

## INCORPORATING SEXUAL ORIENTATION INTO MFT TRAINING PROGRAMS: INFUSION AND INCLUSION

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*Many authors have questioned the preparedness of family therapists to deal with sexual minority clients. Even though the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has called for the integration of sexual orientation into the curriculum of marriage and family therapy training programs, the subject continues to be marginalized. The purpose of this article is to encourage trainers to examine their programs' curricula for evidence of heterosexist bias and introduce ways that they might integrate issues related to same-sex affectional and sexual orientations into their programs via the classroom and the clinic.*

It is estimated that approximately 50 million people in the United States are lesbian, gay, bisexual, or transgendered (LGBT), or are related to someone who is (Patterson, 1995), and therapists report considerable personal and professional contact with gays and lesbians. For example, a survey of 457 clinical members of the American Association for Marriage and Family Therapy (AAMFT) indicated that 72% of the respondents reported that one-tenth of their practices consisted of lesbian and gay clients (Green & Bobele, 1994). In addition, 70% of the sample had a personal (nonprofessional) relationship with a gay man or lesbian. Although this survey did not address the extent to which therapists believed they were prepared to work with gay men and lesbians in their clinical practice, Doherty and Simmons (1996) found that a little more than 50% of marriage and family therapists (MFTs;  $N = 526$ ) in their study felt competent in treating lesbians and gay men. This low level of competency may originate from numerous sources, and clinical training is an ideal place for these issues to be addressed.

In his book, *The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life*, Palmer (1998) wrote about "a culture of fear" (p. 35) that often grips those of us who teach in the academy. He described this fear as distancing us from our students, our colleagues, our research participants, and ultimately ourselves. Palmer outlined four layers of fear: the threat of a live encounter in which the other is free to speak his or her own truth, which we may not wish to hear because it might challenge us in some way; the fear of conflict that will emerge when two divergent truths meet; the fear of losing our own sense of self; and the fear that we may be challenged to change our lives and thus the way that we teach. Students are also subject to fears: fear of failing or not understanding; fear of being drawn into issues that they would rather avoid; fear of having their lack of knowledge or prejudices exposed; and fear of looking foolish in front of their peers (Palmer, 1998). In addition to Palmer's suggestions, we add to this discussion the fears of both faculty and students that their values may not be respected. Consider, in our heterosexist society, all of the multiple

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levels of fear that might surround the inclusion of sexual minorities in MFT training programs and the infusion of relevant material in MFT curricula. How will we get beyond our fears? Bellah (1987) stated:

The university is not only a place for specialized research and the acquisition of skills. It is also a community of interpreters . . . including both teachers and students as they attempt to understand the past that defines them and engage the past in a critical dialogue about our present problems. . . . Learning in such a community is not a matter of acquiring skills or accumulating objective knowledge alone. It is also a process of critical self-reflection, about both ourselves and our world, that calls upon our hearts as well as our minds, and that has the capacity to change both ourselves and the society in which we live. (pp. 9-10)

#### ARE FAMILY THERAPISTS PREPARED TO WORK WITH SEXUAL MINORITY CLIENTS?

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) has called for the integration of sexual orientation into the curriculum of MFT training programs; however, we argue that the subject continues to be marginalized. In fact, many authors question the preparedness of family therapists to deal with sexual minority clients (Clark & Serovich, 1997; Laird & Green, 1995; Long, 1996, 2000). Are MFT training faculties reluctant to deal with this topic or just ill prepared to do so? We suggest that both these options are plausible given that issues of same-sex affectional and sexual orientations were probably rarely addressed when many current faculty were in training.

Supervisors and trainers who are committed to preparing supervisees and trainees to work with a diverse client population will want to ensure that trainees have both an adequate knowledge base and clinical skills to work with LGBT clients. Brown (1991) suggested that when supervisors fail to introduce trainees to LGBT issues, discourage trainees' self-examination regarding sexual orientation, and fail to do consciousness raising regarding sexual minorities, they allow "the development of professionals who are not only deficient in their ability to work with sexual minorities, . . . but in the creation of therapists who are uncomfortable with ambiguities and questions regarding sexuality" (p. 237). Supervisors and trainers who raise or address issues related to sexual orientation encourage trainees to learn about and accept differences and develop an awareness of their personal biases regarding sexual orientation (Long, 1997).

#### *Heterosexual Bias*

Heterosexual bias, a form of multicultural bias, has the potential to harm future clients, trainees, and supervisees (Long, 1996). Spaulding (1999) defined heterosexism as, "a form of social control in which values, expectations, roles, and institutions normalize heterosexuality, which, in turn, is promoted and enforced formally and informally by [social] structures" (p. 13). As Hartman (1999) pointed out, the United States is experiencing a social revolution of acceptance in attitudes and policies toward lesbians and gay men; nevertheless, widespread tolerance, protection, and equality are yet to be attained. Heterosexist bias still pervades our culture and our belief systems and thus our training programs. For example, few textbooks or other writings include clinical case vignettes with sexual minority characters.

#### THE PROCESS OF INFUSION AND INCLUSION

The purpose of this article is to encourage trainers to examine their programs' curricula for evidence of heterosexist bias and to introduce ways that they might integrate issues related to same-sex affectional and sexual orientations into their programs via the classroom and clinic.

We encourage program personnel to consider the following basic questions: Are we training students to be competent in working with LGBT clients? Is our program adequately inclusive of sexual minority training materials? Do trainees have adequate exposure to working with LGBT individuals, couples, and families? If not, why, and what can be done to improve the learning atmosphere? What struggles do we experience in cultivating an inclusive environment?

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### *Terminology*

In this article, we refer to gay men, lesbians, bisexuals, and transgendered persons as a group and frequently use the term sexual minority as a referent. Although it is impossible to establish the validity of the use of the term minority in relation to this population, its use is based on the number of self-acknowledged and openly identified persons who are lesbian, gay men, bisexual, or transgendered. It should also be noted that some persons in same-gendered relationships have affectional relationships as opposed to sexual relationships. Although we often refer to lesbians, gay men, bisexuals, and transgendered persons as members of the LGBT community, it should be recognized that each group within that community has unique attributes that make their experiences different. Thus, where applicable, we will draw requisite attention to the idiosyncratic nature of the individual groups and offer suggestions when appropriate.

### A STARTING PLACE FOR INCLUSION AND INFUSION

In this article we draw on the literature throughout the mental health field, but we also reflect on our own 20 years of experience as MFT faculty members, supervisors, and workshop leaders in this content area. Our goal is to offer an opportunity for MFTs to reflect on their commitment to sexual minority issues and dialogue about strategies to better address these issues. This article is not meant to be a checklist for program or clinic directors, but it does provide some basic suggestions program directors and trainers might take into consideration, particularly if they are unsure of where to start in this process. In addition, this article is not considered to be an end in and of itself, but rather a means to becoming more inclusive and culturally sensitive.

#### *Resistance to Change*

Because we both "grew up" in the MFT training culture and have both spent several years as trainers in accredited programs, we are keenly aware that many faculty and supervisors either openly resist or pay lip service to becoming more open, positive, and knowledgeable about LGBT persons and issues. This article is not intended for persons whose beliefs and values lead them to "tune out" when we or others attempt to enter into a dialogue about this topic. Rather, we hope this article will engage those persons who are willing and open to exploring ways to infuse their training programs with an LGBT friendly and informed environment. Some readers may choose to ignore or dismiss this article because it was written by two LGBT affirmative authors. We embrace this label and, in fact, believe that this quality has enabled us to write this article with more authenticity.

#### *Religiously Based MFT Programs*

A number of COAMFTE-accredited programs are housed within religiously based institutions. The COAMFTE has recognized and addressed this fact in its Standards of Accreditation: "Religiously affiliated institutions that have core beliefs directed toward conduct within their communities are entitled to protect those beliefs" (2002, Preamble, paragraph 6). For example, programs housed in Southern Baptist, Seventh-day Adventists, Church of Christ, and Church of Jesus Christ of Latter Day Saints institutions are bound by church doctrine to be opposed to same-sex "practices and relationships" (e.g., the Seventh-day Adventists Position Statement on Homosexuality, 2002, paragraph 2). If their institution has policies that prohibit the hiring of LGBT faculty, COAMFTE permits administrators/faculty of these programs to discriminate against LGBT persons to protect the core beliefs of their institution. Further, COAMFTE Standard 320.06 states that programs will include content on issues of gender and sexual functioning, sexual orientation, and sex therapy as they relate to couple or MFT theory and practice. Some programs in religiously based institutions have responded to this standard by including in their educational training content related to reparative/reorientation therapies, sexual identity management, and celibacy approaches for persons who are LGBT, as congruent with the beliefs of their religion.

Historically, the field of family therapy has had, and continues to have, strong ties to the pastoral counseling field. Today many trainers and supervisors in the field consider themselves to be pastoral counselors who are also MFTs. Also within the family therapy field, there has been an increased interest in

spirituality (Becvar, 1997). Trainers and supervisors are encouraged to talk more about the advantages of using spirituality as a potential tool in their therapeutic repertoire. They are also encouraged to include spirituality as a part of the system's cultural context. The COAMFTE Standards (2002) prohibit discrimination on the basis of religion. Clearly as a profession we have committed to upholding the rights of our clients and students to be true to their religious beliefs and not to discriminate against them when they are.

The issues involved are complex. For example, most major mental health organizations (ACA, APA, NASW) have taken a strong stance against reparative therapy, and yet, because AAMFT has not taken a stance against this form of therapy, we still have trainees who want to practice reparative therapy and programs that include it in their training content. How do we respond as supervisors or trainers, show respect for differences, and not discriminate on the basis of sexual orientation or religion, especially with conservative religious groups? We believe the complexities of these questions are beyond the scope of this particular article, but they are questions that must be recognized and addressed in the field at large.

We understand that programs located in religious institutions may not be open to incorporating sexual orientation-affirming education or policies because they are in direct conflict with the values of the religious institutions. We are also cognizant that many faculty members in these programs do not adhere to conservative religious belief systems and will be thoughtful as to how they might incorporate our recommendations. Either way, we hope suggestions offered here could serve as a helpful beginning for encouraging creative integration for those open to doing so.

### CLASSROOM ISSUES

The accrediting bodies of all major mental health disciplines have called for the integration of LGBT issues into doctoral and master's curricula. For example, COAMFTE Standard 300.01 states, "Programs are expected to infuse their curriculum with content that addresses issues related to power and privilege as they relate to age, culture, environment, ethnicity, gender, health/ability, nationality, race, religion, sexual orientation, spirituality, and socioeconomic status." The standard can easily be addressed with well-placed articles on clinical issues with sexual minority clients on a few of the course syllabi; however, this amount of exposure hardly prepares beginning therapists for working with this population and is not true to the spirit of infusion.

The following suggestions may be helpful to faculty members as they further seek to incorporate sexual minority issues in the classroom. Although these changes may appear small and trivial, they offer an opportunity for dialogue and for larger concerns to be voiced and discussed.

1. Incorporate readings that contain sexual minority topics across the curriculum and not just in sexuality classes. Materials could include clinical and research articles, as well as clinical case vignettes (e.g., Bepko & Johnson, 2000; Greene & Boyd-Franklin, 1996; Johnson & Keren, 1998; Savin-Williams, 2001).
2. Use films with LGBT content or characters. These may be a bit more difficult to locate. Local LGBT organizations may be of assistance in identifying appropriate documentaries, films, or movies. The Internet is also a helpful resource for identifying appropriate films (<http://glweb.com/lesbianflicks/index.html>).
3. Incorporate examples of sexual minorities and their relationships in role plays or case presentations, including parenting. Recognizing the unique set of family characteristics presented by gay, lesbian, and bisexual families can encourage a broader understanding of family diversity.
4. Recognize and address diversity within sexual minority relationships. Persons of color are becoming the numerical majority in the United States (Yutzenka, 1995). All people including sexual minorities are meeting and entering into relationships with persons from varied cultural backgrounds including race, ethnicity, and class. Their mix of identities and the integration of their multiple layers of complexity will present us with new challenges as therapists and supervisors. We must prepare our students to be sensitive to and respectful of the many layers of culture with which they are working (Long, in press).
5. There are differences both within and between different sexual minority groups. Therefore, it is

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important not to generalize about all sexual minorities based on information about one group. Frequently, gay men and lesbians are grouped together and discussed as though there were no differences between the two groups. Assuming that readings related to gay relationships can be applied to lesbian relationships is erroneous. Even though some similarities do exist, Laird and Green (1995) noted that the differences between gay and lesbian couples are as distinct as the differences between heterosexual and same-sex couples.

6. Invite sexual minorities to be guest speakers in courses. Community agencies and university groups typically offer a speakers bureau. These individuals can offer basic knowledge of the history of the struggle sexual minorities have faced, which is important for therapists (Long, 1997). Other topics that could be addressed include the daily invisibility of same-sex relationships; the "coming out" process with family, friends, and colleagues; the history of the gay rights movement; major social battles which are currently being faced, including issues related to adoption, religious communities, and marriage and commitment ceremonies; and the effects of homophobic actions on self-esteem and personal pride.
7. Pay special attention to language:
  - a. Refrain from using the term homosexual. We find that the students in our classrooms and the participants at national mental health conferences still regularly use this word. This term may perpetuate negative stereotypes because of its historical association with pathology.
  - b. Sexual orientation is preferred to sexual preference, and refers to sexual/affective relationships between lesbians, gay men, bisexuals, and heterosexuals. The word preference suggests a degree of voluntary choice that is not supported by psychological research.
  - c. Use of neutral terminology in the classroom can help students be aware of bias in language both in the classroom and clinic, such as the use of the term partner versus husband or wife, and questions related to sexual activity, rather than sexual intercourse (APA, 2001).
  - d. Use parallel terms when comparing sexual minorities to other groups; for example, lesbians and heterosexual women versus lesbians and conventional women (Long, 1996). As highlighted by one of our reviewers, the subtle use of heterosexist language continues to permeate and contribute to the stereotyping of LGBT persons.
  - e. Finally, pay attention not only to the words that you use but also the intonation of your voice and nonverbal cues. Comments made with an exaggerated voice and rolling of the eyes, such as, "Oh you know how they (gays) are," certainly expose biases and stereotyping.

Many of these suggestions are not our own original ideas. Several of them have also been stated by other mental health professionals (Bernstein, 2000; Brown, 1991; Greene, 1994; Herek, Kimmel, Amaro, & Melton, 1991). We do, however, believe the importance of stating them again because we continue to encounter unfamiliarity with these ideas in our own classrooms and in national workshops.

## CLINICAL ISSUES

Clinical theories and approaches are learned in the classroom but develop a life through practice. Incorporating LGBT issues into clinical training can be an easy way to help trainees develop requisite competence in treating sexual minorities. Having skill and being able to exhibit understanding, however, can be very different phenomena. A therapist can be very skillful in carrying out a certain technique but lack the necessary depth of understanding to fully comprehend another person's situation. This lack of knowledge or sensitivity can and should be remediated through small interventions. Therapists and other mental health staff should develop a keen sensitivity to sexual minority issues as the history of "psychiatric cures" for those with same-sex affection and attraction has led to a climate of distrust between sexual minorities and the health care profession.

### *Working With Trainees Averse to LGBT Persons and Issues*

Although in some instances supervisors are less informed than trainees in regards to LGBT issues, they are still in a particularly good position to detect difficulties a trainee might have with sexual minority clients.

Trainees who are averse to working with sexual minorities pose a unique challenge. Programs should consider having a policy on how to deal with these situations. The following suggestions might be helpful:

1. Allow trainees who are wary of or biased against persons who are LGBT to observe therapy sessions involving sexual minorities from behind the mirror or via videotape with the permission of clients.
2. Carefully monitor the trainee's cases while broadening the trainee's knowledge base. Adding a cotherapist who is sensitive to the needs of sexual minorities would be a good alternative at this point.
3. Assist reticent supervisees in honoring the ethical codes by respecting clients' rights, refraining from discrimination on the basis of sexual orientation, not exploiting clients, and referring these clients when necessary.

In addition, supervisors could:

1. Make supervisees aware of safe places on campus and in the community for sexual minorities to receive support and guidance.
2. Be aware of common stereotypes pertaining to LGBT individuals, couples, and families; for example, in the early literature related to lesbian couples, several authors wrote about merger and fusion in lesbian relationships (Burch, 1982; Kresten & Bepko, 1980; Lindenbaum, 1984). Laird (1999, 2000a, 2000b) and others have challenged these notions and encouraged therapists to look beyond what Green, Bettinger, and Zacks (1996) termed "gender straightjackets" (p.185) to consider new options and meanings in the enactment of gender in LGBT relationships. If supervisors are themselves unaware of these stereotypes, they will not be able to notice and address them with supervisees.

There are other things that clinical directors should be aware of and policies that might be implemented. These include:

1. When indicating marital status for clinic paperwork, include options such as partnered or dating, as well as married, single, widowed, or divorced.
2. Include sexual minorities in clinic brochures as part of the population that is served by the clinic, if the students are prepared to work with them.
3. Incorporate wording into permission-to-treat clinic documents that specifically includes confidentiality of sexual orientation.
4. Make sure that your waiting room and therapy rooms are LGBT friendly. If you have brochures available regarding community resources, include materials for sexual minorities. Include artwork that is inclusive of same-sex couples and families. If a bookcase is present in the room, make sure that some of the books are related to sexual minorities.

Training programs might also consider the following:

1. Recruit sexual minority clients for the clinic. Advertisements or brochures are often welcomed by community LGBT organizations and businesses. Flyers can also be sent to groups in the community to be shared with membership. A call to organizational leaders will help reinforce that the clinic is open to helping members of all communities.
2. Recruit and support sexual minority trainees. See Long (1996, 1997) for further discussion of how to create a safe environment for LGBT trainees.
3. Encourage students to explore their attitudes about sexual orientation and their level of homophobia. Questions such as the following might be explored in supervision: Does the supervisee want to work with gay, lesbian, bisexual, and transgendered clients? If not, what are the reasons (lack of knowledge, lack of exposure, disdain)? Is it acceptable for therapists to decline to learn about sexual minority issues? Can a therapist who has moral objections to a client's sexual orientation work effectively with that client? Might the supervisee with moral objections be interested in undermining same-sex relationships or in changing sexual orientation? How would these motives, if they became a part of the therapy, be violations of ethical codes?

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## PROFESSIONAL RESPONSIBILITIES

There are a number of responsibilities that MFT faculty and supervisors have in addressing sexual orientation in training programs and clinical settings. One is to have faculty who are educated about current issues, resources, and research related to sexual minorities and who have a positive attitude toward LGBT persons. Increasing knowledge is also a way to decrease the amount of heterosexist bias that faculty members are likely to have (Long, 1996, 1997). Knowledge about resources, agencies, and professionals in the community demonstrates sensitivity to sexual minority issues. Furthermore, this knowledge enables the program to keep up-to-date resources available for students, administrators, or clients who may need more information on sexual orientation and support groups. Finally, although there has not been an abundance of empirical research on sexual orientation issues (Clark & Serovich, 1997) in the MFT literature, more work has been done in the allied disciplines of psychology and social work (e.g., Kurdek, 1998; Kurdek & Schmitt, 1987; Patterson, 1994, 1995; Savin-Williams, 2001). Knowledge of this literature allows faculty to demonstrate that their office/classroom is a safe place to talk about any topic, including sexual orientation, and leaves faculty prepared to deliver accurate information about sexual orientation.

### *Program Issues*

The COAMFTE has been responsive to the needs for diversity in the academic training of MFTs. For example, the Commission requires that training programs have nondiscrimination policies, and Standard 100.04 states, "The program will demonstrate that it provides a learning context in which understanding and respect for diversity and non-discrimination are fundamentally addressed, practiced, and valued in the curriculum, program structure, and clinical training." Even though most institutions have such general equal-opportunity statements and at least theoretically support diversity, this may not suffice in the pursuit of equality in a training program. There are a number of ways these statements can be undergirded:

1. Create and enforce a policy regarding homophobic remarks and harassment as a way to communicate your commitment to equal treatment for all.
2. Recruit and support sexual minority faculty members.
3. Encourage faculty to self-assess for homophobia and comfort levels when interacting with sexual minorities (e.g., including an opportunity for self-examination of these issues at a faculty retreat).
4. Provide diversity training for faculty to equip them to educate and treat all students equally.
5. Encourage faculty to seek out personal and professional relationships with sexual minorities.
6. Expand the program or university library to include pamphlets, books, and videos on sexual orientation.

### *Issues of Disclosure for LGBT Trainees*

Program personnel should consider the question: "Would gay, lesbian, and bisexual trainees feel comfortable disclosing their sexual orientation within the environment of this program?" Although the code of ethics clearly states that supervisors must avoid dual relationships, students often turn to faculty in seeking referrals or support for difficult issues. In fact, faculty members are in a unique position of frequently being called on to offer counsel or guidance to students or trainees on personal matters. Therefore, it would not be surprising if a sexual minority trainee sought the advice of a faculty member for a multitude of situations. These situations might include coming out to other faculty or students, decisions about being an "out" therapist in the community, and coming out to sexual minority clients. Some suggestions for handling such disclosures include:

1. Refrain from acting surprised, shocked, or disappointed. Although surprise or shock is a common reaction in our heterosexist culture, sharing or exhibiting this reaction could be harmful.
2. Respect a student's confidentiality by not sharing personal information with other students, faculty, or administration without the explicit consent of the student.
3. Help trainees or students deal with their own feelings and biases related to their sexual orientation.
4. Assess trainees' or students' understanding of same-sex orientation and replace misinformation with accurate knowledge.

5. When students are questioning their sexual orientation, anticipate confusion, especially in the beginning.
6. Do not assume heterosexuality of any student. The presence or absence of children is not an indicator of sexual orientation.

### CONCLUSION

We hope that the ideas presented in this article provide trainers and supervisors with not only an opportunity to acquire knowledge but also a challenge for them to reflect on their own training and preparation for working with sexual minorities. Change happens in small steps. We encourage program directors, faculty, and supervisors to make both reasonable and challenging decisions regarding training curricula addressing sexual minorities. Stretching the boundaries of our knowledge and comfort are required if we are to train a new generation of MFTs who will be faced with a terrain unfamiliar to many of us now. For example, these therapists will be working with gay and lesbian families that include biological and adopted children and stepchildren. Only when we face our own ill preparedness, bias, and fear will we be able to provide the space for our trainees and supervisees to do likewise.

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