Religious Fundamentalism, Empathy, and Attitudes Toward Lesbians and Gays Within the Therapeutic Relationship

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This dissertation titled
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Abstract

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Religious Fundamentalism, Empathy, and Attitudes Toward
Lesbians and Gays Within the Therapeutic Relationship

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The purpose of this study was to explore the relationship between religious fundamentalism, empathy, and attitudes toward lesbians and gays in counselor trainees enrolled in CACREP accredited, master's level counselor education programs. A geographically stratified random sample was used to obtain a sample of 149 unlicensed counseling master students. The individuals took part in four different questionnaires: The Revised Religious Fundamentalism Scale, The Basic Empathy Scale, The Attitudes Toward Lesbians and Gays Scale, and a demographic questionnaire. A correlational analysis and a regression analysis were used to analyze the data.

Results of the study indicated that there was not a statistically significant relationship between religious fundamentalism and empathy in counselor trainees. The relationship between religious fundamentalism and empathy did predict attitudes toward lesbians and gays, but only in the presence of religious fundamentalism. This study
supports the research proposed by Duriez (2004) which suggested that there is not a relationship between religious fundamentalism and empathy. Furthermore, this research supports the literature that suggests that religious fundamentalism does predict attitudes towards sexual minorities.
Dedication

This work is dedicated to my mother Virginia Wolfe, and my grandmother Carolyn Casto. Thanks for instilling in me a strong work ethic, and showing me what joy it is to serve others.
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Chapter 1: Introduction

Members of the Lesbian, Gay, Bisexual, and Transgender (LGBT) community have discriminatory practices within the therapeutic relationship (Priest & Wickel, 2011). The full extent of the discrimination experienced by members of the LGBT community within the therapeutic relationship has been difficult to know. However, members of the LGBT community are victims of unethical referral and sometimes face discrimination from counselors' imposing unethical therapies, which ultimately hurt the patient.

Historically, research has shown that counselors' attitudes toward LGBT community directly impact how effectively they engage in the therapeutic relationship (Allen, Peterson, & Keating, 1982; Herbert, Hunt, & Dell, 1994; Rudolph, 1990). Ethical practice demands that health care professionals not discriminate against members of the LGBT community (ACA, 2005; APA 2002). The literature also suggests that individuals within the helping profession may be unaware of how their biases may impact their ability to engage and interact with their clients (Matthews, Selvidge & Fisher, 2005; Rudolph, 1990; Swank & Riaz, 2010).

There are many factors that underlie these biases, including culture and religious facets of an individual’s
life. Due to the paucity of literature, the relationship between religious fundamentalism, empathy, and attitudes toward sexual minorities has remained unknown. This study explored those relationships in master level counseling students.

**Background of the Study**

**History.**

Members of the LGBT community have been fighting for equal rights since the community was brought to national attention by the Stonewall Riots in 1969. The Stonewall Riots are described as the beginning of the LGBT movement in the United States because they forced Americans to take notice of a community that, up to that point, had been marginalized and hidden (White, 2008). While members of the LGBT community might be more accepted today, there are still challenges that these individuals face, which leads them to seek out mental health services. The LGBT community has been referred to as the invisible minority because there has been no readily identifiable way to recognize or distinguish them from the majority (Lopez & Chism, 1993; Mathison 1998). Visible minority groups typically have a readily identifiable characteristic which distinguishes them from the majority, such as skin color;
but the only readily available way to identify members of the LGBT community has been behaviorally—by engaging in same-sex sexual experiences. This observation by the majority can lead to stereotyping and discrimination of the minority. This labeling has been more deeply problematic because individuals who are minority face multiple levels of oppression, each amplifying the other. An African American male who identifies with the LGBT community, for example, not only experiences the discrimination associated with this particular visible minority, but he also those suffers those attached to the LGBT invisible minority. There are thus many different sociopolitical levels of prejudice and misperception to maneuver.

A recent Gallup poll suggested that 3.4% of the American population identify with part of the LGBT community; young, non-white, less-educated individuals make up the greatest percentage of this population (Gates, 2012). While other minority groups have fought for and achieved equal rights and non-discriminatory policies against the majority culture, individuals within the LGBT community, because of their invisibility, still experience discriminatory practices which continue to flourish within the workplace, on campuses, and within our sociopolitical
environment (Brown, Clarke, Gortmaker, Ragins & Cornwell, 2001; Newman, 2010; Robinson-Keilig, 2004). Additionally, individuals within the LGBT community may face heterosexual bias within the therapeutic relationship, leading to less than desirable outcomes (Glenn & Russell, 1986). Heterosexual bias can take on several faces within the therapeutic relationship. The therapist could inadvertently assume that the patient has been in a heterosexual relationship and refer to the client’s partner as the opposite sex. The counselor could also assume that the reason a homosexual individual would seek therapeutic services was because of his or her sexual orientation. By focusing on this assumption rather than the actual issue, the counselor could unintentionally minimize the negative symptomology which brought the client to counseling in the first place. This hyper-focus on sexual orientation on the part of the therapist, an aspect about which the client may have no qualms, can lead to ineffective counseling sessions. Finally, a counselor may impart biased role expectation upon his client by adhering to gender scripts and role expectations.

The LGBT community has long faced discrimination within the psychiatric domain of the medical community as
well, which has led to some of the residual effects seen today. The mental health field in particular displayed perhaps the most overt discrimination when they attempted to medicalize homosexuality. Because homosexuality was seen as a mental disorder, the mental health field perpetuated a dichotomy of a right versus wrong sexuality. Individuals within the fields of psychology and psychiatry attempted to ‘cure’ the deviant sexuality through newly created therapies. However, during the American Psychiatric Association’s Convention in 1972, individuals within the LGBT community began to challenge the medicalization of homosexuality. These challenges led to the removal of homosexuality from the Diagnostic and Statistical Manual (DSM) as a mental disorder, essentially ‘curing’ members of the LGBT community overnight.

Discrimination against the LGBT community has also been observed within the workplace setting. However, discrepancies exist within the literature concerning the rates of workplace discrimination. Some studies have suggested discrimination rates of 23% while others have indicated rates as high as 66% (Croteau, 1996; Durkin, 1998). Although discrepancies subsist as to the rate at which individuals within the LGBT community experience
workplace discrimination, there remains a widespread consensus that these individual face discrimination due to their sexual orientation. There is both overt and covert discrimination, each of which is hard to prove, due to institutional bias and the lack of federal protection for the LGBT community. Perhaps a more covert form of discrimination has been a differential in wage gaps between heterosexual and homosexual individuals. Carpenter (2005) suggested that bisexual men earn 10-15% less than the typical heterosexual males within the workplace. While bisexual men earn substantially less than heterosexual men, they still earn more than homosexual men. Disparate earnings can lead to resentment from the gay members of the LGBT community against bisexual men for their ability to ‘pass.’ While there certainly has been no way to readily identify bisexual men from homosexual men, a preconception exists that bisexual men can choose to ‘hide’ their sexual orientation in an effort to ultimately earn as much as their counterparts.

While actual discrimination occurs in the workplace and has a negative effect upon a member of the LGBT community, perceived discrimination can be just as detrimental. Perceived discrimination occurs when an
individual feels they are being treated differently because they do not belong to a group within the dominate culture (Ragins, Singh, & Cornwell, 2001). Stigma, the fear associated with coming out, and an individual’s past experiences, can lead to an individual prematurely adopting the notion that they are being treated differently due to their identification with the LGBT community.

Ragins, Singh, and Cornwell (2001) examined the role perceived workplace discrimination plays in the lives of LGBT individuals. The authors obtained a national random sample of 534 gay and lesbian employees using a geographically stratified random sample. This method was used to ensure a particular geographical area was not oversampled. Different facets of the workplace environment were examined, including current legislation, workplace policies and practices, and work group composition (Ragins, Singh, and Cornwell, 2001). In their findings, Ragins et al. (2001) explained that workplace practices, such as the lack of nondiscriminatory policies and diversity training, have the strongest impact on perceived discrimination. The greater the perceived discrimination, the more negative the attitude can be in the workplace, leading ultimately to
fewer job promotions throughout the course of employment (Ragins et al. 2001).

Both students and employees within the LGBT community face a unique battle on college campuses. Many are coming to terms with their new sexual identity while others are still in the beginning stages of their sexual identity development. While many feel that college campus environments are about inclusiveness, some individuals within the LGBT community may still face overt discriminatory practices. Rankin (2003) suggested 89% of the harassment experienced by the LGBT community on a college campus takes the form of derogatory remarks. Perhaps more disconcerting, individuals are able to identify those who harass them 79% of the time (Rankin, 2003). These unique challenges and discriminatory acts prevent members of the LGBT community from achieving their full potential during their collegiate career (Rankin, 2005).

Coming out has been marked as a stressful stage of identity development for individuals within the LGBT community. There are many factors which determine whether an individual ‘comes out’. ‘Coming out’ marks when a person reveals to others their identification with the
label subscribed to by the LGBT community. While there are many factors that shape the course of an individual’s coming out process, perhaps the biggest one is feeling comfortable. While all developmental processes consist of stages, LGBT identity development differs from other types. Individuals who are working through the different stages of LGBT development may not have a supportive community, or may be victimized due to their sexual orientation (Rosario, Schrimshaw, Hunter, & Braun, 2006).

Deciding whether or not to ‘come out’ can directly impact an individual’s mental health simply because the experience is not a onetime occurrence. Every time an individual meets a new person or takes on a new job, they have to decide whether coming out is the safest thing to do. If an individual does not feel safe enough to self-disclose their true identity, they will experience an incongruence. This incongruence will lead to a disconnection with their environment or interpersonal relationships. This disconnection can become especially problematic within the therapeutic relationship because the foundation of a therapeutic relationship should be trust, empathy, and understanding.
Civil rights.

Because members of the LBGT community are cast as the out-group from the status quo in-group, a uniform social justice movement has been difficult to achieve. Because members of the LGBT community are for the most part invisible, discriminatory practices are pervasive within the current sociopolitical environment (Newman, 2010). Perhaps the most salient form of sociopolitical discrimination within the LGBT community is marriage inequality. Newman (2010) suggested that the argument was not purely about the legal right to marry; it was about antidiscrimination. While the United States has openly embraced the idea of equality, the judicial system remains blind to the rights of members within the LGBT community. While states are able to fully legalize and legitimize same-sex marriage, at the federal level, the Defense of Marriage Act (DOMA) reinforces the institutional bias that exists, perpetuating the ‘us versus them’ ideology.

The sociopolitical future for the LGBT community remains uncertain (McThomas & Buchanan, 2012). Although discriminatory practices against the LGBT community are condoned by current legislation, recently there have been a several major recent victories for equal rights within the
LGBT community, one including the repeal of Don’t Ask, Don’t Tell (DADT). DADT was a policy enacted by President Clinton as a compromise with conservative politicians. The policy suggested that members of the LGBT community could serve in the military as long as they were willing to remain quiet about their sexuality. This policy openly demonized gay individuals as being inferior to the heteronormative norm, which suggested that their service would be a distraction due to their sexuality. Moreover, the policy perpetuated the ideology that a non-conformative homosexual ‘lifestyle’ was substandard to conventionality.

Another often overlooked example within the fight for equality has been the definition of family. In the past, there has been a predefined definition of what constitutes family, that being a heterosexual couple who are able to bear their own children. While this view might seem archaic, the definition of family within the current legislation has been heteronormative, not recognizing diversity within families. This has been especially true for bi-national same sex couples. Often, these same sex couples are forced to choose over whether they want to stay within their home country of the United States or move to the country of their partner. The current law stemming
from the Immigration of Nationality Act of 1952 makes sponsoring their partners impossible. Same-sex partners are thus forced to use the Visa Waiver program enacted by the United States, if they qualify. However, because the federal government does not recognize same-sex partnerships, individuals who disclose they are entering the United States to visit their partner may be viewed by the immigration officials as attempting to gain permanent residence within the United States, resulting in the barring of this individual from entering the United States without due process (Garrett, 2012). To remedy same-sex immigration discrimination, the United American Families Act bill has been placed before both chambers of the Senate, which will hope to bring bi-national same-sex partners the same rights afforded to their heterosexual counterparts. While there has been a decline in discriminatory practices, concrete examples still exist as to how the LGBT community faces discrimination throughout their daily lives.

**LGBT community and mental health.**

Identifying what constitutes the LGBT community has been difficult. A stark difference exists between the political labels assigned to non-heterosexual individuals
and the identity these individuals adopt for themselves. When speaking about the LGBT community, it usually constitutes individuals who readily identify with the political labels of Lesbian, Gay, Bisexual, and/or Transgender. While each of these different classifications conjure up an idea of what it means to be, Lesbian, Gay, Bisexual, or Transgender, it is entirely possible to engage in same sex behavior and not subscribe to the predefined label. This can be particularly true for individuals who face multiple levels of oppression, such as African American men who sleep with men (Robinson & Vidal-Ortiz, 2013). While politically their behavior is identified as ‘gay’, they may still choose to identify as straight and living on the ‘down-low’ (Robinson & Vidal-Ortiz, 2013).

Identifying with the LGBT community in no way suggests underlying psychopathology. However, being part of the LGBT community presents a host of challenges that individuals who are heterosexual may not encounter. Homophobia, internalized homophobia, discrimination, and prejudice name a few issues that can affect an LGBT individual’s mental health (Barber, 2012; Barnes & Meyer, 2012; Meyer, 2003). The National Institute on Mental Health (NIMH) suggested that a typical adult has a 25
percent chance of meeting the criteria for a mental health diagnosis within any given year ("Any Disorder Among Adults," 2013). However, psychopathology is 2.5 times more prevalent in members of the LGBT community than in their heterosexual counterparts (Cochran, Sullivan & Mays, 2003). Cochran, Sullivan, and Mays (2003) concluded that sexual minorities used mental health services at a higher rate than their heterosexual counterparts from nationally representative data that was acquired from 2,917 middle aged adults.

LGBT individuals of color experience multiple levels of oppression, and rates of mental illness among this demographic tend to be higher (Diaz, Ayala, Bein, Henne & Martin, 2001). Diaz et al. (2001) collected data using a probability sample from 912 men who self-identified as non-straight and Latino. Their results concluded that the individuals within the sample experienced psychological distress based on their social context (Diaz et al., 2001). Furthermore, it has been well-documented that the LGBT community experiences increased rates of suicide, depression, anxiety, and co-morbid substance abuse, and while identity does not equate to psychopathology, LGBT individuals face higher rates of mental illness when
compared to their heterosexual counterparts (Holt, et al., 2012; Mustanski & Lui, 2012; Wang, Hauserman, Ajdacic-Gross, Aggleton, & Weiss, 2007).

Due to pervasive and widespread discriminatory practices and the mental health issues which naturally arise, members of the LGBT community seek out mental health counseling (Bell & Weinberg, 1978). Counselors are thus in a unique position to help individuals within the LGBT community process their daily experiences. Counselor trainees, though, may not be competent when it comes to administering services (Hays, 2008). While competency is important within the therapeutic relationship, the counselor’s own biases and attitudes towards the LGBT individuals can directly affect positive outcomes.

**Counselor’s attitudes towards LGBT community.**

Promoting wellness has been described as perhaps a counselor’s biggest task within the realm of the therapeutic relationship. However, a counselor’s past histories and own personal prejudices and beliefs can interfere with the counseling process and make it ineffective, even though the American Counseling Association’s (ACA) Code of Ethics makes it clear that counselors should remain unbiased within the therapeutic
relationship (ACA, A.4., 2005). Despite this written code, though, many stereotypes concerning the LGBT individuals still exist within the framework of counseling culture (Chen-Hayes, 1997). Rudolph (1988) suggested that counselors can often remain torn between what the profession says about the LGBT community and what society pronounces, and while a counselor may have a firm grip on individual own biases, beliefs, and personal perspectives and attempt to put them aside in a counseling relationship, subtle forms of homophobia may still exist within the counseling relationship (Weber-Gilmore, Rose, & Rubinstein, 2011). Bowers, Plummer, and Minichiello (2005) conducted a qualitative study that examined homophobia within the counseling relationship. Of the 34 participants that were interviewed, 18 participants were clients and 16 were counselors. Bowers et al. (2005) argued that homophobia within the therapeutic relationship has been a significant concern. Furthermore, Boysen and Vogel (2008) reported that while counselor trainees have reported high levels of multicultural competencies, they can still maintain biases against the LGBT community. These results suggest that homophobia within the therapeutic relationship may be due to a lack of knowledge, assumptions about the community,
bias, and prejudice (Bowers, Plummer, & Minichiello, 2005). Counselors’ attitudes towards the LGBT community may thus not only impact the outcome of the counseling process but may also be a source of dissatisfaction for LGBT individuals seeking help (Rudolph, 1990).

**Religious fundamentalism.**

Altemeyer and Hunsberger (1992) define religious fundamentalism as “...the belief in one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity; that is essential truth is fundamentally opposed by forces of evil which must be vigorously fought; that this truth must be followed today according to the fundamental, unchangeable practices of the past; and that those who believe and follow these fundamental teachings have a special relationship with the deity (p. 118).” There has been a revival in religious fundamentalism within the United States over the past couple decades, with up to 13% of the population describing their religion as being fundamental (Bader, Froese, Johnson, Mencken, & Stark, 2005; Rudolph, 1988).

Fundamental groups protect their ideologies by suggesting that out-groups are norm-violating (Jackson &
Hunsberger, 1999). This view was particularly evident in 2004 when Pat Buchanan declared there was a “culture war”, brewing in which the value-violating LGBT community was diluting the morality of the dominant, largely religious culture. The term ‘war’ implies animosity toward a dissenting view, indifference and even hostility toward that which, in this case, challenges convention. Yet, religious individuals seek to adhere to the Golden Rule, to do unto others as they would have others do unto them. Adhering to such a principle would suggest less judgmental behavior. However, Allport (1954) proposed that religion with regard to prejudice has been paradoxical, in that religion both makes and unmakes prejudice (p. 444). Furthermore, Allport and Ross (1967) submitted that religious individuals have an inclination towards being prejudicial by nature. Indeed, as these studies show, the religious fundamentalism and the prejudice connection between the LGBT community, women, and other out-groups have been well documented within the literature (Altemeyer, 2003; Altemeyer & Hunsberger, 1992; Laythe, Finkel, Kirkpatrick, 2002).

Counseling and counselor education literature does not yet encompass how religious fundamentalism impacts the
therapeutic relationship, but religious fundamentalism has repeatedly demonstrated a trend of intolerance towards marginalized groups of people (Hunsberger and Jackson, 2005). Whitley (2009) conducted a meta-analysis that examined the role religiosity plays in regards to the attitudes directed toward the LGBT community. The meta-analysis consisted of 64 studies, all of which concluded that most forms of religiosity, including fundamentalism, maintained negative attitudes towards individuals within the LGBT community (Whitley, 2009). Because of this supported relationship, it is important to examine how a counselor trainee’s level of religious fundamentalism might affect their attitudes towards the LGBT community.

**Empathy.**

Empathy has been described as perhaps one of the biggest factors affecting the therapeutic relationship (Chi-Ying Chung & Bemak, 2002). Overholser (2007) suggested that counselors need empathy to understand the client’s experiences. If a counselor is unable to empathize, then a positive outcome is unlikely. In fact, Lambert and Barley (2001) explained that empathy is one of the key factors which correlate to a positive therapeutic outcome.
Research has also suggested that empathy can change throughout the course of a person’s life and career (Bellini, Baime & Shea, 2002; Lovell, 1999; Sherman & Cramer, 2005). Duan and Hill (1996) suggested that situational factors, such as awareness of client’s culture and value differences, may impact the way empathy has been displayed within the therapeutic relationship. While counselors are taught not to impose their own belief systems and biases within the therapeutic relationship (ACA, A.4., 2005), their own personal belief systems can influence the expression of empathy (Duan & Hill, 1996). While the relationship between a counselor’s level of religious fundamentalism and empathy has not yet been thoroughly explored, current trends in counselors’ behavior suggests that his religious biases may interfere with the level of empathy given to his LGBT clients.

According to the literature, there is no definite answer to the question: “Does religious fundamentalism impact the amount of empathy a person exhibits?” Duriez (2004) suggested unequivocally and without reservation that there is no connection between religiosity and empathy. However, other researchers have found connections (Khan, Watson, & Habib, 2005; Watson, Hood, Morris, & Hall, 1984).
Bradley (2009) proposed through empirical evidence that religious fundamentalism may lead to lower rates of empathy. If this is true, the question becomes how lower rates of empathy impact the therapeutic relationship when counseling members of the LGBT community.

**Statement of the problem.**

The literature has implied that persons who identify as being LGBT may be at higher risk for discrimination (Whitley, 2009). The ethical standards of all helping professions, including the American Counseling Association, mandate that counselors provide services to every client without prejudice or discrimination with special emphasis on respecting cultural diversity, minorities, and groups that have been victimized or marginalized (ACA, 2005). The discrimination experienced by the client may be overt (Nadal, Wong, Neterko, & Wideman, 2011) or covert (Aberson, Swan, & Emerson, 1999), taking the form of referral instead of treatment. ‘Doing no harm’ must go beyond promoting the good of the client. The clinician needs to remain cognizant that referring out because of a client’s sexual orientation or gender identity can be damaging.
Research questions.

This research sought to examine the relationship between religious fundamentalism, empathy, and attitudes toward the LGBT community. Due to the inconsistencies and gaps within current literature, this report has endeavored to add to the body of literature in the hope of supporting or negating the relationship.

Furthermore, this study has examined religious fundamentalism in counselor trainees to discover attitudes towards sexual minorities. While correlations between religious fundamentalism have been connected to discriminatory practices in the past, this relationship had not been previously examined in counselor trainees. Additionally, the relationship between religious fundamentalism and empathy had not been examined to see if it predicted attitudes toward sexual minorities in counselor trainees.

1) For counselor trainees, is there a relationship between religious fundamentalism and empathy?

2) Does the combination of religious fundamentalism and empathy in counselor trainees predict attitudes toward sexual minorities?
**Null hypothesis.**

1) For counselor trainees, there is no relationship between religious fundamentalism and empathy.

2) The combination of religious fundamentalism and empathy in counselor trainees does not predict attitudes toward sexual minorities.

**Significance.**

While religious fundamentalism has been attributed to discriminatory practices (Brandt & Reyna, 2010; Schwartz & Lindley, 2005; Kirkpatrick, 1993; Laythe, Finkel, Bringle, & Kirkpatrick, 2002), there is a dearth of literature to date that has explored how the religious fundamentalism of counselor trainees might impact the therapeutic relationship. While research has suggested that religious fundamentalism affects attitudes towards the LGBT community, there has been no consensus in the literature regarding the role religious fundamentalism plays with regard to empathy (Bradley, 2009; Duriez, 2004).

Sue, Arredondo, and McDavis (1992) suggested that being a culturally competent counselor involves an awareness of individual beliefs and attitudes and how they might impact the client. In order to comply with ethical standards, counselors need to understand how their own
beliefs and value systems can impact the therapeutic relationship (Sue, Arrendondo, & McDavis, 1992). A counselor’s attitude towards the LGBT community can negatively impact treatment outcomes (Bowers, Plummer, & Minichiello, 2005). If counselors are to practice ethically, these attitudes and their potential impact, as well as the ethical dilemmas created by this form of discrimination, need to be more thoroughly investigated and addressed, thus, exposing counselors to LGBT workshops, panels, and integrating LGBT issues within the counseling curricula can increase knowledge, awareness, skills, and result in more qualified counselors and better treatment outcomes (Croteau & Kusek, 1992; Granello, 2004; Kocarek & Pelling, 2003). This research has given counselor educators a starting point for understanding the role religious fundamentalism plays in regards to empathy and attitudes. Additionally, it will aid counselor educators in developing ethics and multicultural curricula appropriate for the LGBT community.

Limitations and delimitations.

Limitations.

There are several limitations that are present within this study, the first limitation is that the three
assessments given are self-report. Because counselor trainees are educated to be as unbiased as possible, there is the likelihood of over-representing oneself in a positive way. This tendency has been described as faking good, or the desire to show oneself in a positive light (Wiggins, 1966). Research regarding the religious fundamentalism and empathy connection is limited and conflicting. Duriez (2004) suggested that there is absolutely no connection between empathy and religiousness, but Bradley (2009) proffered through empirical research that religious fundamentalism can decrease empathy. This relationship had not been examined in counselor trainees.

**Delimitations.**

Participants in this study were delimited to include only counselor trainees in CACREP accredited programs. Counselor trainees were used because they are individuals who have limited, if any, counseling experience. In addition, they are individuals who have recently been introduced to ethics and the principles of the counseling relationship.
Definition of Terms

Counselor Trainee: For the purposes of this study, a counselor trainee is an individual that is currently enrolled in a counseling Master’s program and does not hold a current state counseling licensure.

Empathy: An individual’s awareness of the way another person is feeling (Hoffman, 1989)

Extrinsic Religiousness: “...the religion of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself (Donahue, 1985, p. 400).

Gay: For the purposes of this study, gay was defined as a male that is sexually attracted to males and identifies with the political label.

Heterosexual Bias: The implicit or explicit assumption that heterosexuality is superior to any other representation of sexuality (Morin, 1977).

Heterosexual Privilege: The benefits, privileges, freedoms, and rights, given to heterosexual individuals that members of the LGBT community do not have (Rocco, 2006).

Homophobia: The irrational fear or hate of LGBT individuals, which can result in prejudicial and discriminatory behaviors (Van Wormer, Wells, & Boes, 2000).
**Internalized Homophobia:** The degree to which an individual internalizes the commonly held ideas, stereotypes, and stigmas associated with the LGBT community (Herek, Cogan, Gillis, & Glunt, 1998).

**Institutional Bias:** “...involves discriminatory practices that occur at the institutional level of analysis, operating on mechanisms that go beyond individual-level prejudice and discrimination” (Henry, 2010, p. 426).

**Intrinsic Religiousness:** A type of religiousness in which an individual tries to internalize their religious faith and live accordingly (Wenger, 2007)

**Lesbian:** For the purposes of this study, lesbian was defined as a female that is sexually attracted to females and identifies with the political label

**Quest Religiousness:** “...religion is an open-ended process of pursuing ultimate questions more than ultimate answers (Batson, Naifeh, Pate, 1978, p. 40)”

**Religiosity:** How involved people are in their religions and religious ideologies (Whitley, 2009).

**Religious Fundamentalism:** “...the belief in one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity
and deity; that is essential truth is fundamentally opposed by forces of evil which must be vigorously fought; that this truth must be followed today according to the fundamental, unchangeable practices of the past; and that those who believe and follow these fundamental teachings have a special relationship with the deity (Altemeyer & Hunsberger, 1992, p. 118).
Summary.

Chapter 1 provided an introduction about the study. This chapter constructed a conversation around the background information of the study, and examined the statement of the problem and the significance of the study. Limitation and delimitations of the study were examined and the definition of the terms were provided. The next chapter provides a literature review regarding the empirical and theoretical assumptions of the study.
Chapter 2 Literature Review

Approximately 3.8% of the American population self-identifies as being Lesbian, Gay, Bisexual, or Transgendered (LGBT) (Gates, 2012). The U.S. Census Bureau (2010) suggested that the population of the United States is approximately 315,334,509. With that said, 3.8% of the United States population would attribute to roughly 11,982,711 individuals who identify with the LGBT community. While 3.8% of the population may seem insignificant, upon closer inspection, approximately 12 million individuals is a significant number.

An observation would be that this number only identifies the individuals who are comfortable enough to self-identify with the label and the stigma that is associated with the LGBT community. There are individuals that experience same-sex attractions but refuse to let their behavior distinguish their identity. Despite the acknowledged inaccurate numbers, Gates (2012) suggested that efforts should be directed toward an in-depth exploration of the problematic issues that surround the LGBT community rather than the actual number associated with them.
The birth of the current LGBT movement within the United States sprang from the seminal uprising at Stonewall on June 27, 1969 (White, 2008). To that point, the efforts to form a cohesive identity within the United States met with much difficulty. The LGBT community attempted to form a coherent identity for years before the events that took place in New York on that evening, but as Bernstein (2002) noted, they faced state politics that encouraged discriminatory practices against them. Individuals within the LGBT community were not protected by their local and state governments, and, during this time, LGBT persons were often arrested and harassed by law enforcement. Furthermore, they were pathologized by the American Psychiatric Association (Bayer, 1987).

The medicalization of homosexuality came from the increasing political and visible LGBT individual seeking a greater sense of acceptance within the overall society (Forstein, 2001). The beginning of this movement began in 1952 with the American Psychiatric Association (APA) classifying homosexuality as a mental illness—calling it a sociopathic personality (Forstein, 2001). This new diagnosis was styled in such a way that it conjured fear within the majority heterosexual population. The
medicalization of homosexuality, which suggested treatability and, eventually, a cure, continued to prevail in the literature and profession as a mental disorder until 1987 when it was eventually removed from the DSM (Forstein, 2001).

**HIV/AIDS and Discrimination**

After the Stonewall Riots, the LGBT community within the United States had a more coherent and visible identity; however, this identity and visibility did not change the fact that many faced on-going personal and political struggles. While their voice was larger, the prevailing attitudes towards this minority group remained negative. The HIV/AIDS crisis brought vocal criticism from both political pundits and religious leaders. Indeed, the AIDS epidemic made discrimination against the LGBT community more noticeable and even justifiable to the heterosexual community (Bernstein, 2002).

During the time of the HIV/AIDS crisis, Reagan was president of the United States. The HIV/AIDS epidemic was more than a public health crisis; it was a political one, too. Francis (2012) observed that, due to political reasons, the Center for Disease Control (CDC) was financially strapped during the years of the HIV/AIDS
epidemic. Francis (2012) further commented that the White House did not understand its role in this public health crisis and refused to sponsor preventive health measures. As a result, more individuals ultimately became infected with the HIV virus which led to a greater loss of life (Francis, 2012).

While the LGBT community has come a long way since the Stonewall Riots, discrimination against the LGBT community still exists in almost every facet of daily life within the United States. While some forms of discrimination are more subtle than others, the general notion of ‘us versus them’ still persist (Harper & Schneider, 2003). Perhaps the most drastic forms of discrimination are the pieces of legislation that differentiates the LGBT community from the straight dominant culture. While Don’t Ask, Don’t Tell was repealed in 2010 (Allen & Tiron, 2010), The Defense of Marriage Act (DOMA), and the other rights that come with heterosexual privilege are still being fought by the LGBT community (Johnsen, 2012).

Scholars have explored the concept of intergroup bias when attempting to understand what mediates or causes these discriminatory practices. Hewstone, Rubin, and Willis (2002) defined intergroup bias as viewing the membership to
one group (in-group) superior to that of the other group (out-group). Johnson, Rowatt and LaBouff (2012) pointed out that many of the world’s major religions encourage followers to be tolerant or accepting of individuals who disagree or hold different belief systems. Despite this, though, it has been argued that the more religious the individual, the more prejudicial he tends to be by nature (Saraç, 2012). Johnson, Rowatt, and LaBouff (2012) reported that higher levels of religiosity directly correlate to intergroup bias towards out-groups, such as the LGBT community. Jackson and Hunsberger (1999) went further in saying that prejudice against religious out-groups exist in all religious individuals, thus explaining and confirming intergroup bias.

**Religious Orientations**

While intergroup bias can explain how an overall group can tend to discrimination and have prejudicial attitudes, scholars have explored individual characteristics which generally appear in prejudiced, religious individuals. Allport and Ross (1967) argued that there are two distinct religious orientations: intrinsic and extrinsic. An individual who holds an intrinsic religious orientation practices his belief pattern for his own personal
fulfillment. Wenger (2007) suggested that such an individual attempts to live according to their internalized religious faith. Alternatively, an individual who uses his religious orientation for social gain holds an extrinsic religious orientation. This dichotomous relationship helped an individual classify ones specific religious orientation and helped one quickly identify whether they were more prone to discriminatory practices. While this revelation is helpful, these two labels remain problematic for individuals who do not altogether fit in either category. Thus, a third type of religious orientation called quest was developed. Individuals with this particular religious orientation tend to be more flexible when faced with the complexities that surround religion.

When attempting to understand the religion-prejudice connection, scholars have used the intrinsic versus extrinsic religious orientations to measure an individual’s likelihood to engage in discriminatory behaviors towards the LGBT community. Herek (1987) investigated the role religious orientation played with regard to attitudes towards the lesbian and gay out-group that is not readily accepted by many religious communities. The participants included 126 total respondents from four universities. The
findings from the study suggested that when religious
doctrine encourages open-mindedness, individuals with an
intrinsic religious orientation tend to be less prejudice
when compared to individuals who hold an extrinsic
religious orientation. However, when religious teachings
do not encourage impartiality, individuals who hold an
intrinsic religious orientation tend to be no less
prejudiced than individuals who have an extrinsic religious
orientation (Herek, 1987). These findings suggested that
individuals who deem the LGBT community as an out-group are
more than likely to be prejudiced, which can lead to
discrimination.

**Religious Fundamentalism**

While researchers have explored intrinsic, extrinsic,
and quest religious orientations in relation to prejudicial
attitudes, they have also made inquiries into another
element of religiosity, that of religious fundamentalism.
Altemeyer and Hunsberger (1992) described religious
fundamentalism as a devotion to a particular set of
religious beliefs that are understood to be the absolute
truth about existence. Kirkpatrick (1993) suggested that
religious fundamentalism was a stronger predictor of
prejudice than any of the previous three listed religious
orientations. Individuals who are religiously fundamental want to protect the ideology of the status quo and resort to discriminating against the out-group (Brandt & Reyna, 2010; Hunsberger & Jackson, 2005).

Brandt and Reyna (2010) implied that religious fundamentalism was powerful in reducing instability within an individual’s life, provided norm stability, and promotes prejudicial behavior. Religious fundamentalists are more likely to have black and white thinking while failing to see the areas of grey, which protects the in-group. Brandt and Reyna (2010) suggested that by discounting out-groups through prejudicial and discriminatory acts, religious fundamentalist are better able to protect the status quo of the in-group. Brandt and Reyna (2010) concluded that an individual with a fundamentalist belief pattern was able to legitimize their prejudicial beliefs and discriminatory acts based on the need for distinct existential answers.

Laythe, Finkel, Bringle, & Kirkpatrick (2002) examined the role religious fundamentalism plays regarding prejudice among a group of students enrolled in introductory psychology and sociology classes. They acquired samples from two mid-western universities and one southern university, comprising 318 students in all. When the
authors ran the zero-order correlations, religious fundamentalism was a strong predictor of homosexual prejudice (Laythe, Finkel, Bringle, & Kirkpatrick, 2002).

Schwartz and Lindley (2005) conducted a study to see if religious fundamentalism and attachment were predictors of homophobia. The sample consisted of 198 students from psychology classes from a southern university. The findings of the study support the notion that religious fundamentalism is positively related to homophobia. Additionally, they concluded that men tend to be more homophobic than women, which was consistent with previous research.

Sanabria (2012) examined religious fundamentalism as a predictor of homoprejudice. The author used a convenience sample of 477 undergraduate students. The author used a multiple regression to examine the relationships in question. The results suggested that religious fundamentalism was a significant predictor of homoprejudice (Sanabria, 2012). The author suggested that counselors should explore their own feelings about homosexuality and religion, examine how fundamentalist beliefs may impact the therapeutic/supervisory relationship, and suggested that
multicultural training could help improve prejudicial attitudes (Sanabria, 2012).

**Religious Orientation, Religious Fundamentalism, and Empathy**

Many of the world’s major religions suggest that we are to treat others as we wish to be treated (Herek, 1987). While this Golden Rule notion has been styled as ideal, religiosity has often fueled hatred and intolerance. Because of the discrepancies between the pulpit and individual/group practice, many have asked if there was a relationship between religiosity, religious orientation, and empathy. Scholars claimed there was a positive relationship between an intrinsic and questing religious orientation and greater levels of empathy (Khan, Watson, Habib, 2005).

Bradley (2009) suggested that previous studies have investigated the religion-prejudice relationship and have reported mixed findings. For instance, Duriez (2004) explored the religion and empathy relationship. A sample of 375 first-year psychology students with a mean age of 18 took part in the study. Duriez (2004) concluded that there was no relationship between religiosity and empathy. Moreover, the author suggested that it was the motive
behind an individual’s approach to religion relates more strongly with his level of empathy. Whether this individual is intrinsically or extrinsically motivated determines how empathetic he will be toward the out-group.

In contrast to Duriez’s findings, other scholars have argued that a relationship does exist between religiosity and empathy. Bradley (2009) used the Interpersonal Reactivity Index (IDI) to measure empathy across four dimensions: empathic concern, perspective-taking, personal distress, and fantasy abilities. This study found that religious fundamentalism led to lower levels of empathy and that lower levels of empathy may lead to prejudicial behaviors, such as homophobic attitudes.

**Current Trends Regarding LGBT Community and Religion**

Henrickson (2009) suggested that same-sex attraction has been one of the most divisive issues that have faced churches. This contentious political issues has took center stage within congregations and carries incredible emotionality (Super & Jacobson, 2011). Lalich & McLaren (2010) suggested that the reason this issue remains charged has been due to the fact that many faiths had a dichotomous belief system, which suggested there was a distinct right versus wrong ideology. This ideology has stemmed from the
literal interpretation of Biblical scriptures that have condemned homosexual activity and homosexual acts.

Literal interpretations of the Bible have fueled some of the homophobic attitudes within church congregations; however, there are changes that have been taking place within mainstream churches. In July of 2012, the Episcopal church supported and same-sex relationships; however, failed to fully legitimize same-sex marriage (“Religious Groups’ Official Positions on Same-Sex Marriage, 2012”). However, the Catholic Church, American Baptist Church, and the Church of Jesus Christ of Latter Day Saints still does not recognize same-sex marriage within the faith communities. Because of this, LGBT individuals who attend these religious services and are part of these fundamental faith communities could potential experience internalized homophobia. This internalized homophobia has been described as a predictor of greater rates of psychopathology (Barnes & Meyer, 2012). Counselors are uniquely positioned to help individuals process their internalized homophobia; however, a counselor’s own personal belief pattern could potentially impact the therapeutic process.
Counselor’s Empathy, Beliefs, and Worldview

In similarity with their clients, counselors have histories that often dictate their worldview. Counselors are expected to provide insight and unbiased counseling within the therapeutic relationship. While ideally a counselors’ own worldview would not get in the way, previous research has suggested that an individual who scores higher on a religious fundamentalism scale will have lower levels of empathic concern, perspective-taking, and fantasy ability regarding the IRI (Bradley, 2009). If greater levels of religious fundamentalism impact the level of empathy, how does that background and approach impact the therapeutic outcomes of the counseling experience?

Empathy has been described as one of the most important features of an effective therapeutic relationship (Chi-Ying Chung & Bernak, 2002). In fact, Roger’s Client-Centered Therapy suggested that empathy was required for the counselor to understand their client’s personal experience (Overholser, 2007). If a counselor is unable to fully enter into what their client is experiencing, the therapeutic experience and relationship would be fruitless.

A counselor’s ability to be empathetic within the therapeutic relationship is vital to positive outcomes.
Mullen and Abeles (1971) explored the relationship of liking, empathy to the outcome of therapy. Their sample consisted of 36 therapists, all of whom participated voluntarily. The findings affirm that successful counseling sessions largely depend upon high amounts of empathy (Mullen and Abeles, 1971). Unfortunately, Feller and Cottone (2003) lately observed a sharp decrease in the amount of empathy within counseling literature. Even more alarming is the dearth of information regarding a counselor’s empathy toward the LGBT community.

**Changes in Empathy**

Empathy has been described as an integral part of the therapeutic relationship (Rogers, 1957). While many believe that empathy is static, Bellini, Baime, and Shea (2002) suggested it is possible for empathy to change over time with an individual’s experience. Bellini et al. (2002) explored medical student’s mood and empathy across a year-long internship. They used the Profile of Mood States Manual (POMS) and the Interpersonal Reactivity Index (IRI) to measure the intern’s mood and empathy. Over the course of the internship, each of the 61 interns completed these two measures four different times. The results suggested
that throughout the internship process, the interns had fluctuating mood and empathetic concerns.

Sherman and Cramer (2005) examined the changes in empathy during dental school. Within this study, the author’s sampled 130 dental students from the University of Washington School of Dentistry. Because students of dentistry begin seeing patients during their second year, Sherman and Cramer (2005) chose the Jefferson Scale of Physician Empathy–Health Profession Version (JSPE-HP), which focuses on actual behavior instead of attitudes. While the results confirmed that the empathetic relationship between the dentist and patient had a dramatic impact on both the patient’s and student’s satisfaction, the results also suggested that dental students in their first year had higher score of empathy than in their second year when they began dealing directly with patients (Sherman and Cramer, 2005). At this point, their empathetic concern dropped. These self-report measures suggest that levels or degrees of empathy are not fixed.

Pecukonis (1990) sought to investigate whether an empathy training program could affect the empathy of adolescent females in a residential treatment facility. During this study, the author explored the relationship
between ego development and empathy. For the sample, the author used 24 female students who were deemed aggressive. These females were administered the Hogan Empathy Test (1969) and a measure of emotional empathy developed by Mehrabian and Epstein (1972) to get their baseline empathy scores, both of which were self-report. The third test measured the girls’ ego development using a semi-projective test constructed by Loevinger and Wessler (1970). The author reported a positive relationship between ego development and both affective and cognitive empathy. Pecukonis (1990) reported that affective empathy scores were positively changed after only six hours of training; however, cognitive empathy scores remained unaffected. These findings suggest that empathy was not a static individual quality. Because of this, counselor trainees’ level of empathy could increase through curricula.

Lovell (1999) conducted a study examining the relationship between cognitive development and empathy in counseling students. Previous research found a positive relationship between higher levels of cognitive development and higher levels of empathy; however, a large nationwide study had not been completed at that point. The authors asked the American Counseling Association (ACA) for a
randomized computer sample of their student members. Of the 2000 students that were sent invitations to participate in the study, the author had 340 usable responses. Lovell (1999) used the Hogan Empathy Scale to measure respondent’s empathy, and The Learning Environment Preferences Scale (LEP) to measure cognitive development. Lovell (1999) concluded that there was a positive relationship between empathy and greater cognitive development. Lovell (1999) thus suggested that if counselor educators can develop higher levels of cognitive development, then this would translate into higher levels of empathy for the counseling students.

The current research demonstrated that empathy was not a static, individualized trait. In fact, research has shown empathy as an on-going, evolving characteristic in an individual’s life (Lovell, 1999; Bellini, Baime, Shea, 2002; Sherman & Cramer, 2005). If cognitive development can increase a counselor’s level of empathy, then focused, purposeful education with the goal of increased awareness can increase the amount of empathy in the therapeutic relationship. While there has been a paucity of research on the role religious fundamentalism has played on a counselor’s empathy within the therapeutic relationship, it
could be argued that religious fundamentalism can directly impact the amount of empathy that a counselor may have for their LGBT client.

**Historical Views in Counseling Regarding the LGBT Community**

Because of the medicalization of homosexuality, the medical community, and more specifically the mental health field have sought ways to minimize or change same-sex sexual behavior and attraction. In fact, Hadleman (1994) suggested that different forms of therapeutic interventions have been used in an attempt to change an individual’s sexual orientation. Within the mental health community, early practitioners held the notion that homosexuality and same-sex attraction was unwanted and unhealthy (Hadleman, 1994). Because of this, sexual orientation conversion therapy was introduced.

Sexual orientation conversion therapy primarily come from two distinct programs: psychological and religious. Both of these treatment modalities are based on the a priori assumption that homosexual behavior and attraction are unwanted by the individual (Hadleman, 1994). Regarding the psychological component of sexual orientation conversion therapy, Hadleman (1994) suggested that most therapies come from two basic hypotheses: attachment
patterns, and faulty learning. Hence, psychoanalytic theory has been used in an attempt to change the ‘faulty’ or ‘unwanted’ sexual orientation. With that said, there has been no evidence that this type of therapeutic intervention has been effective. In fact, the studies that have shown sexual orientation conversion therapy to be effective have methodological flaws (Cramer, Golom, LoPresto, Kirkley, 2008). Due to the lack of empirical evidence for sexual orientation conversion therapy, the therapeutic intervention presented a host of ethical concerns defined by the ACA.

Engaging in sexual orientation conversion therapy presents a host of ethical concerns. Yarhouse and Throckmorton (2002) suggested that there were three reasons to ban sexual orientation conversion therapy: homosexuality was not pathological, internalized homophobia led clients to seek sexual orientation conversion therapy, and human sexuality was unchangeable. Because homosexuality has no longer been labeled as a DSM diagnosable disorder, treatment for homosexuality would not be congruent. The second argument presented by the authors suggested that individuals seek treatment for homosexuality due to their internalized homophobia. Yarhouse and Throckmorton (2002)
suggested that individuals that provided therapy on the basis of this were guilty of prejudice. Sue, Arredondo, and Davis (1992) suggested that counselors should be aware of their own biases and how those biases impact their clients. The third argument was that sexual orientation was static and unchangeable. Because of this, a counselor agreeing to ‘change’ and individual’s sexual orientation would have potentially caused harm going against the ethical principle of nonmaleficence. Nonmaleficence is defined as “doing no harm” to clients.

Counseling Licensure, CACREP, and Counselor Trainees

All helping professions strive for licensure status. Bergman (2013) suggested that helps an organization become more organized and legitimate, while working towards common goals. The counseling profession’s goal has been no different. Although the process took approximately 33 years, all 50 states, as of 2009, licensed counselors (Bergman, 2013).

For a counselor trainee to obtain licensure, there has to be an educational and training component. Bergam (2013) suggested that both educational classes and a training requirement are key ingredients when it comes to licensure. Bergam suggested that all state licensure boards require
that the counseling degree come from an accredited program, and if not, most require the courses to be aligned with the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards.

The educational component ensures that all counselor trainees have met the minimum requires to practice in an ethical manner. Knowledge, skills, and awareness are measured through examinations that have been outlined by the state licensure board. Bergman (2013) suggested that there are two exams that have been used to measure competency: the National Counselor Examination for Licensure and Certification (NCE) and the National Clinical Mental Health Counseling Examination for licensure (NCMHCE). The NCE is a generalist counseling exam that covers the knowledge that counselors should possess before practicing (ACA, 2010). The NCMHCE is an examine that measures a counselor’s ability to analyze and synthesize the competencies needed by counselors (ACA, 2010). The NCMHCE is more specific in nature than the NCE.

**Multicultural Counseling, Legislation, and the LGBT Community**

Empathy has been described as a vital component within the therapeutic relationship (Chi-Ying, Chung & Bemak,
2002; Lambert & Barley, 2001; Overholser, 2007). Yet, the counselor approaches the counseling setting with a past behavioral history that includes beliefs, stereotypes, and prejudices, just as an untrained individual would. While this past learning history is inevitable and perhaps difficult to suppress, the counselor still needs to be cognizant of his personal preconceptions and predispositions so as not to interfere the purpose of the therapeutic relationship, especially regarding the LGBT community. In order to become a more culturally competent counselor, this individual needs to understand the ethical principles set forth by the profession in the hope of being the most effective in his relationship with his patient.

All helping professions, and more specifically the ACA, strictly forbid discrimination against an individual’s sexual orientation. Currently, there is a debate occurring within the Tennessee Legislature which seeks to protect the views of counselor’s whose beliefs forbid them from affirming LGBT individuals. The current act seeks to amend Tennessee Code Annotated, Title 4 and Title 49, which does not allow higher education institutions to discriminate against students who openly refuse to counsel sexual minorities due to their firmly held religious beliefs.
This act is set to take effect July 1, 2013. A similar bit of legislation has been brought forth within the Michigan’s Senate. Senate Bill 975 allows health care facilities to discriminate against individuals based on an individual’s conscience. While this bill does not delineate discrimination based on sexual orientation, it goes further to suggest that one can discriminate based on anything that is against their personal moral code. Hence, this law suggests that a counselor’s individual morality is superior to the ethics of the profession under which they practice. These two laws defeat the multicultural competencies required by the profession, suggesting that counselors come for a position of power, and hence can discriminate against individuals who are different from them. Moreover, it is in direct violation of the ethical principles set forth by the ACA.

The primary responsibility of the therapist is to promote welfare of their clients (ACA, A.1.a., 2005). Regarding the therapeutic relationship, it is important to keep in mind the six ethical principles, as observed by Cottone and Tarvydas (2007): autonomy, nonmaleficence, beneficence, justice, fidelity and veracity. Each of these principles play a unique role in ensuring the client is
protected. Within the therapeutic relationship, autonomy is defined as the freedom and ability to make a choice or decision (Cottone and Tarvydas, 2007). This includes the client’s privacy, informed consent, and respect; however, autonomy within the therapeutic relationship does not suggest unlimited freedom. Restrictions of autonomy include competence and infringing upon the rights of others.

The second principle, nonmaleficence, discourages any harm caused to the client. While the idea of harm seems cut and dry, within the therapeutic relationship, it is hard to dictate the subjective nature of harm. Kitchener (1984) pondered how much harm is too much harm. Section A.4 within the code of ethics echoes Kitchener, suggesting that counselors should avoid harming their clients and imposing their personal values (ACA, A4, 2005). This idea is important with regard to a counselor’s belief pattern about the LGBT community. If a counselor is unsure whether they are able to work with an LGBT client, then the code of ethics dictates that they need to seek knowledge, awareness, and skills to provide culturally sensitive services (ACA, C.2.a, 2005).
The principle of beneficence suggests that counselors should act in a way that is benefiting the client or promoting a positive sense of growth within the individual (Cottone and Tarvydas, 2007). While this would seem like routine practice, counselors within the counseling relationship sometimes do not take into consideration the client’s wishes, ignoring their autonomy in the process.

The last three ethical principles, justice, fidelity, and veracity, are broadly defined as fairness, faithfulness, and truthfulness (Cottone and Tarvydas, 2007). In order to be fair within the therapeutic relationship, counselors would need to understand the facets of the LGBT community and understand their own heterosexual bias, homophobia, and personal prejudices. ACA (2005) code C.5. dictated that a counselor is not able to condone or engage in any forms of discrimination. Kitchener (1984) suggested that all persons have the right to be treated equally. Fidelity within the therapeutic relationship is essential. If there is no faithfulness or trust, a positive outcome would certainly be impossible. Finally, truthfulness, or veracity, is a staple within the therapeutic relationship. Section B, relating to
confidentiality, privileged communication, and privacy, are applicable to veracity.

While the six ethical principles are a guiding light and force within the field of counseling, it can be overshadowed by an individual’s own subjectivity. Kitchener (1984) suggested that applying ethical principles to problem-solving behavior can prove difficult. This is particularly true when counseling individuals hold different belief systems or values to that of their patients.

Sue, Arredondo, and McDavis (1992) proposed a call to the counseling profession because of the quickly changing demographics within the United States. The authors outlined cross-cultural counseling competencies based on knowledge, skills, and beliefs/attitudes, in hopes of promoting the idea of multiculturalism and diversity within the counseling profession. While diversity has focused on race, religion, and ethnicity, it is important for counselors to remain cognizant of the role sexual orientation plays within the counseling profession.

Kinsey, Pomeroy, and Martin (1948) suggested that the LGBT community makes up the largest minority group, accounting for as much as 10-15% of the population. With
numbers this high, it is inevitable that an individual who practices as a counselor will encounter someone who identifies with the LGBT community. While Israel and Hackett (2004) believe many counselors will feel uncomfortable engaging in a therapeutic relationship with members of the LBT community, it would be inappropriate, if not unprofessional, for counselors to remain untrained and unqualified to deal with this growing demographic. The bias that counselors hold towards the LGBT community may stem from stereotypes that are perpetuated to maintain them as an out-group. Since counselors are encountering the LGBT community more and more, understanding stereotypes is important. Chen-Hayes (1997) examined eighteen common stereotypes associated with the LGBT community. Some of the stereotypes explored include bisexuality, the duration of same-sex relationships, parenting, promiscuity, HIV/AIDS, and an LGBT’s faith community. Several stereotypes are presented throughout the article, such as child molesters are homosexuals, homosexual relationships do not last, bisexuality is not a real form of sexuality, and all members of the LGBT community are great dancers (Chen-Hayes, 1997). Afterwards, the author debunks the
stereotype that is often used to protect the ideology associated with the status quo.

While it is hoped that all counseling programs are embedded with ethics and multicultural curricula, the curriculum can be assured if an individual is enrolled within a CACREP accredited counseling program. While all individuals possess their own personal biases and prejudices, it is important for counselor trainees to gain insight into not only how those biases impact their counseling, but how to put them aside in the therapeutic relationship for the most optimal outcome, especially with regard to diverse populations. Since programs are accredited, there is assurance that counseling students are going to gain the specific knowledge required to counseling LGBT individuals and their families. Logan and Barret (2006) suggested that providing culturally sensitive counseling to the LGBT community is vital, and that is the benefit of being enrolled in a CACREP accredited counseling program.

Counselors and counselor trainees must understand the importance of empathy within the therapeutic relationship. Furthermore, understanding the ethical principles and foundations set forth by the ACA is vital in promoting
wellness. This has been particularly true for members of the LGBT community, considering that LGBT individuals incorporate the largest invisible minority.

**Rationale for Instrumentation**

To understand the relationships addressed within the study, the Basic Empathy Scale developed by Jolliffe and Farrington (2006), The Attitudes Toward Lesbians and Gay Men Scale developed by Herek (1988), and the Revised Religious Fundamentalism Scale developed by Altemeyer and Hunsberger (2004) were used.

The Basic Empathy Scale (BES) is made up of twenty self-report questions. The BES measures three types of empathy: affective, cognitive and overall empathy. There are many different types of empathy scales, but none specifically for counselors. The Interpersonal Reactivity Index (Davis 1980; Davis, 1983), Hogan’s Empathy Scale (Hogan, 1969), Jefferson Scale of Physician Empathy (Hojat, Gonnella, Nasca, Mangione, Veloksi, Magee, 2002) are all widely used. When examining the scales, each scale had unique problems. The Interpersonal Reactivity Index (Davis 1980; Davis, 1983) consisted of 28 questions and measured empathy across four dimensions: perspective taking, empathetic concern, personal distress, and fantasy.
Hogan’s Empathy Scale (Hogan, 1969) only measured overall empathy and consisted of 64 questions. The Jefferson’s Scale of Physician Empathy, on the other hand, is specific towards physicians. Thus, the BES seemed like the best fit due to its ability to measure affective, cognitive and overall empathy in twenty questions.

There are several widely used scales within the literature that measure attitudes towards the LGBT community. The Homosexuality Attitude Scale has good internal consistency (alpha >.92) and good test retest reliability (r=.71), but it only measures overall attitudes about the LGBT community (Kite and Deaux, 1986). The Components of Attitudes Toward Homosexuality is a multi-dimensional scale that measures condemnation/tolerance, morality, contact, and stereotypes (LaMar and Kite, 1998). However, this scale fails to provide a detailed analysis of an individual’s attitudes towards the LGBT community (LaMar and Kite, 1998). For this particular study, the Attitude Toward Lesbian and Gay Scale (Herek, 1988) will be used. The Attitude Toward Lesbian and Gay Scale, consisting of twenty questions, is perhaps the scale that is most widely used within the literature when examining attitudes towards the LGBT community. This scale is unique because it
measures overall attitudes towards lesbian and gays, but it can also be broken down into attitudes towards lesbians and attitudes towards gays.

Religious fundamentalism has been on the rise during the past thirty years (Emerson and Hartman, 2006). This rise in religious fundamentalism has led the development of means to measure the construct. Altemeyer and Hunsberger (1992) developed a 20-item scale that used a 9-point Likert scale to measure the intensity of religious fundamentalism. The scale has strong psychometric properties with alphas at .92 (Altemeyer and Hunsberger, 2004). Altemeyer and Hunsberger (2004) suggest that this scale had a problematic theme of focusing on ‘one true religion’ and researchers shortening the scale within their studies. Altemeyer and Hunsberger (2004) developed a Revised Religious Fundamentalism Scale, which shortened the scale to twelve questions, while keeping, and in some cases improving, its psychometric properties. Therefore, the Revised Religious Fundamentalism Scale will be used in this study.

**Theoretical Literature**

In most cases, theory precedes empirical inquiry, which is often the means through which theory is either justified and expanded or discredited. Alternatively, a
theorist may seize upon a small or growing body of empirical literature and create a theoretical structure to house and connect that literature and provide a springboard for future research and present practice. There is not a great deal of empirical or qualitative literature as to the lives and psychology of sexual minorities as interest and inquiry into this demographic is relatively new. As a result, there has been limited theoretical base or structure in this area of study. While some theoretical models of identity have been proposed, such as Troiden's there is not much research beyond this study (Troiden, 1989). Frequently, in such a situation, it is common practice to go "next door" for a other working theoretical models, but no appropriate model exists here in this case.

For example, researchers may be tempted to adopt theoretical models developed for the study of other minority populations, such as women or African Americans, but such models do not travel well when considering sexual minorities. The reason is simple: the normal sexuality of gay men and lesbian women has been defined as pathological by the heteronormative population, by whom and for whom almost all research has been developed and implemented. Much of that research was and is employed to pathologize
the natural feelings of the gay men and further oppress sexual minorities as a whole. Unlike ethnicity, race or class, sexuality cuts across all categories and is both invisible and foundational; the risk of vulnerability increases exponentially with each characteristic.

Unfortunately, no theory has been developed in which to house the existing literature in a meaningful way and provide the counseling profession with a structure within which to counsel and research. This lack is perhaps due to the heternormative/homophobic nature of the dominant culture in the United States. Post-modern feminism and Queer Theory have, to date, provided the best attempts to recognize the gap and begin to address it, but even these sympathetic schools of thought have not yet approached the complex and critical issues of same-sex attraction and religious fundamentalism (Hopkins, Sorensen & Taylor, 2013). It is astounding, but not surprising, that no such efforts have been made for sexual minorities thus far.

While it is an aspect of research that needs to be addressed immediately and while this report seeks to do so, it bears repeating that there no overarching theory of counseling currently exists to explain and interpret the variables that are being examined in this study.
Summary

Chapter two explored the themes and gaps within the current body of literature. There have been no studies that have explored whether there was a relationship between religious fundamentalism and empathy in counselor trainees. Furthermore, there has been no mention as to whether religious fundamentalism predicted attitudes towards sexual minorities within counselor trainees. The literature showed that religious fundamentalism was a predictor of discrimination and prejudicial behavior. However, there was conflicting evidence as to whether religious fundamentalism affected empathy.
Chapter 3 Methodology

The main purpose of this chapter was to describe the methodology and research design of the study. The research design, the operational design of the variables, population, sampling plan, instrumentation, data collection procedures, data analysis procedures and the summary are presented. The researcher obtained approval from Ohio University’s Institutional Review Board (IRB) before the data collection process began.

Research Design

Quantitative research methods were employed to examine the relationship between religious fundamentalism and empathy in counselor trainees. Additionally, the combination of religious fundamentalism and empathy was explored to see if it predicted attitudes toward lesbians and gays in counselor trainees. Descriptive statistics, correlation analysis, and multiple regression analyses were used to ascertain the results, which are presented in Chapter 4. A correlational studies are used to examine links or associations between two variables for research. In research question one, the relationship between religious fundamentalism and empathy is explored. For research question 2, there were a combination of two
variables, religious fundamentalism and empathy, that were used to predict attitudes toward sexual minorities. Descriptive statistics are the basic quantitative measures that are used to describe the data. They are summary information of what the data represents. Factor analysis are ways to measure the number of underlying constructs that are being represented within a survey. Factor analysis were examined on the Basic Empathy Scale, Revised Religious Fundamentalism Scale, and the Attitudes Toward Lesbians and Gays Scale.

**Research Questions**

The following research questions were explored:

1. For counselor trainees, is there a relationship between religious fundamentalism and empathy?

   **Null Hypothesis One:**
   
   For counselor trainees, there is no relationship between religious fundamentalism and empathy.

   **Alternative Hypothesis One:**
   
   For counselor trainees, there is a relationship between religious fundamentalism and empathy.

2. Does the combination of religious fundamentalism and empathy in counselor trainees predict attitudes toward sexual minorities?
Null Hypothesis:
The combination of religious fundamentalism and empathy in counselor trainees does not predict attitudes toward sexual minorities.

Alternative Hypothesis:
The combination of religious fundamentalism and empathy in counselor trainees does predict attitudes toward sexual minorities.

Identification of the Population

The population utilized for this study was counselor trainees from Council for Accreditation of Counseling and Related Educational Programs (CACREP) counseling programs within the United States. There are 622 CACREP school programs within the United States. A geographically stratified random sample was used to obtain the sample. CACREP has divided the 622 different school programs into 5 geographic regions: North Atlantic, North Central, Southern, Rocky Mountain, and Western.

Participants were master level counseling students that had not yet been licensed by their state counseling licensing board. Limiting the study to master level students was important, because they typically have limited clinical experience. While individually, their clinical
experience might have varied, licensure ensures a uniform set of guidelines have been achieved before they are able to practice professionally—ensuring knowledge not necessarily technique or experience. Because CACREP certifies both master and doctoral level counseling programs, a question on the demographic questionnaire was used to ensure only master level students participated.

**Sampling Plan**

CACREP is an accrediting body that ensures that the professional counseling standards are met throughout its coursework. In order to obtain a sample, CACREP liaisons were solicited from CACREP’s website. A geographically stratified random sample of CACREP accredited programs were chosen from the five geographical area. The five geographical areas are the following: North Atlantic, North Central, Southern, Rocky Mountain, Western. The North Atlantic Region is made up of the following states: Pennsylvania, New Jersey, New York, Vermont, New Hampshire, Maine, Massachusetts, Connecticut, and Rhode Island. The North Central region is made up of the following states: North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, Missouri, Iowa, Minnesota, Michigan, Wisconsin, Illinois, Indiana, and Ohio. The south CACREP region is made up of
the following states: Texas, Louisiana, Alabama, Mississippi, Georgia, Florida, South Carolina, North Carolina, Virginia, West Virginia, Kentucky, Tennessee, Arkansas, Maryland, and Delaware. The Rocky Mountain CACREP region is made up of the following states: Montana, Idaho, Wyoming, Utah, Colorado, and New Mexico. The Western CACREP region is made up of the following states: Washington, Oregon, California, Nevada, Arizona, Alaska, and Hawaii. All the programs were listed in alphabetical order and were assigned a number value. In order to ensure a uniform sample, 15% of programs from each geographical area were selected using a number randomizer. The number randomizer created one set of unique numbers. These numbers were created after inputting the numbers desired per set and the number range. After the random sample of CACREP accredited programs are chosen, their CACREP liaison was contacted via e-mail. The email contained a brief overview of the study and described the importance of the study to the counseling profession. A link to the survey was supplied to the CACREP liaison. The CACREP liaison was asked to forward the e-mail to their master level graduate students. A stratified random sample was used for each
school, but a cluster sample was used from each institution.

**Instrumentation**

Three instruments along with a demographic questionnaire were used within this study. The first instrument was the Revised Religious Fundamentalism Scale (Altemeyer & Hunsberger, 2004), the second was the Basic Empathy Scale (Jolliffe & Farrington, 2006), and the third was the Attitudes Toward Lesbians and Gay Men Scale (Herek, 1994). Because the scales are copyrighted material, permission was sought to replicate the questions throughout this dissertation. The authors of the Basic Empathy Scale asked that a copyright symbol be placed next to any exact phasing used from the scale. Additionally, the authors asked that the copyright symbol be placed in the appendix, where the scale was listed. The authors of the Revised Religious Fundamentalism Scale and the Attitudes Toward Lesbians and Gays Scale have not requested that a copyright symbol be placed next to the exact phrasing of the questions. However, the phrasing of the scales are copyrighted and are property of the scale’s owner.
The revised religious fundamentalism scale.

The Revised Religious Fundamentalism Scale (see Appendix A) developed by Altemeyer and Hunsberger (2004) is the shorter version of the original Religious Fundamentalism Scale developed created by Altemeyer and Hunsberger (1992). Permission to use this scale was given by the scale’s creator. The original Religious Fundamentalism Scale consisted of 20 questions; however, the new one consists of only 12. The authors suggested that the original scale over-measured the aspect of having ‘one true religion’ (Altemeyer & Hunsberger, 2004). Therefore, the authors revised their questions to better reflect their definition of religious fundamentalism. Altemeyer and Hunsberger (1992) define religious fundamentalism as:

“the belief that there is one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity; that this essential truth is fundamentally opposed by forces of evil which must be vigorously fought; that this truth must be followed today according to the fundamental unchangeable practices of the past; and that those who believe and
follow these fundamental teachings have a special relationship with the deity” (p. 118). Altemeyer and Hunsberger (2004) suggested that the Revised Religious Fundamentalism Scale had a better internal consistency than the original scale. They further stated that the construct validity of the scale had improved from the scale’s modification.

The Revised Religious Fundamentalism Scale is a 9-point Likert scale that has the following selection options: “-4 if you very strongly disagree with the statement”, “-3 if you strongly disagree with the statement”, “-2 if you moderately disagree with the statement”, “-1 if you slightly disagree with the statement”, “0=neutral”, “+1 if you slightly agree with the statement”, “+2 if you moderately agree with the statement”, “+3 if you strongly agree with the statement”, “+4 if you very strongly agree with the statement” (Altemeyer & Hunsberger, 2004). The authors suggested that an individual might feel like agreeing with one part of the statement, but disagree with another part, if that occurs, then the individual is instructed to average their score (e.g. -2 and +3 would select 1 “slightly agree with the statement”). The scale includes questions such as “God has
given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed” and “‘Satan’ is just the name people give to their own back impulses. There is really no such thing as a diabolical ‘Prince of Darkness’ who tempts us” (Altemeyer & Hunsberger, 2004). To interpret the findings, the items are converted -4 to +4 scores to a number ranging from 1-9. If an individual scores zero, then they would be assigned 5. The total summed scores on the Revised Religious Fundamentalism Scale can range from 12 to 108.

Participants who scored higher, were rated as having a more religiously fundamental ideology. Individuals with this type of religiosity would have answered more strongly (e.g. ‘very strongly agree’) to questions such as “God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed.” and “When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God: and the rest, who will not”. Individuals who are less religiously fundamental would answer more strongly (‘very strongly agree’) to questions such as, “It is more important to be a good person than to believe in God and the right
religion” and “No single book of religious teachings contains all the intrinsic, fundamental truths about life”.

MacInnis and Hodson (2012) used the Revised Religious Fundamentalism Scale to examine intergroup bias against heterosexual and asexuals from using an undergraduate sample. Because Religious Fundamentalism has been viewed as being black and white, the authors suspected that an increase Religious Fundamentalism would be associated with higher rates of less favorable attitudes when it came to asexuals (MacInnis & Hodson, 2012). The findings of the study suggested that participants within with higher levels of religious fundamentalism had higher levels of negative attitudes toward asexual individuals. The findings from using this scale suggested that individuals who are asexual, are in fact a sexual minority that experience prejudice. In fact, the authors suggested that this type of prejudice was extreme (MacInnis & Hodson, 2012).

The basic empathy scale.

The Basic Empathy Scale was developed by Jolliffe and Farrington (2006) to examine the relationship between adolescent bullying and empathy. The Basic Empathy Scale consists of 20 questions that measures two types of empathic responses—affective and cognitive empathy (see
appendix B). Affective empathy is the capability to sense what an individual is experiencing, while cognitive empathy is the ability to understand an individual’s emotional state (Jolliffe & Farrington, 2006). The Basic Empathy Scale uses a 5-point Likert scale with the following options to select: “Strongly Disagree”, “Disagree”, “Neither Agree nor Disagree”, “Agree”, and “Strongly Agree”.

Due to cultural differences, permission was obtained from the authors of the study to change the wording on two of the questions. Question 10 was changed from “I can usually work out when my friend are scared.” to “I can usually figure out when my friends are scared” and Question 14 was changed from “I can usually work out when people are cheerful.” to “I can usually figure out when people are cheerful.” The authors stated that this request is frequently received due to the differences in wording. No other changes were made to the 18 other questions in the Basic Empathy Scale. Permission was also granted from the creator of this scale to use copyrighted material within the study.

The Basic Empathy Scale consists of two subscales; cognitive and affective empathy. Nine of the questions
measure cognitive empathy, and the other eleven measure affective empathy. However, the entire scale has been used to measure overall empathy. For the purposes of this study, the total empathy score will be used, which can be found by adding the cognitive and affective subscales together. The overall reliability for the Basic Empathy Scale is alpha = .87 (Jolliffe & Farrington, 2006).

While no distinct score interpretations have been published within the literature; the creator of the scale suggested dichotomizing the lowest 25% versus the remaining 75% of the results. This would suggest that individuals with the lowest 25% of the scores would have ‘low empathy’ and the individuals with the upper 75% of the scores would have ‘high empathy’ (D. Jolliffe, personal communication, August, 9, 2012). This was done within this study.

The higher that participant’s score on the Basic Empathy Scale, the higher their degree of empathy. Higher empathy has been described as important within the therapeutic relationship. Individuals who scored higher on the Basic Empathy Scale would have agreed strongly to questions such as “I get caught up in other people’s feelings easily©” and “I can often understand how people are feeling even before they tell me©”. Individuals with
lower scores of empathy as described by the Basic Empathy Scale would have agreed strongly to questions such as “My friend’s emotions don’t affect me much” and “I don’t become sad when I see other people crying”.

The Basic Empathy Scale has shown to be flexible when used among diverse populations. Sharp, Ha, Carbone, Kim, Perry, Williams and Fonagy (2013) used the Basic Empathy Scale to measure empathy among adolescents with borderline personality disorder (BPD) traits. The authors used 217 inpatients from an adolescent treatment programs from a private facility. Of the sample 41% met the full criteria for BPD as delineated by the DSM-IV (Sharp et al., 2013). The authors were clear in the fact that self-report measures of empathy are inferior to experimental measures; however, they did suggest that the Basic Empathy Scale would provide a litmus test for an individual’s ability to be empathetic (Sharp et al., 2013). Through the use of this scale, the authors were able to discern that adolescents with BPD traits could benefit from psychoeducational programs.

The attitudes toward lesbians and gay men scale.

The Attitudes Toward Lesbians and Gay Men Scale (Herek, 1988) consists of 20 questions that measures
attitudes towards gay men and lesbians (see Appendix C). Obtaining permission from Herek to use the scale was not necessary as long as the scale was used in an ethical manner. Because of this, permission was not obtained to use copyrighted questions throughout the study. The first 10 questions correspond to lesbian women and questions 11-20 correspond to gay men. The questionnaire can be given in either a written or an oral format. When given as a self-report questionnaire, it is given using a 5-point Likert scale. For this particular study, the respondents will have four options: “strongly disagree”, “disagree somewhat”, “agree somewhat”, “strongly agree”. The “neither agree nor disagree” for the 5-point Likert will be removed. While this is not typical within the written form of the questionnaire, it is advised in the oral version. The “neither agree nor disagree” will be removed to encourage the individual think more clearly about a definite answer.

In order to score the questionnaire, the four options are converted to a numerical value. Within this study, “strongly disagree” will be 1, “disagree somewhat” will be 2, “agree somewhat” will be 3, and “strongly agree” will be 4; however, for some of the items, reverse scoring
will be used. For example, question 7 “Female homosexuality in itself is no problem, but what society makes of it can be a problem” and question 17 “I would not be too upset if I learned that my son were a homosexual” would need to be reverse scored (Herek, 1994).

Regarding this scale, the lower the numerical value, the more positive the respondent views the lesbian and gay community. The same technique applies when using the subscales (ATL and ATG). However, for this study, only the overall scale will be used. Individuals within this study who answered more favorably towards lesbians and gay would have ‘strongly agreed’ with statements such as “A woman’s homosexuality should not be a cause for job discrimination in any situation” and “Male homosexual couples should be allowed to adopt children in the same way as heterosexual couples”. Individuals within this study who had a greater propensity towards having homophobic attitudes would have answered more favorably to questions such as, “Lesbians are sick” and “Homosexual behavior between two men is just plain wrong”.

The Basic Empathy Scale was used for this study because there to date has not been an empathy scale that has been primarily used for counselors or counselor
trainees. The Basic Empathy Scale was shorter than other empathy scales, and had been used widely in the counseling literature. The Revised Religious Fundamentalism Scale was used within the study because it was shown to be more robust than the previous Religious Fundamentalism Scale. The authors have suggested that the Revised Religious Fundamentalism has the ability to measure religious fundamentalism across different facets of religiosity, not just Christianity. The Attitudes Toward Lesbians and Gays Scale was used because it had been described as the ‘Gold Standard’ in measuring attitudes toward sexual minorities; moreover, the scale has good psychometric qualities.

The Attitudes Toward Lesbians and Gays Scale was used as a psychometric instrument within this study, but the scale has also been used to measure attitudes toward sexual minorities within other fields, such as sociology. Baunach and Burgess (2013) sought to understand HIV/AIDS prejudice in the American Deep South. While there were several measures used within the study (e.g. conservatism and traditionalism), the primary interest with regard to this study was how the authors used the Attitudes Toward Lesbians and Gays Scale. The authors obtained a convenience sample of 625 usable questionnaires from an
introductory undergraduate sociology class. Of the sample, 66% of the sample was female and 34% were male. The authors concluded through the use of the Attitudes Toward Lesbians and Gays Scale that participants with higher degrees negative attitudes had higher rates of prejudice with regard to HIV/AIDS (Baunach & Burgess, 2013). Through the use of this instrument, the authors were able to provide recommendations for psychoeducational programs.

To measure factorial validity of the instruments, factor analysis were obtained. Principle Component Analysis (PCA) was used as a method of extraction with varimax rotation. Parallel analysis were used to determine the components within the Basic Empathy Scale. If the Kaiser-Meyer-Olkin measure of sampling adequacy was above .6, the results would indicate that the sample size was sufficient to run the factor analysis. Furthermore, Eigenvalues were explored, and factors greater than 1 were kept.

Data Collection Procedures

Before data collection began, Institutional Review Board (IRB) approval was sought and given. After IRB approval (Appendix D), the online survey was sent out using electronic mail. The survey provided the participant with
an overview of the study, discussed how long it would take to complete the study, and included a statement regarding confidentiality. Additionally, the participants were informed of their rights as a participant and the benefits and risks of taking the survey. Once they proceed voluntarily, taking the survey served as their electronic consent.

The individuals engaging in the study were routed to the survey through Qualtric Survey Software provided by the Gladys W. and David H. Patton College of Education at Ohio University via their CACREP liaison. The individuals first completed the Revised Religious Fundamentalism Scale (Altemeyer & Hunsberger, 2004), then the Basic Empathy Scale (Jolliffe & Farrington, 2006), and finally the Attitudes Toward Lesbians and Gay Men Scale (Herek, 1988). The estimated time to complete the surveys was 25 minutes. If an individual opened a survey and failed to complete it, they were sent an e-mail reminder every two weeks for a total of six weeks. A priori power was assessed. Warner (2007) suggested for high power and low effect size, 153 participants were needed. Given the sample size, from this study, a small effect size was able to be detected from this data. However, because an appropriate sample size was
needed for power, the study had to be resent to participants.

Data Analysis Procedures

After the data collection was completed, all the data was entered into Statistical Package for the Social Sciences (SPSS). Descriptive statistics were utilized for the study. Any potential missing data and possible outliers were identified. Cronbach alphas, reliability, and factor validity were examined.

Analysis of Research Questions

To ascertain if there is a relationship between religious fundamentalism and empathy the following hypotheses were examined.

1. For counselor trainees, is there a relationship between religious fundamentalism and empathy?

Null hypothesis 1: For counselor trainees, there is no relationship between religious fundamentalism and empathy. Question 1 was examined using a correlational analysis. This determined if there is a relationship between religious fundamentalism and empathy. Additionally, it provided insight into whether there was a positive or negative relationship between religious fundamentalism and empathy.
2. Does the combination of religious fundamentalism and empathy in counselor trainees predict attitudes toward sexual minorities?

Null hypothesis 2: The combination of religious fundamentalism and empathy in counselor trainees does not predict attitudes toward sexual minorities.

Question 2 was tested using a multiple regression analysis. Results from this analysis determined if religious fundamentalism predicts attitudes towards gays and lesbians.

**Assumptions of Multiple Regression**

With a multiple regression analysis, there are assumptions that need to be tested. The underlying assumptions needed to be tested because violations of the assumptions could have influenced the interpretation of the results. According to Warner (2008), there are four basic assumptions that need tested for a multiple regression analysis. The four basic assumptions are the following: a normal distribution of the variables, a linear relationship between the independent variables and the dependent variables, there was no interaction between the independent variables and homoscedasticity (Warner, 2008). Regarding the first assumption, attitudes toward lesbians and gays,
empathy, and religious fundamentalism should have a normal distribution. The second assumption was tested by running scatterplots between the independent and dependent variables. While doing this, bivariate outlier were examined. Warner (2008) suggested that there was not sufficient sample size to examine the interaction between independent variables within this study. The fourth assumption of homoscedasticity was examined by using scatterplots and histograms.

**Summary**

This chapter has provided an overview of the quantitative research methodological design used in this study. The discussion included: the population, sampling procedures, instrumentation, data collection procedure, data analysis, research questions, and the analysis of research questions.
Chapter 4 Results

This study added to the paucity of literature regarding the relationship between religious fundamentalism, empathy, and attitudes toward sexual minorities in counselor trainees. The literature suggested that religious fundamentalism was a strong predictor of prejudice (Kirkpatrick, 1993). In fact, religious fundamentalism has been attributed to higher rates of homophobia (Schwartz & Lindley, 2005), but this relationship had not been explored in counselor trainees. The data were derived from the participant’s results of four different surveys: The Revised Religious Fundamentalism Scale, The Basic Empathy Scale, The Attitudes Toward Lesbian and Gay Scale, and a demographic questionnaire. The descriptive results of the data were provided on the participants. Next, the reliability and validity of the research instruments will be examined. Lastly, the research questions will be examined.

Population Characteristics

A geographically stratified random sample of CACREP accredited counseling students were used as participants in the current study. The researcher obtained the sample from randomly selecting 15% of CACREP accredited counseling
programs from the 5 different geographical areas delineated by CACREP. These geographical areas are the following: North Atlantic, North Central, Southern, Rocky Mountain, and Western. The number of participants needed for this study was approximately 153, which was determined by G*Power (Warner, 2007). The numbers of students that participated was adequate enough to allow for invalid surveys and incomplete data. A total number of 178 surveys were taken; however, only 149 surveys were used due to incomplete data, or criteria that made their responses incongruent with the research questions proposed, such as being a doctoral student. The master’s level students that participated in the study took part in a demographic questionnaire that invited them to answer questions about their: age, sex, program enrollment, program year, licensure status, sexual orientation, institution type, and geographic region.

**Age.**

According to table 4.1, of the 149 participants, the age group 25-30 made up the greatest number of participants with 41.6% (n=62). Participants that made up the age group 46-50 made up the smallest percent of participants with their results only accounting for 3.4% of the sample (n=5).
Table 4.1 Age of Population

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>44</td>
<td>29.5</td>
<td>29.7</td>
<td>29.7</td>
</tr>
<tr>
<td>25-30</td>
<td>62</td>
<td>41.6</td>
<td>41.9</td>
<td>71.6</td>
</tr>
<tr>
<td>31-35</td>
<td>12</td>
<td>8.1</td>
<td>8.1</td>
<td>79.7</td>
</tr>
<tr>
<td>36-40</td>
<td>6</td>
<td>4.0</td>
<td>4.1</td>
<td>83.8</td>
</tr>
<tr>
<td>41-45</td>
<td>9</td>
<td>6.0</td>
<td>6.1</td>
<td>89.9</td>
</tr>
<tr>
<td>46-50</td>
<td>5</td>
<td>3.4</td>
<td>3.4</td>
<td>93.2</td>
</tr>
<tr>
<td>50+</td>
<td>10</td>
<td>6.7</td>
<td>6.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.7</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>149</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sex.

The population consisted of 124 individuals that identified as being female. This represented 83.2% of the sample. There were 25 males that completed the study, which accounted for 16.8% of the sample.

Program enrollment.

Participants of the survey were asked to indicate which program they were enrolled in. Of the total sample collected, 7 individuals indicated they were enrolled in a
doctrinal program. These individuals were removed from the survey. The only individuals that were included in the results consisted of 149 master’s level students.

Program year.

Participants were asked to indicate which year they were within their program of study. Of the 149 participants, 53 stated they were in their 1st year of their master’s program, which accounted for 35.6%. 67 participants indicated they were in their 2nd year of study, which accounted for 45%. 24 participants indicated they were in their 3rd year of study, which attributed to 16.1% of the study. Only 4 respondents stated they were in their 4th year of their master’s program, which attributed to 2.7% of the study. Individuals that answered that they were in their 3rd and 4th year of their master’s program were attending a part-time institution. One individual failed to answer the question, which attributed to .7% of the study.
Table 4.2 Years In Program

<table>
<thead>
<tr>
<th>Years In Program</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>53</td>
<td>35.6</td>
</tr>
<tr>
<td>2</td>
<td>67</td>
<td>45.0</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
<td>16.1</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Total</td>
<td>148</td>
<td>99.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>149</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Licensure status.**

Of the 178 participants that responded to the survey, 22 failed to answer the question regarding their licensure status. 7 indicated that they were licensed by their state licensing board. Because of this, 27 individuals were removed from the sample because their answer did not meet the criteria for the research. When these cases were removed, this left 149 individuals who were not licensed and who could participate within the study.

**Sexual orientation.**

The participants of the survey were asked to answer questions regarding their sexual orientation. The sample
consisted of largely heterosexual individuals, with the other labeled sexual orientations being represented, except for transgender. 4 participants identified themselves as lesbian, which accounted for 2.7%. 4 participants indicated their sexual orientation as gay, which accounted for 2.7% of the sample. 4 individuals that participated in the study identified as being bisexual, which accounted for 2.7% of the sample. 131 participants in the sample indicated their sexual orientation as being straight, which represents 87.9% of the sample. 4 participants stated their sexual orientation was queer, which represented .7% of the study. 1 participant indicated their sexual orientation was questioning, which accounted for .7% of the study. 1 individuals specified their sexual orientation as intersex.

Table 4.3 Sexual Orientation

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesbian</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Gay</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Bisexual</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Straight</td>
<td>131</td>
<td>87.9</td>
</tr>
<tr>
<td>Queer</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Questioning</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Intersex</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>149</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Institution.

Because CACREP accredits programs in both public and private universities, participants were asked to answer questions regarding the status of their institution. Of the 149 participants, 138 stated they were at a public institution, which accounted for 92.6% of the sample. 11 individuals stated they were enrolled through a private university, which accounted for 7.4% of the sample.

Table 4.4 Type of Institution

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>138</td>
<td>92.6</td>
</tr>
<tr>
<td>Private</td>
<td>11</td>
<td>7.4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>149</td>
<td>100</td>
</tr>
</tbody>
</table>

Geographical region.

CACREP regions of the United States is made up of 5 geographical areas: North Atlantic, North Central, Southern, Rocky Mountain, and Western. 36 participants reported that they were from the North Atlantic, which attributed to 24.5% of the sample. 27 participants stated they were from the North Central part of the United States, which accounted for 18.4% of the sample. The majority of
the sample came from the Southern CACREP region of the United States, in which 52 reported as their location. This attributed to 34.9% of the sample. 15 participants defined their geographical area as the Rocky Mountain region, which accounted for 10.1% of the sample. 17 participants identified their located as Western, which attributed to 11.4% of the sample. 2 individuals failed to identify their geographical area, which accounted for 1.3% of the data.

Table 4.5 Geographical Area

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Atlantic</td>
<td>36</td>
<td>24.5</td>
</tr>
<tr>
<td>North Central</td>
<td>27</td>
<td>18.4</td>
</tr>
<tr>
<td>Southern</td>
<td>52</td>
<td>34.9</td>
</tr>
<tr>
<td>Rocky Mountain</td>
<td>15</td>
<td>10.1</td>
</tr>
<tr>
<td>Western</td>
<td>17</td>
<td>11.4</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>149</td>
<td>100</td>
</tr>
</tbody>
</table>

Instrumentation.

All participants were invited to take part in 4 questionnaires: The Revised Religious Fundamentalism Scale, The Basic Empathy Scale, The Attitudes Toward Lesbians and Gay Scale, and a demographic questionnaire. The Revised Religious Fundamentalism Scale consisted of 12 questions that measures an individual’s religious fundamentalism.
The Basic Empathy Scale consisted of 20 questions and was used to measure the participant’s empathy. The Attitude Toward Lesbian and Gay scale consist of 20 questions which was used to measure the participant’s attitudes towards sexual minorities.

The mean scores of the participants on the Attitudes Toward Lesbians and (ATLG) scale was 28.78. The scores ranged from 19 to 73. The modal score was 21 (n=26). The standard deviation for the sample was 8.085. When analyzing biological sex, the mean for females is 28.15, and the mean for males was 31.88. This suggested that females had a more positive attitude towards lesbians and gay than males. Females had scores that ranged from 19-73, and males had scores that ranged from 20-65. The standard deviation for females was 10.19, while the standard deviation for males was 14.88.

The mean score of the participants on the Basic Empathy Scale was 78.10 and the median was 78. The mode in this distribution was 75 (n=12). While analyzing biological sex, males had a mean score of 74.44 and females had a mean score of 78.84. The males scores ranged from 62-91, and the female’s scores ranged from 53-98. The standard deviation for males was 7.15, and for females the
standard deviation was 8.09. The authors did not provide guidelines for interpreting scores; however they suggested dichotomizing the lower 25% of the scores as low empathy versus the upper 75% as individuals having higher empathy. The lower 25% consisted of 37 participants. This accounted for 24.8% of the sample. The upper 75% consisted of 112 participants, which accounted for 75.2% of the sample.

The mean score of the participants on the Revised Religious Fundamentalism Scale was 45.55 with a standard deviation of 23.55. When analyzing biological sex, males had a mean score of 50.64 with a standard deviation of 22.98. Scores ranged from 16-91. Females had a mean score of 44.52 with a standard deviation of 23.62. The scores on the Revised Religious Fundamentalism Scale ranged from 12-107. When comparing the mean scores, males were more religiously fundamental than women.
Table 4.6 depicts the means and standard deviations

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>BES</th>
<th>RRF</th>
<th>ATLG</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Atlantic</td>
<td>78.68 (7.8)</td>
<td>44.14 (22.29)</td>
<td>27.69 (12.26)</td>
</tr>
<tr>
<td>North Central</td>
<td>74.52 (7.86)</td>
<td>44.67 (21.28)</td>
<td>28.00 (9.69)</td>
</tr>
<tr>
<td>Southern</td>
<td>80.63 (7.43)</td>
<td>49.62 (26.77)</td>
<td>29.98 (10.95)</td>
</tr>
<tr>
<td>Rocky Mountain</td>
<td>75.93 (7.44)</td>
<td>42.13 (23.43)</td>
<td>31.06 (14.04)</td>
</tr>
<tr>
<td>Western</td>
<td>77.29 (9.83)</td>
<td>42.18 (20.40)</td>
<td>26.82 (9.68)</td>
</tr>
</tbody>
</table>

Note. N=149.

On the Basic Empathy Scale, the North Central geographical area had the lowest mean, and the Southern geographical area had the highest mean. The Rocky Mountain geographical area had the lowest mean on the Revised Religious Fundamentalism Scale, and the Southern geographical area had the highest mean. The Western geographical area had the lowest mean on the Attitudes Toward Lesbians and Gay Scale, while the Rocky Mountain had the highest mean.
Table 4.7 depicts three instruments by sexual orientation.

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Instruments</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BES</td>
<td>RRF</td>
<td>ATLG</td>
<td></td>
</tr>
<tr>
<td>Lesbian</td>
<td>74.50 (4.65)</td>
<td>24.75 (8.22)</td>
<td>23.25 (.500)</td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>74.25 (3.40)</td>
<td>41.50 (25.64)</td>
<td>22.75 (2.50)</td>
<td></td>
</tr>
<tr>
<td>Bisexual</td>
<td>86.00 (11.16)</td>
<td>32.75 (31.63)</td>
<td>24.25 (5.90)</td>
<td></td>
</tr>
<tr>
<td>Straight</td>
<td>77.89 (7.99)</td>
<td>47.62 (23.34)</td>
<td>29.42 (11.63)</td>
<td></td>
</tr>
<tr>
<td>Queer</td>
<td>84.00 (10.80)</td>
<td>20.25 (9.18)</td>
<td>21.75 (1.50)</td>
<td></td>
</tr>
<tr>
<td>Questioning</td>
<td>75.00 (0)</td>
<td>32.00 (0)</td>
<td>32.00 (0)</td>
<td></td>
</tr>
<tr>
<td>Intersex</td>
<td>83.00 (0)</td>
<td>39.00 (0)</td>
<td>33.00 (0)</td>
<td></td>
</tr>
</tbody>
</table>

*Note. N=149.*

On the Basic Empathy Scale, individuals who identified as Gay had the lowest means. In contrast, individuals who identified as Bisexual had the highest mean on the Basic Empathy Scale. Regarding the Revised Religious Fundamentalism Scale, individuals that identified as Queer had the lowest mean, while individuals who identified as straight had the highest mean. On the Attitudes Toward Lesbians and Gays Scale, individuals who identified as Queer had the lowest mean and individuals identifying as Intersex had the highest mean.
Figure 1. Boxplot that examines the outliers for the different CACREP geographical areas.

Regarding the boxplot, there are three potential outliers that have been identified one in the North Atlantic, one in the North Central, and one in the Rocky Mountain region. These individuals had a mean that was twice as much as the sample mean.
To examine for outlier on the Basic Empathy Scale, the total score was transformed to a z-score. After this was completed, there were 5 cases that were found to be outliers due to their absolute value of their z score being greater than two. For the Revised Religious Fundamentalism Scale, there were five outliers because the absolute value of their z score was greater than two. For the Attitudes Toward Lesbians and Gays Scale, there were 8 outliers because their absolute value was greater than two. This finding complements the findings in figure x, which suggested that the variable had a positively skewed distribution.

**Presentation of Results**

**Reliability analysis.**

Each scale’s reliability was tested using Cronbach’s alpha coefficient. Altemeyer and Huntsberger (2004) reported that Cronbach’s alpha for the Revised Religious fundamentalism scale is alpha = .91. Within this study, the alpha = .939, which is greater than the .8 cutoff. The Cronbach’s alpha for the Attitudes Toward Sexual Minority Scale ranges from was typically >.80 and even higher amongst students (Herek, 1988; Herek, 1994). Within this study, Cronbach’s alpha = .954, which was above the .8
cutoff. Jolliffe and Farrington (2006) reported that the Basic Empathy Scale had an approximate reliability of alpha .8. Within this study, the reliability was .856, which was above the .8 cutoff.

The following research questions were examined first within the study:

Research Question 1: For counselor trainees, is there a relationship between religious fundamentalism and empathy?
Figure 2. Scatterplot Examined the Relationship Between BES and RRF

This figure suggested that there is not a relationship between the total Basic Empathy Scale Score and the total Revised Religious Fundamentalism score because there was no discernable pattern in the dots or clustering around a line. Because there was no relationship between the variables, there were no bivariate outliers.
Research Question 2. Does the combination of religious fundamentalism and empathy in counselor trainees predict attitudes toward sexual minorities?

Assumptions of multiple regression.

Multiple Regression was used to study the combination of religious fundamentalism and empathy to predict attitudes toward sexual minorities. Because a multiple regression was used in this study, the underlying assumptions were tested because violations of the assumptions could have influenced the interpretation of the results. In the current study, the two independent variables were empathy and religious fundamentalism and the dependent variable was attitudes toward sexual minorities. There were four basic assumptions that need to be met when using a multiple regression analysis: a normal distribution of the residuals, a linear relationship between the independent variables and the dependent variable, there was no interaction between the independent variables, and homoscedasticity (Warner, 2008).

Regarding the first assumption, both the independent and dependent variables should be normally distributed (Warner, 2008). The three graphs offer a visual representation that the assumption of normal distribution
was not met for attitudes toward lesbians and gays, empathy, or religious fundamentalism. However, of the three, empathy was the closest to having a normal distribution.

Figure 3. Distribution of Scores on the ATLG Scale
Figure 4. Distribution of the total scores on the Basic Empathy Scale

Mean = 78.10
Std. Dev. = 8.085
N = 149
The second assumption to be tested is the linear relationship between the independent and dependent variables. This assumption was tested by running scatter plots. These scatter plots should not have any bivariate outliers.
This scatter plot denied the assumption of linearity, but showed a mild positive relationship between empathy and attitudes toward gays and lesbians. There was no correlation between empathy and attitudes toward gays and lesbians, $r = -0.117$, $n=149$, $p=0.156$. 

**Figure 6. Scatter Plot Between Attitudes Toward Lesbians and Gay and Empathy**
Regarding religious fundamentalism and empathy, the linearity assumption was not met because there was more variance than desired. There was not a linear relationship seen between empathy and religious fundamentalism. Although, there was more of a linear relationship between religious fundamentalism and empathy than between attitudes toward lesbians and gays and empathy. There was no
correlation between Religious Fundamentalism and empathy, $r = -0.110$, $n=149$, $p=0.180$.

The second assumption of linearity between attitudes toward lesbians and gays and religious fundamentalism was met. In fact, among the three scatter plots, this showed the strongest linear relationship. There was a positive
correlation between Revised Religious Fundamentalism and Attitudes Toward Lesbians and Gays, $r=0.675$, $n=149$, $p=.000$. Warner (2008) suggested that there is not a sufficient sample size to run the analyses needed to see if assumption three was met, the interaction between variables.

In testing for assumption four, homoscedasticity, the variance in attitudes toward lesbians and gays should be the same across the variables in religious fundamentalism and empathy.

Figure 6 suggested that religious fundamentalism was heteroscedastic, which was a violation of homoscedasticity. Figure 6 suggested that the variance of attitudes towards sexual minorities was not the same across levels of religious fundamentalism. Furthermore, as the religious fundamentalism score increases, the variance increases; however, for the lower score there was not much variance.
Figure 9. Scatterplot of Standardized Predicted Values When Compared to Standardized Residuals

This plot examined the relationship between the standardized predicted values and the standardized residual values based on the regression analysis. Ideally, all the values should have been clustered around zero. If the variables within the multiple regression were explaining the dependent variable, then most of the values would be
clustered around $y=0$. This graph suggested that there was a presence of outliers.

Figure 10. Distribution of the Residuals in the Multiple Regression Analysis

This graph showed that the residuals/errors are normally distributed; however, they were slightly peaked at zero. There were 10 more cases that have values close to 0 than were expected.
Table 4.8 Significance Test of Multiple Regression

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>8412.595</td>
<td>2</td>
<td>4206.297</td>
<td>61.664</td>
<td>.000a</td>
</tr>
<tr>
<td>Residual</td>
<td>9959.097</td>
<td>146</td>
<td>68.213</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18371.691</td>
<td>148</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Total Empathy, Total Religious Fundamentalism
b. Dependent Variable: Attitudes Toward Sexual Minorities

This table suggested that empathy and religious fundamentalism predicted a non-zero part of the variance in attitudes towards sexual minorities since p<.01.

Table 4.9 Multiple Regression Coefficients Table

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>T</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>18.924</td>
<td>6.904</td>
<td></td>
<td>2.741</td>
<td>.007</td>
</tr>
<tr>
<td>Total RRF</td>
<td>.317</td>
<td>.029</td>
<td>.671</td>
<td>10.939</td>
<td>.000</td>
</tr>
<tr>
<td>Total BES</td>
<td>-.059</td>
<td>.084</td>
<td>-.043</td>
<td>-.697</td>
<td>.487</td>
</tr>
</tbody>
</table>

The relationship between empathy and attitudes toward lesbians and gays in the presence of religious fundamentalism was not statistically significant. Only religious fundamentalism predicted a statistically significant portion of the variation in attitudes toward
lesbians and gays. All of the variation was absorbed by religious fundamentalism. For every 1 point increase in religious fundamentalism, attitudes toward lesbians and gay increase by .317 points. As religious fundamentalism attitudes increased, then attitudes towards lesbians and gays decreased. This suggested that as religious fundamentalism increased attitudes toward lesbians and gays decreased. However, the model suggested that only religious fundamentalism of the two predicted attitudes toward sexual minorities.

Table 4.10 Correlational Coefficients for the Multiple Regression

<table>
<thead>
<tr>
<th>Zero-Order</th>
<th>Partial</th>
<th>Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>.675</td>
<td>.671</td>
<td>.667</td>
</tr>
<tr>
<td>-.117</td>
<td>-.058</td>
<td>-.042</td>
</tr>
</tbody>
</table>

**Factor analysis.**

**Revised religious fundamentalism scale.**

The Kaiser-Meyer-Olkin measure of sampling adequacy was .934 which was above the recommended value of .6 which was above the recommended value of .8, which suggested that the factor analysis was useful for the scale. Due to the Eigenvalue of 7.234, one component was retained for
analysis. The Eigenvalue for the second component was .939, which did not satisfy Kaiser’s Rule (Kaiser, 1960).

**Attitudes towards lesbians and gay men scale.**

The Eigenvalues for component one and two were both greater than 1. Component one was 11.326 and component two was 1.233. Parallel analysis was run to determine the number of components to retain. Parallel analysis results revealed two components with Eigenvalues of 1.85 and 1.67. Since 11.326 was greater than 1.85, component one was retained. However, since 1.233 was not greater than 1.67, component two was not retained. Hence, results revealed one component. Results suggested that the one component retained was attitudes toward lesbians and gays.

**Basic empathy scale.**

Theoretically, the Basic Empathy Scale was to measure three types of empathy: affective, cognitive, and overall. The top three values from parallel analysis were 1.863, 1.67, and 1.56. The next Eigen value according to factor analysis was 1.159, but parallel analysis says 1.456 the Eigen value based on parallel analysis. Therefore, component four was not retained yielding three components. An exploratory factor analysis was conducted to evaluate whether a 3 component model fit the data. Principle
Component Analysis (PCA) was used as the method of extraction with varimax rotation. Parallel analysis determined that there were three components within the Basic Empathy Scale. The three components accounted for 51.65% of the variance in the scale. The Kaiser-Meyer-Olkin measure of sampling adequacy was .827, which was greater than .6. As Warner (2008) suggested the default criterion was to retain only the factors with Eigenvalues that were greater than 1. Additionally Varimax rotation was requested. The items consisted of self-report data that measured affective, cognitive, and overall empathy. Results included Eigenvalues, rotated component loadings, communalities, and proportion of variance explained. Communalities for items were acceptable with values ranging from .267-.751.
Chapter 5: Discussion

This chapter constructed a conversation involving the results presented in Chapter 4. This chapter reviewed the significant findings and limitations of the study. Furthermore, the implications for future research were explored.

This study examined the relationship between religious fundamentalism, empathy, and attitudes toward lesbians and gays among master level counseling students from CACREP accredited programs. To examine the relationship closer, two research questions were examined within this study:

1. For counselor trainees, is there a relationship between religious fundamentalism and empathy?

This research question was explored by using two psychometrically sound instruments: The Revised Religious Fundamentalism Scale and The Basic Empathy Scale. This question was measured using a correlational analysis. There was a dearth of information in the literature that examined the relationship between religious fundamentalism and empathy. In fact, only two studies were found to examine the relationship. Duriez (2004) suggested that there was no relationship between religious fundamentalism and empathy, and Bradley (2009) suggested that religious
fundamentalism led to lower levels of empathy. This study added to the empirical literature regarding the religious fundamentalism and empathy relationship. Furthermore, no previous study had examined to see if the relationship between religious fundamentalism and empathy predicted attitudes toward lesbians and gays.

2. Does the combination of religious fundamentalism and empathy in counselor trainees predict attitudes toward sexual minorities?

This research question employed the use of three psychometrically sound instruments: The Revised Religious Fundamentalism Scale, The Basic Empathy Scale, and The Attitudes Toward Lesbians and Gay Scale. A regression analysis was used to examine this question.

**Characteristic of the Sample**

**Age.**

The typical respondent fell into the 18-30 age range, which made up 71.6% of the population. In fact, 41.6% of the respondents were aged 25-30. This suggested that the students who participated in the study were probably traditional students. This occurrence was not surprising, and probably was representative of current counseling programs.
Sex.

The typical participant within the research study was female. Females made up 83.2% of the sample (n=124), which was unsurprising given that women are more involved in helping professions than men (Taylor & Shrives, 2011). The sample within this study could be representative of the entire counselor population. This was thought to be the circumstance within this study. Moreover, this finding suggested that men were becoming more involved in the counseling profession and could probably be generalized to helping professions in general.

Sexual orientation.

Over 87% of the participants within the study identified as being straight (n=131). Gates (2008) suggested that 3.8% of the population identified with the LGBT community. Within the sample, approximately 8.8% of the respondents identified with the LGBT community. Gate’s estimation of the LGBT population within this study was conservative. In fact, the number of LGBT individuals within the study was more congruent with Kinsey, Pomeroy, and Martin (1948). Kinsey, et al. (1948) suggest that LGBT individuals account for as much as 10-15% of the...
population. This could be representative of this sample with some participants not answering truthfully due to the stigmas associated with the labels of the LGBT community. This would be particularly true for individuals who did not adhere to behavior dictating identity. For these individuals a male having a sexual relationship with a male would not make him gay, and the same could be generalized to the other labels.

**Geographic region.**

Within the current study, approximately 35% of the sample (n=52) was derived from the southern part of the United States. Because the south is considered part of the ‘Bible belt’, this could have potentially skewed the data, if in fact the respondents were religiously fundamental. The study was initially sent as a geographically stratified random sample to the five CACREP regions. However, when the study was sent out the second time, the participation link was placed on a counseling listserv. This could explain the over-representation of individuals from the southern part of the United States; however, it is important to note that within the CACREP regions, the south comprises the greatest number of schools, accounting for approximately 41% of the accredited programs. The response
rate from the schools in the rocky mountain and western part of the United States was the lowest, making up only 21.5% of the respondents. This could have affected the response rates regarding the level of religious fundamentalism and attitudes toward lesbians and gays within the study.

**Purpose of the Study**

This study added to the paucity of literature regarding the relationship between religious fundamentalism, empathy, and attitudes toward sexual minorities in counselor trainees. The literature suggested that religious fundamentalism was a strong predictor of prejudice (Kirkpatrick, 1993). In fact, religious fundamentalism has been attributed to higher rates of homophobia (Schwartz & Lindley, 2005), but this relationship had not been explored in counselor trainees.

**Null Hypotheses**

The first null hypothesis of the study was used to uphold that there was no evidence to suggest that a relationship between religious fundamentalism and empathy existed among master’s level counseling students.

The second null hypothesis was rejected. The model suggested that the relationship between religious
fundamentalism and empathy did indeed predict attitudes toward lesbians and gays. The higher levels of religious fundamentalism have been strong predictors of homophobic attitudes (Laythe, Finkel, Bringle, & Kirkpatrick, 2002; Schwartz and Lindley, 2005)

However, counselor trainees have been trained to keep their biases in check. The finding from the multiple regression suggested that even though there has been multicultural trainings, counselor trainees with high levels of religious fundamentalism have higher rates of homophobic attitudes. These higher rates of homophobic attitudes could lead to ethical concerns such as premature referral, because individuals may feel uncomfortable working with this population

Implications of Findings

The implications of this study are pertinent to counselors and counselor educators. The results of the first research question indicated that there was not a statistically significant relationship between religious fundamentalism and empathy in counselor trainees. This result echoed the research conducted by Duriez (2004), which suggested that there was absolutely no connection between religiousness and empathy. Additionally, this
research augmented the findings presented by the Duriez because this study explored this relationship in counselor trainees.

Even though there was not a relationship between religious fundamentalism and empathy in counselor trainees, future investigations may wish to explore the variables surrounding an individual’s high level of empathy. An interesting finding within the study was that the Southern CACREP geographical region had the highest mean on the Basic Empathy Scale, which would suggest that individuals from the Southern part of the United States are more empathetic. However, the findings from the study also suggested that individuals from the Southern part of the United States had the highest mean of Religious Fundamentalism, which would suggest greater levels of religious fundamentalism. Increased rates of religious fundamentalism have been associated with prejudicial attitudes toward the LGBT community. However, the findings suggested that individuals from the Southern part of the United States have both high levels of religious fundamentalism and high levels of empathy, which would suggests that perhaps their levels of religious
fundamentalism may not impact the level of empathy within the therapeutic relationship.

While empathy is known to fluctuate throughout the course of an individual’s life based on experiences, studies focusing specifically on counselor trainee’s level of empathy throughout the counseling program may provide better variables to explore. However, more specific to this study, would concern the factors that influence empathy with regard to the LGBT community.

The relationship between religious fundamentalism and empathy did predict attitudes toward lesbians and gays. However, empathy did not add any significance. In fact, religious fundamentalism predicted a statistically significant portion of the variation in attitudes toward lesbians and gays. The model suggested that as religious fundamentalism increased, attitudes toward lesbians and gays decreased. This replicated the research conducted by Schwartz and Lindley (2005), which suggested that religious fundamentalism was a strong predictor of homophobia. The expectation was that current multicultural curricula, and ethics training would have taught counselor trainees to be cognizant of their own personal biases and how those biases affect others as suggested by Sue, Arredondo, and McDavis
(1992). The chances are almost certain that a counselor will provide therapeutic services to members within the LGBT community considering they make up the largest invisible minority group. This finding was disconcerting because homophobic attitudes towards members of the LGBT community might be a predictor toward a propensity for unethical referral. Perhaps a review of current LGBT counseling competencies need to be explored within the counseling profession to ensure best practices are maintained.

An interesting similarity between Schwartz and Lindley (2005) and this study consisted of the sample. Schwartz and Lindley (2005) sampled only students from a southern university, which was described as a limitation due to higher rates of fundamentalism in the southern part of the United States. In this study, more than one third of the participants were from the south, which could have affected the outcomes. Schwartz and Lindley (2005) sampled undergraduate students; however, in this study, masters level counseling students were sampled. This was worth noting because this particular sample included counselor trainees who had been trained by CACREP standard to be aware of their own biases and how those biases may impact
others. The study showed that counselor trainees with higher levels of religious fundamentalism display more homophobic attitudes. In fact, the findings from the study suggested that individuals from the Southern CACREP geographical area had more fundamentalism belief systems. Even though master level counseling students had courses in multicultural counseling and ethics, this sample of counselor trainees are homophobic. This is congruent with Boysen and Vogel (2008) who suggested that counselors who have high levels of multicultural competencies can still remain biased against the LGBT community. Bowers, Plummer, and Minichiello (2005) suggested that this may be due to a lack of knowledge, assumptions about the community, bias, and prejudice. Perhaps the lack of knowledge, assumptions, and person bias was the explanation within this study. Even though counselors take multicultural and ethics courses in their programs, these courses may not provide insight into the LGBT community.

The current study suggested that female respondents had a more positive attitude toward lesbians and gays than male respondents. Females would have answered more favorably to questions like, “I would not be too upset if I learned that my son were a homosexual” and “Just as in
other species, male homosexuality is a natural expression of sexuality in them”. This finding was not surprising based on the previous research and replicated that of Schwartz and Lindley (2005). This finding could have been a result of the gender scripts subscribed to by males and females. Also, the concept of societal constructs of sexuality may explain the differences. For example, males are taught that the masculine machismo has no room for anything other than women. The over sampling from the south could have affected this because of the ‘Bible belt’ association.

When testing the assumption of normal distributions, the frequencies of the scores on the Attitudes Toward Lesbians and Gays Scale (ATLG) were not normally distributed. Results of the study suggested that there were a high number of low scores, which indicated more positive views toward lesbians and gays. This finding was not surprising, since a counselor may have elevated levels of empathy when compared to the typical individual. Having higher levels of empathy could be one reason why an individual may enter into the counseling profession. Counselors typically want to be viewed as approachable or affirming of all groups. Additionally, the American
Counseling Association (ACA) mandated that counselors engage with and be competent to work with the LGBT community.

A counselor’s ability to be empathetic within the therapeutic relationship has been described as vital to positive outcomes. In fact, empathy has been described as one of the most important features of an effective therapeutic relationship (Chin-Ying Chung & Bernak, 2002). An important result indicated that 75% of the sample’s participants were particularly empathic. These individuals would have agreed strongly with statements such as, “I can understand my friend’s happiness when she/he does well at something” and “I can usually figure out when my friends are scared”. Perhaps more empathetic individuals were drawn to the counseling profession. Otherwise, as Pecukonis (1990) suggested the counselor trainee’s empathy had been positively affected by their training.

Limitations of the Study

As with any study, there are limitations. The first limitation was sample size. The adequate sample size determined necessary to show power was 153 participants. While 178 surveys were collected, due to limiting criteria and incomplete surveys, the total N=149. Collecting more
data could have remedied this concern, but that option was not feasible.

The next limitation included the sampling procedure. Initially, a geographically stratified random sample was used. After 15% of the schools were randomly selected from a geographical area, the surveys were sent to the CACREP liaison. However, as specified in the methodology, if adequate sample size was not achieved, the survey must be sent out again. When sending out the survey the second time, a CACREP liaison placed the study on a counseling listserv. While initially this was delimited to CACREP accredited institutions, there was no way to ensure that the participants were indeed enrolled in a CACREP accredited program and were the desired sample. However, the informed consent explicitly stated that to participate in this survey the individual had to be a master’s level student enrolled in a CACREP accredited counseling program. Having the survey distributed on the listserv could have influenced the geographical information, and could explain the disparities between the geographical regions.

It is also important to note that certain types of programs may be under-represented due to the CACREP liaison. When first distributing the survey, two CACREP
liaisons, which made the random sample, refused to send their request to their students. One suggested that the study needed to pass their Institutional Review Board (IRB) before they would agree to distribute the survey; however, the other institution, faith-based in character, refused to send out the survey due to ‘moral’ concerns.

The next limitation speaks to the anonymity of the survey participant. While the study ensured anonymity, an individual’s religiousness and their attitudes toward sexual minorities are personal traits that individual’s may not be willing to share openly, even though the survey was self-report. As a result, this study acknowledged the likelihood for a social desirability bias.

**Validity**

Two distinct validity questions are presented within this research. The first was the setting in which each participant took the survey. While one individual could have taken the survey in a quiet room, another participant may have taken the survey in a loud one. Also, an individual’s behavioral history could have affected the outcomes on the survey. For instance, if an individual recently experienced a negative altercation with a member
of the LGBT community, his attitudes toward lesbians and
gays may have been more exaggerated than usual.

**Recommendations for Future Research**

**Application.**

This study sought to understand the relationships
between religious fundamentalism, empathy, and attitudes
toward lesbians and gays in counselor trainees. The research revealed that there was not a relationship between religious fundamentalism and empathy in counselor trainees. However, the research suggested that the relationship between religious fundamentalism and empathy predicted attitudes towards lesbians and gays, only in the presence of religious fundamentalism. These results have suggested that even though counselor trainees have multicultural training, that the training may not be sufficient in preventing homophobic attitudes. The worry would be that the homophobic attitudes would permeate the therapeutic relationship. Bowers, Plummer, and Minichiello (2005) suggested that this may be due to a lack of knowledge, assumptions about the community, bias, and prejudice. Perhaps a LGBT course that examined the assumptions, stereotypes, and misconceptions would prove beneficial because the regression analysis suggested that increased
religious fundamentalism led to decreased attitudes toward sexual minorities. While an entire course may not be feasible for a variety of reasons, Croteau (1992) suggested that LGBT panels promoted a reduction in homophobic attitudes. While these small changes in multicultural counseling courses may be simplistic, they could potentially change attitudes toward the LGBT community. In fact, Rutter, Estrada, Ferguson & Diggs (2008) suggested that a training program had positive effects on the competencies of knowledge and skills regarding the LGBT community. This type of training would help counselor trainees have a better understanding of the LGBT community and how their biased may impact them, considering that most multicultural courses tend to focus on race and ethnicity (Sanabria, 2012).

Research.

Kitchener (1984) suggested that applying ethical principles to problem-solving behavior can prove difficult. This is particularly true when counseling individuals hold different belief systems or values to that of their patients. Future research should seek to understand the differences between males and females with regard to sexual orientation. A finding within the study suggested that
males were more religiously fundamental, which has been suggested to be a predictor of prejudice (Sanabria, 2012). Perhaps a qualitative study conducted in the future would give counselor educators better insight into gender difference. For example, a phenomenological or case study approach could be used.

Future research could also explore the different facets of race and the responses associated with each. Within the demographic questionnaire of this study, there was not a question that addressed race. While knowing an individual’s race was not paramount to the research question, the information could have provided better insight into the survey respondents. Furthermore, the respondents were gender biased, with more females than males participating in the survey.

Future studies may examine the relationship between religious fundamentalism and attitudes toward lesbians and gays using a wider lens. This broader view may show a greater relationship between religious fundamentalism and empathy in predicting attitudes toward lesbians and gays. The results may be different because the general public may not have the same social desirability bias that counselor trainees have been shown to have.
Theory.

The results from the regression analysis suggested that religious fundamentalism could cause an increase in homophobic attitudes in counselor trainees. While the results of this study suggested that there was no correlation between empathy and attitudes toward lesbians and gay, homophobia has shown to negatively affect the counseling relationship (Bowers, Plummer & Minichiello, 2005). For example, in person centered therapy, there must be an unconditional positive regard conveyed by the counselor. If a counselor has homophobic attitudes, then negative outcomes should be expected (Bowers, et al., 2005).

Conclusion

The first research question concluded that there was no relationship between religious fundamentalism and empathy in counselor trainees. This study also suggested that the combination of religious fundamentalism and empathy did predict attitudes toward sexual minorities in counselor trainees, but only in the presence of religious fundamentalism. This finding supported the research that religious fundamentalism predicted negative attitudes toward lesbians and gays, even in counselor trainees.
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Appendix A: The Revised 12-Item Religious Fundamentalism Scale (Altemeyer and Hunsberger, 2004)

This survey is part of an investigation of general public opinion concerning a variety of social issues. You will probably find that you agree with some of the statements, and disagree with others to varying extents. Please indicate your reaction to each statement by blackening a bubble in SECTION 1 of the bubble sheet, according to the following scale:
Blacken the bubble labeled:

- 4 if you very strongly disagree with the statement
- 3 if you strongly disagree with the statement
- 2 if you moderately disagree with the statement
- 1 if you slightly disagree with the statement
+ 1 if you slightly agree with the statement
+ 2 if you moderately agree with the statement
+ 3 if you strongly agree with the statement
+ 4 if you very strongly agree with the statement

If you feel exactly and precisely neutral about an item, blacken the "0" bubble.

You may find that you sometimes have different reactions to different parts of a statement. For example, you might very strongly disagree ("-4") with one idea in a statement, but slightly agree ("+1") with another idea in the same item. When this happens, please combine your reactions and write down how you feel on balance (a "-3" in this case).

1. God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed.
2. No single book of religious teachings contains all the intrinsic, fundamental truths about life.*
3. The basic cause of evil in this work is Satan, who is still constantly and ferociously fighting against God.
4. It is more important to be a good person than to believe in God and the right religion.*
5. There is a particular set of religious teachings in this world that are so true, you can’t go any “deeper” because they are the basic, bedrock message that God has given humanity.
6. When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God: and the rest, who will not.

7. Scriptures may contain general truths, but they should NOT be considered completely, literally true from beginning to end.*

8. To lead the best, most meaningful life, one must belong to the one, fundamentally true religion.

9. “Satan” is just the name people give to their own bad impulses. They really is no such thing as a diabolical “Prince of Darkness” who tempts us.*

10. Whenever science and sacred scripture conflict, science is probably right.*

11. The fundamentals of God’s religion should never be tampered with, or compromised with others’ beliefs.

12. All of the religions in the world have flaws and wrong teachings. There is no perfectly true right religion.*

*indicates item is worded in the con-trait direction, for which the scoring key is reversed.
Appendix B: The Basic Empathy Scale©

The following are characteristics that may or may not apply to you. Please tick one answer for each statement to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Disagree</td>
<td>Neither agree nor disagree</td>
<td>Agree</td>
<td>Agree strongly</td>
</tr>
</tbody>
</table>

1. My friend’s emotions don’t affect me much
2. After being with a friend who is sad about something, I usually feel sad.
3. I can understand my friend’s happiness when she/he does well at something
4. I get frightened when I watch characters in a good scary movie.
5. I get caught up in other people’s feelings easily
6. I find it hard to know when my friends are frightened.
7. I don’t become sad when I see other people crying
8. Other people’s feelings don’t bother me at all.
9. When someone is feeling ‘down’ I can usually understand how they feel.
10. I can usually figure out when my friends are scared.
11. I often become sad when watching sad things on TV or in films.
12. I can often understand how people are feeling even before they tell me.
13. Seeing a person who has been angered has no effect on my feelings.
14. I can usually figure out when people are cheerful
15. I tend to feel scared when I am with friends who are afraid
16. I can usually realize quickly when a friend is angry.
17. I often get swept up in my friend’s feelings
18. My friend’s unhappiness doesn’t make me feel anything
19. I am not usually aware of my friends feelings
20. I have trouble figuring out when my friends are happy.
Appendix C: Attitudes Toward Lesbian and Gay Scale (Herek, 1988)

Scale Items for Attitudes Toward Lesbians and Gay Men (ATLG) scale items 1 through 10 comprise the ATL subscale; items 11–20 constitute the ATG. Scoring is reversed for starred (*)

<table>
<thead>
<tr>
<th>Strongly Disagree =1</th>
<th>Disagree Somewhat =2</th>
<th>Agree Somewhat =3</th>
<th>Strongly Agree =4</th>
</tr>
</thead>
</table>

For the items that are starred (*), reverse scoring will be used.

1. Lesbians just can’t fit into our society.
2. A woman’s homosexuality should not be a cause for job discrimination in any situation.*
3. Female homosexuality is detrimental to society because it breaks down the natural divisions between the sexes.
4. State laws regulating private, consenting lesbian behavior should be loosened.*
5. Female homosexuality is a sin.
6. The growing number of lesbians indicates a decline in American morals.
7. Female homosexuality in itself is no problem but what society makes of it can be a problem.*
8. Female homosexuality is a threat to many of our basic social institutions.
9. Female homosexuality is an inferior form of sexuality.
10. Lesbians are sick.
11. Male homosexual couples should be allowed to adopt children in the same as heterosexual couples.*
12. I think male homosexuals are disgusting.
13. Male homosexuals should not be allowed to teach school.
14. Male homosexuality is a perversion.
15. Just as in other species, male homosexuality is a natural expression of sexuality in human men.*
16. If a man has homosexual feelings, he should do everything he can to overcome them.
17. I would not be too upset if I learned that my son were a homosexual.*
18. Homosexual behavior between two men is just plain wrong.
19. The idea of male homosexual marriages seems ridiculous to me.
20. Male homosexuality is merely a different kind of lifestyle that should not be condemned.*
Appendix D: Participant Demographic Questionnaire

Please answer the following questions to the best of your ability. Your responses will remain anonymous.

1) Biological Sex: Male Female

2) Program Enrollment: Masters Doctoral

   a. What year are you in your program?

3) Age:
   a. 18-24
   b. 25-30
   c. 31-35
   d. 35-40
   e. 41-45
   f. 46-50
   g. 50+

4) What is your sexual orientation
   a. Lesbian
   b. Gay
   c. Bisexual
   d. Transgender
e. Straight
f. Queer
g. Questioning
h. Intersex

5) What type of institution does your program reside in
   a. Public
   b. Private
Appendix E: IRB Approval

A determination has been made that the following research study is exempt from IRB review because it involves:

Category 2. research involving the use of educational tests, survey procedures, interview procedures or observation of public behavior.

Project Title: Heterosexual Fundamentalism, Empathy, and Attitudes toward Lesbians and Gays within the Therapeutic Relationship

Primary Investigator: Jonathan Edward Proctor

Co-Investigator(s):

Advisor: Mora Robinson

Department: Counselor Education and Supervision

Date: 1/18/13

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved prior to implementation.
### Table 11 Factor Analysis for RRF

Component loadings and communalities based on a principle components analysis with Varimax rotation for 12 items for the Revised Religious Fundamentalism Scale (RRF) (N=149)

<table>
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<th>Item</th>
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<th>Communality</th>
</tr>
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<tbody>
<tr>
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<td>.58</td>
</tr>
<tr>
<td>2</td>
<td>.685</td>
<td>.469</td>
</tr>
<tr>
<td>3</td>
<td>.829</td>
<td>.688</td>
</tr>
<tr>
<td>4</td>
<td>.788</td>
<td>.621</td>
</tr>
<tr>
<td>5</td>
<td>.76</td>
<td>.577</td>
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<tr>
<td>6</td>
<td>.71</td>
<td>.503</td>
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<tr>
<td>7</td>
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<td>.687</td>
</tr>
<tr>
<td>12</td>
<td>.802</td>
<td>.644</td>
</tr>
</tbody>
</table>

Eigenvalue: 7.234

% Variance: 60.285

Factor Analysis of Revised Religious
Table 12 Factor Analysis for ATLG

Component loadings and communalities based on a principle components analysis with Varimax rotation for 20 items for the Attitudes Toward Gays and Lesbians Scale (ATLF) (N=149)

<table>
<thead>
<tr>
<th>Item</th>
<th>Component 1: ATLG</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
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<td>.489</td>
<td>.239</td>
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<td>.870</td>
<td>.757</td>
</tr>
<tr>
<td>6</td>
<td>.849</td>
<td>.722</td>
</tr>
<tr>
<td>7</td>
<td>.413</td>
<td>.170</td>
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<td>.740</td>
<td>.548</td>
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<tr>
<td>12</td>
<td>.774</td>
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<tr>
<td>20</td>
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<td>.554</td>
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Eigenvalue  11.326  
% Variance  56.63

*Factor Analysis of the Attitudes Toward*
Table 13 Factor Analysis for Basic Empathy Scale

Component loadings and communalities based on a principle components analysis with Varimax rotation for 20 items for the Basic Empathy Scale (BES) (N=149)

<table>
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<td>.751</td>
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<td>.109</td>
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<td>.577</td>
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<tr>
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<tr>
<td></td>
<td>0.367</td>
<td>0.627</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Eigenvalue: 5.754  2.800  1.777

% of Total: 28.768  14.000  8.884

Variance

Total: 28.768  42.768  51.652

Factor Analysis for the Basic Empathy Scale
Appendix G: Permission to Use Scales

Permission to use the Basic Empathy Scale

--------- Forwarded message ---------
From: Darrick Jolliffe <D.Jolliffe@greenwich.ac.uk>
Date: Tue, Mar 5, 2013 at 2:04 AM
Subject: RE: Permission
To: Jonathan Procter <jonathan.procter@gmail.com>

That's fine - thanks for asking. Can you have a line on it just stating that it is copyrighted (or even a little (c)).
All the best
Darrick
Professor Darrick Jolliffe
School of Law
University of Greenwich
Old Royal Navy College
London
SE10 9LS

From: Jonathan Procter [jonathan.procter@gmail.com]
Sent: 05 March 2013 00:29
To: Darrick Jolliffe
Subject: Permission

Dr. Jolliffe,
Would you grant me permission to include the Basic Empathy Scale and place it within my dissertation as an appendix? I know it is copyrighted, and I wanted to get permission before it went to thesis and dissertation services.
Bests,
Jonathan

--
Jonathan Procter, Ph.D.
Ohio University
Patton College of Education
Counselor Education & Supervision

University of Greenwich, a charity and company limited by guarantee, registered in England (reg. no. 986729). Registered office: Old Royal Naval College, Park Row, Greenwich, London SE10 9LS.

--
Jonathan Procter, Ph.D.
Ohio University
Patton College of Education
Attitudes Toward Lesbians and Gay Men Scale

Per the scale's creator, one does not need permission to use it, if it has passed IRB approval. "It is not necessary to obtain formal permission from Dr. Herek to use the scale in research that meets these conditions, and such permissions are not provided, even upon request."

Thanks,
Jonathan
--
Jonathan Procter, Ph.D.
Ohio University
Patton College of Education
Counselor Education & Supervision

-------- Forwarded message --------
From: R Altemeyer <altemey@cc.umanitoba.ca>
Date: Fri, Mar 8, 2013 at 3:41 PM
Subject: Re: Religious Fundamentalism Scale
To: Jonathan Procter <jonathan.procter@gmail.com>

Yes, of course.

Bob Altemeyer

Jonathan Procter wrote:
Dr. Altemeyer,

Would you grant me permission to put your Revised Religious Fundamentalism Scale as an appendix within my dissertation?

Bests,

Jonathan

On Sun, Nov 4, 2012 at 4:54 PM, R Altemeyer <altemey@cc.umanitoba.ca> wrote:

Yes, in fact you should use the revised version.

Jonathan Procter wrote:
Thanks for your permission! Ill let you know what I find. If I decide to use the revised version would that be okay?
Bests,
Jon

Jonathan Procter

On Nov 4, 2012, at 12:53, R Altemeyer <altemey@cc.umanitoba.ca> wrote:

Jonathan Procter wrote:

Dr. Altemeyer,

I am currently preparing for my dissertation proposal. I am looking at examining the relationship between religious fundamentalism and empathy in counselors in training. I am requesting permission to use your scale in my dissertation.

All the best,

Jonathan

Hi. It's nice to meet you.

I don't think you'll find a correlation, but you're welcome to use the RF scale in your study.