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Treatment Counselor's Attitudes About Lesbian, Gay, Bisexual, and Transgendered Clients: Urban vs. Rural Settings

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ABSTRACT

Treatment counselors' attitudes about lesbian, gay, bisexual, and transgendered (LGBT) clients can have important effects on these client's recovery. There is a common, but unexamined, perception that LGBT people are more accepted in urban areas (and thus urban treatment programs) and that urban counselors have greater knowledge of the needs of the LGBT community. This study examined the attitudes and knowledge of treatment counselors from two geographic regions: urban Chicago ($n = 109$) and rural Iowa ($n = 242$) in 2000. The instrument assessed demographic characteristics, knowledge, and experiences working with LGBT clients, and

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attitudes about LGBT clients (an adaptation of Herek's Attititudes about Lesbians and Gays rating scale). Only a few demographic differences between the urban and rural counselors were identified. Chicago counselors were more racially diverse and more likely to have grown up in an urban area than the Iowa counselors. The Iowa counselors had slightly higher levels of formal education. Although the Chicago providers reported having considerably more contact with LGBT clients and more formal and continuing education about LGBT people, they did not have more positive attitudes or report more knowledge of specific LGBT issues that might influence alcohol and drug treatment. Overall, both Chicago and Iowa counselors had very little formal education regarding the needs of LGBT clients, and nearly half reported negative or ambivalent attitudes. Many of the counselors lacked knowledge about legal issues such as domestic partnership and power of attorney, the concepts of domestic partnership and internalized homophobia, and issues related to family of origin and current family.

Key Words: Homophobia; Attitudes; Lesbian; Gay; Bisexual; Transgender; Substance user treatment; Cultural competence; "Substance abuse."

INTRODUCTION

Treatment counselor's attitudes may significantly affect their clients' chances of recovery (Bell et al., 1997). There is growing recognition that substance user and misuser treatment models based on the experiences of white, heterosexual men have limited applicability to many types of clients, and that for treatment to be most effective, it must address specific cultural variables that influence onset, maintenance, and relapse risk for "substance abuse" (CSAT, 1999). *Cultural competence*, defined as the ability of practitioners, systems, agencies, and institutions to respond to the unique needs of populations whose cultures are different from the mainstream or dominant cultures (USDHHS, 1992) is becoming a core value in the alcohol and drug user counseling field, thus greater attention is being paid to individual counselor attitudes and their potential effect on provision of services.

Although there is tremendous variation among LGBT individuals, there are also unique issues that impact prevention and treatment activities, such as the common experiences of acknowledging and revealing one's sexual or gender identity, and the societal stigma attached to these identities. Existing research consistently reports elevated risk for

"substance abuse" in LGBT people compared with the general population (Bloomfield, 1993; Hughes et al., 1997; Hughes and Eliason, 2001; McKirnan and Peterson, 1989; Skinner, 1994). This risk appears to be related to societal reactions to LGBT people, rather than sexual or gender identity itself. Ways in which societal stigma contributes to risk includes:

- The stress associated with belonging to an often despised minority (Kettelhack, 1999)
- The stress associated with managing a minority identity, such as needing to hide the identity to keep a job or experiencing harassment or discrimination (McKirnan and Peterson, 1988; Rothblum, 1990)
- The role of gay bars as a major (and sometimes only) social outlet (Kettelhack, 1999); leading to finding friends and partners in bar settings, thus increasing the likelihood of adopting a "heavy drinking"/using peer group (Weinberg, 1994)
- Greater likelihood of loss of family and community support (Weston, 1991)
- Fewer traditional roles and responsibilities (marriage, parenthood) that are believed to limit substance use in heterosexual people (Hughes and Wilsnack, 1997)
- Nonacceptance of self (Kus, 1988) or internalized homophobia or transphobia; internalized homophobia/transphobia refers to the acceptance of negative societal stereotypes and attitudes about lesbian, gay, bisexual, and transgendered people, and can result in lower self-esteem and feelings of low self-worth (Ghindia and Kola, 1996)

The greater the number of stigmatized identities (e.g., nonwhite race/ethnicity, disability), the greater the likelihood of experiencing these risk factors. Because of the effects of societal stigma and associated risks, LGBT clients may have somewhat different treatment needs than the general population, needs that are largely overlooked in drug and alcohol user treatment programs (CSAT, 2001). Currently, many programs focus on the individual rather than the larger social context (Van Den Bergh, 1991). For example, difficulty dealing with sexual orientation in a hostile workplace may be explained as an individual short-coming rather than being the result of oppression. When treatment counselors fail to address sociocultural forms of oppression, such as homophobia, racism, and sexism, that create societal stereotypes, they may "blame the victim" and perpetuate oppression. Focusing on the individual rather than making

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assumptions based on stereotypes would benefit all clients of drug and alcohol user treatment.

Research on attitudes about people with minority sexual or gender identities has primarily focused on lesbians and gay men, with very little research on attitudes toward bisexual or transgendered people. Current research suggests that people with negative attitudes are more likely to be male, have less than a college education, have conservative or fundamentalist religious beliefs, and have limited or no personal contact with lesbians or gay men (Eliason, 1995; Herek and Glunt, 1993; Kite and Whitley, 1996), although negative attitudes are not limited to men or people who fit this description. One study found similar correlates for negative attitudes about bisexual people (Eliason, 1998), but there has been no published empirical research on attitudes toward transgendered people. There are reasons to believe that negative attitudes about transgendered people stem from the same underlying reasons as negative attitudes about LGB people, and are primarily related to perceived deviation from societal gender roles and/or perceived violation of traditional religious beliefs.

Even less research has examined the attitudes of treatment counselors about LGBT clients. Hellman et al. (1989) found that more than 80% of counselors in their study in New York City had a college degree, but 71% reported little or no training about lesbian and gay issues. About 44% believed that lesbian and gay clients had the same treatment outcomes as heterosexual clients, but 38% believed that lesbian and gay clients had more difficulty achieving sobriety than heterosexual clients.

Israelstam (1988) surveyed 85 treatment counselors in Ontario and found that most respondents (68%) viewed homosexuality as a learned behavior, and about one-third viewed it as a behavioral disorder. The counselors in this study believed that gay men and lesbians were much more likely to be ''heavy drinkers'' and ''recreational drug users'' than their heterosexual counterparts. Nearly 30% said that they would be uncomfortable working with gay or lesbian clients. The majority agreed that sexual orientation should be taken into account in the treatment of lesbians and gay men, and 44% believed that different treatment methods were needed. The majority believed that treatment should help clients to become comfortable with their sexual orientation (85%), rather than try to cure them of it (only 9% believed this would be valuable). More than one-third of respondents believed that lesbian and gay clients would be more difficult to treat than heterosexuals. The meaning of ''difficult'' was not assessed.

In a study of treatment counselors in Iowa, Eliason (2000) found that counselors as a whole had very little formal education related to LGBT

clients and nearly half held negative or ambivalent attitudes about these clients. The greatest amount of negativity was associated with transgendered (56% of respondents had negative or ambivalent attitudes) and bisexual (47% reported negative or ambivalent attitudes) clients. About one-third of the counselors surveyed reported negative attitudes about gay men (36%) and lesbians (32%). The majority of counselors lacked knowledge about domestic partnership and legal and family issues of importance to LGBT clients. Although most lacked knowledge about internalized homophobia, a substantial proportion believed that LGBT people encounter prejudice and discrimination in treatment settings, have difficulty "fitting in," and are not as honest and open as needed to benefit from treatment. Although findings are interesting, the study is limited by its narrow geographic focus. This is especially important given a common assumption that attitudes toward LGBT people may be more negative in rural than in urban areas.

This current study explores differences in urban and rural treatment counselors' knowledge and attitudes regarding lesbian, gay, bisexual, and transgendered clients. Our hypothesis was that urban counselors would report greater education and awareness of LGBT issues and have more positive attitudes than would rural counselors.

METHOD

Sample

After approval by the institution's human subjects review board in March 2000, questionnaires were mailed to the directors of all community- and hospital-based treatment agencies in Iowa. This includes all the agencies with block grant funding for alcohol and drug user treatment. Then, packets of surveys were sent to a randomly selected sample of 20 treatment agencies in metropolitan Chicago. Because no information about the number of staff per agency was available, 20 questionnaires with stamped return envelopes were sent to every address, with instructions to distribute to staff and, if there were more questionnaires than staff, to return excess questionnaires in an enclosed envelope. A cover letter to potential participants informed them of the purposes of the study, stressing that their responses would be anonymous and that returning a completed questionnaire would be considered evidence of their consent. One thousand questionnaires were mailed in Iowa: 305 were returned as excess, and 242 were returned completed for a return rate of 35%. In Chicago, 400 surveys were mailed to treatment

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agencies; 109 were returned completed and no excess forms were returned, resulting in a response rate of 27%. Because this project was intended as a pilot study and because funding for the project was limited, no follow-up correspondence or incentives were used as a means of improving response rate.

Measures

To increase consistency about the meanings of the terms, lesbian, gay, bisexual, and transgender, the first paragraph of the questionnaire included the following operational definitions:

- *Lesbian* refers to a self-identified woman who has her primary sexual and emotional connections with other women.
- *Gay* refers to a self-identified man who has his primary sexual and emotional connections with other men.
- *Bisexual* refers to self-identified women or men who have sexual and emotional connections with women and men.
- *Transgender* refers to women or men who do not fit into societal gender roles/expectations and include, but not limited to, transsexuals, transvestites, and cross-dressers. Transgendered people may be heterosexual, lesbian, gay, or bisexual in their sexual orientation.

The questionnaire was organized into three sections: (1) attitudes about LGBT people; (2) experience, knowledge, and familiarity with LGBT people and related issues; and (3) demographic variables. Prior to final revisions, five treatment counselors reviewed the questionnaire for content relevance and clarity.

Attitudes

We adapted Herek's (1994) widely used instrument, Attitudes Toward Lesbians and Gays (ATLG), for the study. The short version of this scale includes five questions on attitudes toward lesbians and five on attitudes toward gay men. This 10-item scale has adequate psychometric qualities, including an alpha coefficient of 0.87. The short version is highly correlated with the longer 20-item scale (attitudes toward lesbians, alpha = 0.95; attitudes toward gay men, alpha = 0.96) (Herek, 1994). In the earlier study of Iowa counselors (Eliason, 2000), five parallel items were added to assess attitudes toward bisexual and

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transgender women and men, respectively. Thus, the final scale consisted of 20 questions—five on each of the four groups. Question responses were on a 9-point scale ranging from one (strongly disagree) to nine (strongly agree). Subscales were formed by summing the scores on the five items for each of the four groups. Coefficient alphas were calculated for the total scale (0.94), as well as for each separate subscale (lesbian = 0.78; gay male = 0.84; bisexual = 0.75; and transgender = 0.81).

Experience, Knowledge, and Familiarity

The survey instrument also included questions about counselors' levels of comfort and familiarity with each of the four groups, number of LGBT clients in the past year, and knowledge of common issues for LGBT people. Issues believed to influence substance use treatment for LGBT people (e.g., homophobia, internalized homophobia, heterosexism, coming out, relationships, family and legal issues, hate crimes, domestic partnership) were based on theoretical and empirical literature. Additional questions asked about number of hours of training or formal education focusing on (1) issues relevant to lesbians, gay men, and bisexual women and men; and (2) issues relevant to transgender women and men. Finally, respondents were asked how many of their friends, acquaintances, or relatives were LGB, and how many friends, acquaintances, or relatives were transgendered.

Demographic Variables

The final section of the survey questionnaire collected demographic information, including age, sex/gender, sexual orientation, childhood and current residence (rural area, small town, small city, large urban area), race, level of education, number of years experience as a treatment counselor, religious affiliation, and job and career satisfaction. Academic discipline of the counselors was not assessed.

The last question on the survey assessed the respondents' perceptions about whether LGBT people benefited more, less, or the same from drug and alcohol treatment than heterosexual people.

Data Analysis

Descriptive analyses of the categorical data were conducted to identify prevalence of negative attitudes and degree of knowledge and

experience in each sample. Inferential statistics were used to compare attitudes and knowledge about LGBT people by geographic region, and to determine the correlates of negative attitudes. T-tests were used to compare Chicago and Iowa providers on continuous variables and nonparametric methods (chi squares) were used to assess differences in categorical variables. Stepwise multiple regression was used to assess the influence of demographic variables on attitudes toward LGBT people.

RESULTS

Table 1 summarizes demographic/personal characteristics for the Iowa and Chicago counselors. The two samples were similar on most of the demographic variables, such as age, sex, and sexual orientation. However, the Chicago counselors were more racially diverse: 53% were white compared with 96% of the Iowa sample. The Iowa counselors had slightly more formal education, but the groups had the same number of years as a treatment counselor and were equally satisfied with their jobs and careers. Not surprisingly, more of the Iowa counselors had grown up in rural areas or small towns (52%), compared with the Chicago counselors, of whom one-third grew up in a large urban area. More

Table 1. Selected demographic/personal characteristics of respondents by geographic region.

Characteristic	Chicago providers	Iowa providers
Mean age	41.3	40.9
% Female	60	62
% LGBT	6	6
% White[a]	53	96
Mean years worked as a treatment counselor	7.0	7.2
% With grad school or grad degree	40	46
Mean number of LGBT clients in past year (total)[a]	13.3	5.9
Mean number of LGBT friends, relatives, acquaintances[a]	2.1	0.9
% Who said they were uncomfortable working with LGBT clients	9	10

[a]$p < 0.01$.

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Chicago (17%) than Iowa (10%) counselors agreed that LGBT clients were less likely to benefit from treatment than their heterosexual counterparts ($p = 0.01$).

Experience/Knowledge/Familiarity

Chicago providers reported significantly more education about LGBT issues, both in terms of formal training and continuing education, than did Iowa providers (see Table 2). Chicago providers also reported having worked with more LGBT clients and having more LGBT friends or acquaintances. For example, Chicago providers had worked with an average of more than three lesbians in the past year, compared with two for Iowa providers). In addition, Chicago providers reported more experience with gay men (6.6 compared with 2.0), bisexual women and men (2.7 compared with 1.6), and transgender women and men (0.66 compared with 0.25). Each of these differences was significant at the 0.001 level.

There were no differences between Chicago and Iowa providers on familiarity with lesbians, gay men, bisexual women and men, or transgender people, and no differences in their levels of comfort in working with LGBT clients. The groups were similar in their familiarity with specific issues, such as the coming out process, homophobia, internalized homophobia, family issues, "substance abuse" prevalence, and legal issues. The majority of both groups reported little or no familiarity with legal issues (73% of Iowa providers and 71% of Chicago providers were unfamiliar), family issues (55% of Iowa providers and 56% of Chicago providers were unfamiliar), and domestic partnership

Table 2. Mean hours of training on LGBT issues for Chicago and Iowa substance user treatment counselors.

Group	Chicago mean (SD)	Iowa mean (SD)	*t*	*p*
Formal training				
LGB	11.5 (32.1)	4.6 (12.0)	−2.8 (df = 319)	0.005
Transgender	2.4 (6.4)	1.0 (5.4)	−2.0 (df = 318)	0.05
Continuing education				
LGB	9.1 (18.9)	4.2 (10.1)	−3.0 (df = 331)	0.003
Transgender	3.2 (10.2)	0.47 (1.4)	−4.1 (df = 332)	0.000

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(70% of both). Substantial proportions of both groups lacked knowledge of internalized homophobia (49% of Iowa providers and 47% of Chicago providers) and the "coming out process" (36% of Iowa providers and 38% of Chicago providers). More than one-fourth of the counselors did not think that they knew the prevalence of "substance abuse" in the LGBT community (29% of Iowa providers and 26% of Chicago providers).

Attitudes

No statistical differences were found between the Chicago and Iowa providers on any of the individual item scores. Means and standard deviations of scores for the 20 attitude questions are summarized in Table 3. In addition, the percent of respondents reporting negative attitudes are listed in the second column of Table 3.

Subscale scores were obtained by summing the five items on each scale. Scores ranged from 5 to 45 for each subscale, with higher scores indicating more negative attitudes. Although not statistically significant, the Chicago providers had slightly higher scores on all the subscales. Attitudes about bisexual and transgender people were more negative than attitudes about lesbians and gay men among both groups of counselors (see Fig. 1).

Correlates of Negative Attitudes

Regression analyses were first run separately for the Chicago and Iowa providers. However, because there were no differences between urban and rural providers on any of the predictor variables, the data were combined in subsequent analyses. The dependent variable was a composite score of attitudes toward LGBT people as a group (all 20 items), and the predictor variables included demographic variables (age, gender, sexual orientation, race, religion, geographic region when growing up, and education), the number of hours of training on LGBT issues, and the level of comfort and familiarity with LGBT people. Five variables contributed significantly to the composite attitude scale. Respondents who had negative attitudes about LGBT people were more likely to report that they were uncomfortable with LGBT people ($p < 0.001$). They were also more likely to be heterosexual ($p = 0.05$), belong to a fundamentalist or conservative religion ($p < 0.001$), have less formal education ($p = 0.002$) and have fewer hours of continuing education on LGBT issues ($p = 0.03$).

Table 3. Individual item scores: Means, standard deviations, and percentage of participants with a clearly negative response on each item.

Item	Mean (SD)	% Negative
Lesbians just cannot fit into our society.	2.0 (1.8)	6
State laws regulating private, consenting lesbian behavior should be loosened [R].	6.6 (2.5)	15
Female homosexuality is a sin.	2.8 (2.8)	16
Female homosexuality in itself is not a problem, what society makes of it can be a problem [R].	7.2 (2.4)	15
Lesbians are sick.	1.8 (1.8)	5
I think male homosexuals are disgusting.	2.0 (1.9)	7
Male homosexuality is a perversion.	2.3 (2.3)	8
Just as in other species, male homosexuality is a natural expression of sexuality in men [R].	5.2 (2.9)	45
Homosexual behavior between two men is just plain wrong.	2.9 (2.7)	15
Male homosexuality is merely a different kind of lifestyle that should not be condemned [R].	6.5 (2.9)	40
Bisexuals are sick.	2.3 (2.2)	9
All people are probably born bisexual [R].	5.8 (2.5)	21
There is no place in the moral fabric of society for bisexuality.	2.8 (2.4)	11
Bisexuality is merely one of many normal variants of human sexuality [R].	6.2 (2.8)	45
There should be stricter laws regulating bisexual behavior.	2.4 (1.9)	5
Transgender people are sick.	2.8 (2.4)	12
Laws that regulate people's expressions of gender should be removed [R].	6.4 (2.7)	44
God made man and woman, anything else is abnormal.	3.1 (2.7)	16
Having only two sexes is limiting: transgender people are an expression of the continuum of gender [R].	5.1 (2.5)	42
It is necessary to have clear distinctions between women and men.	4.3 (2.7)	33

DISCUSSION

There were a few clear differences between urban and rural alcohol and drug user treatment providers in this study. The urban sample had more education about LGBT issues, both formal and continuing

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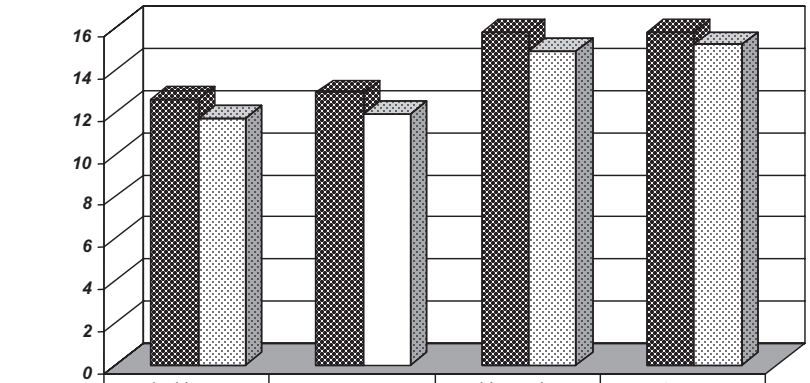

	lesbians	gay men	bisexuals	trans
Chicago	12.6	12.9	15.8	15.8
Iowa	11.7	11.9	14.9	15.2

Figure 1. Attitudes about LGBT people in Chicago and Iowa substance abuse providers. Mean subscale scores. Higher scores indicate more negative attitudes.

education. Urban counselors had worked with more LGBT clients during the past year, and they had more LGBT friends, relatives, and acquaintances. Contrary to previous research suggesting that education about, and exposure to, LGBT people are associated with more positive attitudes (e.g., Duncan, 1988; Wells, 1989), Chicago and Iowa counselors did not differ in their attitudes toward LGBT people. These findings also suggest that education alone is insufficient to change attitudes. Because prejudices such as homophobia are often deeply rooted and resistant to change, multiple long-term strategies are needed.

The finding that attitudes toward bisexual and transgender people were even more negative than attitudes about lesbians and gay men likely reflects society's ambivalence about sexuality and gender, as well as a dearth of valid information about these groups. Transgender clients, in particular, face enormous stigma in society in general and from health care providers (Ettner, 1999; Lombardi and van Servellen, 2000). In the United States and in many other societies, negative images of LGBT people are continually perpetuated in legal institutions, medical discourses, religion, and the media. There is little systematic effort in the drug and alcohol user treatment field to counteract these societal forces. Only recently have U.S. agencies, such as the Center for Substance Abuse Treatment, included sexual orientation and gender identity as forms of cultural diversity.

Human service providers, including drug and alcohol user treatment counselors, are most often trained in the "equal treatment" model of

care (Eliason, 1996). This model, consistent with the 12-step approach, proposes that all substance users, regardless of social or demographic differences, have the disease of addiction, and thus share common characteristics. Although there is some validity to this assumption—individuals addicted to various substances share common experiences, consequences, and cognitive patterns—this model minimizes group and individual differences. Different individuals initiate substance use for different reasons, continue and/or stop using for different reasons, recover in different ways (with or without professional help), have different attitudes about treatment, and are differentially influenced by different "triggers" for relapse. Being a "substance abuser" does not override the social inequalities created by racism, sexism, classism, and heterosexism. The value of more individualized treatment approaches has been touted in the literature, but training has lagged behind this philosophy (CSAT, 1999, 2001). Ideally, all clients should be carefully assessed and matched to appropriate treatment providers and treatment modalities.

In addition to on-going education for staff members regarding issues of importance to LGBT clients, treatment agencies need clear policies and procedures that protect LGBT clients (and staff) from potential treatment and service harm, such as nondiscrimination policies that include sexual orientation and gender identity. Like counselors who sexually harass clients or behave in a racist manner, those who harass or discriminate against LGBT clients should also be sanctioned. Performance evaluations should document unacceptable behavior and propose remedies. Staff must feel safe to explore issues of gender and sexual orientation in their practice without raising questions about their own sexuality, politics, or "morals." Moralizing viewpoints must be reexamined in the context of basic human rights. Until cultural competency becomes a core value in the alcohol and drug user treatment field, counselors are not likely to be committed to examining their own beliefs and learning about cultural differences. In addition, clients, regardless of their sexual orientation or gender identity, would benefit also from more open discussion of the role of gender, sexual identity, and other characteristics on life functioning and adaptation as well as on substance use, addiction, and recovery.

Limitations of the Study

Several limitations in the study limit generalizability of the findings. First, the response rate, although fairly typical for a mail survey, was quite low. Second, because we used a convenience (volunteer)

sample, findings may be biased. Determining the direction of potential bias is difficult. On the one hand, counselors who had more negative attitudes might have been more likely to complete the survey to express their displeasure with the topic. On the other hand, those with more positive attitudes might have been similarly motivated to complete the survey to prove their open-mindedness. Nevertheless, given that the demographic characteristics of the sample are similar to drug and alcohol user treatment counselors in the U.S. Midwest in terms of age, sex, and education, we are confident that the sample is fairly representative.

The alcohol and drug user treatment field has a considerable way to go to achieve cultural competency. This study suggests that rural and urban counselors are more alike than different in their attitudes toward and knowledge of LGBT clients. More important, neither rural nor urban counselors currently have the knowledge or skills to provide culturally competent care to LGBT clients. All treatment counselors and treatment agencies could benefit from examining their policies, instituting training, encouraging open dialogue, and considering methods to assess their outcomes with sexual and gender minority clients. Given large variations in cultural attitudes about sexuality and gender, there is also a great need for research focusing on cross-cultural comparisons of attitudes.

Research is likely to be spurred by the recent Healthy People 2010 (USDHHS, 1992) designation of lesbians, gay men, and bisexual women and men as one of six population groups among which health disparities exist. In addition, two major documents have been published that point out the serious gaps in knowledge about the health of LGBT people and provide guidelines for improvement of healthcare. These include a report form the Institute of Medicine, Lesbian health: Current assessment and directions for the future (Solarz, 1999), and A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender people (Center for Substance Abuse Treatment, 2001). Efforts such as these should help to stimulate changes in policies and treatment that will benefit LGBT people.

GLOSSARY

Homophobia: Negative attitudes about lesbians and gay men.

Heterosexism: A belief upheld by most societal institutions that only heterosexual relationships are normal or natural.

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Sexual identity: The ways that individuals think about their own sexual attractions and behaviors, usually defined in terms of heterosexual, gay, lesbian, or bisexual.

Gender identity: The ways that individuals think of their sex/gender and how they fit into societal expectations for one of their physical body.

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RESUMEN

Las actitudes de los consejeros de tratamiento (treatment counselors) acerca de sus clientes lesbianas, bisexuales, homosexuales, y transexuales. . .(lesbian, gay, bisexual, and transgendered) (LGBT) tienen un significativo efecto en la recuperación de sus clientes, y esto necesita mas estudio. Hay una percepción común, pero aun no probada, que la gente LGBT es mas aceptada en áreas urbanas (y por lo tanto, en tratamientos de programas urbanos) y que estos consejeros urbanos tienen un mayor conocimiento de las necesidades de la comunidad LGBT. Este estudio examina las actitudes y el conocimiento de los consejeros de tratamiento desde dos regiones geográficas: el Chicago urbano ($n = 109$) y el Iowa rural ($n = 242$ en 2000. El instrumento evalúa características demográficas, conocimientos y experiencias trabajando con los clientes LGBT, y las actitudes acerca de estos clientes LGBT (una adaptación de las actitudes de Herek acerca de lesbianas y homosexuales en escala). Solo algunas diferencias demográficas entre los consejeros urbanos y rurales fueron identificadas: los consejeros de Chicago son racialmente mas diversos y con mas probabilidades de haber crecido en una área urbana, a diferencia de los consejeros de Iowa. Los consejeros de Iowa tienen ligeramente mas alto nivel de educación. Aunque los proveedores reportaron tener considerablemente mas contacto con los clientes LGBT, así como una mayor educación formal, continua y especifica acerca de la gente LGBT, ellos no tenían una actitud mas positiva, ni aun

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así algún reporte de tener mas conocimientos específicos acerca de problemas LGBT que ayudan al tratamiento de drogas y alcohol. En si, los consejeros en ambas regiones reportaron muy poca educación formal de las necesidades de los clientes LGBT, casi la mitad de estos tenían actitudes negativas o ambivalentes. Los consejeros carecían frecuentemente del conocimiento legal acerca de problemas como, la pareja domestica (domestic partnership) y el poder de un abogado, los conceptos de pareja domestica y la homophobia internalizada, problemas relacionados con el origen de la familia y la familia actual.

RÉSUMÉ

Les attitudes qu'ont les conseillers de traitement dans le suivi de traitement de leurs clients homosexuels, bisexuels et transsexuels (LGBT) peuvent avoir des effets significatifs sur la guérison de leurs clients et ainsi justifient plus de recherche. Il existe une perception courante mais qui reste encore à démontrer que les personnes LGBT sont plus acceptées dans les régions urbaines (et donc dans des programmes de traitement urbains) et que les conseillers travaillant en ville ont une meilleure connaissance des besoins de la communauté LGBT. Cette étude examine les attitudes et les connaissances des conseillers de traitement de deux régions géographiques: la zone urbaine de Chicago ($n = 109$) et la partie rurale de l'Iowa ($n = 242$) en 2002. L'instrument évalue les données démographiques, les connaissances et l'expérience des conseillers travaillant avec les clients LGBT et les attitudes envers ces clients (une adaptation de l'échelle de notation établie par Herek portant sur les relations conseillers/patients homosexuels). Seulement quelques différences entre les conseillers des zones urbaines et rurales ont pu être identifiées: il y avait plus de diversité raciale chez les conseillers venant de Chicago et ceux-ci avaient une plus grande tendance à avoir grandi dans une zone urbaine que leurs confrères de l'Iowa. De manière générale, ces derniers ont un niveau d'études légèrement supérieur. Les thérapistes font part du fait qu'ils ont eu beaucoup plus de relations avec des clients LGBT, aussi bien qu'une formation continue plus spécifiquement adaptée aux personnes LGBT. Cependant, ils n'avaient pas des attitudes plus positives et ils n'exposaient pas plus de connaissance sur des questions spécifiques LGBT qui pouvaient avoir un impact sur le traitement médical de l'alcool et des drogues. En général, les conseillers des deux régions n'ont

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pas suivi une formation spécifiquement adaptée aux besoins des clients LGBT, et presque la moitié d'entre eux fait preuve d'une attitude négative ou ambivalente en ce qui concerne le traitement des clients LGBT. Ils ne possèdent pas la connaissance nécessaire dans le domaine juridique, par exemple le concubinage des couples homosexuels et la procuration, des concepts du concubinage homosexuel et de l'homophobie réprimée, et les questions portant sur le fonctionnement de la famille d'origine et la famille actuelle.

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