EVALUATING THE EFFECTIVENESS OF THE MARRIAGE AND FAMILY THERAPY PROGRAM AT TRAINING THEIR STUDENTS IN WORKING WITH GAY, LESBIAN, BISEXUAL, AND TRANSGENDERED CLIENTS.

by

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ABSTRACT

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Evaluating the Effectiveness of The Marriage and Family Therapy Program at Training Their Students in Working with Gay, Lesbian, Bisexual, and Transgendered Clients.

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This study was conducted to investigate how prepared MFT graduates felt, upon their graduation from the Program at UW-Stout, to work with gay, lesbian, bisexual, and transgendered clients. Other information asked for on this survey was: what percent of their client base were GLBT persons, whether or not they felt comfortable around GLBT persons and if they thought GLBT persons should be included in the general clinical practice, and finally if they had received any additional training in GLBT issues or had any recommendations for future training at UW-Stout. These surveys were mailed out to all former graduates, from 1974 through 2001, of the MFT Program at UW-Stout in Menomonie, Wisconsin.

The literature review suggested that most counseling programs do not offer training to work with GLBT persons. Other research indicated that exposure to GLBT persons decreased homophobia and increased comfort levels of associating with these persons.

The results found that 51.5% of the graduates did not feel prepared to work with their GLBT clients. Furthermore 93.5% indicated that they currently work with GLBT clients, the majority of them stated that one to ten percent of their clients were from the GLBT population. On the positive side 99% claim to be comfortable around GLBT persons and most of them know at least one GLBT person. Only about 44% of the respondents had received additional training specifically dealing with GLBT issues.

This information will be helpful to the MFT Program in that it revealed a need to address the issue of GLBT clients. It also yielded several suggestion that could be addressed within the Program.

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I wish to acknowledge all of my GLBT friends who have helped me along my own journey. I owe a debt of gratitude to Amy for putting up with my tense disposition through this whole process. Also for her very stringent editing (even when I didn't appreciate it) of my rough draft. My daughter Jessica Wolf was also invaluable to me. Her help with all of the cataloging, adding, and dividing of the data made this a much quicker process.

My appreciation goes out to all of my professors at UW-Stout, but most especially to Dr. John Williams who has been my advisor and my cheering section throughout the process of my researching and writing.

Table of Contents

CHAPTER ONE

Introduction

The face of the American family is changing, but are the therapists who work with families keeping up with these changes? Waters writes in her article that today's family can come in many forms, including two parent heterosexual, single parent, gays or lesbians with their children either biological or adopted (1997a).

In another article Waters writes about straight parents who have gay children. In this article she discusses PFLAG (Parents and Friends of Lesbians And Gays), an organization that helps parents understand and support their lesbian daughter or gay son (1997b). The very existence of organizations like PFLAG is a testimony to the struggles that lesbian, gay, bisexual, and transgendered families face.

It has been more that twenty years since same-sex orientation has been depathologized (Adam, 1995; Morin & Rothblum, cited in Liddle, 1999). The American Psychological Association Council of Representatives adopted a resolution on appropriate therapeutic responses to sexual orientation in August of 1997. This resolution states, in part, that therapists should not treat homosexuality as a mental disorder, nor should they discriminate against any person because of sexual orientation. It also states that if psychologists are having difficulty working with a particular individual or group because of sexual orientation, they should obtain training, experience, consultation, supervision, or make appropriate referrals. It ends by urging all mental health professionals to help in removing the stigma of mental illness associated with homosexual orientation by disseminating accurate information about sexual orientation

and appropriate interventions to counteract bias based on ignorance or unfounded beliefs (DeLeon, 1998).

In their study of graduate students working on psychological counseling degrees, Phillips and Fischer found that gay, lesbian, and bisexual issues were incorporated into some of the course work, but this was less true of bisexual issues. They also noted only half of the participants had been encouraged to explore their own heterosexist biases; only one third of them had a faculty member with expertise in this area; the majority of them had positive/accepting attitudes about gay and lesbian people; and most of these students felt ill-prepared to counsel gay and lesbian clients (1998).

The public schools do not fare much better. Fontaine reports that gays and lesbians may make up the largest minority group in some schools and yet their needs go unmet. This kind of homophobic and intolerant educational environment can only exist when school officials help create it, whether implicitly or explicitly. In her study of school counselors she found that the majority had experience working with at least one student who was struggling with issues of sexual orientation, but that they felt only moderately qualified to work with this population. Most of them indicated a willingness to attend specialized training; however, most believed there was only a very small percentage of gay/lesbian students in their schools (1998).

Curriculum could be used to incorporate information about gay/lesbian issues in the classrooms either by counselors or teachers (McFarland, 1998; Taylor, 2000). Taylor explained that middle schools were created to help young adolescents deal with special developmental and intellectual needs and yet they ignore the needs of their students who may be at most risk for failure. Both therapists and educators need to be more attentive

and mindful of the gay/lesbian youth (2000).

According to the American Association of Marriage and Family Therapist's (AAMFT) Code of Ethics, marriage and family therapists have an obligation to demonstrate professional competence and to work with integrity. In the area of homosexuality, Yarhouse believes this can be done by keeping abreast of current research findings about same-sex attraction and by discussing with others what we know or do not know about homosexuality (1998).

As you may understand by now there are many facets to consider when counseling the gay, lesbian, bisexual, and transgendered (GLBT) community. This study will survey graduates of the Marriage and Family Therapy (MFT) Program at UW-Stout to assess the level of their knowledge about the GLBT population. A secondary part of this study will survey the marriage and family therapists to see if they think knowledge and expertise in this area are necessary or if they see this as a specialty area of therapy.

Statement of the Problem

The purpose of this study is to survey former graduates of the Marriage and Family Therapy Program at the University of Wisconsin-Stout to evaluate the effectiveness of the Program in preparing graduates to work with the gay, lesbian, bisexual, and transgendered population. This survey will be done in the summer of 2001. This survey will be included with a larger survey sent out by the Director of the Marriage and Family Therapy Department. The reason for this research is to determine whether marriage and family therapists have received adequate training for working with gay lesbian, bisexual and transgendered clients.

The survey will be sent to all former graduates of the MFT Program from its

inception in 1974 through May of 2001. The survey is designed to collect data on the frequency of their work with GLBT persons, their preparedness of working with this population and their suggestions for any changes they deem necessary. There will also be an opportunity for them to share anything that they think was helpful in preparing them to work with the GLBT population.

Research Objectives

There are six objectives that this research wishes to address. They are:

1. To assess the preparedness of marriage and family therapists in the area of gay, lesbian, bisexual, and transgendered issues upon graduating from the MFT Program.
2. To assess the comfort level of therapists for working and interacting with GLBT persons.
3. To look at how many therapist actually work with clients from this population.
4. To determine what percentage of clients are from the GLBT population.
5. To determine if any of the respondents have received additional training in GLBT issues.
6. To take suggestions from these graduates about any changes they believe may be helpful in preparing current students to work with the GLBT population.

Definition of Terms

For clarity of understanding, the following terms need to be defined.

Bisexual: an individual who is sexually and affectionally attracted to individuals of both genders.

Gender Blenders: question traditional gender dichotomies by replacing them

with a continuum.

Gender Identity: a person's internal subjective experience of how they feel and express themselves as a gendered person regarding gender roles, attitudes, and behavior.

Heterosexism: a belief system that values heterosexuality as superior to and/or more "natural" than homosexuality.

Homophobia: a fear, anger, disgust, discomfort and aversion to gay individuals. A dread of being in close quarters with homosexuals.

Homosexual/Gay: a self-ascribed definition held by a person over time and across situations as having primary sexual, affectional, and relational ties to people of the same gender. The term "gay" can refer to homosexual males, but can also include lesbians.

Intersexed Persons: are born with both male and female genitals.

Lesbian: a female with a sexual and affectional attraction toward other females.

Transsexual: an individual who feels that they were born with a body of the wrong gender. They may have surgical procedures to change their gender.

Transgendered: an umbrella term for all members of the nondominant gender identity communities, including

transsexuals, cross-dressers, gender blenders, and intersexed persons.

Assumptions

One assumption that can be made is that the participants will fill out and return the survey. The second assumption is that they will answer all the questions on the survey honestly.

Limitations

One limitation is that the study will only apply to marriage and family therapists and may not be generalizable to other counselors. However, it may still be of interest to other counselors, clinicians and educators.

CHAPTER TWO

Review of Literature

Introduction

There have been several studies that show a significant relationship between training/knowledge of GLBT issues and the enhanced effectiveness of therapists with this population. Through this review of the literature you will become aware of this significance and understand that therapists who have been educated about gay, lesbian, bisexual, and transgendered issues are more effective at counseling their GLBT clients. Counselors and educators will be included in this review.

School Counselors

As adolescents grow and mature they are often confused by all the changes taking place with their bodies. The surge of hormones is also very confusing causing mood swings, unfamiliar and heretofore unknown sexual urges or desires. These things alone are very confusing for an adolescent to understand and come to terms with. When these feelings deal with same gender desires or a discomfort with one's own gender, things become even more confusing and complicated.

According to Fontaine's study, the three most common problems of homosexual students are poor self-esteem, depression, and self-doubt; which can be grouped into the broader category of sense-of-self. These results support prior findings about the effects of marginal group status. Fontaine concludes that social stigma tends to create a negative self concept (1998). Couple these findings with the average struggles of adolescence and the outcome may be some very troubled youth.

In a case study, Lock describes working with a young gay man who was severely

homophobic. He reports that as his client approached late adolescence he had difficulty with the idea of being gay for his entire life. Lock cautions that this can be a risky time in working with young gay or lesbian clients, especially those with severe internalized homophobia, because such a long range view may lead to feelings of hopelessness which in turn may lead to thoughts of suicide (1998). This is a time when school counselors could be helpful to these confused and troubled youth if they were attentive and understood the special needs of the gay population. In another article, Lock & Kleis report that by late adolescence most teenagers can predict what being gay will mean for their job prospects and feel it is unlikely they will ever have a long-term, intimate relationship (1998). Counselors need to make available information about being gay that may be helpful to these students in forming a positive self image.

Earlier awareness of sexual orientation, earlier occurrence of first same-gender sexual experience, and more same-gender sexual partners, reports Hershberger & Pilkington, are also related to increased suicide attempts (1997). This makes sense given the stages of development in adolescents. The reasoning skills are not yet as developed in early adolescence and they have less understanding of what is going on with them. Many times they do not have a strong, positive self concept and do not see themselves as an individual who matters. McFarland describes this as an internalized negative image of being bad or worthless (1998). Taylor states that middle schools were established to help young people through these difficult developmental times (2000).

Taylor adds that at a time when adolescents need to develop close friendships and share personal information about themselves without fear of being rejected, the same primary task as most young people, those adolescents with same-sex attractions end up

adjusting to a "socially stigmatized" role that keeps them isolated and without adequate information to develop a healthy acceptance of themselves (2000). It would be helpful if guidance counselors could be open to the gay, lesbian, bisexual, and transgendered student body so that these students would have a place to seek help and support.

According to Hershberger and D'Augelli the single largest predictor of mental health was self-acceptance (1995). Taylor laments the fact that most gay, lesbian, and bisexual youth do not have role models and accurate information about being gay, lesbian or bisexual, which could help them to form a more positive image of themselves. Instead they develop strategies for coping which may include hiding or drug abuse.

Taylor makes recommendations for the schools to integrate information about gays, lesbians, and bisexuals who have made significant contributions to our society. He also believes that teachers should discuss gays, lesbians, and bisexuals when teaching about discrimination (2000). McFarland adds that schools do not do an adequate job of protecting the gay, lesbian, and bisexual youth. They simply turn a blind eye and allow them to be victimized (1998). Taylor recommends that teachers, in addition to school counselors, need training in gay, lesbian, and bisexual issues and need to work on their own heterosexism and/or homophobia (2000).

As McFarland reports, it is not sexual identity which makes gay or lesbian youths particularly vulnerable to suicide attempts, it is the oppressive and hostile environment in which they feel they cannot cope any longer (1998). Given the high incidence of reported harassment and violence in the schools against students who are perceived as gay and the fact that perpetrators of anti-gay violence are usually groups of adolescent males, it is crucial for school counselors to take an active role in advocating for services

and policies to protect the welfare of the gay students (Fontaine, 1998).

Hershberger and D'Augelli found victimization of gays and lesbians, through either verbal harassment or various forms of physical assault, is the most common form of bias-related violence. Victimization of gay, lesbian, and bisexual youth led to a higher degree of mental health problems, which in turn may lead to a higher level of suicide attempts and/or suicide. They also found that more youths who identified as bisexual were multiple attempters (1995). It seems evident that the gay, lesbian, and especially bisexual youth are subjected to more stressors than the heterosexual population.

The National Center for Health Statistics report of 1993 (cited in Hershberger & Pilkington, 1997) found suicide to be the third leading cause of death among adolescents in the United States, accounting for 5,000 deaths in the 15-24 year old age group. Additionally, they report that 40% of the gay, lesbian, and bisexual youth studied have attempted suicide.

It has been estimated that gay, lesbian, and bisexual youth commit suicide three to four times more frequently than heterosexual youth. Because many gay, lesbian, and bisexual youth who commit suicide have not disclosed their sexual orientation to anyone, Hershberger and Pilkington report, there cannot be an accurate account of the gay, lesbian, and bisexual suicides (1997). Most death certificates do not list sexual orientation as part of the demographic data, thus making it difficult to do a historical study of suicides. It is very difficult to study a segment of the population that can remain so hidden.

Professor John Williams from the University of Wisconsin-Stout, Menomonie, in his lecture June 17, 2000, stated that often suicide attempters have a secret that they

carry. He went on to state that the attempters feel this secret is so horrible that they cannot share it with anyone and when the pressure of carrying this secret becomes too great they feel suicide is the only way out.

Among the gay, lesbian and bisexual youth, their sexuality may become this life-threatening secret. McFarland writes that in studies of gay, lesbian, and bisexual students first time attempters are aware of their sexuality, but had not developed to the point of attaining a positive gay identity (1998). This is a huge secret to carry, especially given the religious and societal tenor around the topic of homosexuality.

There is a fear that some suicidal youth are slipping through the cracks because counselors are not aware of the risks particular to the gay, lesbian, and bisexual adolescents. McFarland suggested that any suicidal teen who sees a counselor should be asked if they are concerned about or struggling with their sexuality. There should also be information available to them about homosexual identity formation to help make the process more normal for them. Parents may also need information and assistance to help them understand and support their child (1998).

In a review by O'Hanlan, et al, they mentioned a study done by Hunter (1989) who surveyed 500 adolescents who were applying to a school in New York City for gay and lesbian teens. In this survey, 46% of the respondents reported that they had experienced violence from their families, peers, or strangers related to their sexual orientation (1997).

Fontaine found that included in the many concerns facing gay teens, fear of disclosure to peers and parents, and fear of rejection by family, were among the strongest (1998). The process of coming out, according to Hayes, begins with self-

acknowledgment, followed by the announcement to close friends and family, and if a comfort level is reached, acknowledgment to the rest of society. This is not an easy process, nor does every individual follow it in this order. Coming out involves many obstacles, issues, and problems including fear of isolation, rejection, and internalized as well as external homophobia (2001).

Hershberger & D'Augelli found that more than half of the gay, lesbian, and bisexual youth they surveyed were afraid of what might happen when they came out to their families. Of the mothers who knew about their child's sexual orientation, eight percent were seen as intolerant but not rejecting, and 12% were rejecting. Of the fathers who knew 10% were intolerant and 18% were rejecting (1995).

Lock believes that it is important for therapists to involve families with gay, lesbian, or bisexual adolescents. Sometimes this is not possible due to the family's lack of acceptance. He continues by stating that often the adolescent will project their fears of rejection onto their families and will not accept their support (1998). This is indeed a difficult and confusing situation for adolescents and their families.

In his article Yarhouse states that one of the unique challenges to marriage and family therapists, is a family who presents when an adolescent member has a same gender attraction. He continues by stating that the therapists may not have considered or thought through this scenario and may not have many resources to draw upon for help with the treatment of this family (1998).

It is clear that families need help dealing with the homosexual orientation of adolescents. The following section addresses the issues that family counselors need to keep in mind while working with gay or lesbian youth as well as other family members

who may be gay, lesbian, bisexual or transgendered.

Family Counselors

In his article Green states that we (meaning society) have a long way to go before GLBT families can feel safe and enjoy the freedom and privileges that other families take for granted. He cited several studies done in the marriage and family field; Dougherty & Simmons, 1996; Green & Bobele, 1994; and Clark & Serovich, 1997; which found that members of the AAMFT are working with the GLBT population but that a large majority of them do not feel competent about their abilities to work with them. He also found a lack of articles published on this subject (2000).

Bepko and Johnson note four external factors that influence lesbian/gay couples' functioning: (1) homophobia and heterosexism; (2) gender norms; (3) coming out; (4) social support from families of origin and families of choice. They also note internal factors that are very much like the factors facing heterosexual couples (2000). Therapists who are not sensitive to lesbian and gay issues may inadvertently skip right to the internal factors when it may be the external factors that are the problem for them.

According to Bepko and Johnson disclosure to self and to others is a watershed moment in most lesbian and gay persons lives. Yet, only the act of coming out permits the development of a narrative that can give voice to same sex feelings and can redefine relational connections (2000). The act of coming out may be a foreign concept to some therapists and may hinder their ability to work with gay and lesbian persons.

Bepko and Johnson state that gay and lesbian couples who seek counseling view their committed relationships as seriously as do their heterosexual counterparts and thus deserve to be affirmed by their therapists They also have a right to see a therapist who is

knowledgeable about the meanings and mores of lesbian/gay culture.

Lesbian and gay couples often feel a pull between loyalty to their families of origin and their desire for their partners to be included in that family (2000). If a therapist were to study the guidelines suggested by the American Psychological Association (which follows) they may be able to suggest that the couple "find" their own family to support them. Often if the family of origin rejects or minimizes the couple they will "find" family within the gay and lesbian community.

Last year the American Psychological Association (APA) published guidelines for working with the Lesbian, Gay, and Bisexual clients. These guidelines are as follows: Guideline 1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness. Guideline 2. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated. Guideline 3. Psychologists strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of lesbian, gay and bisexual clients. Guideline 4. Psychologists strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process. Guideline 5. Psychologists strive to be knowledgeable about and respectful of the importance of lesbian, gay and bisexual relationships. Guideline 6. Psychologists strive to understand the particular circumstances and challenges faced by lesbian, gay, and bisexual parents. Guideline 7. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related. Guideline 8.

Psychologists strive to understand how a person's homosexual or bisexual orientation may have an impact on his or her family of origin and the relationship to that family of origin. Guideline 9. Psychologists are encouraged to recognize the particular life issues or challenges that are related to multiple and often conflicting cultural norms, values, and beliefs that lesbian, gay, and bisexual members of racial and ethnic minorities face. Guideline 10. Psychologists are encouraged to recognize the particular challenges that bisexual individuals experience. Guideline 11. Psychologists strive to understand the special problems and risks that exist for lesbian, gay, and bisexual youth. Guideline 12. Psychologists consider generational differences within lesbian, gay, and bisexual populations and the particular challenges that lesbian, gay, and bisexual older adults may experience. Guideline 13. Psychologists are encouraged to recognize the particular challenges experienced by lesbian, gay, and bisexual individuals with physical, sensory, and cognitive-emotional disabilities. Guideline 14. Psychologists support the provision of professional education and training on lesbian, gay, and bisexual issues. Guideline 15. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation. Guideline 16. Psychologists make reasonable efforts to familiarize themselves with relevant mental health, educational, and community resources for lesbian, gay, and bisexual people (Division 44 Committee, 2000).

This author was not able to find a statement from the AAMFT regarding therapy with GLBT clients. However, in the AAMFT's newly revised Code of Ethics (2001) they do state that marriage and family therapists should not discriminate on the basis of race, ethnicity, socioeconomic status, disability, gender, health status, national origin, or

sexual orientation. Also under the section titled Principle, it states that marriage and family therapists should pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, or supervised experience. Clearly a statement from the AAMFT regarding GLBT issues would be helpful since family issues are at the center of GLBT struggles.

For example lesbian and gay male couples may also fear harassment and physical violence if their identities become known. Many of these couples live in states where there is no legislation to protect them from discrimination and/or hate crimes (Bepko & Johnson, 2000). These kinds of fears can and do cause great distress for many couples that therapists may not understand.

In the interim of leaving home GLBT youth face the struggle of establishing relationships. O'Hanlan, et al cites a survey, of Yale lesbian and gay students conducted by Herek, (1993) in which many reported living their college years in secretiveness and fear because they feared anti-gay violence and harassment on campus (1997).

Bepko and Johnson talked about their own approaches to therapy with a gay couple. They stated that they used a Bowenian approach with some modifications. The first modification was a direct discussion about monogamy. They did not assume the heteronormative idea of monogamy, the couple was invited to consider what was best for them at this point in their couple relationship. The other modification the therapists made was a discussion around the effects of homophobia. The couple was allowed to externalize various aspects of their presenting problem in order to reduce shame, self-blame, and helplessness to which their experiences of homophobia left them vulnerable (2000).

Ariel and McPherson write that gay and lesbian parents are often perceived as less stable psychologically than their heterosexual peers. They go on to state that therapists should become aware of two general groups of lesbian and gay families that have recently emerged. First, the group who were in heterosexual relationships and then discovered they were gay. As a result they may have children from their heterosexual relationships that they are now raising with their gay or lesbian partner. The second group are gay and lesbian couples who have either adopted children or had their own biological children with the help of artificial insemination or a surrogate parent (2000).

Some of the challenges to both of these family types are legal issues and stigmatization. Less than half the states in the United States will allow lesbians and gay men to adopt a child (American Civil Liberties Union, 1997, cited in Ariel and McPherson, 2000). This leads to complications if just one of the partners adopt, will the other feel less of a parent? That person also has no legal ties to that child if the adoptive parent should die or if the couple should separate.

Other issues may involve stepparent issues, how involved will the non biological parent be? If a surrogate parent was used, how involved, if at all, will that person be in the child's life? What about the child, will they be stigmatized in school because they have two mommies or two daddies? These are all issues that therapists must be aware of if they are to help lesbian and gay families. This doesn't even address the issues of having a transgendered parent.

Early studies of the effects on the children of gay and lesbian parents done by Golombok, Spencer, & Rutter, 1983; Green, Mandel, Hotvedt, Gray, & Smith, 1986; Gottman, 1990; Patterson, 1994; Bailey, Bobrow, Wolfe, & Mikach, 1995; and

Golombok & Tasker, 1996 (cited in Ariel & Mcpherson, 2000), revealed no evidence of gender identity confusion, no evidence of a-typical gender-role behavior, no difficulties in sexual-identity development, and no evidence of heightened incidence of homosexuality.

According to Hayes there is still a serious lack of knowledge both in the profession and society concerning human sexuality, especially bisexuality. In fact the gay and lesbian community often see bisexuality as a transition period for people on the way to coming out as gay or lesbian (2001). In effect, then, bisexuals do not fit into any social circles, they feel ostracized from all sides. Smiley talks about gay friends of bisexuals who accuse them of trying to maintain heterosexual privilege and non-gay friends who try to persuade them to conform to the heterosexual lifestyle (1997).

A review of the text books used in introductory counseling courses were found to have only one percent of space devoted to gay and lesbian issues. Further, only one of the text books made a specific reference to bisexuals. Hayes believes that counselors should investigate the literature to learn more about working with bisexuals as well as increase their experience base (2001). Smiley adds that mental health counselors should examine their individual preconceptions, prejudices, and professional limitations regarding sexuality (1997).

The transgendered population does not fare much better. Chen-Hayes talks about how transgendered and gender-variant persons are seen as freaks by law enforcement agencies, and if assaulted, they may suffer further abuse at the hands of the police. There are few laws that recognize gender identity and gender expression concerns. Gender-variant persons are often the targets of hate crimes and they have little if any legal

recourse (2001).

Carroll has several suggestions for counselors to help prepare them to better work with GLBT clients. First is for counselor educators and clinical supervisors to move beyond their own disciplines and explore the many resources that deal with queer theories. Second is to use narrative texts and films that will challenge traditional definitions of gender and sexuality. Third is to look at nontraditional approaches to therapy such as constructivist and narrative. Lastly is to read texts "queerly," that means giving attention to themes of power and control (2001).

Conclusion

In conclusion, it is safe to say that professional counselors and educators, as well as marriage and family therapists, have a long way to go in understanding, advocating for, and helping the GLBT population. One author, Chen-Hayes, went so far as to state that we as professionals have a duty to educate society about all of the issues that the GLBT population faces. That includes advocating for social justice and challenging oppression and violence (2001). In becoming aware perhaps the tide will change and oppression and fear will be lessened.

CHAPTER THREE

Methodology

Introduction

This chapter will describe the subjects under study and how they were selected for inclusion in this study. In addition, the instruments that were used to collect information will be discussed as to their content, validity, and reliability. Data collection and analysis procedures will then be presented. The chapter will conclude with some of the methodological limitations.

Description of Subjects

The subjects of this study were graduates from the Marriage and Family Therapy (MFT) Program at the University of Wisconsin-Stout which is located in Menomonie, Wisconsin. Many of these persons were licenced or certified marriage and family therapists. Some of them are therapists in training. Some have gone on to receive doctoral degrees. Others have received degrees in other fields or taken positions outside the arena of marriage and family therapy. Most of them, however, are working in the field of marriage and family therapy. The survey was sent to all those who have graduated from the Program since it's inception in 1973 through those who graduated in May of 2001.

Sample Selection

The participants were from a cluster sample of MFT graduates. This cluster included all graduates from the MFT Program at UW-Stout.

Instrumentation

The survey was designed by the author to measure the therapist's comfort with

working with gay, lesbian, bisexual, and transgendered clients. Participants were asked whether or not they have worked with any GLBT clients, if they know any GLBT persons outside of therapy, and whether any of these GLBT persons are related to them (See Appendix B). This survey was included in the larger survey designed by the Marriage and Family Therapy Program director (See Appendix C). Some of the general data from the MFT survey was incorporated into this study as well. Such information included graduation date from the Program, age and gender of the participant, and how long it has been since they graduated from the Program. The surveys were accompanied by a cover letter from Dr. Barnard, the director of the MFT Program. (See Appendix A)

No reliability or validity have been established as this instrument was created for this study and had no prior testing.

Data Collection

The surveys were distributed to participants by first class mail with a postage paid, self-addressed return envelope. The list of participants was provided by the MFT department and is the same list that they use to mail out their newsletter. 290 surveys were mailed out by the director of the MFT Program. 113 of the surveys were returned but only 107 of the GLBT surveys were returned. Thus the data for this paper will be based on 107 completed surveys.

Data Analysis

Since all of the data is nominal the analysis will be done with nonparametric tests of significance. Frequency and percentages make up the bulk of the statistics. This paper will look at how prepared the participants were to work with the gay, lesbian, bisexual, and transgendered population upon leaving the MFT Program; how many GLBT clients

they work with if they work with any at all; whether these participants know personally or are related to any GLBT persons.

Limitations

One limitation of this study is the participants honesty in answering the survey. Another limitation was the willingness of the subjects to answer and return the survey. A final limitation is that the participants were self-reporting their knowledge and estimating the number of GLBT clients that they have worked with. This of course leaves room for error.

In conclusion the return rate was fair and the results should be generalizable to all marriage and family therapists, but may not be generalizable to all types of counselors.

CHAPTER FOUR

Results

Introduction

This chapter will present the results of the survey about marriage and family therapists working with gay, lesbian, bisexual, and transgendered clients. The demographic and descriptive information will be reported first. Data collected on each of the research objectives will then be given.

Demographic Information

The information is this section of this chapter was taken from the larger survey conducted by the MFT Program (refer to appendix C). Of the 290 surveys that were mailed out five of them were returned without forwarding addresses. Of the remaining 285 surveys 113 or 40% were returned and only 107 or 37.5% also returned the GLBT survey. This report is based on the 107 surveys that were returned.

The results show that the sample for this study consisted of 53% percent females and 47% males. Two of the participants did not respond to this item on the survey. These results correspond with the Program's goal to be diverse and attract male as well as female students.

The average age of the respondents was 50 years. The ages ranged from 27 to 72 years, indicating that seasoned therapists as well as novices are represented in this study. This is also indicative of the longevity of the Program and the attraction of mature individuals into the Program.

The majority of the respondents, 76%, are currently working in the MFT field. In fact, 90% indicated that they had worked in the MFT field at some time since graduating

from the Program. Following is a list of the careers in which the 10% who are not working in the MFT field are currently employed: director of a folk dance center, professor, vice president of student affairs, executive consultant, homemaker, police lieutenant, nurse, several in the social work field, researcher, co-ordinator of a psychiatric unit, psychiatric technician, two are now clergy persons, and three have retired. This is a very good showing of therapists in the MFT field. Many of those who are no longer working in the field are still in jobs that require them to interact with people and the skills that they have learned in the Program can be valuable to them.

Objectives

The information in the remaining sections of this chapter are from the GLBT survey (See appendix B) that was included with the MFT survey.

Objective One: Assess the preparedness of the respondents to work with the GLBT clients. In this area 48.5% of the respondents answered no, they did not feel prepared to work with GLBT clients. The remaining 51.5% answered that they did feel prepared to work with the GLBT population, although some of them qualified that by stating that they had friends or colleagues or other training that had prepared them for this work with GLBT clients before they entered the MFT Program.

Objective Two: To assess the comfort level of these therapists in working with GLBT persons. Ninety five percent reported that they are comfortable being around GLBT persons. This shows a strong correlation with the 99% of respondents who report knowing a gay, lesbian, bisexual, or transgendered person. Of those who do know a GLBT person, 55% know between one and ten persons, and 23% know 11 to 20 persons, and 2% know more than 21 persons.

Objective Three: To ascertain whether or not these graduates/therapists were indeed working with GLBT clients. Ninety three and one half percent reported that they do work with GLBT clients.

Objective Four: To determine what percentage of their clients were from the GLBT population. The majority of the therapists who reported working with GLBT clients stated that between one and ten percent of their clients were GLBT persons. This is in line with the estimated figures that about ten percent of the population is made up of GLBT persons. Considering the prevalence of GLBT clients in therapist's practices it seems imperative that new therapists have some knowledge and skills for working with them.

When asked if they thought working with the GLBT population should be included in general clinical practices, 90% of the respondents answered affirmatively. The remaining 10% felt it should be a specialty practice. Of those who did not think it should be included in general practice, most did not agree with what they deemed the "gay lifestyle" and would refer clients elsewhere. One respondent expressed a fear that a homophobic therapist would do more harm than good if faced with a GLBT client. These responses indicate that there is still homophobia among professional therapists.

Objective Five: To find out if any of the respondents had received training in GLBT issues outside of the MFT Program. Forty four percent of the respondents had received some kind of additional training in GLBT issues. Of those that had received training 51% stated that it was very useful to them, 17% felt it was somewhat useful, 21% felt it was useful, and only .04% felt it was not useful. Some of these respondents claimed that they had received their training from friends, relatives, and clients who are

gay, lesbian, bisexual, or transgendered.

These are the trainings they reported attending:

- Sensitivity to special issues
- Understanding the lifestyle
- GLBT differences and similarities to heterosexuals couples
- Isolation
- Shame
- Self-acceptance
- Issues around coming out
- AODA specifics about relapse potential and the recovery environment and community resources
- Domestic violence
- Homophobia
- Developmental and systemic issues
- Secret keeping process and the stresses involved with being closeted
- Terminology
- Persecution
- Working through anger and grief issues
- Body image therapy with gay/lesbian couples identified with an eating disorder
- AIDS
- Examined my own biases and politics
- Dealing with parenting and step-parenting issues
- The effects on children's development of having a GLBT parent

- Therapist-client relationship
- Acknowledging the spectrum of thoughts and behaviors
- Self-image
- Issues related to HIV/AIDS
- Relational issues
- Community issues of violence
- Couples work
- Some of the respondents noted that they had done reading or self-study.
- Some noted that they had learned from their GLBT friends and clients.
- Some learned through supervision or peer consultations.
- One noted that she had been the "out' lesbian in the MFT Program (cf. comment number 24 which follows under objective six) and had done most of the training in GLBT issues for that class.

Some of these topics might fit well into the MFT Program at Stout. Many of them could be interjected into some of the regular courses taught in the Program.

Objective Six: To ask for suggestions from the respondents as to what kind of changes, if any, the Program could make to better prepare students to work with the GLBT population. This is where the instrument was found to be flawed (refer to appendix B). Question number 10 asked whether or not they had received training in GLBT issues and questions 11-13 followed up by asking what kind of training, where they had received the training, and how useful it was. Two additional questions (14 & 15) were meant to ask general questions about what kind of training might be more useful or any additional comments the respondents may wish to offer. Unfortunately most of

the respondents who had not received additional training did not answer anything after question number ten.

Following is a list of comments that were made in answer to questions 14 and 15.

1. "I am a Rogerian therapist and find that it transcends racial/ethnic/cultural/ gender/economic/etc. boundaries. Why go to classes when I can get unfiltered information from the source directly? To learn from classes is to generalize or stereotype within the larger group."
2. "GLBT's do have their own particular problems, but their relationship issues are no different."
3. "The learning curve was most steep for me in regards to GLBT in my first year working as a nurse in a detox unit with another nurse who was a lesbian. The AODA population and at that time the 'dawn' of working with AIDS brought a very specific perspective and sensitivity to me."
4. "I came out after several years of working in the field."
5. "Only a personal relationship can cut through the bullshit, just as it does with racial issues. I have a hard time seeing transgendered persons as normal. Sometimes sexual preference follows behavior, rather than preceding it. There is a sub population that choose same sex relationships in reaction to or flight from other issues, especially abuse."
6. "Outside of Stout and the University of Minnesota this issue and gender issues are not overemphasized." (This respondent is in Arizona)
7. "Any training would be useful as I haven't had any at all."
8. "I believe GLBT is a choice one makes. They should not receive any special

treatment. I am very professional and respectful when I work with GLBT persons." (This respondent is a law enforcement agent.)

9. "We as MFT's need to be more aware of and prepared to work with GLBT clients. I value the friends I have who have been willing to share with me and educate me."

10. "I feel it would be helpful to offer a diverse enough curriculum that addresses this minority group of people who have a homosexual orientation but deeply desire to change. Step out of the "die cast" of selective tolerance and diversity and offer an exposure to all options...not just those adopted by special interest groups, politicians, and academicians. This might seem threatening to some...but in truth these suggestions simply push the envelope of diversity and tolerance just a bit further...such a curriculum offering would indeed be challenging...I wonder who might have enough integrity to pursue and promote this? Cutting edge stuff is always a bit risky."

11. "I have learned the most from listening to people's experiences, reading, and being taught by lesbian/gay clients and friends. I am least confident with transgendered issues because I have had the least exposure with them."

12. "I am offended by questions three through nine. Why don't we all go to an AIDS funeral and observe them in their own habitat? I believe the Stout MFT Program is a white male Program. In traditional Indian culture the term is "twin-spirited." These people were respected (of course so was everyone else). They could adopt whatever role they chose in a community."

13. "It's irksome to see such a small segment of society with so great an influence

that much larger sub-groups are ignored. Such groups are: disabled, elderly, and religious clients. They are much larger but receive no special focus. It seems the Program is marching to the beat of the political correctness drummer and fearing peer disapproval rather than equipping their new therapists for broader practice. Other neglected groups include: lower functioning parents, inter-generational criminals, and families of behaviorally disturbed children."

14. "Have a gay/lesbian panel talk about their needs, therapeutic and general."
15. "'Compare and contrast' gay/lesbian couples with heterosexual couples."
16. "I need to do more reading concerning research on GLBT issues."
17. "In my MFT training Program Dr. Salt did a good job of teaching GLBT issues and sensitivity."
18. "My personal belief is to offer equality, honor, and respect to the GLBT population as we would to any other population. However, acceptance of sexual behavior among people of same sex is where I beg to differ. I fear that the MFT Program may also not give voice to GLBT's who wish to pursue heterosexuality. Openness to intergenerational/systemic influences to a GLBT lifestyle, such as inadequate bonding with the same sex parent, sexual abuse, incest, touch deprivation at an early age, ADOA emotional dependency issues and other traumatic sexual experiences may not occur. However, I believe Stout's MFT Program would provide and excellent vehicle for addressing general discrimination against the GLBT population in terms of human dignity and worth."
19. Two respondents stated that they have done some reading on their own related to

this topic.

20. "Is homosexual development any different than heterosexual, other than society has difficulty with the topic? So what's the job for us: sexual development or community awareness?"
21. "Small groups for greater interactivity would be helpful. Also longer time frame than an eight hour day."
22. "Doesn't require a course of attention as much as attention all along the process. Just as you would include ethnic specialties."
23. "I would have appreciated more attention to GLBT and learning any special needs/ attention for me to be more alerted to."
23. "General information would be good. I have many more individuals and families dealing with GLBT issues than I had anticipated."
24. "I was the "out' lesbian in my class, so I did a majority of the educating and that was valuable for me."

Summary

In summary these are the results about working with GLBT clients that came from this survey. Even though the response was not great this author believes that they can be generalizable to all of the MFT graduates from the Stout Program. The following chapter will contain the conclusions drawn from these results, any discussion and implications for the marriage and family therapy Program, and recommendations for future research.

CHAPTER FIVE

Discussion, Conclusions, and Recommendations

Introduction

This chapter will include a discussion of the results of this study about marriage and family therapists working with GLBT clients and the conclusions drawn by this author. Following that will be some implications for the Marriage and Family Therapy Program. The chapter will conclude with some recommendations for further research on this topic.

Summary of the Study

This study was conducted to find out how prepared MFT graduates felt, upon their graduation from the Program at UW-Stout, to work with gay, lesbian, bisexual, and transgendered clients. Other information asked for on this survey was: what percent of their client base were GLBT persons, whether or not they felt comfortable around GLBT persons and whether they thought GLBT persons should be included in the general clinical practice, and finally whether they had received any additional training in GLBT issues or had any recommendations for future training at UW-Stout. These surveys were mailed out to all former graduates, from 1974 through 2001, of the MFT Program at UW-Stout in Menomonie, Wisconsin.

Discussion

Objective One: To assess the preparedness of these therapists for working with GLBT persons upon graduation of the MFT Program. A statistic of interest was, that of those who indicated they were not prepared to work with the GLBT population upon graduating, 55% had graduated in1990 or later and only 45% had graduated previous to

1990. Given that gay, lesbian, bisexual, and transgendered persons, as well as research and information, have become much more visible and available in the past decade, it interests me that recent graduates felt less prepared to work with the GLBT population than did their colleagues who graduated prior to 1990. Perhaps this is a good indicator that prior to 1990 the MFT Program at UW-Stout was on the leading edge of sensitivity to diversity. Perhaps in recent years the Program faculty felt that the issue was not as pressing now that it is getting more notice. This survey shows that quite the opposite is true and students still need to learn about the GLBT issues in the MFT Program.

Objective Two: To assess the comfort level of these therapists in working with GLBT persons. Ninety five percent reported that they are comfortable being around GLBT persons. This shows a strong correlation with the 99% of respondents who reported knowing a gay, lesbian, bisexual, or transgendered person. Of those who do know a GLBT person, 55% know between one and ten persons, and 23% know 11 to 20 persons, and 2% know more than 21 persons. This substantiates an earlier study by Lance (1987) that showed personal contact with GLBT persons helped to increase comfort levels of interacting with GLBT persons and also lowered levels of homophobia and heterosexism.

However, all of the respondents who reported being uncomfortable around gay people also have between one and ten acquaintances that are gay. This author can only assume that these respondents have not been able to overcome their own homophobia or perhaps they do not know the GLBT person very well. Lance reported that the more exposure one has to GLBT persons the more comfortable one becomes interacting with them (1987). Religion may play a part in this area as well because the most prevalent

religions in this country do not actively support GLBT persons. Also society as a whole is not very support of GLBT persons and wields a great deal of influence.

Only one of those who reported having at least one relative who is gay, lesbian, bisexual, or transgendered reported being uncomfortable around gay persons. This substantiates Herek & Capitanio's research about intimate contact with GLBT persons leading to higher comfort levels with them (1996).

Objective Three: To ascertain whether or not these therapists are working with GLBT clients. The results show that 93.5% of these therapists are currently working with GLBT clients but only 51.5% stated that they felt prepared to work with them. This is consistent with what Green (2000) reports in his article that members of the AAMFT are working with GLBT clients but that a large majority of them do not feel competent about their abilities to do so.

This author would remind the reader of Tozer & McClanahan's belief that it is possible to be non-homophobic without necessarily being affirmative. They define affirmative psychotherapy as therapy that celebrates and advocates the authenticity and integrity of lesbian, gay, bisexual, and transgendered persons and their relationships. They cited Fassinger's (1991) work around what has been described as the null environment, which is therapy that although not stigmatizing or harmful, fails to offer an affirmative environment (1999). One respondent (cf. comment #20 in chapter four) referred to this attitude when he asked what his responsibility was, sexual development or social awareness? Several of the research articles referred to in Chapter Two of this paper identified both of these areas as the counselor's, educator's, and therapists' duty. Chen-Hayes encourages counselors to take a transgendered person to lunch and to

become an advocate and an ally. Further she advocates that we take a zero tolerance approach toward emotional, physical, or sexual violence and harassment based on gender identity or sexual orientation (2001). Hayes believes that the effective and ethical practice of counseling demands that counselors think critically about their own perspectives and work continually to overcome them (2001). Tozer and McClanahan believe that clients who have been marginalized in society need therapists to be more active advocates and allies to begin to counteract the effects of histories as marginalized groups (1999).

Objective Four: To determine what percentage of their clients were from the GLBT population. The majority of the therapists responded that they work with between one and ten percent GLBT clients. This corresponds to previous research that estimate GLBT persons make up 10% of the entire population. Considering the prevalence of GLBT clients it seems imperative that new therapists have some knowledge and skills for working with them. Of the 10% who said that GLBT persons should not be included in general practice, most did not agree with what they deemed the "gay lifestyle" and said they would refer clients elsewhere. One respondent feared that a homophobic therapist would do more harm that good. (Refer to comments #8, #10, #13, & #18, listed in chapter 4). Several did not feel enough attention was given to reparative therapy.

Objective Five: To find out if any of these graduates/therapists have received additional training specific to GLBT issues. Only 44% of the respondents answered that they had actually received some additional training specifically aimed at working with the GLBT clients. Of those that had received training 51% stated that it was very useful to them, 17% felt it was somewhat useful, 21% felt it was useful, and only .04% felt it

was not useful. Some of these respondents claimed that they had received their training from friends, relatives, colleagues and clients who are gay, lesbian, bisexual, or transgendered. Some of these therapists report doing some studying on their own and feel that they have learned enough to feel comfortable working with GLBT clients. Refer to the detailed list in chapter four on the types of training.

Referring to the APA guidelines that are listed in Chapter Two they clearly state that psychologists (and one would argue marriage and family therapists) should strive to; understand the ways in which social stigma poses a threat to the health and well-being of GLBT persons. The AAMFT Code of Ethics also suggests that therapists keep abreast of new information so as to remain competent in the field.

Objective Six: To ask what kinds of changes, if any, the respondents might suggest for improving the MFT Program in regard to GLBT clients. If it were not for the flaw in the survey at this point, having put this question after the ones about additional training so those who did not have additional training skipped over it, there would undoubtedly have been more responses to this question. The main focus here was that the graduates thought there could be more training on GLBT issues. Just general information and exposure to the idea of working with this population would be a start. Refer to the list of comments in Chapter Four for a more detailed look at the suggestions.

Conclusions Drawn from the Study

This study concurred with the research in the literature review. It is evident by some of the comments made (cf. comments #8, #10, #13, & #18) that homophobia is still prevalent in the MFT and related fields. As was previously noted, Tozer & McClanahan believe it is possible to be non-homophobic without necessarily being affirmative. This

author believes that to be the case with those therapists who state that they are comfortable working with their GLBT clients, yet feel uncertain of their abilities to do so.

Considering that 93.5% of the respondents indicated that they are comfortable around GLBT persons, yet only 51.5% indicated that they feel qualified to work with GLBT clients it seems there is a lack of information about or exposure to the issues being disseminated in the training program. Even though there is a shortage of information in the literature or textbooks perhaps more discussion about what little is in print would help to expose more therapists to the information that is available.

Of methodological consideration are those clients that come in with internalized homophobia and who indicate a desire to be heterosexual. Therapists, especially those who are homophobic or in the null zone, may see that as a need for reparative therapy, without first exploring the clients' internalized homophobia. Most often the clients learn to accept themselves once they can unpack their own homophobia. Clearly, further clarification is needed in the way of guidelines for therapists to cope with confusion around this question.

This study has allowed this author to really hear how the therapists in the field are feeling about their work with the GLBT population. Some of them are stymied, some of them are in the process of learning the issues, some of them are very comfortable with these clients, some are wondering how to affect some kind of social change, some are just doing the best they can and are learning as they go, and some are upset that the GLBT population is getting any attention at all.

It is heartening to realize that most of the respondents are comfortable being around GLBT persons and they want to learn more about the special issues that these

persons face. It was also encouraging that the majority think general practitioners should be prepared to work with this population. According to these results most therapists are going to encounter a GLBT person in their practice. The question remains how do we train these therapists in the issues of the GLBT population?

Implications for the Marriage and Family Therapy Program

Fifty five percent of the respondents did not feel prepared to work with GLBT clients. The MFT Program needs to address this issue and help better prepare their students for working with this population. It is clear that the GLBT clients are out there and seeking help.

AAMFT Code of Ethics states that marriage and family therapists should not discriminate based on race..... gender or sexual orientation and furthermore that therapists should pursue knowledge of new developments and maintain competence in marriage and family therapy through education, training, and supervision. It follows that the AAMFT accredited programs should be responsible for exposing their students to information on sexual orientation and gender identity.

This study showed that homophobia still exists among the MFT therapists. Somehow the Program needs to address this issue. Being direct and up front with students regarding the GLBT population may be the best way to help students talk about, question, and reflect on their own fears and beliefs.

The APA has issued guidelines for working with gay, lesbian, and bisexual clients. Even though the AAMFT has not issued such guidelines, nor indeed even a written statement about this subject, this author would encourage the MFT Program to write their own statement. The statement could include the ways in which the Program

intends to implement instruction in this area, as well as, suggested guidelines for their graduates to follow. Also of note, is the lack of inclusion of transgendered issues in the APA guidelines. This is an area which needs more attention.

There are many topics taken from the respondents suggestions that could be incorporated into some of the required classes already being taught in the Program. For example gay couple issues could be taught in the Communication Relations Training Class, especially now that it has been expanded to include couple's therapy. The developmental issues, community violence and the effects on children's development could be incorporated into the Human Development Class. Sex Therapy would be a good place to talk about some of the relational problems, internalized homophobia, as well as HIV/AIDS. Alcoholism and the Family could touch on the issues surrounding AODA issues and the problems of relapse. Cultural Competency Class would be the perfect setting to talk about the social stigma and violence surrounding the GLBT community. This would also be the venue for the students to explore their own biases and fears. Theories of Family Process could address the complex issues of creating a GLBT family and the special issues faced by these families around the coming out process.

This study also suggests that exposure to GLBT persons is useful in creating a more comfortable relationship with them. This may be an idea for the MFT Program to increase the student's contact with GLBT persons. This could be done by including GLBT persons in the Program, which the staff is currently trying to do. Also including a GLBT person on the staff would increase exposure for the students. Having persons who are GLBT come in as guest lecturers or as participants in a panel discussion could be useful. Although this would not lead to the intimate contact that Herek and Capitanio

suggest leads to more comfort, it could be a place for the students to start exploring their own biases. This research also noted a lack of research and textbooks on this subject. The MFT Program may have to search a bit harder to find inclusive textbooks and perhaps direct students to do research in this area.

Recommendations

This author has three recommendations, the first would be to improve upon the instrument used in this study. Consider the order of the questions and be sure that none of them will be skipped unless there is reason for them to be left unanswered. Be more clear about wanting feedback and suggestions for changing the Program.

Through this study it became known that there are fears and questions around working with bisexual and transgendered clients. The second recommendation would be to do a more detailed survey by breaking survey questions into separate sections for bisexual and transgendered inqueries. An alternate way would be to do a survey devoted solely to bisexual or transgendered research.

The third recommendation would be to include a question about the geographic location of the therapist's practice. It would be interesting to see if the comfort level of working with GLBT clients varies from region to region in this country.

The need for research and training on this topic certainly exists. This author is glad to have contributed to this work.

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Appendix A

M-E-M-O-R-A-N-D-U-M

TO: All UW-Stout MFT Graduates 1974-2001

FROM: Chuck Barnard

RE: Our Five-Year Follow-Up

DATE: June 5, 2001

Greeting to each of you. I apologize for the form letter, but there are too many of you to acknowledge individually. Your number is now over 320 so this is the format that I am forced to rely upon unless I decide not to do any fishing this summer.

Those of you that have been out longer than five years have already completed at least one of these surveys. Believe me when I say the information we receive from you is very valuable and important to us! We just completed a major revision of our Program and feedback form previous surveys was instrumental to that revision. This information is also valuable when the Program receives a site visit form the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

In the past we have always received a return rate of at least 75%. As you know, that kind of return rate to a mailed survey is phenomenal and we hope to even better that 75% return rate this time. I know you are all busy, but please take the 10-15 minutes (maximum) necessary to complete this and return it to us in the stamped and addressed envelop. You will also notice another brief survey that accompanies the Program survey. This is for research being conducted by Val Zellmer, a current student, that focuses on G, L, B, & T related issues. While this will prove helpful to her research, it will also prove helpful to the Program in our ongoing concern with elements of diversity.

Once again, I offer you a sincere thanks for your assistance in keeping our Program strong and vital! Have a great Summer!

lb

Appendix B

Gay, Lesbian, Bisexual, and Transgendered Survey

Please check the answer that most correctly reflects your answer.

1. Have you worked with any gay, lesbian, bisexual, or transgendered (GLBT) clients?

____yes _____no

2. If yes, what percentage of your clients would fall into the GLBT category

_____0-10____10-20____21-30 _____31-40 _____41-50 _____51-60 _____61 or more

3. After completing the MFT, Program did you feel qualified to work with GLBT clients? _____yes_____no

Please explain_____

4. Do you believe that therapy with the GLBT population should be part of the general clinical practice? _____yes, I believe it should _____no, I don't believe it should

5. Please explain your answer to question Number 4.

_____

6. Are you comfortable being around gay, lesbian, bisexual, and transgendered people?

_____yes _____no

7. Do you personally know anyone who is gay, lesbian, bisexual or transgendered?

_____yes _____no

8. If yes, how many GLBT people do you know? _____1-10 _____11-20 _____21-30 _____31-40 _____41 or more

9. How many of the people identified in Number 8 are related to you? _____1-10 _____11-20 _____21-30 _____31 or more

10. Have you received training on how to work with the GLBT population somewhere other than the MFT Program? _____yes _____no

11. If yes, where did you receive the training?

_____

12. What kind of GLBT issues were taught in this training?

_____

13. How useful did you find the training to be? _____very useful _____somewhat useful _____useful _____not very useful _____not useful at all

14. If not useful, what kind of training would have been helpful?

_____

15. Please use the back of this page to offer any additional comments.

Appendix C

University of Wisconsin-Stout

MFT Program Follow Up Questionnaire

Section I:

Demographic information: Please complete the questions asked below. Print or circle answers as appropriate. Be sure to answer each question.

1. Gender Male Female
2. Age _____
3. Marital Status _____(Single, Married or Divorced)
4. Year you graduated from the MFT Program _____
5. Present job title _____

   Salary range $20,000-25,000 _____ $25,000-30,000 _____ $30,000- 35,000 _____$35,000-40,000 _____ $40,000-50,000 _____

   $50,000 or higher _____
6. Have you ever been employed in the MFT field? Yes No If yes, for how long? _____
7. If you answered yes to #6,after graduation, how long did it take you to find employment in the field of MFT?

   a. was already working in the field during graduate study.

   b. 1-6 months c.7-12 months d.13-24 months

   e.other_____

8. Are you presently employed in the MFT field? Yes _____ No _____

If not, why not? Please check and prioritize in order of importance with 1 being primary reason for not.

____Job dissatisfaction____Poor salary___Job discontinued____Better job offer

____Change in locale____Burn-out____Other_____

9. Other graduate degrees, certifications, or training secured.

School or Training facility/organization Location Degree/Certification

_____

_____

_____

10. Licenses or certifications possessed.

License/Certificate State or agency issued

_____

_____

_____

If you are certified or licensed as an MFT in your state, did you have to take the national MFT exam? Yes ____ No ____ grand fathered ____. If "yes", how many attempts did you make to pass? 1 ____ 2 ____ 3 ____. How much time had passed since your graduation prior to taking the exam? 1 year or less ____ 2 yrs. ____ 3 yrs. or more ____.

11. List other job positions or experiences since graduation, progressing from first to the present:

Type of Agency, Position Occupied, Approximate Annual, Salary Time in Position

_____

_____

_____

Section II:

This section is aimed at obtaining information regarding your present or your last clinical practice position. Please answer each question. Circle the answer that best fits you. If you are no longer practicing in the field, please respond as to your last clinical position. If you have never practiced, check ( ) never, and skip to Section III.

12. How many hours per week do you spend doing:

a. individual therapy 0-5 6-10 11-15 16-20 Over 20

b. couple therapy 0-5 6-10 11-15 16-20 Over 20

c. family therapy 0-5 6-10 11-15 16-20 Over 20

d. group therapy 0-5 6-10 11-15 16-20 Over 20

e. in-home therapy 0-5 6-10 11-15 16-20 Over 20

f. Other - specify 0-5 6-10 11-15 16-20 Over 20

13. Beyond therapy, do you provide the following services in your work setting? If so, please indicate number of hours spent per week:

a. consultation 0-5 6-10 11-15 16-20 Over20

b. administrative responsibilities 0-5 6-10 11-15 16-20 Over 20

c. psychological/other assessment 0-5 6-10 11-15 16-20 Over 20

d. research and/or evaluation 0-5 6-10 11-15 16-20 Over 20

e. Other – specify 0-5 6-10 11-15 16-20 Over 20

_____

14. From the skills you developed while in the MFT Program, how qualified do you feel at conducting therapy?

a. Excellent b. Above average c. Average d. Below Average e. Poor

15. Since leaving Stout, how many days of continuing education (inservice) experience do you receive each year? a. 1-2 b. 3-4 c. 5-7 d. 8-14 e.15-28 f.Other_____

16. Which inservice or continuing education experiences have you found most effective in enhancing your professional performance?

_____

_____

17. What school(s) of thought best describes your theoretical orientation to family therapy? Please rank order those that are most appropriate for you (1 = most important, 2 = next most important, and so on.

_____ Behavioral (Stuart)

_____ Cognitive Behavioral (Meichenbaun, Beck)

_____ Communication (Satir, Couples Comm. Program)

_____ Contextual (Nagy)

_____ Experiential (Whitaker)

_____ Feminist

_____ Functional (Alexander)

_____ Intergenerational (Framo, Bowen)

_____ Milan/Systemic

_____ Narrative (White)

_____ Psychoanalytic-Psychodynamic (Ackerman)

_____ Solution Focused-Brief (de Shazer, O'Hanlon)

_____ Strategic (Haley)

_____ Structural (Minuchin)

_____ Integrative-describe_____

18. What is your membership status in AAMFT?

___Clinical member ___Associate member ___Not a member

___Supervisor ___Student member ___Supervisor in training

___Other_____ If not a member, why not?_____

19. Do you identify yourself as primarily a Family Therapist? Yes No

If no, please state your primary professional identity:_____

20. Please rank the five "presenting problems" you most frequently work with in therapy starting with the number 1 as the most frequently encountered, followed by 2-5.

____Financial issues ____Sex therapy

____Remarriage adjustment/stepfamily issues

____In-law issues ____Grief

____Adolescent acting-out/Runaways ____Depression/anxiety

____Current sexual abuse (incest) ____Reunification

____Alcohol & drug abuse ____Eating disorder

____Parent/child problem ____Suicide attempts

____Current physical abuse ____Communication

____Residuals of physical abuse ____Divorce

____Residuals of sexual abuse ____Marital conflict

____Premarital counseling

____Gay, lesbian, bisexual related concerns

____Other - please specify_____

Section III:

In this section please provide a rating for each of the following statements regarding your experience in the Stout MFT program. Circle the one response that best reflects your opinion: Strongly Agree (SA); Agree (A); Undecided (U); Disagree (D); Strongly Disagree (SD).

21. It has been an advantage in obtaining employment to have training from an COAMFTE accredited program. SA A U D SD

22. The MFT program provided adequate information about specialized areas of family therapy (sex therapy, divorce counseling, etc.)
If deficits in what areas_____ SA A U D SD

23. It is better to have a degree in Family Therapy than an M.S.W. when seeking employment as a Family Therapist. SA A U D SD

24. Ethical issues unique to family therapy were adequately discussed in the program. SA A U D SD

25. I am confident that the training received at UW-Stout prepared me to pursue my professional goals. SA A U D SD

26. The MFT program provided a sound understanding of research methodology to my educational background. SA A U D SD

27. I am satisfied with the supervision process offered in the UW-Stout program. SA A U D SD

28. I felt adequately trained to include clinical consultation with my peers as part of my professional practice. SA A U D SD

29. I felt adequately trained to make referrals as part of my professional practice.

SA A U D SD

30. The program was structured to allow for sufficient practicum experiences with families. SA A U D SD

31. The program provided a sound theoretical background in Marriage and Family Therapy. SA A U D SD

32. The program allowed for appropriate consultation with the program director.

SA A U D SD

33. The program allowed sufficient supervision while I worked with my cases.

SA A U D SD

34. In my practice I frequently use the knowledge and skillsI developed in the program. SA A U D SD

35. The course content was found to be relevant for fieldwork in MFT.

SA A U D SD

36. The graduate courses offered a wide spectrum of experiences which allowed me to meet my educational needs. SA A U D SD

37. The program and its structure allowed enough time to getto know the faculty well.

SA A U D SD

38. The use of video equipment and mirrors during supervision was helpful.

SA A U D SD

39. Books and other materials provided in the library were adequate.

SA A U D SD

40. Physical facilities for doing therapy were adequate. SA A U D SD

41. Diversity of family types and problems were adequate.

SA A U D SD

42. Procedures and process employed to evaluate my performance were fair.

SA A U D SD

43. I would recommend the UW-Stout MFT program to a friend.

SA A U D SD

44. I do not regret my decision to attend UW-Stout's MFT program.

SA A U D SD

45. The MFT program socialized me to be an active member of professional organizations, such as my state's MFT organization. SA A U D SD

46. If I could add one course to the UW-Stout MFT curriculum it would focus on:_____

47. Please give a brief response regarding your reaction to the MFT Courier._____

Section IV:

In this section you have the opportunity to make any suggestions or comments which you may think appropriate regarding the improvement of the MFT program. Comments could be focused on supervision, course work, practicum, therapy, intellectual stimulation, thesis, personal growth, clinical problems totally unprepared for, clinical paperwork, etc.

_____

_____

_____

_____

_____

Thank you.