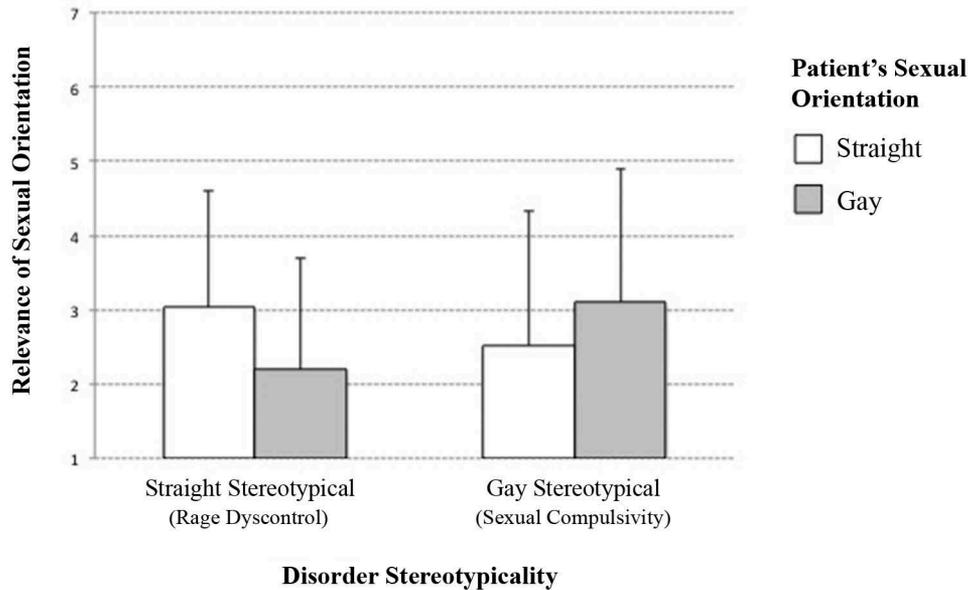


Figure 1. The relevance attributed by psychotherapists to patient's sexual orientation during the diagnostic process by sexual orientation and disorder stereotypicality.

information in the sexual compulsivity condition ($M = 3.10$; $SD = 1.80$) than in the rage dyscontrol condition ($M = 2.19$; $SD = 1.51$), $F(1, 148) = 4.96$, $p = .03$, $\eta_p^2 = .03$. By contrast, for straight patients, the sexual orientation of the patient was rated as relevant in the sexual disorder condition ($M = 2.52$; $SD = 1.79$) as in the rage control condition ($M = 3.02$; $SD = 1.57$), $F(1, 148) = 1.82$, $p = .17$, $\eta_p^2 = .01$. The ANOVA yielded neither a main effect of the sexual orientation, $F(1, 148) = .20$, $p = .65$, $\eta_p^2 = .001$, nor a main effect of the clinical case, $F(1, 148) = .54$, $p = .46$, $\eta_p^2 = .004$.

The Influence of Categorization and Stereotypicality on Treatment Expectations

Next, we submitted the participants' evaluation of the patient's amenability to psychotherapy to a 2 (patient's sexual orientation: straight versus gay) \times 2 (clinical condition: stereotypical of straight men versus stereotypical of gay men) between-participants ANOVA. As displayed by [Figure 2](#), the analysis yielded a main effect of disorder type, $F(1, 148) = 7.47$; $p = .007$; $\eta_p^2 = .05$, indicating that the rage dyscontrol scenario was rated as more

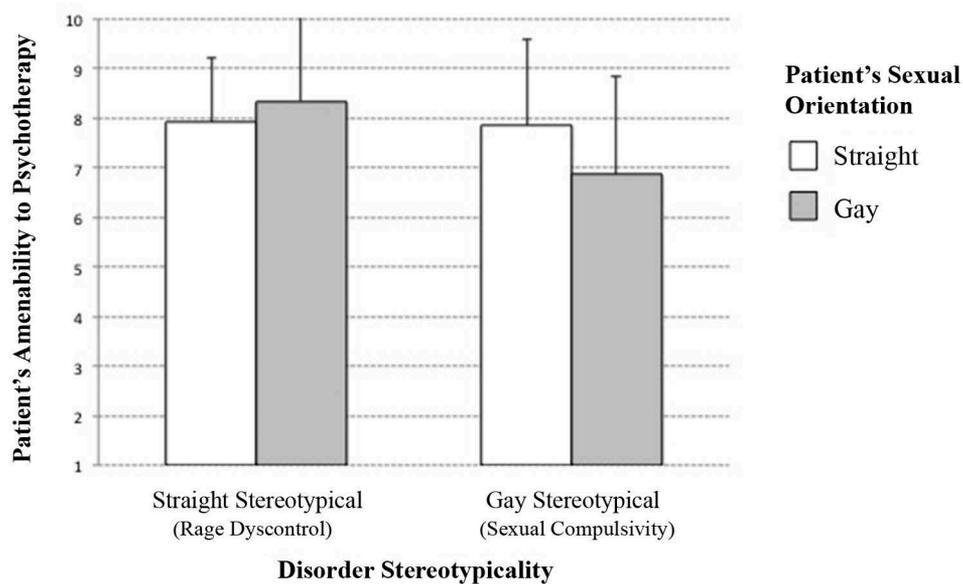


Figure 2. Psychotherapists' judgment on patient's amenability to psychotherapy by patient's sexual orientation and disorder stereotypicality.

amenable to psychotherapy ($M = 8.13$, $SD = 1.56$) than the sexual compulsivity scenario ($M = 7.36$, $SD = 1.88$). The analysis did not yield a main effect of sexual orientation, $F(1, 148) = 1.01$; $p = .32$; $\eta_p^2 = .007$, but revealed a significant interaction between sexual orientation and disorder type, $F(1, 148) = 6.54$; $p = .01$; $\eta_p^2 = .04$. Indeed, gay patients were judged as less amenable to psychotherapy when they were affected by a sexual disorder ($M = 6.87$; $SD = 1.96$), as compared to problems in controlling rage ($M = 8.35$; $SD = 1.84$), $F(1, 148) = 12.82$; $p = .001$; $\eta_p^2 = .08$. By contrast, straight patients affected by a sexual disorder ($M = 7.87$; $SD = 1.70$) and those affected by a rage disorder ($M = 7.91$; $SD = 1.30$) were judged equally amenable to psychotherapy, $F < 1$, $p = .90$. Furthermore, in the gay-stereotypical condition, the gay patient was rated as less amenable to psychotherapy than the straight patient suffering from the same disorder (i.e., sexual compulsivity), $F(1, 148) = 7.09$; $p = .009$; $\eta_p^2 = .04$. By contrast, such a difference did not emerge in the straight-stereotypical condition, $F(1, 148) = 1.09$; $p = .29$; $\eta_p^2 = .007$.

To test the effect of sample characteristics on this interaction, we computed a series of analyses using the following factors as covariates: age, geographical distribution, political orientation, religiosity, and theoretical orientation. The analyses revealed that the interaction effect remained significant when introducing as covariates age, $F(1, 147) = 8.39$, $p = .004$, $\eta_p^2 = .05$, geographical distribution, $F(1, 147) = 6.70$, $p = .01$, $\eta_p^2 = .04$, political orientation, $F(1, 147) = 6.50$, $p = .01$, $\eta_p^2 = .04$, religiosity, $F(1, 147) = 6.10$, $p = .01$, $\eta_p^2 = .04$, and theoretical orientation (i.e., psychodynamic/analytic versus others), $F(1, 147) = 6.23$, $p = .01$, $\eta_p^2 = .04$. None of these variables had a main effect on patient's amenability to psychotherapy, $F_s(1, 147) < 1.27$, $ps > .26$. The only exception was age, $F(1, 147) = 6.54$, $p = .01$, $\eta_p^2 = .04$. The older the therapists were, the more pessimistic they were about the patient's amenability, independently from the experimental condition. Furthermore, we recomputed the analyses on the judgment of the patient's psychopathological severity using the same covariates. The interaction effect between patient's sexual orientation and clinical condition continued to be nonsignificant, $F_s(1, 147) < 2.17$, $ps > .14$.

The Influence of Prejudice

Finally, we tested whether participants' prejudice played any role in leading to the effects we found. To this aim, a moderated moderation model (i.e., a three-way interaction) was explored using PROCESS macro (Hayes, 2013; Model 3, 5,000 bootstrap resampling) with the patient's sexual orientation as a dummy independent variable, type of disorder as first dummy moderator, level of explicit prejudice (ATG) as second continuous moderator, and amenability evaluation as dependent variable. The model did not show a significant interaction effect ($B = .66$, $SE = .66$, $t = .99$, $p = .32$, 95% CI = $[-.66, 1.98]$). Finally, we tested the moderation of implicit prejudice assessed through the IAT (because some participants skipped this second part of the

survey, this analysis comprises 92 participants): consistent with the analysis on explicit prejudice, results did not reveal any moderation effect of implicit prejudice ($B = .15$, $SE = 1.21$, $t = .12$, $p = .90$, 95% CI = $[-2.26, 2.56]$).

The analyses have been recomputed on the other dependent variables (relevance of sexual orientation, severity, and diagnosis). These additional models did not yield a significant interaction (all $ps = n.s.$), thus suggesting that psychotherapists' prejudice (both at explicit and implicit level) did not influence the findings.

General Discussion

As suggested by the sociocognitive literature, the social categorization process and stereotyping are likely to influence the formation of initial impressions and the following inferential process (Fiske & Neuberg, 1990; Hamilton & Sherman, 1996). Stereotype is generally conceived as a set of characteristics and behaviors that is typical of a certain social group (Taylor et al., 1978). However, the cognitive schemata related to social categories may also include specific symptoms and mental disorders, an aspect that has been largely neglected by prior research. Thus, in the present study, we explored whether the social categorization process based on the patient's sexual orientation (i.e., heterosexual versus nonheterosexual) is likely to affect the clinical evaluation and treatment expectations about stereotype-(in)consistent symptoms.

In line with the hypothesis, the findings suggest that sexual orientation and the stereotypicality of the symptoms interact with the clinical evaluation and, precisely, with the treatment expectations. Thus, psychotherapy was judged to be more effective for a gay patient presenting heterosexual-stereotypical disorders (i.e., rage dyscontrol) rather than gay-stereotypical disorders (i.e., sexual compulsivity). Moreover, clinicians explicitly affirmed this information to be relevant to obtain a case formulation. More precisely, sexual orientation was considered a relevant cue to understand sexual compulsivity when treating a gay patient.

Overall, these data suggest that social stereotypes may play a key role in the clinical process. As revealed by prior research (Boysen et al., 2011; Boysen et al., 2006) and by our preliminary study, people, including psychotherapists, activate stereotyped cognitive schemata that are likely to drive their social perceptions and expectations when exposed to heterosexual and nonheterosexual persons. Moreover, in addition to personality traits and behaviors, these stereotypes may comprise information regarding symptoms, typical diseases, and psychological difficulties (Boysen et al., 2006; Burke & LaFrance, 2016). Accordingly, our findings suggest that the subtle effects of sexual orientation arise when the patient's mental health difficulties concern stereotypical disorders rather than psychological problems in general.

One might argue that the differences between gay and straight men regarding sexual compulsivity are real rather than perceived and that clinicians are simply accurate in

defining patients' amenability to psychotherapy. However, a recent study investigating the actual relationship between sexual orientation and sexual compulsivity (Weinstein, Katz, Eberhardt, Cohen, & Lejoyeux, 2015) did not show concrete differences in sexual compulsivity between gay men and straight men. Data suggested that the divergence in sexual control between the two categories represents a social stereotype rather than being real.

These effects may be relevant in clinical practice if we consider that when people and psychotherapists are exposed to social categories, stereotypes activate quickly, unintentionally, and outside of conscious awareness, and they can operate independent of the individual's attitudes or values (Bargh, 1999; Devine, 1989; Devine & Elliot, 1995). Consistent with this assumption, in the present study, the effects of stereotype on treatment expectations have not been moderated by the psychotherapist's religiosity, political orientation, or level of sexual prejudice. It is further noted that not even implicit sexual prejudice, neglected by previous research (Boysen, 2009) and assessed through the IAT, influences this process. Thus, our findings can be explained by the activation of automatic cognitive schemata broadly shared within a large cultural context and triggered by stereotype-related features in the immediate social environment, such as group membership, rather than being explained in terms of individual attitudes (Bargh & Williams, 2006). In other words, the effects of social categorization and stereotyping observed in the present study are inherent to the cognitive process and are not related to the perceiver's hostility, affective reactions, and discrimination toward sexual minorities.

It is important to underline that critical evidence in the present set of findings concerns expectations for treatment efficacy. As presented herein, the data suggest that psychotherapists anticipate a higher efficacy of psychotherapy and amenability for gay patients suffering rage dyscontrol rather than sexual compulsivity. However, the results did not reveal any significant influence of the patient's sexual orientation on other critical measures, such as the diagnostic impression and the severity ratings. Some aspects of the tasks might account for these differential effects. Because judgment on the diagnosis and judgment on the patient's amenability are two different phases of the clinical evaluation, it is possible that stereotype activation has distinctive effects on the two processes. In particular, diagnosis is centered on the present and on the actual patient's condition, whereas treatment expectations and amenability are focused on the future and on the future changes. As prior research shows, stereotypes are more likely to exert their influence on impression formation and on judgments with certain levels of ambiguity (Gaertner & Dovidio, 1977). As such, treatment expectations might be perceived as more subjected to ambiguity and interpretations than other clinical evaluations. Moreover, in contrast to our expectations, the effects we found were more pronounced for the gay patient than for the straight patient. A cognitive tendency might justify these results. Cognitive research has long noted that individuals tend to unduly overestimate the correlation and association of rare, salient, and

distinctive stimuli (e.g., Hamilton & Gifford, 1976; McConnell, Sherman, & Hamilton, 1994). Starting from the heterosexist worldview that all people in society are heterosexual, to be a gay man would be a first deviation from the default assumption; to present psychological symptoms would be a second deviance from normality. Thus, according to the distinctiveness-based approach, these two cues are likely to be strongly associated during the impression formation process and influence the clinical evaluation. Because heterosexuality is less rare, it would be less cognitively salient and less influential on social judgment.

Although the findings in the present research are intriguing and potentially relevant from both a theoretical and an applied perspective, some limitations should be acknowledged. First, further studies are needed to introduce to the experimental procedure adequate measures to directly test possible underlying mechanisms and to explore consequences on the psychotherapists' behavioral reactions. Moreover, we exclusively focused on gay male patients as perceived by male straight psychotherapists. Psychologists who are LGB themselves may have views about sexual orientation or attitudes toward LGBs or heterosexual clients that are informed by their unique personal experiences as members of a sexual minority. Moreover, stereotypes about sexual orientation vary widely among different cultural groups. Future research should explore the effect of symptom stereotypicality on diagnostic impressions of other sexual minorities, such as lesbians, bisexuals, and transgender people, as well as considering female psychotherapists. As such, prior research has shown that heterosexual women display more positive attitudes toward gay men compared to straight men (for a review, see Kite & Whitley, 1996). In line with these findings, female psychologists report more positive treatment expectations for LGB clients than male psychologists (Bowers & Bieschke, 2005). However, some other studies reported that straight men have higher levels of sexual prejudice than straight women, even if they share the same level of sexual stereotyping (LaMar & Kite, 1998). Thus, an intriguing avenue for future research would be to test the influence of sexual stereotyping on treatment expectations of gay patients considering both male and female psychotherapists.

It is worthy to note that this study, which explicitly analyzed the effect of stereotype consistency of symptoms (for gay patients but also for straight ones), paves the way for future experiments on the role of stereotypes in clinical practice with different social categories, including women and ethnic groups. Finally, as we highlighted in the introduction, the present study was conducted in Italy. Therefore, further research should test our assumptions cross-culturally.

As they stand, our results might have relevant implications for clinical practice. The influence of social categorization and stereotyping on expectations about a patient's amenability to psychotherapy may have significant consequences in the clinical setting on the efforts that mental health professionals are willing to invest in the therapeutic enterprise; for example, it could discourage psychotherapists or induce them to deal only with aspects perceived as mutable and amenable.

Moreover, it would be essential that psychologists become aware of the potential influence of sexual stereotyping during each phase of the treatment and be able to recognize the cognitive processes elicited by heterosexual persons or by nonheterosexual minorities (Rutherford, McIntyre, Daley, & Ross, 2012), as well as toward other salient social categories. Indeed, the understanding of these processes would be a first step toward the prevention of their potential adverse effects.

Our results support the need for psychologists to develop and strengthen their ability to self-reflect on their representations of social categories, as awareness may represent a preliminary step that paves the way to increasing knowledge and skills (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). Self-exploration is essential for psychologists to reach a more thorough understanding of their beliefs, attitudes, and values regarding gender, gender-role expectations, and sexual orientation issues. The self-exploration process must include an examination of stereotypes, their origins, their meanings, and their potential consequences (Morrow, 2000). Given the complexity of these issues, psychologists should ground the self-examination process within a broader context that includes a reflection on numerous facets of their identities, such as the influence of their ethnicity, race, and professional responsibilities (e.g., religious beliefs with requirements to provide competent treatment).

It is important to underline that in the heterosexist cultural context (Herek, 2007; Herek, Gillis, & Cogan, 2009; Herek & McLemore, 2013), sexual minorities are subjected to chronic stress related to their everyday interactions and exposure to social stigma (Meyer, 2003; Meyer & Frost, 2013). As a consequence, nonheterosexual individuals have a higher prevalence of mental disorders, deliberate self-harm, and suicide than do heterosexuals (King et al., 2008; Meyer, 2003). Therefore, mental health services could provide essential psychological support to LGB people and be an important resource for minority group members who must cope with minority stress in addition to their personal difficulties. For this reason, a broad investigation of how sexual stereotypes affect clinical practice may have important clinical and social implications. Furthermore, consultation, continuing education, and supervision may also prove to be useful resources for psychologists to continue to explore how stereotypes may affect psychological assessment and the treatment of all clients (Bowers & Bieschke, 2005).

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Appendix: Clinical Vignettes

Rage Dyscontrol (Stereotypical of Heterosexuals)

Mr P., a 42-year-old clerk, comes in for the interview upon his girlfriend's (versus boyfriend's) insistence; the woman (versus the man), a 32-year-old shop assistant, claims she (versus he) cannot tolerate P.'s temper outbursts anymore.

The two have been together for over five years and lived together for four. Mr P. is deeply in love with his girlfriend (versus boyfriend), but he is very preoccupied with getting old, losing his liveliness, and not being able to enjoy her (versus his) love. He often feels that his girlfriend (versus boyfriend) takes his love for granted and that she (versus he) never expresses her (versus his) feelings openly.

P.'s girlfriend (versus boyfriend), who is also present at the intake interview, says that, although there are occasional fights between them, their relationship is all in all quite happy; however, she (versus he) admits that "if P. will not stop going off in that way, I will have to leave him!" The woman (versus man) explains that, occasionally, P. totally loses control to the point of "becoming somebody else."

One day, the woman (versus man) came back home later than usual from work and P. destroyed the house furniture. On another occasion, he tore to shreds all her (versus his) clothes, as he thought that she (versus he) had been spending too much money on them. Recently, annoyed by what his girlfriend (versus boyfriend) had cooked for dinner, he smashed up a whole set of plates and glasses.

Nothing the woman (versus man) can do during those episodes makes P. calm down. She (versus he) is now particularly preoccupied since these episodes are getting more and more frequent. P. has never been aggressive toward her (versus him), as he discharges his aggressiveness only on objects.

Some of these episodes occurred at work and in social situations (with friends and family).

P. can perfectly recall all the episodes his girlfriend (versus boyfriend) mentions and agrees with the account she (versus he) provides; he feels intense and genuine guilt and remorse—not to mention incredulity—for losing control to that point; however, he admits that he "cannot think clearly" during those "attacks." Generally, each episode starts with a minimal annoyance, which might appear irrelevant to an observer; quickly, P.'s rage mounts to the point that he is no longer able to manage it; then the "attack" starts, lasting a few minutes. After that, P. slowly calms down until he eventually is totally relaxed. As previously mentioned, these episodes are consistently followed by a sense of guilt.

P. is afraid that his relationship with his girlfriend (versus boyfriend) may be negatively affected by this problem, and

he is now looking for professional help to keep his impulses under control.

Neither P. nor his girlfriend (versus boyfriend) drinks alcohol or use drugs; as for physical health, no health problem whatsoever emerged in a recent checkup examination carried out by an internist.

There are no symptoms suggesting any mood disorder and, apart from the specific problem mentioned, P.'s overall functioning is good.

Sexual Compulsivity (Stereotypical of Homosexuals)

Mr P., a 42-year-old clerk, comes in for the interview upon his boyfriend's (versus girlfriend's) insistence; the man (versus the woman), a 32-year-old shop assistant, claims he (versus she) cannot tolerate P.'s infidelity anymore.

The two have been together for over five years and lived together for four. Mr P. is deeply in love with his boyfriend (versus girlfriend), but he is very preoccupied with getting old, losing his liveliness, and not being able to enjoy his (versus her) love. He often feels that his boyfriend (versus girlfriend) takes his love for granted and that he (versus she) never expresses his (versus her) feelings openly.

P.'s boyfriend (versus girlfriend), who is also present at the interview, says that, although P. frequently cheats on him (versus her), their relationship is all in all quite happy, but he (versus she) admits that "this has to stop right away."

The man explains that, occasionally, P. totally loses control to the point of "becoming somebody else." P. contacts random men living in the same city through the Internet and has sexual encounters with them. One day, his boyfriend (versus girlfriend) came home earlier than usual and found P. and an unknown man having sexual intercourse on the couch in the living room.

Another day, he (versus she) came across an e-mail on his boyfriend's computer containing details for a hookup the following day. The boyfriend (versus girlfriend) recently saw P. flirting with one of his (versus her) relatives at a wedding party.

P. recounts several other episodes in which he was not able to control himself when an attractive man (versus woman) showed interest in him. Sometimes he feels the urge to meet up with four or five new men (versus women) a week. P.'s boyfriend (versus girlfriend) is now particularly preoccupied since these episodes are getting more and more frequent.

P. can perfectly recall all the episodes his boyfriend (versus girlfriend) mentions and agrees with the account he (versus she) provides; he feels intense and genuine guilt and remorse—not to mention incredulity—for losing control to the point of having sexual intercourse with random men (versus women) in public places where they could easily be seen by others; however, he admits that he "cannot think clearly" during those "attacks."

In the days immediately preceding these episodes, P. can feel an intense sexual urge mounting up; this makes him “confused” and he can only calm down when the urge is fulfilled through sexual intercourse. P. is afraid that the relationship with his boyfriend (versus girlfriend) may be negatively affected by this problem, and he is now looking for professional help to keep his impulses under control.

Neither P. nor his boyfriend (versus girlfriend) drinks alcohol or use drugs; as for physical health, no problem whatsoever was found in a recent checkup examination by an internist.

There are no symptoms suggesting any mood disorder and, apart from the specific problem mentioned, P.’s overall functioning is good.