Attitudes of Upper-Level Undergraduate Students Concerning Refusal of Care to Sexual Minorities Seeking Psychological Treatment

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Above all, to my mother, Randi Baker and my baby sister, Jill who both look down on me from heaven. Mom, your unending support and love for me, belief in me, and trust that I would make you proud pushed me through everything. You taught me empathy, to write, and how be a mom. The energy to fight and survive I got from you, Jill. In my journey writing this work, through you I found myself again; vanished when I lost you both. I love and know you both watch over me every minute. All my triumphs are dedicated to your memories.

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ABSTRACT

The purpose of this work was to examine religious beliefs that contradict professional ethics involving sexual minorities. A survey was created, including three scenarios where care is denied due to sexual orientation or lack of religion. Respondents evaluated their tolerance of refusal, and reality occurrences. Non-binary responses and demographics, including sexual orientation, were obtained. Three hypotheses were tested: There would be a positive correlation between agreement to refusal in treating LGBT[1]* individuals and Christian ideas; Christian respondents having limited knowledge of sexual minority stress occurrences; and utilization of Christianity as justification for discrimination. Results found some significance of religiosity impacting pre-professionals tolerating discrimination, especially with transgenderism. Also, there was prevalence of ethically constructive abilities to separate religion from profession. The most significant religious implications found involved transgender people, and hopefully a development for future research.

[1] LGBT* refers to the umbrella of several sexual and gender minorities; including lesbian, gay, bisexual, and transsexual persons

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CHAPTER 1

INTRODUCTION

Literature Review

Awareness of minority stress, particularly within the sexual minority population, led Ilan Meyer (2003) to introduce the term Minority Stress Model. This revision of other Minority Stress models was developed to encapsulate the need for understanding of mental health and addiction treatment needs for those within the lesbian, bisexual, gay, transsexual (LGBT*) population. The LGBT* acronym has grown to stand for over ten different sexual orientations. Meyer and other researchers like Cochran (2014), Hatzenbeuler (2009), Heck (2015), and McCabe (2014) have noted the paucity of mental health services for LGBT* persons seeking help with life stresses. Court cases (*Goodridge v. Department of Health, 2003; Lawrence v. Texas, 2003; Romer v. Evens, 1996; United States v. Windsor, 2013*) have highlighted issues related to this minority and their rights. As some practitioners have requested not to have to provide services to this population, professional associations including the American Psychological Association (APA) and the American Counseling Association (ACA) have stated that such refusals would be in violation of the ethical guidelines of the professions.

Church Doctrine with Respect to Sexual Minorities

An important factor impacting LGBT* discrimination is the constitutional right to freedom of religious beliefs granted to citizens of the United States. In many fundamentalist churches, beliefs and teachings that same-sex relationships are sins result in repeated exposure to this mindset. Many who oppose the LGBT* person's rights as an American citizen have been

found to hold the belief that their Bible condemns those not living a conventional heterosexual lifestyle.

Roman Catholics, by referring to particular biblical verses and doctrinaire interpretations of those verses, declare in their Catechism Doctrine that "homosexual acts are intrinsically disordered. They are contrary to the natural law. They close the sexual act to the gift of life. They do not proceed from a genuine effective and sexual complementarily. Under no circumstances can they be approved. The number of men and women who have deep-seated homosexual tendencies is not negligible. This inclination, which is objectively disordered, constitutes for most of them a trial" (Catechism of the Catholic Church, 1994, part 3, section 3, ch.2, article 6, subheadings 2331-2391). This doctrine continues with a brief and protective, yet contradictory statement.

"They must be accepted with respect, compassion, and sensitivity. Every sign of unjust discrimination in their regard should be avoided" (Catechism of the Catholic Church, 1994, part 3, section 3, ch.2, article 6, subheadings 2331-2391). This brevity of respect and sensitivity halts and the initial expressions of firm disapproval resume. While there is arguably the conscious effort to state discrimination should be avoided, the overall impact of this doctrine simply makes avoidance of discrimination difficult, let alone sensitivity or respect. Catechism is a vital, required rite of passage and tutelage for Catholics, only earned after months of indoctrination with Bible verses construed to support Catholic doctrines. These rules, Bible verses and dogma are continuously reexamined as Catholics progress in age.

"These persons are called to fulfill God's will in their lives and, if they are Christians, to unite to the sacrifice of the Lord's Cross the difficulties they must encounter from their

condition" (Catechism of the Catholic Church, 1994, part 3, section 3, ch.2, article 6, subheadings 2331-2391). Here, the message seems to attribute non-hetero-sexuality to a condition, relatable in concept to a disorder or other wrongness within. The doctrine ends by proclaiming its diagnoses for this condition. "Homosexual persons are called to chastity by the virtues of self-mastery that teach them inner freedom, at times by the support of disinterested friendship, by prayer and sacramental grace, they could and should gradually and resolutely approach Christian perfection" (Catechism of the Catholic Church in 1994, part 3, section 3, ch.2, article 6, subheadings 2331-2391).

The South is most dominated by the Southern Baptist division of Christianity. Southern Baptists have their own doctrine which mandates their views concerning acceptance of LGBT* people. From Position Statements, the Executive Committee of the Southern Baptist Church declares, "We affirm God's plan for marriage and sexual intimacy- one man, and one woman, for life. Homosexuality is not a "valid alternative lifestyle." They hold that the Bible condemns it as sin. It is not, however, unforgivable sin. The same redemption available to all sinners is available to homosexuals. "They may become new creations in Christ."(Executive Committee of Southern Baptists Convention, 1999-2001). Referring to homosexuality as being "not a valid alternative lifestyle" provides a clear position for members of this religious group. Using these two examples of arguably the largest and most influential of the multitude of Christian churches suggests that religion can have a powerful impact on treatment of the LGBT* community.

The Church's adamant opposition to the LGBT* population uses interpretations of the Bible and God to support this opposition. Church position is that an LGBT* individual can only be accepted by staying in the closet and must go through attempts to reprogram their unnatural urges. Introduced near the end of The Catechism Doctrine is the church-sanctioned option for

the LGBT* individual of working toward some form of teaching and sacrifices that "can and should gradually and resolutely" change their (LGBT* person's) sexual orientation (United States Catholic Conference, Inc., 1994).

Recent Cases and Examples

Fallon Fox, a transgender athlete, and LBGT activist writes about the suicide of 17 year-old Leelah Alcorn and her suicide note in a post on the online journal, *Alternet*. Fallon discloses that when Leelah came out to her mother as transgender, her mother reacted "…extremely negatively, telling me that it was a phase, that I would never be a girl, and that God doesn't make mistakes." Leelah wrote that she had been taken to Christian therapists who reinforced the concept that being transgender was 'wrong' (Fallon, 2015). Following Leelah's death, her parents were interviewed on CNN and according to Fallon (2015) stated they "just wanted to do what was best for their child." In violation of what Fallon claims as the conducive way of addressing a transgender person, both Leelah's parents consistently used the name *Josh* to refer to Leelah. Fallon further discussed Leelah's mother by stating that Mrs. Alcorn "took *Josh* to a psychiatrist who prescribed medication and her child only talked once about being transgender" (Mrs. Alcon as cited by Fallon, 2015).

Gender dysphoria is the condition of suffering from having a body that does not fit one's mind. Fallon writes that in addition to this internal stress, "we (transsexuals) deal with our rejection from society, with those that slam us for having this mental health condition is the first place, and those who don't believe it is a real thing" (Fallon, 2015). From the position of a transsexual professional, Fallon alerts the reader that "telling a person with gender dysphoria that

it is wrong is one of the worst things a transgender person can hear, and it deepens the depression transgender people already seek help from" (Fallon, 2015).

Conversion therapy is form of intervention, the goal of which is to change homosexuals to heterosexuals, and to convince transgender people to identify with the sex and gender they are born as. Fallon (2015) experienced this therapy as an adult, so was able to refuse the treatment once the damage began to build. Even though Fallon was able to leave, unlike juveniles forced to attend, the personal evaluation Fallon (2015) gave was, "I cannot express how harmful it was to my psyche, and I became suicidal when I went through it."

There are many religiously-based programs that are dedicated to changing the sexual orientations of those who complete their interventions to become practicing heterosexuals. One such "camp" was created by Rick Wyler to "rid men of sexual attraction to other men" (Shulleeta, 2010). Wyler (2010) posits that those who argue that sexual identity altering is highly damaging "are ignoring the sexual reorientations for political reasons". Within Wyler's camps, "the Bible is used in conjunction with legitimate counseling professionals and talk-therapy tactics to remove non-heterosexual thoughts from a person in the name of God and His rule" (Journey Into Manhood Mission Statement (*JiM*), 2014).

Many who have explored this topic maintain there is little proof that any form of gay-to-straight therapy is valuable or sound. In fact, scholars suggest that these types of camps and therapeutic programs can and do inflict deep psychological wounds. As cited in *The Daily Progress*, author Shulleeta (2010) referred to the 2009 American Psychiatric Association (APA) report that concluded, "Efforts to change sexual orientation are unlikely to be successful and involve risk." Slulleeta (2010) interviewed Dr. Jack Drescher of the American Psychiatric

Association, who warned that attempting to change a person's sexual orientation could be very dangerous, charging in reference to Christian-based conversion camps, that "the religious right is mostly responsible for the notion that sexual orientation can be changed." Shulleeta (2010) explains Drescher's position concerning politics as being that religious and social conservatives do argue the position that sexuality is not essential to someone's being; which does have political consequences. However, Drescher's position according to Shulleeta (2010), continues by saying that it is these same conservatives who use this type of logic as a platform affirming that non-heterosexuals should not have the same civil rights or protections as other minorities within society. According to Wayne Benson (2010), an author for *TWO; Truth Wins Out*, Shulleeta (2010) used sloppy journalism (2010) and this portion of Shulleeta's article was inserted for balance. In Benson's response article to Shulleeta's (2010) piece about Wyler's camps, Benson (2010) points out that the only valid portion of the article published was the points APA's Dr. Drescher made. Benson (2010) made substantially backed claims that the main component of Shulleeta's article portraying Wyler as being worthy of praise was directly do to pay-offs. According to Benson (2010), Arthur Abba Goldberg, the formerly jailed con artist, is the brains behind Wyler's *People Can Change*, *JONAH*, and *Journey Into Manhood*. Benson (2010) openly and attackingly demands in his rebuttal to Shulleeta, "Do you not understand that these profit-making groups are an industry that has a stake in peddling fake statistics and inflated numbers?" The portion of Sulleeta's article that discussed the responses of those who attended Wyler's camps were statistics directly drafted by the organizations that Wyler runs. Benson (2010) deemed this large portion of Shulleeta's article as statistics derived from a group who is "ex-gay for pay", lending credibility to such conversion camps only through those on the camps payroll (Benson 2010). In response to what Drescher had contributed as a member of the APA

to Shulleeta's (2010) article, Wyler, in turn, charged the APA as being "pro-gay". Due to the vibrant anti-gay implications of Wyler's camps, approaches and opinions, Wyler has kept his corporation, *Journey into Manhood* out of the public eye. LGBT advocacy groups and other non-profit organizations dedicated to human rights continue to argue back and forth. Still, Wyler's and many other camps, their founders, and philosophies are found easily online and in the news for anyone seeking it.

In what is known in America as The Bible Belt, Tennessee provides a prime location in which to view the impact of fundamentalist religion on attitudes toward LGBT* people. When attempting to find mental or medical health care services, the Tennessean LGBT* person may find that although professional ethics regulations prohibit overt discrimination, varying degrees of prejudice and discrimination remain. According to the interpretation of the APA's survey of psychology graduate students, "Many psychologists and students of psychology currently receive little or no exposure to transgender issues in their education and training" (APA, 2009a, p. 62) Nicholas Heck referred to this survey in his work and displayed the results that in this APA survey the Task Force found (2015, p. 30). According to this report a third of the respondents indicated having any work experience with transgender clients, colleagues, or students. In addition, only a quarter of those surveyed thought they were "sufficiently familiar" with issues transgender individuals encounter (APA, 2009a, p. 63). Since religion has positioned itself as a vital authority in the condemning of LGBT* individuals, it is pertinent to systematically investigate how such views relate to the provision of health-care services to LGBT* populations. It is important to determine whether adult pre-professionals entering into the helping professions are able to effectively set aside their religious views and contain them in their private lives while following the ethical standards of their profession which have developed to provide appropriate

helpful services to all persons, regardless of sexual minority status. Keeping Heck's review of the APA Task Force Report in mind, it is clear that there is a great concern that practicing and pre-professional psychologists many not be trained to be competent or comfortable in working with transgender clients. This clearly attests to the need for universities and training to provide developing clinicians with the knowledge needed to in turn provide effective and stigma-free care for this and other sexual minority populations.

Meyer's Minority Stress Model

Psychiatry as a profession has a history of stigmatizing sexual minorities. The Diagnostic Manual of Psychiatric Disorders- Second Edition, (DSM-II, 1968) included any LGBT* population as being mentally ill. While that classification was reversed in 1973 with the Third Edition of the DSM, many helping professionals, historians, and advocates believe that inclusion of the LGBT* population in the earlier edition provided a sanctioned stigmatization of this population. Among this group was Ilan Meyer, who as a doctoral student who wrote his 1993 dissertation on Minority Stress and Mental Health, then developed a model of sexual minority stress (Meyer, 1995). This model is based on the premise that LGBT* persons are stigmatized by a majority heterosexist society, and thereby subjected to chronic stress from expectations and experiences of rejection, discrimination, and various forms of violence. Thus, persons belonging to a group that experience high degrees of discrimination and prejudice are stressed by their surroundings rather than manifesting a diagnosable mental disorder (Meyer, 2003).

Meyer emphasizes that development of the Minority Stress Model was an accumulation contributions made by many researchers, including the work of Durkheim regarding

normlessness and suicide. According to Meyer, (2003) Durkheim wrote that social needs not met due to feelings of being abnormal, having a lack of control over social perceptions, and overall alienations can lead a person to suicide. Meyer was familiar with instances of suicide by LGBT* persons, and cited the suicide of 20-year-old Bobby Griffith as the opening to his dissertation in 1993. Meyer stated at 16, Bobby Griffith had written in his diary, "I can't let anyone find out that I'm not straight. It would be humiliating. My friends would hate me, I just know it. They might even want to beat me up…I guess I'm no good to anyone… not even God. Life is so cruel…" (Meyer, 1995, p. 38). Meyer's summation of Booby Griffith's words led to his conclusion that the true cause of this boy's suicide was due to a homophobic social environment, that had built up to a severity Bobby could no longer tolerate (Meyer, 1995).

Meyer suggests that, like members of other minorities that have been stigmatized by the majority culture, LGBT* individuals are subjected to chronic stress. Meyer felt that use of a distal-proximal continuum of stresses would best reflect the complexity of minority stress. Meyer (2003) defined the distal distinction as stressors that are independent of the individual's perceptions, despite these perceptions are dependent upon the individual's perceptions and ascribed characterizations. One side of a continuum, this dimension relies on the conceptualization of stress. In Meyer's association and interpretation of this dimensional concept to sexual minority stress, the importance lies in its relevant application to these individuals and their perceptions of external conditions that society poses upon them. This concept affects sexual minorities by a social structure and that structure's effect on how the individual manifests distal stress into their thoughts, feelings, and actions. It is by external stressors that prejudice, discrimination, and stigma are introduced, causing a direct effect on the opposite side of this continuum. Distal stressors present continuous and acute objective stressful

events and social conditions to sexual minorities. These distal stressors also cause an expectation within the individual's perception and thought that these events will continuously be present. This thought process then leads to concealment of sexual minority statuses, and the internalizing of the externally originating negative societal attitudes. An example of this approach explains how a woman may have a romantic relationship with another woman and not consider herself a lesbian, while others all around her label her as such. These external societal labels, and the stigmas related to them, can cause suffering from the stressors associated with the LGBT* population.

Meyer's conceptualization of the Minority Stress Model also incorporated the work of Dohrenwood (1998b, 2000) that spoke to the important and basic elements of stress, i.e., advantages and disadvantages within one's environment, individual dispositions, genetic factors, continual events, self-evaluation and coping skills are integral parts of the stress model and essential for a comprehensive understanding of the stress process (Meyer, 2003). Meyer argued that notions of non-heterosexual people being predetermined by their sexuality to be at higher risk for mental health disorders is a falsehood that has misled researchers within a discriminatory environment and stress explains a higher prevalence of mental stress and disorders within the LGBT* population.

This Minority Stress Model is discussed in finer detail due to the fact that in the LGBT* focused articles and studies discussed in this work, each researcher clearly states his or her foundation as Meyer's Minority Stress Model. These additional studies and theories cover the topics of LGBT* discrimination, susceptibility to stress, need for mental health services, the lack of reliable LGBT* data due to incomplete intake processes, bases of LGBT* prejudice in religious beliefs, basic awareness of environmental stresses an LGBT* individual faces, and how

these notions fit into basic discrimination. Additionally, as the psychiatric community is bound by the pages of the recent DSM edition, there will be references made to what the DSM-5 offers with respect to working with the LGBT* community.

Meyer presents empirical data showing that minority stress is a stable and valid factor preventing the LGBT* community from obtaining, being comfortable with, and completing mental health and substance abuse interventional programs. Meyer's (2013) work, demonstrated the relationships between the variables of minority stress, stigma, prejudice, and discrimination. According to Meyer, external stress inflicted upon a person that is built of stigma, prejudice, and other environmental influences including religiosity, is in direct cause for a perceived higher prevalence of mental disorders among LGBT* individuals (Meyer, 2003). Meyer's work has been repeatedly referenced for public policy revisions and has provided the basis for subsequent research in this area.

Hatzenbuehler (2009) developed an additional view of stress within this group. This Psychological Mediation Framework looked at the increased need for mental health intervention for sexual minorities who are at risk for multiple mental health burdens. Hatzenbuehler's goal was to make a firm case that the stressors sexual minorities are exposed to are directly related to stigma within anti-LGBT* environments and perceptions. His theory included focus on stigma-induced stress, pertaining to its link to a myriad of issues within interpersonal relationships, as well as "cognitive processes conferring risk for psychopathology" (Hatzenbuehler, (2009), p. 707). Hatzenbuehler also suggests that minority stress determines a relationship between stigma-related stress and psychopathology, and showed how adversely key stigmas and prejudices are detrimental to the holistic health of the LGBT* population.

McCabe, Boyd, Bostwick, Hughes and West are researchers who have studied the effects of LGBT* minority stress as it relates to mental health. Their study examined different types of discrimination in health-related issues within LGBT* populations. This work introduces the concept of several forms of discrimination, as well as the impact of each of these on LGBT* people. McCabe and colleagues looked at self-identified sexual minorities with additional minority issues, then compared their incidences of mental disorders to the national average. The end theories posited were based on these findings. The theories demonstrated the acute complexity of this issue, as well as the need to further explore the interplay of additional minority statuses to overall minority discriminations. This double jeopardy theory takes the study of Minority Stress a step further.

As supporting evidence for multiple minority discriminations, in the online journal *Alternet*, Starr (2015) states that minority stress is doubled in severity by adding other minority statuses. For example, a white gay man is as an example of being a possible victim of sexual minority stress. However, an African-American woman who identifies as a lesbian would likely face triple minority stress susceptibility including ethnic, gender, and sexual minority statuses. According Starr's reference to the report by the National Coalition for Anti-Violence Programs (NCAVP), "in the year 2014 at least 50 % of the LGBT* homicide victims were transgender women of color" (Starr, 2015). Lending further credibility to the theories of multiple minority stressors, as well as the impact of distal and proximal stress, Starr writes about the rise of transsexual homicides. Starr interviewed Elle Hears, the creator of *GetEQUAL,* an LGBT* advocate program. Starr (2015) quotes Hears as stating that "The men responsible for these murders have internalized Transphobia so much because of the societal views reflected daily in their homes and via social media. That is causing them to discard the lives of women that they

seek out." Starr warns by concluding the post by stating that "interactions with police by the African-American public has become a great fear once again. Being black and trans is an even greater fear that we live with because we never know when death will come" (Starr, (2015), *Alternet*).

Cochran, Flentje and Bacca (2014) looked at mental and medical health intake forms as an significant example of how practitioners are losing and restricting knowledgeable understanding of the LGBT* community. In research, findings are only as stable as the data from which they are derived. Cochran and his team's work addressed practitioners' failure to use intake forms properly, collect basic data fully, or update archaic forms that cause the impossibility to conduct proper research of sexual and gender minorities. Cochran addressed the lack of attention to gender and sexual orientations in the boxes and checkmarks of patient forms. Medical intake forms today fail to include critical data when those data have to do with gender and sexual orientation issues. Standardized, archaic intake forms force the individual to place themselves in a box; symbolic reinforcement of self-concealment, the hidden self, and being "*in the closet*". The first few moments of a sexual or gender minority's time in a medical or mental health office can create feelings that drive a great deal of LGBT* minority stress. Charges are also made that rarely do intake forms within medical and mental health facilities even attempt to acquire data concerning sexual orientation which stands to reflect that sexual identity and gender identity are still not embraced as basic demographics (Cochran et al., 2014, p. 283).

Discussing the prevalence of mental illnesses and transgender medical needs, it is stated that these particular infractions make it impossible to work with valid data. "It is important to consider the best options for the measurement of sexual orientation and gender identity. Measurement guidelines are still evolving, which may be daunting for the researcher.

Nonetheless, some good options for measurement are emerging" (Cochran, et al., 2014, p. 281). These forms and the knowledge they provide are typically monumentally valuable resources and are utilized for a broad spectrum of reasons. Emerging options are being headed by the open-ended response. This form of acquiring data is able to capture both sexual orientation as well as gender identity, which can generate a wealth of informative responses. These non-binary, open-ended response scales can more accurately describe the individual, although as noted by McCabe and colleagues, this form of scales can make data computation more complicated. The benefits of utilizing this type of scales are that even when the research is not aimed at sexual orientation issues of gender, they can provide estimates of effect size and validate gender identities that are not consistent with including only binary options for gender. It is the conclusion of these researchers that providing a studied sample of any kind with non-binary options for gender have the unique benefit of providing a more accurate representation of gender within the research (McCabe et al., 2014). This type of research could begin to account for the variability in health research.

When a member of the LGBT* population goes to a medical or mental health facility or is seeking substance abuse treatment, the initial information is gathered on the pages of intake forms. Yet when an LGBT* individual fills out his/her forms, immediate problems surface. These forms insult and frighten the LGBT* patient, and a lack of the data that is needed to create a clear picture of the LGBT* population within medical and mental care is simply lost (Cochran et. al, 2014). Transgender and gender-queer individuals are forced to label themselves as a male, female, or other which continues the misguided thinking that plagues this particular section of the minority. Cochran posits that this inability to recognize basic demographics of a population properly has led to the elimination of any ability to properly understand sexual minorities and

their mental health needs. This point seems ironic as the explicit purpose of intake forms is to properly understand and evaluate the individual needs, specific group requirements, and whole population necessities as they relate to mental and medical assumptions. Yet the vast amount of uncanvassed pertinent data prevents this.

Cochran (2014) suggests that to attain, clean and study the data found on intake forms that include sexual and gender orientation issues, as discussed by inserting sexual and gender demographics in a non-binary open-ended fashion, would allow for a host of new theories. This format could lend tremendous knowledge about sexual minorities, their medical needs, mental health issues, addiction service requirements, accurate prevalence data, as well as relevant research for issues unrelated to sexual and gender minorities. Prevalence is also unknown due to the inefficiency of current forms, making research terribly difficult and minority demographics vastly underreported. The ability to collect data, study improvements, or further understand a greater amount of disorders is handicapped due to practitioners' and researchers' inability to account for sexual minorities in any consistent or reliable fashion" (Cochran, et.al. 2014, p. 280).

PsychINFO and PubMed databases are known for their wealth of medical and mental health research and data. These databases were tested against these theories by Cochran and his team by searching through articles between 2007 and 2012, containing any information concerning sexual identity. As predicted, the research team did not find significant data concerning the LGBT* population's medical or psychological needs, any accurate prevalence in seeking such services, or usable data applicable to sexual and gender minorities. The percentage of articles that contained information concerning sexual and gender minorities was so low, it supported Cochran's hypothesis that practitioners and researchers were not accounting for this

minority consistently or reliably. The findings also supported Cochran's hypothesis that sexual minority statuses continue to be unacknowledged by the medical and mental health practitioners. It is concluded that this inefficiency by practitioners limits the care that sexual minorities are receiving.

Heck has stressed the necessity to acquire the empirical data needed to properly understand many varying facets of non-heterosexual minorities. Heck has examined many pieces of the vast puzzle concerning different LGBT* groups; addressing different research goals, theories, and using various research teams. One example is the work Heck partnered with Leslie C. Croot and Jennifer S. Robohm to focus on how clinicians and practitioners should be developing psychotherapeutic groups for the Transgender population, as well as why it is so important to do so. Heck and his team's large amount of research builds upon itself in its theory. For example, when Meyer published his Psychiatric Bulletin in 2003, the minority group of non-heterosexuals was known simply as "LGB". The introduction of transsexuals was not yet considered by advocates of the minority in 2003 when this work was published. Through research and investigating, studies like those cited here have created the ever-changing acronym for non-heterosexuals, including so many it is simplified with an asterisk after the "LBGT" acronym. Symbolizing the official inclusion of transsexuals, adding the "T" to this acronym was meant to dedicate aim, distinctive differences from other non-heterosexuals, and integrity to the population it represents. This group has been said to be the most controversial and complex minority of all under the LBGT umbrella due to the mental health and medical needs this group requires (Heck et al., 2015).

There are a number of rationalizations used to condemn transsexuals. One example is that "if God had intended you to be a woman, you would have been born a woman; and to

change your sexuality is defying God's wisdom and an abomination before God" (Christian Press, 2015). The most important and differentiating aspect of the transgender population, concerning psychiatric and medical implications, is that this particular group is in need of support and services from both medical and mental health services. As formerly stated, a transgender person is not gay. Their self-perception of their gender is in direct opposition to their physical gender, categorized by the body they were born with. In the physical transformation from one sex to another, an enormous amount of psychiatric services are required prior to any surgical or medical being conducted. The conducting of physical transformations are exclusive to the medical community. This transformation involves surgeries, medication, the monitoring of both, and professionals willing to operate by the ethical standards governing them. Heck's theories (2015) are built upon the established need to acknowledge the significant differences of the transsexual population from other sexual minorities, and for practitioners to properly attend to the needs of these transsexual individuals. The needs discussed by Heck and colleagues (2015) that reflect minority stress include environmental influences, prejudice and stigmas.

Heck initiates the demand for the informative classification of transsexuals, based on a myriad of studies concerning their unique experiences. An example can be seen in the rising numbers of murdered transsexuals previously discussed. Chia Jinasurat of the NCAVP stated to *BuzzFeed*, an online journal, that "The harm of the media misgendering and victim-blaming is that it sends a message to the public that these homicides are not as serious and somehow transgender people deserve it" (Jinasurat, media interview, 2015). Heck then turned to look at what is needed and expected of those in positions of influence to guide and support the transgendered in an ethical and productive manner.

Heck brings to light the disservices to transgender individuals by stating that within the LGBT* minority group "several barriers exist that make it difficult for them to receive adequate health care" (Heck, 2015, p. 31). Heck also states that in comparison to gay males and females, as well as the heterosexual majority, "transgender persons also evidence elevated rates of suicidality and depression" (Heck, et al., 2015, p. 30). It is Heck's argument that transsexual people face a completely different and intensely experienced set of issues that surpass those faced by individuals who are gay, bisexual or lesbian, "although research suggests that family and school supports can reduce these risks, many transgender people lack social support and experience isolation (Heck et al., 2015, p. 30) It is confidently charged that churches, media, society, politicians, legislators, and medical and mental health practitioners do not show proper treatment of the transgendered because many health training programs are unlikely to provide the coursework and experience necessary" (Heck et al., 2015, p. 30) Beginning with a formulation of therapies developed to the specific needs of transsexuals, Heck attempts to frame a directive for the stigma-free environment essential to ethical treatment.

Since Meyer's presentation of the Minority Stress Model as it applies to the LGBT* community, he and other researchers have continued to examine and define the continuum of factors behind the mental health issues of sexual minority individuals within a collection of studies. Hatzenbueler's contribution to sexual minority stress (2009) focused on the cognitive processes conferring risk for psychopathology. He also explored emotional and physiological consequences to societal stigma, demonstrating how this group's mental health detriments are prominent in their external surroundings. McCabe (2014) extended on to address the relationships between societal treatment of sexual minorities and mental health disorders. Boyd, Bostwick, Hughes, McCabe and West (2014) set out to expand further, examining additional

stresses to the LGBT* individual. Cochran, Flentje and Bacca (2014) theorized that the psychiatric community is eliminating its ability to effectively understand the sexual and gender minority demographic by utilizing archaic intake forms. This research demonstrated that without providing the option for an individual to safely identify as a sexual minority within mental health or medical setting, proper understanding, prevalence, and needed areas of focus are not possible. This illustrates how seemingly small elements of health care continue to force minorities into a box, continuing the antiquated thinking that supports harmful stigmas. Supporting inclusion, Heck focused on transgendered people as well as bisexual individuals and differences in stigma-related issues through exclusion by both heterosexual and other sexual minorities.

Statement of Problem and Hypothesis

The nature and importance of the research demands continuation and seems to arrange itself into an exploration of specific external stressors. Without having helping professionals operating to the ethical standards as posited by Meyer, Hatzenbuehler, McCabe, Cochran, and Heck, as well as professional associations, there is little hope of effectively tackling the issue of continued discrimination. This current study was designed to provide a sample of attitudes of pre-professionals towards working with self-identified members of the LGBT* communities. The process chosen was to present, through scenarios, representative instances of discrimination despite ethical and legal regulations forbidding them and elicit the respondents' approval or disapproval of the acts of discrimination that were depicted in the scenarios. Additionally, a measure of their awareness of real-world occurrences of practitioner stigma, prejudice, and outright discriminatory behaviors was sought. Finally, a request to explain their thinking underlying their responses to each of three scenarios concluded each section of the questionnaire.

Terminology like "*in the closet*" and Meyer's internalizing theories elicited the need to design the survey to allow those responding to self-identify who they were, rather than provide a list of definitions of self that limited choice. Because the research shows differences in discrimination experienced by the different groups in LGBT*, a within-subject design was not used. Three very different scenarios were developed to capture possible differences between the discrimination experiences of a gay Christian man, a transsexual individual, and an Atheist female seeking addiction support from a Christian-based group.

The following hypotheses were tested:

H1. There will be a positive correlation of respondent's agreement with a refusal to treat an LGBT* individual and respondents identifying strongly with Christian ideas.

H2: There will be a positive correlation between respondent's identifying with Christian religions and low awareness levels of sexual minority stress within the helping profession.

H3. There will be a positive correlation between respondent's endorsement of Christian beliefs and the perception or belief that refusal to treat an LGBT* individual is justifiable.

CHAPTER 2

METHOD

Participants

Undergraduate, senior-level students of psychology and related areas of study were recruited from psychology courses. A recruitment letter explaining the study and the participant's role in the study was provided. Through this manner of recruitment, a total of 111 students participated in the study which included 89 women, 19 men, and 3 who self-identified within a gender minority. The ages of these participants ranged from 18 to 44 years of age. There were 87% of the participants who identified themselves as being heterosexual, 12% identified under the LGBT* umbrella, and 9% did not respond to this question. 67% of the sample identified as Caucasian, 20% self-defined as African American or Black, and the remaining 13% was composed of Asian, Hispanic, Latino, and "Mixed" ethnicities. Although the courses were all within the psychology program, there was some diversity of academic majors of respondents. The largest was psychology making up approximately 60% of the respondents, 15% were in nutrition, nursing, pre-med, or other health sciences, 6% identified as being in Sociology, 4% expressed a Communication or Speech major, 7.5% listed some other field of study, 3% were in Education, and 2% were graduate students. The relationship statuses of the sample were mostly single at 67%, followed by 18.2% who were partnered/ life partner, 7.3% were married, 4.5% listed themselves as being separated and the remaining amount spread between widowed and divorced. Religious affiliation held a notable majority of respondents identifying as Christian, church of Christ at 53.6%, 10% Southern Baptist, and 5.5% Catholic totaling about 70% basically conservative Christian religions. Those who stated they were

Atheist or had no religion made up 24.5% with the remainder classifying themselves as not religious but "spiritual" at a percentage of 6.4%.

Instruments and Procedures

The instruments used included the recruitment letter (Appendix A, p. 57), asking for participation and informing each participant of their rights, a consent form that further explained the study enabling the participant to register his or her agreement to participate (Appendix C, p. 59-60), a scenario-based survey that included open-ended questions as well as a demographic inquiry (p. 23-26), and finally a debriefing statement of thanks (Appendix D, p. 61). These documents and study were approved by the IRB, protocol number 15-306 (Appendix B, p. 58)

The survey was given upon receipt of the consent form and was created explicitly for this study (p. 23-26). It contained three scenarios depicting a practitioner refusing to treat a client, which allowed the participants to convey their perceptions and/or attitudes concerning tolerance of LGBT* discrimination by mental and medical health practitioners. This survey is displayed below. It was given to all participants in full. To establish an understanding of the discussion of this survey's design, its placement here, as given to all respondents, will enable full comprehension of its discussion, as well as the results derived from this survey.

Survey

Scenario One- (Jamy)

A gay Christian man named Jamy is seeking therapy at a faith-based counseling center. He arrives for his intake appointment and the therapist reviews his forms and states that the clinic is not conducive to Jamy's demographics, and a community mental health clinic phone number is given to Jamy as he is dismissed.

In response to what you just read, please respond to the following items:

The practitioner was correct in taking the actions they took in this situation.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Please explain your response in the space provided:_____
_____
_____
_____
_____
_____
_____

This kind of situation often occurs in real life.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Scenario Two- (Terry)

Terry is Transgendered and has undergone most of the surgical and psychological procedures to become female. Terry now needs a Primary Care Doctor to oversee his/her medical needs, as well as caring for colds and common ailments. Terry calls to set up an initial appointment with a doctor in her area. When Terry says she is transgendered, the intake secretary quickly says "We don't see that kind of people in *our* clinic…", and the phone is hung up.

In response to what you just read, please respond to the following items:

The practitioner was correct in taking the actions they took in this situation.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Please explain your response in the space provided:_____
_____
_____
_____
_____
_____
_____

This kind of situation often occurs in real life.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Scenario Three- (Joy)

Joy is a recovering addict attempting to join a support group facilitated by a counselor for addicted women. Joy contacts the counselor to make arrangements to begin attending the group. Joy is not a part of the church or a Christian, and with this knowledge the counselor tells Joy she would not be a good fit in the group and denies her admittance.

In response to what you just read, please respond to the following items:

The practitioner was correct in taking the actions they took in this situation.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Please explain your response in the space provided:_____
_____
_____
_____
_____
_____
_____

This kind of situation often occurs in real life.

1= Strongly disagree 2= Disagree 3= Unsure/Undecided 4= Agree 5= Strongly Agree

Demographics

Please fill in or circle an answer with information that best describes you.

Please indicate the gender you identify with_____

Please indicate the sexual orientation you most identify with_____

What is your current age? _____ years

Please indicate your race/ ethnicity_____

Please indicate your academic major or profession if not attending school

_____

Relational Status

1- Single
2- Partnered/ Life-partnered
3- Married
4- Separated
5- Divorced
6- Widowed
7- Other

Please indicate the religion you most identify with.

_____

**Note: Conclusion of actual survey given to all participants*

Each respondent was given all three scenarios to effectively examine perceptions concerning different sexual orientations and a lack of religious belief. After reading each scenario, respondents were asked to rate their opinion of the practitioner's refusal to treat the client, portrayed by the scenario's actor, using the prompt, "The practitioner was correct in taking the action they took in this situation." The respondents rated their opinion using a 5-point Likert scale (1=*strongly disagree,* 2=*agree*, 3=*unsure/undecided,* 4=*agree,* and 5=*strongly agree*). This rating served as a tolerance to discrimination. After each respondent's rating to the practitioner's actions, the participants were asked to explain the score they chose in an open-ended response format. Each scenario ended by prompting the respondents to rate their agreement with the statement, "This kind of situation often occurs in real life". Respondents indicated their agreement to each scenario using the aforementioned Likert scale.

A brief demographics section follows the three scenarios. Likert scales as well as short-answer formatting were used to attain demographic information. Short-answer formatting assessed each respondents' gender, age, race/ethnicity, academic major, as well as religion. The relationship status question cover a range of possibilities that allowed for all relationship models that were appropriate responses for any sexual or gender orientation. A critical aspect of the demographical information, as dictated by my research and the study's design and purpose, was attaining respondents' sexual orientation. Potential respondents were alerted within the consent form (see Appendix p.) that they would be asked for this information in the demographics section of the survey.

Design

Scenario One was used to convey to the participants one example of a sexual minority. Jamy, the actor in Scenario One, is a gay male. He is also indicated as being a Christian who is seeking therapy from a faith-based counselor. He is dismissed and told that due to his sexual orientation, he would not be an appropriate client. He then is offered a phone number referring him to a community mental health clinic. The reasoning behind this scenario was to attain the reactions of participants when a gay individual is also a Christian, and reactions when this individual is not accepted by his faith in a practitioner/client scenario. The implications that this scenario was created to determine were subjective, however the scenario was explicitly written to refrain from guiding the respondents' thinking. There were no references made to why Jamy was seeking therapy or the way he took being refused treatment. This allowed the respondent to use their own knowledge of this type of incident, to rate their agreement and awareness of the scenario being realistic, as well as explain their thinking about aspects of the scenario and its actor left to the reader to infer. To reliably assess these reactions, the scenario was based upon the description of this situation as it occurred with a Christian gay man I had interviewed.

Scenario Two was used to address a perceived heightened tolerance to the discriminatory actions research has specified as applying to transgendered individuals. In this scenario it is implied that Terry, the actor, was born male but identified as having female cognitions. It is implied that it was this awareness led her through the aforementioned process of changing one's physical gender. In the scenario Terry calls a general practitioner's office to establish care for basic issues, in addition to having a practitioner to coordinate specialists Terry would typically see as a transgendered woman. When contacting the office, Terry speaks to an intake nurse to establish this care. Normally, this would involve gathering basic information from prospective

patients. However, once Terry reveals she is transgendered the intake nurse states, "We don't see that kind of people in *our* clinic…" and disconnects the call. This portrayal was also adapted from an actual example as explained to me by interviewing a transgender woman. Terry was referred to with female pronouns throughout the scenario to be able to gather data from participants that is exclusive to this sexual minority. I was looking to see any evidence in participants'' rationale that showed ignorance of appropriate gender speech, or simply ignore any references to the female pronouns and refer to Terry in a male context. Since the research establishes a notable difference in experiences of those under the LGBT* umbrella, this second scenario used an actor of a different sexual minority. Due to the medical aspect of being transgendered as it relates to practitioner discrimination, this scenario was included as part of creating a greater picture of how participants felt and understood transgender minority stress.

Scenario Three was used as a measure of respondents' perceptions of lack of religion as is relates to the refusal to treat. In examining the complexities between LGBT* individuals and religious stigma relating to this minority, it was necessary to look at participants' reactions and note any significant differences. The scenario depicts a woman recovering from addiction. Joy, the actor in Scenario Three, wishes to be a part of an all-female support group that is facilitated by a counselor who bases the group on faith-based recovery techniques. The counselor tells Joy that she would not fit in the group because she has no religious belief structure. This scenario was necessary to look more closely at the way religion and the lack, thereof, was viewed by participants. Being established early on in this work, the relationship between sexual minority stress and the environment has a strong negative religious component. Although Joy is not a sexual minority, this scenario lent validity and depth to responses of each participant. After reading and assessing the respondents' rationales in Scenario One and Two, I found that their

responses to Scenario Three was extremely valuable. This last scenario was designed to effectively link respondents' views of sexual minority stress to their particular religious value system.

In contrast to a possible design of dispersing one of the scenarios at random to each respondent, the complete survey with all three scenarios was given to all respondents included in the study. This design allowed for a deeper glance into respondents' perceptions by gathering data from the different minorities portrayed within the three scenarios. The goal was to be able to find the cohesion of conscience and subs conscience thought by providing a continuum of incidents. This design format allowed for a connection between the respondents' rationales in each of the scenarios, creating a more complete picture of their perceptions of sexual minority stress and their religious value systems.

The demographics page was explicitly created in accordance with the research by Cochran and his colleagues to include both sexual orientation as well as gender, as well as doing so in a non-binary manner. This afforded participants with the right to define their demographics. Specifically, gender was asked using short-answer format by the prompt, "what gender do you most identify with?" This would allow for my respondents who identified with a gender minority to indicate this, rather than having to choose between the standard male and female boxes. Ethnicity of the participants was attained with the prompt, "indicate your race/ ethnicity". Many people find it difficult to box themselves into predefined races and ethnicities as doing so often can delete an intricate part of who they are. Sexual orientation also was attained with short-answer formatting. This demographical status is central to this study. As indicated within the research discussed, this data is often omitted from demographic surveys. Sexual orientation data is critical to understanding sexual minority group, their prevalence within

society, and omitting this question from surveys was shown by my research to contribute to continued exclusion and stigmatization of non-heterosexual individuals. The unique design and the format of these questions allowed respondents to describe themselves. Created with prior research and the impact of minority stress discussed in the Literature Review in mind, this structure was utilized to protect the integrity of my study. This distinctive design was created to empower respondents to define themselves in lieu of researcher-defined boxes that may not encapsulate them. The format demonstrates respect and acknowledgment for those identifying as a sexual or gender minority. It was mandatory for this study to allow for an open diversity with respect to gender and sexual orientations. Accepting what past research has demonstrated, using incorrect labels with an individual's gender or sexuality is not only disrespectful but potentially detrimental.

Data Collection Design for Non-Binary Descriptive Factors

The design for assessing the data collected was created uniquely to fit the aim of my study. A manner in which the respondents' short-answer and open-ended rationales had to be created in a valid and reliable fashion. A code guide that established a continuum for each of the three scenarios was drafted in order to put respondents' written thoughts into usable data. The reliability established by this code was by its formulation having two separate readers looking for specific language used by each respondent. There was an agreement by the two readers after each applying the language of responses into a guide for each scenario. This continuum was readdressed multiple times and was agreed upon unanimously by the readers that it reflected the voice of the participants. This descriptive continuum is explained for each of the scenarios, as well as four additional descriptions of respondent responses that were applied universally.

For Scenario One, the descriptive continuum assigned to respondent responses was as follows: *Acceptance,* (overall tone of client acceptance being the rationale for the rating), *Individual/ Universal Rights,* (referring to the client having the right to be seen without discrimination), *Separation of Church and State,* (direct reference made to the Constitutional amendment), *Christians should be accepting of person,* (Christian values of loving and accepting all people), *Bias of therapist could hurt client,* (speaking of the violation to the golden rule of "Do no harm"), and *Right to refuse (therapist/Organization)* (where it was communicated that clients are subject to acceptance from practitioner's and organization's value judgements). See Table 3a to view results for these descriptive factors and their percentage of occurrence.

For Scenario Two, the descriptive continuum was nearly identical, but had to also account for the medical practitioner aspect of the scenario. The exact code guide explained for Scenario One was used for Scenario Two with one exception. The descriptive response, *"Christians should be accepting of person"*, was substituted in the code guide for Scenario Two with the descriptor *"Medical practitioner should not be discriminatory"*. This reflected respondent language used that referred to medical practitioners should/ are not permitted to show discrimination in the patients they treat or accept. Any variation of this type of statement was accounted for by this descriptor. Scenario Two's descriptive factor results are displayed in Table 3b.

Scenario Three also maintained much of the same continuum used for Scenarios One and Two. However, the *"Acceptance"* response was reworded to better capture the responses given in acceptance of the client actor in the scenario. This changed to the descriptor that *"Acceptance/ Addiction shouldn't have strong religious impact"*, referring to any discussion that Joy's religious beliefs or non-beliefs should not have any bearing on her ability to be included in

an addiction support group. Due to the difference Scenario Three provided in looking at perceptions of denying care based upon an absence of religion rather than the presence of a sexual minority status, an additional descriptor was added to acknowledge the responses given in respondent rationales. Although in all scenarios there were instances of participants' rationales discussing the client needing to be converted into more Christian-like ways, Scenario Three had more instances of this kind of wording due to the religious versus non-religious aspect of the situation. *"Easy to convert"* was therefore added as a descriptive on the continuum in Scenario Three. For example, where respondents wrote in their rationales in reference to Scenario Three wording relating to how pertinent it would be to "walk with Joy in Christ", this descriptor was used. These results can be seen in Table 3c.

Additional Descriptive Factors in Data Collection

The additional four nominal descriptive factors that were universally added to every scenario in order to capture more of the qualitative data derived from the participants' rationale. These descriptive factors were attributed based upon respondents' wording, supplemental to the aforementioned descriptive categories, deemed necessary for further understanding. The first descriptive variable assigned was "*Acceptance"*, meaning the respondent showed an especially strong acceptance of the client mentioned. The descriptive variable, "*Recasted/ Contradicted self"* referred to occurrences where the respondent changed the meaning of the scenario to fit their personal belief structure, or used wording in *direct* opposition to their Likert rating. "*Personal conflict"* was added for respondent language that stated a personal conflict with the scenario either in strong support of (1) LGBT* rights or (2) religious alliance. This descriptive variable was added only when impassioned wording in support of either LGBT* advocacy or strong alliance with disapproving conservative religious values was used by the participant in

their open-ended rationale. The last of the four universally descriptive variables added for each scenario was "*Religious speak"*. This was used to indicate a strong view of conservative religious biases, or a strong disapproval that was based on Biblical and religious values. These four additional descriptive rationale statistics added to all three scenarios, as well as the full continuum of descriptors previously outlined per each scenario will be reported in the Results section. These additional descriptors were needed to augment and further explain each scenario's descriptive continuum and results can be viewed in Table 4.

CHAPTER 3

RESULTS

The results of the survey were entered into SPSS and analyzed by use of a t-test for correlations between religiosity and respondent tolerance level to LGBT* discrimination, and correlations between religiosity and respondent awareness. Results are presented for each of the hypotheses. The variable I thought would differentiate both tolerance to discrimination as well as respondents' knowledge of the occurrences of these types of scenarios happening in real life was religiosity. As such, the reported religions respondents listed were split into religious and non-religious groups. Table 1a shows the means and standard deviations when each scenario is split by the religious variable into religious, and non-religious respondents for the variable of Tolerance that was tested by the Likert-scale that followed each scenario. Table 1b shows the same religious to non-religious respondents' Likert-ratings to the occurrence of the situation happening in real life. Respondent means were tested against the midpoint of the Likert-scale which would be a score of 3. For the scale measuring respondent tolerance to discrimination, a higher score indicates a lower tolerance for the discriminatory actions depicted in the scenarios. For the scale that looked at respondents' knowledge of these scenarios being true to real life, a higher score indicated less knowledge of the situation reflecting real life. The results of the t-test showed that the means for Scenario One and Scenario Three reflected scores that were closely related to the midpoint. The overall mean differences for respondents of all religious backgrounds can be viewed in Table 1c. The mean differences for Scenario Two, relating to a transgender person, showed a mean difference further from the midpoint score. The results of each of these mean differences by each scenario can be viewed in Tables 2a, 2b, and 2c. (2a for Scenario One, 2b for Scenario Two, and 2c for Scenario Three)

Table 1a

Religious vs. Non-religious Mean and Standard Deviation (SD) for Tolerance Scores in Each Scenario

	Religious / Non-Religious		**Religious / Non-Religious**	
	Mean Tolerance	Mean of Tolerance	SD of Tolerance	SD of Tolerance
Scenario				
One	2.36	1.94	1.067	1.205
Two	1.67	1.26	.949	.790
Three	2.15	1.91	1.099	1.026

Note. Religious n = 75/ Non-religious n = 34

Table 1b

Religious vs. Non-religious Mean and Standard Deviation (SD) for Occurrence of Each Scenario to Real-Life Rating

	Religious / Non-Religious		**Religious / Non-Religious**	
	Mean Occurrence	Mean of Occurrence	SD of Occurrence	SD of Occurrence
Scenario				
One	4.01	4.21	.683	.946
Two	3.91	4.26	.808	.931
Three	3.64	4.12	.916	.913

Note. Religious n = 75/ Non-religious n = 34

Table 1c

One-Sample Statistics for Three Scenario Differences

Table 1c

	Tolerance		Occurrence	
Scenario	Mean	Standard Deviation	Mean	Standard Deviation
1	2.34	1.130	4.05	.824
2	1.55	.915	3.99	.904
3	2.09	1.088	3.90	.967

Note. N = 111

Table 2a

Frequencies and Percentages for Tolerance and Occurrence Ratings for Scenario One (Jamy)

	Tolerance	Occurrence
Measure	**Frequency/ Percent**	**Frequency/ Percent**
Likert rating		
Scenario One (Jamy)		
Strongly Disagree (1)	37/ 33.3%	2/ 1.8%
Disagree (2)	30/ 27.0%	2/ 1.8%
Undecided/ Unsure (3)	27/ 24.3%	17/ 15.3%
Agree (4)	14/ 12.6%	58/ 52.3%
Strongly Agree (5)	3/ 2.7%	32/ 28.8%
Total	111/ 100.00%	111/ 100.00%

Note. N = 111

Table 2b

Frequencies and Percentages for Tolerance and Occurrence Ratings for Scenario Two (Terry)

Measure	Tolerance Frequency/ Percent	Occurrence Frequency/ Percent
Likert rating		
Scenario Two (Terry)		
Strongly Disagree (1)	73/ 65.8%	2/ 1.8%
Disagree (2)	21/ 18.9%	2/ 1.8%
Undecided/ Unsure (3)	11/ 9.9%	27/ 24.3%
Agree (4)	3/ 2.7%	43/ 38.7%
Strongly Agree (5)	2/ 1.8%	36/ 32.4%
Total	110/ 99.1%	110/ 99.1%

Note: N = 110 (1 survey was not rated)

Table 2b

Frequencies and percentages for tolerance and occurrence ratings for Scenario Two (Terry)

Table 2b: *Frequencies and*

Table 2c

Frequencies and Percentages for Tolerance and Occurrence Ratings for Scenario Three (Joy)

Measure	Tolerance Frequency/ Percent	Occurrence Frequency/ Percent
Likert rating		
Scenario Three (Joy)		
Strongly Disagree (1)	40/ 36.0%	4/ 3.6%
Disagree (2)	37/ 33.3%	4/ 3.6%
Unsure/ Undecided (3)	19/ 17.1%	20/ 18.0%
Agree (4)	11/ 9.9%	53/ 47.7%
Strongly Agree (5)	3. 2.7%	29/ 26.1%
Total	110/ 99.1%	110/ 99.1%

Note. N = 110 (1 survey was not rated)

Hypothesis One stated that the respondents who strongly related to Christian value systems would be more likely to agree that the practitioner was correct in the action they took in each scenario. This hypothesis looked at tolerance in accepting discriminatory actions of practitioners. A two-tailed t-test for equality of means was conducted to determine correlations between religious and non-religious respondents and their Likert ratings of tolerance to the discriminatory actions in each scenario. It was found that there was marginally significant support for Hypothesis One in Scenario One (t-value = 1.807, *p*-value = .074) that concerned discrimination toward a gay man. This shows that the respondents surveyed did have some trouble in setting aside their religious views, although correlations of this relationship was not below a *p*-value of .05. For Scenario Two, pertaining to tolerance of discriminatory actions toward a transgender individual, Hypothesis One was significantly supported (t-value = 2.153, *p*-value = .034. As discussed by the research explained, the transgender group is arguably the most complex under the LGBT umbrella. There are issues of both psychological and medical needs that when addressing from a religious stance, this group stands as being the most affected by discrimination and the permitting of it. Even amongst educated pre=professionals, it was statistically evident that in this case of a transgender individual, religious respondents were more likely to agree with the practitioner's discriminatory treatment. Pertaining to Scenario Three where discriminatory actions were evaluated in a non-religious individual, there was no significant support for Hypothesis One found (t-value = 1.055, *p*-value = .533).

Hypothesis Two stated that those respondents who strongly related to Christian values would have lower knowledge to occurrences of sexual minority stress, or see that each scenario is true to real life. A two-tailed t-test for equality of means was conducted to determine correlations between religious and non-religious respondents and their Likert ratings of

knowledge of the occurrence that these scenarios have in real life. In Scenario One where Jamy is a gay man seeking a therapist at a faith-based center, there was no significant support given for Hypothesis Two. Respondents saw that this was an incident that would occur in real life and this was shown by their scores (t-value = -1.208, *p*-value = .230). For Scenario Two where Terry, the transgender actor is discussed, again there was significant support for Hypothesis Two (t-value = -2.042, *p*-value = .044). With a majority of Christian respondents, despite their educated awareness of at-risk populations like the transgendered, respondents did not see Terry's situation as being one that would occur in real life and Hypothesis Two was supported with respect to Scenario Two. Lastly, Scenario Three was also looked at for support in Hypothesis Two but there was no statistical support found (t-value = -1.467, *p*-value = .145). Placed within the scenario continuum in order to link the sexual minority population to lack of religion, there was no support given with Scenario Two with respect to Hypothesis Two.

Hypothesis Three was created to specifically address the qualitative data acquired from participants' rationales in the short-answer sections of each scenario. The frequency of these responses, as outlined by the descriptive continuum for each scenario, can be viewed in the following tables (3a, 3b, and 3c). A condensed code guide will be presented prior to the tables in order to understand the data in the tables presented.

Scenario One descriptive data code guide continuum:

Acceptance = 1/ *Individual/Universal Rights* = 2/ *Separation of Church and State* = 3

Christians should be accepting of person = 4/ *Bias of therapist could hurt client* = 5

Right to refuse (therapist/organization) = 6

Table 3a

Frequency of Descriptive Responses for Scenario One (Jamy)

	Mean	Standard Deviation
	3.77	**1.813**
Descriptive Factors	**Percent**	
Acceptance (1)	12.5%	
Individual/ Universal Rights (2)	25.0%	
Separation of Church and State (3)	4.2%	
Christians should be accepting (4)	10.4%	
Bias of therapist could hurt (5)	27.1%	
Right to refuse (6)	20.8%	
Total	100.0%	

Note. N =111

Scenario Two descriptive data code guide continuum:

Acceptance = 7/ *Individual/Universal rights* = 8/ Separation of Church and State = 9

Medical practitioners shouldn't discriminate = 10/ *Bias of therapist could be dangerous* = 11

Right to refuse = 12

Table 3b

Frequency of Descriptive Responses for Scenario Two (Terry)

		Mean	**Standard Deviation**
		9.71	**1.404**
Descriptive Factors	**Percent**		
Acceptance (7)	3.9%		
Individual/ Universal Rights (8)	25.5%		
Separation of Church and State (9)	0.0%		
Medical shouldn't discriminate (10)	52.9%		
Bias could hurt (11)	2.0%		
Right to refuse (12)	15.7%		
Total	100.0%		

Note. N = 111

Scenario Three descriptive data code guide continuum:

Acceptance/addiction has no religious impact = 13/ Individual/Universal rights = 14/ Separation of Church and State = 15/ Christians should be accepting of people = 16/ Easy to convert (to Christian value system) = 17 Bias of therapist could be dangerous = 18/ Right to refuse = 19

Table 3c

Frequency of Descriptive Responses for Scenario Three (Joy)

		Mean	**Standard Deviation**
		16.12	**2.201**
Descriptive Factor	**Percent**		
Acceptance/ Addiction has no religious impact (13)	22.0%		
Individual/ Universal rights (14)	8.0%		
Separation of Church and State (15)	6.0%		
Christians should be accepting (16)	12.0%		
Easy to convert (17)	26.0%		
Bias of therapist could hurt (18)	4.0%		
Right to refuse (19)	23.0%		
Total	100.0%		

Note. *N = 111*

Hypothesis Three stated that "*There will be a positive correlation between respondent endorsement of Christian beliefs and the perception or belief that refusal to treat an LGBT* individual is justifiable.*" According to Tables 2a, 2b, and 2c, Hypothesis Three is discussed as it relates to each of the scenarios. The respondent's rationale for their rating in Scenario One was analyzed and calculated to reflect support or insignificant evidence for Hypothesis Three. As

viewed in table 2a, the highest justification used was that the refusal to treat the client as portrayed by the actor in Scenario One was correct because a majority of respondents (27.1%) conveyed reasoning that the client would be harmed by the biases of the practitioner. This was meant to show that although the largest percentage (60.3%) agreed that the practitioner in Scenario One should have referred Jamy to another clinic, it was not because of discriminatory thinking but to the majority of respondents thinking of Jamy's best interest. Although the second largest percentage endorsed the therapist's right to refuse treatment to Jamy (20.8%), there was not significant mentioning of Christian values in respondent justification. There was not statistical data that supported Hypothesis Three as it applies to Scenario One.

Looking at Scenario Two as it relates to the third hypothesis, table 2b reflects that an overwhelming amount of respondents (52.9%) did not justify the refusal to treat Terry, the transgender actor, but specifically made reference to the discriminatory actions of the intake nurse as being unethical and inappropriate. Hypothesis Three was not supported by the rationales given for Scenario Two. Lending further support, the second highest percentage (25.5%) was attributed to Individual and Universal rights of a client to attain services freely.

Finally, Scenario Three is viewed in Table 2c and the actor Joy, is not a sexual minority, but a religious minority. Scenario Three was able to show proof of its relevance within this study, as it was within the rationales given here that Hypothesis Three was supported. Twenty-six% of the participants used justifications that capitalized on an addict's venerable state, and in a variety of ways, respondents stated that what was important was that Joy would be an *easy conversion*. References like "speaking to her about the Word of God" lent credibility to the majority of respondents who expressed that Joy should be included in this support group because of the importance to preach to her to eliminate her belief structure into that of a Christian. Other

specific quotes will be referred to in the Discussion section. Taken together, Hypothesis Three was not fully supported between the three scenarios. Still, references to Christianity in Scenario Three did offer some support of the hypothesis, as well as the minority percentages present in Scenarios One and Two as viewed in Tables 2a and 2c.

Due to the descriptive content of the respondent's rationales that surpassed what was initially created in the code guide, it was necessary to include four additional descriptive variables to accurately encapsulate the full impact the short-answer rationales. These four descriptors (p.33-34) were described fully in the Design section. The following tables (4a, 4b, and 4c) define the amount of respondents included into these categories; each followed by a short summation.

Table 4a

Additional Descriptive Statistics for Scenario One (Jamy)

Measure	Frequency	Percent of sample
Acceptance	40	36.0%
Recast/ Contradict	18	16.2%
Personal offense	28	25.2%
LGBT*	18	16.2%
Religious	10	9.0%
Religious reasoning	20	16.0%

Note. N = 107 (4 surveys did not necessitate applying these factors: 11-4 = 107)

In discussing the additional factors that were found within the rationales of each scenario, the conclusions that came from this data lent further insight into what the respondents thought about each consequence of the practitioners' actions. In regard to the specific four descriptive factors described in table 4a, a strong voice of acceptance of the client was found in 36% of those surveyed in the first scenario. From the sample, there were a total of eighteen respondents (16.2%) who contradicted their rating or attempted to recast the scenario in their rationale. Of the respondents who expressed strong opposition personally, sixteen of them (16.2%) did so on the bases of an alliance to sexual minority stress and ten (9%) did so based upon their communicated Christian ideals. Twenty participants (18%) justified the refusal to treat based upon Christian wording in their rationales, or used discussion that was exclusive to religious alliances that ignore or invalidate LGBT* issues or Atheist identification.

Table 4b

Additional Descriptive Statistics for Scenario Two (Terry)

Measure	Frequency	Percent of sample
Acceptance	40	36.0%
Recast/ Contradict	21	18.9%
Personal offense	20	18.0%
LGBT*	13	11.7%
Religious	7	6.3%
Religious reasoning	5	4.5%

Note. N = 111

Applying the additional factors to Scenario Two in Table 4b, there were several similarities between the percentages. This may be due to the similarity of the actors in both scenarios being of a sexual minority. The amount of respondents who strongly accepted Terry's experience in the scenario was exactly the same as was with Jamy despite the transgender identification and what that might have invoked. There were three more respondents who contradicted their ratings, or chose to recast the scenario to suit their thinking. Although Scenario Two was subjectively more unethically evident, there were eight fewer respondents who took a personal offense to what occurred. Three less respondents expressed personal offense that supported sexual minorities, specifically transgender individuals, however three less respondents also conveyed a religion-based offense. Finally, and key to Hypothesis Three, only five participants made religious references about Terry. These five religious references were extremely strong-worded, and referred to Terry as "he". There were two respondents who used the word "it" in referring to Terry. A notable quote that followed a rating of "Disagree" to the

practitioner's refusal Terry was, "I personally do not agree with this life choice and feel that no one should have to work with this person if they are as uncomfortable with this choice as I am. God makes us into the gender we are and to try to change that for whatever purpose is a mortal sin." This lends credibility to the format used, rather than relying on only the Likert scales.

Table 4c

Additional Descriptive Statistics for Scenario Three (Joy)

Measure	Frequency	Percent of sample
Acceptance	42	37.8%
Recast/ Contradict	26	23.4%
Personal offense	28	23.4%
LGBT*	7	6.5%
Religious	19	17.1%
Religious reasoning	19	17.1%

Note. N = 111

Scenario Three can be referred to in Table 4c. This scenario had a distinct difference from the previous scenarios in being about a non-religious woman seeking addiction support from a Christian support group facilitator. Here, what is notable is the different wording of the "Acceptance" factor to apply to the respondents wording that reflected a strong supporting of Joy due to their belief that "religion has no place in addiction recovery", as one participant put it. Forty-two respondents agreed or identified with this perception. The second factor, having to do with contradiction and a recast of the scenario was the highest of all three scenarios, with twenty-

six participants showing this in their rationales. This is equal to 4.27% of the sample. Continuing in this change from the first two scenarios is the high percentages of personal offense to the scenario based upon respondents' religious values as well as the general increase of participants who referred to religious reasoning in their justification at the same percentage of 23.4%. The one very unique issue that had to do with the choice to give all three scenarios to every respondent was that they were able to connect their thoughts from LGBT* issues to religion, and referred to an LGBT* alliance who had presented rationales that used Christian wording. In realizing this, it was possible to see in Table 3c that even though it had nothing to do with sexual minorities, seven respondents discussed a strong personal alliance to LGBT* issues. The downside of this is that there were nineteen respondents who did make unethical professional references to religion.

These nineteen participants spoke about personal offense due to their religious beliefs. Twenty-six participants openly spoke about the importance of religion in regard to this scenario. These respondents contradicted their response of "strongly disagree" with the practitioners' refusal to treat. They also continued to contrast this rating and discussed some kind of need to conform someone the actor in the scenario to Christianity. A noteworthy quote in support of this ideology is "speaking to Joy about what is correct in the eyes of God would benefit her greatly". This quote supports of the study's design to provide the ability for respondents to speak freely, as this data would not have been acquired without the creation of the survey used. Overall, the rationales proved highly valuable for insight into each participant's viewpoints, passions, and the level of disgust or support they felt toward the scenario described, and to LGBT* advocacy as well as religious ideals. There is a probability that a few of these rationales will be quoted in future studies, due to extreme views either for or against sexual minorities.

CHAPTER 4

DISCUSSION

What was most interesting and observable by conducting this manner of research and statistical analysis was that even when respondents would initiate disagreement with the practitioner's refusal to treat in their Likert rating, their rationales were found to frequently contradict these ratings. Over 60% of the sample did find serious ethical detriment in the refusal to treat as a combined percentage over all three scenarios. Still, there was about 40% of the respondents who used language that revealed a tolerance to the discriminatory actions referenced in the scenarios. Additionally, there was a prevalence of about 11% of respondent who used Christian-based values and beliefs to justify the practitioner's actions, contradict their initial opinion rating, or simply recast the scenario to fit their own beliefs. This was a percentage attained from combining the three scenario rationales. This means about one out of every ten pre-professionals may have known the ethical response for a simple Likert-rating, but when discussing these issues in their own words, they expressed blurred boundaries with respect to their ability to set aside their religious viewpoints. The most disturbing finding this study unearthed were the various references made suggesting the practitioner could or should use the vulnerability of the client to indoctrinate them into thinking more in line with conservative Christian values. In the cases of Jamy and Terry, the sexual minority actors portrayed in Scenarios One and Two, as well as the recovering addict in Scenario Three, this type of thinking could prove self-defeating and even highly dangerous according to the reviewed research. It was the short-answers respondents provided that became the most valuable aspect of this study,

lending enormous credibility to the non-binary collection of data referred to in the literature reviewed, as well as including both sexual orientation and gender in short-answer format.

All rationales agreeably fit into the continuum discussed for each of the three surveys. An acceptance of the client's rights to be seen as a person and given the respect they deserve without stigma, prejudice, or discrimination is a key component to working within mental health, and it was encouraging to find this reflected in the thoughts of the participants. Individual and universal rights also are a center concept allowing every person, no matter how strongly the practitioner's personal beliefs contradict their client's. The right to receive competent mental and medical health treatments must be consistent and abide by ethical guidelines without discrimination. Separation of church and state, dictated long ago by our government, assures that religion has no place within the execution of mental health or medical treatment to any persons. This is a fundamental issue when discussing sexual and gender minorities. Christian belief proclaims that all true Christians should be kind and supportive to every person regardless of their life and choices. However, this is not always reflected in a healthy way with respect to sexual minorities. As one respondent stated, "real Christians should be accepting of everyone-no matter how good or bad they are". While on the surface this Christian value may seem openly accepting of sexual minorities, the wording used can be in direct opposition.

The discussion of Terry seemed to generate the most argumentative wording; both in support of and in opposition of transgendered people. This was reflected in its statistical significance within the Hypotheses tested. There was one respondent who stated that "No one should ever be treated this way and to do so goes against everything that is said to be a part of Christianity!" Another respondent in discussing Terry's case said that "this was a modest accounting of the disgusting manner in which supposed professionals and the public alike treat

this community". The respondent continued with an example that read, "I have a friend who was literally thrown out of an office and told to go back to San Francisco where they belonged!" Consistent improper references to Terry as "him", despite the repeated gender specifics written in the scenario were found in 17 of the 111 surveys**.** There was even a respondent who wrote "I strongly disagree with this life-choice and do not in any way support changing the gender God blessed you with at birth!" An example of one who did not explain their answer, as they had indicated a disagreement with the refusal to treat, this respondent continued to deviate and stated that, "This is a choice and there is a way to let God in and heal the dysfunctional thoughts that make these people think like this!" Even in the small occurrences of these kinds of statements, it lends tremendous validity to the reasoning behind my aim to seek out how many pre-professionals would speak out this way. It was, however, encouraging to find the ethical and appropriate thinking that was in support of sexual minorities. This should be seen as not only a compliment to those students who showed this intolerance to sexual discrimination, but also to the professors and other leaders in these students' lives who have taught them these critical values.

Limitations of Study

There were many limitations of this study. As such many revised versions need to be created and conducted in order to better understand this critical topic. There needs to be a much larger sample from a more diverse geographical collection. As referred to earlier in this work, the Tennessee area has strong fundamental Christian undertones that begin a person's development and carry them throughout their lives. A sample that included other states and

regions of the country would be a valuable addition for future research. This examination of humanity, as it relates to psychology, would also benefit greatly from a sample that contained specific groups such as Christian church groups, LGBT* advocacy groups, sexual and gender minorities, and a sample of different cohorts from each to properly conceptualize the difference of views each generation holds. Another limitation of this study was also an asset. The survey provided a far more holistic view of the respondents while respecting the minority it studied. However, adding to this survey and testing each portion of it for validity and reliability would be an advantageous addition to future use of this survey. A section of personal viewpoints concerning level of agreement to topics such as same-sex marriages, abortion, and the death penalty would further complete each respondent's perspective. As with much research conducted, while this study answered questions, it has effectively raised many more.

Implications for Future Research

The need to know and the ability to provide the data that is lacking within society as a whole, concerning this minority of sexual and gender orientations, opens this study to an infinite number of implications. The implication of what level of improvement creating intake forms and surveys that include sexual orientation demographics as well as the ability to report gender in a non-binary manner was used in this study. A fluid and progressive insertion of this demographic style into mental health, psychological, and medical data stands to only improve future knowledge of sexual minorities. This need to know is perhaps the largest implication for future research, as it has been touched upon by many advocating researchers and adapted into the

survey created for this study. How is it possible to know information about a group when the amount that belong to that group is not even provided?

A direct implication generated from this study is the possibility of looking at differences between sexual minorities and the stress they experience, especially for transgendered individuals such as "Terry". This population seems to evoke a high level of controversy for many people within the environment, including other sexual minorities. It stands to reason that no longer can all sexual minorities be lumped together viewed as one, or considered to have similar or identical stress within their environment due to their orientations, when extremely unique differences are so prevalent. When there are medical and psychological professionals who routinely justify discrimination toward a group for any reason, there is a serious implication that needs critical and thorough exploration and research. Another valuable implication for the future relates to the government and the legislation that seems to proclaim to support everyone, yet continues to oppress sexual minorities. Any and all research that is conducted based upon the finding here can only assist governmental agencies in also being able to put aside their own personal and religious opinions and ethically include this minority on even and equal ground. Tennessee is one of nineteen states that legally sanctions the dismissal of a sexual minority form their job strictly based on their orientation. Until enough strong research is conducted and analyzed properly for political consumption, sexual and gender minorities will continue to struggle against the distal and proximal stress that places them in need of mental health care.

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APPENDICES

APPENDIX A

Standardized Instructional Invitation for Study Participation Recruitment

You are being invited to be a participant in a research study that examines the personal rights of individuals depicted within four scenarios. No identifying information will be collected in conjunction with your responses. Your consent to participate will be stored separately from the survey you complete at all times and locked in faculty storage. Do not put your name or any information that might identify you in any way. Please keep your responses in line with your thoughts and beliefs. The legal and ethical rules are known; what we are interested in are your thoughts and feelings. Remember that as a willing participant, you are able to ask questions, stop your participation at any time, and refuse to answer any items for any reason without negative repercussions or consequences. Your help is greatly appreciated and will generate further knowledge into human thought!

Thank You!

APPENDIX B

IRB Approval Letter

4/29/2015

Investigator(s): Melani Mood, Gloria Hamilton and Thomas Brinthaupt
Department: Psychology

Investigator(s) Email: mpb3i@mtmail.mtsu.edu; mim2f@mtmail.mtsu.edu; Gloria.hamilton@mtsu.edu; tom.brinthaupt@mtsu.edu

Protocol Title: "Do they have the RIGHT?" *Title changed in final draft of thesis*
Protocol Number: 15-306

Dear Investigator(s),

The MTSU Institutional Review Board, or a representative of the IRB, has reviewed the research proposal identified above. The MTSU IRB or its representative has determined that the study poses minimal risk to participants and qualifies for an expedited review under 45 CFR 46.110 and 21 CFR 56.110, and you have satisfactorily addressed all of the points brought up during the review.
Approval is granted for one (1) year from the date of this letter **for 100 (ONE HUNDRED)** participants.
Please note that any unanticipated harms to participants or adverse events must be reported to the Office of Compliance at (615) 494-8918. Any change to the protocol must be submitted to the IRB before implementing this change.
You will need to submit an end-of-project form to the Office of Compliance upon completion of your research located on the IRB website. Complete research means that you have finished collecting and analyzing data. **Should you not finish your research within the one (1) year period, you must submit a Progress Report and request a continuation prior to the expiration date.** Please allow time for review and requested revisions. Failure to submit a Progress Report and request for continuation will automatically result in cancellation of your research study. Therefore, you will not be able to use any data and/or collect any data. Your study expires **4/29/2016**.
According to MTSU Policy, a researcher is defined as anyone who works with data or has contact with participants. Anyone meeting this definition needs to be listed on the protocol and needs to complete the required training. **If you add researchers to an approved project, please forward an updated list of researchers to the Office of Compliance before they begin to work on the project.** All research materials must be retained by the PI or faculty advisor (if the PI is a student) for at least three (3) years after study completion and then destroyed in a manner that maintains confidentiality and anonymity.

Sincerely,

Institutional Review Board
Middle Tennessee State University

APPENDIX C

Informed Consent Forms

Principal Investigator: Melani Mood
Study Title: "Do They Have the RIGHT?"
Institution: Middle Tennessee State University

Name of participant: _____ Age: _____

The following information is provided to inform you about the research project and your participation in it. Please read this form carefully and feel free to ask any questions you may have about this study and the information given below. You will be given an opportunity to ask questions, and your questions will be answered. Also, you will be given a copy of this consent form.

Your participation in this research study is voluntary. You are also free to withdraw from this study at any time. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to participate in it, you will be notified so that you can make an informed decision whether or not to continue your participation in this study.

For additional information about giving consent or your rights as a participant in this study, please feel free to contact the MTSU Office of Compliance at (615) 494-8918.

1. **Purpose of the study:**
   You are being asked to participate in a research study. We are interested in your opinions and beliefs about certain stigmas and prejudices pertaining to personal rights of various individuals within three different ,s.

2. **Description of procedures to be followed and approximate duration of the study:**
   You will be given three short scenarios and the ability to respond to each. You are asked to read about a person going through some type of medical or mental health intake process. After you read each scenario, you will be asked if you feel the practitioner was correct in the action they took and why you feel that way. It is VITAL to the integrity of the study that you rely solely on your thoughts and beliefs.. After these scenarios, you will have demographical information to include. **Within this demographic section you will be asked for your sexual orientation.** I am hoping for your full input; however your rights as a participant stress you are free to skip items within the survey and/or demographic section or remove yourself entirely from the study at any time for any reason without negative repercussions or consequences. This study should take about 20 minutes. Your identity will be strictly protected. I remind you not to place any identifying information on any portion of the survey.

3. **Expected costs:**
   None

4. **Description of the discomforts, inconveniences, and/or risks that can be reasonably expected as a result of participation in this study:**
   The nature of the scenarios may create mild emotional discomfort based on individual reactions to the discrimination depicted and possible affiliations to certain groups discussed within the scenarios.

5. **Compensation in case of study-related injury:** N/A
   MTSU will not provide compensation in the case of study related injury; however there is no likely injury from participating in this study.

6. **Anticipated benefits from this study:** This study will generate a more in-depth view of offense to discrimination, how people see themselves, and what their value systems are in regard to specific areas. The design will allow for respondents to *inform us* of their thoughts and feelings, rather than be boxed into labels. This study will serve as a benefit by examining different demographic/minority groups and stigmas and discrimination that may/may not be tolerated or known by respondents..

a) The potential benefits to science and humankind that may result from this study include foundations and starting points in viewing the aspect of offense to discrimination of minority groups. It also includes the possibility for other statistical data that can further explain why certain discriminated groups invoke a greater offense and less tolerance of the ill-treatment. This study will also contribute to ethical and legal regulations within health care and mental health by establishing and highlighting broken ethical and legal barriers that may/ may not be occurring, as well as the reactions to them.

b) The potential benefits to you from this study are insight into yourself and a chance to explore the whole of your thoughts and your biases by giving your true reactions to specific stigma and prejudice; with hopes of both conscious and unconscious responses by each participant.

7. **Alternative treatments available:** N/A
8. **Compensation for participation:** N/A
9. **Circumstances under which the Principal Investigator may withdraw you from study participation:** Anyone not wishing to give appropriate attention to this study will be extracted. Anyone appearing to blindly answering without reading items or scenarios they are based on may also be excused. Additionally, anyone who seems overly upset by the scenarios explained will be asked if they would wish to leave.

10. **What happens if you choose to withdraw from study participation:**
    There is NO penalty for withdrawing from the study at any time for any reason.

11. **Contact Information.** If you should have any questions about this research study or would like a final copy of the report generated by your participation, please feel free to contact Melani Baker-Mood at **615-578-6508** or my Faculty Advisor**, Dr. Gloria Hamilton.**
12. **Confidentiality.** All efforts possible will be made to keep personal information you provide us private, however **total** privacy cannot be promised. Your information may be shared with MTSU, the government, such as the Middle Tennessee State University Institutional Review Board, Federal Government Office for Human Research Protections. This consent form will be stored separately from your survey and both will be kept locked in faculty storage. **No identifying information should be put on your survey**!
13. **STATEMENT BY PERSON AGREEING TO PARTICIPATE IN THIS STUDY**
    I have read this informed consent document and the material contained in it has been explained to me verbally. I understand each part of the document, all my questions have been answered, and I freely and voluntarily choose to participate in this study.

_____ _____

Date Signature of patient/volunteer

Consent obtained by:

_____ _____

Date Signature

_____

Printed Name and Title

APPENDIX D

Debriefing and Letter of Thanks

Dear participant-

Thank you very much for your time and effort in completing this survey! The nature of the survey you just took is looking at the various stigmas and prejudiced treatment experienced within the LBGT community compared to those pertaining to religious affiliations within health care and mental health settings. We are trying to see if the middle Tennessee region is a factor in the responses to religious and sexual orientation prejudices. This is only a glance into this vast topic and an introductory examination into what people think about these types of discrimination. We assume there will be further research needed however your participation in today's study has provided a foundation to such future research. Without your contribution this would not have been possible and we thank you very much for your time!

If you have any questions, would like to discuss the research being done, would like to view the final report generated, or have any further concerns please feel free to contact us through the following contact information.

Dr. Gloria Hamilton, Ph.D. Gloria.Hamilton@mtsu.edu

Melani Baker-Mood, B.A.S. mim2f@mtmail.mtsu.edu (615)-578-6508

Thank you again for your help and contribution!

Sincerely,

Melani Baker-Mood

Dr. Thomas Brinthaupt (supervising faculty member)