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Mexican American counselor and client: Perceptions toward substance use disorders

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MEXICAN AMERICAN COUNSELOR AND CLIENT: PERCEPTIONS TOWARD SUBSTANCE USE DISORDERS

A Dissertation

by

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ABSTRACT

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Over 28.6 million Americans have admitted to the ongoing use of illicit drugs and more than half of Americans are current alcohol drinkers yet a significant number of these people do not seek treatment. Trends regarding substance-related treatment have shown Hispanic drug users tend to underutilize drug and alcohol services and treatment avoidance is especially prevalent among Mexican Americans who reside along the US-Mexico border, due in part to the stigma associated with substance use. In addition, counselor attitudes as well as student counselors-in-training attitudes are showing a manifestation of the same kind of stigma toward substance use as the public. The present study was conducted at a large university located on the Texas-Mexico border and included: professional counselors, graduate students-in-training, and clients receiving treatment services for substance use disorders (SUDs). The purpose of the study was to compare perceived stigma of SUDs and to assess for socially desirable responses to rule-out bias. No significance was found in the differences of mean scores between professional counselors, students-in-training, and clients measuring perceived stigma of substance use disorder. However, significant differences were found among the groups on a measure of socially desirable responding, which may indicate participants' responses were socially biased. Implications of the study and recommendations for future research are provided.

DEDICATION

My daily, weekly, monthly, and yearly inspiration to complete this dissertation was the love from my darling wife, Jennifer as well as my two sons, Benjamin and Bruce. This achievement is also dedicated to my parents who have supported and encouraged my scholastic endeavors since childhood. Finally, this dissertation is dedicated to all persons who have experienced life with substance use disorders, their families, and those who dedicate their lives to treating the disorder.

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CHAPTER I

INTRODUCTION

According to the Substance Abuse and Mental Health Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), over 28.6 million Americans (10.6% of the general population) have admitted to the ongoing use of illicit drugs and more than half of Americans (136.7 million) reported they are current alcohol drinkers (SAMHSA, 2017). Moreover, a significant number of individuals surveyed who were alcohol or drug users reported they did not seek treatment for their condition once the substance use developed into a Substance Use Disorder (SUD) as classified in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013). Survey data also showed 21 million individuals (7.8% of the population) were determined to be in need of treatment for either an illicit drug or alcohol use problem yet only one in seven in need of treatment (3.8 million) actually received treatment (SAMHSA). The incongruity between those in need of substance abuse treatment and those who actually received substance abuse services is not likely due to a lack of substance abuse counselors who can provide the service. According to the Occupational Outlook Handbook (Bureau of Labor Statistics, [BLS] 2017), the demand for professionals to provide substance abuse treatment services is, in fact, rising. The BLS projects a 20% increase in positions for substance abuse and behavioral disorder counselors from 2016 through 2026, a much higher than average increase compared to other professions. However, further questioning by the investigators of the NSDUH found the vast majority of people in need

of substance abuse treatment (19 million individuals) did not receive treatment through specialty facilities such as designated alcohol and drug rehabilitation programs (SAMHSA).

Specialty alcohol/drug treatment programs and counselors are not the only avenue to achieving sobriety. Of the few individuals who sought help for their SUD, most received help through the attendance of self-help groups such as *Alcoholics Anonymous* or *Narcotics Anonymous* rather than attendance at either an outpatient or residential rehabilitation setting; a difference of about 1.6 million (SAMHSA, 2017). Additional data collected from the NSDUH provides specific responses pertaining to reasons why people who needed treatment and made an effort to receive treatment failed to pursue such treatment. Almost half of the respondents (45.5%) reported they did not seek treatment due to a lack of insurance coverage and related health care costs. Of the remaining individuals, 29.5% attributed their failure to seek treatment due to a lack of motivation for services. Additionally, 17% attributed their absence from treatment due to logistical reasons (e.g., lack of transportation, lack of treatment programs in the area), and 13% admitted to not seeking treatment because of fear of the negative association that might accompany their reputations in the eyes of others. This negative association is likely to include the negative perceptions from their employers, neighbors, and other community members. Indeed, such concerns are well documented in the literature (e.g., Ali, Teich, & Mutter, 2017; Bathje & Pryor, 2011; Cooper, Campbell, Larance, Murnion, & Nielson, 2018; Corrigan, 2004; Eisenberg, Downs, Golberstein, & Zivin, 2009; Franz, Carter, Leiner, Bergner, Thompson, & Compton, 2010; Jackson & Shannon, 2012; McFarling, D'Angelo, & Drain, 2011) via reports from individuals who chose to forgo rehabilitative services due to the anticipation of negative perceptions by others.

Culture and an individual's race/ethnicity are other factors to consider when investigating disparities in receiving substance use treatment services in that data on the rates of SUDs reflects discrepancies in the rates among various races/ethnicities. For example, the documented rate of Hispanic individuals over the age of 18 who develop a SUD is slightly lower than the rate of White individuals who meet the criteria for a SUD; 7.1% for Hispanics compared to the national average of 7.8% (SAMHSA, 2013) and this slight difference in rates between race/ethnicity has been exhibited for the past several years (SAMHSA). However, the descriptive statistics made available from the survey do not accurately depict some of the existing racial and ethnic disparities regarding the number of individuals who receive treatment. Currently, only about 0.5% (or 205,000) of Hispanics report receiving specialty treatment for a substance use disorder, which is slightly less than the national average of 0.6% (SAMHSA). Further investigation is necessary to determine how cultural perceptions of substance use may affect an individual's motives to seek specialty services.

Many Hispanics enter treatment programs as a means to comply with conditions set forth by an external agency, notably the criminal justice system or social services agencies. The data collected from the national survey on SUDs (SAMHSA, 2017) directly reflects the discrepancy between the types of Hispanic individuals who are clinically in need of treatment from Hispanic individuals who actually received treatment. In-depth sociodemographic data collected by Reif, Horgan, and Ritter (2008) provided a statistical representation of the typical Hispanic who receives treatment. The majority of participants (71%) were referred to treatment services through the legal system (i.e., probation offices, parole offices, and drug courts) for various alcohol and drug-related arrests, with no other dependable payment source for services available to them other than funding from the criminal justice system. The percentage of those Hispanics

who were self-referred for services, or those wishing to attend only by their own accord, was drastically lower when compared to non-Hispanic whites who sought treatment, 15% and 29.5% respectively. The trend among Hispanics receiving substance-related treatment has not changed over the years. For example, Mancini, Salas-Wright, and Vaughn (2015) found Hispanic drug users were less likely than non-Hispanic white drug users to have utilized any type of substance abuse treatment. Data (Wallisch, Zemore, Cherpitel, & Borges, 2017) also shows Hispanics are less likely to receive treatment for SUDs if they live along the US-Mexico border. This comparison provides insight regarding the possibility that persons of Hispanic origin may seek treatment less often for SUDs than Whites due to cultural factors, including the avoidance of possible judgment from others. The largest group of Hispanics in the U.S., those of Mexican origin, account for the highest need of treatment services for SUDs among Hispanics and rank only second behind Native Americans as the race/ethnic group most likely to develop a SUD (SAMHSA). As such, further information is necessary to effectively reduce barriers to treatment services by clinicians who serve Mexican/Mexican American Hispanics.

Trends regarding substance-related treatment attendance have shown Mexican Americans have consistently avoided seeking substance abuse treatment and mental health services (Abreu & Sasaki, 2004; Chartier & Caetano, 2011; Gonzalez, 1997; Guerrero et al., 2017; Reingle et al., 2014; Wallisch et al., 2017). Once Mexican Americans are admitted into treatment, they tend to "drop out" of services sooner than completion of the recommended course of treatment and the retention rates of those who remain in treatment services are less than Caucasians (Chartier, et al., 2015; Saloner & Le Cook, 2013). The perceived public stigma of receiving services for a mental health or SUDs is among one of the recurring factors attributed to the poor utilization of services by Mexican Americans (Fripp & Carlson, 2017; Livingston, Milne, Lan Fang, & Amari,

2011). To a greater degree, within the Mexican American culture, avoidance of attending counseling services is also a means to prevent shame upon the family. It has been noted Hispanic parents are less likely than Caucasian parents to utilize substance abuse services (either outpatient or residential) for their adolescent children when they are most in need (Loza, Castañeda, & Diedrich, 2017) and this lack of utilization can be seen among Hispanic families, regardless of their recent immigration status (Mancini et al., 2015). The ongoing reluctance to utilize substance use treatment facilities indicates Hispanic parents may not want to acknowledge their children have SUDs and could benefit from treatment, a similar Hispanic reaction to the need for mental health services in general (SAMHSA, 2017). Despite efforts made by clinicians to conduct outreach for underserved populations, such as Hispanics (Haughwout, Harford, Castle, & Grant, 2016), there still exists a significant gap in service delivery which indicates the problem may not be a physical barrier to services but rather an attitudinal barrier to services.

The dominant American culture views illicit drug use as problematic, dangerous, generally unacceptable, and shameful (Birtel, Wood, & Kempa, 2017; da Silveira et al., 2018; Nielsen, 2010). Attitudes toward illicit substance use is congruent with policies regarding punitive actions endorsed by American legislation against users of illicit substances. For example, illicit drug-related violations are the single largest category of arrests among federal prisoners, which accounts for over the majority (83%) of incarcerated offenders (Federal Bureau of Investigation, 2016). However, typical users of legal substances such as alcohol and tobacco are not as stigmatized by the general public as those who are known to use illicit substances. Data collected from the National Survey on Drug Use and Health (SAMHSA, 2017) provides an illustration of the variation of substance use rates among different races/ethnicities in the responses offered by their national sample. Therefore, it is possible a variation in the

perceptions, or the acceptance of substance use among these races/ethnicities may also exist. A thorough understanding of how different races/ethnicities perceive substance use may affect the cultural norms and the subsequent influence culture has on an individual's perception of substance use (Evans, Grella, Washington, & Upchurch, 2017). Despite the potential benefits of knowing how disparities in perceptions among races/ethnicities may affect certain individuals, few studies have been published on the perception of substance use and stigma among various races/ethnicities.

There is limited research dedicated to measuring perceptions of substance use or SUDs. Perhaps the most prominent study on the matter is the annual collection of data on substance use and perceived risk of use by a national survey known as *Monitoring the Future* ([MTF] Johnston et al., 2018). The MTF survey is funded by the National Institute on Drug Abuse as an ongoing investigation in substance use trends and perceptions about substance use by adolescents. Demographic information such as race/ethnicity is ascertained from students along with their current patterns of substance use and perceptions of risk of substance use by particular substances. Given the nature of onset of substance use, MTF's intended focus is on adolescents attending secondary schools (Johnston et al.). Based on the availability of the disseminated information following the annual publication of MTF, much of the subsequent literature investigates perceptions of drug use and drug use norms among races/ethnicities, with a focus on adolescents. Specifically, adolescents who attend either secondary school or college are used as the primary targets of studies measuring perceptions of drug use (Javier, Belgrave, Hill, & Richardson, 2013; Johnston et al.). Among the published studies which investigated perceptions toward drug use and SUDs, there are few that focus solely on the influence of race/ethnicity on the development of SUDs among individuals. Additionally, a search of the literature on attitudes

toward SUDs among people of Hispanics, especially those of Mexican origin, yields limited information.

Corrigan and Watson (2007) found a person's ethnicity to be a factor on the degree of stigma an individual experiences due to a mental illness or SUDs. Broad generalizations from their study found non-Whites (ethnic minorities including Hispanics) were more likely to endorse stigma about people with mental illness and SUDs than non-Whites. Although their results were contrary to their hypothesis about prejudice sensitivity from ethnic groups, Corrigan and Watson did not further explore sub-analyses of ethnic groups (e.g., African Americans, Hispanics). Thus, it remains unclear as to the extent which Hispanics stigmatize SUDs among themselves.

First-hand accounts of views on substance use from a Latino community collected by Hadjicostandi and Cheurprakobkit (2002) reflected a negative attitude toward illicit drug use which is consistent with previous findings regarding illicit drug use by the general public. Specifically, Hadjicostandi and Cheurprakobkit surveyed a Hispanic community located in central Texas to ascertain views on substance use and its association with greater issues in the community, including family violence and crime. The researchers found the use of alcohol and tobacco was perceived by Latinos as a more severe problem than illicit drug use and the use of alcohol and tobacco were more strongly associated with family problems than illicit drug use. The attitudes Hispanics have expressed toward illicit substance use is surprisingly congruent with the national view that persons with SUDs are more dangerous than others and many Mexican Americans agree that substance use in their communities poses a problem to their family values and safety (Hadjicostandi & Cheurprakobkit). Additional research shows an ongoing trend on Hispanic's negative views toward substance use despite evidence indicating

substance use has become normalized in predominantly Hispanic communities (Gilliard-Matthews, Stevens, Nilsen, & Dunaey, 2015; Vasilenko, Evans-Polce, & Lanza, 2017).

Theoretical Framework

Many individuals with physical disabilities, mental illnesses, and SUDs are discriminated against by the majority of society due to social constructs which identify them as belonging to a minority class. Weiner's (1986) description of attribution theory, as it applies to psychiatric disabilities and substance abuse, indicates the majority of the general public view individuals with substance use disorders (SUDs) as having control over the onset and continuation of their conditions. Characteristics of individuals with SUDs, as outlined by Weiner, include individuals exercising control over their symptoms, which leads the general population to judge these people in a negative manner. Individuals with specific conditions such as drug/alcohol dependence, obesity, and Posttraumatic Stress Disorder, for example, are viewed as lacking moral characteristics such as the willpower or self-control which are necessary to overcome these disorders (Angermeyer & Dietrich, 2006; Ward, Bowman, & Jones, 2015). Conversely, individuals with physical disabilities who experience limitations due to their symptoms are viewed as lacking control over their conditions and the consensual public perception toward these people is typically of a sympathetic nature (Morales & Roge, 2016; Mosher & Danoff-Burg, 2008; Werner, 2015). The reactions toward individuals with either a mental or behavioral disorder, also known as mental-behavioral stigmas, have been documented as eliciting emotions of anger or aggression toward these individuals (Link, Phelan, & Sullivan, 2017) and people in the general public felt as though individuals with intellectual disabilities should have less fundamental rights than those with physical disabilities (Werner).

Evidence suggests individuals with SUDs are highly susceptible to public stigma as a result of their condition. The concept of behaviors related to substance abuse and development of a SUD is often attributed to a weakness in the morality of the individual which can cease or be controlled through the practice of self-discipline and alignment with spirituality (Henderson & Dressler, 2017; Weiner, 1986). According to attribution theory, the perceived cause of the stigma should determine affective reactions toward the stigmatized individuals, such as anger and pity. Since the general consensus about SUDs is they are a direct result of the individual's willpower, attribution theory maintains these individuals will be subject to ridicule, anger, and pity from others, including family members. While many studies (e.g., Werner & Araten-Bergman, 2017, Werner et al., 2012) have attempted to develop a theoretical model of public stigma on intellectual disability research, the field of rehabilitation has fallen behind some of the research on stigma conducted by mental health investigators (Corrigan, Markowitz, & Watson, 2004; Heary, Hennessy, Swords, & Corrigan, 2017; Link & Phelan, 2001).

Statement of the Problem

Stigma associated with substance use is not only a significant barrier to engaging in treatment services but may also be a barrier to receiving quality services. Evidence of a poor therapeutic relationship between patients who use illicit substances and health care professionals due to negative perceptions from the health care professionals is well documented (Allen & Olson, 2016; Ford, Bammer, & Becker, 2007; McLellan, Lewis, O'Brien, & Kleber, 2000). Mental health, rehabilitation, and even licensed substance abuse counselors are not immune from manifesting bias toward people with a SUD as they begin counseling and other health services (Chasek, Jorgensen, & Maxson, 2012; Geibel et al., 2017; Varas-Diaz & Neilands, 2009). The bias among counselors toward individuals with SUDs may be noted by clients themselves during

the course of treatment, thus confirming their belief that substance use and addiction occur due to their own faults. This stigma may lead the client to feel embarrassment, shame, and distrust toward their counselor as well as a negative perception toward substance abuse counseling in general. An investigation of the perception of stigma among people receiving substance abuse treatment services revealed a similar attitude among themselves and others with SUDs. For example, Luoma et al. (2007) found evidence which supports the notion that many individuals with SUDs strongly believe themselves and other substance users to be morally weak and subsequently experience shame about their substance disorder. Luoma also noted individuals with SUDs acknowledged this moral weakness and shame often dissuaded their decision to seek rehabilitative treatment services.

Another variable that merits investigation regarding differences in attitudes toward individuals with SUDs is the educational disciplines of counseling by service providers. Research conducted by Trevo, Palmer, and Redinius (2004) indicated significant attitude differences among general health professionals from different educational disciplines toward individuals presenting with physical disabilities. Among the many variables believed to influence attitudes was the specific type of educational courses in which students had been enrolled. The investigators found students who attended curriculum that emphasized the intrinsic worth of patients beyond the disability presented with more positive and favorable attitudes toward patients with disabilities than those who did not attend the curriculum. However, the investigators noted it was unclear whether the differences found among health care professionals' attitudes toward persons with physical disabilities would be comparable to attitudes toward persons with SUDs.

Researchers who have attempted to accurately measure the attitudes of service providers toward individuals with SUDs have suggested the benefits of specialized training for those providing services to this population (Geibel et al., 2017; Iarussi, Perjessy, & Reed, 2013; Sias, Lambie, & Foster, 2006). It has been suggested though researchers and practitioners are aware of the concept of SUDs as a disease, they continue to view individuals as responsible for their substance use (Johnston et al., 2018). Evidence has shown these attitudes exist even among practitioners who hold advance graduate degrees and receive education on the disease concept of addiction (Moro, Wahesh, Likis-Werle, & Smith, 2016). Of particular interest is the lack of education or informing practitioners provide their clients about the disease concept of addiction for fear it may encourage clients to excuse their substance use behavior (Bell et al., 2014). Further investigation is necessary in order to properly measure how different educational curriculum could influence students' perceptions toward people with SUDs.

Background and Significance of the Study

The rate of SUDs remains constant within the general population (approximately 11% to 12% of people in the U.S.) as reported through data collected from national surveys during the past 10 years (SAMHSA, 2017). It seems inevitable given the ubiquitous nature of substance use, human service providers will find themselves rendering services to individuals with a SUD. Salyers, Ritchie, Cochrane, and Roseman (2006) published a review on the lack of training available to graduate student counselors by programs accredited by the Council for Accreditation of Counseling & Related Educational Programs (CACREP). Graduate programs offering either master or doctoral degrees accredited by CACREP at the time of the aforementioned study were not required to provide formal training on substance abuse or addictions. Respondents of several CACREP-accredited programs indicated they did not receive formal training about substance

abuse issues through a dedicated academic course, but rather from their clinical experiences in either practicum or internship courses. A revision in standards published by CACREP in 2009 addressed this lack of substance abuse training, yet many institutions are only beginning to implement these standards (Lee, Craig, Fetherson, & Simpson, 2013). The latest revision in standards published by CACREP for 2016 state entry-level counselor education programs must, at a minimum, address "theories and etiology of addictions and addictive behaviors" (CACREP, 2015). Most institutions are accomplishing this by including a course on addiction counseling as part of their curriculum, though the standards encourage that addiction topics be addressed across their core curriculum.

The Commission on Rehabilitation Counselor Certification examination does not specifically test prospective rehabilitation counselors on their knowledge of SUDs. However, both certified rehabilitation counselors (CRCs) and licensed professional counselors (LPCs) are encouraged by their licensure boards to obtain training in methods that properly address substance abuse issues affecting people with diverse needs (Linton, 2012). The recent implementation of standards for graduate programs to address substance use implemented by CACREP foreshadows the possibility that academic programs and licensure boards may soon require competencies and knowledge of substance abuse.

The insufficient training of addiction knowledge among graduate programs is a problem rehabilitation counselors have acknowledged for decades and is why experienced practitioners agree experience should weigh greater than education when serving clients with SUDs (Laschober, de Tormes Eby, & Sauer, 2013, Moro et al, 2016). Of the various issues that may arise when serving a consumer who has been diagnosed with a SUD, the most mindful counselor should be aware of their own personal attitudes toward the consumer/client who is seeking

services. West and Miller (1999) measured attitudes of vocational rehabilitation counselors toward individuals with SUDs and found counselors were serving these individuals below satisfactory levels. The authors ultimately determined that potential personal biases of the rehabilitation counselor may have contributed to substandard services provided to clients/consumers. The researchers also reported a positive correlation between prior substance abuse-related education/training obtained by the vocational rehabilitation counselor and positive attitude scores toward substance abusing clients. The amount of training reported by those CRCs who viewed individuals with SUDs in a positive manner varied from as brief as a one-day workshop to formal graduate coursework. Yet implementation of addiction courses by educators has been stagnant as graduate counseling education programs are not universally providing students with addiction education (Lee et al., 2013; Lee, 2014). The results of the present study may provide substance abuse and rehabilitation professionals with a better understanding of how to provide appropriate training to Mexican American Counselors in Training.

Purpose of the Study

The purpose of this study was to examine the discrepancies between graduate counseling students-in-training and practicing counselors' perceptions toward individuals with SUDs. The study also examined the self-stigma experienced among Mexican American individuals with SUDs. The intention was to provide justification for existing curricula in graduate counseling programs to be appropriately augmented to provide satisfactory training and education geared toward counseling individuals with SUDs, to include consideration for potentially negative attitudes manifested by graduate counselors. Particularly, the focus of this study was on stigma toward substance abuse and related cultural factors reported by graduate-level student

counselors, practicing counselors, and clients with SUDs, especially with Mexican-origin Hispanics.

Research Questions

The following research questions were quantitatively investigated in this study:

1: Are there differences in stigma toward individuals with substance use disorders (SUDs) as perceived among graduate counseling students-in-training, counselors, and clients (with SUDS) who identify as Mexican-origin Hispanics?

Hø1: There will be no significant difference in stigma toward individuals with substance use disorders (SUDs) as perceived among graduate counseling-students-in-training, counselors, and clients (with SUDs) who identify as Mexican–origin Hispanics.

2: Is there a difference between stigma toward individuals with SUDs as perceived by graduate counseling students-in-training and counselors who identify as Mexican–origin Hispanics?

Hø2: There is no significant difference between stigma toward individuals with SUDs as perceived by graduate counseling students-in-training and counselors who identify as Mexican–origin Hispanics.

3: Is there a difference in stigma toward individuals with SUDs among graduate counseling students-in-training who identify as Mexican–origin Hispanics from different educational backgrounds?

Hø3: There is no difference in stigma toward individuals with SUDs among graduate counseling students-in-training who identify as Mexican–origin Hispanics from different educational backgrounds.

All hypotheses will be tested at the .05 level of significance.

Assumptions

It is assumed the distribution of perceived attitudes toward people with SUDs may be normally distributed in a group as homogenous as graduate counselors in training.

Definitions of Terminology

For the purposes of this study, the following definition and terms were used:

Clients- Individuals who have been found eligible for and admitted to specialty substance abuse clinical treatment programs, including detoxification, residential, and outpatient treatment programs.

Counselors- Any professional with a graduate degree (master's degree or above) in a counseling-related discipline. The individual holds a professional counseling license, clinical licensure, and/or certification to practice and provide counseling services. Examples of counselors include licensed professional counselors (LPCs), certified rehabilitation counselors (CRCs), licensed master social workers (LMSWs), and licensed clinical social workers (LCSWs).

Graduate Counseling Students in Training- Students who are enrolled in graduate school counseling programs which satisfy the requirements to meet eligibility to obtain licensure or certification as a counselor. These programs can and are expected to include students from diverse backgrounds from undergraduate programs who have been formally accepted into master or doctoral degree programs spanning disciplines of psychology, rehabilitation counseling, guidance and counseling, and social work.

Mexican-Origin Hispanics- People who report their ethnic origin as Mexican or of Mexican descent. It can include people born in Mexico, in the United States, or in other countries. All responses are based on the individual's self-identification (U.S. Census Bureau, 2017).

Perceived stigma*:* Beliefs that members of a stigmatized group have about the prevalence of stigmatizing attitudes and actions in society (Luoma, et al., 2010).

Provider Stigma- Negative attitudes, beliefs, and behaviors that mental health providers possess and enact toward clients they serve, either unknowingly or subtly (Charles, 2013, p. 361).

Public Stigma- A form of societal prejudice toward characteristics or people of particular marginalized groups. This prejudice is comprised of cognitive, affective, and behavioral reactions (Corrigan & Penn, 1999).

Self-Stigma- A representation of the internalized psychological awareness and impact of public stigma by individuals from a stigmatized group (Corrigan & Watson, 2007).

Stigma- Underlying negative connotations constructed and assigned by society to individuals often belonging to minority groups who are perceived to look, behave, or possess undesirable traits (Goffman, 1963).

Substance Use Disorders- A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems (American Psychiatric Association, 2013).

CHAPTER II

REVIEW OF THE LITERATURE

The term *stigma* is rooted in Greek and its origin word, *stigmata*, refers to "a mark or obvious trait that is characteristic of a defect or disease" (Webster's Collegiate Dictionary, 2017). When used in the context or in reference to mental illness and SUDs, stigma is a construct that involves feelings, attitudes, and behaviors (Link, 1997). Much of the initial literature investigating the phenomenon of stigmatized conditions or groups was published by researchers in sociology. Durkheim's (1951) early work, especially on suicide began the paradigm for sociological research on what was referred to as deviance. Social deviance investigation then gave rise to labeling theory. Gradually, the theories presented by sociology permeated into the fields of psychiatry and psychology once clinicians began to voice concerns about the effects of labeling on psychopathology (Davis, 1972). Further discussion on several theories on the origin of stigma is justified to comprehend how the construct of stigma has significantly impacted individuals with SUDs.

Stigma and Social Identity Theory

Social identity theory examines the manner in which people take labels and social constructs, such as mental illness, into consideration when they judge those who may be different from themselves. Erving Goffman (1963) introduced the concept of social identity theory to describe individuals whose traits or behaviors function outside of the expected norms of the majority of society. Goffman postulated that stigmatized people, as a result of discrimination,

form virtual social identities when they become disfavored in the eyes of society, and subsequently fulfill the role of outcasts. Goffman further defined stigma as an attribute, "that is deeply discrediting" (Goffman, 1963, p. 3). He proposed three different types of stigma, each of which reflect some type of attribute. The first type of stigma relates to physical deformities, or abominations of the body. These are traits commonly visible to others and difficult to hide. The second type of stigma is due to blemishes or perceived flaws of an individual's character. These character flaws often portray the individual as being weak willed. Behaviors associated with this type of stigma may include behaviors of unnatural passions or obsessions which relate to people with mental illness and SUDs, since these individuals have historically been viewed as having character or moral flaws. The third type of stigma includes the tribal stigma of race, nationality, or religion. The stigma associated with the opinion of an individual's character as having a weak will is now commonly known as public stigma.

Corrigan's Public Stigma Model

Common negative attitudes and stereotypes about specific groups are the essential components of public stigma. Corrigan and Penn (1999) published several recurring themes regarding public stigma and stigmatizing attitudes toward individuals of marginalized or minority groups. Often, the negative attitudes are recognized and reinforced by the general public. These negative perceptions are typically unwarranted and are not limited to members of the general public. Furthermore, the themes associated with public stigma include an overgeneralization of negative attributes about the personality characteristics of a marginalized group. The negative attributes typically include the dangerousness of an individual, potential for violence, and undesirability. For example, through their analysis of representations of individuals with mental illness in media and film, Corrigan and Penn (1999) found common misconceptions

which have been accepted by the public. Among the most common misconception is that people with mental illness are homicidal maniacs and pose a dangerous threat to the general public.

Corrigan's Self-Stigma Model

Another domain to consider when addressing the issue of stigma relates to self-stigma. Self-stigma is an internal evaluation process whereby people judge themselves based on their noted differences or defects (Corrigan, 2002). The ensuing judgment experienced from self-stigma could be the result of perceptions from societal norms, but ultimately it is the individual who is creating the judgment toward him or herself. It was traditionally believed those who experienced self-stigma would internalize the harmful effects of the prejudice and the process would lead to a loss of self-esteem (Corrigan & Watson, 2002). The concept of self-stigma is applicable to individuals who have had experienced stigma due to any kind of a disability, whether it be a physical condition (Boyle, 2013) or a mental illness (Corrigan, 2002; Corrigan, Larson, & Kuwabara, 2010). Further study has determined that much like the variable of public stigma, self-stigma can influence an individual's motivation in seeking treatment services for a particular disorder (Brener et al., 2010; Matthews, Dwyer, & Snoek, 2017; Topkaya, 2014) and the outcomes (or lack thereof) during the treatment process (Gary, 2005; Kondrat, 2012; Matthews, Dwyer, & Snoek, 2017; Wahl, 2012).

According to Corrigan, Larson, and Kuwbara (2010), there exists a theoretical model of self-stigma which is composed of four progressive levels: awareness, agreement, application, and harm. Awareness occurs when the stigmatized individual becomes aware of the negative stereotype associated with their condition. Agreement occurs after stigmatized individuals not only agree with the stereotypes of their condition but also hold those stereotypes about other members of the stigmatized group. Agreement leads to application wherein an individual

identifies him or herself with the negative beliefs reflected in the public about their particular conditions. Harm becomes manifest in individuals after reductions in self-esteem, well-being, or an exacerbation of their condition. There has been evidence presented on the application of the aforementioned multidimensional model of stigma (Corrigan et al.) to individuals with specific conditions or disorders (See Figure 1). For example, individuals with mental illnesses have reported experiencing characteristics of self-stigma (Cheng, Wang, McDermott, Kridel, & Rislin, 2018) and many of the symptoms of mental illness can be found in individuals with SUDs. Many clients report one of their desired treatment outcomes to be, in addition to recovery from mental illness or SUD, a sense of "normalcy" and acceptance from others without the sense of stigmatization or alienation (Haskell, Graham, Bernards, Flynn, & Wells, 2016).

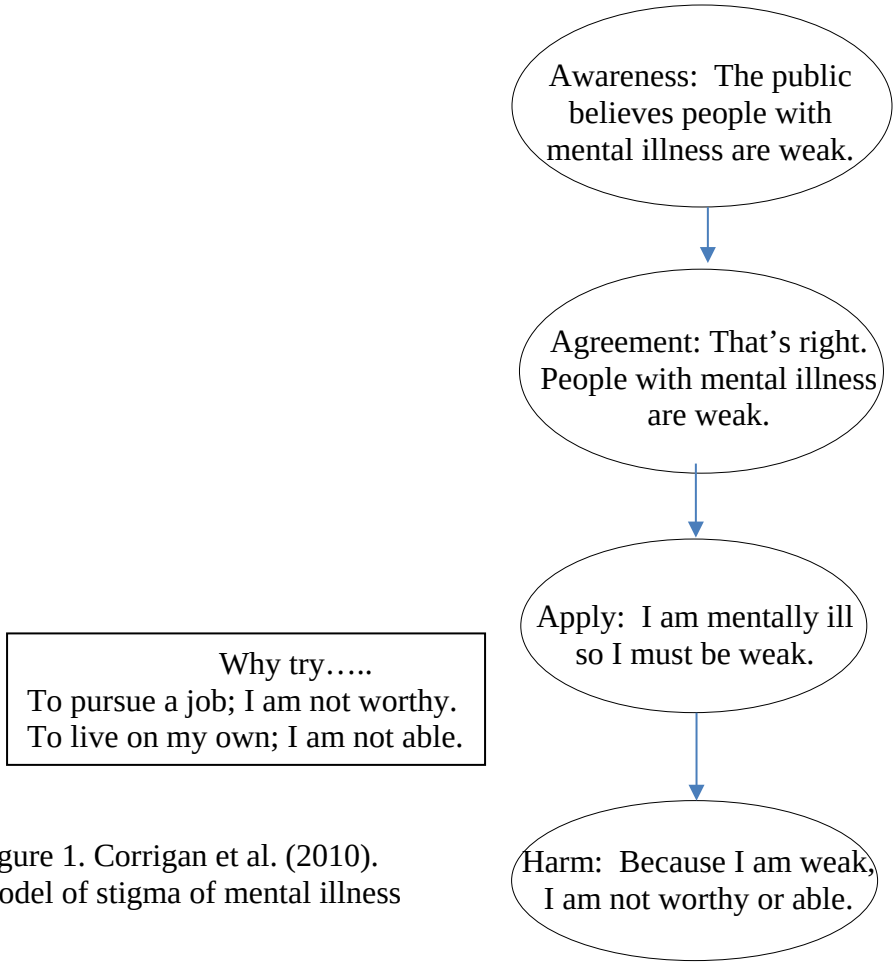

Figure 1. Corrigan et al. (2010).
Model of stigma of mental illness

Evidence has supported an inverse association between public stigma and treatment-seeking by individuals with mental illness (Corrigan, 2004). A similar association has been found between self-stigma and treatment -seeking in individuals with mental illness. Thus, both types of stigma can be detrimental to an individuals' participation in treatment (Figure 2).

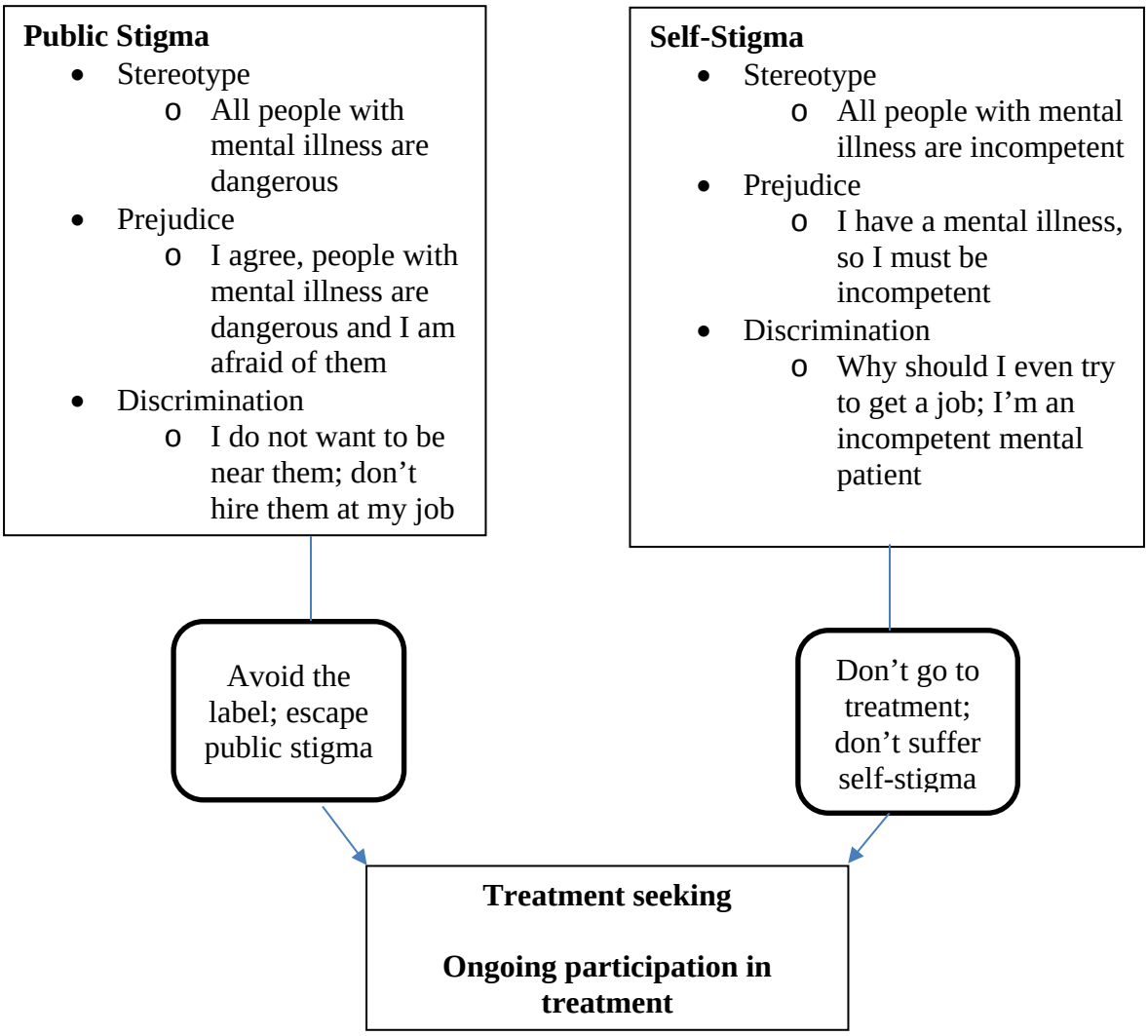

Figure 2. Corrigan (2004). Self-Stigma Model

Watson, Corrigan, Larson, and Sells (2007), however, proposed a model in which self-stigma may actually result in the empowerment of a stigmatized group. The Theoretical Model of Self-Stigma considers divergent reactions to mental illness stigma by the individual (See

Figure 3). Borrowing concepts about labeling theory from social psychology, Watson el al. suggest an individual from a stigmatized group will first experience stigma awareness, which is similar to stereotype awareness. Stereotype agreement then follows as the individual endorses the public stereotype made about their condition, which then results in stereotype self-concurrence. This flow of self-stigma will then lower self-esteem and self-efficacy. The alternative result are concepts labeled as group identification and perceived legitimacy of mental illness self-stigma, which may energize an individual in a positive manner. The researchers conclude there is enough supported by the model to explore how stigma may be a viable ally to empower individuals with mental illness.

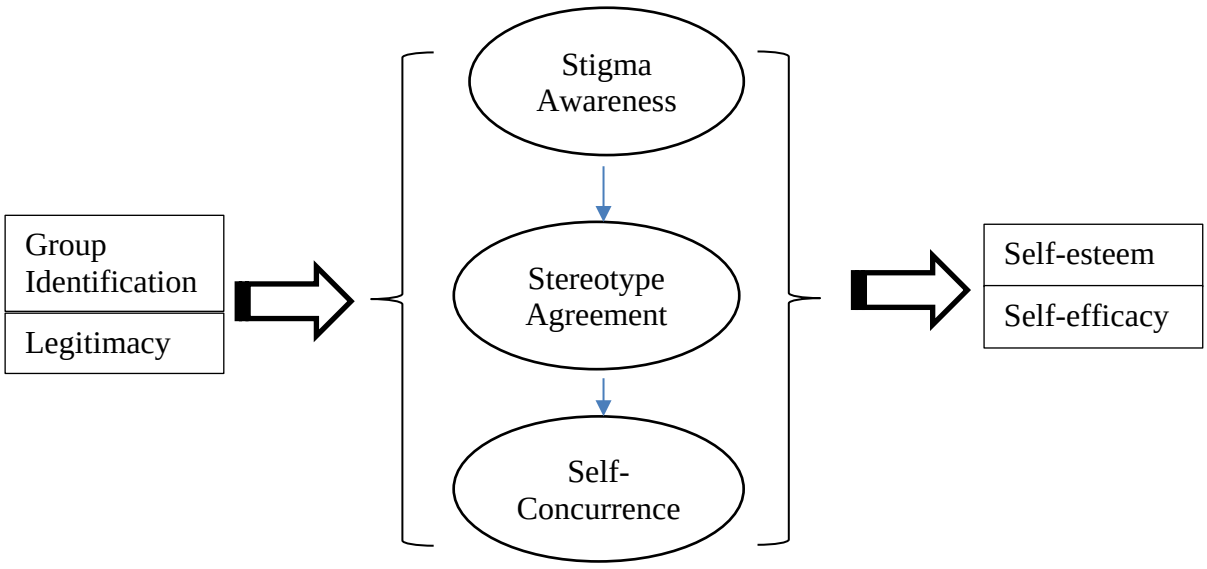

Figure 3. Watson et al. (2007). Self-stigma in people with mental illness.

Provider Stigma

Evidence has shown just as other members of society stigmatize those with disabilities and mental illness, many well-trained professionals manifest the same kind of stigmatizing attitudes toward certain individuals, in particular those with disabilities and mental illness (e.g., Chang, Dubbin, & Shim, 2016; Rao, Mahadevappa, Pillay, Sessay, Abraham, & Luty, 2009). The application of negative prejudices and stereotypes toward individuals with certain disabilities has been exhibited by counselors who serve as mental health and human service providers (Varas-Diaz & Neilands, 2009; Pinderup, 2017). In fact, researchers (Knaak, 2015) have found the negative stigma manifested by mental health professionals similar to the level of public stigma and possibly congruent with levels of stigma from the general public (Schulze, 2007). Araten-Berman and Werner (2017) found a population of clinicians (social workers) which demonstrated the application of the aforementioned attribution model to clients with SUDs and co-occurring mental illness. The researchers were able to identify perceived individual responsibility as the strongest predictor of perceived dangerousness from individuals with SUDs and mental illness. Thus, Araten-Berman and Werner expanded upon the previously published model of attribution theory toward persons with mental illness (Corrigan et al., 2003) to now include characteristics of clinical providers (Figure 4).

Negative attitudes toward individuals with SUDs harbored by the attending counselor may also have a deleterious effect on treatment outcomes. Substantial evidence over the years supports the critical nature of the therapeutic relationship in a multitude of counseling services as a healthy therapeutic alliance is correlated with a greater likelihood of successful therapeutic outcomes (Eaton, Abeles, & Gutfreund, 1988; Gaston et al., 1994; Horvath et al., 2011; Martin et al., 2000) and therapeutic alliance has been shown to be particularly crucial when treating SUDs

(Feldstein & Forcehimes, 2007). The impact of provider stigma continues. For example, Schultz, Martinez Cuccaire, and Timko (2016) recently found stigma among providers as a substantial barrier which deters many veterans (about 54%) from seeking detoxification services for SUDs. Qualitative reports from providers within the aforementioned study supported less empathy demonstrated by providers toward patients with SUDs, especially those with frequent admissions. Kulesza, Hunter, Shearer, and Booth (2017) found provider stigma, rather than provider burnout, to be a great factor in staff and provider turnoff within community SUDs treatment facilities. Frequent turnover of counseling staff in any setting can present a negative impact on the service delivery and treatment outcomes of individuals receiving services, especially to those receiving substance use treatment (Young, 2015).

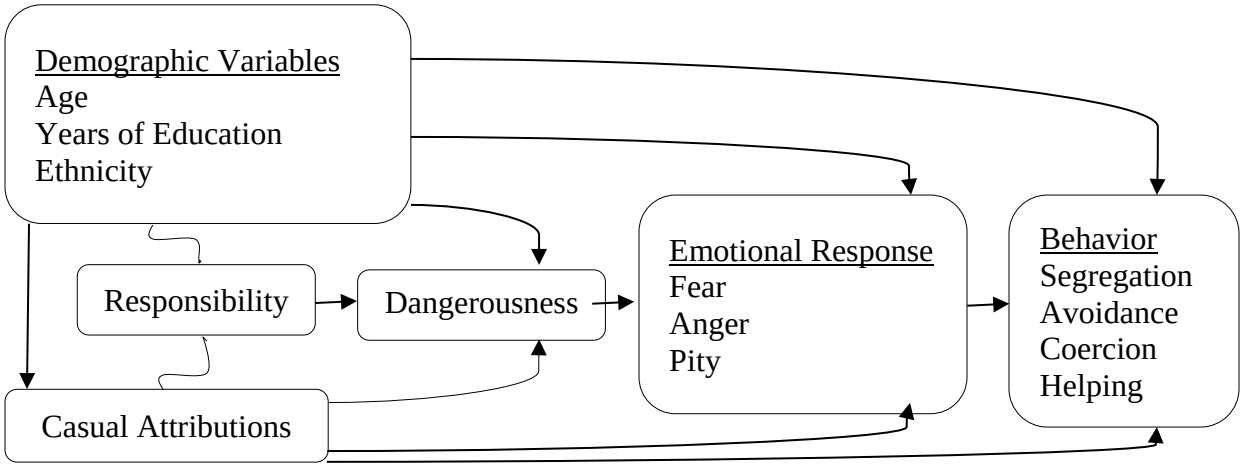

Figure 4. Araten-Bergman & Werner (2017). Attribution model of stigma

Subtle impairments in the therapeutic relationship due to negative attitudes on behalf of the counselor may lead to a disservice by the service provider. The American Counseling Association's Code of Ethics (2014, Section A.4.b.) explicitly warns counselors from allowing their own personal values, attitudes, and beliefs to affect their professional relationship with

clients. However, the attitudes and beliefs held by counselors may serve as only a sample of the attitudes and beliefs widely held toward individuals with SUDs.

The ethical implications of negative stigma and the prejudice toward clients have been addressed through various codes of conduct adopted by professional organizations and licensure boards. The current code of ethics of the ACA (2014) has included the practice of non-discriminatory behavior under Section C.5, *Professional Responsibility*, which explicitly discourages, "discrimination against prospective or current clients, students……based on age, culture, disability…" The code of professional ethics adopted by the Commission on Rehabilitation Counselor Certification (CRCC, 2017) includes a similar declaration against prejudice under Section D.2.c. Cultural Competence/Diversity: "Rehabilitation counselors do not condone or engage in the prejudicial treatment of an individual or group based on their actual or perceived membership in a particular group, class, or category." Researchers (e.g., Michael et al., 2014) have concluded provider stigma is not necessarily intentionally malicious behavior by counselors toward clients but is instead consequential due to a lack of awareness and education. As such, it behooves counselor education programs to provide professional training on the disease concept of SUDs and other relevant literature to reduce ambiguity about the etiology of SUDs and reduce provider stigma.

Evolutionary Origin of Stigma

Some of the recent literature regarding stigma and the practice of discriminatory behavior provides a comprehensive explanation of stigmatizing behavior through an evolutionary psychological perspective. Hypotheses provided by authors of evolutionary psychology are intellectually influenced by the biological paradigm presented from the works of Charles Darwin (Buss, 1999). Darwin proposed all behaviors specific to a certain species are evolutionary

beneficial adaptations and the result of various survival pressures, or natural selectors from the environment (Darwin, 1859). In 1871, Darwin published his theory of sexual selection in the 'Descent of Man and Selection in Relation to Sex' in which he applied many of the principles from his previously published 'On the Origin of Species' to adaptations within the human species. Researchers of this particular school of thought believe individuals engage in behaviors that are learned adaptations and serve to promote the prosperity of a particular species; in this case the entire human population.

Tooby and Cosmides (1990) expanded the foundations of evolutionary psychology by providing researchers with viable hypotheses to conceptualize what they referred to as a *system of behaviors*. The authors stated many of the behaviors individuals engage in are functional, adaptive responses which serve some benefit(s) during the process of human evolution. Systems of behaviors are not necessarily limited to sexual selection or mate selection and include behaviors which motivate kin selection or acceptance of certain individuals into peer groups (Hamilton, 1964).

The aforementioned theories of natural and sexual selection purport that each individual increases the likelihood of the survival of their progeny and future generations by the frequency in which they engage in specific behaviors (Buss, 1995; Williams, 1966). The only criteria for these behaviors to be considered as selected adaptations are their manifestation during early human evolution. The natural selection theory and its rationale describe behaviors exhibited by individuals as non-coincidental, specific responses to avoid threats refined through thousands of years of human existence. There are few but limited literature sources available which support the hypothesis of stigmatization of certain individuals as an evolved, selected adaptation to aid human survival.

The action of intentional social exclusion may appear to be a counterintuitive strategy if the ultimate goal of human existence is survival. Some might argue that inclusion of many into interdependent groups will yield greater benefits, such as emotional and physical support to accomplish endeavors. However, Tooby and Cosmides (1990) proposed that it may be evolutionarily beneficial to avoid social exchanges with certain individuals who may risk the genetic well-being of kin and the entire species altogether. For example, the possibility of death from infectious disease and other hazards of social interaction were legitimate threats to ancestral man (Neuberg & Cottrell, 2008). Given the survival pressures which are ever-present in the environment, it is imperative that each individual attempt to select the best genetically fit partner, or collaborator, to join their kin (Darwin, 1871). Longstanding evidence of preferences and the desire for intimate connections (either of a sexual nature or as collaborations) with individuals who appear to possess optimal genetic and physical traits has been presented as a strategy to ensure the prosperity of the species (Hamilton, 1964).

The ability to discriminate and exclude particular individuals from social interaction seems to have served a valuable function throughout human evolution. More recent evolutionary psychology literature posits the evolved adaptation of recognizing certain individuals who may not provide any type of mutual survival benefit to a group (Kurban & Leary, 2001). This recognition may manifest itself as emotional disgust as a means to dissuade individuals from entering into innate relations with those who themselves or their progeny may not be genetically fit to otherwise survive the environment. For example, someone who is free of mental or health conditions is considered to be more genetically fit in the face of natural and societal pressures which impede survival. However, an individual with a significant mental or health condition may not possess the model genetic qualities necessary for either their own survival or the

survival of their progeny. This could be due to the need for constant physical or emotional care, such as medication monitoring and medical visits, which may lead to less than ideal allocation of effort and resources. According to Kurzban and Leary (2001), stigmatization is the system of behavior to prejudicially exclude others socially. The strategy to cognitively categorize someone as possessing poor genetic qualities (the stigmatization) based on their physical or character attributes was an effective strategy to resolve the natural pressures which occurred during ancestral times. Thus, the universal practice of stigmatization of specific conditions which are easily identifiable to the majority of people remains a socially acceptable exercise (Dijker & Koomen, 2006). Neuroscience researchers even suggest stigmatizing groups may serve to efficiently categorize threats which are necessary for rapid social judgement (Griffith & Kohrt, 2016). Functional brain imaging has recorded the neurocognitive processes which occur within the brains of individuals as they experience stigma as defined by fear, disgust, and suffering (Griffith & Kohrt). Proponents of evolutionary psychology theory of stigmatization have not established criteria as to which conditions are designated as highly undesirable and stigmatized, yet those who perhaps have received the most stigma are generally those with poor physical stature; the elderly; and those with illnesses, cognitive impairments, physical disabilities, and chemical dependency (Kurzban & Leary, 2001). Cross-culturally, Schomerus et al. (2011) found that people with SUDs (particularly alcohol dependence) were more likely to be discriminated against than other conditions by populations in Europe, North American, and New Zealand.

Stigma toward People with Disabilities

Advocates for disability policy and change believe disability to be a social construct (Olkin, 1999). The notion that stigma is also socially constructed in accordance with other social phenomenon, such as labeling or social deviance, allows for those who are labeled as having a

disability to be vulnerable targets of public stigma (Ali, King, Strydom, & Hassiotis, 2016; Green, Davis, Karshmer, Marsh, Straight, 2005; Susman, 1994). It seems the general public, as well as counselors, have practiced inconsistent approaches in the creation of policies which facilitate services and care for individuals with disabilities rather than those with SUDs. In fact, a review of state vocational rehabilitation service agencies found much variability in the policies created for consumers with SUDs (Moore et al., 2008). Further analysis of the available literature is necessary to determine the varying degree of stigma associated with specific types of disabilities.

Public Stigma toward Individuals with Physical Disabilities. Initially, physical disabilities received the focus from research associated with public stigma toward disability. Particularly, disabilities of a physical nature have been categorized as either visible or invisible disabilities based on the extent of visual related factors. One classic study identified individuals who used wheelchairs as belonging to a group of individuals who are commonly stigmatized by the general public due to their particular disability (Cahill & Eggleston, 1995). In their conclusion, Cahill and Eggleston found, through qualitative means, that wheelchair users' encounters with the public were often met with harshness. Further exploration has revealed that not all physical disabilities elicit negative responses uniformly among the general public.

In a series of controlled studies, Weiner, Perry, and Magnusson (1988) sought to determine the true nature of an attributional analysis of disability. The researchers conducted an experiment among university students in an attempt to ascertain the degree of responsibility and blame the students attributed to an individual's disability. Specifically, 13 questions were asked with each response recorded on a 9-point Likert-type scale; the greater responses were labeled as *entirely responsible* to *not at all responsible*. Each of the 13 questions was recorded as

dependent variables and were repeated using 10 conditions associated with negative stigmas, including AIDS, drug addiction, and obesity, along with other illnesses such as blindness, cancer, and heart disease. Fifty-nine students were asked to rate these disability groups on items representing two important constructs in attribution theory: *controllability*, or how much is the person rather than environmental forces responsible for the specific disability, and *stability*, or how much a specific disability is expected to change over time. The results of this experiment showed how conditions which the researchers categorized as mental/behavioral origin (drug addiction and obesity in particular) were deemed by students as higher in controllability than conditions that were categorized as being of physical origin (e.g., blindness and paraplegia).

A second study conducted by Weiner et al. within the same publication was designed to assess whether participants representing the general public viewed individuals with mental illness more harshly than individuals with other disability types. The study consisted of 149 students from two universities who answered similar questions about responsibility and blame for given conditions. Students were randomly assigned to either a control or treatment group in a quasi-experimental design wherein the control group was provided with information regarding the nature of the stigmas. For example, the onset of AIDS was described to be either due to a blood transfusion or from a promiscuous lifestyle; drug addiction onset was noted as a result of treatment of pain after an injury or from excessive experimentation with recreational drugs. The results showed that students perceived physically-based disability stigmas (e.g., blindness, paraplegia) as more stable and manageable than mental-behavioral stigmas such as drug addiction. This information illustrates how perceptions vary between mental illness and physical disability. Specifically, it provides us with an understanding of how conditions such as mental illness and substance use/addiction are perceived as more negative than physical disabilities.

Charles and Bentley (2016) provide their support on the notion that perhaps stigma toward mental illness served to shape early mental health services and provide professional identity to social psychiatry. Prior to the social psychiatry movement, the interaction between person and environment was not taken into consideration when treating mental illness etiology. Charles and Bentley then proceed to describe shortcomings in how clinicians have addressed the effects of stigma on individuals with mental illness. This negative perception of mental illness requires further examination.

Public Stigma toward Individuals with Mental Illness. Recent improvements in data collection have provided increased accuracy in the rates of individuals with mental illness in the U.S. Through data collected at both the national and state level, SAMHSA (2017) estimated there are at least 44.7 million adults or approximately 18.3 % of the population (age 18 or over) with any type of a diagnosable mental illness. This rate is approximately twice as prevalent as the rates of those who report using substances and those who may potentially be diagnosed with a SUD. The definition of any mental illness (AMI) means the presence of symptoms meeting criteria for any of the mental, behavioral, or emotional disorders presented in the DSM-5 (APA, 2013). Among adults with a mental illness, those whose disorder caused substantial functional impairment (i.e., a disorder that interferes with one or more major life activities) are defined as having a serious mental illness (SMI). Major psychotic disorders such as schizophrenia can be categorized as a SMI. The national rate of SMI was estimated at about 4.2%, which equates to two million Americans (SAMHSA). However, despite the likelihood of knowing or having contact with an individual with AMI, the general public continues to stigmatize individuals with a mental illness (Balon et al., 2017; Corrigan 2016; Simmons, Jones, & Bradley, 2017) in a

manner that many believe to be more punitive than those with physical disabilities (Corrigan et al., 2000; Farrelly et al., 2014; O'Driscoll, Heary, Hennessy, & McKeague, 2015).

A review of published works regarding stigmatizing beliefs (Parcesepe & Cabassa, 2013) found the general public to believe individuals with mental illness were more dangerous (to themselves and others), more incompetent, and more likely to engage in criminality than those without a mental illness. An increasing amount of the research on stigma toward mental illness has been published within the past 10 years, with a vast amount of those studies being authored by Corrigan and his colleagues. Many of these studies illustrate how stigma has negatively impacted individuals with mental illness. Initially, the research published established negative attitudes toward individuals with mental illness by the general public and how these negative connotations affected those with mental illness, including discrimination in obtaining housing and employment (Corrigan et al., 2006), poor treatment outcomes due to early withdrawal (Barrett, Chua, Crist-Christoph, Gibbons, & Thompson, 2008), and being the recipients of more coerced treatment admissions as well reduced independence (Corrigan & Shapiro, 2010).

Corrigan and Penn (1999) also identified several recurring themes among their initial observations on the subject of stigmatizing attitudes and mental illness. The first factor they identified was fear and exclusion, or the belief that persons with SMI should be feared and kept away from children and others in the community. The second factor is authoritarianism, meaning persons with SMI are irresponsible and their major life decisions should be made by others. The third factor, benevolence, denotes persons with SMI are childlike and need to be guided and cared for by others in society. This public perception is consistent with previous observations published by Weiner, Perry, and Magnusson (1988) who noted that unlike persons

with physical disabilities, persons with SMI or AMI are perceived to be in control of their illness and responsible for causing that illness.

Individuals with mental illness have reported different consequences due to the perceptions others in the general public may harbor toward them due to their conditions. Generally, work published on the topic reflects many of the negative effects which occur as a result of internalizing the negative attitudes from the general public, the concept previously introduced as self-stigma (Bathje & Pryor, 2011). Vogel, Wade, and Ascheman (2009) found respondents with AMI were less likely than a control group to seek treatment due to the negative beliefs with accompany the stigma of having a mental illness. The fear of scrutiny from the public as well as potential loss of self-esteem (Corrigan & Watson, 2007) may perpetuate a cycle which could potentially exacerbate mental symptoms and create barriers from the individual and the community. However, contradictory reports have been published in the literature on the positive consequences of experiencing self-stigma among individuals with mental illness (Herman & Miall, 1990). Participants in the study by Herman and Miall reported an increase in their motivation to complete treatment, along with stronger family ties, and facilitated growth experiences due to the self-stigma associated with their mental illness. This contradiction would suggest not all consequences of experiencing self-stigma are necessarily negative.

Corrigan et al. (2000) hypothesized the attributional stigma toward mental illnesses would vary due to the type of mental illness presented. For example, the researchers rationalized respondents would perceive emotional or psychotic disorders as more controllable by the individual than another medical or purely physical condition. Since the assumption that emotional and psychotic disorders are controllable, the researchers predicted survey items relating to mental disorders completed by respondents would yield more negative perceptions

about the individual with either an emotional/psychotic disorder. The researchers developed the *Psychiatric Disability Attribution Questionnaire* (PDAQ, 2000) based on the attributional analysis (Weiner et al., 1988) conducted a factor analysis on the items of their questionnaire to determine whether a significant variation existed. However, according to their results, neither type of emotional/psychiatric disorder was viewed as more controllable than the other.

Another important factor which may cause the amount of perceived stigma to vary is if the individual with a mental illness also presents a comorbid or co-occurring physical disability (Bahm & Forchuk, 2008). Although the jargon often varies, the phenomenon of an individual experiencing stigma due to the presence of more than one condition (either a physical condition and mental condition, mental condition and substance disorder) has been also referred to by such terms as *secondary deviance* or *dual discrimination*. Weiss, Ramakrishna, and Somma (2006) concluded since individuals with SUDs and mental illnesses are at greater risk for also having infectious diseases, they would be more likely to experience dual discrimination than those with other co-occurring conditions. Similar findings have been published by researchers who reported clinicians express more caring toward individuals with co-occurring disorders with a dual diagnosis of intellectual disability and mental illness (Araten-Bergman & Werner, 2017). Thus, individuals who experience dual discrimination because of a SUD and other mental illness are prone to be more reluctant to disclose their presenting problems, experience exclusion or rejection from school/work, experience diminished self-esteem, and increased self-blame and devaluation.

Substance Use Disorders

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), not all individuals who use psychoactive

substances develop a serious clinical disorder related to the substance use. Often, non-excessive or maladaptive degrees of substance use are identified and misdiagnosed as chemical dependence or addiction. In order for a clinician to accurately diagnosis someone with a Substance Use Disorder, several specific criteria or symptoms must be attributed to the recurrent use of a particular psychoactive substance and must have manifested within the past year. A total of two of the 11 possible maladaptive use pattern criteria within a 12-month period would provide clinical justification of a specific substance-related disorder. The DSM-5 (APA, 2013) allows for the counselor assigning the diagnosis to use discretion in the determination of an individual's pattern of substance use as manifest by symptoms based on groupings of impaired control, social impairment, risky use, and pharmacological criteria. Counselors can provide further details as to the degree of severity of an identified SUD by applying specifiers to the diagnosis. The presence of two or three symptoms can be described as a mild SUD, meeting between four to five symptoms can be described as a moderate SUD, and meeting six or more of the symptoms can be described as presenting a severe SUD.

Approximately 23.1 million people in America, or 7.5% of the general population, met the criteria for a SUD in 2016, either due to alcohol and/or illicit drug use (SAMHSA, 2017). The rates of SUD have remained constant throughout the population during the past decade. However, the published data should be viewed only as estimates given certain limitations with the collection of survey data, such as the underreporting of substance use and the assumption that many individuals may choose to avoid the stigma that accompanies substance use.

Public Stigma toward Individuals with Substance Use Disorders

A limited number of studies have been dedicated to determine the extent of public stigma toward individuals with SUDs when compared to those which focused on the stigma of general

mental illness (e.g., Balon et al., 2017; Corrigan 2016; Simmons et al., 2017). Corrigan et al. (2000) published findings regarding public stigma in which none of the mental illnesses operationalized in a study were perceived by respondents as being controllable by the individual. Conclusively, only ratings about an item related to cocaine addiction met the severity criterion for controllability contributions. In other words, this finding suggests people view individuals with SUDs as ultimately responsible for their conditions. This concept of personal responsibility for an individual developing a SUD was further underscores during social and political campaigns such as the "War on Drugs" (Livingston, Milne, Fang, & Amari, 2011). The "War on Drugs" and subsequent legislation began as a direct response to the ubiquitous substance use in the U.S. in the mid-1960s (Kreit, 2009). Federal and state laws became more restrictive and punitive, cumulating in the creation of the U.S. Drug Enforcement Administration (DEA).

The entanglement between substance use and law enforcement has led to other measurable consequences, aside from those dispensed by the penal system, including marginalization of people with SUDs by public institutions such as social and health agencies (Room, 2005). Further exploration found the general public overestimated how often people with SUDs actually engage in criminal and dangerous behaviors (Palamar, Kiang, & Halkitis, 2011). Other stereotyped behaviors applicable to persons with SUDs include having a lack of willpower or poor work ethic, and being incompetent, violent, and unreliable (Luoma et al., 2014). The stigma of an individual with a SUD is so powerful its effects have been experienced by family members as well. For example, Corrigan, Watson, and Miller (2006) used vignettes in survey research which featured individuals with drug dependence as well as family members such as parents, children, siblings, and spouses When these vignettes featuring hypothetical individuals with SUDs were juxtaposed with individuals with mental illness or a physical

condition, the researchers found that respondents attributed negative connotations toward the family members of those with SUDs significantly more than those with mental illness or the physical condition. The reported family stigma of addiction supports the notion that the general public views SUDs as controllable by the individual and the public also holds family members responsible for SUDs.

Provider Stigma toward Substance Use Disorders

Given the lack of progress in the reduction of stigma from general samples since Weiner (1986) investigated the matter to recent studies, the matter of concern then shifts to the perception of stigma by counselors. As such, research has increasingly been dedicated to identifying and analyzing how professionals in the counseling field view individuals with SUDs. Kelly and Westerhoff (2009) provided findings on whether the use of particular language in referring to clients/individuals with SUDs affected mental health counselors' perceptions. The researchers queried 728 conference attendees regarding the recommended course of action for individuals with SUDs. Participants received a vignette about identical, hypothetical clients with either one of two distinctions made by referring to the client as either a "substance abuser" or a person with a "substance use disorder." Upon reading the vignette, participants were asked to rate the extent to which they agreed with various causes of the character's substance-related problem and whether the character should receive either therapeutic or punitive action, whether he or she was a social threat and whether he or she was capable of regulating his or her substance use behavior. Groups did not differ on either social threat item by the use of an independent samples *t*- test. However, a difference was detected on the perpetrator-punishment subscale. That is, compared to participants assigned the "substance use disorder" term, those assigned the "substance abuser" term were significantly more in agreement with the notion that the character

was personally responsible for his or her condition. Participants who assigned the "substance abuser" category were also more likely to agree that punitive measures be taken though the sample result represented a small standardized effect size.

This trend of negative attitudes toward clients with SUDs by counselors continues and has even led to counselors denying the use of evidenced-based practices for those clients. Aletraris, Shelton, and Roman (2015) found counselors were least likely to favor the use of contingency management (an evidence-supported behavioral therapy technique) for clients with SUDs. In their discussion, the researchers determine counselors may not agree with the use of contingency management to promote substance abstinence for this population as it provides tangible incentives for behavior which they believe to be should not be rewarded. This evidence further demonstrates how provider stigma may facilitate sub-standard or even harmful services to clients with SUDs.

Provider Stigma by Vocational Rehabilitation Counselors. West and Miller (1999) presented archival data which specified that, on average, individuals with SUDs seeking vocational rehabilitative (VR) counseling services were more likely than individuals with only physical disabilities to have their cases closed earlier and at a higher success rate. The authors suggested individuals with SUDs may have been receiving substandard services and their assigned counselors may have expedited their services rather than having them remain on their active caseloads. These results regarding the attitude of the VR counselor supported the negative bias hypothesis proposed by the researchers. Moore and Li (1998) surveyed VR service providers in several mid-Western states and among the wide range of substances reported, cannabis was the most widely used illicit substance use by those receiving VR services (almost 40%), which is statistically greater than the percentage among the general population. Despite

the negative beliefs held by VR counselors reported in the literature, there is little or no evidence to indicate that substance abusing individuals require more cost in services or a differentiation in types of services provided (West & Miller, 1999). These findings also support, from a provider's perspective, that individuals with both SUDs and physical disabilities may be held in a more negative light than individuals with only physical disabilities. The evidence gathered by Moore and Li (1998) supports a disproportionate rate of substance use among individuals of VR services.

It is very likely the stigma manifested by VR counselors, as with other counselors, perpetuates due to the lack of formal education or professional training about individuals with SUDs. When VR counselors were surveyed about perceived barriers for employment among people with SUDs, counselors reported having little training specific for SUDs (Glenn & Moore, 2008) and lack of knowledge about SUDs further cultivates provider stigma. It has been shown VR counselors also manifest stigma toward clients who present with serious mental illness (Netto, Yeung, Cocks, & McNamara, 2016).

Stigmatizing Attitudes toward Disabilities by Mexican-origin Hispanics

Information regarding the attitudes toward persons with disabilities held by Mexican–origin Hispanics is scarce in the psychosocial literature, despite the rapidly growing number of Mexican–origin Hispanics in the general population. It is uncertain to what extent stigmatizing attitudes vary against other ethnicities or against the attitudes toward the general public. However, Saetermoe, Scattone, and Kim (2001) found that among ethnic minority groups, Latinos (as labeled in their sample) were second only behind Asian-Americans as the ethnic group most likely to stigmatize people with disabilities as measured by social distance rating.

Beyond this, there are only a few studies which have published their attempts to measure how Mexican–origin Hispanics view disability, mental illness, and substance use disorders.

Graf, Blankenship, Sanchez, and Carlson (2007) found common attitudes between groups of individuals who identified themselves as both Mexican Americans and Mexican nationals with regard toward persons with disabilities (PWD). Specifically, groups of individuals who resided in a U.S.-Mexico border area were recruited to participate in a study on attitudes toward PWD. Both groups viewed PWD with a relatively high degree of pity. However, the authors noted the perception of pity toward PWD was not necessarily a negative value judgment but rather an indication of the compassion toward those who many Mexicans believed were less fortunate than others. The authors recommended further exploration into possible varying attitudes by either Mexican nationals or Mexican Americans toward individuals who present with specific types of disability.

A study focused exclusively on the perceptions of Mexican Americans toward mental illness was conducted in the same border area, the lower Rio Grande Valley border region of South Texas (Barrera, Gonzalez, & Jordan, 2013). Qualitative research methods with local mental health practitioners documented many of the fears experienced by clients with mental illness. The practitioners confirmed the fear clients have of being ascribed labels such as crazy or "loca/loco" (Spanish for crazy). Illicit drug and alcohol use were implicitly included, although not explicitly identified, among the various types of mental illnesses discussed by practitioners affecting their clients (Barrera et al., 2013).

Stigma toward substance use by Mexican–origin Hispanics. The literature regarding the extent of stigma toward individuals with SUDs by Mexican–origin Hispanics has been bereft, with the exception of recent studies measuring attitudes and beliefs of special populations of

Mexican Americans. College students at an Hispanic-serving institution along the US-Mexico border reported little or no objection to the use of cannabis to alleviate anxiety if used by family members (Chavez-Palacios, Blanco, & Graf, 2012). Although gender differences were found on survey items which labeled cannabis use as morally "wrong," males tended to agree with the statement, "*Other than medical use, cannabis(marijuana) use is wrong, regardless of the reasoning behind it*" more than females. The overall sample of predominately Mexican/Mexican American students did not oppose the use of cannabis for family members to alleviate their anxiety. Limitations to these findings may be due to trends in the general acceptance of cannabis use by the majority of Americans (Saad, 2014), which is currently over 51%. Another limitation of the study was the relatively young age of the college students (M = 22) who participated in the survey. Given previous literature on the high prevalence of substance use among college students between the ages of 18-25 (SAMHSA, 2017), it is also reasonable to assume many of the participants had been desensitized to cannabis use and were much more open to cannabis use.

On the opposite end of the spectrum, an exploratory study was conducted to determine the beliefs of older Mexican American women about alcohol use (Hatchett, Holmes, Patterson, & Bryan-Young, 2011). Senior citizen-aged women of Mexican origin agreed on items that the public would lose respect for women who spent time in bars, acknowledging the public stigma associated with alcohol use. A significant number of participants in the study also agreed if they were to have a problem with alcohol, they would attempt to conceal the problem (by not seeking assistance), thus supporting the notion of avoidance of public stigma. Despite a study which found differences in the patterns of substance use by Hispanics who identified as either Mexican or Mexican American (Mercado et al., 2016), no further exploration has been done to measure

the perceptions of stigma toward SUDs from either Mexican or Mexican American self-identified Hispanics on the U.S.-Mexico border.

Stigma Mitigation and Education

An encouraging by-product of many of the studies conducted to measure stigma among counselors has been the willingness expressed by counselor participants to further understand the complex nature of mental illness and SUDs. The use of education or training to mediate the effects of stigma has been repeated in the literature. Hayes et al. (2004) provided counselors with education regarding clinical issues related to drug use and the availability of interventions for substance use disorders in an attempt to reduce the negative stigma toward individuals with substance use disorders. A total of 115 counselors were invited to attend different workshops, and 41 signed up, with 29 attending a day-long workshop for multicultural training and substance abuse education. The primary outcome measure, the Community Attitudes toward Substance Abusers (CASA, Hayes, et al.) instrument of stigmatizing attitudes toward substance abusers was modified by the research team. The CASA scale is a modified version of the Community Attitudes toward the Mentally Ill Scale (Taylor & Dear, 1981) with terms such as "drug addicts and alcoholics" used in place of the original term "mentally ill." Participants in the education condition did not improve significantly at immediate post-treatment measures but demonstrated improved scores during follow-up. Interpretation of these results indicates the effects of education about SUDs impacts attitudes of counselors in the long-term. While the results achieved from the Hayes et al. study were encouraging, the researchers explicitly noted how the small size of the sample resulted in limited power of their analyses, thus limiting the generalizability of the results.

It appears more evident that counselors' graduate training should provide them with proper education on SUDs as well as provide insight into how possible stigma toward SUDs may affect their therapeutic effectiveness. Despite the consensus for the inclusion of substance use and addiction studies in graduate counselor curricula, graduate students in training across academic disciplines continue to demonstrate negative attitudes toward working with SUD clients (Mundon, Anderson, & Najavits, 2015). Comprehensive continuous assessment and reporting of these negative attitudes is essential duty to ensure proper counseling services are provided to a population often overlooked.

CHAPTER III

METHODOLOGY

In this chapter, the investigator discusses the study participants, the instrumentation used, and the procedures followed to protect the anonymity of the participants. Also included are the procedures for data collection and data analysis

The present study assessed stigma toward individuals with substance use disorder (SUDs) among graduate counseling students-in-training and professional counselors. The study also examined self-reported stigma among clients with SUDs. Independent variables based on educational background and prior knowledge in addiction studies were recorded to best analyze the relationships between the variables of counseling discipline and any previous knowledge of the complexities in serving individuals with SUDs received through formal education.

Participants

A sample of convenience was used due to the conveniently available research participants. According to Creswell (2013), convenience samples are appropriate when the limited population of individuals are easily identified or randomized but are reflection of the population that is available and accessible for the data collection process. A representative sample was drawn from a university on the U.S.-Mexico border in South Texas. The sample was comprised of three groups (1) graduate counseling students-in-training attending accredited counseling programs at university (i.e., Rehabilitation Counseling, Social Work, Counseling and Guidance, and Clinical Psychology), (2) professional counselors, and (3) clients with SUDs who

were currently receiving substance-related services. This geographical area was also recently selected by other researchers seeking to ascertain data on Mexican Americans as the border area between the U.S. and Mexico provides a respectable representation of Mexican Americans (Cherpitel, Li, Borges, & Zemore, 2017).

Group 1

Graduate counseling student participants were recruited from graduate counseling courses of the University's (1) College of Liberal Arts Department of Psychology Masters in Clinical Psychology Program, (2) College of Health Affairs School of Rehabilitation Services and Counseling Masters in Rehabilitation Counseling Program, (3) College of Health Affairs Department of Social Work Masters in Social Work Program, and (4) College of Education and P-16 Integration Department of Counseling Masters of Counseling and Guidance Program. A listing of all graduate courses offered by each program was compiled and four courses from each discipline were randomly selected for the study. The designated program chairs/directors from each discipline were e-mailed an Institutional Review Board (IRB)-approved recruitment script to request permission to directly contact instructors/professors of the randomly selected courses. Once permission was granted by the program chairs/directors, the professors of the graduate courses were e-mailed an IRB-approved recruitment script seeking permission to visit their classrooms and recruit students in person. Of the 16 instructors contacted (four from the Rehabilitation Counseling Program, four from the Social Work Program, four from the Counseling & Guidance Program, four from the Clinical Psychology Program), six instructors granted permission to recruit students from their courses (two from Rehabilitation Counseling, two from Psychology, and two from Counseling & Guidance). Despite continuous contact, no

responses were returned thus permission was not provided from Social Work faculty to recruit Social Work graduate students.

Group 2

The next group was comprised of professional counselors with at least a master's degree who were practicing counseling services within the South Texas-Mexico border area. Professional counselors, for this study, are defined as individuals with a graduate degree or higher who may or may not provide services to clients with SUDs residing on the Texas-Mexico border. Specifically, all counselors working within the capacity of a human service/mental health provider with a master's or graduate degree were chosen to participate. Participant selection criteria was exclusive to those who held active occupational licensure from one of the aforementioned academic disciplines and were expected to represent a mixture of licensed master social workers (LMSWs), licensed clinical social workers (LCSWs), certified rehabilitation counselors (CRCs), and licensed professional counselors (LPCs). Counselors were recruited through various methods, primarily by email from a compiled list of prospective research participants provided by a local professional association. Additional counselors were recruited in person by the investigator during attendance at two local mental health conferences and the remainder of participants were recruited via telephone from a list of active licensed professional counselors made available by the state licensure website. The recruitment scripts used for the counselor participants including those contacted by email, telephone, and in person were pre-approved by the university IRB.

Group 3

A group of client participants was obtained to determine the variation of stigma among adult clients with SUDs through recruitment from three licensed substance use treatment

program sites in South Texas. Clients were recruited from both public and private outpatient programs. Initial contact was made between the investigator of the present study and the designated program directors of the three programs via telephone and e-mail. Letters of support from the program directors were obtained and submitted to the university IRB prior to client recruitment. Data was collected by the investigator and lead counselors of the respective programs directly after permission to conduct the study was granted by the program directors. Clients with SUDs were recruited from a combination of three licensed chemical dependency treatment and recovery support programs located on the Texas-Mexico border.

Clients were recruited to participate in the study in person by the investigator and no compensation was provided for clients to complete a survey designed to assess perceived stigma of substance use disorders. Specifically, the investigator made requests via email and by telephone to recruit clients with prior approval from the agency directors. Of three treatment agencies contacted by the investigator for approval, two of them agreed with the request and provided letters of support for study participation. Only agencies which served adult clients over the age of 18 were contacted providing substance use treatment services throughout the South Texas border area.

Sample Size

Participants were categorized into three independent groups and operationalized as graduate counseling students-in-training, professional counselors, and clients with SUDs. A published table on achieving statistical power was consulted in order to better understand the proper number of participants necessary to increase power, thus reducing the likelihood of committing a Type II or beta error when comparing means. It was determined at least 52 participants from each group would be necessary for a design with three groups in order for this

study to achieve approximately the medium effect size at Power set for .80 with an alpha level of .05 (Cohen, 1992). Given that a sample of three groups was used in the analysis, a total of at least 156 participants was required.

Instrumentation

Two separate instruments were utilized to measure (a) stigma toward people with SUDs among graduate students-in-training, counselors, and clients and (b) social desirability to respond in a favorable manner. At present, no instrument which specifically measures stigma toward individuals with SUDs by providers/counselors has been developed. Rather, many of the instruments presented and supported in the current literature have been originally created with the intention of measuring stigma toward mental illness ([Attribution Questionnaire] Corrigan et al., 2004; [Perceived Devaluation-Discrimination] Link et al., 1987). To properly gather data on perceived stigma among graduate counseling students-in-training, counselors, and clients with SUDs, a very limited selection of empirically validated scales was taken into consideration. The selected instruments and justification for the selection of said instruments are presented below. Furthermore, a survey was developed by the researcher to record general demographic information for all study participants.

Instrument to Measure Perceived Stigma

The Perceived Stigma of Addiction Scale ([PSAS] Luoma, O'Hair, Kohlenber, Hayes, & Fletcher, 2010) is a valid and empirically supported instrument to determine perceived stigma toward individuals with SUDs. Luoma et al. (2010) developed and tested the PSAS as a self-report instrument designed to measure perceived stigma by substance users. The PSAS was modified from a measurement originally intended to measure self-stigma among individuals with mental illness. Specifically, the PSAS was derived from the instrument originally developed by

Link, Struening, Rahav, Phelan, and Nuttbrock (1997) as a means to measure mental illness stigma as perceived by former mental health clients. The PSAS was modified from the original Devaluation-Discrimination Measure Questionnaire (Link et al.) by replacing the terms "*former mental patient*" to "*someone who has been treated for substance use"*. Luoma et al. found the questionnaire could be reduced from 12 to eight items after receiving feedback on the content quality from field experts as well as through further analysis with a correlation matrix. After administering the scale to a sample of persons in substance abuse treatment, the PSAS internal consistency alpha was .73, which is considered adequate reliability. The scale has been finalized as a short, eight-item questionnaire with each item using a 5-point Likert scale (six items using reverse scoring), from *strongly agree* (1) to *strongly disagree* (5), with possible scores ranging from 8 to 40, with a mean of 24. Permission to use the scale for the purposes of this study was granted via personal correspondence with the developer of the instrument.

Instrument to Measure Social Desirability

One of the many assumptions that underlies the use of attitudinal scales and surveys is that individuals may be unwilling to provide accurate and honest answers. One of the most common examples of inaccurate responding is known as social desirability or "faking good." An individual following the social desirability response set has the tendency to answer survey items in a manner which they perceive to be the most socially acceptable so as to be perceived in a favorable light. The inclination for participants to respond in ways which are socially desirable are most acute when the questions concern sensitive topics, such as attitudes and substance abuse (van Boekel, Brouwers, Weeghel, & Garretsen, 2014). Given the sensitive nature of the study about attitudes along with the solicitation for volunteers, participants present with the compulsion to respond in a manner which they believe the researcher would want or expect. As

such, an instrument to control for the issue of social desirability will be used along with the other measurements in the study.

Socially desirable responses were expected in this study and a scale to measure and account for this issue was provided to participants. Crowne and Marlow (1960) assessed social desirability by means of the *Social Desirability Scale* (SDS). The shortened form of 13 items rather than the original 33 items of the SDS have since been validated for empirical use by Reynolds (1982). Through factor analysis and assessment of the short forms via product-moment correlation coefficients, the 13-item form was recommended due to a reliability estimate of .76 (Reynolds). Given the brevity and good reliability available from the 13-item shortened form of the Marlowe-Crown scale Form C, this short form of the SDS was selected for this study.

Demographic Survey

The researcher of this study developed a brief demographic survey to include educational background, clinical experience, and identification of Hispanic/Mexican origin. For counselors and graduate counseling students-in-training, relevant questions specific to prior knowledge of SUDs was included as well as the existence of any personal relationships with individuals who have had SUDs. For clients, a question was introduced to ascertain how long they have been receiving SUD treatment services.

The stigma (PSAS), social desirability (SDS), and the demographic surveys, yielded a grade reading level of 7.4 on the Flesh-Kincaid reading test which is appropriate for anyone who can read above a seventh-grade educational level. The combined survey containing the PSAS, the SDS, and the demographic survey was presented for feedback and consideration among an expert panel consisting of two English/Spanish-speaking master's level counselors, a graduate

student, and an Hispanic (Mexican American) counseling faculty member to establish readability of the scales, accurate translation into Spanish, and readability above a seventh-grade level. Feedback from the panel was incorporated into the final survey.

Data Collection Procedures

Graduate counseling students-in-training for this study were recruited through e-mail and verbal communication with course instructors and faculty from the four identified academic departments: Rehabilitation Counseling, Social Work, Counseling and Guidance, and Clinical Psychology. No compensation was available for students to complete the written survey items. For data collection, each academic department/school chair/director and graduate coordinator were contacted for approval to conduct the survey among students who are attending required degree courses rather than elective courses. Specifically, the instructors/faculty for each selected course were contacted to request 15-20 minutes of time to conduct the surveys live, in-class. Packets of surveys as well as instructions on how to complete the surveys were provided to students directly by the research investigator and an undergraduate research assistant. A standard IRB-approved recruitment script was read aloud to the students with an emphasis on voluntary participation, informed consent, and instructions to allow the surveys to be collected by the research assistant upon completion. To eliminate the possibility of perceiving coercion, the instructor/faculty agreed to temporarily leave the classroom while students completed the surveys. All completed and incomplete surveys were collected in a secured box by the research assistant after each administration.

All counselors working within the capacity of a human service provider with a master's degree or higher were chosen to participate; however, only those holding an active license were included in the study. Counselors for the study were recruited throughout the community via e-

mail and phone correspondence with supervisors or program administrators as well as in-person solicitation at counseling conferences, workshops, and through a virtual community of counselors on social media after provided with permission to recruit by the page administrator. Additionally, counselors were contacted by the investigator following a narrowed area search of the Texas Department State of Health Services' (DSHS) Professional Licensing and Certification website. The DSHS lists names and addresses of licensed professional counselors (LPCs) and licensed professional counselor supervisors (LPC-Ss), marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs) as well as licensed master social workers (LMSWs) and licensed master social worker-advanced practitioners (LMSW-APs) which all require a graduate degree. No compensation was available for counselors to complete the survey items. After initial contact to participate with counselors was made with the use of an IRB-approved recruitment script, an opportunity to meet with each counselor individually or as a group (if possible) was made to provide each participant with a packet including the survey, consent, and self-addressed stamped envelope if needed. For counselors with Internet access, a web-link to an online version of the survey hosted by Qualtrics was also made available to them for their convenience.

Clients with SUDs were recruited from a combination of three licensed chemical dependency treatment and recovery support programs. The appropriate clinical supervisor of each treatment program was contacted by the investigator to obtain approval to solicit client volunteers during designated group counseling sessions. Clients were solicited to participate in the study in person by the investigator and no compensation was provided for clients to complete the survey. Only adult clients over the age of 18 were contacted throughout the South Texas-Mexico border area at various outpatient substance use treatment programs. The investigator

arrived at the treatment facilities at the beginning of scheduled group sessions to recruit clients to participate via the use of an IRB-approved in-person recruitment script. The investigator then provided packets of surveys, consent forms, and envelopes which the research assistant distributed to all clients. Clients who decided not to participate were allowed to turn in their surveys incomplete. The investigator provided the group of clients with a similar secured box to turn in their consent forms and surveys. The lead counselors were asked to wait outside of the room until the surveys were completed to eliminate coercion.

All participants for this study were provided with IRB-approved informed consent forms (available in either English or Spanish) which were verbally reviewed by the investigator along with participants prior to distribution of the surveys. No participants chose to withdraw or revoke their consent to participate during the study.

CHAPTER IV

RESULTS

The purpose of the present study was to provide evidence to either support or reject three hypotheses related to stigma, Mexican American culture, and academic graduate disciplines (1) Are there differences in stigma toward individuals with SUDs among graduate counseling students-in-training, counselors, and clients with SUDs who identify as Mexican-origin Hispanics (2) Is there a difference between stigma toward individuals with SUDs as perceived by graduate counseling students-in-training and counselors who identify as Mexican-origin Hispanics? and (3) Is there a difference in stigma toward individuals with SUDs among graduate counseling students-in-training from different educational backgrounds who identify as Mexican-origin Hispanics? The researcher conducted the study among 77 master's level counseling students in training, 54 counselors, and 52 clients with SUDs who were actively participating in counseling treatment programs. All participants were of either Mexican or Mexican American heritage residing along the Texas-Mexico border. Chapter four of this study includes presentation of the sample demographics and discussion of participants' demographics. Chapter four also includes a presentation of descriptive statistics and scale/instrument psychometric properties (e.g., reliability coefficients). The dependent or criterion variable utilized for analysis of variance was perceived stigma toward substance use. The independent variables were academic discipline for graduate counseling students-in-training and group type (i.e., student, counselor, or

client). The dependent or criterion variable utilized for t-test analysis was perceived stigma toward substance use. The independent variable for the t-test analysis was professional experience as a counselor. The null hypotheses for the present study were tested with an F distribution or student's t-distribution at the .05 level of significance. A summary and interpretation of the research findings conclude this chapter.

Data collection began immediately upon receiving approval from the IRB and continued over a 10-month period until the number of required participants were met for each group as calculated in the methodology section. General descriptive statistics were conducted using the data gathered from the sample including measures of central tendency and measures of variability (ranges, variances, standard deviations). The primary analysis for the study was an analysis of variance (ANOVA) in order to determine differences among means in responses from each group in the sample with regard to perceived stigma. Given the stigma survey (PSAS) is a measurement using an interval scale, an ANOVA was appropriate. All analyses were conducted using the latest edition of IBM Statistical Package for the Social Sciences (SPSS) version 25.

Sample Descriptive Statistics

A total of 187 prospective surveys were obtained from the three groups of participant pools (1) students (2) counselors (3) clients. It was determined four surveys could not be used due to a significant amount of blank responses and missing data. The four surveys which were excluded were electronic submissions of the survey from the LPC target group, and it was decided to omit these surveys since participants only completed one or two item responses. The remaining participants (N = 183) were comprised of 54 participants from the counselor group, 77 participants from the graduate student group, and 52 from the client group.

A significant majority of the total participants identified their race/ethnicity as "Hispanic/Latino" (*n* = 167, 93.4%) and among those who identified as "Hispanic/Latino" 73.1% (*n* = 122) identified their Hispanic origin as "Mexican American" and 25.1% (*n* = 42) identified as "Mexican." Of the remaining choices available, participants identified as "Other Hispanic" (*n* = 2, 1.1%) and Puerto Rican (*n* = 1, 0.5%). Other participants who did not identify as "Hispanic/Latino" as their race/ethnicity identified as either "White/Non-Hispanic" (*n* = 11, 6.0%), "Asian" (*n* = 2, 0.5%), "American Indian/Alaskan Native" (*n* = 1, 0.5%), or "Black/African American" (*n* = 1, 0.5%). The minimum age of a participant in the sample was 19 (*n* = 1) and the maximum age was 77 (*n* = 1), thus the age range is 58 years and the mean age of all participants was 31 (SD = 9.29). Overall, a greater proportion of the participants were female (*n* = 120, 65.2%) rather than males (*n* = 62, 33.7%) and no participants self-identified as any other gender. Table 1 provides comprehensive demographic information.

Table 1 Group Demographic Information

Characteristics	Students (*n* = 78)	Counselors (*n* = 54)	Clients (*n* = 52)
Gender			
Males	13	14	35
Females	64	40	16
Mean age	26	37	32
Race/Ethnicity Self-identity			
Hispanic/Latino	73	45	49
Mexican-Origin Hispanics			
Mexican	21	13	8
Mexican American	52	32	38

Student Descriptive Statistics

From the six graduate courses in which students were recruited, a total of 78 surveys were returned to the research assistant(s). All 78 surveys were deemed to be valid for inclusion

in this study as only a few items of missing data were recorded, and no surveys were excluded from the sample. The minimum age reported was 21 (n = 1) and the maximum age reported was 52 (n = 1) which indicates an age range of 31 years. The mean age of this group was 26.81 (SD = 6.45). The difference between genders was significant as the vast majority of students were females (n = 64, 82.1%) rather than males (n = 13, 16.7%). When asked to identify their race/ethnicity 93.6% (n = 73) of the students identified as "Hispanic/Latino" and among those who identified as Hispanic/Latino 71.2% (n = 52) specified they were "Mexican American" Hispanics. The remaining Hispanic students (n = 21, 28.8%) identified as "Mexican." As far as academic disciplines reported, most students declared they were studying Rehabilitation Counseling (n = 43, 55.1%) from the College of Health Affairs, followed by Clinical Psychology (n = 19, 24.4%) from the College of Liberal Arts, and then Counseling and Guidance (n = 16, 20.5%) from the College of Education & P-16 Integration.

Approximately 9% (n = 7) of students reported having some experience providing counseling services, with valid responses ranging from three months to three years. Additionally, when asked about experience counseling clients with SUDs the majority of students stated they had no experience (n = 63, 80.8%) and others reported having counseled only a few clients with SUDs (n = 9, 11.5%) followed by students who reported they counseled many clients with SUDs (n = 3, 3.8%) and an equal amount reporting their counseling experience was almost all with clients with SUDs (n = 3, 3.8%). The majority of students reported they had received formal education about SUDs (n = 47, 60.3%) either through attendance of a professional workshop (n = 19, 24.4%) or through enrollment in a formal course (n = 28, 35.9%). However, over one-third of the students (n = 31, 39.7%) reported they had never received formal education about SUDs. When asked if either themselves or if anyone they

personally knew had ever had a personal experience with substance use, the majority (*n* = 60, 76.9%) of students confirmed they had. All but two student participants reported they were pursuing licensure as a professional counselor or were already licensed as a professional counselor (97.4%) and five of the total students (6.9%) reported holding other counseling credentials or certifications including Certified Rehabilitation Counselor (CRC) (*n* =1, 1.3%), Licensed Chemical Dependency Counselor (LCDC) (*n* = 2, 2.6%), and Special Education (*n* =1, 1.3%) (See Table 2).

Table 2 Graduate Counseling Students' Demographic Information

Characteristics	*f*
Academic Discipline	
Counseling & Guidance	16
Clinical Psychology	19
Rehabilitation Counseling	43
Total *n*	78
Hold current license	
Yes	2
No	76
Hold certification	
Yes	7
No	71
Counseled SUDs	
Exclusively	3
Many clients	3
A few	9
None	63
Certification/License types	
CRC	1
LCDC	2
LPC	2
SpEd	1
Addiction Knowledge	
Workshop	19
Formal Course	28
None	31

Counselor Descriptive Statistics

A total of 54 surveys were collected for the counselor group and were deemed valid and usable for analyses. A total of 112 counselors were contacted to participate and received a survey to complete either in-person or via email, thus the response rate was 48%. The minimum age reported was 24 (n = 1) and the maximum age reported was 77 (n =1) which indicates an age range of 53 years. The mean age of this group was 37 (SD = 9.47). As for gender, there were more females (n = 40, 74.1%) who participated in the study than males (n = 14, 25.9%). Most (n = 45, 83.0%) identified their race/ethnicity as "Hispanic/Latino" with the majority of these participants (n =32, 71.1%) identifying their Hispanic/Latino origin as "Mexican/American." Approximately one quarter of the counselors identified their Hispanic/Latino origin as "Mexican" (n =13, 28.9%).

Graduate degree disciplines were recorded among the counselors via an open-ended question in the survey. Of the various graduate disciplines reported by the counselors, the greatest number obtained their graduate degree in Rehabilitation Counseling (n = 14, 25.9%) and the second most represented group obtained their graduate degree in Counseling & Guidance (n = 12, 22.2%). The other graduate disciplines reported were Clinical Psychology (n = 9, 16.7%), Social Work (n = 4, 7.5%), Community Counseling (n = 2, 3.8%), and Behavioral Health (n = 1, 1.9%), Special Education (n = 1, 1.9.0%); the remaining 5 (9.5%) reported were a combination of inconclusive responses such as "CRC," "Medical field," "Licensed Professional Counselor, and Licensed Chemical Dependency Counselor," and "M.Ed., LPC." It is possible many of the participants unintentionally reported their professional credentials for this item rather than their graduate academic disciplines. When asked if they held other professional licenses or credentials in addition to professional counseling licensure, participants from Group 1 also reported being

Licensed Chemical Dependency Counselors (LCDCs) or Licensed Chemical Dependency Counselor Interns (LCDC-Is) (*n* = 13, 24.7%), Certified Rehabilitation Counselors or CRCs (*n* = 5, 9.5%), LPC-Supervisors (*n* = 3, 5.6%), and Licensed Social Workers (*n* = 3, 5.6%).

A range of professional counseling experience was reported by participants in the counselor group, with the minimum experience reported as one year (*n* = 2, 3.7%) and the maximum experience reported as 23 years (*n* = 1, 1.9%) yielding a range of 22 years. The mean years of counseling experience among the counselors was 7.6 years (*SD* = 5.54). Most counselors (*n* = 21, 38.9%) reported they were currently employed in public/non-profit settings followed by those working in a private setting (*n* =15, 27.8%), several working in criminal justice settings (*n* = 3, 5.6%), and the remaining working in a setting described as "Other" (*n* = 5, 9.3%). Ten counselors (18.5%) reported they were currently not working in any type of a clinical setting.

When asked to determine the experience and quantity of counseling services counselors had provided, a slight majority reported having provided counseling services to individuals with SUDs. Specific responses included most counselors reporting they had provided counseling services to many clients with SUDs (*n* = 23, 42.6%) and a few of them reported they exclusively provided counseling services to persons with SUDs (*n* = 6, 11.1%). Conversely, many reported having only provided counseling services to only a few individuals with SUDs (*n* = 17, 31.5%) and eight participants (14.8%) reported having never provided counseling services to persons with SUDs.

Counselors were also queried about their attendance at a professional workshop about SUDs and/or completion of a formal course on SUDs to ascertain specific substance-related education. The majority of counselors reported receiving prior education on SUDs, with most (*n*

= 23, 42.6%) having been enrolled in a formal education course and a similar number (*n* = 22, 40.7%) having attended a professional workshop. However, a few participants reported having no prior education about SUDs (*n* = 9, 16.7%). Of particular interest was the number of counselors who reported personally knowing someone who has had a SUD or even self-reporting having an SUD (*n* = 43, 79.6%). (See Table 3)

Table 3 Counselors' Demographic Information

Characteristics	*f*
Academic Discipline	
Counseling & Guidance	12
Clinical Psychology	9
Rehabilitation Counseling	14
Counseling Psychology	2
Social Work	4
Community Counseling	2
Total *n*	54
Years of Experience	
20+	1
15-19	2
11-14	2
6-10	8
1-5	10
Counseled SUDs	
Exclusively	6
Many clients	23
A few	17
None	8
Certification types	
CRC	5
LCDC	9
Addiction Knowledge	
Workshop	22
Formal Course	23
None	9

Clients Descriptive Statistics

From the four different group counseling sessions at three different substance use treatment settings visited to recruit clients for the study, a total of 52 surveys were completed and returned to the principle investigator. While participants in the counselor and student groups were provided with similar surveys to record demographic information relevant to clinical experience, those items were omitted from surveys provided to participants in the client group. The ages of clients ranged from 19 years old to 55 years old (Range= 36) and the mean age was nearly 32 years old (M = 31.98, SD = 8.6). Clients were the only group in which there were more male (n = 35, 67.4%) than female (n = 16, 30.8%) participants. When asked about which race/ethnicity they most identified with 94.2% (n = 49) responded as "Hispanic/Latino" and 5.8% (n = 3) identified as "White (non-Hispanic)." Among those who identified as Hispanic/Latino, the majority of clients identified as "Mexican American" (n = 38, 73.1%) followed by those who identified as "Mexican" (n = 8, 15.4%), then "Puerto Rican" (n = 1, 1.9%), and "Other" (n = 2, 3.8%) which included one participant who identified as "Dominican" and another who identified as "Peruvian." The final demographic question asked of this group was how long they had been receiving services for their SUD and most indicated they been receiving care for "Less than a year" (n = 40, 76.9%). The following responses about receiving care were between "1-2 years" (n = 5, 9.6%), followed by "3-4 years" (n = 3, 5.8%), and finally "more than 5 but less than 10 years" (n = 4, 7.7%). (See Table 4)

Table 4 Clients' Demographic Information

Characteristics	*f*
Ages	
45+	5
40-44	1
35-39	12
30-34	8
25-29	11
18-24	10
Total *n*	47
Years in treatment	
10+ yrs	4
5-10 yrs	3
1-2 yrs	5
1 yr or less	40
Total *n*	52

Perceived Stigma of Addiction Scale (PSAS) Scores

The Perceived Stigma of Addiction Scale (PSAS; Luoma et al., 2010) was the first scale embedded into the survey to measure perceptions of stigmatizing beliefs toward substance use by all participants. Higher scores indicate perceptions of more frequent negative attitudes toward addiction. Proper scoring of the scale requires reverse-scoring for items 1, 2, 3, 4, 6, and 8. Once reverse-scoring was completed for all the surveys, a total composite score was created and labeled as PSAS. For student participants, the PSAS mean score was 21.44 (*SD* = 4.05). For counselor participants, the PSAS mean score was 21.1 (*SD* = 4.17). For client participants, the mean PSAS score was 22.13 (*SD* = 4.38). (See Table 5)

Within the group of graduate counseling students-in-training, the PSAS scores were collected by the three types of academic disciplines identified. For students in the Counseling & Guidance program, the PSAS mean score was 22.69 (*SD* = 3.48). For students in the Clinical Psychology program, the PSAS mean score was 22.58 (*SD* = 4.26). For students in the Rehabilitation Counseling program the PSAS mean score was 20.47 (*SD* = 3.97). (See Table 6)

Table 5 PSAS Mean Scores by Group

Group Type	*M*	*SD*	*n*
Student	21.44	4.07	77
Counselor	21.10	4.12	50
Client	22.13	4.45	52

Table 6 PSAS Mean Scores by Student Academic Discipline

Graduate Discipline	*M*	*SD*	*n*
Counseling & Guidance	22.69	3.48	16
Clinical Psychology	22.58	4.26	19
Rehabilitation Counseling	20.47	3.97	43

Social Desirability Scale (SDS) Scores

All participants were provided with the Marlowe-Crowne Social Desirability Scale abbreviated Form C at the conclusion of the survey to determine if participants were self-presenting responses with a socially desirable bias (Reynolds, 1982). Reverse scoring was applied to items 5, 7, 9, 10, and 13. Upon the completion of reverse scoring, the total scores were summed into a newly created column labeled SDS scores. The published mean score for this 13-item scale is 7.61 and the mean score for this study's sample was 6.95, slightly below the mean. The minimum score reported in this sample was 2 and the maximum score reported was 11 (Range = 9). For student participants, the SDS mean score was 7.01 (*SD* = 2). For counselor participants, the SDS mean score was 7.73 (*SD* = 1.79). For client participants, the mean score was 6.15 (*SD* = 2.11). (See Table 7)

Table 7 SDS Means by Groups

Group type	*n*	*M*	*SD*	Minimum	Maximum
Student	77	7.01	2.00	2	11
Counselor	48	7.73	1.79	4	11
Client	52	6.15	2.26	2	11
Total	177	6.95	2.11	2	11

Analysis of Variance

The primary statistical analysis used to reject the null hypotheses was a one-way analysis of variance (ANOVA). Three separate ANOVAs were conducted for this study, the first two were comparisons of the means scores on the PSAS by groups (see Table 8) followed by a comparison on PSAS by academic disciplines. (See Table 9). A final ANOVA was conducted to compare mean scores on the SDS which was also recorded from each group of participants in order to measure potential socially desirable response bias. (See Table 10)

Differences in Perceived Stigma among Groups

A one-way analysis of variance was conducted to compare mean scores of the PSAS among the three groups of participants. The differences in mean scores was found to be not statistically significant $F(2, 176) = .999$.

Difference in Perceived Stigma among Academic Disciplines

A one-way analysis of variance was conducted to compare mean scores of the PSAS among the group of graduate counseling students-in-training based on their reported academic discipline. The differences in mean scores was found to be not statistically significant $F(2, 75) = 2.896$. (See Table 9)

Table 8 Perceived Stigma of Addiction Scale (PSAS) One-Way ANOVA

	Sum of Squares	df	Mean Square	*F*	Sig.
Between Groups	35.19	2	17.59	.999	.370
Within Groups	3099.05	176	17.61		
Total	3134.25	178			

Table 9 PSAS One-Way ANOVA by Graduate Student Academic Discipline

	Sum of Squares	df	Mean Square	*F*	Sig.
Between Groups	90.41	2	45.21	2.89	.061
Within Groups	1170.77	75	15.61		
Total	1261.18	77			

Difference in Social Desirability Responses

A one-way analysis of variance was conducted to compare mean scores of the SDS among the three groups of participants. The differences in mean scores was found to be statistically significant $F(2,174) = 7.55$, $p < .001$ (see Table 10). A post-hoc Bonferroni test indicates a significant difference between the mean scores of the Counselor and Client groups, $p < .05$. Specifically, the mean scores on the SDS recorded from the group of counselors were significantly higher than those recorded from the group of clients. This difference in social desirability response bias by counselors could have affected the observed mean scores on the PSAS.

Table 10 Social Desirability Scale (SDS) One-Way ANOVA

	Sum of Squares	df	Mean Square	*F*	Sig.	Partial Eta Squared
Between Groups	62.40	2	31.20	7.55	.001	.080
Within Groups	719.23	174	4.13			
Total	781.64	176				

Independent Samples T-test

An independent samples t-test to compare means scores of stigma on the PSAS was conducted between the participants in the group of graduate counseling students-in-training and the group of professional counselors. There was no significant difference found between the PSAS scores of professional counselors ($M = 21.08$, $SD = 4.11$) and the PSAS scores of students ($M = 21.41$, $SD = 4.06$); $t(125) = -.45$. (See Table 11)

Table 11 Independent Samples t-Test of PSAS Scores

	F	Sig.	*t*	df
Equal variances assumed	.174	.677	-.452	125
Equal variances not assumed			-.451	103.88

Post Hoc Effect Size and Power

Since no statistical significance was found in the hypotheses, post hoc power analyses were conducted as a means to calculate effect size and observed power. According to Cohen's (1988) guidelines, small effect size ranges from eta of .01 to .05, medium effect size ranges from .059 to .1 and large effect size ranges from .138 and above.

For the ANOVA comparing means on SDS scores a medium effect size (η = .08) for the differences in means between the three groups was observed, indicating at least 8% of the variance, or change in the dependent variable (SDS score) can be accounted for by the independent variable (group type). The observed power was for this ANOVA was .94.

For the ANOVA comparing mean scores among graduate students by academic discipline, a medium effect size was met (η = .72). Observed power for this ANOVA was .55. This indicates the power to overcome a Type II-error was not met, thus it may be possible to achieve the power and observed a significant difference in PSAS scores among academic disciplines given a larger sample size.

CHAPTER V

DISCUSSION

Purpose

A primary purpose of this study was to investigate self-stigma among Mexican Americans with substance use disorders (SUDs) involved in counseling services on the U.S.-Mexico border. Attitudes and perceived stigma of SUDs by Mexican American counselors providing services to a predominantly Mexican American population have not been explored. Furthermore the academic graduate programs which provide training to counselors would also provide information about where variation in stigma may originate. Given the recent changes made in accreditation standards for graduate programs to prepare counselors to serve clients with SUDs (Moro, Wahesh, Likis-Werle, & Smith, 2016), this study also served to evaluate whether variation in addiction education among graduate students from different academic disciplines has influenced their attitudes toward SUDs.

Conclusions

This was an exploratory study as a thorough search of the literature on stigma toward SUDs yielded no evidence that compared perceptions of Mexican/Mexican American counselors, graduate counseling students-in-training, and clients who were receiving SUD services. Results from this study revealed no differences in the measured perception of stigma toward SUDs among the three groups of participants; graduate counseling students-in-training, counselors, and clients. Specifically, all three groups recorded similar scores on the Perceived

Stigma of Addiction Scale ([PSAS] Luoma et al, 2010), a modified mental illness stigma scale developed to measure the perception of stigma toward SUDs. This was an unexpected result considering the post-licensure experience and education obtained by professional counselors about clients with SUDs should have manifested as relatively lower stigma toward SUDs than the other groups in this study (Livingston, Milne, Fang, & Amari, 2011). Specifically, professional counselors were expected to manifest lower scores on the stigma scale than students due to the anticipated lack of clinical experience among graduate students. The group of clients with SUDs were expected to manifest the highest stigma scores based on their lived experience and contributing self-stigma, which was expected to affect their perceptions on how other individuals view SUDs. The lack of statistical differences between these groups does not allow us to reject the null hypothesis for research question 1: There will be no significant difference in stigma toward individuals with substance use disorders (SUDs) as perceived among graduate counseling students-in-training, counselors, and clients (with SUDs) who identify as Mexican–origin Hispanics.

While the differences in means scores on the PSAS were not significant, the recorded scores for each group provided unique outcomes. Professional counselors manifested the lowest scores among the three groups, followed by the graduate counseling students-in-training, whose recorded scores were only slightly higher than the professional counselors. As expected, the group with the highest perceived stigma scores were the clients with SUDs. Overall, the three groups' means scores were slightly below the mean for the stigma scale which indicates they all manifested perceived stigma about the same as most others in the general population. This suggests perceived stigma may not vary among Mexican-origin Hispanics. Based on the post hoc test for between-subjects effects, it was determined (had the difference been significant) the

effect size would only meet the small effect size range. Therefore, it can be concluded one of the reasons why a significant difference was not observed among the PSAS scores is due to the size of the sample (O'Keefe, 2007). If this study were to be replicated with a similar population yet a larger sample, it is expected a significant difference in mean scores could be observed.

Additional speculation for the lack of significant difference in perceived stigma could be due to homogeneity in perceived stigma within Mexicans/Mexican Americans who may be acculturated to the dominant American culture. Evidence has shown Hispanics (Mexican Americans included) use illicit drugs at greater rates and are more susceptible to developing SUDs when they are more acculturated to the dominant culture compared to other Hispanics (Mexican Americans) who are otherwise not acculturated to the dominant culture (e.g., Blanco et al., 2013). Much of the previous literature exploring stigmatizing attitudes among Mexican Americans has focused on immigrants and has measured level of acculturation, yet research has shown younger Mexican Americans may manifest less stigmatizing attitudes toward SUDs than older, less acculturated Mexican Americans (Florez et al., 2015; Hamilton, Mann, & Noh, 2011). Acculturation could serve as a confounding variable as the median age of the entire sample in the present study was 29 years old, which is relatively young and indicates this sample may likely include many participants who grew up acculturated to the dominant American culture. If the majority of participants in this study are acculturated to the dominant culture, that could have affected their responses on the perceived stigma scale. The degree of acculturation to the dominant culture can also be observed in this study by the participants' tendencies to self-identify as "Mexican American" rather than "Mexican." However, it cannot be determined exactly how acculturated these participants are to the dominant culture, as acculturation was not one of the independent variables investigated in this study.

The second research hypothesis was contingent upon finding significance in differences among the groups on perceived stigma. Particularly, the second research hypothesis was designed to investigate differences in stigma between counselors and graduate counseling students-in-training. The expected difference was due to the variation in professional training and experience with clients who have SUDs among counselors compared to the amount of training and experience with SUDs among graduate counseling students-in-training. It has been documented that more education about SUDs can reduce the stigma toward addiction in graduate counseling students-in-training and professionals (Moro, Wahesh, Likis-Werle, & Smith, 2015). Although professional counselors reported greater frequency of addiction education attendance than graduate students, the mean stigma scores for both groups were nearly identical. A post-hoc test of between-subjects effects was conducted to determine the potential effect size and observed power of the t-test comparing means between counselors and graduate students. The partial eta squared revealed a small effect size from this analysis and observed power was low as well. It is unlikely a significant difference would have been observed if the sample size for this analysis was larger. It may not be significant due to the possibility that many of the professional counselors who participated in this study attended the graduate programs where the counseling students-in-training received their education. Thus, professional experience may not have affected perceived stigma toward SUDs for either counselors or graduate counseling students-in-training in this sample.

The focus of the final research question was to investigate differences in mean scores among graduate counseling students-in-training due to academic discipline. Based on the previously cited literature on addiction education and stigma (e.g., Lee, 2014), it was assumed there would be variation in the addiction education offered between graduate students in

rehabilitation counseling, counseling & guidance, and clinical psychology, especially if there was variation in the knowledge of SUDs amongst the faculty delivering the content. Although no significant difference was found in perceived stigma based on academic discipline, the rehabilitation counseling graduate students' scores were lower than the scores from counseling and guidance and clinical psychology students. This finding suggests graduate students in the rehabilitation counseling group may have received greater amounts of addiction education or they may have had more exposure to individuals with SUDs which could account for their lower perceived stigma. A post-hoc test of between-subjects effects was conducted to determine the potential effect size and observed power of the ANOVA comparing means amongst academic disciplines. The partial eta squared indicated a small effect size from this analysis and observed power was moderate. As such, it is possible a significant difference would have been observed if the sample of students represented in this analysis were larger, reducing the probably of committing a Type-II (Beta) error.

Limitations

A sample of convenience was obtained by soliciting volunteers which may influence responses due to invalid response sets such as social desirability. Although participants were instructed to respond to the survey questions honestly and offered no tangible incentives to complete the survey, it is possible participants provided responses in a manner they believed to be socially desirable. Controlling for social desirability responses continues to pose a validity problem for social-behavioral investigators who rely on self-report data and subsequent analyses of that data (Lorenzo-Seva & Ferrando, 2012); however, the decision was made to measure social desirability rather than attempting to eliminate it. Social desirability bias was analyzed

with the other participant data collected and the results revealed a significant difference in the amount of socially desirable responses manifested by the counselor group of participants.

Overall, the social desirability scores (SDS) of the entire sample was slightly below the mean for the particular scale used. However, the SDS scores were significantly different between the professional counselor and client participants. This difference indicates counselors completed the survey using socially desirability responses more than graduate students, and even more so than clients with SUDs. Many other inferences can be made due to the significant difference in socially desirable responding. Perhaps the most compelling inference is the support of previous literature which implies social desirability responding can be influenced by cultural normativity (Malham & Saucier, 2016). Although it was not specifically measured, it can be assumed based on the differences observed in SDS scores that culture normativity affected the responses by counselors in this survey. Thus, the measurements of stigma from counselors may have also been influenced by cultural normativity, specifically norms among professional counselors, and the desire to respond in a manner which was deemed to be socially desirable. Conversely, only a slight majority of the counselors reported having provided counseling services to individuals with SUDs and of those, many reported having only provided counseling services to a few individuals with SUDs. As such, counselors may have responded in a socially desirable manner to overcompensate for their limited experience in working with clients with SUDs.

The instrument used to measure perceived stigma, while presenting good reliability, may actually be a limitation in the validity of the concept measured for this sample. For example, the PSAS measures how an individual perceives stigma of others with SUDs. It may be possible that a portion of the graduate counseling students-in-training as well as counselors were

responding in an honest manner and they may not perceive SUDs as a distinct problem. In fact, it may be possible graduate students and counselors, both trained by similar codes of ethics, believe stigma toward individuals with SUDs no longer exists in the public.

Another limitation to consider is previous evidence published in the psychosocial and rehabilitation literature supporting the theoretical basis of this study was ascertained from professionals working as licensed mental health counselors, social workers, substance abuse counselors, and rehabilitation counselors. However, this study was unable to ascertain participants to represent professional social workers and graduate students from social work as well. Previously presented literature on stigma toward individuals with SUDs was collected primarily by using undergraduate student samples and few have investigated stigma among students in graduate studies or those working on advanced degrees in counseling individuals with SUDs. At this time, there was minimal published literature on the attitudes of counselors' who identify as Mexican–origin Hispanics toward individuals with SUDs.

Implications

Initially, this study sought to explore various types of stigma (namely provider stigma) within a culture which has not previously been involved in such investigation. The possible implications can be identified as implications for clinical practice and implications for counselor education.

Implications for Counselor Practice

Perhaps the most notable finding from this study is the continued manifestation of stigma toward SUDs perceived by professional counselors. To remediate such stigma, a suggestion would be for clinical supervisors and mentors to initiate methods to reduce stigma among supervisees and colleagues. Promising strategies have been published on how to reduce provider

stigma for some time (Hayes et al., 2004; Luoma et al., 2008; Michaels et al., 2014), namely by introducing changes in the delivery of professional training to professional counselors. Although much of the current literature offers strategies for reducing provider stigma toward clients with mental illness, it is reasonable to believe these strategies would be applicable for reducing stigma toward clients with SUDs as well. One intervention recommended by Mittal, Corrigan, Drummond, Porchia, and Sullivan (2016) involves having prolonged contact with individuals who have recovered from mental illness. Additionally, the counselors in the study conducted by Mittal et al. (2016) were provided with the ability to suggest the particulars of the intervention being introduced to reduce stigma. For example, the counselors preferred having contact directly in-person with a person in recovery of mental illness and a similar training model can be created with a person in recovery of a SUD instead, if requested by clinicians. This evidence strongly suggests clinical (counselor) supervisors should incorporate more direct contact with an individual in recovery from a SUD to serve as a training opportunity and stigma-reducing intervention.

Implications for Counselor Education

This study provided support for previously published literature on the importance of addiction education and knowledge of SUDs for graduate counseling students-in-training. Aside from providing content which expands on the theories, etiology, and the disease concept of addiction as provided by CACREP standards (Lee, Craig, Fetherson, & Simpson, 2012) graduate school faculty can implement additional interventions to reduce stigma toward SUDs.

The initial intervention to reduce stigma toward SUDs could be to allow graduate counseling students-in-training to reflect on their attitudes toward SUDs in a manner designed to facilitate understanding of the variability of perceived stigma which exists amongst all groups.

Allowing students to understand that variability of perceived stigma is common among graduate counseling students-in-training may reduce the likelihood students would feel compelled to augment their attitudes about perceived stigma in order to fulfill expectations that would met the social norm. In other words, acknowledgement of stigma toward SUDs in graduate school may help promote an individual's professional growth and professional perceptions toward SUDs.

Another intervention suggested by Hayes and Levin (2012) involves providing graduate counseling students-in-training with greater knowledge of addiction-specific counseling theories, such as acceptance and commitment therapy (ACT) and screening, brief Intervention, and referral to treatment (SBIRT) which entails empathetic responses to SUDs. The intervention proposed by Hayes and Levin provides students with additional competencies beyond just the minimal requirements to meet the CACREP standards. Also, graduate faculty should make efforts to reduce stigma by monitoring for pejorative language in addiction scholarship and academic works then bringing that language to the attention of students (Broyles et al., 2014). Evidence has shown the use of "person-first language," focusing on the individual rather than the nature of the condition, can reduce stigma towards a population. As educators, we have many opportunities to guide and correct stigmatizing language into academic works such as publications with other educators or students as the intended audience.

Suggestions for Further Research

The information provided by this study can be built upon with research focused on the same population and culture, Mexican Americans along the U.S.-Mexico border, with various additional research questions. Primarily, the degree of acculturation and the relationship or influence acculturation may have on stigma should be measured. It was noted that because this was a sample of convenience, it was also likely that participants were acculturated to the

dominant culture which could lead them to seek graduate studies, become a professional counselor, or participate in SUD counseling services.

Additionally, greater recruitment efforts should be made to include participants (both students and practitioners) from social work as there is extensive literature which indicates social workers may also harbor stigmatizing attitudes toward people with SUDs (Araten-Bergman & Werner, 2017). However, those attitudes were not captured in this study. Another variable which should be further explored is the variation in the degree of knowledge of SUD observed by the different groups of academic graduate disciplines. While data about variation in addiction studies knowledge was captured in this study; therefore, additional research on knowledge regarding SUDs is highly necessary for understanding stigma toward SUDs.

Although socially desirable responding was recorded among the clients who participated in this study, it was unclear what effect, if any, was made by the clients' willingness to participate in treatment services. That is, it was unclear whether individual clients were mandated to attend treatment services or if they were attending services due to intrinsic motivation. As previously mentioned in the introduction to this study, there are a variety of reasons why clients participate in substance use treatment services. In relation to other clientele, individuals with SUDs are more likely to be mandated to participate in treatment services than individuals with mental illnesses and mandated services may affect client attitudes (Wild, Yuan, Rush, & Urbanoski, 2016). It would provide greater clinical insight if the relationship between perceived stigma and a clients' readiness to change (or stage of change) were explored. It is also likely clients within this particular population, as indicated by their social desirability scores, were more open to discussing stigma than their counselor counterparts.

Finally, efforts should be made to determine effective interventions to reduce stigma among Mexican Americans, especially those living on the U.S.-Mexico border where they are likely to be underserved or provided with below standard services. Much support is available for the use of a few interventions designed to reduce provider stigma, sometimes with mixed results (Crapanzano, Vath, & Fisher, 2014). However, most of these interventions have not been standardized or measured within the Mexican American culture. The creation of an appropriate, culturally-based training intervention model specific to Mexican American counselors and Mexican American counselors-in-training should be based on the evidence presented in this study as well as the suggestions from subsequent publications in order to improve the quality of life of a group of people which, much like individuals living with SUDs, are often forgotten by the mainstream.

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APPENDIX A

APPENDIX A

SUBSTANCE USE ATTITUDE SURVEY FOR COUNSELORS AND GRADUATE COUNSELING STUDENTS

DO NOT write your name on this.

Please Check the Box or Write a Response for the Following Survey Questions:

1. Your age: _____ **2. Your Gender:** ❑ Male ❑ Female ❑ Other

3. With which race/ethnicity do you most identify?

❑ American Indian/Alaska Native ❑ Asian ❑ Black/African ❑ Hispanic/Latino
❑ Native Hawaiian/Pacific Islander ❑ White (non-Hispanic) ❑ Other (*please specify*): _____

4. If you are *Hispanic*, with which *Hispanic* origin do you most identify:

❑ Cuban ❑ Mexican ❑ Mexican American ❑ Puerto Rican
❑ Other Hispanic/Latino (Please specify):_____

5. Are you a current graduate student (Master's or Ph.D.)? ❑ Yes ❑ No

6. What is your graduate academic discipline? (e.g., Social Work, Guidance & Counseling)
_____

7. Do you have any previous experience as a counselor? ❑ Yes ❑ No

8. If *Yes*, How many months/years?_____

9. Have you or do you plan to obtain licensure as a licensed professional counselor (LPC)?
❑ Yes ❑ No

10. Do you have any specific credentials or certifications (e.g., LCSW, CRC)? ❑ Yes ❑ No

11. If so, please list all of them:_____

12. Have you counseled clients with substance use disorders (e.g., alcohol/drug dependence or abuse)?

❑ Yes, almost all of my clients have SA issues ❑ Yes, many clients with SA issues
❑ Yes, but only a few ❑ No, none

13. Have you ever attended a workshop or formal course on substance abuse and/or substance abuse counseling?

❑ Yes, a workshop ❑ Yes, a formal course ❑ No, neither

14. Have you or anyone you know had a significant personal experience with drug use?

❑ Yes ❑ No

15. Which of the following best describes your current/most recent clinical setting (employment)?

❑ Private Agency ❑ Public/Non-Profit ❑ Criminal Justice ❑ Not in a Clinical Setting
❑ Other

The following scale is meant to explore some of *your* feelings toward substance use. It is not meant to test what you know.

Please check the box that best describes *your* attitudes.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Most people would willingly accept someone who has been treated for substance use as a close friend.	❑	❑	❑	❑	❑
2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.	❑	❑	❑	❑	❑
3. Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.	❑	❑	❑	❑	❑
4. Most people would hire someone who has been treated for substance use to take care of their children.	❑	❑	❑	❑	❑
5. Most people think less of a person who has been in treatment for substance use.	❑	❑	❑	❑	❑

6. Most employers will hire someone who has been treated for substance use if he or she is qualified for the job.	❑	❑	❑	❑	❑
7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.	❑	❑	❑	❑	❑
8. Most people would be willing to date someone who has been treated for substance use.	❑	❑	❑	❑	❑

Read each item and decide whether it is true (T) or false (F) for you.	**True**	**False**
1. It is sometimes hard for me to go on with my work if I am not encouraged.	❑	❑
2. I sometimes feel resentful when I don't get my way.	❑	❑
3. On a few occasions, I have given up doing something because I thought too little of my ability.	❑	❑
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.	❑	❑
5. No matter who I'm talking to, I'm always a good listener.	❑	❑
6. There have been occasions when I took advantage of someone.	❑	❑
7. I'm always willing to admit it when I make a mistake.	❑	❑
8. I sometimes try to get even rather than forgive and forget.	❑	❑
9. I am always courteous, even to people who are disagreeable.	❑	❑
10. I have never been irked (*annoyed*) when people expressed ideas very different from my own.	❑	❑
11. There have been times when I was quite jealous of the good fortune of others.	❑	❑
12. I am sometimes irritated by people who ask favors of me.	❑	❑
13. I have never deliberately said something that hurt someone's feelings.	❑	❑

Please provide additional comments (if any):_____

Thank you for your Participation

APPENDIX B

APPENDIX B

SUBSTANCE USE ATTITUDES SURVEY FOR CLIENTS

DO NOT write your name on this.

Please Check the Box or Write a Response for the Following Survey Questions:

1. Your age: _____ Your Gender: ❑ Male ❑ Female ❑ Other

2. With which race/ethnicity do you most identify?
❑ American Indian/Alaska Native ❑ Asian ❑ Black/African ❑ Hispanic/Latino
❑ Native Hawaiian/Pacific Islander ❑ White (non-Hispanic) ❑ Other (*please specify*):
If you are *Hispanic*, with which *Hispanic* origin do you most identify:
❑ Cuban ❑ Mexican ❑ Mexican American ❑ Puerto Rican
❑ Other Hispanic/Latino *(please specify*):_____

3. About how long have you been getting help for alcohol/drug use?
❑ Less than 1 year ❑ 1-2 years ❑ 3-4 years ❑ More than 5-10 years ❑ More than 10 years

The following scale is meant to explore some of *your* feelings toward substance use. It is not meant to test what you know.
Please check the box that best describes *your* attitudes.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1. Most people would willingly accept someone who has been treated for substance use as a close friend.	❑	❑	❑	❑	❑
2. Most people believe that someone who has been treated for substance use is just as trustworthy as the average citizen.	❑	❑	❑	❑	❑
3. Most people would accept someone who has been treated for substance use as a teacher of young children in a public school.	❑	❑	❑	❑	❑
4. Most people would hire someone who has been treated for substance use to take care of their children.	❑	❑	❑	❑	❑

5. Most people think less of a person who has been in treatment for substance use.	❑	❑	❑	❑	❑
6. Most employers will hire someone who has been treated for substance use if he or she is qualified for the job.	❑	❑	❑	❑	❑
7. Most employers will pass over the application of someone who has been treated for substance use in favor of another applicant.	❑	❑	❑	❑	❑
8. Most people would be willing to date someone who has been treated for substance use.	❑	❑	❑	❑	❑

Read each item and decide whether it is true (T) or false (F) for you.

	True	**False**
1. It is sometimes hard for me to go on with my work if I am not encouraged.	❑	❑
2. I sometimes feel resentful when I don't get my way.	❑	❑
3. On a few occasions, I have given up doing something because I thought too little of my ability.	❑	❑
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.	❑	❑
5. No matter who I'm talking to, I'm always a good listener.	❑	❑
6. There have been occasions when I took advantage of someone.	❑	❑
7. I'm always willing to admit it when I make a mistake.	❑	❑
8. I sometimes try to get even rather than forgive and forget.	❑	❑
9. I am always courteous, even to people who are disagreeable.	❑	❑
10. I have never been irked (*annoyed*) when people expressed ideas very different from my own.	❑	❑
11. There have been times when I was quite jealous of the good fortune of others.	❑	❑
12. I am sometimes irritated by people who ask favors of me.	❑	❑
13. I have never deliberately said something that hurt someone's feelings.	❑	❑

APPENDIX C

APPENDIX C

ACTITUDES HACIA EL ESTUDIO DEL USO DE ALCOHOL/DROGAS FOR (SPANISH) CLIENTS

Por favor, círculo o escribir una respuesta para la siguiente pregunta de encuesta:

1. **Con que raza/origen étnico ¿más se identifica?**
   ❑ Sustantivo North American ❑ Asia ❑ Negro africano ❑ Hispano/Latino
   ❑ Native Hawaiian / Islas del Pacífico ❑ Blancos (no hispanos) ❑ Hispano/Latino
   ❑ Otras (*especificar*):
2. **Si eres *hispano*, que el origen *hispano* con usted más se identifica:**
   ❑ Mexicano ❑ México-Americano ❑ Puerto Rico ❑ Cubano ❑ Otros hispanos

3. **¿Cuánto tiempo ha usted estado recibiendo ayuda para el uso de alcohol y las drogas?**
   ❑ Menos de 1 año ❑ 1-2 años ❑ 3-4 años ❑ Más de 5 a 10 años ❑ más de 10 años

La siguiente escala pretende explorar algunas de sus sentimientos hacia el uso de alcohol/drogas. No es para poner a prueba lo que sabes. Por favor marque la casilla que mejor describe su actitud.

	Muy en desacuerdo	**desacuerdo**	**neutral**	**de acuerdo**	**Fuertemente Estoy de acuerdo**
1. la mayoría de la gente aceptaría voluntariamente alguien que ha sido tratada para el uso de la alcohol/drogas como un amigo	□	□	□	□	□
2. la mayoría de las personas cree que alguien que ha sido tratada para el uso de la alcohol/drogas es sólo como digno de confianza como el ciudadano medio	□	□	□	□	□

3. la mayoría de la gente aceptaría a alguien que ha sido tratada para el uso de la alcohol/drogas como un maestro de niños en una escuela pública	□	□	□	□	□
4. la mayoría de la gente sería contratar a alguien que ha sido tratada por uso de alcohol/drogas cuidar de sus hijos	□	□	□	□	□
5. mucha gente piensa que menos de una persona que ha estado en tratamiento por uso de alcohol/drogas.	□	□	□	□	□
6. la mayoría de los empleadores contratarán a alguien que ha sido tratada para el uso de la alcohol/drogas si él o ella está calificada para el trabajo	□	□	□	□	□
7. la mayoría de los empleadores pasa sobre la aplicación de alguien que ha sido tratada para el uso de la alcohol/drogas a favor de otro candidato.	□	□	□	□	□
8. la mayoría de la gente estaría dispuesta hasta la fecha a alguien que ha sido tratada por uso de alcohol/drogas	□	□	□	□	□

Lea cada artículo y decidir si es verdadero (T) o falso (F) para ti.

	Verdadera	**Falso**
1. a veces es difícil para mí seguir adelante con mi trabajo si no me alegra.	□	□
2. a veces me siento resentido cuando no llego a mi manera.	□	□
3. en algunas ocasiones, he dado para hacer algo porque me pareció muy poco de mi capacidad.	□	□
4. ha habido ocasiones cuando sentí ganas de rebelarse contra las personas en autoridad a pesar de que sabía que tenían razón	□	□
5. No importa que estoy hablando, soy un buen oyente.	□	□
6. ha habido ocasiones cuando tomé ventaja de alguien.	□	□
7. siempre estoy dispuesto a admitir cuando cometo un error.	□	□
8. a veces tratan de obtener incluso en lugar de perdonar y olvidar.	□	□
9. siempre soy Cortés, incluso a las personas que son desagradables.	□	□
10. nunca he sido molesto (*molesto*) cuando las personas expresan ideas muy diferentes de mi propia.	□	□
11. ha habido ocasiones cuando yo era muy celoso de la buena fortuna de otros.	□	□
12. a veces estoy irritado por la gente que pide favores de mí.	□	□
13. Nunca deliberadamente he dicho algo que herir los sentimientos de alguien	□	□

APPENDIX D

APPENDIX D

EXPLICIT PERMISSION BY AUTHOR JASON LUOMA TO USE THE PERCEIVED STIGMA OF ADDICTION SCALE (PSAS) FOR THIS STUDY

jbluoma@portlandpsychotherapyclinic.com on behalf of Jason Luoma Mark as unread
Mon 9/8/2014 9:19 PM
Inbox

To: Eluterio Blanco;

You replied on 9/9/2014 9:03 AM.

Feel free to use that measure.

I have some colleagues in Peurto Rico who have created a spanish-language version of the substance abuse self-stigma scale if you are interested in that also. Let me know if you'd like me to connect you with them. U can see the relevant reference on the following page under 2013:

http://www.portlandpsychotherapyclinic.com/training/publications

Best,
jl

BIOGRAPHICAL SKETCH

Eluterio Blanco, Jr. is a Licensed Chemical Dependency Counselor in the state of Texas and a certified Master Addiction Counselor from the National Certification Commission for Addiction Professionals (NCC AP). He has over 16 years of experience working with clients with Substance Use Disorders in South Texas. He obtained his Bachelor of Arts degree in Psychology from the University of Texas at Austin in 2002. He then earned his Master of Arts degree in Clinical Psychology from the University of Texas-Pan American in 2007 and completed his Doctor of Philosophy (PhD) degree in Rehabilitation Counseling from the University of Texas-Rio Grande Valley in 2018.

He is currently a full-time clinical faculty member with the UTRGV School of Rehabilitation Services and Counseling and is the Addiction Studies Program Coordinator. Eluterio holds professional memberships with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), the Texas Association of Addiction Professionals (TAAP), and is the Immediate-Past President of the Valley Association of Addiction Professionals (VAAP). He can be reached for any correspondence at elblancojr@gmail.com or at 1604 South Ohio Street in San Juan, Texas 78589.