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**HETEROSEXIST EVENTS, INTERNALIZED HOMOPHOBIA, AND  
SUBSTANCE USE AND ABUSE FOR LESBIAN, GAY, AND BISEXUAL  
INDIVIDUALS: IMPLICATIONS FOR COUNSELING**

A Thesis in

Counselor Education

by

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## ABSTRACT

This study explored the relationship between heterosexist events, internalized homophobia, and substance use and abuse among lesbian, gay, and bisexual (LGB) individuals. In addition, the study examined the counseling experiences of LGB individuals, and their perceptions of the role of counseling in reducing internalized homophobia. Sequential multiple regression was used to test a model predicting substance use and abuse with a sample of 824 LGB individuals. Results suggested that heterosexist events and internalized homophobia accounted for a small amount of variance of alcohol and drug use and abuse. Findings also indicated that LGB individuals are seeking counseling at high rates, and they strongly agreed with the literature that emphasizes the importance of addressing internalized homophobia in counseling. Limitations of this study and implications for training, practitioners, and research are discussed.

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## Chapter 1

### Introduction

Lesbian, gay, and bisexual (LGB) individuals have faced great societal prohibitions and prejudices based on the expression of their same-gender sexual feelings and behaviors (Stein & Cabaj, 1996). They are considered an at-risk group since they have been exposed to various forms of societal stigma and discrimination that have threatened, and continue to threaten, their psychological well-being and overall quality of life.

Historically, the mental health field viewed all forms of same-gender sexual orientation as pathological, which reflects the larger anti-gay beliefs held by society (Bobbe, 2002; Bringaze & White, 2001). The American Psychiatric Association (ApA) classified same-gender sexual orientation as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* until it was removed in 1973. This affirmative act was a result of research studies in the 1960s that indicated that LGB sexual orientations themselves do not cause pathological conditions. Rather, it is the response of a homophobic and heterosexist society, and the social support of negative myths and stereotypes about LGB people that lead LGB individuals to experience developmental and emotional stress (Bobbe, 2002).

Homophobia and heterosexism are central constructs in the stress experienced by LGB individuals. *Homophobia* is defined as the anxiety, aversion, and discomfort that some individuals experience in response to being around, or thinking about, LGB behavior or people (Davies, 1996). *Heterosexism* resembles racism or sexism and denies, ignores, and disparages nonheterosexual forms of emotional and sexual expression

(Center for Substance Abuse Treatment [CSAT], 2001). Both constructs support the superiority of heterosexuality, and disregard the unique developmental events that LGB individuals experience as they cope with social oppression.

Over the past 20 years, there has been a growing body of research that emphasizes the unique developmental experiences of LGB individuals. Although the professional literature is in its early stages of investigating the phenomenological experiences of LGB individuals, research verifies that many of them are greatly affected by the negative stereotypes and beliefs held by society. As a result, LGB people internalize these anti-gay attitudes and experience negative views of self, which manifest as psychiatric symptoms including but not limited to depression, anxiety, and self-destructive acting-out behaviors such as substance use and abuse (Grossman, 1996; Stein & Cabaj, 1996; Sue & Sue, 1999).

The use and abuse of substances in the LGB community is a growing area of interest for the mental health field because LGB individuals are highly susceptible to the use and abuse of substances as a means of coping with the stress of living as stigmatized individuals (Bux, 1996; CSAT, 2001). Substance use in this context includes the use of alcohol and other mood altering drugs and alcohol. Many LGB individuals use substances to temporarily relieve the negative feelings they have towards themselves as a result of society condemning their same-gender attraction. In addition, due to a lack of social acceptance of same-gender sexual orientation, bars, clubs, and private homes are common meeting places for LGB people. To this end, the use of substances, especially alcohol, is common in the socialization of LGB individuals (CSAT, 2001), which has strong implications for the mental health of LGB individuals. According to Cabaj (1996),

“Many gay people...feel self-hatred; the use of mood-altering substances temporary relieves but then reinforces this self-loathing in the drug withdrawal period...leading to a worsening of self-esteem” (p. 786).

The negative effects of an anti-gay social environment on the lives of LGB individuals are continuing problems, and measures to reduce the psychological and behavioral effects, particularly substance use and abuse, must be taken. Counseling has been identified as both a preventive measure and treatment method in reducing the negative effects of homophobia in the LGB community, and in promoting healthy sexual minority identity development. Cabaj (1996) posits that the treatment of LGB individuals who use and abuse substances must focus on recovery from both substance abuse and from the consequences of homophobia. By externalizing the disapproving feelings of one's same-gender sexual orientation, LGB individuals can enhance their feelings of self-esteem and self-worth while working towards adopting positive and integrated LGB sexual identities (CSAT, 2001; Shidlo, 1994).

#### *Summary of Relevant Literature*

Homophobia and heterosexism are found on both individual and societal levels, and are endorsed through the perpetuation of negative myths and stereotypes about LGB behavior and people (Bobbe, 2002). These concepts lead to the discrimination and prejudice of LGB people across the lifespan (Smiley, 1997). It is important to note that bisexual people may experience additional minority stress that is complicated by marginality by both the straight and gay communities. This marginalization usually includes same-gender oriented friends urging them to adopt a gay lifestyle and

heterosexually oriented friends pressuring them to conform to heterosexual standards (Smiley, 1997).

Homophobia and heterosexism have serious implications for LGB individuals as they lead to homophobic and heterosexist events such as subtle forms of discrimination (e.g., the exclusion of LGB couples in the media) and blatant acts of alienation and discrimination (e.g., individuals refusing to rent to LGB people; Neisen, 1990). Other examples of homophobic and heterosexist events include unfair treatment by family, friends, and peers; loss of employment or lack of promotions; and observing/hearing people making heterosexist jokes (Selvidge, 2000). These events greatly affect the lives of LGB individuals such that many LGB individuals hide their sexual orientation from others, and feel shame and other negative feelings towards themselves (CSAT, 2001).

*Internalized homophobia.* The phenomenon of internalizing society's homophobic and heterosexist attitudes about LGB sexual orientations when one identifies as LGB is known as *internalized homophobia*. Low self-esteem and low self-acceptance; shame; guilt; feelings of inadequacy and rejection; verbal and physical abuse by family, partners, and/or peers; and substance use and abuse are some of the common feelings and/or behaviors that are associated with internalized homophobia (Grossman, 1996; Ross & Rosser, 1996).

According to Bobbe (2002), the negative feelings and behaviors associated with internalized homophobia can have a more painful and disruptive influence on the health of LGB individuals than external, overt forms of oppression such as prejudice and discrimination. Many LGB individuals use alcohol and drugs to ease these negative feelings. Over the past ten years, there has been an increase in research that examines the

substance use patterns of lesbians and gay men. The substance use patterns of bisexuals, however, remains understudied (Cabaj, 1997; Hughes & Eliason, 20002).

*Substance use and abuse.* According to research, substance use rates are higher for lesbians and gay men than for heterosexual individuals (CSAT, 2001; Diamond & Wilsnack, 1978; Lewis, Saghir, & Robins, 1982; Saghir & Robins, 1973; Stall & Wiley, 1988). Although these studies support the prominent role of substance use in the LGB community, they are beset with methodological limitations.

*Internalized homophobia and substance use and abuse.* One may question why substance use and abuse is more prominent in the LGB community than the heterosexual community. Cheng (2003) underscored the internalization of social homophobia and the effects of the gay bar scene as two explanations for the higher rates of substance use and abuse among LGB individuals. A number of studies have examined the relationship between internalized homophobia and substance use and abuse (Amadio & Chung, 2004; Burris, 1997; Cherry, 1997; Jaffe, Clance, Nichols, & Ernschoff, 2000; Kus, 1988). These studies consistently report that substance use and abuse in the LGB community may be attributed to the internalization of anti-gay bias, which “is found in every sector in our society: legal, medical, scientific, religious, political, social, educational, and judicial” (Cabaj, 2000, p. 8).

In addition to the internalization of social homophobia, the same-gender oriented bar scene has been identified as a key risk factor for substance use and abuse (Cheng, 2003). Cheng posits that gay bars have functioned as safe places absent of social stigma and prejudice where LGB individuals can meet friends and sex partners. According to Cabaj (1996), many men and women have had their first same-gender sexual experiences

while under the influence of alcohol, which helped them overcome their “internal fear, denial, anxiety, or even revulsion about gay sex” (p. 786). These findings could have serious repercussions for individuals who are using or abusing substances to relieve the psychological effects of homophobia and heterosexism because the use of substances only exacerbates these symptoms, placing LGB individuals at an increased risk for psychological distress and substance dependence (Bobbe, 2002).

In order to lower the rates of substance use and abuse in the LGB community, it is important for LGB individuals to understand the role of homophobia and heterosexism in the development of internalized homophobia, and their impact on how people create an identity related to their sexual orientation. This increase in awareness can occur in counseling as it provides LGB individuals with the opportunity to reduce internalized homophobia by externalizing negative feelings related to their sexual orientation, develop coping skills to enhance their self-esteem and self-worth, and work towards a positive LGB sexual identity (CSAT, 2001; Shidlo, 1994).

*Counseling and LGB individuals.* The professional literature posits that lesbian and gay individuals seek counseling at higher rates than heterosexual individuals (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Bringaze & White, 2001; Dworkin, 2000). Although there is a scarcity of data that specifically addresses the counseling rates of bisexuals, the aforementioned finding can be applied to bisexuals because they are often grouped with gay and lesbian respondents (Dworkin, 2000). These high rates of counseling can be attributed to the social stigmatization of same-gender sexual orientation and the fact that many LGB individuals turn to counselors to support them in coming to terms with their sexual orientation (Bringaze & White, 2001).



Although LGB individuals are seeking counseling at high rates, few empirical studies explore the counseling experiences of LGB individuals. Bieschke et al. (2000) purport that among the research that does exist, there is considerably more research related to the counseling experiences of lesbians than gay men. One particular study addressed the counseling experiences of lesbians, gay men, and bisexual individuals. Jones and Gabriel (1999) surveyed the psychotherapy experiences of 600 lesbians, gay men, and bisexual individuals who had all been in psychotherapy at least one time in their lives. The number, length, circumstances, and views of each counseling experience were explored. Thirty-nine percent of the participants reported that difficulty associated with their sexual orientation was at least one of the issues that led them to seek counseling. In terms of attitudes towards psychotherapy, 33% reported that counseling had “saved their lives,” 50% described their experiences as “positive,” and 86% stated psychotherapy had a “positive influence on their lives” (Jones & Gabriel, p. 215). Overall, findings indicate that LGB individuals are “among the most active and satisfied – but least acknowledged – consumers of psychotherapy” (Jones & Gabriel, p. 209).

Although there is limited research that addresses the counseling experiences of LGB individuals, the past two decades have demonstrated an increase in the professional literature related to clinical issues common in the LGB community. These clinical concerns may closely resemble those presented by heterosexual individuals (e.g., relationship difficulties, financial stress), but there are distinct experiences that are unique to LGB individuals such as oppression and isolation, sexual minority identity development, and internalized homophobia (Bieschke et al., 2000). In particular, experiences and feelings associated with internalized homophobia are often brought into

counseling by LGB people (Stein & Cabaj, 1996). According to Cabaj (2000), “The way a gay man or lesbian has dealt with his or her internalized homophobia and how he or she has coped with anti-gay bias will inevitably be part of the issues explored in the therapeutic process” (p. 13). Therefore, it is essential that mental health practitioners are aware of the phenomenon of internalized homophobia, as well as its role in the counseling process.

*The role of counseling in reducing internalized homophobia.* Although “internalized homophobia is a central clinical theme in working with LGB clients” (Davies, 1996, p. 55), a very small proportion of the professional literature examines the role of counseling in reducing internalized homophobia for lesbians. Even less research addresses this issue for gay men and bisexual individuals. In fact, a review of the literature generated no results for empirically-based articles that address the role of counseling in reducing internalized homophobia for gay men or bisexual individuals.

An important study that addressed the role of counseling in the lives of lesbians was conducted by Morgan and Eliason (1992). This study compared the attitudes of lesbians and heterosexual women towards counseling, and identified themes that emerged while interviewing lesbians with regard to reasons for seeking counseling. Findings indicated lesbians had more positive attitudes toward counseling and utilized counseling to reduce the effects of oppression due to a homophobic culture. Sophie’s (1987) research with lesbians led her to propose similar findings to those of Morgan and Eliason. Sophie suggests that the goal of counseling for lesbians is to reduce or eliminate internalized homophobia, which helps people accept their attractions to the same gender and achieve a positive sexual minority identity.

Although these studies support the literature that describes internalized homophobia as a significant construct in the symptomatology and treatment of lesbian and gay men (Ross & Rosser, 1996), there is a need for enhanced empirical research in this area, especially for gay men and bisexual individuals. In particular, an exploration of the role of counseling in reducing internalized homophobia from the perspectives of LGB individuals is warranted in order to gain a greater understanding of how to most effectively treat the mental health concerns of this population.

#### *Rationale and Purpose of the Study*

This study is based on my interest in and commitment to improving the mental health of LGB individuals. The theoretical framework that guided this dissertation is McCarn and Fassinger's (1996) Model of Sexual Minority Development, and the literature that discusses the impact of homophobia and heterosexism on the psychological and behavioral well-being of LGB individuals. Transgender individuals were included in the sample because they self-identified as lesbian, gay, or bisexual, and are therefore able to share related experiences of homophobia and heterosexism based on sexual orientation. It is important to acknowledge, however, that transgender individuals may have unique experiences with bias and discrimination as a result of an intersection between sexual orientation and gender identity. This study does not explore their experiences with gender identity, which may affect the outcomes and implications for transgender individuals. Nonetheless, it is important to include transgender individuals who identify as LGB in this study as they are members of the LGB community.

In particular, I was interested in studying how heterosexist events and internalized homophobia affect substance use patterns for LGB individuals, and the role of counseling

in reducing internalized homophobia. To this end, this study identified a sample of LGB individuals and assessed their experiences with heterosexist events, internalized homophobia, and substance use, as well as their experiences with counseling and their perceptions of the role of counseling in reducing internalized homophobia. A major strength of this study was its focus on the role of counseling in reducing internalized homophobia. To date, there are many conceptual studies and a few empirical studies that discuss the construct of internalized homophobia and its relation to counseling, but there are no studies that have taken this research back into the LGB community to confirm or deny its salience.

By addressing the problem of homophobia, heterosexism, and internalized homophobia in the LGB community in this study, I have contributed to the limited empirical research that examines the relationship between heterosexist events, internalized homophobia, and substance use and abuse, and have begun to fill the gap in the dearth of empirical research related to the counseling experiences of LGB individuals.

### *Research Questions*

The independent variables for this study were heterosexist events and internalized homophobia. The dependent variables were: (a) substance use and abuse (alcohol and drugs), (b) previous experiences with counseling, and (c) perceptions of the role of counseling in reducing internalized homophobia.

My research questions for the present study were as follows:

1. Is there a relationship between exposure to heterosexist events and internalized homophobia?

2. Do the independent variables (heterosexist events and internalized homophobia) predict substance use and abuse for LGB individuals?

I also examined the phenomenological experiences of LGB individuals in counseling. The perceptions of LGB people on the role of counseling in reducing internalized homophobia were also explored. The following descriptive questions were assessed in this study:

1. What are your experiences with counseling?
2. What are your perceptions of the role of counseling in reducing internalized homophobia?

## Chapter 2

### Literature Review

This chapter addresses four topics related to the sexual minority identity development and psychological well-being of LGB individuals addressed in the literature. Homophobia and heterosexism, internalized homophobia, substance use and abuse, and the role of counseling in reducing internalized homophobia were topics of interest in the present study.

Society perpetuates negative feelings and attitudes about LGB sexual orientations that lead to prejudice, fear, and even hatred of LGB individuals. Since this population is exposed to prejudice and discrimination on the basis of their same-gender sexual orientation, LGB persons are at-risk for suicide, dropping out of school, verbal and physical abuse by family and/or peers, homelessness, prostitution, HIV/AIDS, psychosocial developmental delays, psychological distress, and substance use and abuse (Grossman, 1997). The impact of these risk factors is a growing problem for this population, and measures to reduce the psychological and behavioral effects of social stigma should be taken to promote a safer world where persons who identify as LGB can freely and comfortably express their sexual identities.

#### *Sexual Minority Identity Development*

Much attention has been given to the sexual minority identity development of LGB individuals since the declassification of same-gender sexual orientation as a psychiatric disorder. In using the phrase *sexual minority identity formation*, I am referring to how individuals create and manage an identity related to their lesbian, gay male, or bisexual sexual orientation. According to Reynolds and Hanjorgiris (2000), the sexual

minority identity formation process involves a period of “intrapsychic and interpersonal experimentation,” and may conclude with public identification as LGB, the synthesis of sexual orientation into an overall self-concept, and some level of membership with the lesbian and gay community (p. 48). Because LGB individuals grow up in a society of “pervasive environmental and internalized homophobia and expectation to be heterosexual” they often “struggle with identity awareness, acceptance, and affirmation” (McCarn & Fassinger, 1996, p. 508). They may block recognition of same-gender feelings and attraction through a variety of defenses that have a high psychological cost on their well-being, which manifests in addictions, suicide, and other mental health distress (Gonsiorek, 1995; Reynolds & Hanjorgiris, 2001). In addition, the LGB community often lacks role models, which further complicates the process of achieving a positive LGB identity (Bringaze & White, 2001). Given that such a process creates developmental challenges for LGB individuals, it is very important that counselor educators and psychologists study the coming out process and sexual minority identity formation for LGB individuals in order to work most effectively with this population.

*Coming out process.* As LGB individuals begin to disclose their sexual orientation to others, they often experience a series of stages that include but are not limited to an initial awareness of being different, grieving, feelings of inner conflict, and an established sexual minority identity with long-term relationships (McGregor et al., 2001). This process is referred to as the *coming out process*, and is described as a developmental process that involves a person’s awareness and acknowledgement of same-gender oriented thoughts and feelings while accepting being LGB as a positive stage of being (Browning, Reynolds, & Dworkin, 1991; Kus, 1990). The process of forming an LGB

identity is a challenging process as it involves adopting a non-traditional sexual identity, restructuring one's self-concept, and changing one's relationship with society (Reynolds & Hanjorgiris, 2000).

According to Cabaj (1997), the coming out process varies among LGB individuals. For example, some same-gender oriented individuals may only come out to selected people (e.g., friends, family, colleagues, teachers, medical providers) rather than everyone at once. Others may come out to particular people, and either take back their disclosure or discontinue any further disclosure. These decisions are affected by one's own understanding of sexual orientation in the context of an oppressive environment.

*Sexual minority identity development models.* There have been numerous models proposed in the professional literature that focus on the processes by which individuals develop a lesbian and gay male identity (Cass, 1979; Fassinger & Miller, 1996; McCarn & Fassinger, 1996; Sophie, 1985/1986; Troiden, 1979), but limited scholarly writings have explored bisexual identity development (Reynolds & Hanjorgiris, 2001). In fact, the development of a bisexual identity remains underexplored and misunderstood. Consequently, bisexual identity development is often explained according to lesbian and gay male identity development (Smiley, 1997). In this section, I will review a sexual minority identity development model that was proposed by McCarn and Fassinger (1996) and later adapted by Fassinger and Miller (1996) in order to be inclusive of gay men. I chose this sexual minority identity model because it provides a basis for my dissertation topic in that it takes into consideration the complex process of sexual identity exploration for lesbians and gay men and the influences of societal homophobia and heterosexism on the development of a lesbian or gay male identity. This model also addresses diversity



within the LGB community (e.g., race, class, age, occupation, and community support), which influences the identity development process (Reynolds & Hanjorgiris, 2001).

McCarn and Fassinger's (1996) model sets the framework to explore sexual minority identity development at both the individual and group-membership level, which occur parallel to each other but not necessarily at the same time. This model also uses the word *phase* in place of *stage*, which allows for more flexibility to move in a "continuous and circular" manner through one's identity development (McCarn & Fassinger, 1996, p. 522). This notion supports Gonsiorek's (1995) proposition that the process of identity development is "unpredictable, with stops, starts, and back-tracking" (p. 31). In general, the model proposes that the sexual minority identity formation process begins when lesbians and gay men feel attracted to the same gender in ways that they don't understand, and may shift to when they feel comfortable with their same-gender sexual orientation regardless of the social context.

Phase one is *Awareness* and involves one's recognition of feelings of being different, and the realization that there are other forms of sexual orientation besides that of heterosexuality. Self-statements of someone who is in this phase may include *I feel pulled towards the same gender in ways I don't understand* and *I had no idea there were lesbian/gay people out there* (McCarn & Fassinger, 1996).

Phase two is *Exploration* and involves actively exploring questions that may arise during phase one as well as the active pursuit of knowledge about the LGB community with regard to the group as a whole and one's membership with such a group. An individual may begin to explore sexual feelings but not necessarily sexual behaviors at this time. This time period could lead to a variety of emotions such as "anger and guilt for

being ‘duped’ by and participating in heterosexism,” as well as “curiosity and exhilarating joy” to explore the existence of other LGB people (McCarn & Fassinger, 1996, p. 525). Self-statements in this phase may include *The way I feel makes me think I’d like to be sexual with the same-gender* and *Getting to know other LGB people is scary but exciting* (McCarn & Fassinger, 1996).

Phase three of the model is referred to as *Deepening/commitment*, and involves a time of self-exploration leading to an increase in self-knowledge, crystallization of some choices about sexuality, and self-fulfillment as a sexual being. An individual in this phase experiences a deepening awareness of the unique value and oppression of the LGB community, and will begin to form a personal relationship with this group. They may also experience a range of emotions such as excitement, pride, anger, and internal conflict. Examples of self-statements in this phase include *I clearly feel more intimate sexually and emotionally with the same gender than with the opposite gender* and *Sometimes I have been mistreated because of my lesbian/gay identity* (McCarn & Fassinger, 1996).

The fourth and final phase is *Internalization/synthesis* of love for the same gender, sexual choices, and overall identity. It also involves self-identification as a member of a minority group, redefinition of the meaning of that group, internalization of this new identity, and synthesis into one’s overall self-concept. Individuals in this phase will now experience dedication and self-love as a same-gender oriented individual in place of feelings such as rage, anxiety, and insecurity. Self-statements reflective of this phase include *I am deeply fulfilled with my relationships with the same gender* and *I feel comfortable with my same-gender sexual orientation no matter where I am or who I am with* (McCarn & Fassinger, 1996).

As demonstrated by McCarn and Fassinger's (1996) model of sexual minority identity development, LGB individuals face unique developmental events as they negotiate the emergence of a positive identity in the face of external oppression (Gonsiorek, 1995). To expand on a discussion of sexual minority identity development that sets the foundation for my study, I will present specific constructs related to sexual minority oppression, as well as the psychological and behavioral effects of such constructs on the lives of LGB individuals.

### *Homophobia and Heterosexism*

Two major influences on the sexual identity development of LGB individuals are *homophobia* and *heterosexism*. Having adverse feelings towards LGB individuals and their behavior on the basis of their sexual orientation is known as homophobia (CSAT, 2001). Homophobia is a form of prejudice that is based on myths and stereotypes about same-gender sexual orientation (Hanley-Hackenbuck, 1988; Neisen, 1990). Examples of homophobia include physical or verbal abuse and name calling either directly or indirectly aimed towards LGB individuals (Flowers & Buston, 2002). "A less visible" form of sexual prejudice "yet...a powerful phenomenon" is heterosexism (Flowers & Buston, 2001, p. 51). Heterosexism is described as the continued promotion of heterosexuality by the major institutions of society while concurrently subordinating LGB sexual orientations (Neisen, 1990). An example of heterosexism is the lack of legal recognition for lesbian and gay committed relationships (Herek, 1996). According to Bobbe (2002), the effects of homophobia and heterosexism are "ongoing forces that will emerge and re-emerge" in the lives of LGB people (p. 221).

It is important to underscore the unique experiences of bisexual individuals with regard to homophobia and heterosexism. Smiley (1997) contends that bisexual people experience additional stress as a result of their marginality by both the heterosexual and same-gender oriented communities. Heterosexual friends may urge bisexual individuals to conform to the sexual majority standards and “act straight,” while same-gender oriented friends may accuse them of trying to maintain heterosexual advantages and thus push for the adoption of a same-gender oriented lifestyle (p. 376). Nonetheless, Cabaj (1997) posits that the experiences of bisexual individuals, particularly if they identify strongly with their same-gender attraction, will be similar to the experiences of lesbians and gay men. To this end, bisexual individuals are often included with lesbians and gay men in the professional literature.

*Effects of homophobia and heterosexism.* The constructs of homophobia and heterosexism are the result of historical legal prohibitions on same gender sexual orientation, and overt discrimination in familial, social, religious, and medical institutions. The American Psychiatric Association, for example, classified same-gender sexual orientation as a psychiatric disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until it was removed in 1973. Although LGB sexual orientations are now viewed as normal forms of human sexual and emotional expression, the stigmatization and discrimination that stem from the DSM classification remain, and the effects of homophobia and heterosexism are still pervasive in our society (CSAT, 2001; Hughes & Eliason, 2002).

Herek (1996) asserts that homophobia and heterosexism lead to the “passing” of same-gender oriented individuals as heterosexual. His assertion is supported by a

qualitative study conducted by Flowers and Buston (2001), which examined the retrospective accounts of gay identity formation for 20 gay men. *Living a lie* was identified as a common theme in their interviews such that many men continued to assume a heterosexual identity as a response to a non-accepting homophobic society. This lie, however, was not something that was simply stated; rather, it had to be created and maintained “all the time” (p. 58), and only temporarily eased the participants’ feelings of isolation and identity confusion (Flowers & Buston).

Homophobia and heterosexism, according to Herek (1996), also lead to the monitoring and restriction of particular behaviors of heterosexual individuals to avoid being labeled as gay, and to the expression of rejection and hostility towards same-gender oriented individuals. LGB individuals who are more visible may face homophobic and heterosexist events such as loss of employment and home, loss off custody of children, and anti-gay violence and discrimination as a result of their sexual orientation (DiPlacido, 1998; McKirnan & Peterson, 1989). The Schedule of Heterosexist Events, a measure developed by Klonoff and Landrine (1995) and adapted by Selvidge (2000), assesses homophobic and heterosexist events encountered by LGB individuals in their lifetime, and lists specific events that may occur. These include but are not limited to being treated unfairly by family, teachers, employers, coworkers, fellow students, strangers, counselors, and/or neighbors; being denied a raise, promotion, and/or tenure; being called a derogatory name referring to sexual orientation; being made fun of, picked on, or threatened because of sexual orientation; and hearing people make heterosexist jokes (Selvidge).

A pilot study by DiPlacido (1998) was conducted to assess various stressors and the overall well-being of lesbian and bisexual women. A significant number of the women in the study experienced negative homophobic and heterosexist life-events as a result of their sexual orientation. For example, 18% reported problems with their families in the past year with regard to their sexual orientation, 18% stated they had experienced verbal harassment, 77% reported they witnessed someone telling an anti-gay joke in their presence, and 35% shared that they had been in contact (live, work, or socialize with) with someone who was homophobic (DiPlacido).

Findings from the National Lesbian Health Care Survey (Bradford, Ryan, & Rothblum, 1994) support DiPlacido's claim. Over half of the lesbians who participated in the survey had been verbally attacked for being lesbian, 13% had lost employment due to anti-gay discrimination, and a small number expressed discomfort and concern with seeking mental health services because of past experiences with discriminatory counselors (Bradford et al.).

As a result of homophobic and heterosexist events and encounters, LGB individuals experience physical and emotional stress, a phenomenon that DiPlacido (1998) refers to as *minority stress*. Depending on where an individual is in terms of his/her sexual minority identity development, he/she may experience external and internal stressors. External stressors include discrimination and anti-gay violence, which originate in the social environment, and internal stressors include self-concealment, emotional inhibition, and internalized homophobia, which are found within the individual. Both forms of stressors have serious implications for the mental health and quality of life for LGB people (DiPlacido, 1998).

A study by Selvidge (2000) does not support DiPlacido's (1998) claim that minority stress affects the mental health of LGB people. Selvidge's study explored minority stress among lesbians and bisexual women by investigating the relationship of sexist and heterosexist events, self-concealment, and self-monitoring to positive psychological well-being. The researcher recruited 415 women from 43 different states and 7 countries outside of the United States. Seventy-seven percent of the sample was White, 8.6% was Black, 4.6% was Latina, 2.9% was Asian, and 7% was Native American. Approximately 68% of the sample had a Bachelor's degree or higher (Selvidge).

Findings from the study indicate that there is a significant relationship between self-concealment and self-monitoring and positive psychological well-being such that women who had higher levels of self-concealment had lower positive psychological well-being. Although there were some very small correlations between frequency of sexist and heterosexist events and positive psychological well-being, there was no significant relationship between these variables. Many participants, however, reported experiences with heterosexist events. For example, 53% reported that they were treated unfairly by people in helping jobs "once in a while" as a result of their sexual orientation, 70% reported that they were treated unfairly by their family "once in a while," 98% reported that they heard people making heterosexist or degrading homosexual jokes "once in a while," and 90% reported that they felt angry about something heterosexist or homophobic that was done to them "once in a while." Selvidge attempted to explain the insignificant findings of her study by stating that lesbian and bisexual women may be resilient in the face of societal oppression, and appear to adapt to the stress of a

homophobic and heterosexist society. Regardless of her findings, stressful heterosexist events are occurring in the lives of lesbians and bisexual women, and are affecting their process of forming a sexual identity.

Although there are studies that explore homophobic and heterosexist events, there are few standardized instruments that measure these phenomena. The Schedule of Heterosexist Events (Selvidge, 2000), which explores experiences with homophobic and heterosexist events, was the only instrument of this nature that could be located in the professional literature. Although this instrument measures experiences with homophobia and heterosexism, research to support its reliability, validity, and applicability to the LGB community are limited. A lack of instrumentation to measure LGB individuals' exposure to homophobia and heterosexism, and a deficiency in research related to the Schedule of Heterosexist Events underscores the difficult nature of measuring homophobia and heterosexism.

### *Internalized Homophobia*

Homophobic and heterosexist attitudes towards LGB individuals have the power to cause them to hide their sexual orientation from others, and feel shame and other negative feelings towards themselves (CSAT, 2001). This problem of internalizing society's negative views about LGB sexual orientations is known as *internalized homophobia*, and often leads LGB persons to experience psychological challenges such as low self-esteem and self-acceptance, self-hatred, self-doubt, and feelings of inferiority and rejection based on their sexual orientation (Ross & Rosser, 1996; Rostosky & Riggle, 2002).



Internalized homophobia is also related to distrust and loneliness, eating disorders, lower social support, participation in hypersexual behavior and anonymous sex, which is often unprotected, impaired sexual functioning, as well as passing and acting as heterosexual (Ross & Rosser, 1996; Shidlo, 1994; Szymanski & Chung, 2001). Furthermore, Rostosky and Riggle (2002) contend individuals with high levels of internalized homophobia are more likely to demonstrate limited success in their intimate relationships and careers. Bisexual individuals may experience a phenomenon called *internalized biphobia*, which results from the marginalization from both the heterosexual majority as well as the lesbian and gay community (CSAT, 2001). Internalized biphobia may cause bisexual individuals to struggle to answer questions such as “Who am I?” and “Where do I fit in?” that prevent them from experiencing pride associated with their bisexual identity (Smiley, 1997, p. 377).

After examining the prevalence data of internalized homophobia among the LGB community, Shidlo (1994) posited that between 25% and 33% of lesbians and gay men may have negative attitudes or feelings about their same-gender sexual orientation at some point in their lives. Other research, however, underscores internalized homophobia as an important construct to study because it is not only a developmental occurrence that *all* LGB individuals experience as a result of living in a heterosexist and homophobic society, but also a significant factor in the coming out process and psychological well-being of LGB individuals (McGregor et al., 2001; Shidlo, 1994; Szymanski, Chung, & Balsam, 2001). Although internalized homophobia is a popular concept in the professional literature, there are few instruments that measure this phenomenon. As for the instruments that do exist, they are often criticized for their negative and extreme

statements, and their inability to capture varying degrees of internalized homophobia (Shidlo, 1994). These criticisms have led to difficult and ambiguous investigations of internalized homophobia.

*Internalized homophobia and the coming out process.* Why should we strive to more fully understand the phenomenon of internalized homophobia? Because the coming out process may be delayed or very difficult depending on the intensity and effects of internalized homophobia (Cabaj, 1997). A study by Rowen and Malcolm (2002) examined internalized homophobia and its relationship to homosexual identity formation, self-esteem, and self-concept among 86 gay men. Results indicated that there was a significant relationship between higher levels of internalized homophobia and less developed gay male identities. In addition, gay men who felt more uncomfortable with their sexual orientations were more likely to experience guilt over their same-gender sexual behavior. Internalized homophobia was also found to be significantly related to lower levels of self-esteem and self-concept in terms of physical appearance and emotional stability. Rowen and Malcolm proposed that their results were consistent with past findings that underscore the importance of reducing or eliminating internalized homophobia in promoting sexual minority identity development.

A qualitative study by Lock (1998) illustrates the impact of homophobia on the sexual minority identity development of a gay male as he moved through early, middle, and late adolescence. The author identified early sexual experimentation, inadequate same-gender or male-female friendships, depression, social isolation, hopelessness, and despair as significant challenges that this gay male faced. This case study supports the

literature that internalized homophobia impacts the coming out process of LGB individuals.

According to Scasta (1998), the process of coming out is a life-long experience as LGB people are constantly coming out to new people. Although this process can cause LGB individuals to experience a wide range of intense emotions and reactions, psychological distress lessens and often clears as the individual moves towards the final stages of self-acceptance and sexual minority identity formation (Ross & Rosser, 1996). This improvement in mental health and overall quality of life can occur if issues related to internalized homophobia are addressed (Wagner et al., 1996).

*Internalized homophobia and psychological distress.* Internalized homophobia has been shown to be associated with psychological distress in the professional literature. A study by Herek, Cogan, Gillis, and Glunt (1997) assessed internalized homophobia, psychological well-being, degree of outness, and perceptions of community among 75 women and 75 men who were recruited at a large LGB street fair in Sacramento, California. Findings from the study suggest a relationship between higher levels of internalized homophobia, more depressive symptoms, and higher levels of demoralization. In addition, lesbians and gay men with higher levels of internalized homophobia were less likely to be open about their sexual orientation, and less likely to feel a sense of belonging to the LGB community (Herek et al.).

It is important to highlight a methodological flaw of this study, which relates to the sample. Participants were recruited at an LGB-sponsored event, which suggests attendees to the event were more involved in the community than other LGB individuals who were less out. Therefore, persons who self-identify as lesbian, gay, and/or bisexual

and are experiencing the highest levels of internalized homophobia may not have participated in this study, resulting in a sampling bias.

Wagner, Brondolo, and Rabkin (1996) conducted a longitudinal study to determine whether internalized homophobia was related to psychological distress and coping style, and whether these relationships were moderated by HIV illness stage. The sample for this study included gay males, who were mostly HIV+, Caucasian, and well-educated. Participants were recruited through gay-identified organizations, advertisements, and by word of mouth, and assessments were administered at baseline and at a 2 year follow-up. The researchers were particularly interested in whether internalized homophobia predicted psychological distress and coping over time in the context of HIV illness progression. Findings revealed a positive correlation between internalized homophobia and self-report measures of psychological distress at both baseline and follow-up. Internalized homophobia was also negatively correlated with proactive coping at baseline and follow-up (Wagner et al.).

There is a major limitation to this study in terms of its generalizability. As with the previous study, the recruitment process was conducted predominantly through LGB-related venues, so individuals who did not access these resources were underrepresented. The lack of diversity among the sample (89% Caucasian, 89% employed, 71% college degree) is also a concern.

### *Substance Use and Abuse*

Due to society's failure to accept or acknowledge LGB individuals, social outlets have been and continue to be limited for this population. Bars, clubs, and private homes, where alcohol and drugs are easily accessible, are often meeting places for LGB people.

Mood altering substances are also used by LGB individuals as a means of coping with the stress of living in a homophobic and heterosexist society. As a result, they often play prominent roles in the socialization and primary sexual experiences of many LGB people (Cabaj, 1996, 2000).

According to the Center for Substance Abuse Treatment (CSAT, 2001), LGB persons are more likely to use alcohol and/or drugs than the general population, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later adulthood. In fact, studies suggest that 20 to 25% of gay men and lesbians are heavy alcohol users, compared to 3 to 10% of the heterosexual population (CSAT, 2001). There is a small body of research that addresses substance use and abuse by lesbians and gay men, and less research exists on the substance use patterns of bisexual individuals (Hughes & Eliason, 2002).

McKirnan and Peterson (1989) examined the general population characteristics and alcohol and other drug use among lesbians and gay men in the city of Chicago. The results from their study were compared to an earlier study of the substance use patterns of men and women in the general population conducted by Clark and Midanik (1982). Thirty-four hundred participants (748 lesbians, 2652 gay men) were recruited through LGB newspapers, organizations, and events (e.g., film festival, a benefit for AIDS research). A small number of bisexual individuals (2%) were included in the study. The sample was predominantly White (88%), male (78%), and college-educated (60%). Findings suggest that there were overall higher rates of substance abuse among lesbians and gay men. Fewer same-gender oriented individuals abstained from alcohol when compared to the general population. Although the LGB sample did not demonstrate a

higher proportion of heavy drinkers, they did show higher rates of alcohol problems. An “alcohol problem” in this study was defined as at least two symptoms of dependency and loss of control over the previous year, which was measured by a condensed version of the dependency and loss of control scales. In particular, alcohol problems for lesbians were greater than those for heterosexual women (23% and 8%, respectively), as were those for gay men and heterosexual men (23% and 16%, respectively). In terms of drug use, McKirnan and Peterson found substantially higher numbers of LGB individuals used cannabis (56%) and cocaine (23%) than the general population (20% and 8.5%, respectively).

According to Bux (1996), this study demonstrates improvements in methodology as it does *not* include a predominantly clinical sample that recruited participants from treatment centers or bar settings, which is not true for many previous studies. Although bias was reduced through the use of a random sample, the Chicago-based sample reduces generalizability to other smaller cities and towns, and makes the comparison to Clark and Midanik’s (1982) study of the substance use patterns of the general population in urban, suburban, and rural areas questionable (Bux, 1996). These methodological concerns compromise the overall strength of the study.

Skinner and Otis (1996) conducted a longitudinal study, known as the *Trilogy Project*, to assess alcohol and/or drug use among a sample of lesbians and gay men living in and around Lexington and Louisville, Kentucky. The study was designed to gather epidemiological data on the lifetime, past year, and past month prevalence rates of alcohol and/or drug use for gay men and lesbians, and was compared to the data from the National Household Survey on Drug Abuse (NHSDA). Surveys were administered to

1,067 lesbians (46.9%) and gay men (53.1%), who were recruited through organization mailing lists, chain referral sampling, and convenience sampling. A significant portion of the sample was White (93.3%), college educated (60.8%), and lived in a city or suburb (80.2%). When compared to the data from the NHSDA, Trilogy Project participants demonstrated higher rates of marijuana, inhalants, and alcohol use. In terms of alcohol use, lesbians from the Trilogy Project sample reported a rate of 87%, while women from the NHSDA study demonstrated a rate of 64.4%. There were similar findings for men such that 84.1% of gay men from the Trilogy Project reported alcohol use compared to 72.1% of NHSDA male participants. Overall findings suggest that individuals who participated in the Trilogy Project drank more frequently than those in the NHSDA study (Skinner & Otis).

As with the study developed by McKirnan and Peterson (1989), sampling bias is limited in this study due to the nature of the recruitment process. The lack of probability sampling, however, prevents generalizing to the greater LGB community. In addition, the sample in this study lacked racial diversity among the participants, which reduces the generalizability even more.

Sorenson and Roberts (1997) reviewed a study that was conducted in 1987 by the Fenway Community Health Center, which is located in Boston, Massachusetts. Through self-report questionnaires, this study assessed the health and life experiences of a national sample of 1,633 lesbian women. The purpose of the study was to create a database of “normal” social and health practices of lesbians in order to compare the daily lives of lesbians to those of the general population. Sorenson and Roberts present the portion of the survey that addresses the use of and satisfaction with mental health services and rates

of alcohol use among the sample. In terms of alcohol use and abuse, 15.1% of women in the sample identified as alcoholics, 29% shared that they had attended Alcoholics Anonymous, and 24.4% revealed that they drank two or more drinks per day. These results, however, should be interpreted with caution due to the lack of racial diversity included in the sample (86.6% percent reported their race as White; Sorenson & Roberts).

As noted above, a review of the research supports the prevalence of substance use and abuse in the LGB population. A major strength of two of these studies is that they were compared with other studies sampled on the general population (McKirnan & Peterson, 1989; Skinner & Otis, 1996). This allowed for a comparison of substance use patterns with sexual orientation as an independent variable. There are, however, many limitations to the existing research that must be underscored. Poor or absent control groups, unrepresentative samples, and inconsistent sexual orientation terminology are a few methodological flaws reported in the literature (Cabaj, 1996). Nonetheless, the findings from these studies consistently demonstrate high rates of substance use and abuse among the LGB community when compared to the general population.

It is important to note that many empirical studies either exclude or blend bisexual individuals into their samples; therefore, data specifically related to bisexual individuals is lacking. Cabaj (1997) asserts, however, that the experiences of bisexual individuals who identify strongly with same gender desires will be similar to the experiences of gay men and lesbians. In light of the aforementioned limitations, however, the studies highlight the salience and importance of substance use and abuse as a clinical issue for same-gender oriented individuals.



One must understand that LGB individuals are not predisposed to the use and abuse of substances; rather, they are an at risk population that often turns to alcohol and/or drug use as a means of coping with the stress of being oppressed. The use of substances allows for the expression of suppressed and repressed desires and needs as well as temporarily relief from the negative feelings associated with internalized homophobia (Cabaj, 2000). Cabaj further posits that substance use disconnects people from feelings of shame and anxiety, provides acceptance, fosters social comfort in bars or unfamiliar social settings, facilitates the acting on feelings long suppressed or denied, allows for denial and even blackouts about sexual behavior, and braces people for rejection by others.

#### *Internalized Homophobia and Substance Use and Abuse*

Although there are various studies that examine the relationship between internalized homophobia and psychological distress (Herek, et al, 1997; Lock, 1998; Szymanski, Chung, & Balsam, 2001; Wagner et al., 1996), there are limited studies that examine the relationship between internalized homophobia and substance use and abuse. In fact, most of the empirically supported research related to this relationship can be found in *Dissertation Abstracts International*, which suggest that there is growing emphasis on the topic but that it is in its early stages. A review of the limited research reveals four studies that examine the relationship between internalized homophobia and substance use and abuse in the LGB community.

A study examining the data from a 1995-1996 survey of 84 gay and bisexual adult men was conducted to examine the association between internalized homophobia and substance use, as well as substance use while engaging in social and sexual relations with

other gay and/or bisexual men. Findings indicate that the relationships between internalized homophobia and high quantity and frequency of alcohol use, higher frequency of alcohol/drug related problems, and high frequency of drug use while engaging in sexual relations were significant (Cherry, 1997).

The results of this study are debatable because the instruments used in Cherry's study were not thoroughly supported with research nor were they clearly explained in the methods section. According to Amadio (2002), Cherry did not report data related to the psychometric properties of a measure of alcohol consumption used in a study by Stall and Wiley (1988) and a second measure that was used by Clark and Midanik in a 1979 national survey of alcohol use (Amadio, 2002). The sample also lacked diversity; a majority of the participants were Caucasian, college educated, and professional, and did not report high levels of substance use or high levels of internalized homophobia. Due to the lack of psychometric support and lack of clarity about some of the instruments, as well as the homogenous sample, Cherry's results should be interpreted with caution.

Jaffe et al. (2000) conducted a study to examine the prevalence rates of alcoholism and feelings of alienation, which result from societal homophobia, in samples of both lesbian and heterosexual women. The sample consisted of 87 lesbians and 89 heterosexual women who were recruited through local women's associations such as professional groups, religious groups, and bookstores. A demographic questionnaire, the Michigan Alcoholism Screening Test (MAST), and the Dean Alienation Scale were measures that were included in the study. Results indicated a higher prevalence of alcoholism among the lesbian participants than the matched cohort of heterosexual women. In particular, 18% of lesbians scored highly on the MAST as compared to 7% of

heterosexual women. Higher scores on the MAST suggest higher levels of alcohol abuse. Although the researchers could not confirm a relationship between alcohol abuse and feelings of alienation, they asserted that high levels of alcohol abuse in the gay community may be attributed to social oppression and internalized homophobia.

A major limitation to this study should be considered when interpreting the results. The study is influenced by sampling bias such that all the lesbian participants were recruited from LGB related groups, which may exclude lesbians who are not out or who are not integrated into the gay community. In addition, when heterosexual participants could not be recruited from comparable settings as the lesbian participants, data was based on an earlier study conducted by Clark and Midanik (1982). No clarification was made besides a small note at the conclusion of the study as to which data was obtained from Clark and Midanik, or if the cohorts matched in terms of geography (e.g., urban, suburban, and rural). Diversity among the lesbian sample is also a concern in terms of education (60% were college-educated or had a professional degree), socioeconomic status (43% were in professional, managerial, or technical jobs), and racial/ethnic backgrounds. The researchers did not include any statistics related to race, but they did note in their conclusion that minority women were “underrepresented” (Jaffe et al., 2000, p. 34). Although there are limitations to generalizing the results, the study supports the research, which underscores internalized homophobia and alcohol abuse as problems in the LGB community.

Burris (1997) developed a dissertation to examine the association between internalized homophobia, self-esteem, and chemical dependency among lesbians. The sample of 204 lesbians produced an important finding that suggested lesbians with higher

levels of internalized homophobia are more likely to be alcoholic, and that internalized homophobia is inversely related to self-esteem. In addition, findings indicated that lesbians who were more involved in the LGB community were less likely to be alcoholic (Burris, 1997). This is consistent with past research, which suggests that internalized homophobia is negatively related to LGB individuals' social interactions with other LGB people such that they are less "out," less integrated into the LGB community, have fewer interactions with other same-gender oriented people, and have less LGB support (Huebner, Davis, Nemeroff, & Aiken, 2002).

Caution should be taken when interpreting Burris' (1997) results. The researcher included the Affective Internalized Homophobia subscale of the Reactions to Anti-Homosexual Prejudice Scale (Kelly, as cited in Burris, 1996) to measure internalized homophobia. Although the internal consistency of this subscale was strong (.76), items for the subscale were not provided, and research related to this unpublished scale is lacking (Amadio, 2002).

A qualitative study by Kus (1988) explored 20 gay male's retrospective accounts of their experiences with alcoholism. All participants had at least one year of recovery from alcoholism, and lived in or around Chicago, Iowa City, Oklahoma City, and Seattle. The researcher examined the process through which the participants achieved sobriety, their level of self-acceptance as gay men, and their perceptions of the relationship between sobriety and self-acceptance as a same-gender oriented individual. Findings suggest that participants did not view their gay male sexual orientation in a positive way while they abused alcohol, and a few participants reported that they abused alcohol as an avoidant coping skill when dealing with their sexual orientation. According to Kus, self-

acceptance of one's same gender sexual orientation is a primary contributing factor in the development and high prevalence of alcoholism among gay men.

Kus's study, however, has limited generalizability. A major weakness of Kus's study is that it was based on only 20 in-depth interviews and the participants' retrospective interpretation of their experiences with alcoholism. According to Cherry (1997), this approach lacks "objectivity and the control of standardized measures" (p. 67). Although the retrospective self-reports of the participants are threats to the reported phenomenon, the data from this study support the importance of self-acceptance in the overall well-being of LGB individuals, and the negative effects of denying one's same-gender sexual orientation.

A study conducted by Amadio and Chung (2004) is one of the most recent publications that examined the relationship between internalized homophobia and substance use among LGB individuals. The purpose of the study was to determine the relationship between internalized homophobia and use of alcohol, marijuana, and cigarettes as well as alcohol- and drug-related problems. The sample included 207 LGB individuals who were recruited during a two-day gay pride festival in Atlanta, Georgia. Findings from this study are contrary to those previously identified and discussed because they indicated a significant negative correlation between internalized homophobia and lifetime of use of alcohol, marijuana, and cigarettes for females. No significant relationships were found for males. These results may be attributed to Amadio and Chung's recruitment methods, which may have failed to include LGB individuals who are less out and had higher internalized homophobia and substance use. A major strength

of the study is inclusion of bisexual individuals (16%), but no analyses by sexual orientation could be located.

The majority of the aforementioned research findings are of concern to me because the use of substances only temporarily relieves but then reinforces feelings of self-hatred and self-loathing that occur during the post drug-use period, which further worsens the psychological well-being of LGB individuals. Although alcohol and drug use provides comfort at times, LGB individuals may experience increased use, abuse, and possible dependency (Cabaj, 2000).

Whether it is to treat existing negative symptoms or prevent potential adverse effects associated with internalized homophobia, LGB individuals need to understand the role of homophobia and heterosexism in the manifestation of psychological distress and subsequent destructive behaviors. Counseling as a preventive and treatment measure provides a supportive environment where LGB people can increase their awareness about personal and collective experiences as oppressed individuals, while increasing their understanding of internalized homophobia and their relationship with a homophobic and heterosexist world (Mair & Izzard, 2001).

#### *Counseling and the LGB Community*

Same-gender oriented individuals are seeking counseling at high rates (Bieschke et al., 2000). Jones and Gabriel's (1999) report of high counseling rates for lesbians and gay men when compared to those of heterosexual individuals support Bieschke's claim, but were based on counseling rates from two studies that were conducted in 1978 and 1992. I was dissatisfied with these older statistics and conducted a literature search to find more recent rates. A review of the literature produced no studies with more recent

data. To this end, I will present three studies that were conducted in 1983, 1985, and 1987, respectively, to highlight the historically high rates of counseling utilized by LGB individuals.

Mapou, Ayres, and Cole (1983) explored the problem areas and counseling experiences of 96 gay White males. The questionnaire used in the study was designed by the researchers and had no prior psychometrics or research applicability. Of the participants, 44% reported having received counseling at some point in their lives. The researchers also presented a list of problems areas, which was adapted from an intake form used by a counseling center at a major southern university, and asked participants if they were “ever a problem” and/or “currently a problem” (Mapou et al., p. 327-328). The most frequently reported problems by participants included termination of a close relationship, dealing with emotions, fears, anxiety, and coming out to family. A majority of the sample also reported that they were satisfied with their counseling experiences (Mapou et al.). Although this study is more than 20 years old, it is the only assessment of gay men’s counseling experiences that I could identify in the professional literature.

The National Lesbian Health Care Survey, conducted between 1984-1985, assessed the demographic, lifestyle, and mental health characteristics of approximately 1,925 lesbians in the United States (Bradford et al., 1994). Surveys assessing participation in and personal experiences with counseling were administered. Findings revealed that 73% of the participants were receiving counseling or had received some form of counseling or support at some time in their lives. Forty-nine percent of lesbians who had received counseling had done so for 1 year or less, 18% for 1-2 years, 11% for 2-3 years, 7% for 3-4 years, and 14% for over 4 years. The demographics of those

receiving or who had received counseling indicated women aged 35-54, who were White or Latina, with advanced degrees, and who identified with Jewish, Unitarian, and Pagan religions sought counseling more frequently (Bradford et al., 1994). Reasons for seeking counseling, as reported by the sample, included but were not limited to feeling sad or depressed (50%), problems with lover (44%), feeling anxious or scared (31%), problems with family (30%), loneliness (21%), issues related to being gay (21%), and alcohol and drug use and abuse (16%; Bradford et al.).

Findings from a study conducted in 1987 by the Fenway Community Health Center in Boston, Massachusetts, assessed the uses of and satisfaction with mental health services of lesbians (Sorenson & Roberts, 1997). As previously noted, questionnaires were administered to 1,633 lesbians that collected information about various areas including but not limited to their demographics, health practices, stress in personal and work lives, and mental and physical health problems. Sorenson and Roberts (1997) reviewed this study and reported findings that support those of the National Lesbian Health Care Survey. In terms of use of mental health services, approximately 80% of the participants shared that they had received counseling at some point in their lives, and about 50% reported that they had been in counseling more than once. Although the demographics of lesbians who received counseling were not discussed, the overall demographics of the sample included women aged 20-39 (80%), who were White (78.1%), in professional occupations (54.1%), and from urban areas (66.3%; Sorenson & Roberts).

From the aforementioned studies, one can assert that lesbians and gay men have historically sought counseling for support with life problems. From my own experience



as a counselor, and from numerous conversations with other clinicians, I purport that lesbians, gay men, and bisexual individuals continue to seek counseling at high rates.

*Counseling and internalized homophobia.* Why are LGB individuals seeking counseling at high rates? Theoretical explanations in the professional literature attribute high usage of counseling to the negative effects of societal oppression such as internalized homophobia (Bradford et al., 1994; Bringaze & White, 2001; Morgan & Eliason, 1992). According to Stein and Cabaj (1996), assessing the form, extent, and direct effects of internalized homophobia is important in working with LGB people in counseling. Internalized homophobia must be reduced or eliminated in order for LGB individuals to experience sexual minority identity formation and improved mental health and overall quality of life (Ross & Rosser, 1996; Wagner et al., 1996). This can be achieved by changing the negative meanings attached to LGB sexual orientations, and replacing them with more positive and affirmative meanings (Ross & Rosser, 1996). The process of counseling provides LGB people with this opportunity. Through the support of a counselor, LGB individuals can reduce internalized homophobia by externalizing negative feelings related to their same gender sexual orientation, develop coping skills to increase feelings of low self-esteem and self-worth, and move through the stages of the coming out process towards adopting a positive and integrated LGB sexual identity (CSAT, 2001; Shidlo, 1994).

A study by Bringaze and White (2001) investigated factors that contribute to success in the coming-out process for lesbians through self-report questionnaires completed by women who were openly lesbian and in positions of leadership. The researchers recruited 62 national leaders and role models in the lesbian community, who

represented Caucasian (81%), Hispanic (8%), bi-racial (7%), African American (2%), and Native American (2%) backgrounds. Eighty-six percent of the sample were college-educated, and approximately 57% held advanced degrees. The following five areas of support were identified as contributing to success in the coming process: association with other gays and lesbians, self-help resources, counseling, religion and spirituality, and, family. In terms of counseling, approximately 35% of the respondents found individual counseling to be a helpful support during their experiences with the coming-out process. Participants described counseling as helpful in providing the opportunity for LGB individuals to normalize same-gender feelings as well as examine internal messages about same-gender sexual orientation that are predicated on external criteria such as familial and social experiences. The authors did not report any information about unhelpful characteristics of counseling. Based on the findings from the study, the authors assert that helping professionals should limit the treatment of LGB individuals' symptoms and place more focus on the societal factors that lead to these problems (Bringaze & White).

The psychotherapy experiences of 600 LGB individuals, who had all been in psychotherapy at least one time in their lives, were examined by Jones and Gabriel (1999). As previously reviewed, the number, duration, circumstances, and views of each therapy experience were assessed. Self-report questionnaires developed by the researchers were administered to the sample, which included items that assessed therapy characteristics such as number of therapy sessions, reason(s) the participant sought therapy, benefit(s) the participants derived from each therapy experience, and overall views on therapy (Jones & Gabriel).

In terms of reason(s) that the participants sought therapy, 39% reported that difficulty associated with their sexual orientation was at least one of the issues that led them to seek therapy. In particular, 35% of participants entered therapy to work through their own reactions as well as the reactions of others to the realization that they are LGB. Although the participants reported that therapy was beneficial for them, the researchers did not identify specific helpful or unhelpful aspects of therapy. Attitudes towards therapy were positive such that 33% stated therapy had “saved their lives,” 50% reported their experiences were “positive,” and 86% stated therapy had a “positive influence on their lives” (Jones & Gabriel, p. 215). Overall, findings indicate that LGB individuals are “among the most active and satisfied – but least acknowledged – consumers of psychotherapy” (Jones & Gabriel, p. 209).

Morgan and Eliason (1992) conducted a qualitative study that explored the disproportionately high rates of counseling services among lesbians. The sample included 40 Caucasian lesbians who were from the Midwest and a middle-class socioeconomic background. Twenty-three women had experience with counseling and 17 did not have experience with counseling. All participants were interviewed about the role of counseling in their own lives as well as other lesbians’ lives. Themes that emerged while interviewing the participants included the influence of societal oppression in disrupting normal developmental tasks and daily living for lesbians, and the openness of lesbians to be introspective and to value personal growth. Lesbians who did receive counseling identified the following as reasons they sought counseling: family of origin issues (52.2%), relationship or couple issues (47.8%), problems with coming out (39.1%), depression (26.1%), and alcohol or drug use (17.4%; Morgan & Eliason).

In terms of helpfulness of counseling, participants were asked why they thought counseling would be helpful. Approximately 57% of women described that they “didn’t know what else to do” or “they were in crisis” (p. 36). Other responses included “they had received a referral from someone else” (39.1%) and “they were seeking personal growth and believing that counseling would assist with that” (21.7%; p. 36). A large portion of the sample found counseling to be helpful (69.6%). Helpful characteristics of counseling reported by the sample included but were not limited to a safe/supportive environment (43.5%), the clarification of problems (34.8%), getting information or new ways to think about things (26%), receiving objective feedback (21.7%), and the facilitation of change (21.7%). Unhelpful characteristics of counseling included but were not limited to poor personality match (17.4%), counselor’s own issues or agenda interfering (13%), and the counselor being homophobic, pushing too fast, being critical, and not understanding the problems (4.3%). An important question in the interview asked participants why they thought a greater percentage of lesbians were in counseling. Eighty percent of the total sample identified “oppression creates greater stressors for lesbians” as a common clinical issue for lesbians (p. 39). Overall findings indicated lesbians had more positive attitudes towards counseling and utilized counseling to reduce the effects of oppression due to a homophobia culture (Morgan & Eliason).

Bobbe (2002) discussed her clinical experience with Denise, a lesbian client who was receiving treatment for alcohol dependency. Bobbe suggests that the introduction of the concept of internalized homophobia to Denise’s treatment led her to look “uplifted by the support she felt from finally being understood....she started to talk with a new sense of pride about herself, her unconscious shame having been named and ‘normalized’ by

the education of about internalized homophobia” (p. 220). According to Bobbe, a greater understanding of internalized homophobia allows for individuals to have a new context in which to understand their experiences.

Friend (1989) underscored an interesting notion related to older LGB individuals’ experiences with sexual minority identity development and how they cope with homophobia and heterosexism. Friend stated that affirmative older lesbian and gay individuals do not internalize society’s anti-gay attitudes; rather, they challenge the negative beliefs about same-gender sexual orientation while reconstructing their own personal sexual identity of what it means to be LGB individuals. These healthy coping strategies, according to Friend, can lead to the formation of an LGB identity and the reduction or elimination of internalized homophobia.

The main tenet of Friend’s assertion is that sexual minority identity development can occur if LGB individuals reclaim the power that was taken from them by society. This increase in power can help them redefine same-gender sexual orientation from a healthier perspective that facilitates positive feelings about themselves. Friend also noted that well-adjusted lesbian and gay individuals more often respond to community outreach such as the Senior Action in a Gay Environment (SAGE) program, which is a social service agency in New York. To this end, I propose that affirmative counseling provides LGB individuals with the opportunity to deconstruct negative heterosexist views, and reconstruct them into more positive, affirming beliefs with regard to LGB sexual orientation.

Neisen (1990) supports the views of Bringaze and White (2001), Jones and Gabriel (1999), Morgan and Eliason (1992), and Friend (1989) such that an emphasis on

the shame that results from homophobia and heterosexism is important for LGB individuals in enhancing their well-being. By recognizing shame as a product of a homophobic and heterosexist society and by reducing or eliminating the subsequent self-hatred, counselors can help LGB individuals feel more positively about their LGB sexual orientation. According to Neisen:

helping the client understand that she/he has been abused and victimized by society is essential in understanding one's negative self-image in relation to cultural victimization, rather than the frequent belief of oppressed individuals that they are innately defective or at fault. (p. 31)

Such efforts facilitate LGB individuals in reclaiming their personal power and making decisions towards a more positive and authentic self (Mair & Izzard, 2001).

*Counseling and substance use and abuse.* To date, there has been little research that addresses the role of counseling with lesbians and gay men who are abusing substances, and even less on bisexual and transgender individuals (Cabaj, 2000). A common theme in the literature is the importance of focusing on the effects of homophobia and heterosexism in substance abuse treatment and in the recovery process.

Cabaj (1997) asserts that the feelings and behaviors associated with both internalized homophobia and substance abuse are very similar. These feelings include but are not limited to denial, fear, anxiety, anger, guilt, depression with hopelessness and powerlessness, low self-esteem, and isolation. These similarities make it difficult for LGB individuals who do not accept their sexual orientation to effectively treat their substance abuse problems. To this end, counseling for LGB individuals with substance abuse concerns must focus on recovery from substance abuse and from the negative

effects of homophobia and heterosexism. Other unique issues that should be addressed in counseling, according to Cabaj, include where the individual is with regard to the coming out process as well as his/her experiences with the coming out process, the individual's support system, current relationship as well as history of relationships, relationships with family of origin, level of comfort with one's sexuality and sexual expression, economic and career status, and health factors.

According to Bobbe (2002), the counselor plays an important role in the counseling process. He/she helps the client explore how shame and internalized homophobia are caused by a homophobic society. Bobbe asserts that Alcoholics Anonymous (AA) meetings, sponsor support, and individual counseling are ways to express feelings associated with internalized homophobia and heal from substance abuse.

Although LGB individuals are seeking counseling services at high rates, there is a dearth of empirical research that assesses their experiences with counseling, or supports the proposition that internalized homophobia is a salient clinical issue for this population. Jones and Gabriel (1999) report that attention to the education and training of counselors to work with LGB individuals in the professional literature has increased in recent times. What is missing from the professional literature, however, "is what the gay and lesbians patients themselves have to say about their experience in psychotherapy or counseling" (p. 210). In addition, there is a plethora of exploratory literature but limited empirical support for internalized homophobia as an important clinical issue for LGB people. In other words, the conceptual literature has identified internalized homophobia as a significant construct in the symptomatology and treatment of lesbian and gay men (Ross

& Rosser, 1996), but no empirical studies that have taken this conceptual literature back into the LGB community for confirmation were located.

As for the existing professional literature that does address the counseling experiences of LGB individuals, there is considerably more research related to the counseling experiences of lesbians than gay men. In fact, relatively little is known about the counseling experiences of gay men (Bieschke et al., 2000). This study filled this gap in the literature by identifying a sample of LGB individuals, and exploring their experiences with counseling and their perceptions of the role of counseling in reducing internalized homophobia.

### Conclusion

Although same-gender sexual orientation was removed as a psychiatric disorder from the *Diagnostic and Statistical Manual of Mental Disorders* in 1973, LGB individuals continue to experience societal homophobia and heterosexism. Consequently, LGB individuals experience additional developmental events as they manage an emerging sexual identity in the context of an anti-gay society (Gonsiorek, 1995).

Members of sexual minority groups frequently witness or are victims of homophobic and heterosexist events, which include subtle and blatant forms of prejudice and discrimination (Selvidge, 2000). LGB individuals often internalize these anti-gay attitudes and behaviors, which causes them to experience emotional stress that manifests in destructive behaviors such as substance use and abuse. It is theorized that LGB persons use alcohol and drugs as a means to temporarily relieve the pain and distress associated with internalized homophobia. The use of substances is by no means a solution to internalized homophobia for LGB people; rather, it worsens the psychological states of



sexual minorities and prevents them from developing healthy coping skills necessary in their negotiation of a positive identity. Although the damaging effects of a non-affirmative environment on the well-being of LGB individuals are continuing problems, they remain understudied in the professional literature.

Measures to reduce internalized homophobia and its negative psychological and behavioral effects, particularly substance use and abuse, need to be identified and implemented. Counseling as a means of support for LGB individuals can prevent and treat the consequences of homophobia and heterosexism, internalized homophobia, and substance use and abuse. By recognizing the source of the distress, LGB individuals are able to externalize the non-affirming feelings of same-gender sexual orientation and enhance their feelings of self-esteem and self-worth, which could lead to a positive synthesis of sexual identity in their overall identity as human beings.

## Chapter 3

### Methodology

This chapter will describe the participants for this study, how they were recruited, and the procedures for the study. The instruments selected for inclusion in this study will also be described.

#### *Participants*

Participants in the study included self-identified lesbian, gay, and bisexual individuals, and individuals who are exploring a lesbian, gay male, or bisexual sexual orientation identity. All participants were over 18 years of age. I recruited participants who represent diversity in terms of race/ethnicity, education level, income, and geographical region. As an incentive for participation, a \$300 donation was made to the Rainbow World Fund (RWF), a gay, lesbian, bisexual, and transgender humanitarian service agency that focuses on global HIV/AIDS, water development, landmine eradication, and hunger. I personally donated \$100, and an anonymous donor, who contacted Dr. Brandon Hunt, contributed the remaining \$200 to the RWF.

Next I will describe the demographics of the sample (see Table 1 for specifics). Study participants (N = 824) ranged from 18 to 81 years of age, with a mean age of 32 years. Sixty-five percent of participants were 18 to 35 years of age, 26% were 36 to 50 years of age, and 8% were 51 years of age and older. There was also a balance between females (51%) and males (45%), with an additional 3% of the sample identifying as transgender and 2% as “Other” (e.g., “gender queer,” “gender neutral,” “femme,” “androgynous”). I included transgender individuals in this study because they self-identified as LGB, or indicated that they were exploring an LGB sexual orientation

identity and are therefore at-risk for bias and discrimination based on sexual orientation. In terms of sexual orientation identity, 36% of participants identified as lesbian, 37% identified as gay male, 16% identified as bisexual, 2.5% were [because the study is over, you need to refer to folks in the past tense]currently exploring a lesbian identity, 1% were currently exploring a gay male identity, 4% were currently exploring a bisexual identity, and 3% identified as “Other” (e.g., queer, fluid). This study uses the term LGB to refer to same-gendering loving individuals. This language, however, acknowledges that many participants who identified as LGBT chose to use other self-identifying terms in this study such as “queer,” “dyke,” “pansexual,” “same-gender loving,” and “fluid.” The sample was predominantly Caucasian (82%), but also included African American/Black (4%), Asian American/Asian (3.5%), Latino/Hispanic (4%), Native American (1.5%), Multi or Biracial (3.5%) individuals, and 2% of individuals who identified as “Other” (e.g., Puerto-Rican, French-Canadian).

The sample also demonstrated diversity with regard to education and household income. Thirty-one percent of participants had a graduate degree (master’s and above), 29% had a bachelor’s degree, 4% had an associate’s degree, 30% attended some college, university, or technical school, and 5% had a high school diploma or equivalent. With regard to income, almost 40% of the sample reported a household income above \$50,000, while approximately 25% reported a household income under \$20,000.

Participants also reported their relationship status. Forty percent of the sample described their relationship status as single, 15% reported being in a relationship less than 1 year, 20% reported 1 to 4 years, 12% reported 4.1 to 9 years, 11% indicated being in a relationship longer than 9 years, and 2% responded with “Other” (e.g., open relationship,

married). Finally, participants reported how they heard about the study. The majority of the sample (75%) indicated that they heard about the study through email list-servs, 19% heard through emails from friends, 2% heard from an online advertisement or link on the web, 1% heard from advertisements in print materials, and 2% heard through word of mouth.

### *Recruitment*

Rothblum (1994) posits that most of the existing research related to the LGB community has been conducted with LGB individuals who were recruited from gay and lesbian community groups. The National Lesbian Health Care Survey (Bradford et al., 1987) used a diversity of recruitment methods to gather 1,917 participants from all 50 states. These included lesbian and gay health and mental health organizations, professional LGB organizations, bookstores, women's organizations, prisons, gay newspapers, and personal networks (Bradford et al., 1994). According to Bradford et al., personal networks include "volunteer distributors" who describe the study to friends or colleagues in hopes of recruiting LGB individuals from social and organizational contacts (p. 230). This allows for a diverse group of individuals who fit the criteria for the population of interest.

The Internet is also an important vehicle for recruitment. Gay and lesbian individuals are common users of the Internet, and their numbers are increasingly growing (Mustanski, 2001). This study used the Internet to recruit LGB participants. Mustanski identified posting to appropriate newsgroups, list-servs, and webpages as useful methods of online recruitment. I recruited participants through e-mail advertisements to LGB list-servs; posters in LGB restaurants, bookstores, and community centers; e-mail

advertisements to the directors of LGB resource centers on college campuses; and personal networks. In addition, I distributed email advertisements to my colleagues and friends who acted as “volunteer distributors” of the email advertisement to their friends and colleagues. See Appendix A for a copy of the recruitment advertisement, and Appendix B for a list of LGB list-servs used in this study.

Some of the aforementioned methods of recruitment are often criticized for being nonrepresentative or nonrandom because they include LGB individuals who are more open about their same-gender sexual orientation, as evidenced by their attending LGB events or reading LGB newspapers or magazines (Rothblum, 1994). In addition, Rothblum suggests survey responses that are based on members of the LGB community lack multicultural representation since most participants are “young, White, and college educated” (p. 215). I utilized a confidential Internet survey to recruit LGB individuals who may be more comfortable disclosing information related to their sexual orientation identity where their confidentiality is protected. In addition, I made efforts to recruit LGB people of color through multicultural LGB list-servs, and email advertisements to multicultural LGB magazines including *The Advocate*, *Girlfriends*, and *En La Vida*.

It is important to note that the use of the Internet to collect data has not been viewed as a strong research tool because of problems of self-selection, selection bias, and response rates (Koch & Emrey, 2001). Nonetheless, Koch and Emrey stated it is better to conduct research that has explainable limitations rather than to neglect to address important topics relevant to hard to identify populations.

Mustanski (2001) supports Koch and Emrey’s perspective on the use of the Internet in survey research. Mustanski notes that the use of the Internet to collect data

related to sexuality is an “exciting new frontier for researchers” (p. 292). Due to the anonymous and accessible nature of Internet surveys, larger samples that are more representative of their target populations are identifiable (Mustanski, 2001). In addition, the use of the Internet allows for research on marginalized and difficult to identify populations such as LGB individuals (Koch & Emrey, 2001). To test this notion, Koch and Emrey conducted an online study with LGB individuals, which included online surveys that were posted on a gay/lesbian website. The researchers compared the demographic information they collected to national data on gay men and lesbians. No significant differences were found between the study sample and the national sample indicating the Internet is an effective tool in recruiting hard to identify populations.

In order to determine the appropriate sample size for the proposed study, an a priori power analysis was conducted using G\*Power (Faul & Erdfelder, 1992). This computer program requires the researcher to input the desired effect size, alpha level, and power value. I selected multiple regression with two predictor variables and set the effect size at .1, alpha level at .05, and power level at .80. An effect size of .1 was identified based on Cohen’s (1977) characterization of .1 as a small effect size, .25 as a medium effect size, and  $> .4$  as a large effect size. An alpha level of .05 was selected because this value is viewed as the standard minimum for rejecting the null hypothesis (Cohen, 1988). Finally, the level of power selected for this study is .80, which is a power level that has been described by Heppner, Kivlighan, and Wampold (1999) as the “accepted standard” (p. 328). Based on the information that was inputted into the G\*Power program, a total sample size of 100 was determined necessary for the present study. My online

recruitment methods produced a sample of 824 participants, which was above and beyond the required sample size.

### *Procedure*

In accordance with the aforementioned research on Internet surveys, I developed a website through PsychData, which is a web-based company that conducts Internet-based research in the social sciences. The website opened with the requirements for the study (e.g., you are at least 18 years of age) and a voluntary informed consent statement (see Appendix C). After participants agreed to the requirements and accepted the informed consent statement, they were introduced to the instruments included in the study. All submissions were encrypted using SSL (secure server layer) technology. To this end, security and confidentiality were maintained.

### *Measures*

Four measures were used to assess the independent variables (e.g., heterosexist events, internalized homophobia) and dependent variables (e.g., alcohol use, drug use). Each measure is identified and described below.

*Demographic questionnaire.* The demographic questionnaire (see Appendix D) assessed age, gender, sexual orientation, ethnicity/race, education level, and income level. I also assessed geographical region, relationship status, and method of learning about the study for the following reasons: (a) an assessment of geographical region provided me with data on whether I recruited a national and/or international sample, (b) relationship status allowed me to examine if internalized homophobia is related to whether one is in a relationship, and (c) method of learning about the study provided me with valuable

information with regard to the most effective recruitment methods that I can share with other researchers.

*Schedule of Heterosexist Events (SHE)*. The frequency of heterosexist events encountered by LGB individuals in their lifetimes was measured using the Schedule of Heterosexist Events (SHE; Selvidge, 2000; see Appendix E). This scale was adapted from the Schedule of Sexist Events (SSE; Kolonoff & Landrine, 1995), which measures lifetime experiences of sexist events for women. Based on the strong psychometric properties of the SSE, Mary Selvidge, a student working on her dissertation, changed the wording of the questions to reflect heterosexist events. This new version reflected similar psychometric properties in both a pilot study and Selvidge's dissertation, which included lesbians. There is no data on this scale for men that I could locate.

The SHE includes 17 items that measure frequency of heterosexist events using a 6-point Likert scale that ranges from 1 (*this has NEVER happened to you*), to 6 (*this has happened to you ALMOST ALL OF THE TIME* [more than 70% of the time]). Selvidge scored the SHE using a mean computation method for each participant, where scores could range from 1 (representing lowest frequency of lifetime heterosexist events) to 6 (representing highest frequency of lifetime heterosexist events). This scoring procedure was utilized in this study.

The SHE demonstrated strong internal consistency in a pilot study of 21 women in the LGB community in Memphis, Tennessee (Chronbach's alpha = .91), which was conducted by Selvidge before using the newly developed measure in her dissertation. Findings from Selvidge's dissertation indicate similar strong internal consistency (Chronbach's alpha = .92). The Chronbach's alpha for the SHE in this study was .90. Due



to the fact that no data exists for use of this scale with men, results from this study will be examined to assess if the SHE is an appropriate measure of heterosexist events for men.

*Internalized Homophobia Scale (IHP)*. Internalized homophobia was assessed using the Internalized Homophobia Scale (Martin & Dean, 1987), which is a 9-item measure adapted for self-administration (see Appendix F). The IHP items were originally derived from the diagnostic criteria for ego-dystonic homosexuality presented in the 3<sup>rd</sup> edition of the *Diagnostic and Statistical Manual of Mental Disorders* (Herek et al., 1997). The IHP inquires about the extent to which same-gender oriented people are “uneasy” about their sexual orientation (Meyer, 1995, p. 43).

Items were administered according to a 4-point scale, ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Using the nine items, a mean computation method was used to identify an IHP score for each participant. This scoring method was developed and used by Meyer and Dean, two researchers who contributed to the development of this scale (Meyer, personal communication, December 20, 2004). To this end, scores ranged from 1 (representing low to no internalized homophobia) to 4 (representing high internalized homophobia).

This scale is appropriate for lesbians, gay males, and/or bisexuals. Herek et al. (1997) used the IHP to assess internalized homophobia and its correlates among lesbians and gay men. Their findings suggest a Chronbach’s alpha of .71 for women and .83 for men. This supports past research that indicated the IHP has acceptable internal consistency (Meyer, 1995), and correlated as expected with relevant measures (Herek et al., 1997). I was unable to find further information related to reliability or validity on the IHP in the professional literature. The IHP for this study had a Chronbach’s alpha of .87.

*Alcohol Use Disorders Identification Test (AUDIT)*. The AUDIT was developed in a World Health Organization (WHO) collaborative project carried out in primary care facilities in both developing and developed countries (Australia, Bulgaria, Kenya, Mexico, Norway, and the United States; Saunders, Aasland, Babor, & De La Fuente, 1993; see Appendix G). The AUDIT is a 10-item self report questionnaire that measures alcohol consumption, dependency symptoms, and personal and social harm as a result of alcohol use occurring during the recent past, rather than one's lifetime (Allen, Litten, Fertig, & Babor, 1997; Bohn, Babor, & Kranzler, 1994). This brief screening instrument can be administered in 2-3 minutes (Conigrave, Hall, & Saunders, 1995; Hays et al., 1993; Hays, Merz, & Nicholas, 1995). Questions 1-3 assess alcohol use, questions 4-6 probe into symptoms of alcohol dependence, questions 7-8 relate to adverse reactions to using alcohol, and the final two questions explore alcohol-related problems (Conigrave et al., 1995).

In terms of scoring, individual item scores range from 0 to 4, with total AUDIT scores ranging from 0 to 40. Scores of 8 or above have been used to identify individuals who may be at risk for or who are experiencing alcohol problems (Bohn et al., 1994; Conigrave et al., 1995). The cutoff point of 8 has been found to have sensitivity and specificity ranging from .66 - 1.0, with most studies being accurate in detecting harmful and hazardous alcohol use (Conigrave et al., 1995). A cutoff score of 8 was used in this study.

Research studies that examined the internal consistency of the AUDIT propose a Chronbach's alpha ranging around .80, which suggests it has high consistency and is a reliable measure (Allen et al., 1997; Barry & Fleming, 1993; Fleming, Barry, &

MacDonald, 1991; Hays et al., 1995; Schmidt, Barry, & Fleming, 1995). The Chronbach's alpha for the AUDIT in this study was .80. The AUDIT demonstrates acceptable validity with regard to other self-report alcohol screening measures such as the Michigan Alcohol Screening Test (MAST), MacAndrew Scale, and the CAGE (Allen et al., 1997). In addition, the AUDIT is appropriate for use with males and females, as well as with people from a variety of ethnic groups since validity did not differ as a function of ethnicity (White, Black, Mexican American) or race (White, Black; Allen et al., 1997).

According to Allen et al. (1997), the "brevity and ease of administration of the test, absence of a copyright fee, and the rich multinational database used in developing the AUDIT" underscores this instrument's applicability across a "wide range of contexts and populations at risk" (p. 618). To this end, the AUDIT was used with the present population of interest.

*Drug Abuse Screening Test (DAST)*. The Drug Abuse Screening Test (Skinner, 1982) was designed to provide a brief screening instrument for clinical and treatment evaluation research. The original DAST is comprised of 28 self-report items, which yield a quantitative index of a variety of problems as they relate to drug misuse over the past 12 months (Cocco & Carey, 1998). Total scores range from 0 to 28, with a cut-off score for the DAST of 6 or greater (Staley & El-Guebaly, 1990). Individuals who score 6 or more are considered to be involved with and having problems associated with the abuse of drugs. Individuals who score below 6 are screened out as non-substance abusers. According to Skinner (1982), the DAST was developed using a clinical sample of 256 drug/alcohol abusing individuals, which resulted in an internal consistency estimate of .92, and a factor analysis that suggested it is a unidimensional scale. A study by Staley

and El-Guebaly (1990) supported these results and added that the DAST has acceptable diagnostic validity such that it attained a maximum overall accuracy of 89% in classifying individuals according to the DSM-III Substance Abuse diagnosis.

Two shorter forms of the DAST have been developed, which include a 20-item version and a 10-item version (DAST-20 & DAST-10; Cocco & Carey, 1998). Findings from research studies suggest that all three versions of the DAST demonstrate considerable promise as screening instruments (Bohn, Babor, & Kranzler, 1991; Skinner, 1982; Skinner & Goldberg, 1986).

For the present study, the DAST-20 was used (see Appendix H) and a cut-off score of 5 was applied. Participants who scored 5 or greater were considered involved with and having problems associated with drug abuse (Cocco & Carey, 1998). This cut-off score is supported by Gavin, Ross, and Skinner (1989), who suggest that a cut-off score of 5 has the best balance between sensitivity (.96) and specificity (.79). Further empirical support for this measure was provided by Cocco and Carey (1998), who evaluated the use of the DAST-20 and the DAST-10 among individuals with severe mental illness who frequently have co-existing substance abuse and dependence problems. For the DAST-20, the researchers applied a cut-off score of 5. Item analysis for the DAST-20 revealed strong item-scale correlations (.39 to .78) and an alpha coefficient of .92, which was described as “excellent” internal consistency (Cocco & Carey, p. 412). The Chronbach’s alpha for the DAST-20 in this study was .81.

For the present study, I changed the wording of questions 8 and 9 in order to be inclusive of LGB individuals. For example, I changed “Does your spouse and/or parents ever complain about your involvement with drugs” to “Does your partner and/or parents

ever complain about your involvement with drugs?” In addition, I changed “Has drug abuse ever created problems between you and your spouse and/or parents?” to “Has drug abuse ever created problems between your and your partner and/or parents?” I received copyright permission from the Addiction Research Foundation (Toronto, Canada) to use this measure at no cost.

*Experiences with counseling.* For this survey, I developed questions that assessed the phenomenological experiences of LGB individuals (see Appendix I). These questions included but were not be limited to the following, which had designated choices: “Have you participated in counseling?” (designated choices included yes and no) and “What issues/concerns did you discuss in counseling?” (designated choices included financial stress, family problems, employment worries, illness or death, relationship problems, participation in community activities and social life, depression and anxiety, suicide, physical and sexual abuse, experiences with anti-gay attitudes, discrimination, impact of AIDS, alcohol and drug use, and eating disorders, which are based on findings from the National Lesbian Health Care Survey, as cited in Bradford et al., 1987). The following open ended statements were included: “In a few words, please describe what you found to be the most helpful aspect of counseling.”; “In a few words, please describe what you found to be the least helpful aspect of counseling.” Responses to these two open-ended statements will not be coded and explored for this dissertation; rather, they will be examined in future analyses.

*Perceptions of the role of counseling in reducing internalized homophobia.* I developed the items in this questionnaire, which were based on a review of the conceptual literature on the role of counseling in reducing internalized homophobia (see

Appendix J). Participants were asked to respond to statements derived from the professional literature using a five point Likert scale 1 (*strongly disagree*) to 5 (*strongly agree*). Examples of the statements include: “I believe that counseling provides lesbian, gay, and bisexual (LGB) individuals with the opportunity to reduce the negative feelings that may result from anti-gay bias and discrimination”; “Helping LGB individuals understand that they have been unfairly treated by society is essential in shifting the blame from self (I am at fault for being LGB) to society (Society has perpetuated myths and stereotypes about LGB people)”; and “I believe that reducing internalized homophobia, or the personal internalization of social anti-gay attitudes and beliefs, is an important goal in counseling for LGB individuals.” The aforementioned questions were used to confirm the salience of internalized homophobia in counseling, as emphasized in the conceptual literature. This study was the first of its kind in that particular concepts presented in the exploratory literature on counseling LGB individuals were taken back to the LGB community for evaluation. In terms of analysis, the Likert scale responses for these questions were examined, and descriptive measures are discussed in the Results section.

#### *Research Questions, Hypotheses, and Analyses*

Two research questions and two descriptive questions were used in the current study. The research questions, subsequent hypotheses, and methods of analysis are listed below. The two descriptive questions are also listed.

1. Is there a relationship between exposure to heterosexist events and internalized homophobia for participants?

Hypothesis 1: There will be a strong significant correlation between exposure to heterosexual events and internalized homophobia.

Analysis of Hypothesis 1: Bivariate Correlation

2. Do the independent variables (heterosexual events and internalized homophobia) predict substance use patterns for LGB individuals?

Hypothesis 2: The independent variables will account for a significant portion of the variance of alcohol and drug use and abuse for participants.

Analysis of Hypothesis 2: Sequential Multiple Regression Analysis

I also investigated the phenomenological experiences of LGB individuals in counseling, and the perceptions of LGB people on the role of counseling in reducing internalized homophobia were also examined. To this end, the following descriptive questions were explored in this study.

3. What are your experiences with counseling?

Questions that assessed the participants' experiences with counseling are similar to those included in studies conducted by Jones and Gabriel (1999), Morgan and Eliason (1992), and in the National Lesbian Health Care Survey (Bradford et al., 1987).

4. What are your perceptions of the role of counseling in reducing internalized homophobia?

Questions that assessed the participants' perceptions of the role of counseling in reducing internalized homophobia were adapted from conceptual statements in the professional literature.

When evaluating the responses to questions 3 and 4, various methods of analysis were used. For questions with designated choices, the percentages with regard to

response rates are reported in the Results section. For the open-ended questions, I will wait to analyze the data as this analysis is beyond the scope of this dissertation.

Responses to the questions will be compared to participant responses in similar studies conducted by Bringaze and White (2001), Jones and Gabriel (1999), Morgan and Eliason (1992), and the National Lesbian Health Care Survey (Bradford et al., 1987).



Table 1  
*Personal Demographics Description of Sample*

	<i>n</i>	% of sample	<i>M</i>	<i>SD</i>
<i>Age</i>			32.3	12
<i>Gender Identity</i>				
Female	421	51		
Male	369	45		
Transgender	22	3		
Other	12	2		
<i>Sexual Orientation Identity</i>				
Lesbian	294	36		
Gay Male	310	37		
Bisexual	132	16		
Exploring Lesbian Identity	21	3		
Exploring Gay Male Identity	9	1		
Exploring Bisexual Identity	31	4		
Other	25	3		
<i>Race/Ethnicity</i>				
African-American/Black	32	4		
Asian-American/Asian	28	3		
Caucasian	676	82		
Latino-American/Hispanic	32	4		
Native American	12	2		
Multi- or Bi-Racial	29	4		
Other	12	2		
<i>Education Level</i>				
Some High School	10	1		
High School Diploma/GED	30	4		
Some College, University, or Technical School	248	30		
Associate's Degree	36	4		
Bachelor's Degree	238	30		
Master's Degree	181	22		
Doctoral/Professional Degree	77	9		
<i>Household Income</i>				
Under \$10,000	100	12		
\$10,001-20,000	97	12		
\$20,001-35,000	138	17		
\$35,001-50,000	138	17		
\$51,000-75,000	143	17		
\$75,001-100,000	84	10		
Above \$100,000	91	11		
<i>Relationship Status</i>				
Single	333	40		
Relationship less than 6 months	64	8		
Relationship 6 months – 1 year	58	7		
Relationship 1.1 years – 2 years	69	8		
Relationship 2.1 years – 4 years	93	11		
Relationship 4.1 years – 9 years	96	11		
Relationship 9 years or longer	90	11		
Other	18	2		

## Chapter 4

### Results

In this chapter, I present the results from the online survey. Before discussing the regression analysis, I will present a variety of preliminary analyses including descriptive statistics and bivariate correlations. I will then introduce results from the regression analysis related to my research questions. Finally, I will present descriptive statistics obtained from survey questions that explored the counseling experiences of LGB individuals.

#### *Pre-analysis*

First, I downloaded data from the [www.psychdata.com](http://www.psychdata.com) website. A total of 1000 people started the survey; however, there were a number of individuals who did not complete the survey. To this end, I visually inspected the data to begin a process of eliminating surveys that were inadequately completed. This process led to the removal of 72 surveys that were not completed beyond demographics or the first scale, 2 surveys that were excluded because the participants were under 18 years old, and 1 survey that was excluded because the participant did not complete the demographics. In addition, 101 surveys were excluded from data analysis because they were received after I began the process of data analysis. These surveys will be included in future analyses. Pre-analysis procedures left a total usable sample of 824 participants (83% of total sample).

The first step in pre-analysis was the examination of missing data among responses to the scales. I found missing responses for all the scales, particularly the AUDIT and the DAST. One procedure for handling missing data is to drop any cases that include missing data, which is based on the assumption that they seem to be a random

subsample of the whole sample (Tabachnick & Fidell, 2001). After considering the random nature of the missing data and the parallel direction of the items on each scale, I decided to drop cases if they did not meet a specific minimum of completed items. I chose this method of dealing with missing data because I did not want to take participants out of the variable and my sample simply because they did not fully complete a scale, thus causing "unit" nonresponse. Rather, I preferred to have some "item" nonresponse by keeping the participants in the variable and the sample if their responses constituted valid responses based on my criteria (J. Trusty, personal communication, April 13, 2005). This prevents substantial loss of cases (Tabachnick & Fidell, 2001) and the introduction of systematic item response bias in the sample.

To this end, I worked with a statistical consultant to examine missing data for each scale. Upon reviewing each scale thoroughly, we specified a minimum number of responses that participants must meet in order to be included in the analysis. This specified number was based on our belief that the variable of interest would still be captured even when the mean scores were computed with missing responses. For the Schedule of Heterosexist Events (SHE), the total number of possible responses to the 18 items was 14,832. Out of this total, there were 67 missing responses (less than 1%). Based on the design of the SHE, I chose to include participant responses if they completed at least 10 out of 18 items. SHE scales that were at least 60% complete would still allow for measurement of participants' experiences with heterosexist events. This led to only one participant being removed from the analysis ( $n = 823$ ).

The total number of possible responses to the nine items of the Internalized Homophobia (IHP) scale was 7,416. Out of this total, 21 responses were missing (less

than 1%). Based on the design of the IHP, I chose to include participant responses if they answered 4 out of 9 items. IHP scales that were at least 45% complete would still allow for measurement of participants' internalized homophobia. This led to one participant being excluded from the analysis ( $n = 823$ ).

Next, I examined the responses to the Alcohol Use Disorders Identification Test (AUDIT). This scale had a total number of possible responses of 8,240, and had 213 missing responses (2.5%). Based on the design of the AUDIT, participants were included in the analysis if they responded to at least 5 out of the 10 items. AUDIT scales that were at least 50% complete would still allow me to measure participants' alcohol use and abuse. This led to the removal of 12 participants ( $n = 812$ ) from the analysis.

Finally, the total number of possible responses to the Drug Abuse Screening Test (DAST) was 16,480. This scale had the highest number of missing responses (706, 4%). Based on the design of the DAST, I chose to include participants in the analysis if they answered 10 out of 20 items on the DAST, which led to the removal of 35 participants ( $n = 789$ ). DAST scales that were at least 50% complete would still allow for measurement of participants' drug use and abuse. The higher number of missing responses for the AUDIT and the DAST may be attributed to the sensitive nature of the questions about personal alcohol and/or drug use, as well as the "confusing" range of answers to some of the questions, as was reported by a number of study participants.

Additional screening of the data included identifying out-of-range values and outliers. A visual inspection of out-of-range values did not result in finding any, which could be attributed to the use of a website to collect data and the restricted possible range of responses. According to Tabachnick and Fidell (2001), "an outlier is a case with such

an extreme value on one variable or such a strange combination of scores on two or more variables that they distort statistics” (p. 66). A simple way to identify outliers is to examine box plots for each of the scales. Although there were a few points that looked like outliers, particularly on the AUDIT and the DAST, the scores were all within the possible range of scores for the scales. Therefore, I included these outliers in the initial data analysis.

Next I examined histogram charts to assess normal distribution of the scores for the SHE and IHP (see Figure 1), and the AUDIT and DAST (see Figure 2). None of the variables were normally distributed; rather, all histograms presented moderate to extreme skewness and kurtosis. To this end, I decided to transform all the scores of the variables in hopes of normalizing the distribution of scores. According to Tabachnick and Fidell (2001), it is best to transform variables towards normality unless interpretation is not feasible with the transformed scores. The SHE was the only scale that was affected by transformations. In fact, two transformations substantially changed the SHE scores. Double transformations are appropriate if they “produce the skewness and kurtosis values nearest zero, the prettiest picture, and/or the fewest outliers” (Tabachnick & Fidell, 2001, p. 81). All other scales (IHP, AUDIT, and DAST) were left in their original scoring forms because they did not show any reduction in skewness or kurtosis after being transformed.

### *Measures and Bivariate Correlations*

The means, standard deviations, alpha coefficients, and skewness statistics for the scores of all measures are presented in Table 2. The means suggest that the sample participants mostly experienced lower levels of heterosexism, internalized homophobia,

and alcohol and drug use and abuse. In particular, participants in the study reported that they experienced heterosexist events once in a while ( $m = 2.2$ , or less than 10% of the time) and they disagreed with the statements that determined whether they experienced or were experiencing internalized homophobia ( $m = 1.7$ , or disagree). It is important to note that using the mean for the IHP can be misleading because it doesn't allow for a specific focus on 8% of the sample ( $n = 63$ ) who were experiencing higher levels of internalized homophobia (a score of 3 or higher). Although the findings of this report were based on the mean of the IHP, a number of participants were experiencing internalized homophobia at the time of the study but not enough to influence the general findings of the study. Future analyses should focus on participants who experienced higher levels of internalized homophobia in order to report their substance abuse patterns specifically.

The mean from the AUDIT ( $m = 4.3$ ) does not suggest alcohol abuse among the sample, which is determined with a cut off score of 8. Furthermore, the mean from the DAST ( $m = 3.3$ ) is below the identified cut off score of 5 and does therefore not suggest drug abuse among the sample.

Next I examined the skewness and kurtosis of the scales. Analysis of the participants' range of scores indicates the scales were not normally distributed. The IHP, AUDIT, and DAST were positively skewed at greater than 1. The SHE was not as positively skewed as the other scales, with a skewness statistic less than 1. The DAST and AUDIT had high levels of kurtosis (10 and 7.4 respectively). The IHP had a kurtosis level of less than 1.

I then conducted an investigation of correlations between variables, which resulted in a number of interesting correlations. Table 3 presents correlations between the

demographic variables (age, gender identity, sexual identity, race/ethnicity, education, income, and relationship status) and scales of interest (SHE, IHP, AUDIT, and DAST). First, I examined whether the scales were correlated with each other. The scales measuring alcohol use and drug use and abuse were moderately correlated with each other ( $r = .39, p < .01$ ). The DAST was slightly correlated with the SHE ( $r = .19, p < .01$ ), as was the AUDIT with the IHP ( $r = .16, p < .01$ ). There were low correlations between the IHP and the DAST ( $r = .08, p < .05$ ), and the SHE and the IHP ( $r = .07, p < .05$ ). I also examined correlations between the demographic variables and the scales, which resulted in several significantly low correlations. For example, age was negatively correlated with the AUDIT ( $r = -.18, p < .01$ ), IHP ( $r = -.14, p < .01$ ), SHE ( $r = -.12, p < .01$ ), and DAST ( $r = -.08, p < .05$ ) indicating that as age increases, experiences with heterosexism and internalized homophobia decrease, and the use and abuse of alcohol and drugs decreases.

Gender identity and sexual identity were both significantly correlated with the IHP ( $r = .13, p < .01, r = .19, p < .01$ , respectively). In particular, males showed the highest level of internalized homophobia ( $r = .17, p < .01$ ). Lesbians showed lower levels of internalized homophobia ( $r = -.2, p < .01$ ), and individuals exploring a lesbian, gay, or bisexual identity showed higher levels of internalized homophobia ( $r = .11, p < .01, r = .2, p < .01, r = .15, p < .01$ , respectively).

Education was negatively correlated with the DAST ( $r = -.16, p < .01$ ), IHP ( $r = -.16, p < .01$ ), SHE ( $r = -.15, p < .01$ ), and AUDIT ( $r = -.08, p < .05$ ). Income was also negatively correlated with the DAST ( $r = -.11, p < .01$ ), IHP ( $r = .11, p < .01$ ), SHE ( $r = -.1, p < .01$ ), and AUDIT ( $r = -.08, p < .05$ ). These particular correlations suggest that

higher levels of education and income both lead to fewer experiences with heterosexist events and internalized homophobia, and a decreased use and abuse of alcohol and drugs.

Finally, relationship status was negatively correlated with the IHP ( $r = -.15$ ,  $p < .01$ ), AUDIT ( $r = -.11$ ,  $p < .05$ ), and DAST ( $r = -.1$ ,  $p < .01$ ), indicating that longer relationships lead to lower internalized homophobia and decreased use and abuse of alcohol and drugs. Race/ethnicity was not significantly correlated with any of the scales.

By looking at Table 3, one can also see that a number of demographic variables had significant correlations with other demographic variables. For instance, household income was positively associated with age ( $r = .35$ ,  $p < .01$ ) and education ( $r = .22$ ,  $p < .01$ ); and relationship status was positively correlated with age ( $r = .34$ ,  $p < .01$ ), household income ( $r = .3$ ,  $p < .01$ ), and education ( $r = .26$ ,  $p < .01$ ).

## Research Questions 1 and 2

### *Research Question 1*

Is there a relationship between exposure to heterosexist events and internalized homophobia? Descriptive statistics were used to summarize the results for research question 1.

Using the SHE and a six point scale ranging from 1 (this has NEVER happened to you) to 6 (this has happened to you ALMOST ALL OF THE TIME), participants reported their experiences with heterosexist events. In this study, the Chronbach's alpha for the SHE was .90. Items with the highest overall mean scores included "How many times have you heard people make heterosexist jokes, or degrading homosexual jokes?" ( $m = 3.6$ ) and "How many times have you wanted to tell someone off for being heterosexist or homophobic?" ( $m = 3.5$ ). The IHP was used to measure participants' level



of internalized homophobia, which utilized a five point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The Chronbach's alpha for the IHP was .87. Items with the highest overall mean scores included "I have tried to stop being attracted to the same gender in general" ( $m = 2.3$ ) and "I have tried to become more sexually attracted to the opposite gender" ( $m = 2.2$ ).

In order to address my first research question, I ran a correlation between mean ratings from the SHE and IHP. Correlation assesses the degree of a relationship between two continuous variables (Tabachnick & Fidell, 2001). Using the SPSS Graduate Pack 13.0 for Windows, I calculated an average SHE rating for each of the 18 items. In order to promote a more normally distributed sample with regard to the SHE, I transformed the variable heterosexual events twice by taking the square root of each average SHE rating. I then calculated an average IHP rating for each of the 9 items. Using these variables (heterosexual events and internalized homophobia), I created a scatterplot (see Figure 3) and calculated a Pearson correlation to determine the magnitude of the relationship. Results indicated a correlation of .067 ( $n = 823$ ,  $p = .055$ ). I removed two outliers visible in the upper section of the plot to examine how that might change the strength of the correlation. This resulted in a correlation of .071 ( $n = 821$ ,  $p < .05$ ). Although the correlation is significant, the correlation is very low, indicating that the two variables are not closely related. To this end, I rejected the hypothesis that there will be a strong significant correlation between exposure to heterosexual events and internalized homophobia.

### *Research Question 2*

Do the independent variables (heterosexist events and internalized homophobia) predict substance use patterns for LGB individuals? To answer research question 2, I used sequential multiple regression analysis. According to Tabachnick and Fidell (2001), sequential multiple regression allows researchers to enter variables into an equation in an orderly fashion as a way to assess their contributions in predicting the dependent variable. Sequential multiple regression was used in the present study to determine the contribution of demographic variables, heterosexist events, and internalized homophobia in predicting alcohol and drug use and abuse.

Using SPSS regression analysis, I entered variables into two models, and examined their contributions in predicting alcohol and drug use and abuse. I conducted two separate analyses with the same independent variables (demographics, heterosexist events, and internalized homophobia), but with different dependent variables (alcohol and drug use and abuse). The first model contained the variables age, gender identity (coded as 1 = female, 2 = male, 3 = transgender, 4 = Other), sexual identity (coded as 1 = lesbian, 2 = gay male, 3 = bisexual, 4 = exploring a lesbian identity, 5 = exploring a gay male identity, 5 = exploring a bisexual identity, 6 = Other), race/ethnicity (coded as 1 = African American, 2 = Latino/Hispanic, 3 = Caucasian, 4 = Asian American/Asian, 5 = Native American, 6 = Multi or Bi-Racial, 7 = Other), income, education, and relationship status. The second model contained heterosexist events and internalized homophobia.

Tables 4 and 5 illustrate the summary for each model in the sequential multiple regression equation for variables predicting alcohol and drug use and abuse, respectively. First I will discuss the results from the sequential multiple regression for alcohol use and

abuse. Then I will present a discussion of the results of the sequential multiple regression for drug use and abuse.

With regard to alcohol use and abuse, there was a statistically significant increase in the F values for each model in the regression equation, which means that the second model of the equation was statistically significant and contributed to the prediction of alcohol use and abuse beyond the contribution of the first model. The first model (demographics) accounted for 6% of the variance of alcohol use and abuse. After entering the second model (heterosexist events and internalized homophobia), the variance increased to 7%. To this end, the practical significance, also known as the effect size, was .01. Each model in the equation was statistically significant and contributed to the prediction of alcohol use and abuse at  $p = .00$  and  $p = .00$ , but accounted for a small amount of variance.

The standardized betas and their statistical significance levels for each variable in predicting alcohol use and abuse are also presented in Table 4. The variables age and internalized homophobia were statistically significant predictors of alcohol use and abuse at  $p < .01$ . Results also suggest that the variable Asian American/Asian could be a statistically significant predictor of alcohol use and abuse ( $p = .05$ ). The variable heterosexist events was not a statistically significant predictor of alcohol use and abuse; therefore, internalized homophobia is the variable that further predicts alcohol use and abuse beyond that of the demographic variables.

Results from the sequential multiple regression predicting drug use and abuse demonstrate incremental F values that were statistically significant. This means that the second model was statistically significant and contributed to the prediction of drug use

and abuse beyond that of the first model. The first model (demographics) explained 5% of the variance in drug use and abuse. The variance increased to 8% after the second model (heterosexist events and internalized homophobia) was added to the equation. To this end, the practical significance, also known as the effect size, was .03. Although each model was statistically significant and contributed to the prediction of drug use and abuse at  $p = .01$  and  $p = .00$ , they accounted for little variance.

Table 5 also presents the standardized betas and their corresponding statistical significance levels for variables predicting drug use and abuse. The variables exploring a gay male identity and income were statistically significant predictors of drug use and abuse at  $p < .05$ . The variable income, however, did not remain statistically significant when the second model was entered into the equation. The variables education and heterosexist events were also statistically significant predictors of drug use and abuse at  $p < .01$ . Internalized homophobia was not a statistically significant predictor of drug use and abuse; therefore, heterosexist events is the variable that adds variance in predicting drug use and abuse beyond the demographic variables.

There are additional findings related to alcohol and drug use and abuse that are important to report. Although the mean total score for both the AUDIT and DAST in this study fall below the identified cut-off scores presented in the literature (8 and 5 respectively), 15% of participants ( $n = 123$ ) scored 8 or above for the AUDIT, and 17% ( $n = 139$ ) scored 5 or above for the DAST. With regard to gender, 14% of women ( $n = 60$ ), 16% of men ( $n = 58$ ), and 10% of transgender individuals ( $n = 2$ ) scored higher than 8 on the AUDIT. In addition, 16% of women ( $n = 67$ ), 13% of men ( $n = 47$ ), and 21% of transgender individuals ( $n = 4$ ) scored higher than 5 on the DAST. Although these

percentages do not provide confirmation of the hypotheses in this study, they do underscore the rates of problem alcohol and drug use and abuse among the sample, which is consistent with past research on prevalence rates of alcohol and drug use and abuse among the LGB community .

### *Research Question #3*

What are the phenomenological counseling experiences of LGB individuals? What are the participants' perceptions of the role of counseling in reducing internalized homophobia? To answer these final two research questions, I will report descriptive statistics related to counseling rates, length of counseling, issues discussed in counseling, and satisfaction with counseling. In addition, I will report mean ratings for four research statements that were derived from the professional literature and emphasize the role of counseling in reducing internalized homophobia, which confirmed the accuracy of these research statements.

Out of 824 participants, 70% ( $n = 580$ ) of the participants reported that they had been in counseling in their lifetime. In particular, 75% ( $n = 314$ ) of women, 64% ( $n = 237$ ) of men, and 86% ( $n = 19$ ) of transgender individuals received counseling services. With regard to length of their counseling experiences, 47% ( $n = 271$ ) responded with less than 1 year, 17% ( $n = 98$ ) reported 1.1 to 2 years, 8% ( $n = 49$ ) selected 2.1 to 3 years, 7% ( $n = 38$ ) indicated 3.1 to 4 years, and 17% ( $n = 99$ ) reported 4.1 to 5 years. See Figure 4 for length of counseling for participants by gender.

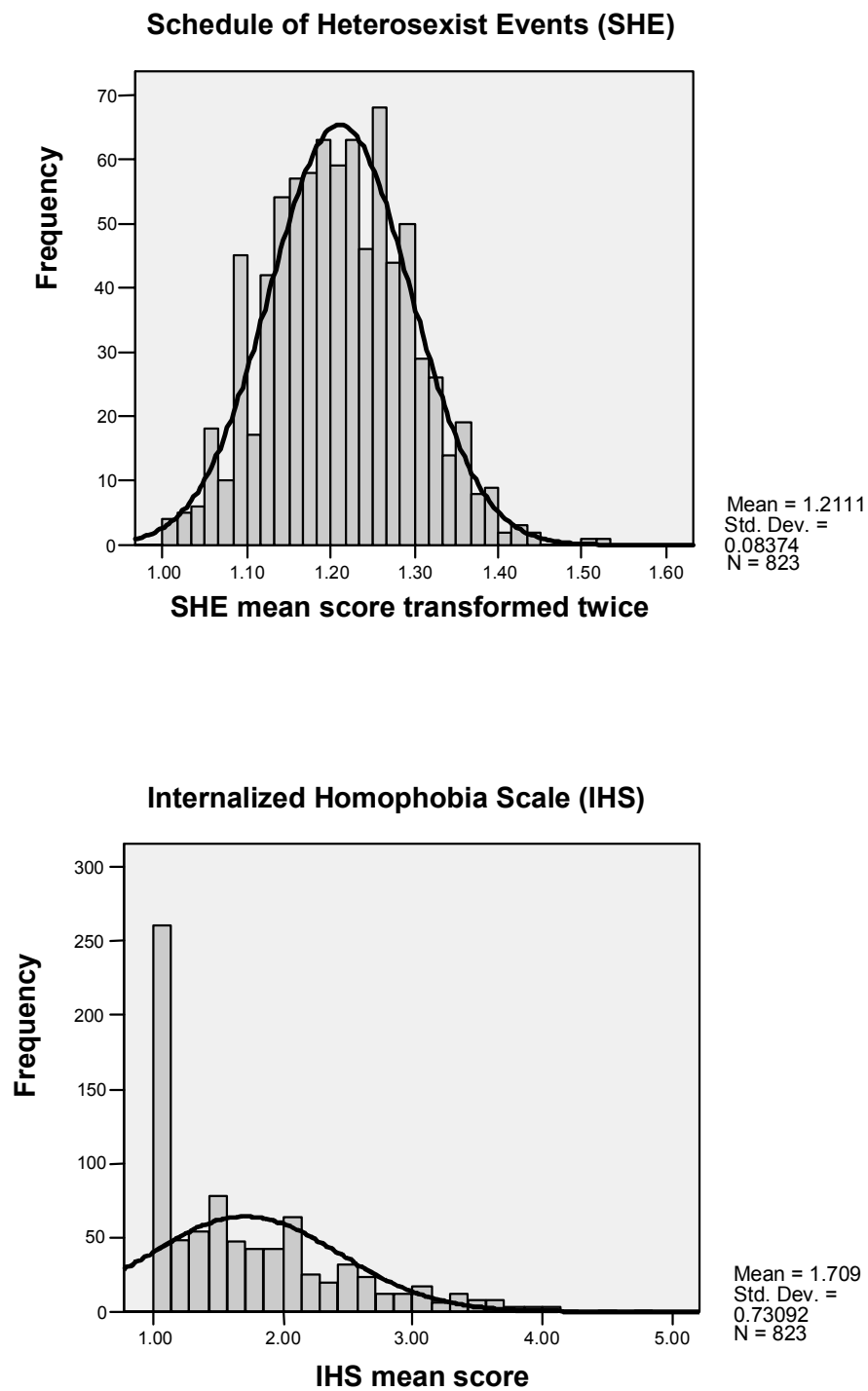
Participants were also asked to identify specific counseling issues from a list derived from a National Lesbian Health Care Survey (Bradford et al., 1987). Participants were able to select more than one counseling issue. To this end, they selected the

following counseling issues: *depression and anxiety* ( $n = 423, 51\%$ ), *family problems* ( $n = 385, 47\%$ ), *relationship problems* ( $n = 362, 44\%$ ), *activities/social life* ( $n = 209, 25\%$ ), *suicidal thoughts and attempts* ( $n = 199, 24\%$ ), *illness/death* ( $n = 157, 19\%$ ), *experiences with anti-gay attitudes* ( $n = 151, 18\%$ ), *employment worries* ( $n = 144, 18\%$ ), *financial stress* ( $n = 130, 16\%$ ), *discrimination* ( $n = 116, 14\%$ ), *physical/sexual abuse* ( $n = 115, 14\%$ ), *participation in community* ( $n = 89, 11\%$ ), *eating disorders* ( $n = 80, 10\%$ ), *alcohol and drug use* ( $n = 64, 8\%$ ), and *impact of AIDS* ( $n = 35, 4\%$ ). See Figure 5 for issues in counseling for participants by gender.

Participants who reported that they had participated in counseling also indicated their satisfaction with counseling with ratings from 1 (*very satisfied*) to 4 (*not at all satisfied*). Thirty-five percent ( $n = 208$ ) of participants reported that they were very satisfied with counseling, 28% ( $n = 162$ ) were somewhat satisfied, 23% ( $n = 135$ ) were satisfied, and 14% ( $n = 80$ ) were not at all satisfied. See Figure 6 for satisfaction with counseling for participants by gender.

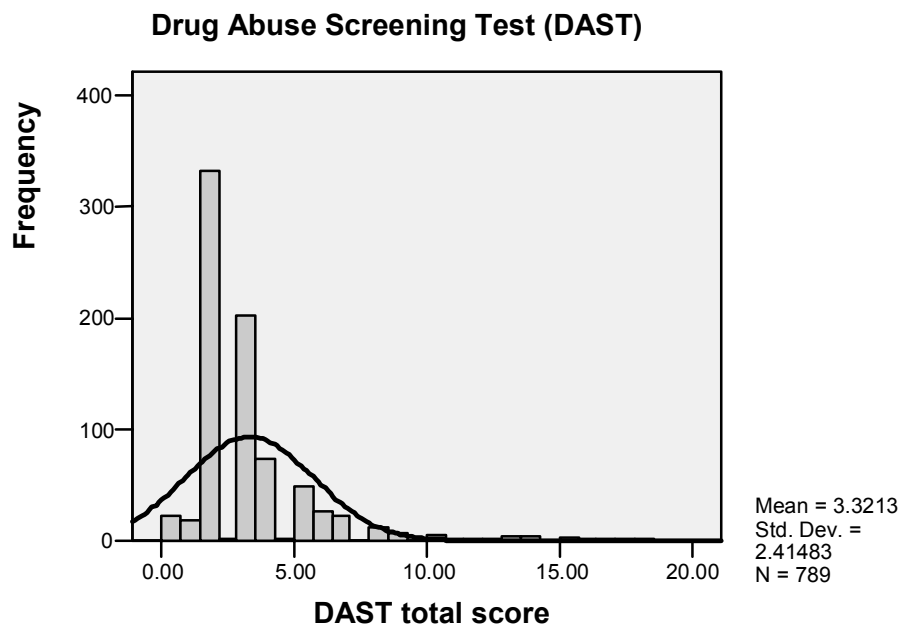
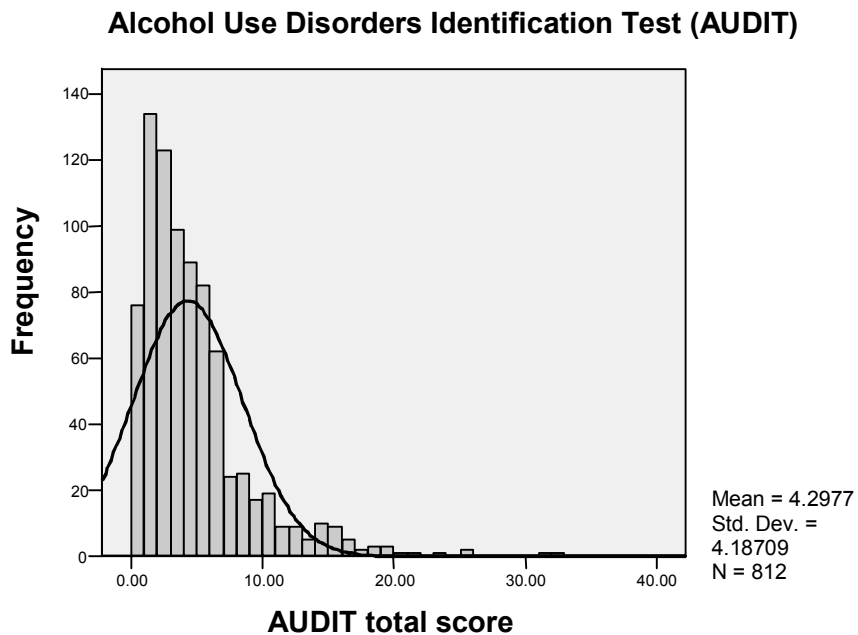
Finally, participants were asked to rate four statements that emphasized the role of counseling in reducing internalized homophobia. I developed these statements based on a review of the professional literature. Ratings for these statements ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Seventy-one percent ( $n = 585$ ) of participants *strongly agreed* or *agreed* with statement 1 (I believe that counseling provides lesbian, gay, and bisexual individuals with the opportunity to reduce the negative feelings that may result from anti-gay bias and discrimination), 75% ( $n = 619$ ) *strongly agreed* or *agreed* with statement 2 (I believe that helping LGB individuals understand that they have been unfairly treated by society is essential in shifting the blame from self “I am at fault for

being LGB” to society “Society has perpetuated myths and stereotypes about LGB people”); 88% ( $n = 725$ ) of participants *strongly agreed* or *agreed* with statement 3 (I believe that developing coping skills to increase low self-esteem and self-worth that often result from anti-gay bias is important in achieving a positive lesbian, gay male, or bisexual identity), and 85% ( $n = 702$ ) of participants *strongly agreed* or *agreed* with statement 4 (I believe that reducing internalized homophobia, or the internalization of society’s anti-gay attitudes and beliefs, is an important goal in counseling for LGB individuals).



*Figure 1.* Histograms assessing normality of the Schedule of Heterosexist Events (SHE) and the Internalized Homophobia Scale (IHP).





*Figure 2.* Histograms assessing normality of the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST).

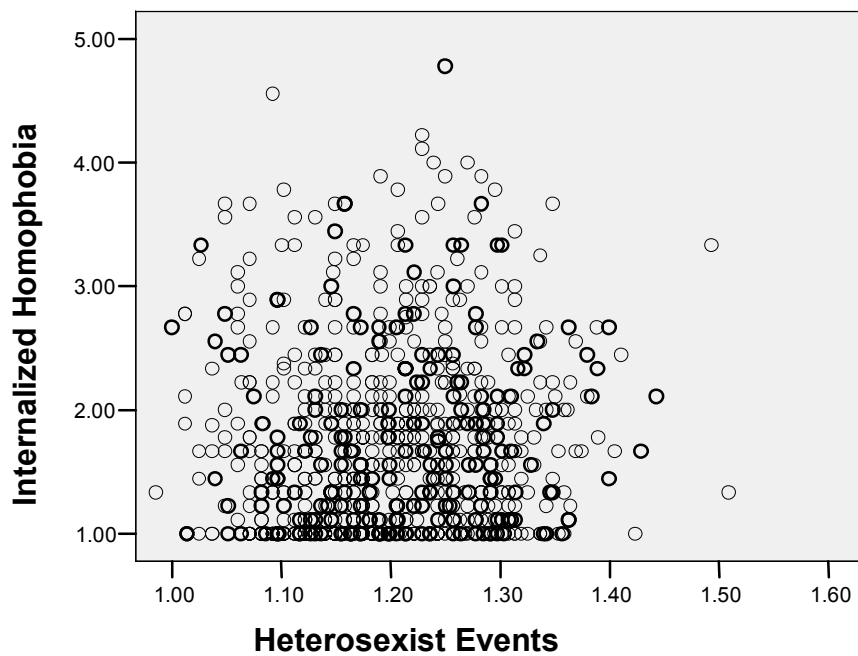
Table 2  
*Univariate Statistics for Scales*

	Heterosexist Events	Internalized Homophobia	Alcohol Use	Drug Use
Scale Alpha	.90	.87	.80	.81
Number of Scale Items	19	9	10	20
Scale <i>m</i>	2.2	1.7	4.3	3.3
Scale <i>SD</i>	.62	.73	4.2	2.4
Poss. Range of Scores	1-6	1-5	0-40	0-28
Part. Range of Scores	1-6	1-5	0-33	0-18
Skewness	.785	1.16	2.2	2.8
Kurtosis	1.2	.92	7.4	10

Table 3  
*Intercorrelations Between Scales and Demographic Variables*

	1	2	3	4	5	6	7	8
1. Heterosexist Events	1	.07	.04	.19**	-.12**	-.15**	-.10**	-.03
2. Internalized Homophobia		1	.16**	.08*	.14**	-.16**	-.11**	-.15**
3. Alcohol Use			1	.39**	-.18**	-.08*	-.08*	-.11**
4. Drug Use				1	-.08*	-.16**	-.11**	-.10**
5. Age					1	.40**	.35**	.34**
6. Educational Level						1	.22**	.26**
7. Income							1	.30**
8. Relationship Status								1

*Note:* \*\* =  $p < .01$ , \* =  $p < .05$ .



*Figure 3.* Scatterplot showing relationship between heterosexual events and internalized homophobia.

Table 4  
 Summary of Regression Analysis for Variables Predicting Alcohol Use ( $N = 824$ )

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Demographics						
5 Age	-.06**	.02	-.17	-.06**	.02	-.16
Gender Identity						
Male	1.17	.68	.14	.92	.69	.11
Transgender	-.83	1.02	-.03	-.76	1.01	-.03
Other	.01	1.35	.00	-.18	1.35	-.01
Sexual Identity						
Gay Male	-.45	.75	-.05	-.39	.75	-.04
Bisexual	.25	.50	.02	.26	.50	.02
Exploring Lesbian ID	1.20	1.00	.04	.80	1.00	.03
Exploring Gay Male ID	2.20	1.54	.06	1.35	1.56	.03
Exploring Bisexual ID	.53	.87	.02	.30	.88	.01
Other	-1.13	.94	-.05	-1.04	.94	-.04
Race/Ethnicity						
African-American/Black	-3.68	2.42	-.30	-3.70	2.40	-.31
Asian-American/Asian	-4.86	2.55	-.21	-4.98*	2.54	-.22
Latino-American/Hispanic	-3.33	2.53	-.15	-3.18	2.52	-.15
Native American	-3.93	2.71	-.12	-4.46	2.70	-.13
Multi-or Bi-racial	-4.09	2.56	-.17	-4.03	2.54	-.17
Other	-4.84	2.77	-.13	-5.20	2.75	-.14
Education	.02	.11	.01	.06	.11	.02
Income	-.03	.09	-.01	-.02	.09	-.01
Relationship Status	-.09	.07	-.05	-.07	.07	-.04
Independent Variables						
Heterosexist Events				1.85	1.88	.04
Internalized Homophobia				.70**	.22	.12

Note.  $R^2 = .06$  for Model 1;  $R^2 = .07$  for Model 2. \* $p \leq .05$ . \*\*  $p < .01$ . The following variables were used as comparison variables and are not presented in the table: Female, Lesbian, Caucasian.

Table 5  
 Summary of Regression Analysis for Variables Predicting Drug Use (N = 824)

Variable	Model 1			Model 2		
	B	SE B	$\beta$	B	SE B	$\beta$
Demographics						
Age	-.00	.01	.02	.01	.01	.04
Gender Identity						
Male	-.12	.41	-.02	.02	.41	.00
Transgender	-.52	.61	-.03	-.63	.60	-.04
Other	.26	.78	.01	-.10	.77	-.01
Sexual Identity						
Gay Male	.23	.44	.05	.07	.44	.02
Bisexual	-.03	.29	-.00	.11	.29	.02
Exploring Lesbian ID	-.15	.60	-.01	-.02	.59	-.00
Exploring Gay Male ID	2.10*	.94	.09	1.93*	.93	.08
Exploring Bisexual ID	.40	.51	.03	.56	.51	.04
Other	.69	.57	.05	.71	.57	.05
Race/Ethnicity						
African-American/Black	.37	1.39	.05	.45	1.37	.06
Asian-American/Asian	.19	1.48	.02	.40	1.45	.03
Latino-American/Hispanic	1.24	1.47	.10	1.50	1.44	.12
Native American	-.28	1.56	-.01	-.51	1.54	-.03
Multi-or Bi-racial	.21	1.48	.02	.25	1.46	-.02
Other	-.45	1.60	-.02	-.49	1.57	-.02
Education	-.21**	.07	-.13	-.17**	.07	-.11
Income	-.10*	.05	-.08	-.08	.05	-.07
Relationship Status	-.04	.04	-.04	-.05	.04	-.05
Independent Variables						
Heterosexist Events				5.19**	1.10	.18
Internalized Homophobia				.13	.13	.04

Note.  $R^2 = .05$  for Model 1;  $R^2 = .08$  for Model 2. \* $p \leq .05$ . \*\*  $p < .01$ . The following variables were used as comparison variables and are therefore not presented in the table: Female, Lesbian, Caucasian.

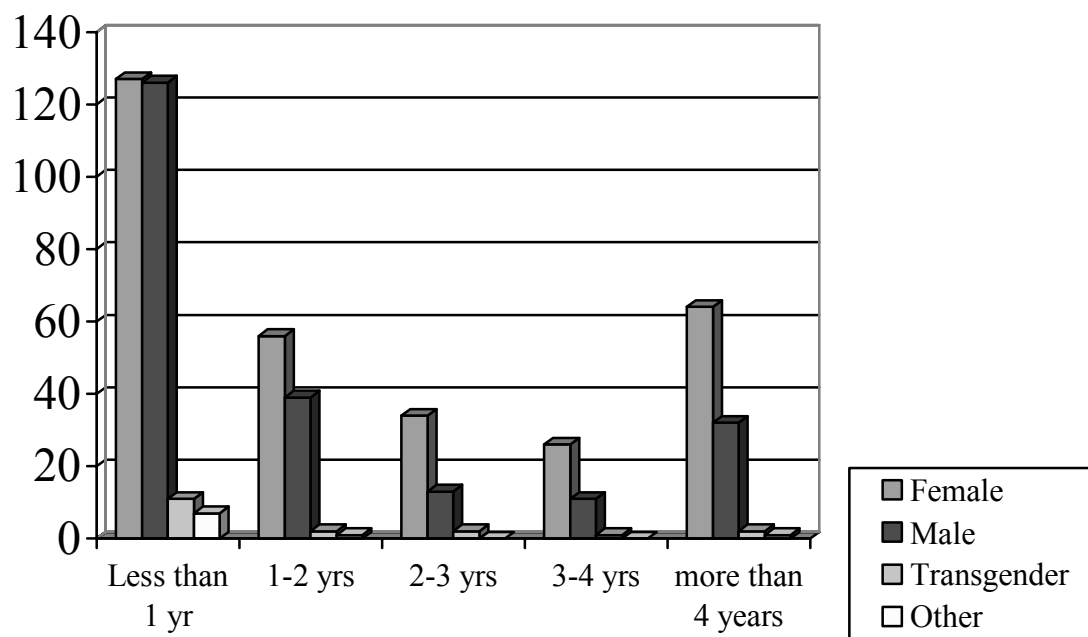


Figure 4. Bar chart showing length of counseling for participants by gender ( $n = 580$ ).

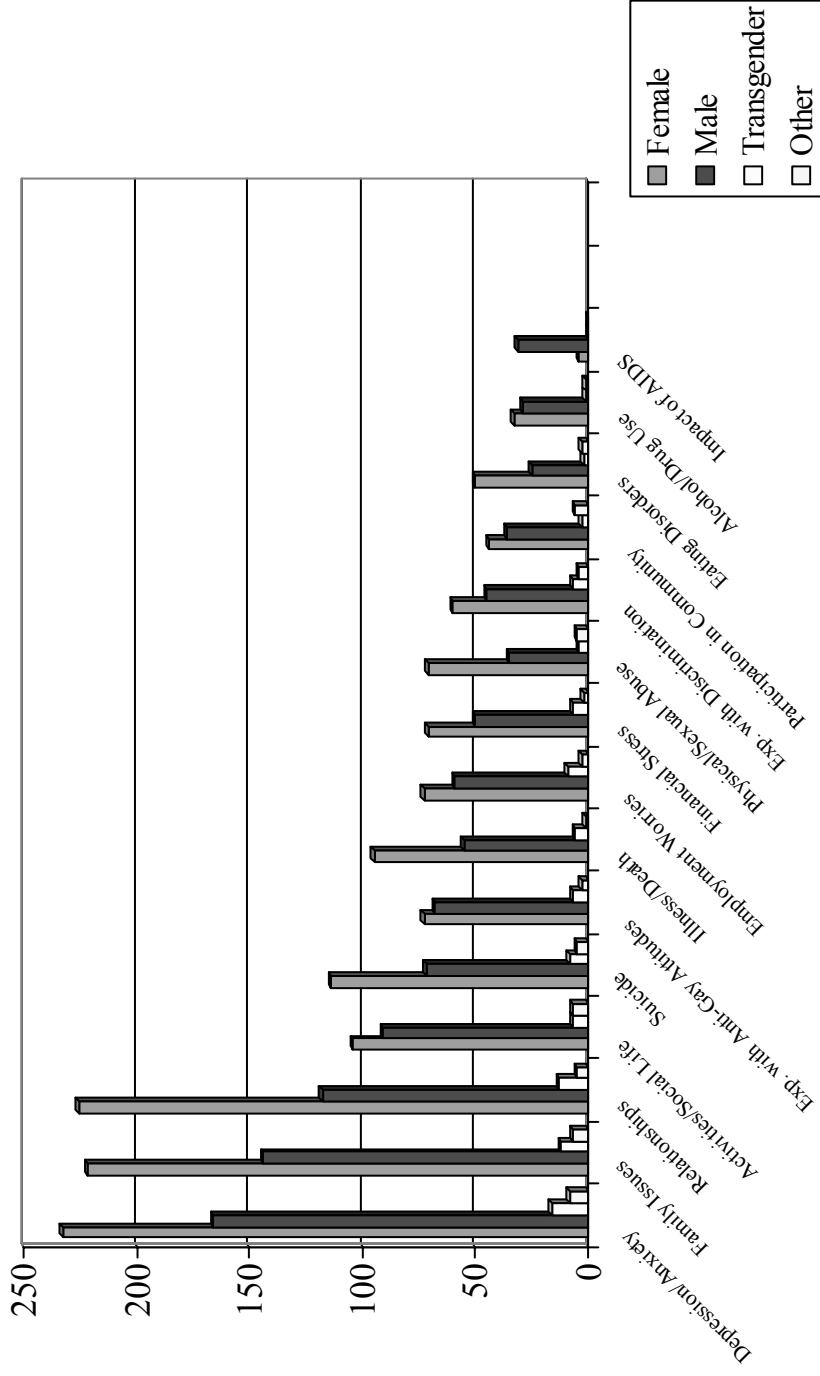
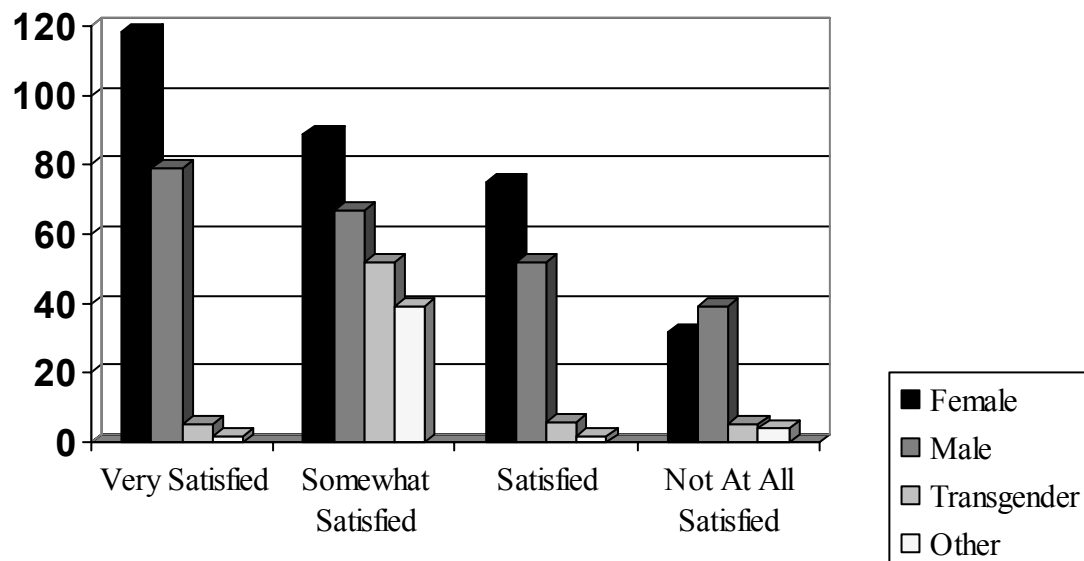


Figure 5. Bar chart showing issues in counseling for participants by gender (n = 580)





*Figure 6.* Bar chart showing satisfaction with counseling for participants by gender ( $n = 580$ ).

## Chapter 5

### Discussion

This chapter includes a summary of the results presented in Chapter 4. Limitations of the study are discussed, as well as implications for educational settings, practice, and research. Suggestions for future research are also presented.

#### Findings Related to Research Questions

##### *Research Question #1*

*Overview.* This research question sought to identify the strength of the relationship between exposure to heterosexist events and level of internalized homophobia for LGB individuals. I hypothesized that there was a significant relationship between exposure to heterosexist events and internalized homophobia. This hypothesis was based on McCarn and Fassinger's (1996) Model of Sexual Minority Identity Development, and their proposition that pervasive societal homophobia fosters a specific struggle with sexual minority identity awareness, acceptance, and affirmation. Before investigating this particular relationship, I examined descriptive statistics related to each variable. This allowed me to draw conclusions about the sample's overall experience with heterosexism and internalized homophobia. To this end, I will discuss participants' experiences with heterosexist events and internalized homophobia. I will then present conclusions based on a correlation analysis between these variables. Throughout this section, I will refer to McCarn and Fassinger's (1996) Model of Sexual Minority Development as a framework for presenting my conclusions.

In general, the sample for this study reported little experience with heterosexist events and internalized homophobia. While some participants experienced more

heterosexist events than others as evidenced by the range of scores, the mean score for the SHE indicated the majority of LGB individuals in this study had not been exposed to the types of heterosexism described in the professional literature (DiPlacido, 1998; Flowers & Buston, 2001; Herek, 1996; Neisen, 1990; Shidlo, 1994). In particular, DiPlacido (1998) stated that because of their sexual minority status, LGB individuals are at risk for negative life events such as loss of employment and antigay violence and discrimination. Results from the National Lesbian Health Care Survey (NLHS, Bradford et al., 1987) indicated similar risk factors. The overall mean scores for the SHE for this study did not support DiPlacido's findings or the results from the NLHS.

It is important to note, however, that average exposure to two specific heterosexist events were above a rating of 3 (this has happened SOMETIMES – 10%-25% of the time). These events include hearing people make heterosexist or degrading homosexual jokes and wanting to tell someone off for being heterosexist or homophobic. These specific findings are consistent with a study conducted by DiPlacido (1998) that assessed the overall well-being of lesbian and bisexual women. In particular, DiPlacido described hearing anti-gay jokes as a chronic daily hassle for LGB individuals, and found that 77% of lesbians in his study reported they witnessed someone telling an anti-gay joke. Selvidge (2000) also presented similar findings in her study where 98% of her sample reported that they heard people making heterosexist or degrading homosexual jokes “once in a while” and felt angry about something heterosexist or homophobic that was done to them “once in a while.” Becoming aware of heterosexism and homophobia in one's environment, and feeling angry as a result of being “duped” by the majority population, are characteristics of the Exploration phase of McCarn and Fassinger's (1996)

Model of Sexual Minority Identity Development that guided this study (p. 525).

Evidently, based on the results of the SHE, a significant number of participants could be characterized as being in the Exploration phase of their sexual minority identity development at the time of this study. This means that many participants were actively exploring questions that arose during the Awareness phase, and were in the active pursuit of knowledge about the LGB community. Participants may have been experiencing a variety of emotions such as “anger and guilt” for being trained in and participating in heterosexism and homophobia, as well as “curiosity and exhilarating joy” as a result of exploring the existence of other LGB individuals ( McCarn & Fassinger, 1996, p. 525).

Although the majority of the sample reported lower internalized homophobia, a substantial number of participants agreed with *at least* one of the statements that explored negative attitudes towards self based on sexual orientation. According to Meyer (personal communication, December 20, 2005), it is possible to assume that an individual has experienced or is experiencing internalized homophobia if he/she agrees with at least one of the statements in the IHP. In addition, approximately 8% of the sample demonstrated moderate to high scores on the IHP (3 or higher). This means that although the majority of the sample was experiencing lower levels of internalized homophobia, a portion of the sample was experiencing the phenomenon of internalized homophobia. To this end, the mean score for the IHP can be misleading because it does not directly acknowledge those who were experiencing internalized homophobia, nor does it allow for the inclusion of their experiences into the results and implications of this study. Future analyses of the data should include a specific focus on participants who had high scores on the IHP.

The variability in scores for the IHP for this study is consistent with the professional literature. In particular, Shidlo (1994) suggests that the internalization of homophobia is a developmental occurrence experienced at varying levels by almost all lesbian and gay individuals raised in an antigay society. The range of scores for internalized homophobia in this study support this notion, which underscores the fact that anti-gay beliefs and attitudes held by society affect the lives of LGB individuals, but affect some LGB individuals more than others. This finding is important to consider since the degree of internalized homophobia, according to McCarn and Fassinger (1996), will likely determine the difficulty of moving through the phases of sexual minority identity development towards dedication and self-love as LGB individuals and away from rage, anxiety, and insecurity.

Overall, the mean scores for the SHE and the IHP suggest that a majority of LGB individuals do not experience heterosexism and internalized homophobia as often as the professional literature purports, or at least the participants in this study did not. This may be attributed to the increasing inclusion of LGB individuals in the media, to the rise of anti-discrimination policies in our society, or to the resiliency and coping skills of LGB individuals in response to societal oppression. Nonetheless, the variability in scores on both the IHP and SHE support the different phases proposed by McCarn and Fassinger's (1996) Model of Sexual Minority Identity Development, and their perspectives on the differing levels of impact of societal oppression on one's development.

My hypothesis was not supported by a correlation analysis between heterosexist events and internalized homophobia. Although this correlation was statistically significant ( $.07, p < .05$ ), it was very low and suggested a weak relationship between the

two variables. This is a surprising finding because not only is McCarn and Fassinger's (1996) Model of Sexual Identity Development built on this assumption, but it is logical to purport that increased exposure to the negative attitudes and beliefs held by society leads an LGB individual to feel negatively towards him/herself based on sexual orientation. This notion, however, was not supported by the results of my study. Whether or not there is a relationship between societal heterosexism and internalized homophobia is a question that can only be answered by future research.

### *Research Question #2*

*Overview.* This research question sought to identify the contribution of heterosexist events and internalized homophobia in predicting alcohol and drug use and abuse. I hypothesized that heterosexist events and internalized homophobia predict substance use patterns for LGB individuals. This hypothesis was influenced by McCarn and Fassinger's (1996) assumption that LGB individuals feel anger, rage, and anxiety in response to heterosexism and homophobia as they develop a sexual minority identity, and Cabaj's (1996, 1997) research that proposes LGB individuals use and abuse substances to manage the negative effects of living in an anti-gay society. Before investigating the contribution of these variables in predicting the substance use patterns of LGB individuals, I examined overall rates of alcohol and drug misuse among the sample in order to compare my results to existing prevalence rates. To this end, I will first present overall rates of alcohol and drug use and abuse among the sample, and then I will present the results from the regression analysis and relate them to McCarn and Fassinger's (1996) Model of Sexual Minority Identity Development when appropriate.

The professional literature suggests that alcohol and drug use and abuse are more prevalent among LGB individuals than the general population (CSAT, 2001; McKirnan & Peterson, 1989; Saghir & Robins, 1973; Skinner & Otis, 1996; Sorenson & Roberts, 1997). In particular, CSAT (2001) suggested that 20 to 25% of gay men and lesbians are heavy alcohol users compared to 3 to 10% of heterosexuals. Furthermore, McKirnan and Peterson (1989) purported that LGB individuals are more likely to use cannabis and cocaine than the general population. The present study investigated substance use patterns for LGB individuals and found lower rates of use and abuse than those reported in the professional literature. In my study, 15% of the sample reported they had abused alcohol and 17% indicated they abused drugs in the past year. These rates were identified by examining all participants who scored above 8 on the Alcohol Use Disorders Identification Test (AUDIT), and above 5 on the Drug Abuse Screening Test (DAST). Scores of 8 or above on the AUDIT are used to identify individuals who are at risk for or who are experiencing alcohol problems, and scores of 5 or above on the DAST indicate involvement with or having problems with the abuse of drugs (Bohn et al., 1994; Cocco & Carey, 1998; Conigrave et al., 1995). With regard to gender, 14% of women ( $n = 60$ ) and 15% of men ( $n = 58$ ) had scores that indicated alcohol abuse. These findings are lower than those reported by CSAT (2001), Jaffe et al., (2000), Lewis et al., (1982), McKirnan and Peterson (1989), Saghir and Robins (1973), and Stall and Wiley (1988), who posit prevalence rates between 18% and 25%. The rate of alcohol abuse for females, however, is comparable to rates identified by Sorenson and Roberts (15%, 1997). I could not locate any comparison statistics related to alcohol abuse among transgender individuals.

The overall statistics for drug abuse among the sample in my study are similar to rates of alcohol abuse. Sixteen percent of women ( $n = 67$ ) and 13% of men ( $n = 47$ ) had scores that indicated drug abuse. These findings are consistent with a study conducted by Amadio and Chung (2004). Findings from their study suggest that 15% of females and 11% of males in their sample scored above 8 on the DAST, and were therefore characterized as drug abusers. I was unable to locate any other studies in the professional literature that measured and reported prevalence rates of drug abuse among LGB individuals, nor could I locate comparison statistics for transgender individuals. I hope that the rates of drug abuse generated by my study will be used as a comparison for future research.

Next I will discuss the results from the sequential regression analysis that was used to examine the contribution of demographic variables, heterosexist events, and internalized homophobia in predicting alcohol use and abuse. I rejected my hypothesis that suggested heterosexist events and internalized homophobia are both significant predictors of alcohol use and abuse. There were, however, significant findings that are important to discuss. In particular, the variable age significantly predicted alcohol use and abuse at  $p < .01$ . This means that as a LGB individual ages, he/she is less likely to use and abuse alcohol.

Internalized homophobia, a major variable of interest, was also determined to be a significant predictor of alcohol use and abuse. This suggests that internalized homophobia positively affects alcohol use such that a LGB individual with higher internalized homophobia is more likely to use and abuse alcohol. Cherry (1997) reported similar results with regard to internalized homophobia and alcohol use and abuse among



gay and bisexual men. In particular, he found a significant positive relationship between internalized homophobia and high quantity and frequency of alcohol use, and higher frequency of alcohol related problems. Amadio and Chung (2004) also found a significant relationship between internalized homophobia and frequency of lifetime alcohol use, but only for females. These reported rates of alcohol use and abuse among LGB individuals have been attributed to the use of alcohol as a means of coping with a lack of self-acceptance of LGB sexual orientations and feelings of alienation as a result of living in an anti-gay society, which was proposed by Cabaj (1996), Jaffe et al. (2000), and Kus (1988). The results of my study support those found by the aforementioned researchers, as well as McCarn and Fassinger's (1996) position on the pervasive effects of societal heterosexism and homophobic on the sexual minority identity development of LGB individuals.

Heterosexist events, the second major variable of interest in this study, was not a significant predictor of alcohol use and abuse. Therefore, I cannot conclude whether exposure to heterosexist events affects the alcohol use patterns of LGB individuals. This relationship warrants further investigation in future studies.

A sequential regression analysis was also used to examine the contribution of demographic variables, heterosexist events, and internalized homophobia in predicting drug use and abuse. I hypothesized that both heterosexist events and internalized homophobia are significant predictors of drug use and abuse. Although I rejected this hypothesis, there were significant findings that are important to discuss. In particular, men who are exploring a gay male identity was a significant predictor of drug use at

$p < .05$ . This means that men who are questioning their heterosexual sexual orientation, or who are exploring a gay male identity, were more likely to use or abuse drugs. This is consistent with McCarn and Fassinger's (1996) Model of Sexual Minority Identity Development such that LGB individuals who are in the earlier phases of sexual minority identity development are more likely to experience rage, anxiety, and insecurity, which are often feelings that lead individuals to use and abuse substances.

In addition, household income was identified as a significant predictor of drug use and abuse at  $p < .05$ . This suggests that drug use was affected by level of income; in particular, higher income related to less drug use and abuse. The variable income, however, was no longer significant when the two major variables of interest (heterosexist events and internalized homophobia) were entered into the regression analysis.

Education was also a significant predictor of drug use and abuse at  $p < .01$ . To this end, I concluded that higher levels of education lead to lower levels of drug use or abuse. A study by Greenwood et al. (2001) supports this finding. In Greenwood et al., level of education was significantly related to polydrug use and frequency of drug use such that gay men who started but did not finish college were more likely than gay men who completed college to be polydrug users and to be frequent drug users. Greenwood et al. did not include lesbians so this finding should not be generalized to lesbians.

Finally, the variable heterosexist events was a significant predictor of drug use and abuse at  $p < .01$ . DiPlacido (1998) reported that negative heterosexist and homophobic life-events cause LGB individuals to experience physical and emotional stress, which he refers to as minority stress. Cabaj (1996, 2000) reported that LGB individuals use mood-altering substances to manage this stress, but at the same time place

themselves at risk for increased use, abuse, and possible dependency. Although the results of this study cannot confirm rates of drug dependency, the prevalence rates of drug use and abuse, and the significant relationship between exposure to heterosexual events and patterns of drug use and abuse support Cabaj's claim.

Internalized homophobia was not a significant predictor of drug use and abuse. Consequently, I cannot assume that internalized homophobia affects the drug use patterns of LGB individuals. This relationship warrants further exploration in future studies.

Although there are significant findings for both regression analyses in predicting alcohol and drug use and abuse, the variables accounted for a small amount of the variance. Therefore, I am cautious in drawing conclusions based on my findings and in generalizing them to the LGB community. Future research should examine other contributing factors that may account for the remaining variance.

McCarn and Fassinger's (1996) model does not directly address substance use and abuse in the context of sexual minority identity development; rather, it underscores the emotional intensity and difficulty of the process of developing a sexual minority identity and the negative impact of societal oppression. Based on Cabaj's (1996, 1997) research, many LGB individuals use substances to numb the pain associated with the negative effects of societal oppression and internalized homophobia. Therefore, if an LGB individual is abusing substances to numb the pain associated with internalized homophobia, it is likely that he/she is struggling to develop a sexual minority identity as outlined by McCarn and Fassinger's (1996) model. This proposition, which is based on work by McCarn and Fassinger (1996) and Cabaj (1996, 1997), and the results from this

study, underscore the relationship between heterosexist events, internalized homophobia, and substance use and abuse.

### *Research Question #3*

*Overview.* This research question sought to identify the phenomenological counseling experiences of LGB individuals. In doing so, I explored counseling rates of the participants, length of their counseling experiences, particular issues that they discussed in counseling, and their overall satisfaction with counseling. In addition, I developed four statements that emphasized the role of counseling in reducing internalized homophobia, which were based on the professional literature, and brought these statements back to the LGB community for review. First, I will discuss the counseling experiences of LGB individuals, and will follow with a discussion of how salient the aforementioned statements were to the LGB community. I report the counseling experiences of transgender individuals as there is limited literature on this group, and the field of counselor education can benefit from increased knowledge of their counseling activity.

Due to the scarce amount of research that examines counseling experiences of LGB individuals, I am limited to comparing my results to two older studies of mental health service utilization by lesbians (Bradford et al., 1994; Sorensen & Roberts, 1997), and one that examined the problem areas and counseling experiences of gay males (Mapou et al., 1983).

Overall, 70% of participants in the current study had participated in counseling in their lifetime. In particular, counseling rates for lesbians and bisexual women (75%,

$n = 314$ ) were similar to those found by the National Lesbian Health Care Survey (73%; Bradford et al., 1994) and the Boston Lesbian Health Project (80%; Sorensen & Roberts, 1997). Although I did not explore the type of counselor sought for support, Bradford et al. (1994) reported that private counselors (63%), school counselors (14%), counselors in clinics (14%), and counselors in hospitals (7%) were the most common sources of support. The high rates of counseling found among my sample corroborate other rates presented in the professional literature (Bieschke et al., 2000; Jones & Gabriel, 1999). I could not locate any counseling rates for heterosexual women that could be used as a comparison to the findings in this study.

The counseling rates for gay and bisexual men in my sample were lower than those for lesbians and bisexual women (64%,  $n = 237$ ), but are still important to underscore because 6 out of 10 gay and bisexual men in the current study participated in counseling at some point in their lives. These rates are higher than those purported by Mapou et al. (1983), whose study indicated that 44% of gay males in his study had been in counseling either at the time of the study or at some previous point in their lives. I was unable to find counseling rates for heterosexual men that could be used as comparative statistics.

In addition, 86% ( $n = 19$ ) of transgender individuals in my sample had sought counseling services. Although there was only a small sample of transgender individuals who participated in my study, the high counseling rates speak to their active utilization of mental health services.

Lesbians in my study reported varying lengths of counseling, which is similar to findings from the National Lesbian Health Care Survey (Bradford et al., 1994). The

majority of the lesbians in my study sought counseling for less than 1 year (41%). An interesting trend in my data as well as the data generated by Bradford et al. (1994) demonstrates a dichotomy in reports of length of counseling such that most of my sample who participated in counseling did so for less than 1 year (33 %), or for more than four years (12%). This trend is also evident in the length of counseling for gay and bisexual men in my study. The majority of gay and bisexual men sought counseling for less than 1 year (53%), or four or more years (14%). A similar trend can be seen in the length of counseling for transgender individuals. These findings suggest that a significant number of LGB individuals are discontinuing services during the first year of counseling, but many also continue services for four or more years. The shorter lengths of counseling may be attributed to individuals achieving their personal goals within a limited number of counseling sessions, or to less positive counseling experiences that may involve counselors who are “homophobic” and “critical,” or who don’t understand the problems presented by LGB clients (Morgan & Eliason, 1992). Shorter periods of counseling could also reflect limited coverage for counseling sessions by insurance companies, or clients who chose to discontinue services for personal or financial reasons.

A significant portion of the sample in the current study participated in counseling for longer than 4 years. The longer lengths of counseling may demonstrate a sense of connectedness between counselor and client, which allows for a safe and supportive environment where change towards a “stronger sense of self” can occur (Lebolt, 1999).

Participants also reported specific issues that they discussed in counseling. They were able to select more than one issue from a list of 15 issues identified in the professional literature (Bradford et al., 1994). For all study participants who received

counseling, the most commonly reported reason why they sought counseling was for depression/anxiety. Lesbians, bisexual women, and transgender individuals also reported relationship and family problems as the second and third top issues addressed in counseling. Gay and bisexual men also discussed these issues, but ranked family problems before relationship problems. The high rate of depression and anxiety as a reason for attending counseling among the sample is consistent with reports from the National Lesbian Health Care Survey (Bradford et al., 1994), Mapou et al. (1983), and Sorenson and Roberts (1997). Bradford et al. indicated that almost half of their sample had been depressed and sought counseling for their depression, and more than half had felt anxious to “accomplish ordinary activities” (p. 239). In addition, 44% of lesbians reported they sought counseling because of problems with lovers, and 34% because of problems with their family (Bradford et al.).

Sorenson and Roberts (1997) also described depression and relationship problems as commonly reported focal issues for lesbians in counseling, but indicated that family problems were addressed in less than 10% of counseling encounters. Mapou et al. (1983) identified depression and anxiety as a common problem among 60% of their gay male participants. Since LGB individuals in the current study also cited depression/anxiety and problems with relationships and family as top counseling issues, I purport that they are relevant issues to the LGB community as a whole.

I would also like to underscore the important issue of suicide in the LGB community. Approximately 24% of my sample reported suicide as an issue commonly discussed in counseling. Although this is less than the rates reported by Bradford et al. (1994) and Sorenson and Roberts (1997), it is an important issue that threatens the well-

being of the LGB community and should be noted as such. Furthermore, with regard to the role of sexual orientation in the high rate of counseling among my sample, only 18% of participants discussed exposure to anti-gay attitudes in counseling, and only 12% addressed experiences with discrimination. This suggests that many LGB individuals may enter counseling for general reasons that are also relevant to heterosexual individuals such as dissatisfaction with their relationships and their general sense of happiness (Jones & Gabriel, 1999). Without an examination of the relationships between homophobia, depression, and family and partner relationships, I am unable to clarify the role of sexual orientation in the counseling experiences of my sample. This is an important area of research that warrants further investigation.

When asked about their satisfaction with counseling, 86% of study participants reported that they were very satisfied to satisfied. These satisfaction rates are consistent with findings by Jones and Gabriel (1999) and Sorensen and Roberts (1997). According to a study conducted by Jones and Gabriel, 33% of LGB individuals reported that counseling had “saved their lives,” and an additional 50% indicated that their counseling experiences had been “very positive” (p. 215). Sorenson and Roberts found that the majority of the respondents in their study described their counseling experiences as “positive.” It is important to note, however, that 14% of participants in my study reported that they were “not at all satisfied” with their counseling experiences. Since I did not explore this dissatisfaction in detail, I am unable to draw conclusions from this statistic. Generally speaking, it is possible that some counselors are not trained to effectively work with this population, or that community agencies are not providing services that are



tailored to the needs of LGB individuals. This is another area of research that warrants further investigation.

In order to confirm the conceptual literature on the role of counseling in reducing internalized homophobia, I developed four statements that were based on the professional literature and asked participants to rate the accuracy of these statements. A minimum of three-quarters of the sample strongly agreed with all four statements. This means that participants strongly believed that counseling provides LGB individuals with the opportunity to reduce the negative feelings that may result from anti-gay bias and discrimination, and that reducing internalized homophobia is an important goal in counseling. In addition, they strongly agreed that helping LGB individuals understand that they have been unfairly treated by society is essential in shifting the blame from self (i.e., I am at fault for being LGB) to society (i.e., Society has perpetuated myths and stereotypes about LGB people). Finally, they strongly supported the notion that developing coping skills to increase low self-esteem and self-worth that often result from anti-gay bias is important in achieving a positive LGB identity.

#### *Limitations of the Study*

There are limitations to this study that should be noted. First, caution should be taken when generalizing the results from my study to the LGB community at large. Although my study included a large sample of LGB individuals (N = 824), random sampling was not used and therefore limits the generalizability of the findings. According to Heppner et al. (1999), studies using nonrandom selection can follow the “good enough” principle in interpreting and generalizing the results (p. 324). This means that nonrandom samples can have characteristics of a certain population, and generalizations

deduced from such a study are reasonable. Due to the diversity among my sample with regard to demographics, I believe generalizations of my results are reasonable. To this end, I can make valid inferences to “a hypothetical population resembling” my sample (Heppner et al., 1999, p. 324), which in this case is the LGB community.

It is important to note that this study recruited participants through LGB list-servs, LGB Internet sites, and LGB venues (e.g., LGB community centers, LGB student resource centers, and LGB bookstores). It is likely that individuals who accessed these sites, or visited these venues, were more integrated into the LGB community and were therefore further along in their sexual minority identity development. Since internalized homophobia delays the coming out process for LGB individuals, it is likely that those who are integrated into the LGB community and further along in their sexual minority identity development have lower internalized homophobia (Cabaj, 1997). This is important to underscore because I sought to recruit participants who had high internalized homophobia in order to more accurately measure the construct of internalized homophobia and its role in alcohol and drug use and abuse. Future studies should seek to develop recruitment methods that can identify individuals who are in the earlier stages of sexual minority identity development and have higher internalized homophobia.

A second limitation is the use of self-report measures. According to Heppner et al. (1999), self-report measures are “vulnerable to distortions by the participants,” which may lead to a response bias (p. 304). Participants may consciously or unconsciously respond in a way that they think is in agreement with the researcher’s hypothesis, in a manner that makes them appear good, in a way that causes them to appear more distressed in order to be eligible for particular services, or in a socially acceptable way

(Heppner et al., 1999). Due to the sensitive nature of the questions included in the AUDIT and the DAST, it is possible that participant responses were influenced by social desirability. A number of the questions in both the AUDIT and the DAST investigated consequences of alcohol and drug use and abuse with regard to employment, relationships, and family, as well as illicit use and abuse of drugs. It is likely that participants were hesitant to admit such consequences and illegal activity even though the survey was confidential. It is also possible that individuals who have such consequences in their lives may not be aware of them or in denial of them at the time of the survey. These disadvantages of self-report measures may have led to an under-reporting of alcohol and drug use and abuse for participants.

In addition, the use of the IHP to measure internalized homophobia has been criticized in the professional literature because it “taps rather extreme internalized homophobia associated with the desire to change a homosexual orientation” (Shidlo, 1996, p. 187). Therefore, this measure may be helpful with very homophobic LGB individuals, but may not be so accurate in identifying subtle to moderate internalized homophobia. Also, there are inconsistent structured responses and scoring procedures for the IHP that are noted in the literature. For example, Likert responses are often used for the IHP, but some researchers have used “yes” and “no” responses (Meyer, personal communication, December 20, 2005). Although Likert responses can provide a mean score for the IHP, there are no comparison scores identified in the research nor are there explanations of what the scores mean. When scoring the IHP using “yes” and “no” responses, Meyer reported that one or more “yes” responses to any of the questions could represent internalized homophobia. This ambiguous scoring procedure is not supported

by the literature. More research on the psychometrics of this scale, as well as its appropriateness for gay men, lesbians, and bisexual individuals, is warranted.

Another limitation to my study is the use of the Internet in both recruiting participants, and in participants completing the study. Although my sample included approximately 35% of individuals who have less than a college education, and 25% of individuals who have a household income of less than \$20,000, a majority of the sample (96%) heard about the study through web-related advertisements, and all participants completed the survey online through [www.psychdata.com](http://www.psychdata.com). This may have excluded participants of lower socioeconomic status, lower education, and less knowledge of and/or access to the Internet. Researchers who develop future studies should consider the use of various recruitment methods in identifying LGB individuals, and then use statistical analyses to compare the demographics of participants recruited by each method. Koch and Emrey (2001) compared the demographic information of LGB individuals who were recruited through the Internet to national data on gay men and lesbians, and found no significant differences with regard to demographics between the two groups. Although Koch and Emrey's study has strong implications for the use of the Internet in recruiting LGB individuals, it is necessary for other studies to replicate their methodology in order to support their claims.

A final limitation to my study is the lack of exploration of transgender participants' experiences with bias and discrimination on the basis of their gender identity. This may have led to inaccurate findings of the study such that transgender participants' experiences with transphobia, or the discomfort with and discrimination against transgender individuals, may have been translated into experiences with homophobia and

heterosexism. Future studies should explore the intersection of sexual orientation and gender identity for transgender individuals, and findings should be reported for both identities. Nonetheless, it was important to include transgender individuals in this study as they self-identified as LGB individuals and are therefore members of the LGB community.

#### *Implications for Training, Practice, and Research*

The findings presented in this study can be helpful to counselor educators, counselors, and researchers of LGB issues. The results have relevance for training programs that prepare counselors to work with the LGB community. The professional literature consistently reports that there are a number of counseling issues for LGB individuals that may differ from those of a non-gay clientele. Yet, there are also many problems reported by LGB individuals in counseling that are similar to those presented by heterosexual individuals in that they are of a “social nature” (Mapou et al., 1983). The results from the present study indicate that depression, anxiety, and problems with relationships and family are common counseling issues for LGB clients. These issues may be related to the LGB sexual orientation of the client, and his/her experience growing up in an anti-gay society. A training program should equip counselors with the skills to assess whether these issues are in fact related to the client’s experiences as a sexual minority, as well as how to tailor their counseling approaches to most effectively serve the client’s specific needs.

The high rate of counseling utilization by LGB individuals found in the current study also has strong implications for training programs such that the inclusion of LGB related material into clinical coursework and practicum is essential. I am not saying that

training programs should create independent courses that specifically focus on LGB issues. This may be difficult due to financial restraints, limited faculty who have expertise in this area, and the fact that students have a limited amount of time to complete a specific number of courses. What I do propose is that faculty ensure that they incorporate LGB issues into counseling courses (e.g., introduction to counseling, counseling theories, marriage/family counseling, personality and human development, career counseling, multicultural counseling, and assessment in counseling; Buhrke, 1989), in case study applications, and in other innovative ways to help students learn about this population. For example, this study supports the research on high rates of substance use and abuse in the LGB community. Training programs could apply this finding to the development of curriculum by ensuring that this topic is addressed in a human development, multicultural, or crisis counseling course.

The current study also has implications for counselors who work with LGB individuals in their clinical practice. According to this study, LGB individuals are actively seeking counseling to manage problems with mental health and interpersonal relationships that may be related to how they are perceived and treated by society. Nonetheless, 10% of these LGB individuals were dissatisfied with their counseling experiences. One participant reported that counseling was unhelpful for him because the counselor was “homophobic and lacked knowledge about the gay community.” Another participant described her counselor as “poorly trained on lesbian and gay issues.” A third participant reported that the counselor “focused on homosexuality as being an issue instead of homophobia in our society.” These responses emphasize the importance of practitioners who are committed to increasing their awareness and knowledge of LGB

issues, and enhancing their skills to work with members of the LGB community. This personal and professional development can be accomplished by participating in workshops and conferences, and by reading the professional literature.

This study also has implications for substance abuse counselors and substance abuse programs. According to Cabaj (1997), there are special treatment concerns for LGB people in addition to recovery from substance abuse such as recovery from the consequences of homophobia. One particular result from this study, which highlights the importance of addressing homophobia in counseling, supports this notion. To achieve recovery from substance abuse and homophobia, an LGB client needs to address his/her own acceptance of self with the support of a gay-sensitive and gay-affirmative counselor. It is important that the counselor identifies that shame and internalized homophobia are the results of an anti-gay culture and also encourages the use of counseling and Alcoholics Anonymous as a means of expressing feelings (Bobbe, 2002). Treatment plans should address the degree and impact of internalized homophobia, the stage in the coming out process and the experience of coming out, and other experiences, influences and effects of being an LGB individual (Cabaj, 1997).

With regard to substance abuse programs, Cabaj (1997) posits that few inpatient or outpatient treatment programs have knowledge about same-gender sexual orientation and are often unaware that they have LGB clients because “they are too frightened to come out to the staff” (p. 30). Consequently, attitudes and beliefs of staff and counselors about same-gender sexual orientation are crucial in the successful treatment of LGB clients. The results from this study underscore substance abuse among LGB individuals, and support the importance of addressing internalized homophobia in counseling. To this

end, staff and counselors in substance abuse treatment programs need to increase their awareness of LGB issues and people . For example, an outpatient substance abuse treatment center in New York City offers an LGB outpatient group, which is led by an affirmative counselor who is knowledgeable about LGB identity development, the coming out process, and other important counseling issues relevant to the LGB community. This group creates a safe environment where clients can freely discuss their experiences as LGB individuals, and how these experiences have affected their substance abuse behaviors. It is important to note that the issues discussed in such groups may have little or nothing to do with sexual orientation, but the groups still provide a sense of acceptance and support, which may provide a new experience for LGB clients (Hicks, 2000).

Finally, the results from my study have implications for researchers who develop studies to explore the lives of LGB individuals. The current study examined substance use and abuse among the LGB community, as well as the counseling experiences of LGB individuals, which are limited areas of research presented in the professional literature. Although there has been an increase in empirical studies that examine LGB issues and experiences over the past ten years, we still have a long way to go before we have enough studies that warrant making conclusions about the LGB community. There are numerous conceptual articles that discuss specific issues and problems common to LGB individuals, but there are few studies that are designed to test these conceptual propositions. The lack of empirically-based studies may be attributed to the fact that LGB individuals are a hard to identify population (Koch & Emrey, 2001), and the inconsistent definitions of sexual orientation terminology (Shidlo, 1996). The inadequacy of research on LGB issues may



also be due to limited measures that assess sexual minority identity development, internalized homophobia, and experiences with homophobic and heterosexist events. Findings from the present study support the use of the SHE, IHP, AUDIT, and DAST with LGB individuals, and the continued investigation of substance use and abuse as an important concern among the LGB community.

### *Suggestions for Future Research*

Although I have suggested topics for future research throughout this section, I will summarize them here as well. First, future research should include both quantitative and qualitative studies with large samples to explore issues common to LGB individuals such as depression and anxiety, and problems with relationships and family, which were top counseling issues identified in my study. We as counselors and researchers could benefit from an increased understanding of the effects of heterosexism and homophobia on the lives of LGB individuals, particularly how they affect the mental health and well-being of the community.

Future research should also examine the counseling experiences of LGB individuals, in particular gay men and bisexual individuals. This will inform practitioners about the most effective counseling practices for LGB individuals who seek our services. Also, researchers should continue to explore the diversity among the LGB community with regard to race/ethnicity, socioeconomic status, religion, etc., in order more fully understand the dynamics of this population.

A third suggestion for future research is in the area of substance use and abuse for LGB individuals. The results of my study can be used as comparisons for future studies that investigate the relationship between heterosexism and internalized homophobia as

well as predictors of drug and alcohol use and abuse for LGB individuals. This will allow for future studies to support or refute my results and conclusions, and add to a “neglected area” of research (Shidlo, 1996, p. 199). According to Bux (1996), there is much that remains “unknown about the etiology of drinking problems in gay men and lesbians” (p. 295). This also applies to drug use and abuse because there are limited studies that address etiology of drug-using problems in LGB individuals. The regression results of my study indicated that demographic variables, heterosexist events, and internalized homophobia account for only about 7% of the variance in alcohol and drug use and abuse. An important goal for future research is to identify other factors that contribute to the remaining 93% of the variance. A number of possible contributors to substance use and abuse besides those of heterosexist events and internalized homophobia have been identified in the professional literature such as childhood sexual abuse, domestic violence, social roles and responsibilities, and gender role conflict (Bux, 1996; Hughes & Eliason, 2002). I would encourage researchers to consider these risk factors when developing studies to investigate the substance use patterns of LGB individuals.

### *Conclusion*

The results of this study indicate that heterosexism and homophobia affect the substance use behaviors of LGB individuals. In addition, study results suggest that LGB individuals are seeking counseling services at high rates, which concurs with research findings that underscore the importance of counseling in the lives of LGB individuals. Most of the findings in my study support the professional literature that examines the relationship between internalized homophobia and substance abuse, as well as using counseling as an effective means of reducing the negative effects of homophobia and

heterosexism (Amadio & Chung, 2004; Bradford et al., 1994; Burris, 1997; Cherry, 1997; Jaffe et al., 2000; Jones & Gabriel, 1999). These issues deserve much attention from educators, practitioners, and researchers, and it is our joint responsibility to create an environment where LGB individuals can feel safe and confident to be their true selves. It is my hope that the increased exposure of LGB individuals in society and the continued efforts to celebrate diversity will help bring homophobia, heterosexism, and internalized homophobia to an end.

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## Appendix A

### Recruitment Advertisement

Are you a lesbian, gay male, or bisexual individual? Are you exploring a lesbian, gay male, or bisexual identity? Please take some time to participate in my study, which explores the possible effects of anti-gay bias and discrimination on the lives of people who identify with, or are exploring, same gender or bisexual sexual orientations. You must be 18 years of age to participate. For every 100 respondents who complete this on-line survey, I will personally donate \$50 to The Rainbow World Fund, a gay, lesbian, bisexual, and transgender humanitarian service agency that focuses on global HIV/AIDS, water development, landmine eradication, and hunger.

Participation in this study is simple. All you need to do is go to [www.psychdata.com](http://www.psychdata.com) and enter this survey number - 8439. The survey will take approximately 15-20 minutes to complete. Confidentiality will be maintained to the extent permitted by the technology used. In particular, since the Internet is being utilized, I cannot guarantee protection from third party access; however, the data is encrypted as soon as it is sent and stored on a secure server. Additional information with regard to security is available on the PsychData website. The survey will not ask for any information that would identify who the responses belong to (i.e., name, email address).

This study was reviewed and approved by the Social Science Institutional Review Board at the Pennsylvania State University (IRB#20345, phone 814-865-1775). Your participation is voluntary and is for research purposes. You can ask questions about this research by contacting me, Genevieve Weber, at Penn State University through e-mail at [genevievenweber@yahoo.com](mailto:genevievenweber@yahoo.com), telephone (917) 968-5409, or mail: 301 CEDAR Building, University Park, PA, 16803. You can also contact my advisor, Dr. Brandon Hunt, through email at [bbh2@psu.edu](mailto:bbh2@psu.edu) or by telephone (814) 863-2408.

Thank you in advance for your support!!

Genevieve N. Weber, M.A.



## Appendix B

### LGBT List-Servs

#### Yahoo groups

ACLUJax  
Activistqueercollegekids  
Arizonagaystudents  
ASU-GSA  
AtlantaLesbianLifestyles  
BClgbtq  
Bi-Gay-Men-Arkansas  
Bi-Gay-Men-Dallas  
Bi-Gay-Men-Kansas  
Bi-Gay-Men-Minnesota  
Bi-Gay-Men-Nevada  
Bi-Gay-Men-New-York  
Bi-Gay-Men-Tennessee  
BiGLM  
BiMuslims  
Bisexual-Females  
Bisexual-friends-alaska  
Bisexual\_in\_utah  
Bisexual\_Netherlands  
BISEXUAL-ORG  
Bisexual-personals5  
BlackGayBusinessUnited  
BlackGayChristian  
BlackGayWomenandMenOfAction  
Blackgayserve  
Blacklesbianprofessionals  
Blacklesbians1  
Blacklesbiansinlittlerock  
BSTPhillipines  
Centraltlgbtclub  
Chennaigaystudents  
Chicago\_Queer\_As\_Folk\_Fans  
Columbia\_queer-connections  
DCBlackPride  
DenverGayFriendsNetwork  
Everyone\_is\_bisexual  
FourthTuesdayAtlanta  
Gay-desi-sfbay  
Gaygreeks  
Gay\_houseboating\_fun

Gay\_Men\_Alberta-Canada  
GayMichiana  
Gay-princeedwardisland  
Gay\_song\_club  
Gay-texas-exes  
Gay-gondia  
Gay\_iitm\_students  
Gay\_men\_alberta\_canada\_grande  
Gay\_school  
Gay-students\_and\_friends  
GLBT\_KansasMissouriColleges  
GLBTstudentsofSanAntonio  
Lgb-elder-studies  
Lgbti\_latino  
Lgbtnewyorkcity  
Lgbtout\_and\_community\_events  
LgbtPittsburgh  
LongIslandSocialCircle  
Mahagonylesbians  
MenforgayarabmeninNY  
MexicanLesbians  
MississippiBlackPride  
NewEnglandQueerPagans  
Nigeriangaysociety  
Njmarriageequality  
NuestraSalud  
NYC-queer-celibate  
Phillygaybicollegestudents  
Q-saints  
Queer-Anti-racist  
QueerAtlanta  
Queerwritings  
Queer-Aging  
Queer-connection-NY  
Queer-ladies  
Rainbowalliance  
Rainbowkenyalgbt  
Theallies  
Therainbowconnection  
Two\_Spirited1Z  
UK-gay-students  
Uklambda2  
Uppermanhattangaynetworking  
URIlgbt  
Wonderfulwomynofcolor  
Workingclassqueerpeople

## Appendix C

### Requirements and Informed Voluntary Consent Statement

Exploring the Effects of Anti-Gay Attitudes and Discrimination on the Lives of Same-Gender Oriented Individuals

**Principal Investigator:**

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The Pennsylvania State University  
University Park, PA 16801  
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[genevievenweber@yahoo.com](mailto:genevievenweber@yahoo.com)

**Advisor:**

Brandon Hunt, Ph.D., CRC  
327 CEDAR Building  
The Pennsylvania State University  
University Park, PA 16801  
Phone: (814)863-2408  
[bbh2@psu.edu](mailto:bbh2@psu.edu)

**Purpose:** The purpose of the present study is to explore how anti-gay attitudes and discrimination possibly affect the lives of people who identify with, or are exploring, same gender or bisexual sexual orientations. In order to participate, you must be at least 18 years of age, lesbian, gay, or bisexual, or exploring a lesbian, gay, or bisexual identity. For every 100 surveys submitted, the principle investigator will personally donate \$50 to The Rainbow World Fund, a gay, lesbian, bisexual, and transgender humanitarian service agency that focuses on global HIV/AIDS, water development, landmine eradication, and hunger. This study is part of a doctoral dissertation at the Pennsylvania State University.

**Procedures To Be Followed:** You will be asked to complete an online survey. Your participation and responses are confidential. Please answer the questions as openly and honestly as possible. You may skip questions, but skipping too many could affect your inclusion in the study. If your demographic data shows that you do not meet the aforementioned requirements, your responses will not be included in the study.

**Discomforts and Risks:** Due to the personal nature of some of the questions, you may experience some discomfort in completing the survey. If this occurs, you may want to seek support from a counselor or another helping professional.

**Benefits:** The benefits to you may include an increased awareness of whether you have been exposed to anti-gay attitudes and discrimination. The benefits to society include an increased awareness and understanding of the impact of anti-gay attitudes and discrimination on the lives of people who identify with, or are exploring, same gender or bisexual sexual orientations.

**Duration/Time:** This online survey will take approximately 15-20 minutes to complete. There is no required participation beyond this time.

**Statement of Confidentiality:** Confidentiality will be maintained to the extent permitted by the technology used. In particular, since the Internet is being utilized, protection from third party access cannot be guaranteed. The data is encrypted, however, as soon as it is sent and is immediately stored on a secure server. Additional information with regard to

security is available on the PsychData website. The survey will not ask for any information that would identify who the responses belong to (i.e., name, email address). Genevieve Weber and her advisor will have access to the final records. The Pennsylvania State University's Office for Research Protections and the Social Science Institutional Review Board may review records related to this project.

**Right to Ask Questions:** You can ask questions about this research. The researcher for this study is Genevieve Weber, a Ph.D. candidate at Penn State University. She can be contacted via email at [genevievenweber@yahoo.com](mailto:genevievenweber@yahoo.com). Her advisor is Dr. Brandon Hunt, and she can be reached at [bbh2@psu.edu](mailto:bbh2@psu.edu). You can also contact The Office for Research Protections directly at (814) 865-1775 with any questions. If you are interested in the final results of this study, please email Genevieve Weber. The final results may be published in a professional counseling journal over the next few years.

**Voluntary Participation:** Your decision to be in this study is voluntary. Please note that you can choose to withdraw your responses at any time before you submit your answers.

If you agree to take part in this research study and the information outlined above, please click on the "Continue" button below, which indicates your consent to participate in this study. It is recommended that you print this statement for your records, or record the address for this site and keep it for reference.

This informed consent form was reviewed and approved by the Social Science Institutional Review Board (IRB# 20345) at The Pennsylvania State University on February 16, 2005. It will expire on February 15, 2006.

**Appendix D**  
**Demographic Questionnaire**

1. What is your age? \_\_\_\_\_
2. What is your gender identity?
  - a. Female
  - b. Male
  - c. Transgender
3. How would you describe your sexual identity?
  - a. lesbian
  - b. gay male
  - c. bisexual
  - d. I am currently exploring a lesbian identity
  - e. I am currently exploring a gay male identity
  - f. I am currently exploring a bisexual identity
  - g. Other \_\_\_\_\_
4. What is your race/ethnicity?
  - a. African-American
  - b. Asian-American
  - c. Caucasian
  - d. Latino-American
  - e. Native American
  - f. Multi-or Bi-racial
  - g. Other: \_\_\_\_\_
5. What is your education level?
  - a. Some High School
  - b. High School Diploma / GED
  - c. Some College, University, or Technical School
  - d. Associate's Degree
  - e. Bachelor's Degree
  - e. Master's Degree
  - f. Doctoral / Professional Degree
6. What is your household income level?
  - a. Under \$10,000
  - b. \$10,001-20,000
  - c. \$20,001-35,000
  - d. \$35,001-50,000
  - e. \$51-75,000
  - f. \$76-100,000
  - g. Above \$100,000

7. What state/district do you live in?

- a. Alabama
- b. Alaska
- c. Arizona
- d. Arkansas
- e. California
- f. Colorado
- g. Connecticut
- h. Delaware
- i. Florida
- j. Georgia
- k. Hawaii
- l. Idaho
- m. Illinois
- n. Indiana
- o. Iowa
- p. Kansas
- q. Kentucky
- r. Louisiana
- s. Maine
- t. Maryland
- u. Massachusetts
- v. Michigan
- w. Minnesota
- x. Mississippi
- y. Missouri
- z. Montana
- aa. Nebraska
- bb. Nevada
- cc. New Hampshire
- dd. New Jersey
- ee. New Mexico
- ff. New York
- gg. North Carolina
- hh. North Dakota
- ii. Ohio
- jj. Oklahoma
- kk. Oregon
- ll. Pennsylvania
- mm. Rhode Island
- nn. South Carolina
- oo. South Dakota
- pp. Tennessee
- qq. Texas
- rr. Utah

- ss. Vermont
- tt. Virginia
- uu. Washington
- vv. Washington, D.C.
- ww. West Virginia
- xx. Wisconsin
- yy. Wyoming.
- zz. Other \_\_\_\_\_

8. What is your relationship status?

- a. Single
- b. Relationship less than 6 months
- c. Relationship 6 months – 1 year
- d. Relationship 1.1 years – 2 years
- e. Relationship 2.1 years – 4 years
- f. Relationship 4.1 years – 9 years
- g. Relationship 9.1 years or longer

9. How did you hear about this study?

- a. E-mail list-serv
- b. E-mail from friend
- c. Advertisement or link on Web
- d. Advertisement in print materials (wall posting, magazine)
- e. Word of mouth
- f. other \_\_\_\_\_

## Appendix E

### Schedule of Heterosexist Events (SHE) (Selvidge, 2000)

Please think carefully about your life as you answer the questions below. For each question, read the question and circle the number that best describes events in YOUR ENTIRE LIFE, using these rules:

Circle 1 if this has NEVER happened to you

Circle 2 if this has happened ONCE IN A WHILE (less than 10% of the time)

Circle 3 if this has happened SOMETIMES (10% - 25% of the time)

Circle 4 if this has happened A LOT (26% - 49% of the time)

Circle 5 if this has happened MOST OF THE TIME (50% - 70% of the time)

Circle 6 if this has happened ALMOST ALL OF THE TIME (more than 70% of the time)

1. How many times have you been treated unfairly by teachers and professors because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
2. How many times have you been treated unfairly by your employers, bosses and supervisors because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
3. How many times have you been treated unfairly by your coworkers, fellow students and colleagues because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
4. How many times have you been treated unfairly by people in service jobs (store clerks, waiters, bartenders, waitresses, back tellers, mechanics and others) because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
5. How many times have you been treated unfairly by strangers because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
6. How many times have you been treated unfairly by people in helping jobs (by doctors, nurses, psychiatrists, case workers, dentists, school counselors, therapists, pediatricians, school principals, gynecologists and others) because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
7. How many times have you been treated unfairly by neighbors because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
8. How many times were you denied a raise, a promotion, tenure, a good assignment, a job or other such thing at work that you deserved because you are lesbian, gay, or bisexual? 1 2 3 4 5 6



9. How many times have you been treated unfairly by your family because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
10. How many times have people failed to show you the respect you deserve because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
11. How many times have you wanted to tell someone off for being heterosexist or homophobic? 1 2 3 4 5 6
12. How many times have you been really angry about something heterosexist or homophobic that was done to you? 1 2 3 4 5 6
13. How many times were you forced to take drastic steps (such as filing a grievance, filing a lawsuit, quitting your job, moving away, and other actions) to deal with some heterosexist thing that was done to you? 1 2 3 4 5 6
14. How many times have you been called a derogatory name referring to your sexual orientation? 1 2 3 4 5 6
15. How many times have you gotten into an argument or a fight about something heterosexist that was done or said to you or done to somebody else? 1 2 3 4 5 6
16. How many times have you been made fun of, picked on, pushed, shoved, hit, or threatened with harm because you are lesbian, gay, or bisexual? 1 2 3 4 5 6
17. How many times have you heard people making heterosexist jokes, or degrading homosexual jokes? 1 2 3 4 5 6

18. How different would your life be now if you HAD NOT BEEN treated in a heterosexist, homophobic, and unfair way?
 

Same as Now	A Little Different	Different in A Few Ways	Different in A lot of Ways	Different in Most Ways	Totally Different
1	2	3	4	5	6

## Appendix F

### Internalized Homophobia Scale (IHP) (Martin & Dean, 1987)

*Please rate the following statements according to the scale provided.*

1. I have tried to stop being attracted to the same gender in general.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
2. If someone offered me the chance to be completely heterosexual, I would accept the chance.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
3. I wish I weren't a same-gender oriented individual.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
4. I feel that being a same-gender oriented individual is a personal shortcoming for me.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
5. I would like to get professional help in order to change my sexual orientation from same-gender to straight.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
6. I have tried to become more sexually attracted to the opposite gender.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree
  
7. I often feel it best to avoid personal or social involvement with other same-gender oriented individuals.  

1	2	3	4	5	
strongly	disagree	neither	agree	strongly	
disagree			nor disagree		agree

8. I feel alienated from myself because of being same-gender oriented.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

9. I wish that I could develop more erotic feelings about the opposite gender.

1	2	3	4	5
strongly disagree	disagree	neither agree nor disagree	agree	strongly agree

## Appendix G

### **The Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland, Babor, & De La Fuente, 1993)**

*Please answer the following statements according to the responses provided.*

1. How often do you have a drink containing alcohol?  
(0) Never (1) Monthly or less (2) 2-4 times/month (3) 2-3 times/week (4) 4+ times/week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?  
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 or 9 (4) 10 or more
3. How often do you have six or more drinks on one occasion?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?  
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?  
(0) No (2) Yes, but not in the last year (4) Yes, during the last year
10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you should cut down?  
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

## Appendix H

### The Drug Abuse Screening Test (DAST-20) (Skinner, 1982)

Instructions: The following questions concern information about your potential involvement with drugs *not including alcoholic beverages* during the past 12 months. Carefully read each statement and decide if your answer is “Yes” or “No.” Then select the appropriate response beside the question. In the statements “drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

- |     |  |     |    |
|-----|--|-----|----|
| 1.  | Have you used drugs other than those required for medical reasons?   | Yes | No |
| 2.  | Have you abused prescription drugs?  | Yes | No |
| 3.  | Do you abuse more than one drug at a time?   | Yes | No |
| 4.  | Can you get through the week without using drugs?  | Yes | No |
| 5.  | Are you always able to stop using drugs when you want to?  | Yes | No |
| 6.  | Have you had “blackouts” or “flashbacks” as a result of drug use?  | Yes | No |
| 7.  | Do you ever feel bad or guilty about your drug use?  | Yes | No |
| 8.  | Does your partner and/or parents ever complain about your involvement with drugs?                                      | Yes | No |
| 9.  | Has drug abuse created problems between you and your partner and/or your parents?                                      | Yes | No |
| 10. | Have you lost friends because of your use of drugs?  | Yes | No |
| 11. | Have you neglected family because of your use of drugs?  | Yes | No |
| 12. | Have you been in trouble at work because of drug abuse?  | Yes | No |
| 13. | Have you lost a job because of drug abuse?   | Yes | No |
| 14. | Have you gotten into fights when under the influence of drugs?   | Yes | No |
| 15. | Have you engaged in illegal activities in order to obtain drugs?   | Yes | No |
| 16. | Have you been arrested for possession of illegal drugs?  | Yes | No |
| 17. | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?                               | Yes | No |
| 18. | Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc)? | Yes | No |
| 19. | Have you gone to anyone for help for a drug problem?   | Yes | No |
| 20. | Have you been involved in a treatment program specifically related to drug use?  | Yes | No |

## Appendix I

### Experiences with Counseling

1. Have you participated in counseling?    Yes \_\_\_\_\_    No \_\_\_\_\_

a. If you answered *no* to question 1, please continue to the next survey.

b. If you answered *yes* to question 1, how long did you receive counseling?

Please select the appropriate response.

Less than 1 year                    \_\_\_\_\_  
 1. 1 – 2 years                        \_\_\_\_\_  
 2. 1 – 3 years                        \_\_\_\_\_  
 3. 1 – 4 years                        \_\_\_\_\_  
 more than 4 years                  \_\_\_\_\_  
 other (please specify) \_\_\_\_\_

2. What issues/concerns did you discuss in counseling? Please mark all that apply.

financial stress	_____
family problems	_____
employment worries	_____
illness or death	_____
relationship problems	_____
experiences with anti-gay attitudes	_____
experiences with discrimination	_____
participation in community activities and social life	_____
depression and anxiety	_____
suicidal thoughts/attempts	_____
physical and sexual abuse	_____
impact of AIDS	_____
alcohol and drug use	_____
eating disorders	_____
other (please specify)	_____

3. How satisfied were you with your counseling experience(s)?

very	somewhat		not at all
satisfied	satisfied	satisfied	satisfied
1	2	3	4

4. In a few words, please describe what you found to be the *most* helpful aspect of counseling.

5. In a few words, please describe what you found to be the *least* helpful aspect of counseling.

## Appendix J

### Perceptions of Counseling

*Please rate the following statements according to the scale provided.*

1. I believe that counseling provides lesbian, gay, and bisexual (LGB) individuals with the opportunity to reduce the negative feelings that may result from anti-gay bias and discrimination.

1	2	3	4	5
strongly disagree	disagree	neither disagree nor agree	agree	strongly agree

2. I believe that helping LGB individuals understand that they have been unfairly treated by society is essential in shifting the blame from self (“I am at fault for being LGB”) to society (“Society has perpetuated myths and stereotypes about LGB people”).

1	2	3	4	5
strongly disagree	disagree	neither disagree nor agree	agree	strongly agree

3. I believe that developing coping skills to increase low self-esteem and self-worth that often result from anti-gay bias is important in achieving a positive lesbian, gay male, or bisexual identity.

1	2	3	4	5
strongly disagree	disagree	neither disagree nor agree	agree	strongly agree

4. I believe that reducing internalized homophobia, or the internalization of society’s anti-gay attitudes and beliefs, is an important goal in counseling for LGB individuals.

1	2	3	4	5
strongly disagree	disagree	neither disagree nor agree	agree	strongly agree

*Please provide your response to the following question.*

5. Are you in recovery from alcohol and/or drug abuse? Yes \_\_\_\_\_ No \_\_\_\_\_

**GENEVIEVE N. WEBER**

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**EDUCATION**

**The Pennsylvania State University, University Park, PA**

Doctor of Philosophy, Counselor Education and Supervision; August, 2005

Dissertation Title: Heterosexist Events, Internalized Homophobia, and Substance Use: Implications for Counseling Lesbian, Gay, and Bisexual Clients

**New York University, New York, NY**

Master of Arts, Counseling in Community Agencies, 2002

**University of Vermont, Burlington, VT**

Bachelor of Arts, Psychology, 1999

**RELATED EXPERIENCE**

***Addictions Counselor***

06/05 – present; 06/04 – 08/04; 01/01 – 08/02

Midtown Center for Treatment and Research, Weill Medical College, Cornell University, New York, NY

- Provide individual and group counseling to a culturally diverse population of individuals with substance abuse and/or mental disorders.

***Programming Assistant***

01/05 – 06/05

LGBTQA Student Resource Center, The Pennsylvania State University, University Park, PA

- Coordinated outreach activities that were aimed at promoting a safer campus environment for members of the LGBTQA student body.

**PRESENTATIONS**

Hunt, B., & Weber, G.N. (2005, October). *Enhancing the doctoral teaching internship*. Poster session accepted for the Association of Counselor Education and Supervision Conference, Pittsburgh, PA.

Weber, G. N. (2005, April). *Internalized homophobia and substance use/misuse among lesbian, gay, and bisexual individuals*. Poster session presented at the American Counseling Association Convention, Atlanta, Georgia.

Weber, G. N. (2005, March). *Heterosexist events, internalized homophobia, and substance use among lesbian, gay, and bisexual individuals: Implications for counseling*. Poster session presented at The Pennsylvania State University Graduate Exhibition, University Park, Pennsylvania.