SEXUAL ORIENTATION STEREOTYPY IN THE DISTORTION OF CLINICAL JUDGMENT

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ABSTRACT. It has been suggested that if a person's sexual orientation is unconventional, their nonsexual psychological problems will be construed in sexual terms to a marked degree. An experiment is described in which undergraduates read a case study of a man troubled by depression, catastrophizing, heavy drinking, and other maladaptive behaviors not obviously related to his sexuality. Half the subjects were told that the patient had had several extramarital affairs, exclusively with men; the others, affairs exclusively with women. Blind content analyses of subject responses revealed that when the man was described as having had homosexual involvements, he was more likely to receive a diagnosis of sexual deviation or have his nonsexual diagnosis justified on the basis of homosexuality, more likely to have his sexual or marital life investigated, and more likely to have his sexuality construed as important in the etiology of his nonsexual psychological problems. The authors' analogue findings confirm cautions voiced by previous researchers regarding predictable distortions to which clinicians may be susceptible in their interpretation of patient problems when homosexuality is part of the patient's past or present life-style.

The selective nature of perception is a time-honored topic in experimental psychology (Boring, 1957). A generalization deserving the label "fact" in a science where facts are less prevalent than hypotheses is that, given the same stimulus input, different people can perceive different things. The recognition of subjective factors in perception is found as well in the problem-solving literature (e.g., Luchins, 1942) and, more recently, in philosophical discussions of scientific inquiry. Thomas Kuhn (1962), in particular, has sensitized us to the often subtle influences our preconceptions have on what we, as scientists, discover. This biasing effect extends to the very definition of a datum

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and to the procedures considered legitimate for use in gathering knowledge. Kuhn's concept of paradigm is widely acknowledged to be a useful conceptual tool to help us understand the nature of scientific inquiry.

On a less lofty plain—but one perhaps more germane to everyday life—several workers have studied the effects of bias on complex, quasi-clinical problem-solving. Langer and Abelson (1974), for example, provide data that suggest that behaviorally trained therapists are influenced less by a "patient label" than are clinicians trained in psychoanalytic approaches. In a more controversial study, Rosenhan (1973) showed that even skilled clinicians can err in judging a pseudopatient to be a genuine mental patient, given the context of a mental hospital. Though Rosenhan's study has been criticized (Davison & Neale, 1978; Spitzer, 1975), it nonetheless supports the view that, at least to some extent, believing is seeing.

In two experiments on the effects of labeling bias and attitudes toward behavior modification, Woolfolk, Woolfolk, and Wilson (1977) showed that when students were shown identical videotapes of a teacher using classroom reinforcement methods, the students' evaluation of the teacher and of the lesson was affected by the label assigned to the tape. When the events on the tape were described as "humanistic education," as compared to "behavior modification," the teacher was rated significantly more favorably and the teaching method seen as more likely to promote academic learning and educational growth.

Few empirical studies have examined the nature of bias by clinicians as regards sexually variant groups. Davison and Wilson (1973) investigated the attitudes of behavior therapists toward homosexuality. They found that American and British behavior therapists reported having used aversive procedures with homosexual clients who requested a change in sexual orientation and that many therapists tended to neglect heterosexual aspects of the homosexual client's lifestyle, such as the extent and nature of heterosexual experiences. In addition, therapists did not generally inquire about the client's specific homosexual activities, did not have much direct acquaintance with homosexuality, and tended to share some common stereotypes of male homosexuality as being less good, less rational, and less masculine than male heterosexuality. However, the behavior therapists responding to the survey denied attempting the sexual reorientation of homosexual clients who did not wish to change. The therapists did not view homosexuality as prima facie evidence for psychopathology and expressed the opinion that homosexual individuals can live happy lives. The therapists also stated they had helped or would help homosexual clients become more at ease with their homophile orientation.

In an article summarizing recent research on homosexuality, Morin (1977) concludes that "To a large extent, heterosexual bias is present in this research, as evidenced by the proportion of research reflecting questions of diagnosis, cause, and cure" (p. 636). Morin defines heterosexual bias as a belief system that values heterosexuality as superior to or more "natural" than homosexuality. He calls for more research that elaborates the nature and meaning of attitudes towards homosexuality.

This paper focuses on a potential biasing effect in explaining abnormal behavior when homosexuality is part of the clinical picture. Our clinical experience suggested that a problem not obviously related to sexuality is more likely to be associated with a patient's sex life if there are unconventional sexual components present. With regard to homosexuality, this has been put clearly by two sociologists, Gagnon and Simon (1973), who wrote:

> [We have allowed] ... the homosexual's object choice to dominate and control our imagery of him (or her). We have let this single aspect of his (or her) total life experience appear to determine all his products, concerns and activities. This prepossessing concern on the part of nonhomosexuals with the purely sexual aspect of the homosexual's life is something we would not allow to occur if we were interested in the heterosexual.... The mere presence of unconventional sexuality seems to give the sexual content of life an overwhelming significance. [But] homosexuals ... vary profoundly in the degree to which their homosexual commitment and its facilitation become the organizing principle of their lives. (p. 137)

We decided to examine this supposition experimentally. Undergraduates enrolled in an abnormal psychology course were asked to read a fictional case study of a 36-year-old male patient referred for psychotherapy by his physician because of headaches and insomnia. The patient was described as very depressed, worn-out, and somewhat dissatisfied with his job. His problems included concerns about disasters at work. He used alcohol to dispel these fears. His work suffered, and he was in danger of losing his job. The patient was described as having been married for 15 years. The final paragraph of the case report contained the experimental manipulation. In the control condition, there was mention of "an extramarital affair with a woman in the neighborhood. Through the 15 years of his marriage he has had a series of affairs with a variety of people. Each one lasted for a short while. Despite these extramarital activities, he has never considered getting a divorce." In the experimental condition, the word

man was substituted for *woman* in the first sentence quoted above. All subjects, therefore, read exactly the same case study, except for the indication that the extramarital affairs were with women or with men.

Subjects were asked six questions designed to assess the degree to which a labeling bias was present. We hypothesized that in the homosexual-affair condition subjects would: (a) more often apply a diagnostic label referring to a sexual deviation or justify a nonsexual diagnosis (e.g., neurotic disorder) on the basis of the patient's sexuality, (b) regard the patient as being in greater need of psychoactive medication, (c) be more interested in obtaining information on sexual or marital issues, (d) see the core problem more in terms of the patient's sexuality, (e) more often choose to work first on the patient's sex life, and (f) more often mention sexuality as a factor in the etiology of the patient's complaints.

Method

Subjects and Materials

The respondents were 235 undergraduate students enrolled in an abnormal psychology course taught by the first author at the State University of New York at Stony Brook. During a regular class period in the second week of the semester, we distributed a one-page case report followed by six questions. These materials are shown below. As mentioned above, half the subjects at random read a case report in which the patient was said to have had extramarital affairs with men; the other half, with women.

Case Report

The patient, a 36-year-old librarian, was referred for psychotherapy by his physician because of headaches and insomnia. During the initial interview, he was quite visibly depressed. He sat slumped in the chair as if his body could no longer support him. He spoke barely above a whisper. For the first 10 minutes or so of the interview, the patient repeatedly emphasized his desire that all discussions remain confidential.

Physically the patient looked worn-out and exhausted. He said he hadn't slept soundly in several months because of various thoughts which wouldn't leave his mind. These thoughts were of possible disaster at work. To get these thoughts out of his mind, he had begun to drink heavily. As a result of his morbid preoccupations and drinking, his work had suffered greatly and he was in danger of losing his job.

The patient was the eldest in a family of six boys. His brothers had always looked up to him, and he had enjoyed being the "big brother." He got along reasonably well with his parents, but at times his relationship with his father was a stormy one. He left home when he got married. After 15 years of marriage, he and his wife did not have any children.

He described his job as one which he had never been happy with. He had always dreamed of being a fireman, but he hadn't been able to pass the physical. He sort of drifted into his present job, and he has never been happy with it. He has had tremendous personality conflicts with his supervisors and nearly lost his job several times.

In addition to his problems at work, he has had problems relating to people. He has never been able to have a close relationship with another person. He feels "phony" when talking to people. Throughout his life, he has been able to "make friends" but has not been able to keep them.

His relationship with his wife has never been a good one. Right after his marriage, he had an extramarital affair with a woman (man) in the neighborhood. Through the 15 years of his marriage he has had a series of such affairs with a variety of people. Each one lasted for a short while. Despite these extramarital activities, he has never considered getting a divorce.

In a few short sentences, please answer the following questions:

1. Using the DSM-II categories, how would you diagnose this client? Why?
2. Do you believe this patient requires medication? Why? Or, why not?
3. What additional information would you like to get? Why?
4. What do you think is the patient's central problem?
5. What area of the patient's life would you work on first? Why?
6. How do you think he got the way he did?

After the completed questionnaires had been collected, the lecturer explained the purpose of the survey and incorporated the ensuing discussion into the substance of the course.

Results

The brief written answers of the undergraduate subjects were content-analyzed by two independent raters. Since the questionnaire was separate from the case report, it was easy to keep the raters blind as to experimental condition. Reliabilities for the ratings of each question are shown in Table 1, along with the chi-squares computed on the 2 x 2

TABLE 1

RELIABILITIES OF RATINGS AND

RESULTS OF CHI-SQUARE ANALYSES

	Reliability of Content Analysis		Probability
Question #1 (Diagnosis)	**.99**	33.05	$p < .0005$
Question #2 (Medication)	.94	1.82	$p < .10$
Question #3 (Information on Sexuality)	.95	14.08	$p < .0005$
Question #4 (Central Problem)	.94	.01	NS
Question #5 (Clinical Target)	.98	.53	NS
Question #6 (Sexuality in Etiology)	.90	3.72	$p < .04$

tables derived from the content analyses. All tests are one-tailed.

It can be seen that, of the six separate questions, three (Questions 1, 3, and 6) achieved significant differences in the predicted direction: Subjects who had read of homosexual affairs more often applied a diagnostic label referring to a sexual deviation or justified a nonsexual diagnosis on the basis of the patient's sexuality ($\chi^2 = 33.05$, $p < .0005$), were more interested in obtaining information about the patient's sexual or marital life ($\chi^2 = 14.08$, $p < .005$), and more often mentioned sexuality, or feminine or masculine feelings, as being important in the etiology of the patient's problems ($\chi^2 = 3.72$, $p < .04$), than did those who had read of heterosexual affairs.

While the other three questions did not yield reliable differences, nevertheless the differences were all in the predicted direction. (The probability of obtaining six sets of results in the predicted direction out of six comparisons is .016 on a sign test: Siegel, 1956.)

Discussion

In our view, the findings of this study support the contention that an individual's psychological difficulties will be construed in sexual terms to a greater degree if homosexuality is part of the individual's history. In other words, the person's sexual orientation is seen as contributing to, or as bearing importantly on, their nonsexual psychological problems to a greater degree if the person is (or ever has been) homosexual. Subjects who had read of homosexual affairs when deciding on a psychiatric diagnosis focused more on the patient's sexuality, were more concerned with learning about the patient's sexual or marital life, and invoked sexuality more often as an etiological factor in the patient's nonsexual presenting problems.

As with all analogue studies, questions can be raised about the external validity of these results. The subjects were undergraduates who were just beginning an intermediate course in abnormal psychology, hence, considerably less sophisticated than practicing clinicians. It is possible that experienced clinicians would not be as readily swayed by a patient's unconventional sexual orientation. On the other hand, previous research (Langer & Abelson, 1974; Rosenhan, 1973) would discourage us from expecting greater academic and clinical experience to make clinicians less susceptible to a biasing effect. In fact, one might expect even greater labeling distortion among people who have already formed a professional commitment to a point of view that regards homosexuality as abnormal or at least of special significance in a patient's clinical picture. This possibility is certainly testable.

We hasten to acknowledge that our results are silent on the important issues of whether an unconventional sex life is indeed of special significance in the etiology of nonsexual disorders or whether it is (or is not) worthy of closer scrutiny when dealing with patients whose problems bear no obvious relationship to sexual orientation. Our concern, rather, is with a tendency in the mental health professions—and among laypeople as well—to interpret a person's life in terms of her or his sexuality only when this deviates from societal norms. Given scientists' relative ignorance of psychopathology and how best to prevent it or ameliorate it, it is particularly important to become aware of personal biases and of how these can affect the data sought and the manner in which they are interpreted. We have put forth similar arguments (Davison, 1976) in the proposal to terminate change-of-orientation programs for homosexual individuals. Without ignoring the psychological problems that homosexual clients sometimes have, therapists should focus on life problems rather than on the so-called problem of homosexuality.

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