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THE RELATIONSHIP BETWEEN HOMOPHOBIA,
PEER COUNSELING EFFECTIVENESS, AND PEER
COUNSELING SELF-CONFIDENCE

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The relationships between a peer counselor's level of homophobia, their self-perceptions of counseling ability, and their effectiveness as a peer counselor were examined. Resident Assistants (RA's, N=27) completed the Index of Homophobia (Hudson & Ricketts, 1980) and the Peer Counseling Comfort Scale. Resident students (N=159) evaluated their RA's performance and ability as a peer counselor. Results from the three surveys were correlated. A significant correlation was found between Homophobia scores and self-perceptions of ability. Implications for counseling practice and suggestions for further research are discussed.

INTRODUCTION

In the United States today, gay males, lesbians, and bisexuals continue to be frequently discriminated against and are often targets of prejudice. This prejudice is displayed in behaviors ranging from on-the-job discrimination to verbal harassment and violent attacks. The National Gay Task Force (1984, cited by Herek, 1988) reported that over 90% of gay males and

75% of lesbians have been verbally harassed because of their sexuality. One-third of gay males and lesbians have been physically threatened and one-fifth have been physically attacked because of their sexual orientation.

In 1975, the American Psychological Association adopted a policy statement which stated that "Homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." The statement went on to urge psychologists to "take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations" (Conger, 1975, p. 633).

Homophobia is simply defined as personal and institutional prejudice against lesbians and gay men (Herek, 1988). Gay males, lesbians, and bisexuals often internalize the homophobic attitudes expressed by individuals around them (Sophie, 1987), which can have negative implications for their mental health. As Gibson (1989) stated, "When you have been told that you are sick, bad, and wrong for being who you are, you begin to believe it" (p.113). The internalization of this negative self-image leads to a range of psychosocial problems for gay males and lesbians including poor self-esteem, depression, drug and alcohol dependency (Moses & Hawkins, 1982) and school failure (Gibson, 1989). Gibson found that up to 30% of teenage suicides are committed by gay male, lesbian and bisexual adolescents going through the coming out process and that these youth have a rate of suicide attempts two to three times that of heterosexual teenagers.

Twenty years after the adoption of the APA policy statement, however, psychologists in clinical practice frequently maintain stereotypical beliefs concerning gay males, lesbians, and bisexuals. Rothblum (1994) found that many clinicians still considered homosexuality to be a mental disorder and considered gay male and lesbian relationships to be less mature than those of heterosexuals. At present,

clinicians vary widely in their use of gay-affirming practices. According to research cited by Rudolph (1989), gay males and lesbians are two to four times as likely as heterosexuals to enter counseling. They are, however, significantly more likely to be dissatisfied with their counseling experiences than are heterosexual clients. One of the major causes cited for this dissatisfaction is the client's perception of the counselors' "ignorance of or prejudice toward homosexuality" (p.81).

These findings have implications for college campuses as well. College is a time when, "free from the scrutiny of family and high school friends, lesbian and gay youth may acknowledge their feelings and begin to expand the network to whom they disclose their orientations" (D'Augelli & Rose, 1990, p. 485), perhaps for the first time in their lives. A barrier to this acknowledgment comes from homophobic attitudes expressed by the students around them. A study conducted by D'Augelli and Rose (1990) found high levels of homophobic attitudes in a sample of college freshmen. Of those surveyed, 29% believed that the university would be a "better place" if only heterosexual students were allowed to attend. Almost 50% found gay male sexual behavior to be "plain wrong" and described gay males as "disgusting."

According to D'Augelli and Rose (1990), because of the fact that many traditionally-aged college students live in university residence halls, these areas are places where anti-gay attitudes are often shown. These attitudes not only influence the beliefs of heterosexual students, but have a strong negative impact on gay males, lesbians, and bisexuals living in the residence halls. Hearing anti-gay comments from their peers and neighbors can create substantial fear and anxiety in gay male, lesbian, and bisexual students.

Many colleges and universities utilize Resident Assistants as paraprofessional staff members providing

peer counseling services for students living in the residence halls. In many instances, a Resident Assistant is the initial link in the counseling process, providing peer counseling for a variety of issues and, when necessary, referring students to the university's counseling center or other appropriate service providers (Blimling & Miltenberger, 1990). Resident Assistants engage in peer counseling with the students living on their residence halls and are, in fact, the single largest group of peer counselors on most college campuses (Supton & Wolf, 1983). Deluga and Winters (1991) found that a primary reason cited for becoming a resident assistant was the opportunity to help students with personal problems.

Peer counseling is broadly defined as "the use of active listening and problem-solving skills, along with knowledge about human growth and mental health, to counsel people who are our peers" (D'Andrea & Slalovey, 1983, p.3). Shipton and Schuh (1982) offer a broader definition of "helping students make choices, . . . bringing about changes in their pattern of actions, thoughts or feelings; or referring students to mental health professionals on campus for personal assistance" (p. 247). Delworth, Sherwood, and Casaburri (1974) described the Resident Assistant's competency as a counselor as the major criterion used for judgment of their effectiveness.

A study by D'Augelli (1989) found that students applying to be Resident Assistants had attitudes towards gay males, lesbians, and bisexuals similar to those found in the general college population. Seventy-seven percent had made homophobic comments or told homophobic jokes. Male Resident Assistants were found to have significantly more homophobic attitudes than were females.

Resident Assistants' views about and actions toward gay males, lesbians, and bisexuals affect their ability to relate to gay male, lesbian, and bisexual

students living on their residence halls. Gay male, lesbian, and bisexual students avoid contact with individuals who express views hostile to them and their sexual orientation.

According to D'Augelli (1989), Resident Assistant attitudes and actions related to gay males and lesbians are important for two reasons. First, the Resident Assistant is likely to be the most immediately available representative of the university for their resident students. Second, if harassment, discrimination, and/or violence does occur, the Resident Assistant may be the first person to whom a gay male or lesbian student turns. A homophobic RA might not be responsive to a student's situation and might not take action to prevent further harassment from occurring. This leads to the student's failure to report incidents, increased secretiveness on the part of the student, and increased fear for the student (Lance, 1987).

One of the tasks which Supton and Wolf (1983) identify as critical to effective peer counseling is putting one's personal values aside in order to help the client deal with his or her problem. Unfortunately, this may be difficult to do with an attitude as deeply held as homophobia. D'Andrea and Salovey (1983) outline "eight commandments" of peer counseling. One of these, "Be Empathetic" has particular relevance for the current discussion. They define empathy as "the ability to see a problem from the counselee's point of view and, accordingly, to be warm and supportive" (p. 5). A peer counselor who holds homophobic attitudes is unlikely to be able to be truly empathetic with a gay male or lesbian student. Winston, Ullom, and Werring (1984) state that to be effective peer counselors RA's must: "establish relationships of mutual trust and respect, communicate their willingness to be of assistance, and make a commitment to expend the time and energy required to help residents deal with their personal concerns" (p. 53). A "relationship of mutual trust and respect" may,

however, be difficult to establish between an RA with homophobic beliefs and a gay male, lesbian, or bisexual student.

D'Augelli and Rose (1990) suggested that further research concerning homophobia in Resident Assistants should assess the impact which their homophobic attitudes have on their behaviors in the residence hall setting. This study examined the relationship between Resident Assistants' levels of homophobia and their effectiveness and confidence levels as peer counselors in the residence hall setting. It was hypothesized that, because of the problems discussed above with displaying proper empathy, developing a counseling relationship, and putting values aside in a counseling situation, homophobic attitudes would be negatively correlated with counseling effectiveness and self perceptions of counseling ability.

METHOD

Participants

All participants were students at a small, public, four-year university in the Southeastern United States. In Phase One of the study, 27 Resident Assistants (17 women and 10 men, mean age = 20.5 years) volunteered to participate in the study. In Phase Two, 159 Resident students (110 women and 49 men, mean age = 19.7 years) living on the residence halls of the RA's who participated in Phase One were surveyed. All participants were treated in accordance with the Ethical Principles in the Conduct of Research with Human Participants (American Psychological Association, 1982).

Survey Instruments

In Phase One, the Resident Assistants completed the Peer Counseling Comfort Scale (PCCS) designed for

use in this study (see Appendix A for the text of this scale) and the Index of Homophobia (IHP; Hudson & Ricketts, 1980). The PCCS is a modification of the Counseling Self-Estimate Inventory developed by Larson, et.al. (1992). The scale consists of 20 Likert-type items and delivers an general measure of self-confidence regarding peer counseling (GS) as well as six subscale scores: microskills (M), process skills (P), difficult client behaviors (DCB), cross-cultural counseling skills (CC), and awareness of counseling values and ethics (AV). Each scale and subscale delivers a score from 25-100, with higher scores indicating a higher level of self-confidence. The IHP is a 25-item, Likert-type scale which delivers an overall measure of homophobia ranging from 0-100 with higher scores indicating higher levels of homophobia. The IHP has been found to be reliable and valid (coefficient alpha = .901; SEM = 4.75; Hudson & Ricketts, 1980).

In Phase Two, the RA Performance Rating Scale (PRS, see Appendix B for the text of this scale) was completed by students living on the residence halls of RA's who participated in Phase 1. The PRS is a 10 item Likert-type scale which delivers an overall rating of RA performance (OP) as well as two subscale scores: (a) counseling performance (CP) and (b) discipline-maintenance performance (DM). Each scale and subscale delivers a score from 10-50, with higher scores indicating higher ratings of performance.

Procedure

In Phase One of the study, Resident Assistants were instructed that they were participating in two separate studies: a study of sexual attitudes and a study of peer counseling self-confidence. Each RA completed an informed consent form and was then given a packet containing a demographic survey, the Peer Counseling Comfort Scale, and a Survey of Attitudes on Sexual Issues, which contained the Index of Homophobia and

several distractor items. RA's completed the surveys individually and returned them via campus mail.

In Phase Two, RA Performance Rating Scales were distributed to dormitory rooms of students whose RA's participated in Phase 1 of the study. Residents were instructed to complete the form and to return it to drop boxes provided in each Residence Hall. Seven Hundred and Fifty-nine surveys were distributed and 159 were returned, for a return rate of 21%.

RESULTS

Resident Assistant scores on the Index of Homophobia tended to show somewhat lower levels of homophobia than the general population, although scores were highly variable ($M=33.81$, $SD=19.61$). Peer Counseling Comfort Scale scores clustered in the "above average" to "well above average" range ($M=79.26$, $SD=6.86$). Scores on the Resident Assistant Rating Scale-Counseling Performance Subscale were somewhat variable and tended to cluster in the "average" to "above average" range ($M=13.43$, $SD=2.74$).

Negative correlations were found between the IHP scores and the PCCS-General score ($r=-.25$, $p<.1$) and between the IHP scores and three of the PCCS subscales (PCCS-M: $r=-.28$, $p<.1$; PCCS-CC: $r=-.26$, $p<.1$; PCCS-AV: $r=-.25$, $p<.1$). Complete correlation results are summarized in Table 1.

Table I. Means, Standard Deviations and IHP Correlations for Survey Data

<u>Variable</u>	<u>Mean</u>	<u>Std Dev</u>	<u>Correlation with IHP Score</u>
IHP	33.8	19.8	-----
PCCS-GS	79.3	6.86	-.25*
PCCS-M	81.0	9.18	-.28*
PCCS-P	75.8	6.21	-.03
PCCS-DCB	80.9	11.7	-.18
PCCS-CC	83.0	12.7	-.26*
PCCS-AV	72.6	14.8	-.25*
RARS-CP	13.4	2.7	-.09

* $p < 0.1$

DISCUSSION

Although a small number of studies have examined levels of homophobia in groups of peer counselors, this study is the first to directly examine the relationship between those levels and peer counseling effectiveness. The results of the study partially supported the original hypothesis. It was found that levels of homophobic attitudes are negatively correlated with self-perceptions of counseling effectiveness. There was not, however, a significant correlation between homophobia and resident students' ratings of peer counseling effectiveness. Resident assistants participating in the study tended to have lower levels of homophobia than the general population, although scores were highly variable. Peer counseling self-confidence scores were generally well above average,

and peer counseling comfort scores tended to be average or above average.

The small sample size of the current study and the low resident survey return rate limits the reliability of the data collection. The current study was also the first to use the Peer Counseling Comfort Scale. Validity and reliability of the scale needs to be assessed. Further study could either further refine the PCCS or utilize other counseling instruments to assess counseling skill levels.

In general, the findings of the current study support the hypothesis that individuals with high levels of homophobia will be less likely to possess the skills identified in the literature as being necessary for effective peer counseling. Further research, in addition to the suggestions provided above, could begin to look at ways of developing these skills in homophobic peer counselors--both by looking at ways to reduce levels of homophobia in those individuals and by looking at ways to provide specialized skill training for homophobic individuals.

APPENDIX A. Peer Counseling Comfort Scale

All items were presented in a Likert-type format, with 5 answer choices from (1) "Almost Never" to (5) "Almost Always".

- 1) I am afraid that I do not understand and properly interpret the resident's behavior while I am helping them.
- 2) I feel that I may give the resident advice when helping them with their problems.
- 3) I feel that I respond to the resident's statements and concerns in an appropriate length of time (neither interrupting nor waiting too long to respond).
- 4) When using active listening skills, I am confident that I am concise and to the point.

- 5) I worry that my skills and responses are not helpful in assisting the resident in solving the problem.
- 6) I am confident that I am able to understand the resident's problems.
- 7) I am confident that I respond appropriately to the resident in view of the things that the resident expresses (e.g., my questions are meaningful and are not concerned with trivial details).
- 8) My assessment of the resident's problems is not as accurate as I would like for it to be.
- 9) I am not able to maintain the intensity and energy level needed to make the resident confident in my skills and to encourage them to actively work towards solving their problem.
- 10) I feel confident that I appear confident about my helping abilities to the resident.
- 11) In working with culturally different residents I have a difficult time viewing situations from their perspective.
- 12) I worry that the type of things that I say to the resident at a particular time may not be the appropriate things to say at that time.
- 13) I feel that I have enough fundamental knowledge to do effective peer helping with my residents.
- 14) I worry that the things that I say to the resident are confusing and hard to understand.
- 15) When working with ethnic minority residents, I am confident that I am able to bridge cultural differences when helping the resident.
- 16) I feel confident regarding my abilities to deal with crisis situations which may arise with my residents.
- 17) I am likely to impose my values on the resident when helping them with problems.
- 18) I am confident that the things that I say to the resident are clear and easy to understand.

19) I do not feel I possess a large enough repertoire of helping skills to deal with the problems presented by my residents.

20) I feel that the things I say to the resident will make sense and will be useful based on what the resident is saying to me.

Appendix B. RA Performance Rating Scale

All items were presented in a Likert-type format. Boldfaced questions were used in the calculating of the PRS-Counseling Effectiveness measure.

- 1) Does your RA enforce the rules fairly and consistently?
- 2) **Do you feel that your RA is able to effectively handle crisis situations on the hall (e.g. suicide, alcohol poisoning, etc.)?**
- 3) Does your RA successfully resolve conflicts occurring on the hall?
- 4) Is your RA effective at maintaining hall discipline?
- 5) **Do you feel comfortable going to your RA for help with your personal problems?**
- 6) Does your RA make your hall a safe and healthy place to live?
- 7) **Do you feel that your RA possesses adequate skills to help you with your personal problems?**
- 8) Is your RA available when you need his/her help?
- 9) **Would you recommend your RA to a friend who needed help with a personal problem?**
- 10) What is your overall rating of your RA's effectiveness?

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