

COUPLE AND FAMILY THERAPY STUDENTS' ATTITUDES
TOWARD BISEXUAL CLIENTS

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Couple and Family Therapy Students' Attitudes Toward Bisexual Clients

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ABSTRACT

Few studies have focused on student therapists' beliefs about bisexual clients and the impact of affirmative training on these beliefs. The current study explored 1) the level of experience couple and family therapy (CFT) students have with gay, lesbian and bisexual clients; 2) whether CFT students' levels of biphobia and homophobia differ; and 3) whether LGB affirmative training had an impact on self-reported levels of biphobia. Secondary data were used from data collected through electronic and paper surveys. The results revealed that CFT students have similar levels of experience working with bisexual and lesbian clients, but report significantly lower levels of experience with gay male clients. Furthermore, CFT students reported nearly identical levels of biphobia and homophobia. Finally, the results of this study suggest that more LGB affirmative training was associated with lower levels of self-reported biphobia. The findings of this study support CFT training programs implementing LGB affirmative training.

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If I learned one thing in grad school, it was that no one lives in a vacuum, not even me.

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CHAPTER ONE. INTRODUCTION

Though there are a significant number of articles available on the topic of therapy with lesbian, gay, and bisexual (LGB) clients, much of the literature focuses on working with gay men and lesbians and does not address working with bisexual identified clients (Malley & McCann, 2002; Negy & McKinney 2006). Only recently have researchers begun to explore the therapy experiences of bisexual clients (Dodge & Sandfort, 2007; Mohr, Israel, & Sedlacek, 2001; Mohr, Weiner, Chopp, & Wong, 2009). This shift in the research is important for a number of reasons. First, the idea of bisexuality goes against the normative, dichotomous way of thinking about sexual orientation and thus may create within therapists a form of phobia that is different from the more commonly discussed homophobia (Herek, 2002). Additionally, bisexual individuals may experience unique challenges when seeking mental health services due to societal beliefs about bisexuality (Dworkin, 2001). Given these unique challenges, researchers need to develop a better understanding of the beliefs that couple and family therapists (CFTs) have about bisexual clients in order to develop better mechanisms of training student therapists to provide affirmative services to this population.

The incredible diversity of feelings, attitudes and behaviors associated with bisexuality make it difficult to define accurately (Weasel, 1996). Some scholars define bisexuality based on attraction, others based on sexual behaviors. Other researchers define bisexuality based on having had relationships with individuals of both genders (Weasel, 1996). While there are a variety of ways of defining bisexuality, the vast majority of scholars who research bisexual individuals and therapy with bisexual clients do not define bisexuality (e.g., Liddle, 1997; Page, 2004). Without a clear definition, it is difficult to study bisexual individuals or bisexuality or even to decide who might be considered bisexual. In this way, bisexuality is troubling because it

gives the illusion of choice; a bisexual individual may be able to choose whether to be in a cross-gendered or same-gendered relationship. Thus, one of the common mistakes made by some scholars is to infer overtly or covertly that bisexuality itself is a choice, while being heterosexual, gay, or lesbian is not a choice. Inferring or stating that bisexuality is a choice causes bisexual individuals to be treated differently and may lead CFTs to encourage bisexual clients to alter their sexual orientation to a more “fixed” state. Thus, for the purpose of this study bisexuality is defined as a stable sexual orientation in which the individual has inherently fluid preferences for sexual partners.

The inconsistent definitions of bisexuality are problematic for researchers but create a greater problem for bisexual clients, as bisexual clients reported that the most important quality they look for in a therapist is a belief that bisexuality exists (Page, 2004). For a marginalized population to assert that therapists do not believe they exist indicates that not only may therapists hold negative stereotypes about bisexual clients, but a bisexual individual’s very sense of self may be called into question when she or he seeks clinical services. Researchers have also found that living in a heterosexist society can have negative impacts on the mental health of bisexual individuals and all marginalized groups (Lewis et al., 2006; Pachankis & Goldfried, 2010).

Due to the stigma that comes with being bisexual, it is unsurprising that bisexual individuals struggle with mental health issues more often than gay males and lesbians. In particular, bisexual individuals report higher rates of anxiety, depression and suicidal ideation (Page, 2004). It follows that bisexual individuals might need to seek out therapeutic services from CFTs who are able to provide competent affirmative services to bisexual clients. Moreover, members of the LGB community, as a whole, seek out therapy at a higher rate than heterosexual individuals. In particular, LGB individuals seek clinical services at least two times the rate of

heterosexual individuals (Bradford, Ryan & Rothblum, 1994; Liddle, 1997). Additionally, researchers have found that LGB individuals comprise a significant portion of the caseloads of CFTs (Green, 1996; Green & Bobele, 1994).

Given that the majority of CFTs will have at least one LGB client in their career (Doherty & Simmons, 1996), it is important that CFTs are properly trained to work with this population. The research that has been done on the amount of affirmative training CFTs receive has focused on serving the LGB community as a whole. In particular, researchers have argued that clinical students are not receiving the amount of training they need in order to be successful LGB affirmative therapists (Godfrey, Haddock, Fisher, & Lund, 2006; Phillips & Fischer, 1998; Rock et al., 2010). Rock and colleagues (2010) found that over 60% of CFT students had received no LGB affirmative training. Considering that the training students receive regarding LGB individuals often gives more attention to working with lesbians and gay men, it could be inferred that CFT students receive very little training to provide affirmative therapy to bisexual clients; however, there is no research on this at this time. Thus, it is important to gauge the level of students' competence for working with bisexual clients. Considering that LGB affirmative training was correlated with positive attitudes toward LGB identified individuals (Rock et al., 2010), it follows that more training in regard to therapy with bisexual individuals might lead to more positive attitudes toward bisexual clients.

Research on bisexual individuals' experiences in therapy provides further support for the need for LGB affirmative training (Page, 2004). Specifically, many bisexual individuals report that they have negative experiences in therapy. For instance, in a study with 217 bisexual individuals who sought mental health services, many reported receiving negatively biased therapy (Page, 2004). In particular, Page (2004) found that 15.7 % were told their bisexuality

would disappear once their presenting clinical issue was resolved or improved, 12.4 % were told that becoming heterosexual, gay or lesbian would improve their presenting problem (e.g., their depression would disappear), and 11.1 % experienced attempts by their therapists to convert them to hold a heterosexual, gay or lesbian orientation. Considering the negative experiences documented by Page (2004), it seems even more important that CFT students receive affirmative training regarding working with bisexual clients.

With this in mind, research needs to be done regarding the differences between how CFT students perceive their bisexual clients and how they perceive their gay male and lesbian clients. In particular, I sought to explore differences in homophobia and biphobia. The current study also sought to explore CFT students' attitudes about and level of experience with bisexual clients and whether or not LGB affirmative training positively impacted these attitudes and students' biphobia.

CHAPTER TWO. LITERATURE REVIEW

Though research on the topic of bisexuality is still sparse, there are important studies on biphobia and the mental health status of bisexual individuals. There is less research focused specifically on LGB affirmative therapy with bisexual clients and how CFT students might be trained to work more affirmatively with bisexual clients. It seems important to note that the vast majority of the literature on biphobia and bisexual individuals is comprised of theoretical articles that present no empirical data, which suggests that more research is needed that not only uses empirical methods to study the experience of bisexuality, but especially to study mental health professionals' attitudes and knowledge regarding bisexuality. Thus, the literature reviewed for this study focused on 1) biphobia, 2) affirmative therapy with bisexual individuals, and 3) implications for training CFT students to provide affirmative therapy to bisexual clients.

Biphobia

The literature addressing biphobia is a combination of empirical and theoretical articles. It is important to acknowledge the pervasiveness of biphobia in our larger society. In particular, the existing literature appeared to suggest that biphobia is pervasive due to the fact that bisexuality defies the dichotomous way that sexual orientation is conceptualized, which has created negative cultural beliefs about bisexual individuals (Mulick & Wright, 2002). While more historical articles have not distinguished biphobia from homophobia (Diamant & Wold, 2003; Herek, 2000), in more recent articles biphobia is defined by the following components: 1) bisexual invisibility or the questioning of bisexuality as a legitimate identity and/or sexual orientation, 2) a lack of acceptance in both the straight and gay or lesbian communities, and 3) a societal belief that bisexual people are by nature promiscuous, or the belief that bisexual individuals cannot be fulfilled by monogamous relationships with either a man or a woman

(Dworkin, 2001; Israel, 2007; Mohr et al., 2009). This section of the literature review explores each of these three components of the definition of biphobia and also looks at the impact that biphobia has on the mental health and well-being of bisexual individuals.

Questioning the Legitimacy of Bisexuality

This first component of the definition of biphobia, questioning of bisexuality as a legitimate identity and/or sexual orientation, was explored by a number of researchers (Barker, 2007; Barker, & Landridge, 2008; Eliason, 2001). For example, Eliason's (2001) study with 229 heterosexual undergraduate students indicated that many of the participants may have had insufficient information regarding bisexuality. In particular, when asked a series of questions about bisexuality 30% to 57% of the participants responded to any one question "I don't know," which implies that the students did not have the information or had never thought about the questions presented about bisexuality (Eliason, 2001). Bisexual individuals also face a lack of representation in the media, and even when there is some representation, it is rarely positive as negative stereotypes far outnumber more accurate portrayals of bisexuality (Bradford, 2006). Another study that documented the invisibility of bisexuality was a content analysis performed by Barker and Landgridge (2008), which pointed out that in popular culture, sexual orientation is often seen as dichotomous. For example, these researchers cited examples such as the 2005 movie *Brokeback Mountain* having been billed as a "gay western" though both male main characters have long-term relationships with women. Thus, the movie could have been storied as a movie about bisexual individuals. The consequences of invisibility in popular culture have not been examined in the existing literature. However, a lack of recognition may contribute to the lower mental health status experienced by many bisexual individuals (Diamant & Wold, 2003; Ross et al., 2010). In addition to the invisibility in popular culture, in a study of psychological

textbooks, all of the textbooks studied made mention of a gay or lesbian orientation as a normal and natural orientation, but only one third of those textbooks even mentioned bisexuality (Barker, 2007).

Lack of Acceptance

While there are several examples of questioning the legitimacy of bisexuality, research also documents the lack of acceptance of bisexual individuals as a group (Herek, 2002; Mulick & Wright, 2002). For instance, in a 2002 study, Herek found after surveying heterosexual individuals that only people who injected illegal drugs inspired “cooler” feelings than bisexual individuals (p. 268). Thus, Herek (2002) found that his participants held more positive beliefs about African Americans, gay men, lesbians, people living with AIDS, Jews, Mexican Americans, Catholics and many other groups. While Herek’s (2002) study does reflect homophobia it is important to note that the participants had slightly more negative beliefs about bisexual individuals, especially bisexual men, than gay men and lesbians, which could suggest that biphobia influences beliefs in a way that differs from homophobia. In another study, Mulick and Wright (2002) found that though heterosexual individuals scored highly on both homophobia and biphobia scales, gay males and lesbians scored highly only on the biphobia scale. The levels of biphobia reported by Mulick and Wright (2002) suggest that in each of these three communities there is limited acceptance of bisexuality.

In yet another study with 346 self-identified lesbian women, Rust (1993) found strong evidence to suggest that lesbians believe bisexual women are more likely to be transitioning into a lesbian identity than to have a stable sexual orientation as a bisexual, are more willing and more likely to try to pass as straight, are more likely to desert their female friends, and should not be given a lesbian woman’s full trust. These findings suggest that lesbian women in this study

exhibit fairly high levels of biphobia, which has led them to not accept bisexuality as a legitimate sexual orientation. However, this study is almost 20 years old and these attitudes could have evolved and changed.

Hartman (2006) found in a qualitative study of 16 members of the LGBT community that bisexual women reported experiencing a “chilly climate” within the LGBT community. In particular, the bisexual women interviewed reported feeling that lesbians mistrusted them and would not date them. One woman reported that she was confronted about not being “good enough” for her lesbian partner because of her bisexual identity. Participants asserted that though there is not discrimination in the LGBT community, it is not entirely welcoming or accepting for bisexual individuals (Hartman, 2006). Moreover, bisexual individuals reported lower level of belonging to the LGBT community (Herek, et al., 2009). In another qualitative study of 60 Australian bisexual individuals, McLean (2008) found that almost all of the participants had experienced invisibility and discrimination in the gay and lesbian community. However it should be noted that attitudes toward members of any marginalized community can vary by culture and thus McLean’s (2008) findings may not reflect the attitudes I find in my U.S. based sample. Respondents reported that though there were some gay men and lesbians who respected their identities, most of the lesbians and gay men that they knew believed them to be in a “phase,” or an immature or incomplete place as far as their sexual orientation. One-third of respondents reported that they avoided the gay and lesbian community altogether for fear of discrimination and lack of acceptance (McLean, 2008). In another international study which took place at the Euromediterranean Summer School for Homosexualities, Welzer-Lang (2008) found that 45% of 93 responding attendees (all of the respondents in this sample were gay or lesbian except two bisexual individuals) exhibited some form of biphobia, 30% expressed neutrality about

bisexuality, and only 25% had positive attitudes about bisexuality. This study supports the notion that bisexual individuals threaten not only the established dichotomy of sexual orientation, but have the potential to reap the benefits of heterosexual privilege as participants noted that bisexual individual could “pass” as heterosexual (Weiss, 2004). However, it is important to note that attitudes are cultural constructs and therefore these results may not be generalizable to a U.S. sample.

To further understand the relationships among bisexuals and the lesbian and gay community and the heterosexual community, Yoshino (2000) termed as the “epistemic contract of bisexual erasure,” which is a silent political agreement among gay men, lesbians and heterosexual individuals to discount the existence and experiences of bisexual individuals (p. 2). Because bisexual individuals are able to have both same-gendered and cross-gendered relationships, many gay males and lesbians view them as having heterosexual privilege, especially if they are involved in a long-term heterosexual relationship (Embaye, 2006; Janson & Steigerwald, 2002). On the other hand, many heterosexual individuals feel uncomfortable at the idea of fluid sexuality, perhaps due to homophobia (Bradford, 2006; Goetstouwers, 2006; Yoshino, 2000). Thus, again these trends illustrate the lack of acceptance of bisexual individuals in both the LG community and the heterosexual community. Scott (2006) supported this idea, with the explanation that bisexuality subverts the sexual dichotomy as it is currently understood. In short, Scott (2006) argued that monosexual (i.e., gay male individuals, lesbians and heterosexual people) individuals benefit politically by marginalizing bisexual individuals and thus exclude them from their communities.

Societal beliefs about Promiscuity, Monogamy, and Bisexuality

This isolation and lack of acceptance may be supported by pervasive societal ideas that bisexual individuals are by nature promiscuous and not satisfied by one partner at a time (Ross, et al., 2010). The idea that bisexual people are unable to be faithful to partners of either sex due to their simultaneous attraction to both sexes undermines trust monosexual individuals might have in bisexual individuals (Herek, 2002). Though some bisexual individuals may choose a polyamorous lifestyle, it is not typical of the bisexual population; most bisexual individuals develop and maintain monogamous relationships (Weitzman, 2006). Additionally, most bisexual individuals reported that the gender of their partner did not matter to them, which implies that bisexual individuals do not feel a need to be involved with both genders simultaneously and therefore feel comfortable in monogamous relationships (Weitzman, 2006).

One of the reasons people hold these negative views about bisexual individuals' ability to be fulfilled in a monogamous relationship might be the pervasive belief that bisexual individuals are promiscuous. For example, in a qualitative study one bisexual participant reported, "my sister told me... I would prefer it if you were just my gay brother, and not this slutty person who just sleeps with everyone" (Ross et al., p. 498). This belief that bisexual individuals are promiscuous has also created a false belief that all bisexual individuals are more likely to participate in casual or unprotected sex and therefore are more likely to contract and spread sexually transmitted infections (Bradford, 2006; Fox, 2006; Goetstouwers, 2006; Kristal & Szymanski, 2008, Weitzman, 2006). Thus, these stereotypes of bisexual individuals as being both unfaithful (i.e., not able to maintain a monogamous relationship) and promiscuous are examples of biphobia, which leads to a lack of societal acceptance.

Implications of Biphobia on Bisexual Individuals

While biphobia has been shown to have negative impacts on the physical health of bisexual individuals (Goetstouwers, 2006), this section of the literature review will focus on the mental health implications as those implications are most relevant for this current study. For example, in a literature review by Dodge and Sandfort (2007), which reviewed ten years of articles from 1994 to 2004 in the PSYCHINFO database, they found only five studies that separated the mental health concerns of bisexual individuals from those of gay male, lesbian and heterosexual individuals. Their review showed that bisexual individuals consistently scored highest on measures of suicidal ideation, depression and anxiety. For instance, Paul et al. (2002) found in a randomized telephone survey that bisexual individuals had the highest rates of suicide attempts among any sexual orientation. Similarly, in a population-based survey of high school students, Robin et al. (2002) found that bisexual students were more likely to have attempted suicide than those of any other orientation. Robin et al. (2002) also found that the bisexual students in their study were more likely to be involved in violent activities, use drugs and alcohol, and engage in unhealthy weight control practices such as purging or fasting when compared to a gay and lesbian sample. Furthermore, Warner et al. (2004) found that compared to gay males, bisexual males had higher scores on measures of anxiety and depression as well as more mental health concerns such as obsessive compulsive behaviors, panic attacks and phobic anxiety. Moreover, bisexual individuals were less likely to have positive support systems and more likely to have experienced childhood adversity (Dodge & Sandfort, 2007; Jorm et al., 2002).

Though there are pronounced differences in the way people perceive lesbians and gay men in comparison to bisexual individuals, there is some empirical support for the notion that the

impact of biphobia on bisexual individuals is very similar to the impact of homophobia on gay males and lesbians (Goetstouwers, 2006). For instance, Horowitz, Weis and Laflin (2003) found no significant differences between bisexual individuals' health indicators, which included happiness, perceived health, and job satisfaction than those of heterosexual or gay males and lesbians. While some studies have documented similarities in health indicators for members of the LGB community and heterosexual individuals, when factors such as violence are considered, differences emerge in the experiences between these communities. For example in 2010, 1,470 hate crimes based on sexual orientation were reported (U.S. Department of Justice Federal Bureau of Investigation). It is important to remember that being gay, lesbian or bisexual is dangerous in our society, and this fear of being harmed might have a significant impact on LGB individuals' mental health (Herek, 2000). While all LGB individuals face the potential for experiencing physical violence due to homophobia and biphobia, Horowitz et al. (2003) found that bisexual women experience a higher level of violence than lesbian women.

Ross and colleagues (2010) documented reasons for these negative mental health outcomes in a qualitative study that involved interviewing 55 bisexual individuals. Their participants reported that several factors contributed to their poor mental health, including the invisibility of bisexuality, assumptions of promiscuity and polyamory, views of bisexual males as disease carriers, views of bisexual females as objects of heterosexual males' sexual objectification, and the threat of hate crimes. The threat of homo- or biphobic violence has the potential to have significant impacts on the mental health of bisexual individuals, especially considering that bisexual individuals have shown higher rates of anxiety than those of other sexual orientations (Warner et al., 2004). This threat of violence can also be internalized as Herek and colleagues (2009) found that bisexual individuals may also face self-stigma due to

various social constraints and societal messages that support biphobia. For instance, bisexual males scored the highest on a measure of self-stigma when compared to gay men, lesbians and bisexual women. Additionally, Herek et al. (2009) found that the bisexual individuals in their sample reported the highest level of anxiety about their sexual orientation and reported the lowest level of self-esteem. Thus, it is important for the affirmative therapist to recognize that this anxiety may be the result of biphobia and not something that is internal for bisexual individuals.

Affirmative Therapy with Bisexual Clients

Given the mental health implications of biphobia on bisexual individuals, it is important that CFTs provide affirmative therapy when working with bisexual clients. While no clear definition exists in the literature of what constitutes affirmative therapy with bisexual clients, it is generally thought to involve embracing a positive view of bisexuality, supporting bisexual clients in their relationships and lives, and understanding the influence of biphobia and heterosexism on all individuals, including the therapist (Bradford, 2004; McGeorge & Carlson, 2010; Mohr, Israel, & Sedlacek, 2001). It is important to note that Knudson-Martin and Laughlin (2005) asserted that CFTs may be better equipped to provide affirmative therapy than other mental health clinicians. These scholars believe that due to the relative newness of the field of family therapy in comparison to other mental health disciplines, CFTs have not had to go through a process of “de-pathologizing” any particular sexual orientation. Knudson-Martin and Laughlin (2005) further argued that it may be easier for CFTs to learn affirmative practices considering that family therapy has experienced a significant boom in recent decades along with the LGB movement.

Prior to exploring the literature on affirmative therapy, it is important to review the studies that highlight the influence of biphobia on clinicians and the services they provide the bisexual community. For example, Mohr et al. (2009) surveyed 108 mental health clinicians and found that these clinicians ranked bisexual clients as more confused and conflicted and having more sexual identity issues than an identical gay male or heterosexual client. However, it may be more concerning that their findings do not significantly differ by level of training to work with LGB clients or level of experience working with LGB clients. This may imply that training to work with “LGB” clients may not focus enough on therapy with bisexual clients.

Holding more negative attitudes toward bisexual individuals appears to impact therapists’ ability to provide competent services to bisexual individuals. For example, Mohr et al. (2001) found that counselors with negative attitudes toward bisexual individuals had a higher tendency to pathologize bisexual clients and gave a sample client who was identified as bisexual a lower Global Assessment of Functioning score than counselors with more accepting attitudes. Furthermore, counselors with negative attitudes were less likely to be aware that their bias might have an impact on the therapy process. (Mohr et al., 2001). In addition to experiencing biphobia from their therapist, bisexual individuals are often faced with the problem of having to educate their therapists about bisexuality (Page, 2004). Bisexual clients cited this as a difficult position to be in; though some felt they wanted to educate the therapist, many felt it was not their job to educate the therapist on issues the therapist should have been familiar with in the first place (Page, 2004).

Given that many clinicians appear to not be practicing affirmative therapy with bisexual clients, it is important to more closely examine the four primary components of affirmative therapy with bisexual clients. These components are: 1) knowledge of bisexual topics, 2)

normalizing or accepting attitudes, 3) therapist self-awareness and 4) maintaining a certain level of activism on behalf of their bisexual clients (Bradford, 2006; Dodge & Sandfort, 2007; McGeorge & Carlson, 2011; Scott, 2006) Each of these components will be described in the following four sections.

Knowledge about Bisexual Topics

Literature suggests that therapists should be aware of a number of bisexual-specific topics in order to properly work with bisexual clients in an affirmative manner (Dodge & Sandfort, 2007). Dworkin (2001) suggested that therapists working with a member of a marginalized group should explore their client's lived experiences of oppression and not assume that they understand that experience without appropriately exploring it. Therapists should be aware that a long history of biphobia and invisibility may be the cause of some of a bisexual clients' presenting issues (Embaye, 2006; Keppel, 2006) and be able to walk the client through some of his or her experiences with this lens (Bradford, 2006; Embaye, 2006; Scott, 2006). Similarly, therapists should also be aware of the possible lack of community for bisexual individuals and that the strength of their memberships to a gay male, lesbian or straight community may be a large part of why some bisexual individuals choose not to "come out" (Bradford, 2006; Goetstouwers, 2006; Martell, 1999).

It may be particularly important for CFTs to be aware of the consequences of coming out as bisexual. Though some bisexual individuals are welcomed in the LGB community, a woman in a lesbian relationship who comes out as bisexual or asserts that she may like to have relationships with men risks losing her place in the lesbian community (Keppel, 2006). Similarly, coming out as a bisexual in a straight community could mean a variety of losses depending on the client's situation, including loss of a job, spouse, custody of children, and of course a sense

of belonging in a straight community (Herek, 2000). Therapists should also be aware of where people are in the coming out process and if they wish to come out at all.

Normalizing or Accepting Attitudes

Considering the particular struggles bisexual individuals face, it is important for a therapist to have a positive, affirmative stance regarding bisexuality (Bradford, 2006; Butt & Guldner, 2003; Embaye, 2006; Godfrey et al., 2006; Keppel, 2006; Scott, 2006). Specifically, the therapist should hold an attitude that affirms bisexuality as a legitimate sexual identity and bisexual individuals as normal and healthy (Godfrey et al., 2006). The therapist should neither over- or under-pathologize the client's bisexuality (Scott, 2006); that is, an affirmative therapist might defer to the client as to whether bisexuality is an issue she or he would like to discuss in therapy. This is particularly important considering that many clients will change the subject or hide their orientation if it is pathologized or limited in the therapeutic context (Keppel, 2006). Additionally, while experiences of biphobia may influence the client's presenting problem, it is important that a therapist not assume that the client's sexual orientation should be the primary focus of therapy (McGeorge & Carlson, 2011).

Therapist Self-Awareness

Not only should an affirmative therapist hold a positive stance toward bisexuality, but in order to properly work with bisexual clients, a therapist should also spend some time considering her or his own biases and beliefs around bisexuality, and bisexual individuals and relationships (Dworkin, 2001; McGeorge & Carlson, 2011). In order to do this, it is extremely important for a heterosexual therapist to be aware of her or his heterosexual privilege (Bradford, 2006; Janson & Steigerwald, 2002). In their 2011 article, McGeorge and Carlson outlined a process that heterosexual therapists might follow in order to better understand their heterosexual privilege

and their own heterosexual identities. These steps are: 1) exploring heteronormative assumptions, such as that all clients are heterosexual or are in heterosexual relationships; 2) exploring heterosexual privileges, such as having relationships that are supported and encouraged both publicly and privately; and 3) exploring the development of a heterosexual identity, which involves considering questions such as “have you ever worried that you might be “outed” as heterosexual?” (p. 6). Thus, it is important not only to be aware of the biases and privileges one experiences as a heterosexual therapist due to the marginalization of LGB individuals, but to own it in a therapeutic context and begin a process of advocating for clients in both therapeutic and public contexts.

Activism

With the awareness that most heterosexual therapists have heterosexual privilege, it would be appropriate for an affirmative therapist to use that privilege to advocate for bisexual individuals within the context of their community. Thus literature suggests that, in order to be fully affirmative a therapist should work not only to promote equality for bisexual individuals (Scott, 2006), but to undo some of the negative stereotyping bisexual individuals are subjected to (Embaye, 2006). In a Delphi study involving mental health professionals with expertise on LGB topics, Godfrey et al. (2006) found that two ways a therapist might advocate for their LGB clients are by integrating into the LGB community in order to provide support and resources to LGB clients and being an advocate against heteronormative assumptions and structures. This advocacy or activism is based on the idea that CFTs have a responsibility to seek out clients from under-served groups and advocate for them both in and out of the therapy room (McGeorge & Carlson, 2010). In the literature there are a number of different examples of actions that an LGB affirmative therapist can take, which include participating in Pride events, writing letters to the

editor in support of LGB civil rights, and campaigning or voting for elected officials who support LGB rights (Lee, 1998; McGeorge & Carlson, 2011). Being involved in a community effort might show that a therapist is truly dedicated to improving the mental health of bisexual individuals. Since most of this research on activism is focused on the LGB community as a whole, one can assume that these advocacy concepts are also applicable to the bisexual community.

Training Implications

In order for CFTs to provide affirmative therapy to bisexual clients, they must receive the appropriate training. The literature provides a few suggestions about how training programs might implement more LGB affirmative training. There is little empirical research on how to most effectively train students to provide affirmative therapy to clients who identify as bisexual, which lends credence to the current study. It is problematic that a majority of students in their final year of master's study self-reported feeling unable to adequately address bisexual issues (Phillips & Fischer, 1998). Rock, Carlson and McGeorge (2010) found that 60.5 % of participants ($N = 190$) reported they had received no training on affirmative therapy with LGB clients. Moreover, Mohr et al. (2001) surveyed 97 counselor trainees from eight training programs and found that 30 % of those who did receive "LGB" training did not receive any training regarding working with bisexual clients in therapy. Therefore a need for more literature on family therapy students' attitudes toward bisexual clients and how training might be changed to be more affirmative is indicated. The literature that does exist provides a couple of suggestions for training programs, such as 1) provide student therapists the opportunity to work with bisexual clients and expose them to films or literature on bisexual topics (Israel, 2007; Lidderdale, 2002); and 2) engage heterosexual students in activities and discussions that facilitate them considering

their own sexual orientation, how their sexual orientation developed, and their biases toward bisexual individuals (Butt & Guldner, 2003; Israel, 2007; McGeorge & Carlson, 2011). Each of these two primary suggestions for training CFTs to provide affirmative therapy to bisexual clients is discussed in the following sections.

Opportunity to See Bisexual Clients and Exposure to Bisexual Topics

The literature suggests that there is some support for the idea that having interactions with bisexual individuals or viewing films or presentations around bisexual topics may help to increase positive attitudes toward bisexual clients (Lidderdale, 2002). With this in mind, it seems as though even small steps may be helpful for creating a more affirmative atmosphere within training programs. Instructors could provide even one elective course on bisexual topics, which might increase affirmative attitudes, even if the students did not take the course (Lidderdale, 2002). Even having a course available may help students think about their sexual orientation and how their sexuality developed. Reflections on this may be helpful for students to better understand the experiences of their bisexual clients (Lidderdale, 2002).

Furthermore, Israel (2007) asserted that familiarity with LGB-related material may be helpful especially if there were specific discussions about whether or not the material had any bearing on working with bisexual clients. Having conversations around why the material might fit with the bisexual experience and specific reasons why it may not apply can be helpful not only to begin recognizing specific issues related to bisexuality, but the differences and similarities that exist within the lesbian or gay male experiences and bisexual experiences (Israel, 2007). It may also be helpful to recruit bisexual clients specifically so CFT students are able to get supervised experience with bisexual clients (Israel, 2007).

Self Reflections on Personal Sexuality and Biases

Israel (2007) also suggested an activity for clinical students to explore their own sexual orientation. She suggested that an instructor ask the students to consider what they might feel or experience if her or his partner were to come out as bisexual. The students could be asked to discuss and process what this might mean and the concerns that might come up as a result. Israel (2007) asserted that it is important for students to explore where these feelings come from and the implications these biases might have in counseling or therapy.

Finally, the most helpful piece of becoming an affirmative therapist might be developing a positive attitude toward bisexual clients (Godfrey et al., 2006). This might be done by completing the above explorations of sexual orientation and positionality. Many of the suggestions presented around training students to provide LGB affirmative therapy mirrors my previous discussion on LGB affirmative therapy and the process of providing affirmative services to bisexual clients. Therefore, I will not repeat that literature again here.

Research Questions

Because there is relatively little conclusive research available, the current study focused on research questions, as there was not enough information to form educated hypotheses. The current research sought to answer the following three research questions: 1) How do CFT students' level of experience working with lesbian, gay male and bisexual clients in a therapeutic context differ?; 2) How do CFT students' attitudes about bisexual clients differ from their attitudes about lesbian and gay male clients?; and 3) How does the amount of affirmative training a CFT student receives predict attitudes toward bisexual clients?

CHAPTER THREE. METHOD

In this section I described the sample for my study as well as the data collection and analysis procedures. The data for this study were secondary data from a larger data set on CFT students' beliefs about their competence to work with LGB clients and their self-reported levels of homophobia.

Participants

Participant Recruitment

Participants were recruited in two ways: 1) at an annual national conference of the American Association of Marriage and Family Therapy (AAMFT), posters were put up and announcements were made in sessions instructing students how they could receive a paper copy of the survey, and 2) program directors from all accredited CFT master's and doctoral programs received an email that requested that the director forward information about the study to the students in their program. There was a link to the electronic version of the survey in the recruitment email. The paper and electronic version of the survey were identical.

Participant Description

The sample for this study was 248 CFT master's and doctoral students enrolled in graduate programs that were accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE; see Table 1). The students had been in their CFT programs on average 16.71 months ($SD=14.30$). Seventy (28.1%) respondents were working toward their Ph. D. and 177 (71.1%) were working toward their master's degree. Just under half (48.2%) of respondents had experience working with LGB clients. The majority (79.9%) of participants were white. There were 190 (76.3%) female participants and 58 (23.3%) male participants. Thirteen (5.2%) respondents identified as bisexual, five (2.0%) identified as gay,

five (2.0%) identified as lesbian and 217 (87.1%) identified as heterosexual. Additionally, the sample ranged in age from 21 to 61 years, with a mean age of 29.50 years ($SD = 7.79$). The sample composition for this study appears to mirror the population of CFTs in terms of gender and race as the majority of CFTs are white and female (Northey, 2004).

Measures

The data for this study were collected using a revised version of the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005) and the Affirmative Training Inventory (ATI; Carlson, McGeorge, & Rock, 2007). A modified version of the SOCCS was used to measure CFT students' self-reported competency in working with LGB clients (Bidell, 2005). The SOCCS is made up of 29 items but the analyses for this study will use only a small sub-set of items. The SOCCS as a whole appears to demonstrate good reliability and validity. The overall SOCCS has an alpha coefficient of .90 and a one-week test-retest reliability of .84 (Bidell, 2005). Criterion validity was established by examining how scores on the SOCCS varied based on demographic information such as participants' sexual orientation and level of education. Specifically, Bidell (2005) found that those with more education and LGB identified individuals had higher scores on the SOCCS. Three existing measures (i.e., Attitudes Toward Lesbians and Gay Men Scale, Multicultural Counseling Knowledge and Awareness Scale, and Counselor Self-Efficacy Scale) were used to establish convergent validity for the SOCCS.

For the larger study from which the data for this current study comes, the SOCCS was modified in three primary ways (See Appendix A). First, one item was added that assessed students' experience working with bisexual clients and two items were added that assessed their beliefs about bisexual clients. These three added items were modeled exactly after existing items that assessed experience working with and attitudes towards lesbian and gay clients. An example

of one of these items is “Personally, I think bisexuality (both female and male bisexuality) is a mental disorder and/or a sin and can be treated through therapy or spiritual help.” Second, items three, four, seven, eight, and 18 of the SOCCS were altered to better fit the experience of student therapists. For example, item four originally stated “I have experience counseling gay male clients” and was revised to read “I have had the opportunity to work with gay male clients in therapy.” This change was made because student therapists may not, due to having begun doing therapy only recently, have had experiences with any specific group of clients. Finally, the original version of the SOCCS used a 7-point Likert scale, but for this current study a 6-point scale was used, which ranged from 1 (strongly disagree) to 6 (strongly agree). This change was made to eliminate a neutral response or to create a forced choice and to have a common scale across all the instruments used for the study. The alpha coefficient for this revised version of the SOCCS was .89 (Rock et al., 2010). In order to score the SOCCS some of the items were reverse coded so that higher scores are associated with higher levels of competency working with LGB clients.

The ATI (Carlson et al., 2007) was developed to assess the extent to which CFT programs integrate affirmative practices and ideas into the courses and curricula (See Appendix B). In particular, the ATI contains items that assess: 1) the level of content that students report receiving in their CFT coursework related to heterosexism, heterosexual bias, heterosexual privilege, and affirmative therapy practices, 2) the amount of opportunities that students reported receiving during their graduate training to explore their own heterosexual biases and privileges, and 3) the degree to which students are provided with opportunities to work with LGB clients. The ATI contains nine items and utilized the same 6-point Likert scale as the SOCCS, ranging from 1 (strongly disagree) to 6 (strongly agree). It is important to note that higher scores on the

ATI are associated with greater levels of LGB affirmative training. The ATI has an alpha coefficient of .86.

Procedure

Participants were provided with either a paper copy of the survey or an electronic version. Both versions were identical. Participants first completed the SOCCS, then the ATI and finally the demographic questions. When participants mailed back or submitted the electronic survey consent was assumed. Additionally, participants were not compensated in any way for their participation in this study. The study was approved by the North Dakota State University Institutional Review Board.

Data Analysis Plan

The data analysis plan for each of the three research questions is detailed in the below sections.

Research Question One

As stated previously, the first research question is how do CFT students' level of experience working with lesbian, gay male and bisexual clients in a therapeutic context differ? The analysis for this research question focused on items four, eight, and 18 of the revised SOCCS, which asked participants their level of experience working with each of the three populations (i.e., lesbian, gay, and bisexual clients). In particular, I examined the mean difference that exists in participants' responses across these items using two paired-sample *t*-tests. I first calculated a paired-sample *t*-test to compare participants' level of experience working with lesbian clients and bisexual clients and then computed a separate paired-sample *t*-test to compare participants' level of experience working with gay male and bisexual clients. If

either of the paired-sample *t*-tests was significant then I calculated a Cohen's *d* to determine the effect size and add more confidence to any significant findings.

Research Question Two

As stated previously, the second research question was how do CFT students' attitudes about bisexual clients differ from their attitudes about lesbian and gay male clients? To explore this research question I focused on items 27, 28, 30, and 31 of the revised SOCCS. In particular, I created a mean composite score for participants' beliefs about bisexual clients by averaging participants' responses on items 28 and 31. Item 28 states that "Personally, I think bisexuality (both female and male bisexuality) is a mental disorder and/or a sin and can be treated through therapy or spiritual help" and item 31 states "When it comes to bisexuality (both female and male bisexuality), I agree with the statement 'You should love the sinner but hate or condemn the sin'. These two questions together measure negative beliefs or attitudes about bisexuality. The correlation between these two items is 0.83 which suggested it was appropriate to combine these items as a composite score. I also created a mean composite score for participants' beliefs about lesbian and gay clients by averaging participants' responses on items 27 and 30. Item 27 states "Personally, I think homosexuality (gay male and lesbian relationships) is a mental disorder and/or a sin and can be treated through therapy or spiritual help," and item 30 states "When it comes to homosexuality (gay male and lesbian relationships), I agree with the statement: 'You should love the sinner but hate or condemn the sim.'" The correlation between these two items was also 0.83. Prior to calculating the analyses to explore this research question, I examined the correlation between the attitudes about bisexual individuals sub-scale and the attitudes about LG individuals and found that were correlated at .996 ($p < .001$). To compare participants' beliefs about these populations, I computed a paired-sample *t*-test. If the paired-

sample *t*-test was significant, I then calculated a Cohen's *d* value to add greater confidence to my findings and assess the effect size of any difference that might exist.

Research Question Three

As noted earlier, the third research question was how does the amount of affirmative training a CFT student receives predict attitudes toward bisexual clients? To explore this research question, I used the participants' mean composite score on the ATI as the independent variable and the participants' mean composite score on the beliefs about bisexual clients subscale as the dependent variables. In particular, I calculated a multiple regression and entered demographic variables into the first step of the regression in order to control for the variance that they would explain. All demographic variables that are non-continuous were dummy coded to be dichotomous variables. I entered in participants' mean composite score on the ATI in the second step of the regression.

CHAPTER FOUR. RESULTS

Research Question One: Comparing Levels of Experience

I explored the first research question regarding the differences between student therapists' experience working with gay male, lesbian, and bisexual clients with two paired samples *t*-tests. The first paired samples *t*-test was calculated to compare students' experience providing clinical services to gay male clients and bisexual clients. The mean level of experience students had with gay male clients was 2.81 (SD = 1.79) and the mean level of experience that students reported with bisexual clients was 3.07 (SD = 1.75). As a reminder experience could range from one to six with six representing the highest level of experience. Thus, these participants on average were reporting a moderate level of experience with each of these populations. A significant difference was found with participants reporting higher levels of experience working with bisexual clients, $t(245) = 2.46, p < .05$. Since the paired samples *t*-test was found to be significant, I then calculated a Cohen's *d* value. The Cohen's *d* was 0.15; according to Pycza (2003) this indicates a small level of difference.

The second paired samples *t*-test was calculated to examine the level of experience that students had with lesbian and bisexual clients. The mean level of experience students had with lesbian clients was 3.12 (SD = 1.83) and the mean experience with bisexual clients was 3.06 (SD = 1.74). The *t*-test was not significant, $t(243) = 0.65, p > .05$. Thus, there is not a significant difference in the level of experience that students reported working with bisexual and lesbian clients.

Research Question Two: Comparing Attitudes Towards Bisexual Individuals and LG Individuals

Research question two regarded the differences participants' attitudes towards bisexuals and LG individuals. The mean level of attitudes towards bisexuals for the sample was 5.00 (SD = 1.55). The mean level of attitudes LG individuals towards for the sample was also 5.00 (SD = 1.56). Again, the range of response options was from one to six with one representing negative attitudes and six representing positive attitudes. Thus, this sample reported relatively positive attitudes. Though unnecessary given the nearly identical means for attitudes towards each of the sub-groups, I calculated a paired sample *t*-test, which was not significant at a .05 level ($t(243) = .69$ $p > .05$). This is not surprising given that the mean levels of attitudes towards bisexual individuals was nearly identical (the difference existed in the thousandth decimal point) to the mean level of attitudes towards LG individuals.

Research Question Three: Affirmative Training Predicting Attitudes Towards Bisexual Individuals

Research question three, regarding whether or not affirmative training influenced students' attitudes toward their bisexual clients was tested with a multiple hierarchical regression. Thus, the independent variable was amount of affirmative training as measured by the ATI. In particular, I used the participants' average score on the ATI, and participants received an average score as long as they answered 70% of the items that comprise the ATI. The dependent variable was participants' self-report level attitudes towards bisexual individuals, as measured by participants' mean score on the two items from the R-SOCCS. The correlations for all of the variables used in each of the two steps of the regression can be found in Table 2.

In the first step of the regression I included the demographic control variables, which were total number of clinical hours with LGB clients, type of educational institution the students were currently enrolled in (0 = religious university, 1 = non-religious university), whether participants were master's or doctoral students (0 = master's, 1 = Ph.D.), gender (0 = men, 1 = women), and sexual orientation (0 = LGB, 1 = heterosexual). The results of this step were significant ($F(6, 203) = 6.61, p < .001$). The R^2 for this first step was 0.16. The B and beta coefficients for gender were significant at the $p < .001$ and B and beta coefficients for sexual orientation and type of educational institution were significant at the $p < .05$ level (See Table 3 for B and Beta coefficients and Standard Errors). Thus, women, LGB identified persons, and those attending secular educational institutions reported more positive attitudes towards bisexual individuals.

The second step of the hierarchical regression involved entering the participants' mean score on the ATI into the model in an attempt to determine the degree of variance within participants' attitudes towards bisexual individuals that could be explained by their level of affirmative training. The second step of the regression was also significant at a $p < .001$ level. Thus, a significant regression equation was found ($F(7, 202) = 6.37, p < .001$), with a R^2 of .18. The R^2 change was also significant at the $p < .001$ level. The B and beta coefficients for gender, sexual orientation, type of educational institution, and the ATI were all significant at the $p < .05$ level. Most interestingly, the ATI was a significant predictor of participants' attitudes towards bisexual individuals in that the more affirmative training participants received was associated with more positive attitudes towards bisexual individuals.

CHAPTER FIVE. DISCUSSION

This chapter is divided into sections, which are: 1) Main findings from the research, 2) Limitations of the study, 3) Clinical implications, 4) Suggestions for future research, and 5) Conclusion.

Main Findings from Research Question One

I found no significant differences in the level of clinical experience CFT students reported having with lesbians and bisexual individuals. However, I did find a significant difference between their level of clinical experience with gay males and bisexual individuals, with students having a higher level of experience with bisexual individuals. Thus, overall students reported working with lesbian and bisexual clients at a similar rate and working with gay male clients at a statistically lower rate. Overall, students reported a moderate level of experience working with lesbian and bisexual clients and a low to moderate level of experience working with gay male clients. Though not discussed in the literature review, it is possible that these results are confounded by gender. As women seek therapy at a greater rate than men (Cochran, Sullivan & Mays, 2003; Nam et al., 2010), it seems more likely that lesbian and bisexual women seek therapy more often and thus, students might have more experience with female populations. However, it is important to note that no data were collected from participants about the gender of bisexual clients that they worked with.

Moreover, the fact that CFT students reported having more experience with bisexual individuals than gay men may also be explained by bisexual individuals having more mental health struggles than gay males due to living in a biphobic society (Page, 2004; Robin et al., 2002). Considering that bisexual individuals struggle with a different type of stigma, it is possible that they have differing and perhaps more severe mental health difficulties, thus

requiring the use of mental health services at a higher rate. It is important to note that I am not suggesting that bisexual individuals intrinsically struggle with mental health concerns, but that these concerns are due to biphobia and the marginalization that bisexual individuals experience in both the heterosexual and LG community (Hartman, 2006; Keppel, 2006; McLean, 2008; Rust, 1993). Additionally, I was not able to locate a study that specifically examined the differences in therapy usage rates between bisexual, lesbian, and gay male clients, which highlights an interesting suggestion for future research in this area.

Main Findings from Research Question Two

I found no differences between CFT students' attitudes toward bisexual clients and gay male and lesbian clients and was able to document fairly positive beliefs about both bisexual individuals and LG individuals. This is an encouraging finding as it suggests there could be a growing acceptance among family therapy students of both communities. However, this is perhaps unsurprising since it is possible that heterosexual therapists see bisexual individuals, gay males and lesbians as members of one group ("LGB"), and therefore feel similarly about each of these three subgroups (Diamant & Wold, 2003; Herek, 2000; Mulick & Wright, 2002). In addition, my findings appear to contradict much of the literature, which suggests that levels of biphobia or negative attitudes towards bisexual individuals are higher than reported levels of homophobia (Hartman, 2006; Welzer-Lang, 2006). For instance, Herek (2002) found by surveying a large sample of heterosexuals that they reported more negative attitudes toward bisexual individuals than lesbians and gay males. However, it is possible that the participants in the current study were reticent to report differing feelings between LG individuals and bisexual individuals due to social desirability. Conversely, it is possible that the survey was not in-depth enough to parse out areas in which the participants' feelings about these groups differed. For

example, Ross and colleagues (2010) found that people believe that bisexual individuals are more promiscuous and more likely to be unfaithful. Without specific questions regarding the perceived characteristics of bisexual individuals, it is possible that participants did not have adequate prompts to express the differences that they perceive in LGB individuals. However, the literature does suggest that bisexual invisibility is a part of biphobia (Herek, 2000; Page, 2004) and it is possible that bisexual invisibility had an impact on this lack of difference.

Thus, it appears that the literature and our results are not in agreement. In addition to the ideas discussed above this disagreement can also be explained in terms of my sample. Most of my participants were relatively young (i.e., mean age of 29.50), and the existing literature suggests that younger adults appear to have lower levels of prejudice in general (Krendl, Heatheron, & Kensinger, 2009). Finally, the difference between my results and the existing literature could be explained by a possible selection bias in that students who participated in my study could hold more positive beliefs about LGB clients than the general population of CFT students.

It is also possible that this finding indicates a positive shift in attitudes about bisexuality and that bisexual individuals are more accepted than they were when many of the studies reviewed were originally conducted. Thus, as stated earlier, my findings appear to be encouraging as they offer support to the idea that bisexuality and bisexual individuals may be more widely accepted than previously thought. Queer theory may also shed some light on this finding. Queer theory is the thought that human sexuality (and gender representation) has no or should have no boundaries and furthermore that socially constructed heteronormative binaries should be challenged (Halperin, 2003; Oswald, Blume & Marks, 2005). Queer theory may have led to more support for bisexual individuals in that both queer theory and bisexuality defy the

dichotomy that the previous paradigm of sexuality was based upon. It is possible that increased acceptance of the idea that the boundaries of human sexuality are fluid through the increased popularity of queer theory (Halperin, 2003) has in fact increased acceptance for bisexual individuals such that being bisexual is not perceived any differently than being gay or lesbian.

It should be noted that I was interested in studying the construct of biphobia, however the data used for this thesis more accurately measured attitudes toward bisexual individuals which is a component of the construct of biphobia. In order to fully test and measure biphobia, a new scale will have to be developed. However, I believe that measuring negative attitudes is an important first step in developing a broader instrument that fully measures the complexity of biphobia.

Main Findings from Research Question Three

I found that the more LGB affirmative training my participants received was predictive of having more positive attitudes toward bisexual clients. Considering the literature indicating that more exposure to LGB topics can have a positive influence on attitudes (Barker, 2007; Barker & Landridge 2008), it follows that having more LGB affirmative training experience would have a positive impact on students' attitudes toward bisexual clients. Additionally, researchers have found that LGB affirmative training is associated with lower levels of homophobia, which seems to support my current finding (Carlson, McGeorge, & Toomey, in press; Rock et al., 2010). However, it is important to note that the scale, the ATI, I used for this study did not specifically address affirmative training with only bisexual identified clients, but instead addressed affirmatively working with LGB clients as a group.

In addition to finding that the level of LGB affirmative training that students received predicted their attitudes toward bisexual individuals, the results of the analysis for this research

question also revealed that being a woman, identifying as LGB, and having been educated at a secular institution were also significantly predictive of having more positive attitudes toward bisexual individuals. Other researchers have found that women report lower levels of homophobia than men (Henke, Carlson, & McGeorge, 2009; Nagoshi et al., 2008) so it would fit that women might also report lower levels of biphobia. Additionally, given the marginalization that women experience it make sense that they could be more accepting of members of other marginalized groups. Researchers have also found that LGB identified individuals appear to report lower levels of homophobia (Henke et al., 2009; Rock et al., 2010); however, the existing literature on biphobia suggested that gay men and lesbians in fact do, on average, exhibit significant levels of biphobia (Hartman, 2006; Herek et al., 2009; McLean, 2008; Rust, 1993; Welzer-Lang, 2008). Thus, my findings that LGB individuals report more positive attitudes toward bisexual clients appear to contradict the existing literature; however, it is important to note that the attitudes my sample had toward bisexual individuals and gay male and lesbian individuals were identical. Therefore, this finding could reflect a measurement issue in that the sub-scales that I used to measure those attitudes did not fully distinguish between these two sub-groups. However, it is possible that given the passage of time and the increasing level of acceptance for the LGB community as a whole has created space for LG individuals to be more accepting of bisexual individuals. Queer theory also offers support for this notion of wider acceptance that rather than having separations between the subgroups LGB persons may experience a greater level of acceptance for one another and are more united under the umbrella term of “queer,” (Callis, 2009). Thus, this finding might be considered a significant improvement over the pact of invisibility and mistrust noted in previous literature (Ross et al., 2010; Yoshino, 2000).

In terms of my finding that students attending secular family therapy programs reported more positive attitudes than those attending religious training programs, it is difficult to connect this finding to the existing literature as there is very little written on this topic. Researchers have found that religious individuals report higher levels of homophobia (Balkin, Schlosser & Levitt, 2009), but other scholars disagree with these findings as some faith traditions promote very affirmative attitudes towards LGB individuals, couples, and families (Johnston, 2004). Thus, this is an area that needs to be further researched.

Limitations

Though the study had many strengths, there are limitations or areas of improvement for this current study that could affect the generalizability of the current findings. Considering that our topic is currently considered “hot-button,” it is most likely that the people who chose to complete the survey had strong opinions on one side or the other, and those with more moderate opinions may have passed the survey by, especially considering the tendency of this topic to be divisive. It is also possible that people having positive feelings toward LGB individuals or heterosexual people who identify as allies may have been more likely to participate in this study. Thus, a selection bias could exist with my sample. In addition to concerns about selection bias, another factor that could limit the generalizability of this study is the composition of the sample. My sample was predominantly White and female, which according to the existing data on the CFT field is reflective of the larger field (Northey, 2004); however, it would be interesting to repeat this study with a more racially diverse sample with a better gender balance.

Furthermore, this study should be considered exploratory for two reasons. Firstly, the measure of attitudes toward bisexual clients was limited as it was only comprised of two items and did not directly measure biphobia. These two items also both made reference to religious

terminology, and this may have had an impact my findings. Second, because this topic has not been widely researched, much of the literature in the literature review was purely theoretical.

Clinical Implications

The findings of this research lend toward several implications for both CFT training and practice. First, my analyses found that LGB affirmative training does have a positive impact on attitudes towards bisexual individuals. This encouraging finding suggests that CFT training programs need to provide their students with affirmative training that addresses the students' skills as well as their personal beliefs and biases about the LGB community. Moreover, my findings suggest that students have similar attitudes toward bisexual individuals and gay men and lesbians; however, there still might be little understanding about the different lived experiences of bisexual identified individuals and lesbian and gay individuals. Recognizing these differences may help to dissuade from a "democratic," model of looking at the LGB community and instead help to promote a distinct understanding of all LGB members (Goldfried, 2008). For instance, training programs might foster discussions about differences between the sub-groups in the LGB community. It might be helpful for programs to bring in a panel of people with differing orientations to discuss the similarities and differences in their lived experience.

Given that LGB affirmative training predicted more positive attitudes toward bisexual individuals and previous researchers have found that it is associated with lower levels of homophobia (Rock et al., 2010), CFT graduate programs should integrate LGB affirmative curricula into their training. A part of that affirmative training could be to explore the history of marginalizing LGB individuals in the helping professions. Though having a non-heterosexual identity is no longer officially pathologized, there are some vestiges of negative beliefs within the CFT field that can be found in the theoretical approaches to therapy (Eubanks-Carter,

Burckell & Goldfreid, 2005). Discussing the negative attitudes that exist within the CFT field as well as processing the impacts of negative beliefs and homophobic and biphobic interventions may help students to become more aware of times when negative biases might be impacting their work. Better awareness of biases within theory and interventions may also help students brainstorm new, positive interventions, therefore contributing directly to the affirmative curriculum of their programs.

Based on my findings, implementing new LGB affirmative training techniques will make a difference for new therapists. However, this study has implications for practicing CFTs as well. The results of this study suggest that student therapists do not see differences between bisexual individuals, lesbians and gay men. It is possible that even this inability to differentiate between the groups is a part of bisexual invisibility and may be improved upon by further education on bisexual topics. Furthermore, it may be helpful for current CFTs to modify their therapy practices, such that they expect and investigate the differences between these populations; particularly that they allow the client to define these differences and help the client reflect upon whether or not the group they specifically belong in has an impact on the level of prejudice or discrimination that they experience. Having further knowledge about the distinct experiences of these three groups may help practicing CFTs craft their therapy with LGB individuals to be more helpful and client-focused.

Furthermore, based on the results of my research, CFT programs should focus client recruiting efforts not only on the LGB community as a whole (Long & Serovich, 2003), but have a special focus on recruiting gay male clients. Training clinics might benefit from advertising their therapy services as safe and open for gay men and gay male couples in particular. Even simple advertising choices such as putting a picture of a gay male couple rather than a

heterosexual or a lesbian couple may serve to improve recruitment. It was encouraging to see that students appeared to have some experiences with each of the three sub-groups that comprise the LGB community.

Suggestions for Future Research

Considering my current findings, I have a number of recommendations for future research. For example, further studies should be done addressing the differences in therapists' beliefs about bisexual men and bisexual women. Given that the present study did not distinguish between beliefs that student therapists hold about bisexual men as opposed to bisexual women, it would be helpful to know how these beliefs vary and, in particular, if attitudes toward bisexual individuals vary once gender is also considered. Additionally, if future studies looked at sexual orientation and gender, a fuller exploration could occur to determine if the level of experience students have with gay men, lesbians, and bisexual identified clients can be accounted for by gender or sexual orientation. Another study could be done to explore specifically the kind of training that CFT programs are providing their students and whether or not the training adequately addresses both biphobia and topics related to working with bisexual identified clients. Studies should also be performed to explore the type of clinical training that is associated with providing competent therapy to bisexual clients. Additionally, a study utilizing a sample of bisexual clients focused on identifying helpful strategies and positive therapeutic experiences would be helpful to identify ideas for training therapists to provide affirmative therapy to bisexual clients. Finally, as I shared, the scale we used to measure attitudes toward bisexual individuals was limited. In the future, a new scale of biphobia should be developed that is more nuanced and looks at specific aspects of biphobia that are suggested in the existing theoretical literature.

Conclusion

No differences were found between CFT students' attitudes toward bisexual and lesbian and gay clients. This is perhaps unsurprising since it is possible that heterosexual therapists see bisexual individuals, gay men and lesbians as members of one group, and therefore feel similarly about each of these three subgroups (Diamant & Wold, 2003). In addition, my findings appear to contradict much of the literature, which suggests that levels of biphobia are higher than reported levels of homophobia (Hartman, 2006; Welzer-Lang, 2006). This is encouraging given that Herek (2002) found that heterosexuals reported more negative attitudes toward bisexuals than lesbians and gay men. Additionally, I found that affirmative training does have a positive impact on attitudes towards bisexual individuals. This is an important finding as it suggests that CFT training programs need to provide their students with affirmative training that addresses both the students' skills as well as their personal beliefs about the LGB community. My hope is that this study will serve as a catalyst for further explorations of the diversity that exists within the LGB community and in particular the impact of biphobia on the therapy process as well as to improve current available instruments that measure biphobia.

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Table 1. *Characteristics of the Sample (N = 247)*

Characteristics	<i>N</i>	%
Race		
African American	16	6.4
Asian American/Asian	9	3.6
Biracial/Multiracial	11	4.4
European American/ White	199	79.9
Latina/o/Hispanic	8	3.2
Middle Eastern/Arabic	1	0.4
Pacific Islander	1	0.4
Other	3	1.2
Sexual Orientation		
Bisexual	13	5.2
Gay	5	2.0
Heterosexual	217	87.1
Lesbian	5	2.0
Questioning	1	0.4
Other	7	2.8
Type of Institution		
Private Non-Religious	27	10.8
Private Religious	61	24.5
Public/Secular	159	63.9
Level of Program		
Master's	177	71.1
Ph.D.	70	28.1

Table 2. *Correlation Matrix (N=247)*

Variables	1	2	3	4	5	6	7	8
1. Level in Program	--	.09	-.02	-.12	.08	-.08	.32**	-.01
2. Type of Institution		--	.00	.13	.00	.15*	.01	.23**
3. Sexual Orientation			--	.06	.30**	.02	-.03	-.15*
4. Gender				--	-.17*	.07	-.06	.30**
5. Total Hours with LGB Clients					--	-.03	.17*	.00
6. ATS Total Average						--	.01	.16*
7. Work with LGB Clients							--	.04
8. Biphobia								--

** Correlation is significant at the $p < .001$ level

* Correlation is significant at the $p < .05$ level

Table 3. Summary of Hierarchical Regression Analysis for Variables Predicting Biphobia using the Affirmative Training Scale

<i>Variable</i>	<i>B</i>	<i>SE B</i>	<i>β</i>
Step 1			
Constant	4.38	0.44	
Gender (Women)	1.21	0.25	0.32**
Sexual Orientation	-1.03	0.39	-0.18*
Type of Institution (Secular)	0.61	0.24	0.16*
Level of Program (Ph. D)	0.30	0.24	0.01
Work with LGB Clients	0.16	0.22	0.05
Hours with LGB Clients	0.00	0.00	0.00
Step 2			
Constant	3.33	.67	
Gender (Women)	1.20	.25	.32**
Sexual Orientation	-1.10	.39	-.19*
Institution (Secular)	.54	.24	.15*
Level of Program (Ph.D.)	0.08	0.24	0.02
Work with LGB Clients	0.13	0.22	0.04
Hours with LGB Clients	0.00	0.00	0.00
ATS Total Average	.26	.13	.14*

Note: $R^2 = .16$ for Step 1; $R^2 = .18$ for Step 2. * $p < .05$ ** $p < .001$

APPENDIX A. REVISED SEXUAL ORIENTATION COUNSELOR COMPETENCY
SCALE

For questions 1-41, please use the following scale and rate your level of agreement to each item.

1	2	3	4	5	6
Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree

1. I have received adequate clinical training and supervision to provide therapy to lesbian, gay, and bisexual (LGB) clients.

1 2 3 4 5 6

2. The lifestyle of a LGB client is unnatural or immoral

1 2 3 4 5 6

3. I know where to find resources to enhance my therapy skills when working with LGB clients by monitoring my functioning/competency—via consultation, supervision, and continuing education.

1 2 3 4 5 6

4. I have had the opportunity to work with gay male clients in therapy.

1 2 3 4 5 6

5. LGB clients receive less competent treatment than heterosexual clients.

1 2 3 4 5 6

6. At this point in my professional development, I feel competent, skilled, and qualified to provide therapy to LGB clients.

1 2 3 4 5 6

7. I have had the opportunity to work with lesbian or gay couples in therapy.

1 2 3 4 5 6

8. I have had the opportunity to work with lesbian clients in therapy.

1 2 3 4 5 6

9. I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.

1 2 3 4 5 6

10. It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.

1 2 3 4 5 6

11. I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.

1 2 3 4 5 6

12. I have received course work that focused on LGB issues in family therapy.

1 2 3 4 5 6

13. Heterosexist and prejudicial concepts have permeated the mental health professions.

1 2 3 4 5 6

14. I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.

1 2 3 4 5 6

15. I am knowledgeable about LGB identity development models.

1 2 3 4 5 6

16. I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.

1 2 3 4 5 6

17. It would be best if my clients viewed a heterosexual lifestyle as ideal.

1 2 3 4 5 6

18. I have had the opportunity to work with bisexual (male or female) clients in therapy.

1 2 3 4 5 6

19. I am aware of institutional barriers that may inhibit LGB people from using mental health services.

1 2 3 4 5 6

20. I am aware that therapists frequently impose their values concerning sexuality upon LGB clients.

1 2 3 4 5 6

21. I think that my clients should accept some degree of conformity to traditional sexual values.

1 2 3 4 5 6

22. Currently, I do not have the skills or training to do a case presentation if my client was LGB.

1 2 3 4 5 6

23. I believe that LGB clients will benefit most from therapy with a heterosexual therapist who endorses values and norms that promote a heterosexual lifestyle.

1 2 3 4 5 6

24. Being born a heterosexual person in this society carries with it certain advantages.

1 2 3 4 5 6

25. I feel that sexual orientation differences between therapist and client may serve as an initial barrier to effectively working with LGB individuals.

1 2 3 4 5 6

26. I have done a therapeutic role-play as either the client or therapist involving a LGB issue.

1 2 3 4 5 6

27. Personally, I think homosexuality (gay male and lesbian relationships) is a mental disorder and/or a sin and can be treated through therapy or spiritual help.

1 2 3 4 5 6

28. Personally, I think bisexuality (both female and male bisexuality) is a mental disorder and/or a sin and can be treated through therapy or spiritual help.

1 2 3 4 5 6

29. I believe that all LGB clients should be discreet about their sexual orientation around children.

1 2 3 4 5 6

30. When it comes to homosexuality (gay male and lesbian relationships), I agree with the statement: "You should love the sinner but hate or condemn the sin".

1 2 3 4 5 6

31. When it comes to bisexuality (both female and male bisexuality), I agree with the statement: "You should love the sinner but hate or condemn the sin".

1 2 3 4 5 6

APPENDIX B. AFFIRMATIVE TRAINING INVENTORY

32. Content related to the experiences of LGB individuals is specifically addressed in each of my family therapy courses.

1 2 3 4 5 6

33. I learned about the presence of heterosexual bias (i.e., the act of conceptualizing human experiences in heterosexual terms, thereby discounting LGB experiences and relationships) in my family therapy training program.

1 2 3 4 5 6

34. I learned about the concept of heterosexism (i.e., a belief system supported by laws and societal customs that legitimizes heterosexuality as the only acceptable way of being which leads to the unequal treatment of LGB individuals) in my family therapy training program.

1 2 3 4 5 6

35. I learned about the concept of heterosexual privilege (i.e., the unearned advantages given to heterosexual individuals based solely on their sexual orientation) in my family therapy training program.

1 2 3 4 5 6

36. The faculty in my family therapy program encourages students to explore their own heterosexual biases (i.e., the act of conceptualizing human experience in heterosexual terms, thereby discounting lesbian, gay, and bisexual lifestyles and relationships).

1 2 3 4 5 6

37. The faculty in my family therapy program would be supportive of students pursuing research on topics related to LGB individuals, couples, and/or families.

1 2 3 4 5 6

38. My program provides students with the opportunity to work with LGB clients.

1 2 3 4 5 6

39. My program takes an affirmative (i.e., a positive view of LGB identity and relationships) stance toward LGB individuals and relationships.

1 2 3 4 5 6

40. My program provides students with information on LGB affirmative therapy (i.e., an approach to therapy that embraces a positive view of LGB identity and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGB clients) through readings, lectures, supervision, etc.

1 2 3 4 5 6