EVALUATING SEXUAL PREJUDICE AMONG SUBSTANCE ABUSE COUNSELORS

by

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ABSTRACT

JAMES EDWARD POWELL. Evaluating sexual prejudice among substance abuse counselors. (Under the direction of DR. JOHN R. CULBRETH)

Sexual minority individuals seeking substance abuse treatment services are not immune from barriers of sexual prejudice. Although ethical standards and recommended best practice guideline admonish substance abuse counselors harboring sexual prejudice, research demonstrates the continued existence of sexual prejudice. Research into the nature of sexual prejudice of substance abuse counselors has been conducted for many decades, resulting in accepted associated variables of sexual prejudice. This study explored sexual prejudice as predicted by religious beliefs, education level, and various demographic factors of substance abuse counselors. The research design included bivariate correlational and regression analyses to evaluate data from substance abuse counselors who were members in a national association of substance abuse counselors. The sample of 652 substance abuse counselors completed a confidential online survey. Results indicated moderately strong correlations between sexual prejudice, religious beliefs, and the demographic variables of race, familiarity with sexual minority issues, gender, and age. Religious beliefs, race, familiarity with sexual minority issues, gender, and age were all significantly negatively correlated with sexual prejudice. Multiple regression results indicated that 47% of the sexual prejudice variance was accounted for by religious beliefs, education level, and the demographic variables of race, gender, age, and familiarity with sexual minority issues, though education level was not a significant predictor. Implications of the results for the fields of counseling and substance abuse treatment are discussed.

DEDICATION

I would like to dedicate this body of work to my parents, Janice and Larry Powell. My parents divorced when I was a very young age. The issues of my parents' divorce were never attributed to me; my parents love of and for me, I never felt their love and support faulted or waned. I can see this clearly now in adulthood, though my adolescent development provided me plenty of time to question and challenge the love of my parents.

My father taught me many life living qualities. He believes in; being respectful of and to others; being committed and loyal, not only to my word, but also my beliefs; fiscal responsibility; and the value of common sense and independence. For these lessons of my dad, I am forever grateful.

My mother provided me with important aspects of living a genuine and authentic life. She believed in; being herself and being happy with yourself, even if others aren't; accomplishing your hearts desires and dreams, even when circumstance says you can't; the importance of patriotism; unconditional love and acceptance. My mother recently passed away. She was not only my mother as she was my news, weather, and sports reporter. My mom was my best friend; we talked three or four times a day. I miss her terribly.

Furthering my education has always been my desire and decision. I never pursued any of my education as purpose of making my parents proud. However, I do hope that in pursuing my hearts desires and dreams, making my parents proud has occurred along my journey. For these reasons, I dedicate this body of work to my dad and mom, Janice and Larry Powell.

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Dr. Jack Culbreth, my dissertation chairman, provided support, wisdom, foresight, which have made me a better counselor, counselor educator, and person. Dr. Culbreth spent much time providing me feedback and support during this process that I feel went above and beyond his role. I am very much appreciative of my other dissertation committee members: Dr. Lyndon Abrams, Dr. Pamela Lassiter, Dr. Claudia Flowers, and Dr. Donna Kazemi. These members were always supportive and nurturing as they provided thoughts and recommendations to enhance this study. Their insights and recommendations greatly benefitted me and this study. Dr. Pat Partin, former professor and now colleague, has continued to provide me with resources and support. She is my counseling "guru" and very much appreciated, valued, respected and loved by me.

Lastly, the support and encouragement of my family and friends over the past four years is the anchor that has kept me grounded, focused, and kept me from losing myself during this process. Billy, Thank you. The Sunday races and dinners with your family were valued. Ricky and Debbie, Thank You for keeping me involved. Scott, Thank You for keeping me centered on the priorities of life. Members of my cohort, Thank you for sharing this experience and truly understanding my pains and joys. Mom and Dad, I cannot Thank You enough, I am fortunate to call you my parents. I Love You.

INTRODUCTION

As I began to mature professionally as a professional counselor, I recognized that personal biases were beginning to affect my professional career. I harbored sexual prejudice and this prejudice was contrary to my professional career as well as my Christian faith. Being a Christian of my own defining, I believed that leading a Christian life was not to judge, but here I was judging others.

After experiencing much personal pain and suffering from past life experiences, I decided that I would pursue possibly a doctorate. During the admission process, I informed the committee that the strength of this unique program was my personal and professional weaknesses. I was not pursuing a PhD primarily for professional reasons, my main purpose for the program was to become a better person while becoming a more effective and valuing counselor.

By beginning to share experiences with sexual minorities and other activities, I was able to work through my sexual prejudice issues. I challenged my socialized prejudices' by selecting topics and activities that connected me with sexual minority individuals. As I progressed through clinical substance abuse program components, I began to notice salient sexual prejudice during practicum and internship experiences. This salient sexual prejudice resonated with me personally because of my related biases. My professional interest in substance abuse and personal sexual prejudice work were being fused together. Therefore, contemplating topics of dissertation involved combining my desire to evaluate sexual prejudice among substance abuse counselors has resulted in this research dissertation study. A dissertation derived from professional interest founded upon personal insight and need.

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CHAPTER 1: INTRODUCTION

Prejudice

Individuals who identify as lesbian, gay male, bisexual are considered sexual minority individuals because same-sex attractions and relationships are marginalized in most cultures (Balsam & Mohr, 2007), with transgendered individuals being generally recognized members of this marginalized group. Prejudice is a universal feature in the lives of these sexual minority individuals (Balsam & Mohr, 2007; Cochran, Peavy, & Santa, 2007; Eliason & Hughes, 2004; Herek, Gillis, & Cogan, 2009). Prejudice toward sexual minority individuals has decreased in the past two decades (Herek et al., 2009; Loftus, 2001), though sexual minority individuals continue to experience prejudice (Herek, 2009a; HR 2015, 2007; Rostosky, Riggle, Horne, & Miller, 2009).

Homosexual individuals have been noted to exists in every historical time period, society, and culture (Harvey, 1978). Sexual minority behavior has been both accepted and rejected at varying historical periods (Sullivan, 2003; Talmey, 1938; Weeks, 2007). The acceptance or rejection of sexual minority behaviors are often associated with one's causal belief or value of sexual minority behavior (Drescher, 2008). Sexual minority behavior rejection may be demonstrated as negative attitudes. It is these negative attitudes, occurring toward individuals as a result of overgeneralizations, which result in prejudice (Allport, 1954). Allport (1954), defined prejudice as thinking ill of others without warrant (1954), which is consistent with Herek, Gillis, and Cogan (2009). Herek,

et al. (2009) recently noted that prejudice represents an evaluative attitude, though Allport (1954) earlier noted prejudice to contain an essential ingredient in addition to attitude, prejudice also contains belief factors.

Attitudes are psychological tendencies demonstrated with some degree of favor or disfavor (Eagly & Chaiken, 1993), based upon behaviors, beliefs, and affect (Herek, 2009b), resulting in an affective response from cognitive evaluations and emotional reactions (Stephan & Stephan, 1993). Beliefs are generally accepted as believing something to be true and affect is the experience of feeling or emotion, inherent in religion. Prejudicial beliefs of have been reported to be founded in religious beliefs (Allport, 1954; Allport & Ross, 1967). Specifically, sexual prejudice beliefs are supported by Judeo-Christian traditions (Kinsey, Pomeroy, & Martin, 1948; Weinberg, 1972). Therefore, it appears that prejudicial beliefs and attitudes, are connected behaviorally, which is noted to be a common assumption (Schope & Eliason, 2000) as prejudicial acts have been associated by a person's religious beliefs (Herek, 1987, 1995; Kinsey et al., 1948; Satcher & Leggett, 2007; Shackelford & Besser, 2007).

Religion and Prejudice

Religious beliefs have historically been directly correlated with prejudicial attitudes in general (Eliason, 2000; Eliason & Hughes, 2004; Herek & Capitanio, 1995; Shackelford & Besser, 2007), and as an important variable in considering sexual prejudice (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004). In fact, when examining factors of sexual prejudice, religiousness has been found to be related to increased sexual prejudice (Allport & Ross, 1967; Malcomnson, Christopher, Franzen, & Keyes, 2006) and to be a significant predictor of prejudicial attitudes toward

gay men (Schulte & Battle, (2004). The sociological and cultural context of religion in Western society may provide a conceptual framework from which sexual prejudice may be influenced by religion (Bullough, 1979; Sullivan, 2003).

Sexual minority behavior is forbidden by the Bible (Sullivan & Wodarski, 2002). This forbidden behavior may influence sexual prejudice toward sexual minority individuals by associating a possible etiological view (Drescher, 2008), based in religious traditions (Bullough, 1979; Kinsey et al., 1948; Sullivan & Wodarski, 2002; Sullivan, 2003; Weinberg, 1972). These traditions concur that sexual minority behavior is against God, and punished by death among the Hebrews (Talmey, 1938). The possible punishment by death for individuals engaging in sexual minority behavior by the Hebrews demonstrates, not only the relationship between sexual prejudice and religious belief, but also the extent individuals will act out prejudice behaviorally to defend values in which they live by and for (Allport, 1954).

Americans overwhelmingly (95%) value a belief in God or a higher power, and this figure is reported to have never dropped below 90% over the past fifty years (Gallup & Lindsay, 1999). Since many theological leaders and scholars believe that the Bible prohibits same-sex relationships, it is not surprising that religion has been demonstrated to be significantly related to more prejudicial attitudes in American society (Bullough, 1979; Eliason, 2000; Eliason & Hughes, 2004; Herek & Capitanio, 1995; Kinsey et al., 1948; Shackelford & Besser, 2007; Weinberg, 1972). These discriminatory practices and beliefs have been demonstrated to exist among heterosexuals toward sexual minorities (Allport, 1954; Herek, 1987, 1988, 1994, 2000a, 2002b), in the form of sexual prejudices.

Sexual Prejudices

Herek (2009b) conceptualizes sexual prejudice as attitude, based upon perceived sexual orientation (Eagly & Chaiken, 1993). As sexual prejudice is manifested as negative attitudes toward sexual minority individuals (Herek et al., 2009), being the target of sexual prejudices has demonstrated that sexual minority individuals over a life span report being more victimized and abused than heterosexuals (Balsam, Rothblum, & Beauchaine, 2005) as compared to their siblings. Sexual minority individuals report having experienced more psychological, sexual, and physical abuse than their siblings. Being the victim of prejudicial attitudes, sexual minorities experience physical and emotional stress in an anti-gay society (Weber, 2008). As sexual minorities are exposed to sexual prejudiced events, substance use and dependence may increase as a result of experiencing sexual prejudice (Cabaj, 2000; Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Santa, 2007).

Prejudice and Substance Abuse

There is a disparity between sexual minority and heterosexual individual's substance use and abuse. As being the victim of historical prejudices, sexual minorities' substance abuse rates provide interesting findings when compared with heterosexuals (Cochran & Cauce, 2006; Cochran, Ackerman, Mays, & Ross, 2004b; Cochran, Keenan, Schober, & Mays, 2000). Previous research (Cochran & Cauce, 2006; Cochran et al., 2004b; Cochran et al., 2000) comparing specific substances used among sexual minority and heterosexual individuals provide insight into the severity of substance use disorders among sexual minority individuals (Cochran, Peavy, & Santa, 2007; Cochran, 2001; Cochran et al., 2004b; Cochran et al., 2000) and sexual minority individuals cultural and

social frameworks (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Santa, 2007; Cochran et al., 2004b; Greenwood, White, Page-Shafer, Bein, Osmond, Paul et al., 2001).

In comparing specific substance usage among sexual minority and heterosexual individuals, it should be noted that moderate elevation of drug use is more frequent among sexual minority individuals than heterosexual individuals (Cochran, Peavy, & Santa, 2007; Cochran et al., 2004b), specifically gay men as compared to lesbians (Cochran, Peavy, & Santa, 2007; McCabe, Boyd, Hughes, & d'Arcy, 2003). Substance dependence upon marijuana, is found to be higher for sexual minorities (Cochran et al., 2000). Though alcohol is generally accepted as the most substance of dependence in America, only lesbian women were found to use alcohol more than heterosexual women.

Lesbians were more likely to report the use of marijuana and analgesics or pain relievers while Cochran et.al (2004b) and Cochran, Peavy, and Santa (2007) found lesbians to be at an increased risk for cocaine use, in comparison to gay men. Cochran and Cauce (2006) found gay men reported to be more likely to use substances such as, methamphetamine, marijuana, cocaine, and heroin, on a more consistent daily basis than heterosexual men. As substance abuse rates have been demonstrated to increase as a result of such prejudicial attitudes, it is imperative that these attitudes among treatment providers be examined as sexual minorities may avoid treatment due to sexual prejudice (Cochran, Peavy, & Santa, 2007).

Sexual Prejudicial Attitudes

Allport (1954) believed that negative attitudes will be expressed in action, of some form such as explicit and implicit prejudice (Cochran, Peavy, & Cauce, 2007;

Herek, 2000a; Neville & Henrickson, 2006). Schope and Eliason (2000) expounded from Allport's (1954) belief that negative attitudes will be expressed in a behavioral action as they noted a common assumption that attitudes, either positive or negative, shape behavior. Individuals with prejudicial attitudes were more likely to engage in discriminatory, harassing or even violent acts, as opposed to individuals with less prejudicial attitudes, who were found to be engaged in helping behaviors and less likely to engage in prejudicial acts (Schope & Eliason, 2000).

Research examining sexual prejudicial attitudes toward sexual minority clients has been diverse. Studies have been conducted to examine this phenomena among different professionals such as psychologists (Hayes & Erkis, 2000), social workers (Berkman & Zinberg, 1997) and school counselors (Satcher & Leggett, 2007). Cultural and ethnic prejudicial attitudes toward sexual minority clients have also been conducted among Black heterosexuals adults (Herek & Capitanio, 1995), and social work students in a major university in Israel (Ben-Ari, 1998).

One area of specialized counseling that has received limited focus concerning prejudicial attitudes is that of substance abuse counselors. Similar to previous studies examining attitudes toward sexual minority clients among professions (Berkman & Zinberg, 1997; Hayes & Erkis, 2000; Satcher & Leggett, 2007), cultures, and ethnic groups (Herek & Capitanio, 1995), sexual prejudicial attitudes among substance abuse counselors toward sexual minority clients have been found to exist (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004) .

Characteristics of Sexual Prejudice

In reviewing literature of sexual prejudice, there are variables that are consistently associated with sexual prejudice. Variables that have been identified include education, gender, and religion. Education is associated with sexual prejudice as less education is found to be a characteristic of individuals demonstrating sexual prejudice (Eliason, 2000; Eliason & Hughes, 2004; Herek, 2002b; Klassen, Williams, & Levitt, 1989; Loftus, 2001; Shackelford & Besser, 2007; Weber, 2008). Gender is also another characteristic that is associated with sexual prejudice (Cochran, Peavy, & Cauce, 2007; Eliason, 1995, 2000; Herek, 1988, 1995, 2002b; Larson, Reed, & Hoffman, 1980; Lim, 2002). Religion has historical and contemporary associations with sexual prejudice (Allport, 1954; Allport & Ross, 1967; Eliason, 2000; Eliason & Hughes, 2004; Herek, 1987; Herek & Capitanio, 1995; Kinsey et al., 1948; Larson et al., 1980; Negy & Eisenman, 2005; Satcher & Leggett, 2007; Tucker & Potocky-Tripodi, 2006).

There have also been studies that examined other associations of sexual prejudice. The substance abuse counselors' familiarity of sexual minority issues (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Robohm, 2007; Eliason & Hughes, 2004; Ghindia & Kola, 1996), and personal contact with sexual minority individuals (Ben-Ari, 1998; Berkman & Zinberg, 1997; Eliason, 2000; Hayes & Erkis, 2000; Herek & Glunt, 1993; Satcher & Leggett, 2007) have been demonstrated to be associated with decreased sexual prejudice. Substance abuse counselors' recovery status (Culbreth, 2000) may provide insight as to characteristics of effective counseling skills serving sexual minority individuals, as viewed by substance abuse counselors. Examining characteristics of sexual prejudice may identify substance abuse counselors' who may be

benefit from sexual prejudice training and awareness, whereby ethical standards are reinforced.

Ethics of Sexual Prejudice

As sexual minority clients have accelerated rates of substance abuse in comparison with heterosexuals (Cochran et al., 2000; Cochran & Mays, 2000b, 2006; Cochran, Mays, Alegria, Ortega, & Takeuchi, 2007; Jordan, 2000; Koh & Ross, 2006; Mayer, Bradford, Makadon, Stall, Goldhammer, & Landers, 2008), and may be subject to prejudicial attitudes by treatment providers (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Cauce, 2007; Cochran, Peavy, & Robohm, 2007; Eliason, 2000; Eliason & Hughes, 2004; Lucksted, 2004; Substance Abuse and Mental Health Services Administration, 1999), professional associations may need to invest more resources toward this population. The professional ethics of the American Counseling Association (ACA) and the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) address advocacy for treatment concerns of ethnic, religious, and sexual minorities, and other marginalized groups (ACA 2005; NAADAC 2004). ACA and NAADAC both have placed non-discriminatory practices as a top priority in their statements of non-discrimination.

It is interesting to note that ethical violations for ACA during January 2008 until August 2008 did not include a violation based on discrimination. The violations reported during this time were complaints of practicing without a license and dual-relationship of a romantic nature, malpractice, and Medicaid fraud (Freeman, 2008). Though discrimination against sexual minority clients has been demonstrated, it appears that these ethical violations are possibly not being reported by colleagues who are aware of

such incidents or by clients who experience the discrimination (Anderson & Holliday, 2007). It is important to note that as society is not immune from discrimination, counselors are not free from biases as a result of ethical codes (Oliver, 2009).

Sexual Prejudice Variables

The following outcome and predictor variables will be briefly described and are significant to this study: The outcome variable is sexual prejudice. The predictor variables are: (a) substance abuse counselors: religious beliefs, educational level, and various demographic variables include, but not limited to sexual identity and recovery status.

Outcome

Sexual Prejudice. Herek (1994) noted two important events that provided pathways to begin measuring prejudicial heterosexual attitudes towards sexual minority clients in modern research. In 1972, the term "homophobia" was first introduced by George Weinberg in his *Society and the Healthy Homosexual*. The American Psychiatric Association (APA) removed homosexuality from the Diagnostic and Statistical Manual (DSM) in 1973. This action removed homosexuality from being viewed as a pathological disorder. Herek reports that studies of the 1970's and 1980's did not assess attitudes towards lesbians and gays separately, as scales of those studies were limited in that they were not able to examine sexual minority groups separately.

However, further studies have demonstrated significant differences among these subgroups of sexual minority clients. Eliason (2000) reports studies examining attitudes towards gay and lesbian individuals who were receiving substance abuse treatment as beginning to occur in mid-1980s. Eliason noted that these studies, much like Herek's

(1994), grouped gays and lesbians together. Bisexual and transgendered individuals were not specifically included. As studies of prejudicial attitudes towards sexual minority clients began to include subgroups of sexual minorities, the attitude constructs also became more definitive.

In order to fully comprehend the magnitude of how one's attitude and belief can impact substance abuse counseling, an understanding of historical and philosophical underpinnings of substance abuse treatment is essential. Two important constructs dominate substance abuse treatment. First is the philosophical view of complete abstinence, a widely-held notion among the majority of treatment facilities requiring participation in Alcoholic Anonymous (AA) for clients (Thombs, 2006), an organization likewise devoted to abstinence (Alcoholics Anonymous, 2001). A second approach is Harm reduction (Miller, 2005). This approach is not abstinence based, but focuses more on the individual reducing harm connected with the using behavior (Miller, 2005). These two constructs have separated the field of substance abuse counselors into two opposing camps.

Predictor

Religious Beliefs. Including spirituality in a comprehensive treatment plan is generally considered paramount to successful treatment. Though this assumption is recognized as important to recovery for some clients (Galanter, Dermatis, Bunt, Williams, Trujillo, & Steinke, 2007), religious attitudes regarding sexual minority individuals have been proven to be a significant factor in prejudicial attitudes toward these same people (Scheepers, Te Grotenhuis, & Van Der Silk, 2002). These religious beliefs, as significant factors of prejudicial attitudes (Eliason, 2000), may exert a

powerful influence on client treatment processes, as part of the counselor's impact upon treating sexual minority individuals (Miller & Rollnick, 1991), thus creating a significant treatment issue due to substance abuse counselors' sexually prejudiced attitude (Eliason, 2000).

Other studies of substance abuse counselors have demonstrated prejudice attitudes towards sexual minorities (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004). The inclusion of religious beliefs among substance abuse counselors is warranted due to other studies either noting a relationship between religiosity and sexual prejudice (Allport, 1954; Allport & Ross, 1967; Eliason & Hughes, 2004; Herek, 1994) toward sexual minorities or studies reporting religiosity as a predictor of prejudicial attitudes towards minorities in general (Allport & Ross, 1967; Herek, 1987), while education as also been associated with sexual prejudice (Eliason, 2000).

Education. Education level has been demonstrated to be associated with sexual prejudice (Eliason, 2000; Herek, 2002b; Hicks & Tien-tsung, 2006; Shackelford & Besser, 2007). Eliason (2000) found that individuals with sexual prejudicial attitudes were uneducated. Herek (2002b) and Hicks and Tien-tsung (2006) found sexual prejudice to be associated with less education, which was further supported by Shackelford and Besser (2007), though Herek (2002b), Hicks and Tien-tsung (2006), or Shackelford and Besser (2007) did not categorize education levels. Loftus (2001) earlier concluded that increasing educational levels were associated with changing sexual prejudice toward sexual minority individuals, which is now recommended as the identity development of sexual minorities' are complex and difficult due to prejudice (Cochran, Peavy, & Cauce, 2007).

Sexual Identity. Sexual identity or orientation may be just as important a sexual prejudice variable as religious beliefs or education, as substance use issues may be related to coming to terms with prejudice of a person's sexual identity (Cochran, Peavy, & Santa, 2007). Though sexual identity is a fundamental feature of human experience, identity and development (Carver, Egan, & Perry, 2004), sexual concerns are rarely addressed in the substance abuse treatment process (SAMSHA, 2001; Lucksted, 2004). Therefore, this omission of addressing sexual concerns may be tied to heterosexism (Eliason & Hughes, 2004; Herek et al., 2009; Morin, 1977).

Prejudice, based upon sexual identity may be perceived as sexual prejudice (Herek, 2000a; Herek et al., 2009), possibly due to sexual minority individuals not being viewed in the same terms as heterosexual individuals (Eliason & Hughes, 2004), based upon sexual identity. As a possible result of sexual prejudice, some sexual minority individuals may have negative attitudes towards heterosexuals and feel discomfort as well (White & Franzini, 1999). It appears that to lessen discomfort, sexual minority individuals may seek out other individuals sexual identity and have shared experiences (Jordan, 2000; Weber, 2008), much like individuals seeking recovery from substances can only be possibly treated by individuals of similar experiences and have recovered (Mathews, Lorah, & Fenton, 2006).

Recovery. A theoretical belief of some traditional substance abuse counselors, is that only individuals with a personal history of recovery can be effective substance abuse counselors, based upon the belief that addicted individuals will only listen to individuals in personal recovery (Culbreth, 2000). The earliest members of mutual aid societies believed that having a history of personal recovery was viewed as essential in working

with addicts (White, 2008). Therefore, providing effective substance abuse services is inherently thought to be connected to the recovery status of the substance abuse counselor. Culbreth reported tension often exists between counselors in personal recovery and counselors not having experienced personal recovery.

It appears that expanding this recovery status rationale to sexual minority individuals, instead of addicted individuals, suggests that only sexual minority individuals are able to provide effective services for sexual minority individuals. Though research supports this concept (Mathews et al., 2006; McDermott, Tyndall, & Lichtenberg, 1989), there has been no difference of effectiveness or difference of treatment outcomes have been demonstrated (Culbreth, 2000), based upon the recovery status of the counselor. Culbreth (2000) reported personality and attitudinal differences between recovering and non-recovering counselors, that may impact interactions between clients, co-workers, and supervisors. It appears that these differences, may account for the often existing tensions (Culbreth, 2000), between recovering and non-recovering counselors.

Culbreth (2000) reported findings of studies that investigated personality and attitudinal differences of recovering and non-recovering counselors. Recovering counselors tend to be less accepting of change, inflexible, opposing alternative viewpoints and conventional (Hoffman & Miner, 1973), rigid belief of disease model, less likely to incorporate treatment plan that included Harm reduction goals, (Moyers & Miller, 1993). Culbreth also noted that recovering counselors were less likely to consider counseling training, less positive about additional professional development as compared to non-recovering counselors. It appears that some recovering counselors would not

benefit sexual minority individuals as working with sexual minority individuals would require considering alternative views (Center for Substance Abuse Treatment, 2001; Mayer et al., 2008; Substance Abuse and Mental Health Services Administration, 1999), professional development and education around sexual minority issues to become culturally responsive (Cochran, Peavy, & Robohm, 2007; Eliason, 2000; Eliason & Hughes, 2004; Lassiter & Chang, 2006) to the unique treatment needs of sexual minority individuals.

Sexual Minority Clinical Treatment Perspectives

The population of substance abusers include diverse issues and often requires integration of different treatment and services (Polcin, 2000), though no definition of sexual minority specific treatment has been defined (Cochran, Peavy, & Santa, 2007). Polcin reports that specialized substance abuse treatment should include subspecialties such as dual diagnosis of psychosis and addiction, a comprehensive adolescent model, and an outpatient model that incorporates a cognitive behavioral approach combined with twelve step principles. It is interesting to note that Polcin does not include sexual identity or orientation as a specialty area to consider.

A common goal of any substance abuse treatment facility or provider is to focus on stopping substance abuse that interferes with the client's well being (Center for Substance Abuse Treatment, 2001). A comprehensive treatment approach is often described as being "holistic". This approach includes biological, social, psychological, as well as a person's spiritual development, often referred to as the "biopsychosocialspiritual" model (Wallace, 2003, p. 11), which has been found to be a significant component of recovery for some individuals (Galanter et al., 2007). Though

comprehensive and holistic in nature, this approach does not immediately address underlying emotional issues. Emotional issues receive their focus in the substance abuse continuum of care generally regarded as “aftercare”.

Best Practice

Best practice treatment protocols recommend that treatment plans be individualized to the needs of the client and to the services offered by the treatment provider or treatment facility (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999). Lucksted (2004) reports that healthcare settings are uncomfortable addressing the sexual aspects of clients’ lives, it appears that clients’ sexual identity concerns are rarely included in client treatment plans. Therefore, substance abuse counselors may not address sexual concerns of the client because of not having adequate training or preparation to handle the unique needs of sexual minority individuals (Mayer et al., 2008; Pachankis & Goldfried, 2004).

Sexual Minorities. Regarding the unique treatment needs of sexual minorities, the mental health and substance abuse needs of these individuals is paramount. Sexual minority individuals are more apt to seek mental health services as compared to heterosexual individuals (Cochran, Peavy, & Santa, 2007; Koh & Ross, 2006). Psychiatric disorders and symptom development has been found to be closely associated with stigmatization. As a result of stigma, prejudice and discrimination, sexual minorities experience increased social stressors in their environment which supports the higher prevalence of psychiatric disorders among sexual minorities (Cochran, Peavy, & Santa, 2007; Meyer, 2003).

The combination of stigma, prejudice and discrimination may foster another possibility related to increased mental health concerns may be internalized homophobia (Bobbe, 2002; Cochran, Peavy, & Santa, 2007). Internalized homophobia occurs as a sexual minority individual begins to incorporate societal stigma, prejudice and discrimination into feelings of self loathing of their sexuality. Healthy sexual identity development is pivotal (Goldfried, 2001) as substance abuse in sexual minority individuals may be linked to feelings of marginalization as they seek relief from depression and isolation (Savin-Williams, 2001). Substance abuse and mental health disorders are interconnected (Jordan, 2000; Koh & Ross, 2006; Russell & Joyner, 2001; Sullivan, 2003; Weber, 2008) for sexual minority individuals as sexual prejudice, in the form of stigma, discrimination and internalized homonegativity, may place sexual minority individual at greater risk for mental health and substance abuse disorders among sexual minority individuals (Cochran, Peavy, & Santa, 2007; Goldfried, 2001; Russell & Joyner, 2001).

Statement of Problem

Prejudicial attitudes are clearly evident in society (Allport, 1954; Bullough, 1979) as well as the treatment communities of mental health (Lucksted, 2004; Pachankis & Goldfried, 2004; Polcin, 2000) and substance abuse (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004; Hellman, Stanton, Lee, Tytun, & Vachun, 1989; Israelstam, 1988). Substance abuse counselors' attitudes toward their clients play a significant role in client recovery (Eliason, 2000; Miller & Rollnick, 1991). There are many factors that help develop a person's attitude toward minority individuals (i.e., religious beliefs, education and amount of contact) (Allport, 1954; Eldridge, Mack, &

Swank, 2006; Kinsey et al., 1948; Lassiter & Chang, 2006; Satcher & Leggett, 2007; Weber, 2008). Religion has been found to be a significant predictor of sexual prejudice attitudes (Allport, 1954; Kinsey et al., 1948) toward sexual minority clients among substance abuse counselors (Eliason, 2000; Eliason & Hughes, 2004).

As attitudes influences behavior (Schope & Eliason, 2000), sexual prejudice among substance abuse counselors is admonished by ethical standards (American Counseling Association, 2005; National Association for Alcoholism and Drug Abuse Counselors, 2004). Adherence to ethical codes appear not to be a diminishing factor of sexual prejudice among substance abuse counselors, as varying degrees of sexual prejudice continues to exist among substance abuse counselors (Eliason, 2000; Eliason & Hughes, 2004; Israelstam, 1988; Schope & Eliason, 2000). In evaluating sexual prejudice, factors that reduce sexual prejudice have been demonstrated.

Education (Ellis, Kitzinger, & Wilkinson, 2003; Herek, 2002b; Loftus, 2001; Steffens, 2005), training (Cochran, Peavy, & Cauce, 2007; Satcher & Leggett, 2007), have been found to be related to decreased sexual prejudice. The experience level of substance abuse counselors may also be associated with decreased sexual prejudice as the potential for contact and interaction with sexual minority individuals is inherently increases as years of experience increases for substance abuse counselors. Interaction and contact with sexual minority individuals have been found to be associated with decreased sexual prejudice (Allport, 1954; Altemeyer, 2001; Ben-Ari, 1998; Eldridge et al., 2006; Eliason, 1995, 2000; Eliason & Hughes, 2004). As education, training and sexual minority contact appear to reduce sexual prejudice, these factors warrant further examination among substance abuse counselors, as sexual minority individuals are

marginalized and at risk for psychiatric disorders (Alexander, 2002; Cochran & Mays, 2006; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001; Goldfried, 2001; Mayer et al., 2008; Weber, 2008) and substance abuse disorders (Cochran & Cauce, 2006; Cochran, Mays et al., 2007; Hughes & Eliason, 2002; Jordan, 2000).

Purpose of the Study

The purpose of this study is to measure sexual prejudice among substance abuse counselors while evaluating possible significant factors associated with this attitude. Previous studies only consisted of one geographical location (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Israelstam, 1988), compared one rural area with a metropolitan area (Eliason & Hughes, 2004) or a specific type of agency (Hellman et al., 1989). Due to the continued existence of sexual prejudice among substance abuse counselors (Cochran, Peavy, & Cauce, 2007; Eliason & Hughes, 2004), and the lack of understanding the unique needs of sexual minority individuals (Hellman et al., 1989; Lucksted, 2004), substance abuse counselors may to continue to be inadequately trained and prepared to address the unique issues of sexual minority clients (Eliason, 2000; Eliason & Hughes, 2004; Pachankis & Goldfried, 2004). This study will expand previous research by distinguishing itself from previous studies (Eliason, 2000; Eliason & Hughes, 2004) by utilizing a national sample from which sexual prejudice will be evaluated in regard to educational levels, religious beliefs, and experience level, familiarity of sexual minority issues, sexual minority contact, and recovery status.

Significance of Study

The significance of this study is multi-dimensional as the focus is to provide a baseline of data constructed quantitatively to evaluate sexual prejudice in substance abuse

counselors. Underlying sexual prejudice require the immediate attention of substance abuse treatment counselors as substance abuse counselors' attitudes are critical in serving the clinical needs of this population (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Miller & Rollnick, 1991). For treatment that is developed to serve the best clinical interest of our clients, we must afford the sexual identity of our clients the same respect that we afford heterosexuals in treatment (Center for Substance Abuse Treatment, 2001). By not recognizing the sexuality of the sexual minority client the treatment process, the treatment community may be operating in heterosexist manner (Center for Substance Abuse Treatment, 2001; Herek, 2000b, 2007; Mayer et al., 2008; Weber, 2008), thus it appears that substance abuse counselors operating in a heterosexist manner need to become aware of sexual prejudice.

As substance abuse counselors become aware of sexual prejudice, as ethically required (American Counseling Association, 2005; National Association for Alcoholism and Drug Abuse Counselors, 2004), sexual prejudice may be reduced as a result of attitudes can change (Altemeyer, 2001; Ben-Ari, 1998; Berkman & Zinberg, 1997). Therefore, the clinical needs of sexual minority individuals are more effectively met (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999) as they are being treated in not a "biopsychosocialspiritual" (Wallace, 2003) model but a more accurately "biopsychosocialspiritualsexual" framework. The addition of the term "sexual" within this holistic treatment encapsulates the complex interaction emphasis of biological, psychological, social, spiritual, and sexual factors upon an individual. Thus, inviting a

personalized treatment while possibly strengthening Miller's (2005, pp. 10-12) discussion of Perkinson's (1997) "biopsychosocial" model of addiction.

Research Questions

In reviewing current literature in the field of substance abuse, deficits in the area of substance abuse counselor's attitude toward sexual minorities and recognizing sexual identity or sexual orientation were identified. Based on this brief literature review and that in chapter 2, the purpose of this study will be to examine the following research questions:

The intent of this study is to examine the following research question:

Can sexual prejudice be predicted among substance abuse counselors in regards to:

A. Religiosity (to the degree substance abuse counselors adhere to their religious beliefs).
B. Education Level (completed high school, completed trade or business school, some college, completed bachelor's degree, some master's level work, completed master's degree, some doctoral work, or completed doctoral degree).
C. Various variables (gender, age, race, years of experience as a substance abuse counselor, recovery status, familiarity of sexual minority issues, and participant self report of their sexual orientation).

Delimitations

The delimitations of this study consist of factors that the researcher maintains control over. The study will be delimited to data based on self-report instruments. Participants voluntarily participated and received no incentives to participate. Another delimitation of this study is participants must be members of a professional substance abuse association, the National Association of Alcoholism and Drug Abuse Counselors (NAADAC). Anonymity and confidentiality is ensured, though the population selection is maintained by the researcher to protect the integrity of the research study.

Limitations

The results of the study may be impacted by factors that are beyond the control of the researcher. Findings of the study may not be generalizable to substance abuse counselors who are not members of this professional association. Participants may not respond to survey instruments honestly or accurately, thus resulting in self-report bias. The possibility of nonresponse bias will be addressed, as the researcher will try to obtain a heterogeneous sample. The process of disseminating the survey by NAADAC may also have limited the results of the study.

To further remove the possible NAADAC member's perception of NAADAC's endorsement of this study, NAADAC required additional information be included. This additional information required that; that all email solicitations identified the specific purpose of examining substance abuse counselors' attitudes toward sexual minority individuals, this purpose be reflected in the title of the survey link posted on NAADAC's "Research" webpage, and also that email solicitations contain portions of the Informed Consent Form (see Appendix D) addressing contact information, should potential

NAADAC member participants have any concerns or comments regarding the purpose of the study. The initial email disseminated by NAADAC contained incomplete text and replaced the direct survey link with a link to NAADAC's "Research" webpage.

The initial email dissemination from NAADAC required members to access the survey from NAADAC's "Research" webpage, thus adding an additional step for accessing and participating in the survey. Due to the explicit purpose of the study being stated in all study participation references received by NAADAC members, it is possible that only NAADAC members who identified as a sexual minority or individuals who were comfortable or knowledgeable of sexual minority issues, chose to participate in this study. Due to these limitations, as required by NAADAC, the results may be skewed.

Assumptions

Assumptions made in the implementation of this study represent a comprehensive consideration of participants. Participants were able to understand the survey instruments as comprehension ability and education were considered in selecting survey instruments. Additionally, participants demonstrated the ability to respond to survey instruments in an honest nature due to anonymity and voluntary participation in study. The make-up of participants was assumed to be homogenious because of current membership of a national organization of substance abuse professionals with over 10,000 members.

Operational Definitions

This study is focused on at a number of different factors. These factors require defining appropriately to reflect the meanings of these constructs as utilized within this study. The terms sexual identity, sexual orientation, sexual minority, internalized sexual

stigma, sexual stigma, sexual prejudice, heterosexism, addiction, and recovery are defined below to clarify meaning, both conceptually and organizationally.

- Sexual identity-a term used by individuals to describe their identity formulation in terms of the level of congruence around their sexual orientation (Rosario, Schrimshaw, & Hunter, 2006).
- Sexual orientation-the direction of an individual's sexuality, usually conceived of as classifiable according to the sex or gender of the persons whom the individual finds sexually attractive (Savin-Williams, 2006).
- Sexual minority-categories of orientation consisting of heterosexual, lesbian, gay or bi-sexual (Cochran, Peavy, & Santa, 2007; Eliason, 2000; Eliason & Hughes, 2004; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002), and transgender (Cochran, Peavy, & Santa, 2007; Eliason, 2000; Eliason & Hughes, 2004).
- Internalized stigma- the internalization of stigma to an individual's value system and self-concept (Herek, 2009b).
- Sexual stigma- stigma attached to nonheterosexual behavior (Herek, 2009b).
- Sexual prejudice-internalized sexual stigma that results in the negative attitude towards sexual minorities (Herek, 2009b). It is generally accepted that these negative attitudes are derived from a foundation of heterosexism.
- Heterosexism- the denying, denigrating, and stigmatization of any non-heterosexual form of behavior, identity, relationship or community (Herek, 1996). This study will add bisexual and transgender individuals to remain consistent with identified gaps of research in the area.

- Addiction-a complex brain disease that is characterized by drug craving, drug seeking, and drug use despite negative consequences (National Association of Drug Abuse (NIDA), 2008).
- Recovery-the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White, 2007).

Summary

Historical foundations of prejudicial attitudes toward sexual minorities demonstrates the victimization these individuals have endured since the early 20th Century (Bullough, 1979; Sullivan, 2003). As these individuals have struggled to overcome such prejudicial attitudes, they may have experienced increased risks for substance abuse issues (Cochran et al., 2004b; Mayer et al., 2008) as a result of stigma of being members of a marginalized group (Jordan, 2000; Meyer, 2003; Weber, 2008) and the internalized homophobia such membership carries with it (Herek, 2004). Education (Klassen et al., 1989; Loftus, 2001) and religiosity (Allport & Ross, 1967; Herek, 1987; Satcher & Leggett, 2007) have been found to be predictors of prejudicial attitudes.

Awareness of prejudices are addressed ethically as ethical codes (American Counseling Association, 2005; National Association for Alcoholism and Drug Abuse Counselors, 2004) require professional substance abuse counselors to become aware of their own biases. Prejudicial awareness is logical, as treatment guidelines specific to

substance abuse treatment for sexual minority individuals (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999; Van Den Berg & Crisp, 2005), recommend that services be delivered in a atmosphere that is respectful and valuing of their sexuality (Mayer et al., 2008). This research study is warranted, as previous studies (Eliason, 2000; Eliason & Hughes, 2004; Israelstam, 1988), could not be generalized to a national population of over 10,000 substance abuse counselors. Therefore, previous research results and implications may not have been perceived as valid among some substance abuse counselors, thus possibly allowing sexual prejudice to continue operating as treatment barrier for sexual minority individuals seeking substance abuse treatment.

Organization of the Study

This study consists of five chapters. Chapter one provides a brief introduction that presents the specific need of this study. Chapter two reviews the current literature surrounding the topic in order to establish a foundation for need of this study. Chapter three outlines and describes the methodology utilized to effectively evaluate homonegativistic attitudes among substance abuse counselors. Chapter four provides the results of the study. Chapter five provides a discussion that includes implications, areas of future research identified, and the limitations of the study.

CHAPTER 2: REVIEW OF RELATED LITERATURE

Introduction

Sexual prejudice among substance abuse counselors toward sexual minorities have been demonstrated to exist (Eliason, 2000; Eliason & Hughes, 2004; Israelstam, 1988), and as a result, these clients may feel victimized from the very people who are supposed to be helping them through their difficulties with addictive disorders (Cochran, Peavy, & Santa, 2007; Eliason, 2000). This continued victimization can result in ineffective services for sexual minorities seeking substance abuse specific services (Eliason, 2000). Eliason further suggests that tailoring treatment to meet the client's uniqueness is more likely to result in successful services. One component that may influence sexual minority substance abuse treatment is the attitude of the substance abuse counselor (Eliason, 2000; Eliason & Hughes, 2004; Miller & Rollnick, 1991).

Eliason (2000) recognized the important influence that substance abuse counselors have over sexual minorities in treatment. The attitude of the substance abuse counselor is generally considered to be included in this influence. Schope (2000) noted the common assumption that attitude shapes behavior, while Herek (2000a) reported that sexual prejudice attitudes contributes to sexual prejudicial behavior. Sexual minorities, appear to be at an elevated risk for mental health and substance abuse disorders due to sexual prejudice

(Goldfried, 2001; Mayer et al., 2008; Meyer, 2003; Russell & Joyner, 2001; Sullivan, 2003; Szymanski & Carr, 2008), as their substance abuse patterns have been found to be elevated in comparison with heterosexuals (Cochran et al., 2000). Therefore, it is important to critically examine possible variables that work to decrease prejudicial attitudes towards sexual minorities.

The purpose of Chapter Two is to provide a literature review about the history of prejudicial attitudes towards sexual minorities and how this phenomenon has impacted these individuals when seeking counseling services, and specifically, substance abuse counseling services. A limited historical perspective of such prejudicial attitudes will be provided as a foundation of the continued victimization of sexual minorities. The mental health issues that sexual minorities demonstrate as a result of being victimized are reviewed. The substance abuse patterns among sexual minorities further signify the impact of victimization (Center for Substance Abuse Treatment, 2001; Cochran, Sullivan, & Mays, 2003; Eliason & Hughes, 2004; Herek, Chopp, & Strohl, 2007), as substance abuse is a significant risk factor for people who are subjected to sexual prejudicial attitudes (Bauermeister, 2007; Cochran et al., 2003; Ford & Jasinski, 2006; Gilman et al., 2001).

Sexual prejudicial attitudes among substance abuse counselors will be examined to support the importance of counselor attitude in treatment (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004; Miller & Rollnick, 1991), in order to evaluate variables that may work to decrease such prejudicial attitudes. The importance of addressing such prejudicial attitudes, in the

context of receiving substance abuse treatment among sexual minority individuals, is imperative in order to meet the treatment needs of this marginalized group (American Counseling Association, 2005; Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Cauce, 2007; Eliason, 2000; National Association for Alcoholism and Drug Abuse Counselors, 2004). Variables of the study's research question (i.e.: substance counselors religious beliefs, educational level, recovery status, and various demographic variables), as identified in the current literature review, will be discussed with a view toward developing interventions to effectively reduce sexual prejudice among substance abuse counselors. A summarization then provides the conceptual rationale to proceed with this study.

Historical foundations of Prejudice

Prejudice toward individuals engaging in homosexual behaviors has existed since the beginning of recorded human history (Bullough, 1979) and occurring in many different cultures (Sullivan, 2003). As Bullough (1979) reports homosexual behavior as having been present in the cultures of Ancient Egypt, China, India and Greece, prejudice toward individuals engaging in homosexual behaviors were not always negative. The Greeks idealized homosexuality while the Jews condemned such behavior (Bullough, 1979).

In his seminal work The Nature of Prejudice, Allport (1954) defined prejudice as being erroneous cognitions of others without justification. Allport stated that individuals fall into prejudice because of erroneous generalizations, and hostilities are natural capacities of the human mind to justify and secure our own existence. According to

Allport, human beings naturally contain the necessary prerequisites for prejudicial attitudes. This is an important aspect in recognizing that prejudicial attitudes happen naturally, through no fault of the individual. It is the manner in which prejudicial attitudes are expressed behaviorally that may negatively impact individuals (Allport, 1954). Allport postulated that more intense prejudicial attitudes are more likely to result in varying degrees of prejudicial acts. Interestingly, Allport published his landmark work in an era which precluded the Civil Rights Act of the 1960s.

The Civil Rights Act (CRA) of 1964 was a result of attitude change toward individuals, that were different from young, able-bodied white, males and that had been subjected to prejudice in the United States (Ramey, 2007). As a result of the CRA, sex discrimination illegal became illegal (York, Tyler, Tyler, & Gugel, 2008). Though the CRA afforded protection, though primarily workplace protection, from prejudice based upon religious beliefs, racial and ethnic identity and gender, sexual minority individuals were excluded from exercising rights and privileges from prejudice that the CRA affords to other minority individuals (Katz & LaVan, 2004). Prejudice expressed to sexual minority individuals, or Sexual Prejudice (Herek, 2000a), negatively impacts both sexual minorities and heterosexuals (Sullivan, 2003). Sullivan (2003) noted that prejudice of individuals engaging in homosexual behaviors received little focus until the Victorian Age.

Religion. During the Victorian Age, "homosexual" was first termed in 1869 and homosexuality became a criminal offense in many European and American societies (Sullivan, 2003). Sullivan (2003) reported that the source of sexual prejudicial bias to be

Judeo-Christian traditions, which concurred with earlier studies (Kinsey et al., 1948; Kinsey, Pomeroy, & Martin, 1953) and noted by Weinberg (1972). The Judeo-Christian traditions of sexual behaviors are biblically based, as homosexual behaviors are unholy and forbidden by the Bible (Sullivan & Wodarski, 2002). However, Bullough (1979) minimized these Judeo-Christian traditions to be just one important factor for individuals in western society, forming their prejudicial attitude toward sexual minority individuals. The controversy surrounding Kinsey et. al's (1948, 1953) sexual behavior research continues to be criticized among religious leaders (Griffith, 2008, September).

Sexual prejudices have been evidenced among some individuals who attend religious services frequently (Cochran et al., 2007; Eliason, 2000; Eliason & Hughes, 2004), as well as individuals that have high religious beliefs (Schulte & Battle, 2004). Religious denominations also influence sexual prejudice of some individuals, (Malcomnson et al., 2006) with some denominations being more accepting of sexual minority individuals than other denominations (Herek, 1987). Herek (1987) found that the influence of religious orientation on prejudice depends on the religious teachings of tolerance and who the out-group may be as religious orientation is an important component between religion and sexual prejudice (Tsang & Rowatt, 2007).

Allport and Ross (1967) introduced the concepts of intrinsic and extrinsic religious orientation, in which individuals with extrinsic religious orientation demonstrated high prejudicial beliefs. Extrinsic values were defined as primarily utilitarian, finding religion to provide security, sociability, status and self-justification, while intrinsic values were linked to a more internalized process of realizing beliefs fully

and living out those beliefs. Extrinsic orientation, as noted by Allport and Ross (1967), was correlated with individualistic needs. Security, comfort, status and social support were shown to be areas in which individuals with extrinsic orientation sought support from religion.

The purpose that religion serves individuals can be viewed as either extrinsic or intrinsic (Tsang & Rowatt, 2007), which Allport and Ross believed provided a framework of prejudice attitude (1967). Though religious intrinsically oriented individuals report less prejudice (Allport & Ross, 1967), Herek (1987) found intrinsically oriented individuals to be more prejudiced toward sexual minority individuals than extrinsic oriented individuals. Herek (1987) noted that the influence of religious orientation on prejudice depends upon the religious teachings of the individuals, specifically teachings of traditional values, authoritative submission and possibly aggression (Tsang & Rowatt, 2007). As religion is considered by many individuals in the United States to be an important aspect of their lives (Cochran et al., 2007), it appears, from Griffith's (2008, September) report of religious encounters of Alfred Kinsey, that sexual prejudice is inherently associated with religion. Therefore this important aspect of American society, religion, is reported to influence societal prejudicial attitudes (Gallup & Lindsay, 1999).

Societal Prejudice toward Sexual Minorities

The prevailing attitude in the United States toward sexual minorities has been that of revulsion and hostility (CSAT, 2001) . With the exception of the 1920's, in which American gay life flourished in larger cities where commercial establishments catered to

the gay lifestyle through restaurants, night clubs, and bath houses for the gay population (Sullivan, 2003), attitudes in the United States toward sexual minorities have generally been negative (Herek, 1988; Negy & Eisenman, 2005). Herek (2007) reported that sexual minorities continue to be the targets of considerable prejudice. The most widely recognized prejudice is homophobia, which can be expressed directly or indirectly toward sexual minority individuals, according to Herek.

Homophobia. Homophobia was first termed in 1972 (Herek et al., 2009; Weinberg, 1972). Sullivan (2003) characterized homophobia as dislike or hatred toward homosexuals, which included both cultural and personal bias. Weinburg used the term homophobia to refer to "the dread of being in close quarters with homosexuals—and in the case of homosexuals themselves, self-loathing"(1972, p. 4). A more detailed description of homophobia encompasses the private thoughts and feelings of individuals to the policies and procedures of agencies, government and organized religion (Herek, 1988; Negy & Eisenman, 2005). Herek (2000b) noted that the rethinking of sexual orientation began in the 1960's, which was crystallized in Weinberg's (1972) publicized term "homophobia".

Homophobia involves two components; an affective and a cognitive response (Herek, 2004). Affective responses include fear, anxiety, anger, and discomfort as a person encounters a sexual minority. Homophobia may or may not include a cognitive component as these sexual prejudicial attitudes can be manifested in less dramatic bias (Herek, 1988), which provides additional support for thoughts becoming manifested behaviorally. Being rooted in attitude, sexual prejudice can lead to sexual prejudicial

behaviors. This is evidenced by the finding that individuals with sexual prejudicial attitudes are more likely to engage in discriminatory, harassing or even violent behavior towards sexual minorities (Adams, Wright, & Lohr, 1996; Negy & Eisenman, 2005), prejudice less behaviorally oriented or engaging is heterosexism (Herek, 1996).

Heterosexism. The systemic view of homosexuals as being inferior to heterosexuals is known as *heterosexism* (Herek et al., 2009; Morin, 1977; Schope & Eliason, 2000). A heterosexist bias views the human experience in only heterosexual terms (Herek, 2000a) or is ideological view that works to the disadvantage of sexual minority individuals (Herek et al., 2009). According to Herek et al. (2009) heterosexism presumes everyone to be heterosexual, referred to as "The Heterosexual Assumption", which sexual minority individuals remain unacknowledged by society. Once sexual minorities do become recognized, they are pathologicalized. This conceptualized bias ignores or invalidates any behavior or culture that is not strictly heterosexual. Therefore, sexual minorities' relationships and lifestyles are considered inferior relative to heterosexuals.

Sexual Prejudice. Herek (2000a) uses the term "sexual prejudice" to refer to negative attitudes towards individuals based on sexual orientation, thus encompassing heterosexual negative attitudes toward sexual minorities. Sexual prejudice, as a term of anti-sexual minority bias, has advantages. As a descriptive term, it conveys no prior assumptions about origin, dynamics or underlying motivations. Sexual prejudice explicitly links the study of anti-gay hostility to social psychology research. Another advantage is that using this term, as a description of anti-gay prejudices, does not create

value judgments that anti-gay attitudes are irrational or evil. Herek (2007) clarifies sexual prejudice as an individualistic response that is congruent with prejudicial responses of society. Sexual prejudice is a perception that considers sexual minority individuals as inferior to heterosexuals (Herek, 2000a; Morin, 1977; Schope & Eliason, 2000).

Sexual prejudice involves negative attitudes, beliefs and actions toward sexual minority individuals (Herek, 2000a; Herek, Kimmel, Amaro, & Melton, 1991). Sexual prejudice as prejudice toward sexual minority individuals in the areas of civil and social justice has been further identified (Cerny & Polyson, 1984; Herek, 2007; Hudson & Ricketts, 1980; Morrison, Parriag, & Morrison, 1999). Sexual prejudice, for example, may be demonstrated by a person's prejudicial belief that same sex couples should not be allowed to adopt children, a possible view of heterosexism (Herek, 2000a), as only heterosexual relationships are viewed as normal (Eliason & Hughes, 2004).

Previous Sexual Prejudice Studies.

Herek (2002b) noted the events of ; Weinberg's (1972) concept of homophobia and the removal of *homosexuality* from the DSM IV by the American Psychological Association, as having paved the way for modern research in the area of evaluating attitudes towards sexual minorities, studies have been conducted that demonstrate that prejudicial attitudes towards sexual minorities do exist. The American Psychological Association (APA) recognized a need for sexual minority affirmative scientific research. Most previous research studies in this area lacked reliability or validity, were excessively long, resulting in poor practicality, were not psychometrically sound and were not relevant to practicing professionals (Herek et al., 1991). For these reasons, these studies

are not included in this literature review. Additionally, these earlier studies were very broad in nature, as they evaluated heterosexuals' attitudes towards gay or lesbian individuals separately rather than collectively as a group.

Examining sexual prejudice among heterosexuals is a fairly recent phenomenon. The major focus of early sexual minority research was on diagnosis, cause, and cure (Herek, 1994; Kite & Deaux, 1986). Morin (1977) reported that only 8% of questions contained in studies of psychological research on sexual minority individuals examined heterosexual's attitudes towards sexual minorities. The analysis of literature demonstrates this study to be the earliest empirical research to examine attitudes of heterosexuals towards sexual minorities. When viewing this early research, it is important to understand personality and demographic factors that predict heterosexual attitudes toward sexual minorities as a foundation of the conceptualization of sexual prejudice.

Larson, Reed, and Hoffman (1980) developed an instrument to measure attitudes toward sexual minorities called the Heterosexual Attitudes Toward Homosexuality (HATH) Scale. Their results suggested that anti-homosexual attitudes were related to fundamentalist religiosity, frequent church attendance, and gender. It appears that being male, a religious fundamentalist, and a frequent church attendee demonstrates a demographic pattern of anti-prejudicial attitudes towards homosexuals.

Herek (1988) noted, however, that these and other studies refer only to "homosexuals", and felt this was inappropriate. Herek suggested that respondents generally equate "homosexuality" and "male homosexuality" and that this does not encompass the spectrum of attitudes toward all homosexual individuals. Herek reported

that in order to examine sex differences of homophobia, an instrument capable of separating attitudes towards gay and lesbian individuals needed to be developed. Thus, Herek (1988) created the Attitude Toward Lesbians and Gay men (ATLG) Scale. This ground breaking work established that attitudes toward gay men or lesbians may be different and can be measured.

Herek (1988) recognized two events as being significant in establishing research examining heterosexuals' attitudes toward sexual minority individuals. The concept of homophobia was introduced in Weinberg's (1972) Society and the Healthy Homosexual. Weinberg's use of homophobia began to challenge society's hostile attitudes towards sexual minorities. Satcher and Leggett (2007) noted attitudes of individuals, specifically, school counselors, towards sexual minorities may influence their interactions with sexual minorities. This is supported by Ajzen (1972), who found that people act in accordance with their attitude. In 1973, the second event was when the American Psychiatric Association (APA) voted to remove *homosexuality* as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This action removed the homonegativistic view of homosexuality as pathology, thus allowing these individuals to begin to be recognized as mentally healthy along with their heterosexual counterparts.

Mental Health Issues Among Sexual Minority Individuals

As recently as 2008, sexual minority health concerns have been identified as a key area of focus for clinicians and public health officials (Mayer et al., 2008). Over the past few decades, the unique health concerns of sexual minorities have received increasing recognition. Mental health and substance abuse issues disproportionately impact sexual

minorities (Mayer et al., 2008), though these issues are not inherent as a result of sexual minority membership. Mental health and substance abuse disorders among sexual minorities may cause such impairment, or dysfunction, at a level that requires treatment or a clinical focus (Mayer et al., 2008).

Sexual minorities have a higher prevalence of mental disorders as compared to heterosexuals (Cochran, Peavy, & Santa, 2007; Mayer et al., 2008). Stigma, prejudice, and discrimination create environments that foster increased risk factors for mental health issues. Though sexual minorities clearly are in need of clinical services (Meyer, 2003), they have been historically victimized within the confines of the therapeutic milieu (Cochran, Peavy, & Santa, 2007; Cochran et al., 2003). This is evidenced as the mental health profession has historically demonstrated heterosexist and homophobic beliefs, biases, prejudices and oppressive practices upon sexual minorities, placing the burden of stress upon clients and their possession of an illness (Eliason, 2000; Eliason & Hughes, 2004), which further victimizes them.

Conceptualization of Mental Illness among Sexual Minorities

Sexual minorities, appear to be at an elevated risk for mental health and substance abuse disorders due to sexual stigma (Cochran, Peavy, & Santa, 2007; Goldfried, 2001; Mayer et al., 2008; Russell & Joyner, 2001; Sullivan, 2003). Sullivan (2003) found that 65% of sexual minorities seek treatment for depression, which is often the result of adjusting to the stigma associated their sexuality. Sullivan (2003) noted low self esteem to be a common predisposing psychosocial factor for ethnic and sexual minority

individuals, while Szymanski and Carr (2008) reported the importance of self esteem for sexual minority males.

Thus it appears that, as low self-esteem may be a precipitating symptom prior to onset of substance abuse and mental disorders. For some sexual minority individuals, substance abuse appears to aid or mediate mental illness associated with feelings of fear of rejection, victimization, as a possible result of concealing their sexuality (Koh & Ross, 2006; Weber, 2008). This rationale of substance use and abuse has been to possibly begin during adolescence among some sexual minority adolescents (Russell & Joyner, 2001).

Mental health issues between sexual minority groups are beginning to be examined. Balsom and Mohr (2007) found bisexuals to be confused about their sexual identity. Sexual identity confusion may include underlying negative societal beliefs about same sex attractions. Due to possible higher levels of internalized homonegativity and an increased risk for mental health issues compared with their other sexual minority individuals, bisexual individuals appear to need additional support in meeting their mental health needs. Therefore, treating sexual minorities as a single group may impede the development of knowledge of sexual minority stigma (Sullivan, 2003), and possible mental health consequences fostered by sexual identity confusion.

Though this finding is significant, the demographics of the respondents provide possible limitations to the generalizability. This study lacked ethnic and racial diversity among participants, therefore nullifying the results individuals of color. The gender makeup of participants consisted of almost 64% females and did not include the sexual minority transgendered individuals. Participants were recruited primarily via sexual

minority venues that specifically targeted lesbian, gay or bisexual self identified individuals.

Outness. A unique feature of sexual minorities is the option of concealing their stigmatized sexual identity status (Balsam & Mohr, 2007). A possible adaptation to their stigmatized status is the extent to which the sexual minority individual discloses his or her sexual identity or sexual orientation status is known as *outness level*. Sexual minority individuals are less likely to disclose their sexual orientation in perceived hostile environments (Burn, Kadlec, & Rexter, 2005).

Balsam and Morh (2007) investigated differences among 613 sexual minorities and their adaptation to sexual orientation stigma. Balsam and Morh found level of outness among bisexual individuals to be related to social-contextual factors (e.g., social support) rather than to psychological adjustment (e.g., depression and anxiety). Bisexual individuals were found to have higher levels of identity confusion and be less out than other sexual minority individuals, as well less connected socially to the sexual minority community. Bisexual individuals were found to be less likely to be out to their parents as compared with the majority of other sexual minorities' sexual orientation being known by one or both parents (Herek et al., 2009)

In a study examining sexual orientation and outness on the mental health of sexual minority and heterosexual women, Koh and Ross (2006) found significant mental health issues among participants. Being a sexual minority woman does not imply psychiatric disorders or symptoms, but rather the development of mental health concerns are related to stigmatization (Balsam & Mohr, 2007). In a survey of women (n =1304)

receiving outpatient services at 33 outpatient clinics across the U.S., Koh and Ross (2006) found that level of outness impacted the likelihood of current or previous mental health problems.

Bisexual women were found to be more than twice as likely to have had an eating disorder compared to lesbian women. In comparing lesbian women, who were not out with their sexuality, and bisexual women, who were out with their sexuality, bisexual women were found to be almost 2.5 times more likely to have experienced suicidal ideation within the past 12 months. Yet, lesbian women seek services more than bisexual or heterosexual women. Therefore, though bisexual women appear to need increased services more than lesbian women, this is not happening. This finding is also supported by Balsam and Morh (2007), who found that bisexual individuals were not receiving needed services as well.

In surveying the sexual orientation disclosure perceptions of New Zealand sexual minorities, Neville and Hendrickson (2006) found that disclosing one's sexual orientation is unique to sexual minorities. This is a result of fear of homophobic reactions from healthcare professionals, based upon previous negative experiences. Negative experiences, such as assuming all clients are heterosexual and judgmental interactions during health interviews, can present a barrier to sexual minority clients seeking treatment services. Assessment instruments rarely include non-heterosexual responses.

Eliason and Hughes (2004) noted the experiences of acknowledging and revealing one's sexual identity as a unique issue that may impact prevention and treatment services. Ghindia and Kola (1996) went further, suggesting a possible

detrimental impact for these individuals. Eliason and Hughes (2004) supported Ghindia and Kola's (1996) suggestion that counselors should become familiar with "coming-out" models that describe stages or psychological issues sexual minority clients may experience. Eliason and Hughes (2004) believe this would be helpful to counselors working with sexual minority individuals.

Integrating sexual identity into the intake process and providing a safe environment for sexual minority clients is recommended (Eliason, 2000; Hicks & Tien-tsung, 2006; Van Den Berg & Crisp, 2005). CSAT (2001) supports this recommendation, suggesting that counselors who are ignorant of the sexuality concerns of their clients may not provide services that meet clients' unique sexuality needs. This possible service neglect has been addressed through the treatment recommendations and guidelines of CSAT (2001).

Neville and Hendrickson (2006) conducted a national survey of sexual minority individuals. Respondents (n=2,269) were highly educated, therefore suggesting that most respondents were higher in socio-economic status (SES). Sexual minority individuals reported that the healthcare professional's attitude toward sexual identity was important, specifically when they chose a provider. The respondents reported that their healthcare professional 'usually' presumed their sexuality as heterosexual, unless told differently. Thus it appears that this heterosexual assumption may continue to subtlety victimize sexual minority clients as a result of fear of homophobic reactions, as individuals are keenly aware of how others perceive them (Richman & Leary, 2009).

Victimization. Victimization among sexual minorities results from being the target of many types of prejudicial behaviors, such as discrimination, sexual stigma (CSAT, 2001) and oppressive bias (Herek, 2009a; Herek et al., 2007). Herek (2009a) reported that 20% of the US sexual minority population has experienced a crime, based upon their sexual orientation. Gay men have been found to be more likely to be the target of negative attitudes (Herek, 1995; Herek & Capitanio, 1999; Hopwood & Connors, 2002; Kite & Whitley, 1996; Schope & Eliason, 2004), property crimes and harassed because of their sexual orientation, as compared to lesbian and bisexual individuals (Herek, 2009a).

Targets of antigay violence, such as hate crimes, sexual minority individuals have been shown to demonstrate significantly higher levels of depression and anxiety (Greene & Muran, 2007). It appears that the psychological distress of such experiences should be considered by mental health professionals working with this population (Herek, 2009a). Though the research about victimization among sexual minorities has been sparse (Herek et al., 2007), the need to examine the prevalence of victimization occurring over the lifespan of sexual minorities continues to exist (Herek, 2009a).

Neville and Henrickson (2006) recommended that sexual minority clients be versed in possible subtle, though victimizing, prejudicial or biased nuances of the counselor during the initial assessment process prior to engaging in treatment. The sexual minority individual may benefit from being able to recognize varying forms of sexual prejudice as Herek (2000b) found that sexual prejudices can be manifested in less dramatic ways, such as Allport's (1954) antilocution.

Antilocution (Allport, 1954), the mildest form of acting out prejudice, occurs as people talk about their prejudices. It appears that biases or prejudices may be evidenced by the words people speak or don't speak. These events can be classified as heterosexist events, and as a result, many sexual minority individuals hide their sexual orientation from others and may feel shame or other negative feelings about themselves (Weber, 2008) . Though Neville and Henrickson's (2006) results are significant, a limitation of this study is that participants were self-selected, and therefore may have been more comfortable with their sexuality and were wanting their voices to be heard.

Weber (2008) found significant relationships between exposure to the presence of heterosexist events and use of alcohol or other drugs (AOD), as well as a relationship between internalized homophobia and AOD, while Myer (2008) noted the relationship between heterosexist events and mental health issues. As a result of being a sexual minority in a society that is predominantly anti-gay, sexual minorities experience both physical and emotional stress. Negative self view can lead to decreased self-esteem and feelings of inadequacy, specifically among sexual minority men (Szymanski & Carr, 2008) and increased risk for mental health (Meyer, Dietrich, & Schwartz, 2008; Szymanski & Carr, 2008) and substance abuse issues (Weber, 2008).

Such research to examine the prevalence of self-reported psychological, physical, and sexual abuse in childhood and adulthood was conducted by Balsam et al.(2005). In a comparison of sexual minority and heterosexual siblings (n=1274), sexual minority respondents reported higher levels of psychological, physical, and sexual violence in both childhood and adulthood. Sexual minority individuals reported elevated rates of

childhood sexual abuse and reported a significantly higher amount of rape. Although less than 2% of heterosexual men reported being the subject of a sexual assault, 1 in 10 gay men reported having had this experience.

An important finding of Balsam et al.(2005) is that many of these sexual minority individuals reported being sexual abused. These types of discriminatory experiences have been shown to be directly related to mental health and substance abuse issues (Meyer, 2003). While there are limitations to this study that may have influenced the results, such as recall of childhood events, a willingness to report such events, and that ethnic minorities were not included, these findings are significant. It appears that a possible link, between being subjected to discriminatory practices and mental health or substance abuse issues, is the internalization of homophobia for some sexual minority individuals. As a sexual minority individual internalizes negative constructs of society's homophobic beliefs about sexual minorities to their own sexual identity, internalized homonegativity begins to develop within the sexual minority individual.

Internalized Homonegativity. Internalized homonegativity is the self loathing an individual begins to believe about him or herself as result of societal stigma (Herek et al., 2009; Mays & Cochran, 2001). Internalized homophobia has several implications for both adolescents and adults in that they often need assistance negotiating effects of personal and institutional homophobia on their identity development (Weinberg, 1972). Goldfried (2001) identifies this concept beginning to occur in the crucial developmental phase in sexual minority youth. Sexual minority youth are not gradually building self-esteem and a positive self identity as they learn that they are among the most hated

members of our society. The complexity and difficulty of sexual identity development makes this developmental period important for all individuals, but especially for sexual minorities (Sullivan, 2003).

It is important to note the significant role internalized homophobia may play in the mental health of sexual minority individuals, as the origins of substance abuse within the LGB youth appear closely linked with feelings of marginalization such as depression and isolation, as suggested by Jordan (2000). Feelings of marginalization appear to be the emotions sexual minority youth are trying to escape and may, therefore, continue into adulthood (Pachankis & Goldfried, 2004). Feelings of shame, guilt, rejection, mental health and substance abuse disorders are associated with internalized homophobia (Weber, 2008).

Amadio (2006) conducted a study to examine the relationship between internalized homophobia, alcohol use and alcohol-related problems. A convenience sample was surveyed from sexual minority specific listservs, social networks and a Pride festival in Atlanta, Ga. The findings of this study suggest that internalized homophobia is partially supported for females but not males. Amadio (2006) found a relationship between internalized homophobia and alcohol use or alcohol-related problems, however, Amadio noted that it was not possible to determine causality between the two constructs. Therefore, it appears that a perpetual cycle exists between Meyer's (2003) and Weber's (2008) finding that feelings of shame, guilt, rejection, substance abuse and mental health disorders are associated, though possibly not causal with internalized homophobia. Thus

the need to include mental health disorders as a factor in investigations is evident (Barbara, 2002).

Mental Health Disorders and Comparisons

While Alexander (2002) noted that being a sexual minority does not automatically mean that a person will have a mental illness, Koh and Ross (2006) noted that being a sexual minority female impacted the likelihood of mental health problems. Therefore, the professional community must be mindful of the extent sexual minority status and gender impacts the lives of sexual minority individuals. In an attempt to draw conclusions about the mental health of sexual minorities, Alexander (2002) noted that only two studies that included questions about sexual behavior and orientation within the broader context of mental status.

Gillman et al.(2001) and Russell and Joyner (2001) found that stress associated with stigmatization and being subjected to discriminatory behavior appears to increase the risk of mental health disorder. Russell and Joyner (2001) echoed these sentiments for sexual minority adolescents. These studies clearly demonstrate the mental health consequences of discrimination and victimization upon sexual minority individuals, regardless of age, though Cochran and Mays(Cochran & Mays, 2000a) had earlier examined the mental health and substance abuse impact of prejudice.

Cochran and Mays (2000a) sampled men (n=3503) from the Third National Health and Nutrition Examination Survey (NHANES III). Men who reported same sex partners during their lifetime were significantly more likely to meet diagnostic criteria for depression when compared to exclusively heterosexual men. These respondents were also

found to more likely meet the criteria for affective disorders such as dysthymia or bipolar. Not surprisingly, prior suicide attempts were more prevalent among respondents as well. One significant limitation to the generalizability of these results is the fact that not all sexual minority groups were included, such as lesbians, bisexual or transgendered individuals.

Cochran and Mays (2000b) followed up their previous study to include gender. The 1996 National Household Survey on Drug Abuse (NHSDA) produced by SAMSHA is like the NHANES III, in that both were national household probability samples (*n*=12,837). Consistent with the NHANES III study, depression was found to be consistently more prevalent among gay men. Though lesbian women were found to be no more depressed than heterosexual women, lesbian women were significantly more likely to evidence substance abuse dependency symptoms. Of specific relevance to this current study, social views and discrimination were found to encourage substance use among sexual minority individuals. Mental health and substance abuse issues continued to found more prevalent among sexual minority individuals than heterosexual individuals (Gilman et al., 2001).

In a study using the National Comorbidity Survey (NCS), a national representative sample household survey of people aged 15-54 (*n*=5,877), that found that respondents of same-sex partners demonstrated a higher prevalence of anxiety, mood and substance abuse disorders and of suicidal thoughts than respondents with opposite-sex partners (Gilman et al., 2001). Gilman et al (2001) demonstrated the significant relationship between mental illness and substance abuse disorders among sexual minority

individuals. This study utilized disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition (DSM-III-R). A replication of this study using the Diagnostic and Statistical Manual of Mental Disorders, Revised Fourth Edition (DSM-IV-TR) would strengthen this study as the DSM-IV-TR utilizes empirical research to define disorders (Gilman et al., 2001).

A limitation of Gilman et al (2001) is an omission of individuals not within the age parameters of the study. The prevalence of mental illness and related substance abuse disorders of sexual minority individuals not meeting age criteria may have increased the results, as members of this omitted population may have experienced increased sexual prejudices. Another limitation, as reported by the authors, is that sexual orientation was defined behaviorally. Therefore, not including sexual identity as a definition component, individuals who may engage in homosexual behaviors but identify as heterosexual may have been excluded.

Sexual Orientation. Cochran, May, Algeria, Ortega, and Takeuchi (2007) examined mental health and substance abuse comorbidity based on sexual orientation, Asian American and Latino individuals were examined using the National Latino and Asian American Survey (NLAAS), a probability household sample. The respondents, (*n*=4,469) were provided the NLAAS in a face to face interview to ensure clear communication. As the language of the instrument was in the respondent's native language, it is unclear if wording of items were clearly translated to the respondent's native language.

Cochran et al.'s (2007) results were somewhat consistent with previous research (Cochran & Mays, 2000a, 2000b) that found that sexual minority men were significantly more likely to report a history of a suicide attempt and demonstrated a greater prevalence of depression when compared to heterosexual men. Sexual minority woman demonstrated a greater prevalence of substance abuse disorders than heterosexual women. It appears that sexual minority orientation is a risk indicator for mental health and substance abuse comorbidity within the Asian American and Latino population and these findings are not unique to one sexual minority group (Jorm et al., 2002).

Jorm et al. (2002) examined individuals of homosexual and bisexual orientation, as compared to heterosexual orientation. A community survey of 2530 participants was collected. Bisexual individuals appeared to have the most severe mental health issues as. Anxiety and depression was found to be the highest among bisexual respondents. Among bisexual individuals, bisexual men were found to have a higher prevalence of depression, panic attacks and psychological distress. Lesbian-bisexual women demonstrated a greater prevalence of generalized anxiety disorder than their heterosexual counterparts. These results continued to be demonstrated by Cochran, May, Algeria, Ortega, and Takeuchi (2007).

Important components of mental health unique to sexual minority individuals have been presented. Outness, victimization, and internalized homophobia have each been associated with increased mental illness. Koh and Ross (2006) found that level of outness impacted the likelihood of current or a previous mental health problem. Eliason and Hughes (2007) noted that revealing one's sexual identity may impact prevention and

treatment services. Being subjected to victimization as a result of antigay violence, sexual minority individuals has been shown to be related to increased mental health disorders (Eliason & Hughes, 2004). In addition to victimization, internalized homophobia has also been associated with increased mental health disorders (Herek et al., 2007). It appears that the constructs of outness, victimization, and internalized homophobia impact the mental health and well being of sexual minority individuals. This is consistent with previous research indicating the elevated risk not only for mental health, but substance abuse disorders as well, due to sexual stigma (Meyer, 2003; Weber, 2008). The relationship between mental health and substance abuse issues warrants including substance abuse issues among sexual minority individuals in this literature review.

Substance Abuse Problems Among Sexual Minority Individuals

Sexual minority individuals have been reported to be at an elevated risk for mental health and substance abuse disorders due to sexual stigma (Cochran, Peavy, & Santa, 2007; Cochran et al., 2007; Gilman et al., 2001; Weber, 2008). The purpose of this section is to focus on the substance abuse issues among sexual minority individuals. Substance use patterns is discussed within a developmental context compared with heterosexual and sexual minority individuals, that includes adolescents, young adults and adults, as substance abuse and sexual orientation have been found to be related (Mathews et al., 2006). The substance use patterns among individual subgroups of sexual minority individuals (lesbian, gay, bisexual and transgendered individuals) are briefly presented. Risk behaviors of sexual minority individuals associated with substance abuse provide a

theoretical rationale for substance abuse and mental illness that is unique to sexual minority individuals (Rosario et al., 2006).

The increased sexual risk behaviors associated with substance abuse continue to demonstrate the comorbid relationship between substance abuse and mental health problems of sexual minority individuals. The association of increased risk of mental health (Cochran, Keenan, Schober, et al. 2000) and substance abuse (Koh & Ross, 2006), appear to increase sexual risk behaviors among sexual minority individuals (Rosario et al., 2006). The relationship associations of mental health and substance abuse issues justify the inclusion as individual aspects of substance abuse among sexual minority individuals. These sections will provide information about substance abuse and mental health problems unique to sexual minority individuals.

Adolescents

Research has demonstrated that sexual minorities are at-risk for substance abuse (Cochran, Mays, Allegria, et al. 2007; Jordan, 2000; Koh & Ross, 2006). One possible consideration of substance abuse among sexual minority individuals is that substance abuse behaviors may originate in adolescence or early adulthood (Cochran et al.2007; Jordan, 2000) as sexual identity development begins to occur. As sexual identity continues to progress, sexual minority individuals begin to accept their sexuality and begin to recognize their stigmatized minority status (Cass, 1984; Cochran, Peavy, & Santa, 2007). Cochran, Ackerman, Mays, and Ross (2004b) suggested that substance abuse may originate as a result of being members of a stigmatized group.

Another potential contributing factor of substance abuse among sexual minority individuals is that socializing in bars often plays an important role in the social network of sexual minority individuals (Cochran et al., 2004b). This is one way for sexual minority individuals to feel that they are a part of a mainstream sexual minority community (Jordan, 2000; Meyer, 2003; Weber, 2008). However, it is hard to escape the fact that this form of socializing centers around the consumption of alcohol and may create or exacerbate substance abuse; bar attendance has been found to be related to heavy alcohol consumption (Cochran et al., 2004b; Ghindia & Kola, 1996). Cochran et al. (2004b) note "circuit" parties as being a venue within the sexual minority subculture which may have as many as 15,000-25,000 individuals in attendance.

Adults

A study of college students found no significant differences of marijuana or other illicit drug use among sexual minorities compared to heterosexuals (Bauermeister, 2007). A 1999 Harvard School of Public Health College Alcohol Survey involved collecting data on more than 14,000 college students. Only bisexual males were found to have used both marijuana and illicit drugs, though the prevalence of this use was not reported. Bisexuality of males was found to be a significant predictor of other illicit drug use; in addition, depression was found to be a predictor of drug use for the total sample.

These findings are consistent with Ford and Jasinksi's (2006) research that demonstrated a relationship between mental illness and substance abuse. Results of Ford and Jasinski's (2006) work were very limited in that the focus of the instrumentation was alcohol, and the theoretical differences in marijuana and other drugs on sexual orientation

were unable to be examined. The fact that mental illness was found to be related to overall drug use also supported Cochran et al.'s (2003) and Gilman et al.'s (2001) findings.

One study examining the association between sexual orientation and substance abuse among college students found contrary findings (McCabe et al., 2003). The study was conducted at the University of Michigan, where undergraduate students (*n*=7,000) completed a survey about their alcohol use. Results suggested that there was no difference in alcohol use patterns among sexual minority and heterosexual women, which differed from results of Cochran et al.(2000) and Cochran and Cauce (2006) . However, sexual minority women were found to have reported more driving under the influence incidents, unplanned sexual episodes, suicidal thoughts and being sexually harassed after drinking. These results suggest that being a member of a marginalized minority group may place members at greater risk of negative consequences as a result of using substances.

Another surprising finding of McCabe et al., (2003) was that sexual minority males were more likely to use substances, which reinforced the findings of Cochran et al., (2003), McKirnan and Peterson (1989), Cochran et al (2000); and Cochran et al (2004b). Additionally, sexual minority males were shown to be significantly less likely to drink heavily, which differed from the research of McKirnan and Peterson (1989). Both sexual minority men and women were found to be almost five times more likely to use prescribed anti-depressant drugs as heterosexual men and women. This supports previous findings that mental health and substance abuse (Cochran et al., 2003; Gilman et al.,

2001) are significantly related among sexual minority individuals and provides insight into sexual minority individuals seeking counseling services.

An examination of sexual minority adult substance abuse patterns revealed several trends in clients seeking counseling. Sexual minority individuals report for treatment with severe substance abuse problems, greater psychopathology and medical services utilization than heterosexual clients (Cochran, 2001). Cochran & Cauce (2006) noted that more research is needed in the areas of sexual minority substance abuse treatment to evaluate how the development and prevalence of substance abuse disorders and treatment needs differ from those of heterosexuals. The unique needs of sexual minority individuals entering substance abuse treatment has also been demonstrated (Cochran & Cauce, 2006);

Cochran and Cauce (2006) conducted a study of sexual minority and heterosexual individuals (*n*=17,386) from Washington State. These clients were receiving public funded treatment for chemical dependence. Though sexual minority individuals were found to not use alcohol as a primary substance to abuse, other substances, such as methamphetamine, were more likely to be use by sexual minority males, and sexual minority females were more likely to use heroin. These results suggest that the use of these highly addictive drugs may place sexual minority individuals at greater risk for substance abuse problems. Additional findings included sexual minority individuals having increased psychopathology, psychosocial characteristics and medical service utilization, including previous mental health hospitalization, past domestic violence, and homelessness.

These studies clearly demonstrated that sexual minority individuals have a pattern of more severe substance abuse problems than heterosexuals. Possible reasons identified by Cochran and Cauce (2006) included coping with a stigmatized sexual identity, dealing with stressors of being members of a minority group and the internalizing of negative attitudes towards self, or internalized homophobia as defined by Weinberg (1972). Sexual minority individuals enter treatment with more severe substance abuse problems and greater psychopathology as compared to heterosexual patients entering treatment. Therefore, Cochran and Cauce (2006) recommended CSAT's (2001) published guidelines that may work to meet the unique needs of this population.

An examination of homosexual adult substance abuse patterns provided insight into how factors such as gender of sexual minority individuals might be related to substance use (Cochran et al., 2000). Cochran et al. (2000) found that lesbian women were more likely to use alcohol than heterosexual women. Homosexual male and female patterns of alcohol use were similar, though it appears that men may be at more risk of problems associated with alcohol due to social networks of sexual minority males being active in bars (CSAT, 2001; Greenwood et al., 2001). Cochran et al.'s (2000) comparison of substance abuse patterns of sexual minority clients with heterosexual clients also found gender differences in moderately elevated drug use and dependence.

Cochran et al. (2000) found that homosexual men were more likely to use substances on a more consistent daily basis. Homosexual men were more likely to use marijuana, cocaine, and heroin; sexual minority women were more likely to report the usage of marijuana and analgesics or pain relievers. Overall, sexual minority clients were

shown to be more likely to use alcohol and drugs and have higher rates of general substance abuse compared to non-sexual minority individuals (Cochran et al., 2000) possibly as a means to cope with their lack of self-esteem and sexual identity (Ghindia & Kola, 1996).

In a study comparing patterns of drug use and dependence between sexual minority individuals and heterosexuals, sexual minority individuals were found to use substances more frequently (Cochran et al., 2004b). The results of a 1996 National Household Survey, a cross-sectional American household survey, reinforced these findings. Though the primary sexual orientation of the participants were heterosexual (*n*=9714), sexual minorities (*n*=174) were found to have moderate elevated substance use patterns. Sexual minority men were found to more likely report use of marijuana, cocaine, and heroin, and to use substances more frequently. Sexual minority women were more likely to report use of marijuana, and analgesic use was found to be unique to sexual minority women.

Cochran et al's. (2004b) findings are consistent with previous studies as marijuana was found to be the most commonly used drug as well as the drug that homosexual men and women were more likely to become dependent upon (Cochran et al., 2004b). Sexual minority women appeared to have an increased risk for cocaine use. Along with the prevalence of drug patterns among sexual minorities, Cochran et al (2004b) also provided a possible rationale for this elevated rate. The differences of drug use patterns may originate in adolescence or early adulthood (Cochran, Mays et al., 2007; Jordan, 2000) with the cultural importance of socializing in gay bars enhancing substance

abuse patterns among sexual minorities (Center for Substance Abuse Treatment, 2001; Cochran et al., 2004b; Greenwood et al., 2001), though substance abuse patterns of bisexual and transgendered individuals are not included.

Sexual Minority Groups

Research concerning substance abuse among bisexual and transgendered individuals is scant (Cochran et al., 2000; Gilman et al., 2001). Hughes & Eliason (2002) conducted a literature review of studies examining substance abuse prevalence among bisexual and transgendered individuals. Hughes and Eliason (2002) noted that most studies grouped bisexual individuals with lesbian women or gay men, depending upon their biological sex, or excluded bisexual people due to a low number of bisexual respondents. Hughes and Eliason focused upon within-group substance abuse prevalence among sexual minorities

Bisexual men and transgendered individuals have been included in previous substance abuse-related studies mainly because researchers were seeking a greater understanding of risk factors associated with HIV/AIDS and other sexually transmitted diseases (STDs). These studies appear to be focused on sexual behaviors, not sexual identity, as possible risk factors for contracting HIV/AIDS or STDs, which has been noted to be a common occurrence (Cochran et al., 2004b), though a recent study found sexual identity to be substance use disorder risk factor for bisexual individuals (Meyer et al., 2008).

Meyer et al. (2008) conducted a study of mental health prevalence among Black, White or Latino New York City residents who self identified as gay, lesbian, or bisexual.

Bisexual individuals were found to have higher prevalence of substance use disorders among sexual minority populations, though not a higher prevalence for mental disorders. This finding is contrary to Hughes and Eliason's (2002) finding that bisexual individuals have higher rates of mental health disorders, though bisexuals demonstrated more internalized homonegativity than other sexual minority groups (Herek et al., 2009). Meyer et al. (2008) continued the exclusionary trend of not including transgendered individuals (Hughes & Eliason, 2002).

Hughes and Eliason (2002) noted that transgendered individuals were studied even more rarely as a group, though transgendered individuals are believed to experience greater stigma, violence and marginalization (Jorm et al., 2002). Hughes and Eliason (2002) noted that it appears that bisexual and transgendered individuals are at an elevated risk of substance abuse as compared with lesbian women and gay men. These demonstrated risks of substance use and mental health disorders, among sexual minority individuals and sexual minority subgroups, may also increase risk for physical health complications (Cochran et al., 2004b; Kalichman, Tannenbaum, & Nachimson, 1998).

Increased Sexual Risk Behaviors

Kalichman, Tannenbaum, and Nachimsom (1998) showed that increased substance use in sexual minority individuals was a valid predictor of sexual risk behaviors. These behaviors often resulted in sexually transmitted diseases such as HIV/AIDS because substance use reduced these individuals' sexual inhibitions (Kalichman et al., 1998). In 1992, data from the Young Men's Health Study was collected from households in San Francisco to examine the epidemiological profile of

heavy substance abusing sexual minority men (Greenwood et al., 2001). HIV positive men were found to be more likely to abuse multiple substances on a more frequent basis. The cycle that emerged showed that sexual minority people, especially men, would begin using substances to escape from sexual stigma and mental health concerns (Greenwood et al., 2001). Individuals who were HIV positive or infected with other STDs also were found to use substances as a means of minimizing or medicating mental health problems. This study examined only male participants who lived in San Francisco, a city with a very large population of HIV positive sexual minority individuals, which makes generalization of the results difficult.

Alcohol has been shown to be associated with sexual risk behaviors (Russell & Joyner, 2001; Sullivan, 2003), thus increasing HIV risk (Greenwood et al., 2001). Vanable et al. (2004) found a high correlation between risky sexual behavior and heavy drinking (with heavy drinking defined as an individual who consumes four or more drinks). Vanable et al. (2004) conducted research in San Francisco, Denver and Chicago on men who have sex with men (MSM) (n=1712), though excluded sexual minority women. Alcohol heavy use is significantly related to having unsafe sexual practices involving non-primary partners. These results suggest that men engaging in heavy drinking in bars are more likely to participate in unprotected sex with strangers. Heavy consumption of alcohol was found to be more closely associated with unsafe or unprotected sex than to recreational drug use among men who have sex with men.

The credibility of Vanable et al.'s (2004) study was reinforced by the consistent findings among participants in San Francisco, Denver and Chicago. These results could

not be generalized to sexual minorities since sexual orientation was not a factor in the study. The nature of non-primary versus primary partners with participants merits further study.

It is apparent that sexual minorities are at-risk for substance abuse (Vanable et al., 2004), and that the use of substances for some sexual minority individuals may have clinical consequences unique to this population. The use of substances may be a conduit to feeling connected to a mainstream sexual minority community for some sexual minority individuals (Cochran et al.2007; Jordan, 2000). For some young sexual minority adults, depression was found to be a predictor of drug use (Cochran et al., 2004b). Adult sexual minority individuals report for treatment with severe substance abuse problems, with greater psychopathology and report more utilization of medical services utilization than heterosexual clients (Cochran et al., 2003; Gilman et al., 2001; Greenwood et al., 2001; Sullivan, 2003). For sexual minority individuals, it appears that there are greater risks of negative consequences, such as unplanned pregnancies, driving under the influence (Cochran & Cauce, 2006), and sexual risk behaviors (Sullivan, 2003) as a result of using substances.

Sexual Prejudice Toward Sexual Minority Individuals

The heterosexist perspective continues to negatively diminish the self concept of sexual minority individuals by invalidating any behavior not heterosexual (Herek, 2000a; Morin, 1977; Schope & Eliason, 2000), which is included in Herek's (2000a) concept of sexual prejudice. It appears that individuals need to be educated upon sexual prejudice, as sexual prejudice may be demonstrated, though not intentionally. That the majority of

participants demonstrated heterosexist attitudes implies that sexual minorities might be ignored or devalued by these respondents in future therapeutic settings.

Associated Characteristics

Hicks and Tien-tsung (2006) specifically examined the influence of attitudes upon sexual minority clients. Hicks and Tien-tsung found that the participant's age, gender, religiosity, opinion concerning gender and racial issues, partisanship, and ideology, to be related to negative attitudes towards sexual minorities. Hicks and Tien-tsung (2006) showed that examining participants' age, education, religiosity, gender, and anti-abortion position could help in developing effective targeted interventions which might reduce negative attitudes.

Using public opinion data, Hicks and Tien-tsung (2006) demonstrated that positive attitudes toward sexual minority individuals were held by were women, people who were younger, strong supporters of the Democratic party, higher educated people, those reporting themselves as less religious, and those who supported gender equality and abortion rights. The need for developing strategies targeting substance abuse counselors having these characteristics is further strengthened as Miller and Rollnick (1991) noted that substance abuse counselors hold considerable influence over their clients and can directly impact or hinder their clients' recovery.

In reviewing data from the 1993 General Social Survey (GSS), Shackelford and Bess (2007) found that respondents who were less educated, older, conservative, fundamentally religious and geographically immobile reported less favorable attitude toward sexual minority individuals. These findings reflect a gradual increase in more

accepting beliefs among Americans about sexual minority individuals and a gradual increase in the belief that homosexuality is an acceptable alternative lifestyle. There has also been a shift in attitude about the legality of homosexuality, as 54% of Americans now agree that homosexual relationships between consenting adults should be legal (Shackelford & Besser, 2007). As Shackelford and Besser (2007) and Hicks and Tien-tsung (2006) both examined shifts in attitudes toward sexual minority individuals, both studies demonstrated unique variables associated with sexual prejudice consistent with previous studies.

Variables that are consistently associated with sexual prejudice from other studies include education, gender, and religion, counselor experience level and sexual orientation. Educational level is associated with sexual prejudice (Eliason, 2000; Eliason & Hughes, 2004; Herek, 2002b; Klassen et al., 1989; Loftus, 2001; Shackelford & Besser, 2007; Simoni & Walters, 2001; Weber, 2008). These studies demonstrated that the individuals demonstrating sexual prejudice had received very little education, though educational levels were not indicated. Educational level of participants may be inferred along with characteristics of study participants.

Gender is also another characteristic that is associated with sexual prejudice (Cochran, Peavy, & Cauce, 2007; Eliason, 1995, 2000; Herek, 1988, 1995, 2002b; Kite & Whitley, 1996; Larson et al., 1980; Lim, 2002; Schope & Eliason, 2004; Simoni & Walters, 2001) as males demonstrate sexual prejudice more often in comparison to females. Religion is associated with sexual prejudice as well (Allport, 1954; Allport & Ross, 1967; Eliason, 2000; Eliason & Hughes, 2004; Herek, 1987; Herek & Capitanio,

1995; Kinsey et al., 1948; Larson et al., 1980; Negy & Eisenman, 2005; Satcher & Leggett, 2007; Tucker & Potocky-Tripodi, 2006), in which sexual prejudice is associated with adherence to personal religious beliefs.

Attitude and Behavioral Manifestations

Schope and Eliason (2000) focused their research upon the attitudes and behaviors of heterosexual individuals toward sexual minority individuals. A commonly held assumption identified by Schope and Eliason (2000) is that attitudes shape behavior. Schope and Eliason concluded that individuals with prejudicial attitudes would be more likely to engage in prejudicial acts. People with pro-sexual minority attitudes were shown to be more likely to engage in helping behaviors and less likely to demonstrate sexual prejudicial behavior. Though all participants were college undergraduates, primarily female and exclusively heterosexual, the results clearly reinforce the idea that attitude can be communicated through behaviors at any age.

Schope and Eliason (2000) highlighted the importance of the connection between attitudes and behaviors of sexual prejudice. Sexual prejudice may not always be manifested by acts of discrimination, but communicated more subtlety or implicitly (Herek, 2000b). Sexual prejudice occurring implicitly or explicitly, as acts of discrimination, is sexual prejudice (Herek, 2007; Herek et al., 2009) and therefore is victimizing sexual minority individuals (Center for Substance Abuse Treatment, 2001; Herek et al., 2007; Weber, 2008).

Herek (2000b) is consistent with Steffens (2005), which found that sexual prejudice may be communicated by implicit attitudes, as communication has been

inferred to be 7% verbal, 38% vocal, and 55% facial (Mehrabian & Ferris, 1967). The possible negative impact of sexually prejudicial implied attitudes upon sexual minority individuals receiving clinical services is that treatment effectiveness may be reduced (Eliason, 2000; Miller & Rollnick, 1991). Sexual prejudice is examined among clinical settings demonstrate the existence of sexual prejudice in clinical setting as school counselors (Satcher & Leggett, 2007), substance abuse counselors (Eliason, 2000; Eliason & Hughes, 2004; Hellman et al., 1989; Israelstam, 1988)social workers (Berkman & Zinberg, 1997), and psychologist (Hayes & Erkis, 2000) are not immune to sexual prejudice (Eliason, 2000).

Evidenced in Clinical Settings

Mental health professions who work with sexual minority clients must become aware of their own potential for heterosexist assumptions and homophobia. These biases and prejudices have been demonstrated to exist prior to individuals entering the helping professions (Ford & Jasinski, 2006). However, it is possible for sexual prejudicial individuals to become more affirming, in attitude and behaviorally, for sexual minority individuals (Altemeyer, 2001; Ben-Ari, 1998; Berkman & Zinberg, 1997). Developing affirmations toward sexual minority individuals, both attitudinally and behaviorally, is associated with the experience level of the counselors (Mathews, Selvidge, & Fisher, 2005).

Being affirming and sensitive to issues related to sexual orientation have been demonstrated to be successful with sexual minority individuals (Mathews & Selvidge, 2005). Lucksted (2004) reported that for sexual minority individuals seeking treatment,

their sexual identity often gets ignored, which is a an exclusively heterosexist viewpoint or heterosexual event (Weber, 2008), and may be a subtle form of sexual prejudice (Herek, 2000b; Herek et al., 1991). Hayes and Erkis (2000) demonstrated that sexual prejudice directly influences how treatment providers view client problems.

Lucksted (2004) noted that varying data sources reported encountering mental health professionals who considered sexual minority individuals to be ill, delusional or having a level of arrested psychosocial development. These prejudices were found in the counseling community despite homosexuality having been removed as a pathological disorder in the Diagnostic and Statistical Manual of Mental Disorders more than two decades prior (Goldfried, 2001; Pachankis & Goldfried, 2004). Sexual prejudice is not unique to mental health professionals, as some individuals in the helping professions of psychology (Hayes & Erkis, 2000) and social work (Berkman & Zinberg, 1997) demonstrate sexual prejudice.

Helping Professions. Berkman and Zinberg (1997) surveyed members of the National Association of Social Workers (NASW) who held Master of Social Work (MSW) degrees. Questionnaires were sent to 376 randomly selected participants. Most of the participants were female and predominantly white, with a response rate of 54% (n=187). The study found the majority of participants to be heterosexist who do not acknowledge or value any sexual orientation other than heterosexuality. This is interesting, as only 10% of participants were found to demonstrate a significant level of sexual prejudice toward sexual minority individuals. Herek (2004) and Weinberg (1972) have noted the detrimental heterosexist impact upon sexual minority individuals.

Berkman and Zinberg (1997) found that interpersonal contact with sexual minorities, reduces feelings of prejudice, which is supported by research (Allport, 1954; Eldridge et al., 2006; Eliason, 1995, 2000; Herek & Glunt, 1993). In addition, for these participants, having been in personal therapy was found to be associated with having a more positive attitude toward sexual minority individuals. This finding suggests that participating in personal therapy allows helping professionals to begin developing an awareness of their own biases. Berkman and Zinberg's (1997) finding that interpersonal contact reduces sexual prejudice among social workers continued to be validated as Satcher and Leggett (2007) found favorable attitudes toward sexual minority individuals, among school counselors, were related to interpersonal contact.

Satcher and Leggett (2007) found that professional school counselors, overall, are not negative toward sexual minority students. Satcher and Leggett (2007) found sexual prejudice among their sample of female professional school counselors from the southeastern United States. Results showed that participants possessed negative prejudices towards sexual minority students when compared by race and political affiliation. Caucasian respondents and individuals who reported as Republicans demonstrated higher sexual prejudice scores. While professional school counselors in this study did not indicate strong objections toward sexual minority students, they also did not indicate positive attitudes about sexual minority individuals.

The variables of Satcher and Leggett (2007) significantly related to having a more positive attitude were (a) having a sexual minority for a friend or personal acquaintance, (b) having participated in trainings about sexual minorities, and (c) having worked with

individuals seeking assistance because of their own sexual orientation or questioning their own identity. The interpersonal contact identified by Ben-Ari (1998) and Berkman and Zinberg (1997) is further supported as a possible intervention strategy to reduce prejudicial attitudes toward sexual minority individuals. The results of this study are important as they reinforce the importance of experiential training components (Satcher & Leggett, 2007). Individuals who demonstrated less positive attitudes reported more frequent church attendance. This supported the premise raised by previous studies that religiosity is strongly related to anti-gay prejudices (Herek, 1988).

Satcher and Leggett's (2007) study was limited to only one gender, as the majority of professional school counselors were female. Since participation in this study was voluntary, professional school counselors with strong negative beliefs toward sexual minorities may have chosen not to participate. The instruments of the study also provide further limitations as they have not been widely used to demonstrate reliability and validity across populations.

Sexual prejudice, among school counselors (Satcher & Leggett, 2007) and social workers (Berkman & Zinberg, 1997), may impact sexual minority individuals from seeking intensive mental health services. School counselors and social workers are generally regarded as an initial contact for individuals seeking mental health or substance abuse services. Individual seeking professional services may be referred to other continuum of care professionals, such as psychologist and psychiatrist, by school counselors and social workers. The significance of the existence of sexual prejudice among school counselors (Satcher & Leggett, 2007), substance abuse counselors

(Berkman & Zinberg, 1997; Eliason, 2000; Eliason & Hughes, 2004; Hellman et al., 1989; Israelstam, 1988) and social workers (Berkman & Zinberg, 1997), is that sexual prejudice is being demonstrated along the continuum of care, as psychologists also have been found to demonstrate sexual prejudice (Hayes & Erkis, 2000).

Hayes and Erkis (2000) surveyed psychologists (*n*=425), predominantly white male American Psychological Association (APA) members, to evaluate homophobia and client sexual orientation when working with individuals infected with HIV. Hayes and Erkis (2000) found that therapists held the client responsible for contracting HIV. Homophobic prejudice was shown to directly influence how these therapists viewed the original cause of the client's problems. This suggests that therapists with higher levels of homophobia may view HIV as a gay disease and blame the client for becoming HIV positive. While participants in this study reported low levels of homophobia, the authors could not pinpoint the specific point at which that homophobia became a barrier to treatment.

Hayes and Erkis (2000) suggested that therapists continuously examine their attitudes and beliefs about sexual minority individuals. They recommended increasing personal interactions to effectively reduce sexual prejudice. These results cannot necessarily be generalized to therapist reactions to actual clients, since participants in this survey only responded to case vignettes. Actual clients with HIV may demonstrate more ambiguity in clinical settings, as opposed to the specific client information provided in the vignettes that were used in this study. Hayes and Erkis's (2000) recommendations may allow also reduce the pathological view found by Lucksted (2004). Implementing

Hayes and Erkis's (2000) may have assisted treatment interventions for sexual minority individuals in substance abuse treatment by increasing their sexuality comfort (Israelstam, 1988), while also reducing sexual prejudice found among some substance abuse counselors (Eliason, 2000; Eliason & Hughes, 2004).

Substance Abuse Counselors. Israelstam (1988) authored one of the first studies to examine attitudes of substance abuse counselors toward sexual minorities. Substance abuse workers in Ontario, Canada were surveyed to examine their beliefs about issues affecting sexual minority individuals. The focus of this research was to identify the therapeutic environment that sexual minority individuals may encounter once they begin treatment. Participants included the staff of one agency that covered all regions of Ontario. Only 40% of the participants indicated they had worked with sexual minority individuals. The respondents reported believing that sexual minority individuals were heavier drinkers than the general population. Surprisingly, these treatment providers felt that sexual orientation was a factor that should be taken into account when intervention takes place. Israelstam (1988) reported that treatment interventions should help sexual minorities feel comfortable with their sexuality.

In a similar study, Hellman, Stanton, Lee, Tytun, and Vachun (1989) examined substance abuse workers (n=164) in government funded agencies in New York City. Significant deficiencies in substance abuse treatment for sexual minority individuals were identified. Supervision and training around sexual minority issues was non-existent. Sexual orientation was rarely discussed, though respondents believed client sexual orientation was important, revealing a bias against valuing sexual minority individuals.

A portion of Hellman et al's. (1989) respondents believed sexual minority individuals had difficulty, more than the norm, achieving and maintaining sobriety, and that, as a result, were less likely than heterosexual individuals to seek help for substance abuse. Respondents consistently expressed these assumptions despite the fact that 80% of them had college degrees. This was significant because research (Eliason, 2000; Eliason & Hughes, 2004; Herek, 2002b; Herek & Capitanio, 1995) has demonstrated the relationship between less education and higher sexual prejudice, which supports Loftus's (2001) supposition that increasing education may account for American attitudes changing toward sexual minority individuals.

Cochran, Peavy and Cauce (2007) evaluated sexual prejudice attitudes, both explicit and implicit, toward sexual minority individuals among substance abuse counselors. In a west coast metropolitan area a racial and gender diverse sample (n=46) participated in a study about attitudes toward providing treatment to sexual minority individuals. Cochran, Peavy and Cauce (2007) concluded that counselors need to receive education and training about this population, especially about the importance of respecting and valuing the pervasive influence of societal stigma on sexual orientation. Cochran et al. (2007) noted that clinicians asking clients about their sexuality, both from a clinical and informational perspective, would communicate acceptance and safety of the therapeutic milieu to sexual minority clients.

Cochran et al. (2007) found individuals holding the most positive attitudes toward sexual minorities proved to be those who identified themselves as a member of a sexual minority, thus skewing the results. The sampling conducted in this study may have been

biased in terms of individuals being overrepresented in their interest in sexual minority issues. The skewed nature of these results is reinforced by the fact that almost 30% of respondents identified as sexual minority individuals. Having more individuals who reported themselves as exclusively heterosexual would have provided more practical reliability and validity to the study.

Eliason (2000) surveyed substance abuse counselors (*n*=242) in the state of Iowa who reported having very little formal training or education regarding the needs of sexual minority clients. Nearly half of the respondents reported negative or ambivalent attitudes towards sexual minority individuals, assigning the most negative attitudes to transgendered individuals. The majority of the respondents in this study were female and 93% reported being heterosexual.

Eliason's (2000) finding is contrary to other studies (Ellis et al., 2003; Herek, 2002a; Lim, 2002; Steffens, 2005) that suggested that females tend to be less negative than males in their attitudes toward sexual minorities. The education level for the majority of respondents (74%) was at least a baccalaureate degree. Previous research indicated that less education is associated with sexual prejudice towards sexual minorities (Eliason, 2000; Herek, 2002b; Hicks & Tien-tsung, 2006; Shackelford & Besser, 2007) . Eliason (2000) noted that as training programs and continuing education forums have begun to increasingly address the needs of diverse clients, sexual minority clients may still be ignored or omitted in graduate training programs (Mathews et al., 2005). This idea was supported by Lassiter and Chang (2006), who found that, while substance abuse counselors with at least a master's degree rated themselves as competent in multicultural

knowledge, they did not consider themselves to be multiculturally aware, about sexual minority individuals.

Eliason (2000) also found that, in general, people with negative attitudes toward sexual minority individuals are likely to be male, uneducated, and fundamentally religious, with limited or no personal contact with sexual minority individuals. These results reinforced previous findings by other researchers (Eliason, 2000; Herek & Glunt, 1993; Klassen et al., 1989; Lim, 2002; Loftus, 2001; Shackelford & Besser, 2007; Weber, 2008). Eliason (2000) contended that while substance abuse counselors lacked knowledge about sexual minority issues, they might be more accepting; however, 44% of respondents were found to demonstrate negative or ambivalent attitudes towards sexual minority individuals. This shows that substance abuse counselors might attempt to treat sexual minority individuals the same as heterosexuals, and thus refuse to value their client's sexual identity. Unlike other studies, this study did not find men to be more negative toward sexual minority individuals than women.

In an expansion of Eliason's (2000) earlier work, Eliason and Hughes (2004) compared substance abuse counselors from Iowa and Chicago. The participants in the Chicago study were more racially diverse; though they were still predominantly white (53%). Only a third of the Chicago respondents indicated they grew up in a rural, area as compared to 52 % in Iowa. More Chicago respondents (17%) felt that sexual minority individuals were less likely to benefit from treatment than heterosexual individuals, as compared to 10% of the respondents from Iowa having this belief. This suggests that

growing up in a more urban area might not promote a more positive view of treatment for sexual minority individuals.

While the Chicago participants reported being more educated about sexual minority issues and having more contact with sexual minority co-workers or friends, this study found no significant difference in their attitudes towards sexual minority individuals compared to the Iowa substance abuse counselors. This is not supportive of research that indicates education (Loftus, 2001) and personal contact or interaction with sexual minority individuals (Eldridge et al., 2006; Herek & Glunt, 1993; Hinrichs & Rosenberg, 2002; Tucker & Potocky-Tripodi, 2006) works to reduce prejudicial attitudes toward sexual minority clients. Eliason and Hughes'(2004) findings warrant additional research involving a larger, more geographically representative sample to examine whether education and personal contact with sexual minority individuals reduces sexual prejudicial attitudes of substance abuse counselors.

The fact that the research of Eliason and Hughes (2004) seemed to both support and contradict previous research may be clarified by examining the overall statistics. The response rates for both studies were low, collectively yielding a 27% return rate. Additionally, both studies utilized a convenience sample, making it more difficult to generalize the results. These limitations provide additional reasons for further studies in which the research design can better control for such issues.

Eliason and Hughes (2004) concluded that agencies should develop anti-discrimination policies and procedures that include sexual orientation and identity. These authors recommended that discriminatory behavior should be documented in employee

performance evaluations and treated in the same context as sexual harassment. These conclusions underscore the need within the substance abuse field to develop consistent cultural competencies; clearly, there are still areas to be further examined to assist in establishing effective interventions based on those competencies.

As sexual prejudice among substance abuse counselors has been found to exist (Eliason, 2000; Eliason & Hughes, 2004; Israelstam, 1988), and these sexual prejudicial attitudes may impact treatment outcomes for sexual minority individuals (Eliason, 2000; Miller & Rollnick, 1991). Therefore the nature of sexual prejudice manifestations are important (Herek et al., 2009). Sexual prejudice can be reduced by implementing recommendations (Ben-Ari, 1998; Berkman & Zinberg, 1997; Eliason, 2000). Though sexual prejudice appears to have decreased since 1990 (Loftus, 2001), sexual prejudice continues to exist (Herek, 2009a; Herek et al., 2009), as does the need to change sexual prejudice.

Factors of Change

While sexual prejudice does exist among helping professionals as identified by Ben-Ari (1998), Berkman and Zinberg (1997), Hayes and Erkis (2000), Satcher and Leggett (2007) and Altemeyer (2001) and Ben-Ari (1998) noted the importance of experiential activities in reducing sexual prejudice, though Satcher and Leggett (2007) reported the association of heterosexual interpersonal experiences with sexual minority individual and sexual prejudice. Altemeyer's (2001) study examined heterosexual attitudinal change toward sexual minority individuals . Experiential activities that increase personal contact with sexual minority individuals apparently are an effective

method to reducing prejudicial attitudes (Altemeyer, 2001; Satcher & Leggett, 2007). By incorporating experiential activities, attitudes and values of sexual prejudice can be evaluated and challenged to develop more sexual minority affirming attitudes (Ben-Ari, 1998; Berkman & Zinberg, 1997; Satcher & Leggett, 2007).

Altemeyer (1988) examined attitudes towards homosexual individuals through a survey conducted with Canadian students (*n*=557) and their parents (*n*=521). Altemeyer focused on comparing changes in attitudes over time among students and their parents toward sexual minority individuals. Over half of these respondents reported hostile or rejecting statements concerning homosexual individuals. When this study was replicated again in 1996 and 1998, feelings of hostility and rejection toward homosexual individuals appeared to have decreased, as the respondents fell more solidly within the "acceptance' range.

Altemeyer (1988) demonstrated that women significantly changed their attitudes more than men. Surprisingly, the other group who showed significant positive change was individuals who identified themselves as "right wing authoritarian." These individuals were identified as followers who were likely to submit to established authorities in their lives. One relevant component to changing attitudes noted by Altemeyer (2001) centered on how social attitudes mirrored legislative and religious shifts in attitude towards sexual minorities.

A study of third year social work students in Israel (Altemeyer, 2001) described their attitudinal change. The experimental group participated in a course specific to homosexual issues that was theoretical and experiential in nature, which led to a decrease

in this group's homophobia scores. The experimental group differed significantly in scores of homophobia from the control group, as well as in the scope of free associations raised by the concept of homosexuality. These findings are important as they identify possible interventions to help reduce negative attitudes towards sexual minorities. Such interventions included in the experiential treatment included meeting a mother and her gay adult son who shared their personal stories with the class, and viewing a relevant movie. Theoretical underpinnings included sexual identity models, with a specific emphasis on coming out in general, and on coming out to significant family members. The sharing of personal stories, as indentified by Ben-Ari (1998), is found to be an agent of change in attitudes toward sexual minority individuals.

Ben-Ari (1998) reported that participants indicated the experiential component of personal stories and the gaining of theoretical and empirically-based information were the two main factors identified as causing attitude change. Further research on these topics is vital to raise awareness regarding individuals who feel that they are "different" or marginalized. The integration of both experiential and theoretical components into a curriculum could be replicated. Ben-Ari (1998) reinforces the findings of Berkman and Zinberg's (1997) study which found that peer contact with minority individuals reduces prejudicial attitudes toward minority individuals. As experiential activities work to reduce sexual prejudice (Ben-Ari, 1998; Berkman & Zinberg, 1997), characteristics of individuals with sexual prejudice have also been indentified (Hicks & Tien-tsung, 2006; Shackelford & Besser, 2007).

Diminishing Sexual Prejudice

Over the past 30 years, Americans have demonstrated that they are becoming more accepting of sexual minority individuals (Hicks & Tien-tsung, 2006; Schope & Eliason, 2000), though Schope and Eliason noted that a significant portion of heterosexual people retain overtly negative attitudes toward sexual minority individuals as Hicks and Tien-tsung reported sexual prejudice in rural areas. While attitudes appear to have grown more positive toward sexual minority individuals in the last decade (Loftus, 2001), values inherently impact sexual prejudicial attitudinal change (Vicario, Liddle, & Luzzo, 2005).

Allport (1954) believed that individuals live for and by their personal values and prejudice is founded upon beliefs that secure or threaten our value system. Sexual prejudicial values or beliefs, are often deeply rooted and resistant to change, requiring long-term strategies to reduce sexual prejudice toward sexual minority individuals (Cochran et al., 2007). Attempts to change attitudes without considering values that individuals feel strongly about are likely to fail (Altemeyer, 2001; Eliason & Hughes, 2004). Interventions that offer ways of changing attitudes within a person's existing value structure may be more likely to succeed (Vicario et al., 2005). It is important to acknowledge that attitudes and prejudicial behavior have the potential for positive change (Eliason & Hughes, 2004; Ellis et al., 2003; Herek, 1988, 2002a; Larson et al., 1980). As societal attitudes toward sexual minority individuals become more accepting in the last two decades (Loftus, 2001), it is important to examine how these positive changes may occurring.

Using data from the 1973-1998 General Social Survey, Loftus (2001) identified changes in demographics and cultural ideological beliefs as possible factors for more accepting attitudes toward sexual minority individuals. The changes in demographics are primarily reported as increasing levels of education while ideological cultural beliefs include traditional religious beliefs, political views, and morality of sex outside of marriage (Loftus, 2001). These cultural ideological beliefs may be considered values as they can be identified as major themes within a person's cognitive or personality structure (Rokeach, 1973). Rokeach (1968a, 1968b) described attitude as a number of beliefs around a specific entity and value as a single belief (Rokeach, 1973).

Clinical Implications of Sexual Prejudice

As therapists were found to report lower levels of sexual prejudice than the general public, sexual prejudice was found to interfere with clinical service for sexual minority individuals (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000). In a comprehensive literature review, Lucksted (2004) identified themes reported by sexual minority individuals and examined the needs, unique experiences and recommendations of sexual minority individuals reporting to public mental health agencies. A significant amount of archival data, published and unpublished, and key interview sources noted little or no recognition of sexual minority issues in public or community mental health agencies. This literature review shows the urgent need for further training and education for treatment providers. Most sources reported that staff members who worked in public mental health agencies did not know how to address the concerns of sexual minority clients. Instead, sexuality was treated as an "invisible" factor that was only recognized

when it seemed to be associated with specific client issues, such as HIV risk or unwanted pregnancy.

Cultural Sensitivity

Lucksted (2004) also found that sexuality is a factor that is often misunderstood by clinical staff who exhibit anti-sexual minority stereotypes. This finding suggests that these -sexual minority stereotypes often emerge from inherent, socially-stigmatized, and negative attitudes towards sexual minority individuals (Herek et al., 2007). One related construct that consistently emerged was that of the clinical staff not understanding, not liking, or not wanting to work with sexual minority clients due to prejudicial views regarding client sexual orientation.

By not respecting or valuing a client's sexuality, the implied assumption of the substance abuse counselor, may be that the client is heterosexual (Center for Substance Abuse Treatment, 2001; Eliason, 2000; Herek et al., 2009). Therefore, the counselor may not gain the client's perspective from their world view, and not be culturally competent or sensitive to the unique treatment needs of the sexual minority individual (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999; Van Den Berg & Crisp, 2005). Treating a client in this manner violates ethical codes (American Counseling Association, 2005; National Association for Alcoholism and Drug Abuse Counselors, 2004) and is not being culturally competent substance abuse counselor (Lassiter & Chang, 2006; Van Den Berg & Crisp, 2005). Clinical implications of cultural competency deficits, such as sexual prejudice, continue

to place sexual minorities in an inferior context as compared to heterosexuals (Israelstam, 1988).

Israelstam (1988) reported that substance abuse counselors believed sexual minority individuals were heavier drinkers compared to the general population. This belief suggests that substance abuse counselors view the sexuality of the client as the cause of the client's problem, instead of having a non-judgmental approach to problem causality (Israelstam, 1988). Viewing a client's sexual identity as causal of his or her substance abuse may be similar to the sexual prejudice view of sexual identity held by the APA until 1973. Sexual prejudice among substance abuse counselors has been demonstrated (Herek et al., 2007). And while factors influencing sexual prejudice are becoming more understood, this phenomenon continues to need further evaluation as sexual minority individuals are presenting for treatment with severe mental health and substance abuse issues (Cochran & Cauce, 2006).

Client Impact

Due to sexual minority individuals utilizing therapy services more than heterosexual individuals (Cochran et al., Cochran & Cauce, 2006; 2007; Eliason, 2000; Eliason & Hughes, 2004), the uniqueness of these individuals in treatment must be considered (Bauermeister, 2007; Cochran et al., 2007; Ghindia & Kola, 1996; McCabe et al., 2003; Sullivan, 2003). The stigma and social isolation associated with sexual minority individuals may reduce their level of trust of the heterosexual world (CSAT, 2001; SAMSHA, 1999).

Individuals who have substance abuse disorders are a very diverse group (Goldfried, 2001). Generalizations based upon a person's demographic characteristics, substance use, and treatment history; limit the ability to make treatment outcome predictions. Cochran, Peavy and Robohm (2007) assert that despite accumulating evidence of sexual minority individuals having higher rates of substance abuse, very little research has identified effective interventions specific to this population. In light of evidence that suggests substance abuse counselors have ambivalent or negative attitudes towards sexual minority individuals (Israel, Gorcheva, Walther, Sulzner, & Cohen, 2008), it appears that sexual minority individuals may have a counselor preference.

Counselor Preference. Liddle (1999) noted that sexual minority individuals report greater satisfaction with therapy, which may be partly attributed to improvements in mental health service areas. Prior to 1985, sexual minority individuals felt that most heterosexual therapists were not helpful. Beginning in the late 1980's, these ratings began to rise, sharply surpassing heterosexual client ratings of therapists. This increase may partly be attributed to the shift that has occurred as older therapists, who had previously viewed homosexuality as a disorder, began to retire and were replaced by younger, more accepting therapists. Sexual minority clients may have also become more selective in choosing therapists.

McDermott, Tyndall, and Lichtenberg (1989) examined sexual minority clients' preference for counselor sexual orientation. Participants were homosexual men and women from the Midwest. The race of the participants was primarily Caucasian (89%). Of the participants, 98% had a high school diploma, and 35% had received their

Bachelors degree. McDermott, Tyndall, and Lichtenberg (1989) found that 49% of respondents indicated a preference for a gay or lesbian counselor, though 39% did not believe the sexual orientation of their counselor made a difference. A significant finding of this study was that 89% of the participants indicated having been to at least one counselor. Of these 89% having seen a counselor, only 46% reported that their counselor was a heterosexual, 22% did not know the sexual orientation of their counselor. McDermott et al. (1989) found, supported recently by Mathews et al. (2006), that sexual minority individuals reported to have benefitted from recovering counselors, but also counselors that identified as a sexual minority.

The generalizability of McDermott et al. (1989) is limited due to the geographic region of participants. Individuals of the Midwest have been shown to have high reports of negative attitudes toward sexual minorities (McDermott et al., 1989). In addition, the results of this study may have been limited by the worldview of the participants, which was primarily heterosexual. The more homophobic the respondents were, the less likely they were found to be comfortable in discussing various sexual concerns with a counselor of unknown sexual orientation. This suggests that counselors may benefit from training that allows sexual minorities to feel affirmed while seeking therapeutic services (Klassen et al., 1989; Mathews et al., 2006; Vicario et al., 2005).

Client and Counselor Priorities. There is very limited research into what is discussed in treatment, as well as what both clients and counselors believe should be addressed in treatment (Cochran et al., 2007). Miovic, McCarthy, Badaracco, Greenberg, Fitzmaurice, and Peteet (2006) conducted a study at three outpatient

psychiatric treatment centers, with both clinicians and clients, to explore similarities in treatment experiences. There was significant agreement between clients and staff as to what should be addressed in treatment.

Surprisingly, the love domain, which included sexuality, was found to be consistent among both groups, though the reported frequency of this topic being addressed was not found to be consistent (Miovic et al., 2006). Clients viewed themselves as being the topic of discussion less frequently than counselors. However, sexuality concerns were not specifically identified as a domain in this study. It appears that, again, sexual concerns were not addressed, though there was agreement about its importance. In light of this evidence, one would assume that sexual minority individuals would not be satisfied with their therapeutic experience, but this has not been the case.

Miovic et al.(2006) found agreement between clinicians and sexual minority individuals about what should be discussed in treatment, specifically love, though the frequency is not consistently agreed upon. Surprisingly, Liddle (1999) noted that sexual minority individuals are beginning to report greater satisfaction with therapy. This finding may be a result of sexual minority individuals preferring a sexual minority counselor (Liddle, 1999) with whom sexual minority individuals do not encounter sexual prejudice.

Reducing sexual prejudice that sexual minority individuals may encounter while seeking substance abuse treatment, may increase the chances of recovery for sexual minority individuals (Hicks, 2000). The reduction of sexual prejudice will allow for recommended themes to be addressed in treatment for sexual minority individuals

(Barbara, 2002). The ability to discuss sexual orientation, discrimination, internalized homonegativity, and social supports are themes that are identified to be addressed unique to sexual minority individuals in substance abuse treatment (Barbara, 2002), the omission of such themes, creates barriers to receiving treatment for sexual minority individuals (Goldfried, 2001).

Barriers to Treatment.

For sexual minority individuals seeking treatment, sexual prejudice may impede treatment, if their sexuality is not valued and respected in treatment planning (Bauermeister, 2007; Cochran et al., 2007; Ghindia & Kola, 1996; Mayer et al., 2008; McCabe et al., 2003; Sullivan, 2003). Failure to recognize or affirm the sexuality of sexual minority clients seeking treatment may result in sexual minority individuals developing perceived barriers to treatment (CSAT, 2001; SAMSHA, 1999). Sexual prejudice enacted upon sexual minority individuals seeking treatment, may place additional stigma upon sexual minority individuals and result in a heterosexual bias towards the substance abuse counselor (Rosario et al., 2006) due to their level of discomfort (White & Franzini, 1999). Sexual prejudicial barriers also exist systemically as well among the substance abuse profession (Goldfried, 2001).

Goldfried (2001) identified barriers that sexual minority individuals may encounter in receiving clinical. Goldfried noted barriers include a reluctance to disclose sexual identity, institutional and procedural barriers to access health insurance, limitations on visiting and decision making for sexual minority partners, a lack of preventative services developed within a cultural context, and a lack of providers trained

in sexual minority issues. There also is barrier of evidenced based treatment interventions and services (Hicks, 2000). Though many substance abuse treatment centers report providing treatment unique to sexual minorities, only 7.3 % reported as having current such specialized services (Cochran, Peavy, & Robohm, 2007).

Reducing sexual prejudicial barriers allows for a more welcoming environment for sexual minority individuals and creates an awareness of the sexual minority individual's worldview (Center for Substance Abuse Treatment, 2001; Eliason, 2000; Eliason & Hughes, 2004; Mayer et al., 2008). Treatment that affirms the uniqueness of sexual minority individuals is viewed as supportive to the clinical needs of sexual minority individuals (Hicks, 2000; Julien, Chartrand, & Begin, 1999). Substance abuse counselors exhibiting ambivalent or negative attitudes towards sexual minority individuals (Eliason, 2000; Eliason & Hughes, 2004; Israel et al., 2008) is not in the best interests of sexual minority individuals seeking clinical services.

Summary

The purpose of this chapter has been to provide an overview of the literature on prejudicial attitudes towards sexual minorities, and specifically the prejudicial attitudes of substance abuse counselors. Sexual prejudice began to be examined in the literature in the late 1970's and early 1980's. Due to the early studies not having employed valid and reliable statistical procedures, much of the early research has not been practical for practicing professionals (McDermott et al., 1989). Morin (1977) reported that early sexual minority research focused on diagnosis, cause, and adjustment. As the American Psychological Association removed homosexuality as a diagnosis from the Diagnostic

and Statistical Manual of Mental Disorders in 1973, sexual minority men and women began to be viewed as mentally healthy.

Clinical Needs

Sexual prejudice and discrimination fosters increased risk factors for mental health (Herek, 1994; Kite & Deaux, 1986; Mayer et al., 2008) and substance abuse problems (Mayer et al., 2008; Meyer, 2003; Sullivan, 2003). A possible explanation for increased risk factors for mental health and substance abuse illnesses is internalized homophobia as a result of sexual prejudice. Internalized homophobia is the self loathing an individual begins to believe about him or herself as a result of societal stigma and messages (Cochran et al., 2007; Eliason, 1995, 2000). Meyer (2003) and Weber (2008) both reported a relationship between feelings of shame, guilt, and rejection, and mental health and substance abuse problems associated with internalized homophobia.

While sexual minority individuals have a higher prevalence of mental disorders (Cochran et al., 2000; Jorm et al., 2002; Mayer et al., 2008; Weber, 2008) and enter treatment with more severe substance abuse problems than heterosexual individuals (Meyer, 2003), Lucksted (2004) reported that healthcare settings are uncomfortable addressing the sexuality of clients. The level of discomfort found by Lucksted (2004) was also previously demonstrated by Eliason (Eliason, 2000), who contended that as a group, substance abuse counselors lacked knowledge about sexual minority issues. The lack of knowledge of issues unique to sexual minority individuals may very well be related to prejudicial attitudes of substance abuse counselors toward sexual minority individuals, which has been demonstrated (Cochran & Cauce, 2006)

Sexual Prejudice

Sexual prejudice, existing in any form, such as heterosexism or homophobia, among substance abuse counselors has the potential to negatively impact the treatment of sexual minority individuals (Cochran et al., 2007; Eliason, 2000; Eliason & Hughes, 2004). Miller and Rollnick (1991) acknowledged the power and influence that substance abuse counselors hold and the importance of their attitude toward sexual minority individuals. There is always potential for oppressive behaviors in anyone who holds social advantage or privilege, and the power that accompanies it (Allport, 1954; Miller & Rollnick, 1991).

Clinical Implications

The clinical implications of sexual prejudice are important as sexual minority individuals are seeking clinical services more than heterosexual individual (Allport & Ross, 1967; Herek, 1987). To help assist sexual minority individuals seeking clinical services, counselors are encouraged to recognize or affirm the sexuality of sexual minority clients to help decrease hetero-negative bias (Bauermeister, 2007; Cochran et al., 2007; McCabe et al., 2003; Sullivan, 2003) and other identified barriers and other barriers to treatment (Goldfried, 2001; Mayer et al., 2008). Though sexual minority individuals reported satisfaction in therapy (Goldfried, 2001), counselors must continue to follow guidelines established to meet the unique needs of this client population (Center for Substance Abuse Treatment, 2001; Liddle, 1999; Mayer et al., 2008; Substance Abuse and Mental Health Services Administration, 1999; Van Den Berg & Crisp, 2005).

Sexual prejudice encompasses negative attitudes toward sexual minority individuals (CSAT, 2001; Herek, 2007; SAMSHA, 1999). Sexual minority individual health concerns are a focus for treatment professionals (Herek, 2000b; Mayer et al., 2008). Victimization (Koh & Ross, 2006; Weber, 2008) and internalized homonegativity (Herek et al., 2007) are factors of stress that appear to increase risks factors of mental illness (Cochran & Mays, 2000a; Jorm et al., 2002; Weber, 2008) and substance abuse disorders (Amadio, 2006; Gilman et al., 2001). Sexual minority individuals are reporting for treatment with severe mental health and substance abuse problems. Upon entering substance abuse treatment, sexual minority individuals may continue to be targets of sexual prejudice by substance abuse counselors (Cochran & Cauce, 2006). However sexual prejudice may be experienced by sexual minority individuals, prejudicial attitudes of can be changed to more positive and affirming attitudes (Altemeyer, 2001; Ben-Ari, 1998; Satcher & Leggett, 2007).

CHAPTER 3: METHODOLOGY

Research has demonstrated sexual prejudice to exist among certain substance abuse counselor populations (Eliason, 2000; Eliason & Hughes, 2004; Israelstam, 1988). Currently, there have been no studies evaluating sexual prejudice among substance abuse counselors in a national population of substance abuse counselors. The purpose of Chapter 3 is to describe the methodology and procedures used in investigating the outcome variable of sexual prejudice and predictor variables of substance abuse counselors' religious beliefs, education level, recovery status, sexual identity, and various demographic variables. Exploratory analysis was utilized to determine if there is a significant level of sexual prejudice among substance abuse counselors, and the degree of relationship among sexual prejudice, if found to exist, and outcome variables among substance abuse counselors. The outline of this chapter includes research design, research question, research variables, and description of the participants, data collection procedures, instrumentation, data analysis, and summary.

Research Design

A correlational study using survey research methods will be utilized to meet the purpose of this study. In a quantitative study, data is gathered numerically in order to explain or predict the phenomena (Gay, Mills, & Airasian, 2006) of prejudicial attitudes among substance abuse counselors. This study is a non-experimental design, as no manipulation of variables by the researcher will occur (Gravetter & Wallnau, 2007). The

correlational relationship will be analyzed to determine the prevalence of sexual prejudice among substance abuse counselors toward sexual minority individuals. Inferential statistics are utilized to generalize the participant sample responses to substance abuse counselors of NAADAC (Gay et al., 2006), and potentially to the general substance abuse population.

Prejudicial attitudes have reported to exist among substance abuse counselors in Iowa and Chicago (Eliason and Hughes, 2004), but there is no evidence about the degree of difference or similarity when education, training, and experience is accounted for. However, a limitation of correlational designs is determining causal inferences as the researcher cannot make a prediction that one variable causes change in other variables (Gravetter & Wallnau, 2007). This research study will explore the relationship between the outcome variable of sexual prejudice and the predictor variables, including various demographic variables among substance abuse counselors toward sexual minority individuals.

Research Question

The intent of this study was to examine the following research question:

Can sexual prejudice be predicted among substance abuse counselors in regards to:

A. Religiosity (to the degree substance abuse counselors adhere to their religious beliefs).
B. Education Level (completed high school, completed trade or business school, some college, completed bachelor's degree, some

master's level work, completed master's degree, some doctoral work, or completed doctoral degree).

C. Various variables (gender, age, race, years of experience as a substance abuse counselor, recovery status, familiarity of sexual minority issues, and participant self report of their sexual orientation).

Description of Participants

Participants for this study were a convenience sample from the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) which reports over 10,000 members (National Association Alcohol and Drug Addiction Counselors, 2009). NAADAC is a national association that provides national certification for substance abuse counselors. This study will only focus on the sexual prejudice, education levels, religious beliefs, recovery status, and sexual identity of NAADAC members. Members of National Association of Alcoholism and Drug Abuse Counselors (NAADAC) are a very diverse group (NAADAC, 2009) .

These members represent a variety of demographic categories. According to NAADAC's 2008 Annual Report (NAADAC, 2009), women account for 54.5% of the membership, with 56.2 % of members having at least a Master's degree. Age, gender, socio-economic status (SES), and race are not reported. The majority of NAADAC members are certified and/or licensed substance abuse counselors as 80.6% meet this level of training. Almost 60% self report working as a counselor as their primary job function. Over 74% have been in the addiction services field for longer than 10 years.

Surveys, instruments, and instructions will be displayed in English. Therefore, participants will need to be able to comprehend English. The minimum age of participants is 18 years old. Due to the study examining homonegativistic attitudes among licensed and certified counselors, the goal is to recruit participants who range in demographic characteristics while meeting the inclusion criteria. By accessing the membership of a national association that provides a national credential, it is anticipated that a more representative sample of current substance abuse counselors practicing nationally will be accessed.

Data Collection Procedures

Permission will be obtained from the Institutional Review Board for Human Subjects of the University of North Carolina at Charlotte prior to data collection. Once participants granted permission, they clicked on the link embedded in the invitation (Appendix A) and follow up emails (Appendix B and Appendix C) to connect the participant to a secure website. As part of NAADAC member services, NAADAC will post on their official "Research" website, accessed only by members, a notice of invitation to participate in this study. NAADAC's website posting will last for one month. Members of NAADAC received an invitation emails (Appendix A and Appendix B) from NAADAC, as all communications to participants were disseminated by NAADAC, to participate in this study. Subsequent follow up emails (Appendix C) were also disseminated to members, as recommended by Dillman (2007).

Dillman's (2007) Tailored Design Method provides the framework from which this study will solicit participation from the population of NAADAC. Dillman's (2007)

Tailored Design Method is a proven framework to which return rates and accurate results have been consistently demonstrated. Email solicitation attempted to follow Dillman's (2007) Tailored Design Method, in which four contact emails are sent, though the fourth email dissemination was not needed.

An initial email inviting participants, describing the purpose of the survey, was disseminated to participants. The initial email contained an Introductory Email (see Appendix A). Members were also sent a reminder email (see Appendix C) at the end of the first, second, and third week. A page of gratitude was displayed upon the completion of the on-line survey for participants. Emails contained a direct link to the web-based survey link within Survey Monkey.

Survey Monkey is the electronic survey administrator of the instruments. The entire population of NAADAC members will receive all emails. Inclusion criteria were verified by participants in the informed consent acknowledgment acceptance. Participants met inclusion criteria that required members to have a current valid email address on file with NAADAC, be a current resident of the Continental United States, or Hawaii, be an individual member of NAADAC, to meet inclusion criteria for participation in this studies' web based survey.

The web based survey followed Dillman's (2007) principles for web based surveys. An Informed Consent Form (see Appendix D) immediately appeared on the website stating participation is completely voluntary, anonymous, and confidential. Participants were also informed that participation could be immediately stopped at any time without penalty. After clicking on the Informed Consent agreement, participants

then began to complete the survey. Participants completed the on-line survey one time. The survey remained on-line for 19 days after IRB approval was received and NAADAC disseminated introductory solicitation emails. After the data collection period, the researcher closed the link. All data collected was downloaded to the Statistical Package for Social Sciences (SPSS) software (SPSS Inc, 2006). In consideration of the length of the data collection time period of 19 days and population size reduced from 10,000 (NAADAC, 2009) to 6,161 members (Croy, 2009a), as a result of valid email addresses (Croy, 2009b), target sample size was evaluated and identified (Faul, Erdfelder, Lang, & Buchner, 2007).

A minimum total sample size of 146 is deemed necessary by G* Power 3 general power analysis program (Faul et al., 2007). An overall target sample size of 300 participants was agreed upon. This sample size allowed for adequate power (.80) (Huck, 2004) in order to identify a moderate effect size (.09) (Cohen, 1988).

Dillman (2007) recommended four procedures to assist in reducing the amount of possible errors. For the purpose of this study a sampling error of plus or minus five percent will be tolerated. The population size from which the sample will be drawn is over 10,000 (National Association Alcohol and Drug Addiction Counselors, 2008). The population of NAADAC is homogeneous to this studies' characteristic of interest, which is substance abuse counselors. Reducing the possibility of sample bias in this study will assist in controlling for coverage and sample errors.

Coverage and sample errors included measurement, nonresponse, coverage and sampling errors (Dillman, 2007). Measurement error accounted for items that were

misunderstood or incorrectly answered while nonresponse error takes into consideration the difference between the individuals who completed the survey and the individuals who did not respond. Coverage error specifically addresses the possibility of including everyone in the studies' population as not having a known, non-zero chance of being included in the sample. Sample error is the result of collecting data from only one subset of the studies' population. This study followed Dillman's (2007) recommendations to ensure that these types of errors were controlled

Survey Protocol

The web based survey will contain a welcome page with instructions. The informed consent page will contain confidentiality and anonymity assurances, and then the questionnaire will then begin. Each questionnaire item will be configured to insure readability as each screen will remain consistent throughout the progression of the questionnaire. At the completion of response submission, the final page provides a contact list for participant to access resources, if they so choose, such as the primary researchers' contact information and a Thank You for Participating message from the researcher.

As participants completed the web based survey, the completed survey results were submitted to a secure database. This allows the data to be forwarded to an account accessible only by the primary researcher and faculty advisor. Once the data collection time period expired, the data was downloaded and quantified. The data will be secured via password protection on flash drives (two) and placed in a locked file cabinet.

Instrumentation

A pilot study was conducted prior to actual data collection to ensure clarity of directions to participants and conciseness of instrument items. The pilot study population consisted of 15 individuals. This population was actual practicing substance abuse counselors and counselor educators. A think aloud interview was conducted with participants (Dillman, 2007). Feedback concerning clarity, conciseness of instrument and how much time it took participants to actually complete the entire instrument were evaluated as a result of the think aloud interview.

Information was collected in a multiple choice format. Respondents completed the web based survey in the following order: Informed Consent (see Appendix D), the ATLG--S5 titled "Sexual Minority Beliefs" (Appendix E) (Eliason & Hughes, 2004; Herek, 1994) and the Demographic Questionnaire (see Appendix F). The demographic questionnaire was designed after a careful literature review of related studies and expanded to fit the purpose of the current study. The total time for the complete instrument should take approximately ten to fifteen minutes.

Research Variables

This study examines complex issues that are pivotal factors in achieving the purpose of this study. These factors are categorized as predictor and outcome variables. The outcome or dependent variable is sexual prejudice. The predictor or independent variables are (a) religious beliefs of substance abuse counselors, (b) demographic variables that include substance abuse counselors: female, age, race, education level, years of experience as a substance abuse counselor, recovery status, familiarity of sexual

minority issues, personal contact with sexual minority individuals, and participant self report of their sexual orientation. These variables are clarified in order to identify and define their role in conducting analysis.

Solicitation Emails (Appendix A, Appendix B, and Appendix C)

An introductory letter *(Appendix A)* was sent in the body of the email to members of NAADAC. This letter explains the purpose of the study and the voluntary nature of the study. Voluntary participation, that is also anonymous and confidential, will also be communicated in these email solicitations. A follow up letter *(Appendix B)* was sent to members of NAADAC explaining the technological errors contained in the initial dissemination by NAADAC. A subsequent follow up email *(Appendix C)* was sent to NAADAC members notifying of final participation opportunity and closing date of study's data collection opportunity.

NAADAC members received three email solicitations to be consistent with Dillman's Tailored Design Method recommendations (2007), though the final solicitation email was not disseminated. In consultation with this study's Chair, it was agreed upon that a fourth email solicitation was not needed due to participants generously exceeding targeted sample size, in addition to the unforeseen extended time required to receive IRB and NAADAC dissemination approval. The total time lapse from IRB proposal submission and email dissemination being implemented was 71 days.

Informed Consent (Appendix D)

Prior to participating in this study, participants electronically signed an Informed Consent Form that is presented at the beginning of the survey. This form included the

following information: eligibility criteria, purpose of the research study, estimated time required to complete the survey, and benefits and risks to taking part in this human subjects study. Information contained in the Introductory Letter will be reiterated, such as the voluntary, anonymous and confidential nature of participation in the study.

The ATLG--S5 (Appendix E)

The dependent variable of sexual prejudice, being evaluated in this study, is measured by the Eliason and Hughes (2004) modification of the ATLG-S5 (Herek, 1994), titled "Sexual Minority Beliefs" on the on-line survey. Herek's (1994) Attitudes Towards Gay and Lesbians Short (ATLG-S5) was initially adapted from an earlier version, the ATLG Herek (1994). All versions of the ATLG are generally accepted instruments to measure attitudes of heterosexuals toward lesbians and gay men. The ATLG revisions have maintained statistical integrity as reported by Herek (1998)**.**

The ATLG-S5 (Herek, 1994) consists of two 5-item subscales. One sub-scale measures attitudes toward gay individuals (ATG) and one measures attitudes toward lesbian individuals (ATL). The ATLG-S5 is a Likert-format questionnaire with a 5 point scale ranging from "1=strongly disagree" to "5=strongly agree**.** Scores below 3 indicate agreement, whereas scores above 3 indicate disagreement. Reverse scoring is used with specific items. Herek found the psychometric properties to be statistically valid. Alpha coefficients demonstrated acceptable levels of internal consistency for the ATLG and the ATLG-S5 (α =.87) and the subscales, α =.95 for the ATL and .96 for the ATG. ATL and ATG scores were significantly (p<.05) correlated with construct validity measures (Herek, 1994).

Eliason (2000) and Eliason & Hughes (2004) modified the ATLG-S version to include an additional 10 items measuring heterosexual attitudes toward bisexual and transgender individuals, 5 items for each group. This study includes questions such as "I think bisexuals are disgusting" and "I think transgendered individuals are disgusting" to measure sexual prejudice of substance abuse counselors to bisexual and transgendered individuals. Eliason (2000) reported alpha coefficients of the subscales of the modified ATLG-S (lesbian scale=.78, gay male scale=.84, bisexual scale=.75, and transgender scale=.81). The Eliason (2000) and Eliason and Hughes (2004) modified ATLG-S consists of five items for each subscale: gay, lesbian, bisexual and transgender, for a total of twenty items. These additional questions contain response set and scoring that is consistent with the published guidelines of the ATLG-S5 (Herek, 1998). However, for purposes of this study, only the total ATLG-5S score was used to encapsulate sexual minority individuals globally.

Demographic Questionnaire (Appendix F)

Demographic information collected consisted of participant gender, age, race, region, education level, years of experience as a substance abuse counselor, recovery status, religious beliefs, familiarity of sexual minority issues, personal contact with sexual minority individuals, and participant self report of their sexual orientation. This demographic information was compiled and expanded from Eliason (2000), Eliason and Hughes (2004), and Herek and Capitanio (1995). Demographic information collected from other studies, identified in Chapter 2, also contributed to the demographic design of this study.

Data Analysis

SPSS will be used to analyze the data. All completed online surveys will be assigned a number as they are completed. SPSS will used to screen the data, gather descriptive statistics, and conduct a multiple regression. The descriptive statistics will be used to describe the respondents.

Screening Data

The instruments utilized in this study are considered to be self-report measures. The researcher assumed that participants responded in an honest and trustworthy fashion. The results are assumed to accurately reflect the research question variables of this study. Information collected from participant responses was screened for missing data, outliers, normality of distribution, and statistical assumptions before conducting the analyses.

Descriptive Statistics

Descriptive statistics were used to summarize, organize, and simplify data to describe the participants (Gravetter & Wallnau, 2007) in terms of variables or combination of variables (Tabachnick & Fidell, 2007). Information regarding participant gender, age, race, region, education level, years of experience, religious beliefs, recovery status, familiarity of sexual minority issues, personal contact with sexual minority individuals, and participant self report of their sexual orientation, were analyzed. This information allowed for the description of participants in analyzing the results of this study.

Correlational Analysis

Correlational analysis is used to measure and describe a relationship between variables (Gravetter & Wallnau, 2007) . The direction of such a relationship ranges from +1.0 to -1.0. A positive relationship indicates that as one variable (x) increases, variable (y) also tends to increase. In negative relationships, as variable (x) increases, variable (y) tends to decrease, thus an inverse relationship. Data collected during the study was calculated by correlational analysis to describe degree of relationships and direction (positive, negative, or none) among variables.

Multiple Regression

A regression analyses allowed the researcher to assess the variance between the outcome variable of sexual prejudice and the predictor variables (Tabachnick & Fidell, 2007). Nominal outcome variables were dummy coded for inclusion in the statistical analysis. Multiple regression analysis determined if religious beliefs, education level, sexual identity, recovery status and other demographic variables of substance abuse counselor's continued to be a predictor of sexual prejudice among substance abuse counselors.

The researcher believed that as education and experience of substance abuse counselors' increase, religiosity and sexual prejudice of substance abuse counselor would decrease, collectively. Eliason (2000) noted that though substance abuse counselors appear to be accepting, sexual prejudice is collectively evident (Cochran, Peavy, & Cauce, 2007; Cochran, Peavy, & Santa, 2007; Eliason, 2000; Eliason & Hughes, 2004).

Eliason (2000) further stipulated that the presence of any sexual prejudice among substance abuse counselors' can affect the entire agency or treatment milieu.

Summary

Chapter 3 provided a methodological framework from which this study operated. This chapter provided specific detail to ensure participant protection, as required by the Institutional Review Board of Human Subject. Chapter sections outlined the research design of the study. The research question of this study was designed after identifying deficits between theoretical and best practice principles in the substance abuse field regarding sexual minority individuals (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Robohm, 2007; Eliason, 2000; Eliason & Hughes, 2004; Substance Abuse and Mental Health Services Administration, 1999). Information regarding the validity and reliability of selected web based survey instrument, as well the instrument scoring methods (Eliason, 2000; Eliason & Hughes, 2004), is provided in the instrumentation section. Data analysis is included in this chapter, specifically, the rationale of selecting exploratory statistics to maintain the law of Parsimony (Keith, 2006) for this study.

CHAPTER 4: RESULTS

The purpose of this research study was to evaluate sexual prejudice among substance abuse counselors. Specifically, this study explored the possibility of predicting sexual prejudice among substance abuse counselors in regards to their religiosity (degree of religious belief adherence), educational level, female, age, race, experience, recovery status, familiarity with sexual minority issues, and sexual orientation in a national sample. This chapter will describe the sample participants, the ATLG-S5 instrumentation, data management and analysis, and summary.

Description of Participants

The National Association of Addiction and Drug Abuse Counselors (NAADAC) reports having over 10,000 members (NAADAC, 2009). NAADAC disseminated 6,161 emails announcing the survey and requesting participation (D. Croy, personal communication, August 5, 2009) to NAADAC members with email addresses. Forty emails were returned as undeliverable (D. Croy, personal communication, August 7, 2009). Therefore the total number of possible NAADAC members meeting the inclusion criterion of having valid email address was 6,121.

The total number of substance abuse counselors who agreed to the informed consent and chose to voluntarily participate in this study was 655, providing a response rate of almost 11% (10.7%). This sample size exceeds that of 146 deemed necessary by G* Power 3 general power analysis program (Faul et al., 2007). Therefore, the response rate was deemed to be acceptable. The participants were residents of the Continental

United States, or Hawaii, and an individual member of NAADAC. Three individuals were excluded for invalid Sexual Prejudice scores, as these individuals did not respond to the majority of the Attitudes Toward Lesbians and Gays (ATLG) instrument.

After an initial pre-analysis screening, there we no individuals identified as outliers. The remaining 652 participants included some who chose not to respond to each item of the survey. These individuals were not removed from the sample, as individuals were not required to answer each item. The decision was made to exclude participants who did not complete the majority of ATLG items, though individuals choosing to omit any demographic information were included. The number of participants omitted responses is reported for demographic information collected.

Demographics

Demographic data collected from substance abuse counselors consisted of religious beliefs, educational level, gender, age, race, region of the country, years of experience, recovery status, familiarity with sexual minority issues, personal contact with sexual minority individuals, and participant self report of sexual orientation. The demographic information provides characteristics of the sample population. These characteristics were then evaluated for sexual prejudice. Distributions other than normal are noted.

Participants were asked to identify their religious beliefs using one global religious view or belief question. The scale asked participants to select a corresponding label they identified their religious view or beliefs to be. The labels were assigned a number, 1-6, based upon the label location in the drop down menu. The drop down menu

choices ranged from 1 being strongly conservative to 6 being strongly liberal. The religious views or beliefs of participants are described in Table 1. The majority of participants identified as having liberal beliefs (74.5%). Participants reporting strongly conservative beliefs were relatively small (2.0%). Twenty one participants chose not to report their religious beliefs (*n*=21, less than 5% of total *N*=652), the second highest omitted response.

Table 1: Participants by Religious Beliefs

View / Values	*N*	%
Strongly Conservative	13	2.0
Conservative	54	8.3
Slightly More Conservative	78	12.0
Slightly More Liberal than	124	19.0
Liberal	232	35.6
Strongly Liberal	130	19.9
Omitted	21	3.2
Total	652	100.0

Education levels of the participants are reported in Table 2. The educational level of participants was high, with 84% of participants reported having completed a bachelor's degree or higher. The majority of participants reported having completed a master's degree (48.5%). This sample of participants having completed their masters' degree is 7.7% less than the general population of NAADAC members. NAADAC's reports that 56.2% of NAADAC members have completed this level of education (National Association Alcohol and Drug Addiction Counselors, 2009). Nine individuals chose not to self report their educational level (*n*=9, less than 5% of total *N*=652).

Table 2: Participants by Educational Level

Education	*N*	%
Completed High School	7	1.1
Completed Trade or Business	7	1.1
Some College	81	12.4
Completed Bachelor's Degree	68	10.4
Some Master's Level Work	51	7.8
Completed Master's Degree	316	48.5
Some Doctoral Work	50	7.7
Completed Doctoral Work	63	9.7
Omitted	9	1.4
Total	652	100.0

The overwhelming gender of participants was female (*n*=394, 62%). Though female participants accounted for the majority of this sample, the sample population of NAADAC female members is reported to be 55% (NAADAC, 2009). Fourteen individuals did not report their gender (*n*=15, less than 5% of total *N*=652).

The age of participants indicated the majority (61%) of participants to be age 50 or older. Participants reported ages ranging from 23 to 79 (*M*=52.11, *SD*=10.59). The median age of the sample was 54, with a reported mode of 59. Thirty-two participants omitted their age (*n*=33, less than 5% of total *N*=652), which was the highest omitted response.

Participant ethnicities are reported in Table 3. The sample was primarily White (81%). Participants reporting ethnicities of Latino, African American, Native American and Multi-Racial accounted for a minority representation of 15.7%, reflecting a positively skewed distribution. No participant reported as Asian American. Six individuals chose not to report their race (*n*=6, less than 5% of total *N*=652).

Table 3: Participants by Race

Race	*N*	%
White	530	81.0
Latino	19	2.9
African American	56	8.6
Native American	11	1.7
Multi-Racial	17	2.6
Other	15	2.3
Omitted	6	0.9
Total	652	100.0

Participants must have resided within the United States, an inclusion criteria contained in the participant informed consent agreement. Participants choosing to participate in this study must have agreed to the informed consent. Participant geographic location is reported in Table 4. The majority of participants reported their geographic region to be South (33.3%). Eleven individuals chose not to report their geographic location (*n*=11, less than 5% of total *N*=652).

Table 4: Participants by Geographic Region

Region	*N*	%
Midwest	110	16.9
Northeast	148	22.7
South	217	33.3
West	166	25.5
Omitted	11	1.7
Total	652	100.0

Experience level reported by participants is quite high, as 70% of participants reported substance abuse counseling experience of 10 years or more, compared with 74% of the NAADAC membership (NAADAC, 2009). Participants reported years of substance abuse counseling experience ranging from 1 to 48 (*M*=16.64, *SD*=9.82). The

median years of experience of the sample were 16 with a reported mode of 11. Eight participants chose to omit their experience level (*n*=8, less than 5% of total *N*=652).

Participants were asked to identify their recovery status. The single item asked participants to select either "in" or "out" of recovery. A slight majority of participants reported being in recovery (*n*= 336, 51.5%). Nineteen participants selected to omit their recovery status (*n*=19, less than 5% of total *N*=652).

Respondents were asked about their familiarity with sexual minority issues such as "coming out" models and legal and social implications of being a sexual minority. Respondents indicated their level of familiarity as "not familiar", "familiar", or "very familiar'. The overwhelming majority of participants (*n*=569, 87.7%) reported being at least familiar with sexual minority issues. A significant number of these participants reported being very familiar with sexual minority issues (*n*=217, 33.3%). Seven individuals chose not to report their level of familiarity (*n*=8, less than 5% of total *N*=652).

The participants were asked about personal contact with a sexual minority individual in a social, family, or professional context. Participants overwhelmingly indicated having such personal contact with sexual minority individuals (*n*=638, 97.9%), reflecting a positively skewed distribution. One (.2) participant reported having such personal contact as unknown. Five individuals did not respond (*n*=5, less than 5% of total *N*=652).

Participants were asked to identify their sexual orientation using one global sexual orientation item. Respondents were asked to select their sexual orientation from a drop

down menu ranging from 1 being bi-sexual to 5 being transgendered. The sexual orientation of participants is reported in Table 5. The overwhelming majority of participants reported their sexual orientation to be heterosexual (79.4%). Traditional categories of sexual minority individuals (i.e., bi-sexual, homosexual, lesbian, and transgendered) accounted for 19.1% of sample. Nine individuals chose not to report their sexual orientation (*n*=9, less than 5% of total *N*=652).

Table 5: Participants by Sexual Orientation

Sexual Orientation	*N*	%
Bi-sexual	32	4.9
Heterosexual	518	79.4
Homosexual	49	7.5
Lesbian	42	6.4
Transgendered	2	.3
Omitted	9	1.4
Total	652	100.0

The range of affective attitudinal responses is summarized in Table 6. As measured by the ATLG-S5, participants predominantly appear to have positive attitudes towards sexual minority individuals. The majority of participants (*n*=573, 78.9%) agreed with affirmation statements that tap participants' affective responses regarding sexual minority individuals and related issues.

Table 6: Participants by Affective Attitudinal Response Range

Sexual Orientation	*N*	%
Strongly Agree-Agree Somewhat	450	60.0
Agree somewhat-Neither agree or disagree	123	18.9
Neither agree or disagree	61	9.3
Disagree-Strongly Disagree	4	2.8
Total	652	100.0

Instrumentation

Instrumentation for this research study consisted of individuals completing an on-line survey. This study followed Dillman's (2007) recommendation of pilot testing to clarify instructions and procedures for participants. The pilot testing may have increased the response rate. The ATLG-S5, a commonly accepted measure of sexual prejudice, reduced survey administration time for participants. Collectively, pilot testing and the ATLG-S5 may have decreased incomplete survey items.

Pilot Testing of Instruments

A description of the pre-data collection procedures are discussed in this section. The pilot testing examination included survey design, on-line procedures, readability, and incorporation of feedback used to improve the data collection experience for participants. The goal for conducting a pilot study was to identify potential areas of weakness or problems that participants may experience with the instrument. A respondent-friendly questionnaire or process is one element of increasing survey response rates (Dillman, 2007).

The pilot study population included a variety of professional counselors, including substance abuse counselors. The participants were provided detailed

instructions about issues that could increase participant satisfaction. These issues addressed content clarity, readability, comprehension, time administration, and on-line navigation of survey. Participants were also asked to read aloud the ATLG-S5 items to assist in readability. Two individuals reported inconsistent item responses. Three individuals reported time administration of less than 10 minutes. Item responses were reviewed and adjusted prior to dissemination to the NAADAC sample. A total of 8 individuals participated in the pilot study.

ATLG-S5 Instrument

The dependent variable of sexual prejudice was measured by Herek's (1994) Attitude Toward Lesbians and Gay Men Short (ATLG-S5) as modified by Eliason (2000) and Eliason and Hughes (2004) *(Appendix E)* to include bisexual and transgendered individuals**.** The ATLG-S5 *(Appendix E)* is a Likert-format questionnaire with a 5 point scale ranging from "strongly disagree" to "strongly agree, with 1="strongly disagree" and 5="strongly agree"**.** The response set and scoring is consistent with the published guidelines of the ATLG-S5 (Herek, 1998). Reverse scoring is used with specific items (2, 4, 8, 10, 12, 14, 17, and 19). Scores below 3 indicate agreement, whereas scores above 3 indicate disagreement. The possible range of total ATLG-S5 scores range from 20 (extremely positive attitudes) to 100 (extremely negative attitudes).

The mean score, standard deviation, and estimate of internal consistency for the 20 item ATLG-S5 are presented in Table 7. This data provides sexual prejudice levels of respondents. Participant scores ranged from 1.0 to 4.80, with a mean score of 1.863 (*SD*=.815). Cronbach's alpha internal consistency estimates for the Attitude Toward

Lesbians and Gays (ATLG) was .95, reflecting a sufficiently high estimate of reliability for this study. Values of skewness (+1.459) and kurtosis (+1.471) indicated a positively skewed distribution (Huck, 2004).

Table 7: Instrument Means, Standard Deviation, Skewness, and Coefficient Alphas

Instrument Scale	*N*	*M*	*SD*	*Sk*	α
ATLG-S5	652	1.863	.815	1.459	.952

Note. ATLG-S5= Attitude Toward Lesbians and Gay Men Scale

Data Management and Analysis

The dataset was created immediately after the data collection period expired. Data was downloaded and saved into an excel spreadsheet located on encrypted and password protected disk drives. The excel spreadsheet was then converted into an SPSS file to conduct the analyses. The SPSS data file was then encrypted and password protected.

Prior to analysis, data were screened for missing items. Of the participants (*N*=655), three individuals were excluded for not completing more than 60% of the Attitudes Toward Lesbians and Gays (ATLG) instrument (*n*=12). The remaining 652 participants included those who chose not to respond to each item of the ATLG or the demographic questionnaire. These individuals were not removed from the sample, as individuals were not required to answer each item. It was decided to leave the missing items blank and include in the data in the overall analysis.

The data was screened for outliers. Univariate outliers were identified and examined for impact upon analysis results. The dummy coding of variables for bivariate and multiple regression analyses included respondents who reported their sexual

orientation (1=heterosexual and 0=not heterosexual) into heterosexual, their race (1=white and 0=non-white) into White, gender (0=male and 1=female) into Female, and their recovery status (1=in and 0=out) into recovery.

The SPSS software program generated output containing histograms and indices of skewness and kurtosis to determine the normality distribution for each variable. Histogram analysis found religion, education, female and age to be negatively skewed, though skewness and kurtosis indices generally, did not exceed ± 1.0. However, race and orientation did have skewness scores above ±1.0, while female, race, recovery, and orientation, had kurtosis indices above ±1.0.

Only personal contact was deemed to have potential impact on the results of the analysis. However, geographic region was deemed to have no statistical impact upon the result due to similar equal representation. Personal contact with sexual minority individuals indicated the majority of participants (*n*=638, 97.9%), reported as having such contact. The skewness (9.661) and kurtosis (103.995) indices of personal contact indicated concerns of normality. The decision was made to exclude personal contact and region as variables within the research question, while including additional univariate outliers.

SPSS was used to analyze the data for linearity, homoscedasticity of residuals, and collinearity. There were no areas of concern indicated by scatterplot or scores from predicted or residual regression plots. Table 8 illustrates the skewness and kurtosis indices for each remaining univariate variable.

Table 8: Skewness and Kurtosis Indices

Variable	Skewness	Kurtosis
Age	-0.502	-.066
Education	-0.568	-0.015
Years of Experience	0.361	-0.676
Religious Beliefs	-0.718	-0.245
Familiarity of Issues	-0.226	-0.656
Sexual Prejudice ATLG-S5	1.459	1.471
White	-1.646	0.713
Female	0.487	-1.777
Recovery	-0.124	-1.991
Heterosexuals	-1.548	0.398

Bivariate Correlation Analysis

Prior to running the correlation analyses, all variables were examined for outliers, missing data, and normality. Bivariate correlational analysis demonstrated significant positive and negative relationships between sexual prejudice and some independent variables.

A Pearson product-moment coefficient was conducted between the ATLG-S5 and predictor variables of religious beliefs, educational level, and demographic variables (female, age, years of experience, recovery status, familiarity of sexual minority issues, and respondent sexual orientation). Significant relationships were found, with the exception of education level. The ATLG-S5 was significantly correlated with respondents who reported their sexual orientation as heterosexual (r=.243, p<.01). However, this relationship is not surprising, reporting sexual orientation as heterosexual was also significantly negatively correlated with having personal contact with sexual minority individuals (r= -.404, p<01), religious beliefs (r= -.207, p<01), and familiarity

of sexual minority issues (*r*= -.121, p<01). This relationship finding suggests that participants reporting as heterosexual tend to have less contact with sexual minority individuals, more conservative in their religious beliefs, be less familiar with sexual minority issues, which is supported in significant negative correlations.

Significant negative correlations with the ATLG-S5 were found. Religious beliefs (*r*= -.656, p<01), race (*r*= -.234, p<01), familiarity of sexual minority issues (*r*= -.222, p<01), years of experience (*r*=-.151, p<01), recovery status (*r*= -.135, p<01), age (*r*= -.127, p<01), and female (*r*= -.104, p<01) were all significantly negatively correlated with the ATLG-S5. These relationships suggest that higher prejudicial attitudes are correlated with conservative religious beliefs, being "white", more work experience, not being in recovery, being older, being male, and not being familiar with sexual minority issues. Table 9 presents the correlation matrix.

Table 9: Correlation Matrix for Dependent Variable and Independent Variables

Factors	1	2	3	4	5	6	7	8	9	10
1. ATLG-S5	1	**-.656	-.041	**-.104	**-.127	**-.151	**-.135	**-.222	**.243	**-.234
2. Religious		1	.019	**.105	.049	.032	**.137	.093*	**.127	-.047
3. Education			1	-.077	**.135	-.044	**.254	**-.173	**.140	-.031
4. Female				1	**-.135	.011	**-.137	**-.143	*-.091	.020
5. Age					1	*.091	**.567	**.194	**.104	-.030
6. Yrs.Ex.						1	-.011	**.131	-.026	
7. Recovery							1	.060	-.053	
8. Familiarity								1	-.039	
9. Hetero										
10. White										

Note. *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).
ATLG-S5=Attitude Toward Lesbians and Gay Men as modified by Eliason (2000), Eliason and Hughes (2004).

Multiple Regression Analysis

Multiple regression analyses were used in this study to predict or explain the phenomena (Keith, 2006) of sexual prejudice among substance abuse counselors. The intent of this study is to examine the following research question:

Can sexual prejudice be predicted among substance abuse counselors by their: (a) religiosity (the degree that substance abuse counselors adhere to their religious beliefs); (b) education level; and (c) demographic variables of female, age, race, years of experience as a substance abuse counselor, recovery status, familiarity of sexual minority issues, familiarity with sexual minority individuals, and participant sexual orientation.

Prior to running the multiple regression analysis, data for the independent variables were examined for normality of distribution, skewness, and kurtosis, as well as collinearity. Predictor variables of race and sexual orientation did have skewness scores above ±1.0, while demographic variables (i.e., female, race, recovery status, and sexual orientation), had kurtosis indices above ±1.0. The variables that were dichotomized included sexual orientation (1=heterosexual and 0-=not heterosexual) into "heterosexual", race (1=white and 0=non-white) into "White", recovery status (1=in and 0=out) into "Recovery" and gender into "Female" (0=male and 1=female). Heterosexual and White continued to have skewness scores above +-1.0. The skewness scores were considered legitimate to the sample. The Variance Inflation Factors for all independent variables were less than 2.0, suggesting the estimated β's were well established in the regression models.

A standard multiple regression model was conducted to examine predictors of sexual prejudice and to examine the amount of variability among the dependent variable of sexual prejudicial attitude and independent variables. The results of the multiple regression model for all variables indicated that the variance accounted for (R^2) by religious beliefs, educational level, and demographic variables equaled .485 (adjusted R^2=.477), which was significantly different from zero [($F_{(11,559)}$ =59.090, p<.001)]. The R^2 of the multiple regression analysis indicates that the independent variables account for, or predicted, .477 (proportion) or 47.7% of ATLG-S5 scores, which represents a medium statistical effect size (Keith, 2006). An overall *R* value of .696 between the dependent variable of ATLG-S5 scores and the independent variables indicated significant predictability among independent variables. Three independent variables (Religious Beliefs, White, and Familiarity with Sexual Minority Issues) contributed significantly at the p<.001 level to the prediction of sexual prejudice attitudes of participants, while female contributed significantly at the p<.05 level. Table 11 reports *p-values* for dependent variable of sexual prejudice and all independent variables.

Regression coefficients (standardized and unstandardized) were used to infer the magnitude of the relationship between sexual prejudice (ATLG-S5) and the predictor variables (Keith, 2006). For all regression coefficients that differed significantly from zero, 95% confidence limits were calculated. The unstandardized coefficient (*B*) is interpreted as the change in outcome for each unit of change in the influence, while the standardized coefficient (β) utilizes a consistent standard deviation unit for all variables) (Keith, 2006). The standardized (β) and unstandardized (*B*) regression coefficients

assisted in interpreting the multiple regression results to respond to this study's research question of predicting sexual prejudice among substance abuse counselors based upon specific independent variables. The interpretation of the multiple regression results indicates the possible explanation of sexual prejudice and some dependent variables.

Religious Beliefs. The first variable, religious beliefs of substance abuse counselors, proved to be the strongest predictor of sexual prejudice. The significance is indicated by the regression results for religious beliefs scores, (p<.001) and the largest (t) -18.047 and (β) -.588, of sexual prejudice, as measured by the ATLG-S5. It appears that the more conservative participants reported their religious beliefs to be, the higher these participants scored on the ATLG-S5. It appears that among participants, the increase in sexual prejudice is influenced by the -.588 (β) and partial correlation -.605 (*sri).* This is a negative association, indicating that as sexual prejudice attitude scores (ATLG-S5) increased among participants, individuals became more conservative in their religious beliefs.

Education Level. Education level of participants proved not to be a significant predictor of sexual prejudice among substance abuse counselors. Participants' reported educational level was high, with 65.8% of the participants reporting their education level to be at the graduate level. Graduate level education included having at least a master's degree; bachelors' level education included a minimum of at least a bachelor's degree and non-degreed included individuals not meeting the graduate or bachelor level categories.

Combining education levels into non-degreed, bachelors' and graduate categories demonstrated that as education increases, sexual prejudice attitudes decrease. It appears that as participants' educational level increased beyond high school, their attitudes of sexual prejudice tended to become more accepting. Table 10 reports these findings.

Table 10: Educational Means and Standard Deviation

Education Level	*N*	*M*	*SD*
Non-Degreed	*95*	*1.937*	*.801*
Degreed	*119*	*1.901*	*.786*
Graduate	*429*	*1.827*	*.821*
Total	*643*	*1.857*	*.812*

Note. ATLG-S5= Attitude Toward Lesbians and Gay Men Scale

Demographic Variables. Predictor demographic variables of race, familiarity with sexual minority issues, and gender proved to be significant predictors of sexual prejudice among substance abuse counselors. These demographic variables provide a description of sexual prejudice among these participants. The standard coefficients (β) and p-values for the dependent variable, sexual prejudice (ATLG-S5), and regression model of all independent variables are reported in Table 11.

The dichotomized variable of White, from race, was a significant predictor of sexual prejudice among the participants ($p<.001$), (*t)* -4.571, (β) -.236, and -.189 (*sri).* Participants' reporting their race as white is a negative association with sexual prejudice. Therefore, individuals who reported their race as being white were more likely to have negative prejudicial attitudes.

Being familiar with sexual minority issues proved to be a significant predictor of sexual prejudice among the participants ($p<.001$), (*t)* -3.369, (β) -.114, and -.140 (*sri).*

Being familiar with sexual minority issues is a negative relationship. It appears that being less familiar with sexual minority issues were more likely to have negative prejudicial attitudes.

Female among participants was found to be significant predictor of sexual prejudice among the participants ($p<.05$), (*t)* -2.680, (*β*) -.085, and -.112 (*sri)*. The gender of participants indicated a negative relationship. It appears that individuals reporting their gender as male participants tended to have more negative sexual prejudicial attitudes. Table 11 reports the standard coefficients *(β)* and *p-values* for dependent variable of sexual prejudice and all independent variables.

Table 11: Unstandardized Regression Coefficients (B), and Constant, Standardized Regression Coefficients (β), t-values, p-values, and Semipartial Correlations (sr_i) for Independent Variables

IVs	*B*	*β*	t-value	p-value	*Semi-Partial*
Constant	4.376		20.397	<.001	
Religious	-.374	-.588	-18.047	<.001	-.605
Education	.002	.004	.138	.890	.006
Female	-.141	-.085	-2.680	<.05	-.112
Age	-.005	-.069	-1.821	.069	-.076
White	-.304	-.142	-4.571	<.001	-.189
Years of Exp	-.001	-.013	-.333	.740	-.014
Recovery	-.055	.053	-1.032	.303	-.140
Familiarity	-.145	-.114	-3.369	<.001	-.043
Heterosexual	.132	.063	1.837	.067	.077

a Dependent Variable: Sexual Prejudice (ATLG-S5)

Summary

This chapter provided the results of the data analysis for the study. The participants were primarily liberal in their religious beliefs (*n*=486, 74.5%), were educated at the master's degree level (48.5%), and were more women (*n*=394, 62%) than

men. The participants were in their early to mid fifties (*M*=52.11, SD=?), primarily Caucasian (81%), and experienced as substance abuse counselors (70% with 10 years or more). A small majority of participants reported being in recovery (*n*= 336, 51.5%). Participants primarily classified their sexual orientation as heterosexual (79.4%). Due to the predominance (*n*=638, 97.9%), of having had a sexual minority personal contact among participants, personal contact was excluded as a research question variable of consideration.

The Cronbach's alpha internal consistency estimate for the ATLG-S5 was .95, reflecting sufficiently high estimates of internal consistency for this study. Though participants knew the intent and purpose of this study, sexual prejudice, as measured by the ATLG-S5, was evident. Sexual prejudice was not significant, as only 2.8% of participant ATGL-S5 scores were not supportive attitudes toward sexual minority individuals.

Significant correlation relationships were found between sexual prejudice and some independent variables. The ATLG-S5 was significantly correlated with direction of Religious Beliefs, reporting as Heterosexual, being White, having more years of work Experience, being in Recovery, older in Age, and being of male Gender. Multiple regression analysis demonstrated some of these correlations to be significant predictors of sexual prejudice as well. These significant correlations of sexual prejudice among some dependent variables were confirmed in the results of the regression analysis.

A multiple regression analysis overall R^2 of .477 between the dependent variable of sexual prejudice and independent variables indicated significant predictors. The results

of the multiple regression model for all variables indicated that the variance accounted was 47.7% of ATLG-S5 scores. Religious beliefs, White (race), and Familiarity of Sexual Minority Issues significantly predicted sexual prejudice at the $p<.001$ level, and female significantly predicted sexual prejudice at the $p<.05$ level.

CHAPTER 5: DISCUSSION

This research study sought to examine the sexual prejudice of substance abuse counselors. The findings of this study are presented as they relate to contemporary sexual prejudice literature and research. This chapter consists of the following sections: overview of the study, discussion of the results, limitations, implications of the findings, recommendations for future research, and concluding remarks.

Overview

The purpose of this study was to examine sexual prejudice among substance abuse counselors and to identify predictive factors of sexual prejudice. A comprehensive literature review identified characteristic factors associated with sexual prejudice. Factors previously found to be associated with sexual prejudice among substance abuse counselors include religious beliefs (Allport, 1954; Hicks & Tien-tsung, 2006; Kinsey et al., 1948; Larson et al., 1980; Weinberg, 1972), education level (Eliason, 2000; Eliason & Hughes, 2004; Loftus, 2001; Weber, 2008), female (Hicks & Tien-tsung, 2006; Larson et al., 1980), and age (Hicks & Tien-tsung, 2006).

Although sexual prejudice research among substance abuse counselors has been conducted for three decades (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004; Hellman et al., 1989; Israelstam, 1988), it appears that sexual prejudice among substance abuse counselors continues to lack priority and focus among researchers. Though research is evidenced, previous studies did not incorporate national

samples, go beyond correlational analysis, or examine sexual prejudice as a predictor of possible sexual minority individual affirmations (Mathews et al., 2005). These limitations were removed from this study, therefore increasing this study's significance.

The researcher sought out participants from a national organization, The National Association of Alcoholism and Drug Abuse Counselors (NAADAC). NAADAC reports having over 10,000 members (National Association Alcohol and Drug Addiction Counselors, 2009), which provided this study's national sample. The sampling frame consisted of 6,100 NAADAC members. A total of 655 members responded to the survey resulting in a response rate of almost 11%. After eliminating respondents with missing (see individual demographics, though less than 5%) or invalid data (n=3, less than 5%), a total of 652 participants were included in the study. The participants completed the ATLG--S5 titled "Sexual Minority Beliefs" (Appendix E) (Eliason & Hughes, 2004; Herek, 1994) and a demographic questionnaire (see Appendix F).

Discussion of the Results

The results of this study provide many benefits to the knowledge base of sexual prejudice. Substance abuse counselors participating in this study demonstrated sexual prejudice is a phenomenon that exists among substance abuse counselors. As a result of the presence of sexual prejudice, characteristic variables significantly associated with sexual prejudice were identified. The results are discussed in terms of substance abuse counselors' demographic characteristics, sexual prejudice as measured by the ATLG-S5, and correlation and multiple regression analyses.

An examination of demographic data indicated a lack of diversity among participants. Participants primarily identified as liberal, had at least a bachelor's degree, were "White", highly experienced as counselors in terms of years of counseling experience, familiar with sexual minority issues, tended to be female, beyond age 50, and identified as heterosexuals. Sexual minority representation (19.1%) was similar to Cochran et al., (2007). Participant demographic characteristics are similar to published member demographics of NAADAC (2009) and previous studies of sexual prejudice among substance abuse counselors (Cochran, Peavy, & Cauce, 2007; Eliason, 2000; Eliason & Hughes, 2004; Hellman et al., 1989).

Participants primarily reported positive attitudes towards sexual minority individuals. While it appears that the majority of participants were not sexually prejudiced in their attitudes toward sexual minority individuals, sexual prejudice was found among participants. There were ATLG-S5 scores that indicated either ambivalent or sexually prejudiced attitudes toward sexual minority individuals among participants in this study.

Correlation analysis results indicated that many demographic factors significantly correlated with sexual prejudice among substance abuse counselors. The ATLG--S5 demonstrated high estimates of reliability, providing statistical integrity to the correlation findings. It appears that as sexual prejudice increases among participants, participants become more conservative in their religious beliefs, consider their sexual orientation to be heterosexual, tend to be White, report being familiar with sexual minority issues, have considerable years of work experience, are not in recovery, are older, and are male. These

correlations confirm that these variables are significantly related to sexual prejudice among participants.

In general, religious beliefs have the most extensive history of association with sexual prejudice (Allport, 1954; Cochran & Beeghley, 1991; Herek, 1987; Herek & Capitanio, 1995; Kinsey et al., 1948; Schulte & Battle, 2004; Weinberg, 1972), and among substance abuse counselors (Cochran et al., 2007; Eliason, 2000; Eliason & Hughes, 2004). Sexual prejudice among participants of this study confirmed additional associations of sexual prejudice. These associations of sexual prejudiced individuals include possible individuals who report their sexual orientation as heterosexual, race as white and gender as male. Eliason (1995) previously noted a gender association with sexual prejudice. However, the extent of the association between being familiar with sexual minority issues and sexual prejudice has only recently been demonstrated as significant (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Robohm, 2007; Eliason & Hughes, 2004).

Additional significant associations with sexual prejudice indicated by the results of this study include experience, and recovery status of the participant. Participants of this study who reported higher years of experience were more associated with sexual prejudice, though this was previously reported to have less of an association with behavioral manifestations of sexual prejudice (Mathews et al., 2005). It seems logical that as experience increases, exposure to sexual minority individuals also increases. Therefore, individuals harboring sexual prejudice attitudinally have learned to not demonstrate such behaviors openly.

The recovery status of participants in this study demonstrated that individuals who reported their recovery status as being in recovery were found to have less sexual prejudice levels than participants not being in recovery. Inherent in the area of recovery is the focus for individuals to focus on personal character inconsistencies. Inherent in the area of recovery is individual focus on personal character inconsistencies. This emphasis on self development may assist in decreasing personal biases as a result of practicing l2 step life principles, a generally accepted aspect of recovery. Therefore, experience levels, and recovery status, are associations of sexual prejudice among participants of this study.

The variable of education level was found to have no significant correlation with sexual prejudice. Interestingly, education level has been demonstrated (Eliason, 2000; Eliason & Hughes, 2004; Herek, 2002b; Klassen et al., 1989; Loftus, 2001; Shackelford & Besser, 2007; Weber, 2008) to be associated with sexual prejudice in other studies. The correlation analysis of this study did not confirm these previous findings. However, by categorizing educational levels into non-degreed, bachelors' and graduate level, results did find that individuals with less education reported higher sexual prejudice scores. Thus, the findings of this study do follow this previously accepted premise.

To examine the overall research question of predicting sexual prejudice among substance abuse counselors, a standard multiple regression analysis was utilized. The multiple regression analysis result of this study indicated that religious beliefs, being white, female, and familiar with sexual minority issues, were significant predictors of sexual prejudice. The result of the multiple regression model accounted for 47.7% of sexual prejudice, representing a medium statistical effect size (Keith, 2006).

Based on interpretation of the standard coefficients, four independent variables (religious beliefs, race, and familiarity of sexual minority issues, and female) contributed significantly to the prediction of sexual prejudice. Religious beliefs of substance abuse counselors proved to be the strongest predictor of sexual prejudice. This is consistent with previous studies (Eliason, 1995; Eliason & Hughes, 2004; Herek & Glunt, 1993; Satcher & Leggett, 2007; Shackelford & Besser, 2007; Tucker & Potocky-Tripodi, 2006). Being White was the next strongest predictor of sexual prejudice, though not previously considered as a predictor in previous research, possibly due to samples being predominantly white.

Being familiar with sexual minority issues resulted in a significant prediction of sexual prejudice (Center for Substance Abuse Treatment, 2001; Cochran, Peavy, & Robohm, 2007; Eliason & Hughes, 2004) among participants in this study. The gender of participants demonstrated to be a significant predictor of sexual prejudice (Cochran, Peavy, & Cauce, 2007; Hicks & Tien-tsung, 2006) among participants of this study. Sexual prejudice in this study is similar to Eliason's (1995) study, which found that participants demonstrating high levels of sexual prejudice tend to be males.

Education level of participants, as evidenced by previous research, proved to not be a significant predictor of sexual prejudice in this study. Participant years of experience, recovery status, or being a heterosexual, were not found to be significant predictors of sexual prejudice as well. It appears that classifying oneself, as a heterosexual is not unique to having sexual prejudice, though a correlation does exist.

Contributions of this research benefit counselor education and training programs in terms of increasing awareness and identifying social advocacy efforts concerning

sexual prejudice. Sexual prejudice is evident among some substance abuse counselors based on this study. Of these participants, there were variables with significant associations with sexual prejudice. From these contributions, awareness and advocacy of social justice can be increased to reduce sexual prejudice among substance abuse counselors.

It is important to note that this research study was the first in the sexual prejudice literature to empirically examine factors that predict sexual prejudice. Participants' religious beliefs, identifying sexual orientation as heterosexual, reporting racially as white, being familiar of sexual minority issues, experience level, recovery status, and female were all found to be associated with sexual prejudice among substance abuse counselors.

This study contributes to the overall understanding of the phenomena of sexual prejudice among substance abuse counselors. The use of a professional national organization, which yielded a large sample size that increased effect and power for this studies' results, may have increased generalization of the results among substance abuse counselors. By following the recommendation of using a national sample, the current knowledge base of sexual prejudice, both favorable and unfavorable, is increased.

Among participants, sexual prejudice was not evidenced significantly by the ATLG-S5 results. A significant contribution of this study can be interpreted to be the primary absence of sexual prejudice among substance abuse counselors in this national sample. It appears that sexual prejudice among these participants is relatively low.

However, the contributions of this study must be interpreted and generalized with caution, as sexual prejudice was found to be evident.

Implications of the Study

The contribution of the findings expands previous research by demonstrating significant correlations and predictors of sexual prejudice. This study contributes to the overall understanding of sexual prejudice by examining predictive factors of sexual prejudice. An in-depth analysis of the data found significant correlations and predictors of sexual prejudice. Therefore, the findings present several implications for counselor educators and teachers in other related disciplines.

The demographic characteristics of the study participants demonstrate that among substance abuse counselors, diversity is lacking. While it is generally accepted that substance abuse impacts individuals of all social classifications, substance abuse counselors of this study were primarily white and heterosexual. The possibility of matching clients and substance abuse counselors based on similarities may enhance rapport (Balkin, Schlosser, & Levitt, 2009), as clients have been found to prefer counselors who are similar to them (Liddle, 1999; McDermott et al., 1989). And yet, interestingly, in the area of recovery similarity, the recovery status of the substance abuse counselor has not made a difference in effectiveness or differences of treatment outcomes (Culbreth, 2000). Therefore, though clients may appear to prefer counselors of similarity, research has demonstrated that outcome effectiveness of therapy is not impacted by counselor similarity with clients. However, counselor similarity effectiveness among sexual minority individuals remains to be evaluated.

The participants of this study who identified as being in recovery were significantly correlated with sexual prejudice. It appears that substance abuse counselors in recovery have less sexual prejudice than counselors that not in recovery. Therefore, it is not surprising that sexual minority individuals have reported to have benefitted from recovering counselors (Mathews et al., 2006; McDermott et al., 1989). Recovering counselors' provided these clients with similarity and comfort, which provide a safe environment for marginalized clients, as recommended in previous research findings (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999).

A noted aspect of professional development among substance abuse counselors is varying education levels among recovering counselors (Culbreth, 2000). Culbreth (1999) reported that recovering substance abuse counselors have less education than non recovering counselors, which historically is consistent as early treatment of substance abuse issues was provided by lay persons (White, 2008). The noted trends of White (2008) and Culbreth (1999) are consistent with findings of this study. In comparing education level and recovery status, a significant negative correlation was identified. Yet, sexual prejudice among participants was less for participants in recovery, though these participants had less education than individuals not in recovery.

It appears that being in recovery encompasses a myriad of factors, of which, education is just one. The process of recovery, or 12 step principles of Alcoholic Anonymous (2001), may provide individuals additional insights and benefits beyond sobriety. A generally recognized element in substance abuse treatment and recovery is

spirituality or religious beliefs. The religious or spiritual element of recovery is recognized as important in maintaining sobriety by fostering an internal focus of individuals rather than on external aspects beyond the individuals' control. This may play a part in the reduced amount of sexual prejudice found in these recovering counselors.

Participant religious beliefs were a significant factor of sexual prejudice in this study. Of these participants' religious belief responses, comments along the conservative continuum appear to be more closely associated with sexually prejudiced responses. For participants responding along the conservative continuum, their religious beliefs may be perceived as they believe God is judgmental of immoral acts and very present in the world (Froese & Bader, 2007). These highly religious or conservative beliefs, possibly held by counselors, may influence their ability to be genuine and accepting with clients (Laythe, Finkel, Bringle, & Kirkpatrick, 2002) and complicate the therapeutic relationship by demonstrating less acceptance toward sexual minorities (Balkin et al., 2009). Religious beliefs were the strongest predictor of sexual prejudice identified in this study.

Research findings suggest that sexual minority individuals are already faced with limited services designed to meet their unique needs (Center for Substance Abuse Treatment, 2001; Lucksted, 2004). Substance use and abuse among sexual minority individuals exceeds that of heterosexuals (Cochran, Peavy, & Santa, 2007; Cochran, Ackerman, Mays, & Ross, 2004a; Gilman et al., 2001; Weber, 2008). This results in sexual minority individuals having greater needs for treatment, and possibly with more severe treatment needs, than heterosexual clients (Cochran, 2001).

Best practice treatment protocols, for sexual minority individuals with substance abuse needs recommends that treatment plans be individualized to the needs of the client and to the services offered by the treatment provider or treatment facility (Center for Substance Abuse Treatment, 2001; Substance Abuse and Mental Health Services Administration, 1999). For sexual minority individuals seeking treatment, sexual prejudice may impede treatment if their sexuality is not valued and respected in treatment planning (Bauermeister, 2007; Cochran et al., 2007; Ghindia & Kola, 1996; Mayer et al., 2008; McCabe et al., 2003; Sullivan, 2003).

Substance abuse counselors are required to follow ethical codes of conduct (American Counseling Association, 2005; International Association of Addictions and Offender Counselors (IAAOC), 2004; National Association for Alcoholism and Drug Abuse Counselors, 2004) and accredited counselor education programs are required to adhere to accreditation standards (Council for Accreditation of Counseling and Related Educational Programs, 2009). Contained within these codes and standards are specific behaviors prohibiting discriminatory practices while requiring social justice advocacy of marginalized individuals. Therefore, becoming multiculturally competent is inherently required among professional organizations and individual counselors. To ethically comply with such standards of multicultural competence, counselors and counselor educators must recognize, become aware of, and work to remove sexual prejudice wherever it exists.

Social advocacy policy and procedures that focus on sexual prejudice awareness and reduction is recommended by the results of this study. Sexual prejudice advocacy

focusing on sexual minority issues may now be an area of focus in the field of substance abuse counseling. Such efforts include awareness and professional development relevant to sexual prejudice and sexual minority individuals. Sexual prejudice awareness toward sexual minority individuals includes increasing sexual prejudice training opportunities and the inclusion of this topic as a standard part of the clinical supervision of counselors.

An interesting finding of this study is the influence of education upon sexual prejudice. Education was not a significant factor of sexual prejudice. Participants in this study who reported their education as nondegreed scored higher in sexual prejudice. This finding supports the idea that sexual prejudice is associated with less education (Eliason & Hughes, 2004; Shackelford & Besser, 2007). In terms of reducing sexual prejudice, it appears to take more than just education to achieve (Eliason & Hughes, 2004). As indicated by this study's findings, recovery status is an area that appears to reduce sexual prejudice, as being in recovery is strongly associated with having less sexual prejudice.

It appears that sexual prejudice mirrors the historical perspective of power and prejudice in American society. This power and prejudice phenomena are generally associated with white, conservative, heterosexual, males. The findings of this study found that sexual prejudice appears to follow this theoretical concept of prejudice and power. This theoretical generalization of power and prejudice, as indicated by the associated characteristics or variables, provides a physical manifestation of sexual prejudice.

Limitations

Several limitations of this study must be recognized and discussed as the results may have been impacted by factors that are beyond the control of the researcher. It is

important to address each limitation's relevancy to the research question, as the results should be interpreted with caution in relation to these limitating factors. These limitations include the defining of religious beliefs for each participant, socially desirable responses, and the generalizability of the findings.

Americans' overwhelmingly indicated a belief in God or a higher power, 95% (Gallup & Lindsay, 1999), a figure reported to have never dropped below 90% during the past fifty years (Miller & Thoresen, 2003). However, defining religious belief for participants of this study is beyond the scope of this study as opinions of God are personal, deeply impactful and can inspire life changes among individuals, social movements, as well as social conflicts (Froese & Bader, 2007). Therefore, socially desirable responding must be recognized as a factor in the results of this study.

Socially desirable responding is believed to be a significant factor of research involving self report data (Thomas, Grawitch, & Scandell, 2007). Specific to this study, socially desirable responding is a significant factor in attitudinal research (Schweitzer, Perkoulidis, Krome, Ludlow, & Ryan, 2005) and religious beliefs (Rowatt & Schmitt, 2003). Concerning this study's attitudinal research, socially desirable responding from NAADAC participants may have influenced the results and must be considered when interpreting or extending the results.

Findings of the study may not be generalizable to substance abuse counselors who are not members of this professional association. This study's results are only representative of individual members of NAADAC who completed the survey. Only

individual NAADAC members with a valid email address received an invitation to participate. This limitation may have influenced the response rate and the final results.

Recommendations for Future Research

This research study has provided substance abuse counselors and counselor educators with future research opportunities and directions for clinical practice. These recommendations include education, training, and awareness of sexual prejudice and sexual minority issues. The conclusions of this research study contribute to further understanding sexual prejudice among substance counselors; however, some important questions regarding sexual prejudice have emerged. This study found that sexual prejudice is significantly influenced by unique characteristics of substance abuse counselors. Future research should consider several areas in an effort to further understand issues of sexual prejudice among substance abuse counselors.

Although the response rate in this study was acceptable, limiting this study's research design to include only email and internet accessibility of a web-based survey may have been confining. Increasing recruitment venues and survey accessibility for participants may have increased the response rate. Increasing the response rate in future research would provide strength to future findings. Increasing the response rate may result in a more diverse pool of participants.

This research study was conducted among members of a national professional association. There may be differences between counselors of this organization and those who maintain other national, statewide, or local professional affiliations. In addition, there may be differences among counselors who are members of professional

associations and those who are not. Future research could be more inclusive of substance abuse counselors in general. By being more inclusionary of substance abuse counselors, future efforts may increase diversity among participants.

This study examined attitudes of sexual prejudice, which currently is a topic of contention in our society. Sexual prejudice and other exclusionary practices against marginalized groups or minority individuals is consistently a topic of national debate. Therefore, participants' responses may be biased due to social desirability. Social desirability bias occurs as participants, either consciously or unconsciously, attempt to respond in a socially acceptable manner (Paulhus, 1991). Future research involving attitude factors among participants would benefit from including specific measures to account for social desirability response bias.

Only one previous study (Mathews et al., 2005) closely resembled this study. Mathews et al. (2005) examined predicting sexually prejudicial behaviors toward sexual minority individuals. As attitudes are noted to be psychological tendencies (Eagly & Chaiken, 1993), based upon behaviors, beliefs, and affect (Herek, 2009b), this study is unique as having evaluated the attitudinal nature of sexual prejudice and associated variables. Intentionally, religious beliefs were not defined nor measured in this study. As such, participants were left to their own interpretation of liberal and conservative beliefs. Future research would benefit in utilizing instruments specific to the constructs of liberal-conservative religious beliefs along with sexual prejudice.

Finally, this study was a result of a comprehensive review of sexual prejudice literature. This study's research design was developed from gaps in the sexual prejudice

literature, as well as findings and recommendations from previous studies. Further research would benefit by replicating this study among substance abuse counselors from more diverse settings and associations, along with other helping professions.

Following these suggested recommendations may resolve questions arrived from the results of this study. Clearly, sexual prejudice toward sexual minority individuals is socially unjust, and this study attempts to provide a foundation of advocacy and awareness of sexual prejudice as it currently occurs among substance abuse counselors. The continuation of sexual prejudice research will increase awareness and social advocacy needs in the substance abuse counseling profession, and possibly other related professions.

Concluding Remarks

Since the first time two individuals met for the purpose of staying sober, the only issue of importance was sobriety. As the number of individuals who attempt to maintain or seek sobriety has increased tremendously over the decades, societal influences were bound to impact individuals afflicted with substance abuse. Substance abuse treatment is complex, with many believing that the treatment environment may well be a microcosm of society (Eliason, 2000). Therefore, the substance abuse arena is not immune from phenomena that occurs naturally within societies (Allport, 1954), such as prejudice and, more specifically, sexual prejudice.

Sexual prejudice, over the last two decades, has become the topic of national and religious debate. As society has begun to be aware of sexual prejudice, negative attitudes, and associated behavioral manifestations, social justice advocacy is gaining support.

Social justice advocacy efforts may be grounded by Allport's (1954) postulation that prejudice is ill thinking toward marginalized groups and individuals without justification. However, religious beliefs may provide justification for individuals possessing sexual prejudice as foundations of sexual prejudice have been found to exist in religious traditions (Kinsey et al., 1948; Sullivan, 2003).

As substance abuse counselors are not exempt from having religious beliefs, it is apparent that sexual prejudice may exist among individuals of the profession. Sexual prejudices exist in society and other professions as well. However, substance abuse counselors have ethical standards to uphold which are not supportive of prejudice and specifically speak to gaining awareness and insight to alleviate any prejudice of marginalized individuals or groups.

The results of this study suggest that sexual prejudice does exist among substance abuse counselors and that there are many significant factors associated with this existence. As a result of clarifying the importance of sexual prejudice variables, awareness of these characteristics may be heightened. Counselor education program faculty, clinical supervisors, and professional development trainers can gain from these results by implementing social advocacy policy and procedures that focus on sexual prejudice, specifically designing strategies that target these associated sexual prejudice characteristics.

Sexual prejudice historically has negatively impacted the lives of sexual minority individuals. Abusing substances increases the level of distress associated with being a member of a marginalized group. As these individuals seek treatment to relieve substance

related impairments, encountering sexual prejudice is not beneficial to successful treatment outcomes. Conducting this type of research that seeks to decrease sexual prejudice will better prepare not only substance abuse counselors, but hopefully, counselors of all specialty areas, to meet the unique needs of this marginalized group of sexual minority individuals.

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APPENDIX A: INTRODUCTORY EMAIL

Dear Substance Abuse Professional Counselor,

You have been selected to receive this email as an invitation to participate in an online survey titled "Attitudes of Substance Abuse Counselors toward Sexual Minorities" as part of my dissertation requirements for the Doctor of Philosophy Degree in counseling at the University of North Carolina at Charlotte. With the exception of demographic information, this survey instrument, the Attitude Toward Lesbians and Gay Men (ATLG-S5), has been used in previous studies **(Eliason & Hughes, 2004; Herek, 1994).** The purpose of this study is to examine attitudes of practicing substance abuse counselors and not intended to offend but gather information regarding attitudes toward sexual minority individuals.

You are receiving this email directly from the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), The Association for Addiction Professionals, though this study does not express or represent the beliefs or opinions of NAADAC. Any inquiries regarding this survey should be directed to Jamie Powell, jepowell@jepowell@uncc.edu or phone 828-657-5923. This study has received UNC-Charlotte's Institutional Review Board (IRB) for Research with Human Subjects approval.

The survey will take approximately less than 15 minutes to complete. Your participation in this research will be a valuable contribution to the field of substance abuse counseling. If you choose to participate in this study, the information you provide will be anonymous and confidential. There is no identifying information being sought in your responses. You may choose to withdraw from participation at any time without penalty.

Please click on the following link to complete the survey.
https://www.surveymonkey.com/s.aspx?sm=ixsvlrdT6hKFlG8SN78KRw_3d_3d

Your participation is greatly appreciated. Thank You

James Powell, M.A.,
Doctoral Candidate
Department of Counseling, University of North Carolina at Charlotte

APPENDIX B: INTRODUCTORY RESEND EMAIL

Dear Substance Abuse Professional Counselor,

Due to previous technical difficulty, you may have received an earlier email invitation to participate in the study below. This previous email may or may not, have possibly contained confusing strikethrough text. The confusing appearance may have influenced your decision to participate in the study. Therefore, we apologize and are resending this email, in the hope that you receive a concise email to assist in your participation consideration.

You have been selected to receive this email as an invitation to participate in an online survey titled "Attitudes of Substance Abuse Counselors toward Sexual Minorities". This survey is part of my dissertation requirements for the Doctor of Philosophy Degree in counseling at the University of North Carolina at Charlotte, with Dr. John Culbreth serving as my Dissertation Chair. With the exception of demographic information, this survey instrument, the Attitude Toward Lesbians and Gay Men (ATLG-S5), has been used in previous studies **(Eliason & Hughes, 2004; Herek, 1994).** The purpose of this study is to examine attitudes of practicing substance abuse counselors and not intended to offend but gather information regarding attitudes toward sexual minority individuals.

If you have already participated in this study, please disregard this email. However, if you have NOT yet participated, please read this email and consider participating. Your participation is greatly appreciated.

You are receiving this email directly from the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), The Association for Addiction Professionals, though this study does not express or represent the beliefs or opinions of NAADAC. Any inquiries regarding this survey should be directed to Jamie Powell, jepowell@jepowell@uncc.edu or phone 828-657-5923. This study has received UNC-Charlotte's Institutional Review Board (IRB) for Research with Human Subjects approval.

The survey will take approximately less than 15 minutes to complete. Your participation in carrying out this research will be valuable

contributions to the field of substance abuse counseling. If you choose to participate in this study, your information will information will be anonymous, confidential. There is no identifying information being sought in your possible responses. You may choose to withdraw from participation at any time without penalty.

Please click on the following link to complete the survey.
https://www.surveymonkey.com/s.aspx?sm=ixsvlrdT6hKFlG8SN78KRw_3d_3d

Again, your participation is greatly appreciated. Thank You

James Powell, M.A.,
Doctoral Candidate
Department of Counseling
University of North Carolina at Charlotte

APPENDIX C: SUBSEQUENT FOLLOW UP EMAIL

Dear Substance Abuse Professional Counselor,

If you have already participated in this study, please disregard this email. However, if you have NOT yet participated, please read this email and consider participating. Your participation is greatly appreciated. This is the final email participation solicitation of this study. The survey will close on August 17th. 2009 and NOT be available on August 18th, 2009.

You have been selected to receive this email as an invitation to participate in an online survey titled "Attitudes of Substance Abuse Counselors toward Sexual Minorities". This survey is part of my dissertation requirements for the Doctor of Philosophy Degree in counseling at the University of North Carolina at Charlotte, with Dr. John Culbreth serving as my Dissertation Chair. With the exception of demographic information, this survey instrument, the Attitude Toward Lesbians and Gay Men (ATLG-S5), has been used in previous studies (Eliason & Hughes, 2004; Herek, 1994). The purpose of this study is to examine attitudes of practicing substance abuse counselors and not intended to offend but gather information regarding attitudes toward sexual minority individuals.

You are receiving this email directly from the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), The Association for Addiction Professionals, though this study does not express or represent the beliefs or opinions of NAADAC. Any inquiries regarding this survey should be directed to Jamie Powell, jepowell@jepowell@uncc.edu or phone 828-657-5923. This study has received UNC-Charlotte's Institutional Review Board (IRB) for Research with Human Subjects approval.

The survey will take approximately less than 15 minutes to complete. Your participation in carrying out this research will be valuable contributions to the field of substance abuse counseling. If you choose to participate in this study, your information will information will be anonymous, confidential. There is no identifying information being sought in your possible responses. You may choose to withdraw from participation at any time without penalty.

Please click on the following link to complete the survey.
https://www.surveymonkey.com/s.aspx?sm=ixsvlrdT6hKFlG8SN78KRw_3d_3d

Again, your participation is greatly appreciated. Thank You

James Powell, M.A.,
Doctoral Candidate
Department of Counseling
University of North Carolina at Charlotte

APPENDIX D: INFORMED CONSENT

Dear Participant,

As a substance abuse counseling professional you are invited to participate in a quantitative research study that will examine attitudes of practicing substance abuse counselors toward sexual minority individuals. You are eligible to participate because you are an individual member of the National Association of Alcohol and Drug Abuse Counselors (NAADAC), and you are located geographically in the United States. Your participation will involve completing a brief survey.

The study will take approximately 10-15 minutes. The data collected by the investigators will not contain any identifying information or any link back to your participation in this study. Therefore, any information collected will be anonymous and confidential.
The benefits of your participation in this human subjects study include contributing to the current knowledge, characteristics, and views regarding issues in the substance abuse profession. The results may assist substance abuse counselor educators in curriculum development for current and future substance abuse counselors and trainees.

A potential risk may involve uncomfortable emotions. Should this occur, the researcher, a Licensed Professional Counselor in private practice, will be available through email (jepowell@uncc.edu) or direct telephone contact at 828-657-5923. As with all on-line and web-based interactions, there is always the risk of intrusion. Virus scans and firewalls can add greater security for anyone utilizing the Internet. These risks have been anticipated, and to further minimize the possibility of these risks, the researcher is utilizing Secure Sockets Layer (SSL) encryption within the survey server and database. You may withdraw or decline at any time.

You are a volunteer. The decision to participate in this study is completely up to you. If you decide to be in the study, you may change your mind at any point in the process and stop without penalty.

UNC Charlotte intends to ensure that you are treated in a fair and respectful manner. Contact the University's Research Compliance Office at 704-687-3309 at any time if you have questions about how you are being treated as a study participant. If you have questions about the

research study, you may contact me, James Powell at 828-657-5923 or my Dissertation Chair, Dr. John R. Culbreth at 704-687-8973.

By clicking on the “Next” button at the bottom of this screen, you are indicating that you have read the above information and consent to participate in this study. You are also agreeing that you are currently located in a United States geographic region, and you are a member of NAADAC. Click "Next" to AGREE to participate and continue to the survey.

Thank you for taking the time to participate.
Sincerely,

James Powell, M.A.,
Doctoral Candidate
Department of Counseling
University of North Carolina at
at Charlotte

John R. Culbreth, PhD.
Dissertation Chair
Department of Counseling
University of North Carolina
at Charlotte

APPENDIX E: SEXUAL MINORITY BELIEFS

Instrument: ATLG-S5 (Herek, 1994) Modified by Eliason and Hughes (2004)

Please check only one response to each statement below that you feel best describes your perspective about sexual minority individuals.

Lesbians just can't fit into our society.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

State laws regulating private, consenting lesbian behavior should be loosened. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Female homosexuality is a sin.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Female homosexuality in itself is not a problem, but what society makes of it can be a problem. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Lesbians are sick.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

I think male homosexuals are disgusting.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Male homosexuality is a perversion.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Just as in other species, male homosexuality is a natural expression of sexuality in man. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Homosexual behavior between two men is just plain wrong.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Male homosexuality is merely a different kind of lifestyle that should not be condemned. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Bisexuals are sick.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

All people are probably born bisexual. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

There is no place in the moral fabric of society for bisexuality.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Bisexuality is merely one of many variants of human sexuality. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

There should be stricter laws regarding bisexual behavior.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Transgendered people are sick.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Laws that regulate people's expression of gender should be removed. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

God made man and woman: anything else is abnormal.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

Having only two sexes is limiting: transgendered people are an expression of the continuum of gender. *
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

It is necessary to have clear distinctions between women and men.
☐ Strongly Disagree ☐ Disagree somewhat ☐ Neither agree nor disagree ☐ Agree Somewhat ☐ Strongly Agree

*=Items Reversed Scored.
All of the items were rated on a

APPENDIX F: DEMOGRAPHICS

Please check the appropriate box that best describes you.

Gender
☐ Male ☐ Female

What is your age? (Drop down)
Please select from the "Click Here" Menu. Response choices:
18-80

What is your ethnicity?
☐ Caucasian ☐ Latino/Latina ☐ African American
☐ Asian American ☐ Native American ☐ Multi-racial
☐ Other

What is your geographical location? (Drop Down)
Please select from the "Click Here" Menu. Response choices:
Midwest
Northeast
South
West

Please select the response that best describes your highest educational achievement. (Drop Down)
Please select from the "Click Here" Menu. Response choices:
Completed high school
Completed trade or business school
Some college
Completed bachelor's degree
Some master's level work
Completed master's degree
Some doctoral work
Completed doctoral degree

Please select the response that best describes your years of experience as a substance abuse counselor?
DROP DOWN
Please select from the "Click Here" Menu. Response choices:
0-50

I consider my religious views or values to be: (Drop Down)
Please select from the "Click Here" Menu. Response choices:
Strongly conservative
Conservative
Slightly More Conservative than liberal
Slightly More Liberal than conservative
Liberal
Strongly liberal

What is your recovery status?
☐ In Recovery ☐ Not in Recovery

How familiar are you with issues specific to sexual minorities, such as "coming out" models, legal and social impacts of being a sexual minority? (Drop Down)
Please select from the "Click Here" Menu. Response choices:
Not familiar
Familiar
Very familiar

To the best of your knowledge, have you ever had personal contact with a sexual minority individual, either in a social, family, or professional context?
☐ Yes ☐ No ☐ Unknown

How do you describe your Sexual Orientation? (Drop Down)
Please select from the "Click Here" Menu. Response choices:
Bi-sexual
Heterosexual
Homosexual
Lesbian
Transgendered

If you would like to provide additional comments, please use the space below.

APPENDIX G: INSTITUTIONAL REVIEW BOARD APPROVAL

UNC CHARLOTTE

Compliance Office / Office of Research Services

9201 University City Blvd, Charlotte, NC 28223-0001
t/ 704.687.3311 f/ 704.687.2292 www.research.uncc.edu/comp/complian.cfm

Institutional Review Board (IRB) for Research with Human Subjects

Certificate of Approval

Protocol #	**09-05-25**		
Protocol Type:	**Expedited**	7	
Title:	**Evaluating Sexual Prejudice Among Substance Abuse Counselors**		
Initial Approval:	**6/24/2009**		
Student Investigator	**Mr. James**	**Powell**	**Counseling**
Responsible Faculty	**Dr. John**	**Culbreth**	**Counseling**
Co-investigator	**Dr. Claudia**	**Flowers**	**Educational Leadership**

After careful review, the protocol listed above was approved by the Institutional Review Board (IRB) for Research with Human Subjects. This approval will expire one year from the date of this letter. In order to continue conducting research under this protocol after one year, the "Annual Protocol Renewal Form" must be submitted to the IRB. This form can be obtained from the Office of Research Services web page. (www.research.uncc.edu/comp/human.cfm).

Please note that it is the investigator's responsibility to promptly inform the committee of any changes in the proposed research prior to implementing the changes, and of any adverse events or unanticipated risks to subjects or others. Amendment and Event Reporting forms are available on our web page at http://www.research.uncc.edu/Comp/human.cfm.

M. Lyn Exum 6-23-09

Dr. M. Lyn Exum, IRB Chair Date

Table 9

Correlation Matrix for Dependent Variable and Independent Variables

Factors	1	2	3	4	5	6	7	8	9	10
1. ATLG-S5	1	**-.656	-.041	**-.104	**-.127	**-.151	**-.135	**-.222	**.243	**-.234
2. Religious		1	.019	**.105	.049	.032	**.137	.093*	**.127	-.047
3. Education			1	-.077	**.135	-.044	**.254	**-.173	**.140	-.031
4. Female				1	**-.135	.011	**-.137	**-.143	*-.091	.020
5. Age					1	*.091	**.567	**.194	**.104	-.030
6. Yrs.Ex.						1	-.011	**.131	-.026	
7. Recovery							1	.060	-.053	
8. Familiarity								1	-.039	
9. Hetero										
10. White										

Note. *Correlation is significant at the 0.05 level (2-tailed). **Correlation is significant at the 0.01 level (2-tailed).
ATLG-S5=Attitude Toward Lesbians and Gay Men as modified by Eliason (2000), Eliason and Hughes (2004).