REFERRING CLIENTS BASED SOLELY ON SEXUAL ORIENTATION: AN EXPLORATION OF THE ROLE OF HOMOPHOBIA AND CLINICAL COMPETENCE

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ABSTRACT

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The purpose of this study was to explore how homophobia and clinical competence influence experienced clinicians' beliefs and practices regarding referring a LGB client based solely on the sexual orientation of the client. The data for this study came from a larger study with a sample of 741 experienced clinicians who were all members of the American Association of Marriage and Family Therapy (AAMFT). Participants were contacted through email and if they chose to participate they completed the survey on-line. There were two measures used for this study, 1) the combined Modern Homophobia Scale (MHS); (Raja & Stokes, 1998) and 2) the combined knowledge/skill subscale from the Revised-Sexual Orientation Counselor Competency Scale (R-SOCCS); (Bidell, 2005; Carlson, McGeorge, & Toomey, in press) as well as two yes/no questions about referring LGB clients. The results of this study indicated that therapists who have referred a LGB client based solely on the client's sexual orientation had higher levels of homophobia than those who had never referred a LGB client based solely on the client's sexual orientation. Clinicians' level of clinical competence to work with LGB clients did not appear to influence their beliefs about the ethical nature or practices of referring a LGB client based solely on the client's sexual orientation. Furthermore, many therapists in this study believe it should be ethical to refer a client based solely on the sexual orientation of the client, though most of them had not actually made such a referral. The AAMFT Code of Ethics is discussed throughout this thesis in order to explore the ethical issues related to referring a client based solely on the client's sexual orientation. This study provides important

implications for therapists, couple and family therapy training programs, as well as the AAMFT regarding the ethical nature of the practice of referring a LGB client based solely on the client's sexual orientation.

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CHAPTER ONE. INTRODUCTION

It could be argued that as a group couple and family therapists (CFTs) are becoming more aware of the importance of being affirmative in their work with lesbian, gay, and bisexual (LGB) clients; however, some therapists still choose to refer LGB clients based solely on the client's sexual orientation (Shiles, 2009; Woody & Woody, 2001). Therapists who choose to refer based solely on the client's sexual orientation do so for a number of reasons. Some therapists may make such referrals because they do not feel competent to work with LGB clients due to lack of training or exposure to the LGB community (Ford & Hendrick, 2003; Shiles, 2009; Woody & Woody, 2001). Still others may refer LGB clients based on their own values and negative beliefs (i.e., homophobia) about LGB individuals and relationships (Brock, 1998; Huber, 1994; Shiles, 2009). In particular, some therapists cite their religion as informing their belief that being LGB is morally wrong, and thus, because of their religious beliefs decide to either refer LGB clients or terminate therapy (Priest & Wickel, 2011). However, the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics that guides the CFT field does not allow for groups of clients to be treated differently based solely on clients' demographic characteristics. In particular, the AAMFT Code of Ethics states that:

> Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation (AAMFT Code of Ethics, Principle 1.1, 1991).

This above statement from the AAMFT Code of Ethics illustrates the purpose of the code, which is to protect clients and to ensure that all people have access to services.

Furthermore, in accordance with the AAMFT Code of Ethics, Brock (1998) and Woody and Woody (2001) argued that it would be an ethical violation to refuse services based on one's own values and biases. Thus, referring clients based solely on the client's sexual orientation should be seen as a violation of Principle 1.1 of the AAMFT Code of Ethics, and thus unethical. However, to date, very little has been written on the topic of referring clients based solely on the client's sexual orientation (Shiles, 2009). Therefore, this study sought to explore if experienced CFTs feel it is ethical to refer a client based solely on the client's sexual orientation and if they themselves have referred a client based solely on the client's sexual orientation.

While the act of referring clients based on the sexual orientation of the client appears to be a clear violation of the AAMFT Code of Ethics, some therapists could argue that such a referral is in the best interest of the client and protects the client from discriminatory services. The problem with this argument is that it allows therapists to deny their responsibility to be prepared to work with *all* clients. If therapists do not feel prepared to work with a particular population based on personal biases, religious beliefs, or feelings of incompetence, then there are steps they should take to improve their competence (Brock, 1998; American Psychological Association, 2000). Some believe that when such a predicament arises, the therapist should seek supervision or consult another therapist to work through her or his discomforts, rather than referring the client (Brock, 1998; Woody & Woody, 2001).

As I have just discussed, while some scholars feel that referring clients based solely on the client's sexual orientation is against the AAMFT Code of Ethics and argue that therapists should prepare themselves to work with LGB clients, this practice does continue

to occur even among experienced clinicians and is seen by some as an acceptable practice (Ford & Hendrick, 2003; Shiles, 2009). While refusing to work with other marginalized groups (e.g., women, people of color, etc.) is no longer seen as an acceptable practice by the therapeutic community, refusing services to the LGB community is still seen as an acceptable practice by some clinicians. One of the reasons referring clients based solely on the client's sexual orientation may still be viewed as acceptable, or at least understandable, by some clinicians is the strong influence that homophobia continues to have on mainstream culture and the therapeutic community. The acceptance of this practice may also be partially due to the fact that sexual orientation was the last demographic factor to be added to the non-discrimination clause of the AAMFT Code of Ethics (Brock, 1998; Woody & Woody, 2001). Furthermore, it was not until 2005 that the AAMFT board joined the other mental health disciplines in clearly stating that "homosexuality" is not a psychological disorder (AAMFT, 2005), though homosexuality was removed from the Diagnostic and Statistical Manual (DSM) as a psychological disorder in 1973 (McHenry & Johnson, 1993; American Psychiatric Association, 2000). The American Psychiatric Association (ApA), the American Psychological Association (APA), and the National Association of Social Workers (NASW) all formally and publicly stated their support for the removal of homosexuality from the DSM in the 1970s (American Psychiatric Association, 1973; Conger, 1975).

In addition to being slow to acknowledge that "homosexuality" is not a psychological disorder, the AAMFT has not provided specific guidelines for the ethical treatment of LGB clients; however, they have made a number of statements about LGB clients and therapy. For example, the AAMFT board released a statement, *What is*

Marriage and Family Therapy?, in July 2005, which expressed a clear desire to provide services to the LGB community. In particular this statement included the following passage:

> We invite members of heterosexual, same-sex, culturally similar, intercultural/interracial and other forms of family composition to engage with marriage and family therapists for relational development and problem solving within their cultural contexts. We welcome all who would seek out our services in order to build strength and health in their lives, relationships, and in society (¶ 4)

While this statement depicts all CFTs as being open to working with clients of all cultural contexts, and specifically welcomes persons of a same-sex sexual orientation to seek out therapy services, there is then a need for AAMFT to provide clearer guidelines around such practices as affirmative therapy with LGB clients as well as guidelines about appropriate referral practices. These guidelines could be modeled after guidelines in other clinical professions, such as the guidelines created by the APA or the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (ALGBTIC) a division of the American Counseling Association (ACA). For example, the ALGBTIC developed competencies to guide counselors in providing affirmative therapy. In particular, the ALGBTIC (1999) argued that competent counselors must be aware of the injustices LGB clients face, and furthermore, that all people should be given the opportunity to reach their full potential by receiving appropriate clinical services.

Since the CFT field does not have these clear guidelines, clinicians who are trying to make the decision to refer or not refer a LGB client have few resources to turn to and are left to make the decision based on their own judgment. Thus, a CFT's decision to refer a

client based solely on the client's sexual orientation could be tied to the therapist's own homophobia, personal beliefs, and/or lack of training or expertise (Shiles, 2009), though currently the research does not exist to determine what factors influence a CFT to refer a client based solely on the client's sexual orientation. Thus, this study sought to explore the relationship between the decision to refer a client based solely on the client's sexual orientation and the CFT's level of homophobia and perceived competence to work with LGB clients. This study also explored the factors that influence a CFT to believe that it is ethical to refer a client based solely on the client's sexual orientation. Through assessing such beliefs, it is hoped that this study will encourage CFTs to employ ethical practices in their work with LGB persons, and in turn lead to better ways of working with LGB individuals, couples, and families.

CHAPTER TWO. LITERATURE REVIEW

The literature review for this thesis will focus on three areas: 1) ethical considerations related to making a therapeutic referral based solely on the client's sexual orientation, 2) legal considerations related to making a therapeutic referral based solely on the client's sexual orientation, and 3) reasons CFTs provide for making a therapeutic referral based solely on the client's sexual orientation. The majority of the literature that will be reviewed is theoretical articles as there is little empirical research that directly addresses the process of therapeutic referrals based on the sexual orientation of the client.

Ethical Considerations

There are a number of ethical considerations that scholars have highlighted in relation to the decision to refer a client based on her or his sexual orientation. For example, Brock (1998) argued that referring a client based solely on the client's sexual orientation is an act of discrimination and thus, is a violation of any code of ethics that states that therapists should not discriminate against a client based on a client's demographic characteristics (e.g., gender, race, sexual orientation, etc.). Other scholars have supported Brock's argument and in particular have argued that the code of ethics governing psychologists does not support the act of referring based on not having the expertise to work with a particular population. These scholars go on to suggest that a psychologist's "decision to refer rather than obtain the multicultural training and skills make his [sic] decision to refer potentially unethical" (Shiles, 2009, p. 150).

Moreover, Remley and Herlihy (2005) argued that CFTs are ethically required to educate themselves about groups of clients who differ from themselves and thus cannot ethically make referrals based on not having learned about different groups of people. This

argument is further supported by the AAMFT Code of Ethics (1991), which states that CFTs are ethically required to educate themselves about current research and practices. Moreover, this segment of the AAMFT Code of Ethics actually highlights the ethical importance of CFTs seeking out current knowledge about groups of clients that they are less familiar with or feel less competent to work with (Hermann & Herlihy, 2006; Rigby & Sophie, 1990; Woody & Woody, 2001).

Other scholars have argued that CFTs need to work through their prejudices and stereotypes regarding same-sex sexual orientation, as it has been shown that such attitudes coming from a therapist will likely be harmful to the client, especially if a client has disclosed that they are lesbian or gay after already having established a relationship with their therapist (Corey, Corey, & Callanan, 2007). These scholars suggested that prior to making a referral a CFT should seek out supervision or consult with another clinician to explore why they want to make a referral, as the referral could be unethical if it is based on the therapist's own biases or beliefs. In particular, Corey and colleagues (2007) argued that "merely disagreeing with a client or not particularly liking what a client is proposing to do is not ethical grounds for a referral....If you have sought consultation and exhausted all other possibilities and still feel that you are at an impasse, you may need to consider a referral" (p. 77). Thus, Corey and colleagues (2007) suggested that there may be times when making a referral based solely on the client's sexual orientation is ethical, but only after the CFT has attempted to work through her or his own biases and attempted to increase her or his knowledge about LGB clients.

Finally, in order to fully consider the ethical concerns of referring clients based solely on the client's sexual orientation, it is important to return to my earlier discussion of

the statements released by some of the major mental health associations. Prior to reviewing these statements, it is essential that I acknowledge that no major mental health association has made a statement directly pertaining to the process of referring clients based solely on the client's sexual orientation; however, the statements that they have released are relevant for understanding the intent of the associations with regard to how LGB clients should be treated. For example, the ALGBTIC division of the ACA stated in their mission statement that, "we believe that all individuals should be free to develop their full potential regardless of sexual orientation and gender identity, and that professional counselors must understand the unique ways gays, lesbians, bisexuals and transgendered individuals experience inequality and injustice resulting from discrimination and prejudice" (ALGBTIC, n.d.). While this statement from a division of the ACA does not directly address referring practices based solely on the client's sexual orientation, it does provide encouragement for counselors to develop their competency to work with LGB clients and to ensure that they are not adding to the discrimination already experienced by this marginalized population. Another example comes from the APA Council of Representatives (2000b) *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients,* which states that according to the APA Ethics Code, psychologists:

> ...are aware of culture, individual, and role differences, including those due to... sexual orientation ...and try to eliminate the effect on their work of biases based on [such] factors' (APA, 1992, 1599-1600). Hence, psychologists are encouraged to use appropriate methods of self-exploration and self-education (e.g., consultation, study, and formal continuing education) to identify and ameliorate preconceived biases about homosexuality [sic] and bisexuality.

Again, this statement provides insight into the expectations placed on psychologists to do the necessary self-of-the-therapist work in order to minimize the discrimination experienced by LGB clients.

Though included previously, it seems important to highlight again the AAMFT Code of Ethics. The AAMFT Code of Ethics includes a statement or principle which explains that CFTs should not be discriminatory in their clinical services. Thus, similarly to the ACA and APA, the AAMFT Code of Ethics clearly states that clients cannot be discriminated against due to their sexual orientation; however, the AAMFT has failed to specify what counts as discrimination and thus, in particular, has not taken a stance on whether or not referring a client based solely on the client's sexual orientation counts as discrimination.

Legal Considerations

In addition to the ethical considerations I have discussed there are also legal considerations that need to be explored when discussing the act of referring a client based solely on the client's sexual orientation. For example, one legal case involved a therapist who was terminated by her employer because of her refusal to work with a client on matters regarding the client's same-sex relationship. In response to her termination, the therapist sued her employer and the case became known as *Bruff v. North Mississippi Health Services, Inc.* Bruff argued that same-sex relationships were against her religious beliefs, and because of her beliefs, she refused to counsel LGB clients in regards to their intimate relationships. Bruff's argument was that her employer was violating federal law by not excusing her from working with LGB clients (Hermann & Herlihy, 2006). Hermann and Herlihy (2006) wrote an article in response to the case in which they stated:

> According to the court, providing counseling only on issues that do not conflict with a counselor's religious beliefs is an inflexible position not protected by the law. The court further acknowledged that homosexual [sic] clients may not seek counseling in a setting that allows counselors to refuse to work with clients on issues related to the client's sexual orientation. The court found this discriminatory result was not legally permissible either. (p. 416).

Not only did the court claim such practices as refusing to work with LGB clients as unethical and illegal, but furthermore, stated that refusing to counsel clients due to their presenting issue (e.g., problems within same-sex relationships) could cause harm to those persons (Hermann & Herlihy, 2006). In the court's ruling against Bruff, it was determined that a person seeking services could be emotionally harmed if a therapist refers them to another clinician because of their sexual orientation. Hermann and Herlihy (2006) argued that "all of the elements of malpractice could be established in a case in which the counselor refused to counsel a homosexual [sic] client on relationship issues" (p. 417). Additionally, Hermann and Herlihy (2006) argued that not only had Bruff violated the law, but she also violated the ACA code of ethics and in particular, "the moral principles of justice (fairness), beneficence (doing good), nonmaleficence (doing no harm), and respect for autonomy all seem to apply to the *Bruff* case" (p. 417). Furthermore, Corey and colleagues (2007) concluded from the Bruff case that:

> Bruff's inflexibility and unwillingness to work with anyone who has conflicting beliefs is not protected by the law, a counselor who refuses to work with homosexual [sic] clients can cause harm to them. The refusal to work on a

> homosexual [sic] client's relationship issues constitutes illegal discrimination. Counselors cannot use their religious beliefs to justify discrimination based on sexual orientation, and employers can terminate counselors who engage in this discrimination (p.134).

Bruff is not the only case where the U.S. Supreme Court took a stand for LGB persons ruling that their rights should be protected by the Equal Protection Clause of the Fourteenth Amendment. For example, in the case of Romer vs. Evans, the Supreme Court determined that "states violate the Equal Protection Clause of the Fourteenth Amendment if they discriminate on the basis of sexual orientation, even if some of their citizens may have personal or religious objections to homosexuality [sic]" (Hermann & Herlihy, 2006, p. 416). This is yet another example among a growing number of court cases where courts, at all levels, have argued that LGB individuals cannot legally be discriminated against, which includes the right to access mental health services.

Reasons Why Therapists Refer a Client Based on Sexual Orientation

In addition to considering ethics and legalities relevant to the process of referring a client based solely on the client's sexual orientation, it is also important to review the limited literature on why therapists refer LGB clients. A therapist's decision to refer may be due to their religious beliefs and values, homophobia, and their own sense of competence to work with LGB clients. Again, it is important to note that most of the research reviewed reflects non-empirical theoretical articles.

Values

While no researchers have systematically studied why therapists refer LGB clients based solely on the client's sexual orientation, some scholars have argued that these

referrals occur because of therapists' own values and religious beliefs (Ford & Hendrick, 2003; Shiles, 2009). In particular, Huber (1994) argued that "values gained from personal life experiences and professional training interact with and filter societal values about professional practice to influence every therapeutic decision. These decisions may govern who will be offered services, the goals of those services . . ." (p. 226). While it is obvious that therapists have personal values and beliefs, it is important that they are aware of how these values and beliefs influence their ability to provide appropriate therapeutic services and whether they are still able to practice within the realm of their professional code of ethics.

A significant influence on many individuals' values is their religious or spiritual beliefs and these beliefs are particularly relevant when discussing clinicians' values concerning sexual minorities. When exploring therapists' values and religious beliefs with regard to sexual orientation, it appears that Christian therapists, compared to non-Christian therapists, are more likely to have negative attitudes toward LGB individuals and couples. For example, Newmanxy (2002) surveyed men and women around the U.S. who had recently entered an accredited master-level program for social work or counseling in order to measure their attitudes and beliefs about lesbians and gay men, and specifically looked at how these students' religious beliefs corresponded with their attitudes regarding sexual orientation. Newmanxy's (2002) sample included Conservative Protestants, Moderate Protestants, Liberal Protestants, Catholics, Jews, as well as persons who identified themselves as Atheist, Agnostic, or who did not identify with any religion. While only 173 of the 2,585 heterosexual students surveyed (6.7%) held negative beliefs about lesbian and gay sexual identities, students who were Conservative Protestant had the most negative

attitudes about lesbians and gay men. Those who had no religious affiliation, and those who identified as Atheist, Jewish, or Agnostic held more positive attitudes about lesbians and gay men. Newmanxy's (2002) study adds to previous research which has consistently shown a higher correlation between conservative religious beliefs and homophobic attitudes than any other religious affiliations.

Evans (2003) studied how counselors who were also practicing Christians stayed true to their professional code of ethics when working with lesbian and gay clients, and in particular, how these counselors integrated their religious beliefs into their professional practice. Of the 31 Christian counselors included in her study, ten of them conveyed some rejection of LG persons. Evans (2003) concluded that four of those participants would have major difficulties counseling lesbian and gay clients in a respectful manner that did not exude judgment. Evans (2003) suggested that counselors do self-work examining their own beliefs in order to see if they are meeting the standards outlined in their professional code of ethics.

Moreover, Ford and Hendrick (2003) assessed therapists' values around sexuality and found non-religious therapists to hold more positive beliefs about LGB individuals when compared to Christian therapists. In particular, Ford and Hendrick (2003) examined differences that arise between therapists and clients in regards to sexual values. The participants for this study consisted of 314 therapists who were members of either the APA or the AAMFT. Their results indicated that the therapists in their study referred clients to another clinician 40% of the time when they had a conflict around sexual values. While it was shown that therapists and clients often have opposing values around issues like sexual orientation and sexual practices, Ford and Hendrick (2003) determined that therapists are

generally able to provide appropriate and supportive services even when their belief systems and values around sexuality and sexual orientation differ from those of their clients. This seems to be an encouraging finding as it would suggest that therapists are able to set aside their own values when working with clients. Conversely, Greene (2007) stated that making a referral is appropriate when a therapist has negative views about LGB persons in general, such that they see them as flawed or not worthy of help based solely on their sexual orientation. Finally, Remley and Herlihy (2005) argued that if clinicians are not able to provide appropriate services just because their values conflict with those of their clients', they can not practice ethically and therefore should not be in a helping profession.

Homophobia

Another reason that the literature suggests that therapists refer clients based solely on the client's sexual orientation is because of their own homophobia. In particular, researchers have documented the fact that many practicing therapists continue to hold homophobic attitudes (Annesley & Coyle, 1995; Haldeman, 1994). For the purpose of this study, homophobia is defined as "an intolerance for any sexual difference from the established norm'' (Ritter & Turndrup, 2002, p. 12). When exploring the influence of homophobia and oppression on the therapy process, Nystrom (1997) found that about 46% of LGB persons who present in therapy have felt discriminated against based on their sexual orientation and felt that their therapists held homophobic attitudes or beliefs. Nystrom (1997) did not explore whether or not clinicians referred clients based on holding homophobic beliefs, however, this study is still relevant as it highlights the impact of homophobia on the therapy process. Similarly, Henke, Carlson, and McGeorge (2009) found that CFTs' level of homophobia impacted their self-reported competence to work

with LG clients. Thus, if CFTs' level of homophobia impacts their own sense of competence in working with LG clients then it is possible that CFTs with high levels of homophobic beliefs could be more likely to refer a client.

Kidd (2005) studied CFTs levels of "homoprejudice", a term defined by Aronson (1980) as "a hostile or negative attitude toward a distinguishable group (gays/lesbians) based on generalizations derived from faulty or incomplete information" (p. 197). The concept of homoprejudice expands on the ideas originally captured by homophobia to include the holding of negative views about LGB persons and relationships. In particular, Kidd (2005) studied the ways that CFTs' levels of homoprejudice influence the CFT when working with gay and lesbian clients and how homoprejudicial attitudes influence CFTs' perception of their working alliance with LG clients. The study gathered information from 102 CFTs, all of whom were clinical members of the AAMFT. The study showed that CFTs do tend to have some homoprejudicial attitudes toward LG clients, and clinicians with high levels of homoprejudicial attitudes were likely to have a weaker working alliance with their LG clients while clinicians with lower levels of homoprejudice attitudes were likely to have stronger working alliances with LG clients. Thus, clinicians with more negative attitudes toward LG persons are not as likely to build a strong working alliance with LG clients. It seems then that higher levels of homoprejudicial attitudes may also lead clinicians to refer LG clients as when clinicians do not have a strong working alliance with their clients they are more likely to make a referral.

Additionally, McHenry and Johnson (1993) argued that a therapist who refers a LGB client to a different therapist that self-identifies as LGB is also an example of homophobic attitudes influencing the therapy process. In particular, McHenry and Johnson

(1993) used the term "homophobic referral collusion" as the improper practice of referring clients to a therapist who self-identifies as LGB, simply because the client identifies as such. The reason McHenry and Johnson (1993) portray this act as homophobic is based on the assumptions that go along with making such a referral. For example, making a referral based on the assumption that a therapist who identifies as lesbian must then be more equipped to work with a client who also identifies as lesbian. The problem with this is that there is less consideration for pairing a client with a skilled or competent therapist and more investment in matching the client's sexual orientation with that of their future therapist. This may be more easily understood if we think in terms of race rather than sexual orientation – would it be ethical to refer an African American person to an African American therapist or would that be seen as a referral influenced by racism? Unfortunately, all people, including LGB persons, have some degree of homophobia. If CFTs recognize how their homophobia is influencing the therapy process, they will be more able to recognize how such referral practices could be harmful to clients.

Competence

The final reason I will discuss as to why CFTs might refer a LGB client based solely on the client's sexual orientation is the CFT's own sense of competence to work with LGB clients. For example, Rigby and Sophie (1990) argued that there are two primary ethical concerns that therapists face when working with lesbian clients—their own negative biases about same-sex relationships and their lack of understanding and knowledge pertaining to lesbian individuals and relationships. Self-reported competence to work with LGB clients has been linked to levels of homophobia, thus, much of the literature discussed in this section is directly related to the literature reviewed in the previous section.

Rosik (2003) argued that therapists who feel incompetent to treat LG clients should refer LG clients to therapists who are considered more competent to work with this population. However, Greene (2007) responded to Rosik's argument, stating that therapists who refer clients they feel unable to serve must also own their incompetence and thus convey to the client that their decision to refer is not any fault of the client but reflects the therapist's inability to work with a particular population. Beckstead and Israel (2007) also stated that referring LG clients may be the most ethical decision in some situations, especially when the therapist lacks significant information about working with LG clients or when their biases hinder their competence such that they get in the way of the therapist providing effective services. Shiles' (2009) review of the literature showed that much of the reason therapists choose to refer LGB clients is due to their own discomforts working with this population, which is then written off as incompetence, meaning that they are unable to provide proper services. Unfortunately, the literature does not suggest that therapists first make an effort to work through their discomforts in order to become competent.

Denying services to LGB persons based solely on the clients' sexual orientation puts clients at risk of harm and CFTs at risk of malpractice, though the research confirms that it is common for CFTs to lack training in working with LGB persons (Godfrey, Haddock, Fisher, & Lund, 2006; Long & Serovich, 2003; Rock, Carlson, & McGeorge, 2010). This lack of training is expressed, for example, by only one half of a national random sample of AAMFT clinical members reporting feeling competent to work with LG clients (Doherty & Simmons, 1996). However, it is important to note that all of the ethical codes say that therapists have an obligation to keep up on recent research and to develop

the skills to competently serve a diverse group of clients. Thus, some scholars have argued that not being competent is not an ethical reason to refer an entire group of potential clients (Brock, 1998; Fisher, 2003; Shiles, 2009). However, the solution to gaining the competence to work with a population involves seeking additional supervision, training, and/or continued education.

While there are many arguments that a clinician could provide for referring LGB clients rather than agreeing to work with them, if one's own personal biases, levels of homophobia, and perceived level of competence hinders her or his ability to provide helpful services to specific populations, there is then a reason to question the therapist's competence to work with any person. Fisher (2003) argued that therapists must "respect the dignity and worth of all people" (p. 59). Such a statement supports the idea that denying services to specific populations based on demographic features (i.e., African Americans, women, LGB persons) is unethical and, thus, also allows for the questioning of whether there is room in the mental health field for clinicians whose biases or homophobic attitudes are so strong that they prevent them from working with specific populations (e.g., LGB clients).

Research Questions

Given the literature review, this study explored the following research questions: 1) how are experienced clinicians' self-reported levels of clinical competence related to their decisions to refer a client based solely on the sexual orientation of the client? and 2) how are experienced clinicians' self-reported levels of homophobia related to their decision to refer a client based solely on the sexual orientation of the client?

CHAPTER THREE. METHOD AND METHODOLOGY

This chapter is divided into four sections: 1) participants, 2) measures, 3) procedures, and 4) data analysis plan. It is important to note that the data that was used for this study is secondary data from a larger study of the overall attitudes held by experienced clinicians about LGB clients and their competence to work with LGB clients.

Participants

Participant Recruitment

The larger study, from which the data for this study came, involved recruiting participants via email. Emails were sent to clinical members of the AAMFT, who were selected through the AAMFT Therapist Locator database. In order to recruit a diverse sample, clinical members were recruited from eighteen different states (i.e., California, Colorado, Florida, Georgia, Iowa, Michigan, Minnesota, Mississippi, Missouri, New Mexico, New York, Oregon, Pennsylvania, Tennessee, Texas, Utah, Washington, and Wisconsin) and the District of Columbia. Up to 400 clinical members were emailed from each state. In states that had less than 400 members, all members were sent an email inviting them to participate in the study. Due to the varying number of clinical members within each state, the number of potential participants from each state was between 15 (i.e., the District of Columbia) and 400 (i.e., California and Texas), resulting in an average of 165 clinical members receiving an email in any one state. Initially, there were a total of 3,166 emails sent out, followed by two emails that reminded potential participants about the study.

Sample Description

The response rate for the survey was 24.0%. A total of 759 surveys were completed, though only 741 of the participants who completed the survey were clinical members of the AAMFT and thus the sample for this study was 741 participants. The age range of the participants in this sample was 27 to 79, with a mean age of 54.29 (SD= 10.24). The majority of the sample identified as White (i.e., 93%), heterosexual (i.e., 88%), and female (i.e., 57.4%). Additionally, 79.9% of the sample identified marriage and family therapy to be their primary professional affiliation. As far as their education, 54.7% of the sample had earned a master's degree and 30.9% had earned a Ph.D. Furthermore, 27.1% of the sample were approved supervisors for the AAMFT. The amount of post-master's level clinical experience of participants ranged from two to 54 years, with a mean of 19.12 years (SD = 9.79). The overall sample had worked with an average of 41.98 LG clients (SD = 145.26). The range of LG clients that participants reported working with was zero to 2,500, though the participant who reported having 2,500 LG clients in his or her clinical experience was an outlier and was removed prior to our analyses. Participants who had reported working with 30 or fewer LG clients throughout their clinical career made up 66.3% of the sample. Of the sample, 47.6% reported working with 15 LG clients or less, and 91% of the sample responded that they had worked with 1 or more.

Measures

There are two primary measures for this study as well as two individual "yes/no" items. The first measure is the Modern Homophobia Scale (MHS); (Raja & Stokes, 1998). The MHS was created to evaluate therapists' beliefs about sexual orientation, specifically looking at therapists' personal biases concerning LG persons. Since Raja and Stokes'

(1998) research indicated differences between therapists' attitudes about lesbian women versus their attitudes about gay men, two versions of the MHS were created in order to obtain a more precise measure; the MHS-Gay (MHS-G) and the MHS-Lesbian (MHS-L). A sample item from the MHS-G is "I am comfortable with the thought of two men being romantically involved" and a sample item from the MHS-L is "Lesbians are as capable as heterosexuals of forming long-term romantic relationships." The responses ranged from one (strongly agree) to six (strongly disagree).

Raja and Stokes (1998) reported that the alpha coefficients for both the MHS-G and MHS-L were .95, and I found each to have an alpha of .97. Additionally, when examining the correlation between these two subscales I found it to be .98, which suggests that the MHS-L and the MHS-G were not measuring unique constructs. Thus, for the purpose of this study I merged the 22-item MHS-G and 24-item MHS-L, and ended up with a combined MHS that had an alpha coefficient of .98 (See Table 1).

Table 1: Items Comprising the Modern Homophobia Scale

I wouldn't mind going to a party that included gay men
I am tired of hearing about gay men's problems.
I would not vote for a political candidate who was openly gay.
Physicians and psychologists should strive to find a cure for male homosexuality.
I am comfortable with the thought of two men being romantically involved.
I won't associate with a gay man for fear of catching AIDS.
Gay men could be heterosexual if they really wanted to be.
I would not mind working with a gay male.
Gay men want too many rights.

Table 1 (continued)

Gay men should be allowed to be leaders in religious organizations.

I don't think it would negatively affect our relationship if I learned that one of my close relatives was gay.

I would remove my child from a class if I found out the teacher was gay.

Male homosexuality is a psychological disease.

It's all right with me if I see two men holding hands.

Marriages between two gay men should be legal.

Hospitals shouldn't hire gay male doctors.

I would be sure to invite the same-sex partner of my gay male friend to my party.

I don't mind companies using openly gay male celebrities to advertise their products.

Gay men should not be allowed to join the military.

Gay men should undergo therapy to change their sexual orientation.

I welcome friends who are gay.

Movies that approve of male homosexuality bother me.

If my best female friend was dating a woman it would not upset me.

Lesbians who adopt children do not need to be monitored more closely than heterosexual parents.

I wouldn't mind going to a party that included lesbians.

Lesbians should be allowed to be leaders in religious organizations.

I would not mind working with a lesbian.

I am tired of hearing about lesbians' problems.

Lesbians are incapable of being good parents.

Teachers should try to reduce their student's prejudice toward lesbians.

Table 1 (continued)

I would not vote for a political candidate who was openly lesbian.

I don't mind companies using openly lesbian celebrities to advertise their products.

Lesbians should undergo therapy to change their sexual orientation.

Employers should provide health care benefits to the partners of their lesbian employees.

I don't think it would negatively affect our relationship if I learned that one of my close relatives was a lesbian.

Female homosexuality is a psychological disease.

Marriages between two lesbians should be legal.

School curricula should include positive discussions of lesbian topics.

Physicians and psychologists should strive to find a cure for female homosexuality.

It's all right with me if I see two women holding hands.

Lesbians are as capable as heterosexuals of forming long-term romantic relationships.

Movies that approve of female homosexuality bother me.

Lesbians should not be allowed to join the military.

I welcome new friends who are lesbian.

I am comfortable with the thought of two women being romantically involved.

I would be sure to invite the same-sex partner of my lesbian friend to my party.

The second measure used for this study was the Revised-Sexual Orientation Counselor Competency Scale (R-SOCCS); (Bidell, 2005; Carlson, McGeorge, & Toomey, in press), which was created to measure attitudes, knowledge, and skills of therapists in order to assess their overall self-perceived clinical competence to work with LGB clients. The original version of the SOCCS is made up of three subscales: awareness (9 items),

knowledge (7 items), and skills (12 items); however the R-SOCCS is comprised of two subscales: (1) the original awareness subscale (Bidell, 2005) and (2) a new subscale that combines the items from the original knowledge and skills subscales (Carlson et al., in press). Carlson et al. (in press) found through confirmatory factor analysis (CFA) that the original subscales did not work statistically and also argued that the original three subscales did not make theoretical sense. In particular, combining the knowledge and skills subscales made theoretical sense as the individual items that comprised the original skills subscale actually appear to measure the amount of knowledge that clinicians have about important topics related to LG individuals and the items that comprised the original knowledge subscale appear to more accurately measure the skills clinicians have to provide LG affirmative therapy (Carlson et al., in press). However, the present study used only the new knowledge/skills subscale. Since the awareness subscale measures homophobia, this portion of the R-SOCCS was not used, and instead this study relied on the combined MHS in order to measure therapists' attitudes and levels of homophobia. Additionally, the scores on the MHS combined were highly correlated (r=.94) with the SOCCS awareness subscale scores, which further supports the notion that the two measures were assessing the same construct.

The knowledge/skills subscale included 16 items (see Table 2). Sample items from this subscale include "I am aware of institutional barriers that may inhibit LGB people from using mental health services" and "I check up on my LGB counseling skills by monitoring my functioning/competency—via consultation, supervision, and continuing education" (Bidell, 2005; Carlson et al., in press). The options for response in this new subscale ranged from one (strongly disagree) to six (strongly agree).

Table 2: Items Comprising the Combined Knowledge/Skills Subscale of the SOCCS

I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.
I check up on my LGB counseling skills by monitoring my functioning/competency—via consultation, supervision, and continuing education.
I have experience counseling gay male clients.
At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.
I have experience counseling lesbian or gay couples.
I have experience counseling lesbian clients.
I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.
I have been to in-services, conference sessions, or workshops, which focused on LGB issues in psychology.
Heterosexist and prejudicial concepts have permeated the mental health professions.
I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.
I am knowledgeable of LGB identity development models.
I have experience counseling bisexual (male or female) clients.
I am aware of institutional barriers that may inhibit LGB people from using mental health services.
I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.
Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.
Table 2 (continued)
I have done a counseling role-play as either the client or counselor involving a LGB issue.

In addition to the MHS and SOCCS, this study also utilized data from two questions that look specifically at beliefs about referring LGB clients based solely on the clients' sexual orientation. The first question asked CFTs if they believe it is ethical for a CFT to refer a client based solely on the client's sexual orientation. The second question asked the participant if they have ever referred a client based solely on the client's sexual orientation.

Procedure

The procedures for the larger study from which the data for the current study came, involved sending an email to potential participants which contained an invitation to participate in a study as well as the link for the on-line survey. If participants clicked on the link, they were first presented with a consent form, which explained the study and the rights of participants. The participants were then presented with a scale that assessed their self-reported competence to work with LG clients (i.e., R-SOCCS). After completing the scale, participants were asked to complete the MHS, a demographic questionnaire and lastly, two likert scale questions and four "yes/no" questions. Informed consent was assumed if the survey was submitted.

Data Analysis

Data Analysis for Research Question One: Clinical Competence and Decision to Refer

As stated previously, the first research question explores the relationship between clinicians' self-reported competence and their decision to refer a client based solely on the sexual orientation of the client. To analyze this question, I have defined the dependent variables as the answers to the dichotomous (i.e., yes/no) questions: 1) is it ethical for a therapist to refer a client based solely on the client's sexual orientation?, and 2) has the participant therapist referred a client based solely on the client's sexual orientation? The

independent variable is clinical competence to work with LGB clients, which is measured by the R-SOCCS knowledge/skills subscale. Given that there are dichotomous dependent variables, I calculated two logistic regressions to explore this research question.

Data Analysis for Research Question Two: Homophobia and Decision to Refer

My second research question, as stated earlier, is how are experienced clinicians' level of homophobia related to their decision to make referrals based solely on the sexual orientation of the client? The same dependent variables that were used to explore research question one, were also used to explore this research question. The independent variable for this research question was the clinicians' self-reported level of homophobia, which was measured by their average composite score on the combined MHS. For the purpose of this study, participants who answered at least 70% of the questions on the MHS received a mean composite score. Again, due to having dichotomous dependent variables, I calculated two logistic regressions to explore this research question.

CHAPTER FOUR. RESULTS

Results for Research Question One: Clinical Competence and Decision to Refer

As stated previously, the analysis for this research question involved two logistic regressions. Prior to running the logistic regressions, I calculated the correlations between all of the independent variables (see Table 3). I also calculated basic descriptive statistics on the independent and dependent variables and found that 61.7% believe it is ethical to refer a client based solely on the client's sexual orientation, 28.2% believe it is not ethical to refer a client, and 10.0% of my participants did not respond to the question. Additionally, 88.4% have not referred a client based solely on the client's sexual orientation, 7.3% reported they had referred a client based solely on the client's sexual orientation, and 4.4% of the sample did not respond. I also found that participants' mean score on the knowledge/skills subscale was 4.29 (SD = 0.92), with a range from 1.46 to 6.00. It is important to note that the higher values on the knowledge/skills subscale are associated with greater levels of self-reported clinical competence to work with LGB clients and the overall scale ranges from one to six. Thus, a mean score of 4.29 suggests that on average participants report moderate to high clinical competence to work with LGB clients.

The two logistic regressions for this first research question only varied in terms of the dependent variable. For the first logistic regression the dependent variable was is it ethical to refer a client based solely on the client's sexual orientation. The independent variables were entered into the logistic regression in two separate blocks. The first block contained the demographic control variables, which were gender (0 = man, 1 = woman), sexual orientation (0 = heterosexual, 1 = LGBTQA), education (1= master's, 2= Ph.D.),

Table 3: Correlation Matrix (N=741)

Variables	1	2	3	4	5	6	7	8	9
1. Gender	--	.04	-.03	-.19**	-.06	-.21**	.01	.09**	-.29**
2. Sexual Orientation		--	-.10**	-.11**	.29**	-.07	.05	.29**	-.23**
3. Age			--	.66**	.05	.13**	.07	.06	-.04
4. Years of Clinical Experience				--	.19**	.25**	.16**	.16**	-.08*
5. Number of LGB Clients Worked with					--	.14**	.11**	.39**	-.19**
6. Education						--	.05	.14**	.01
7. Worked with a LGB Client							--	.35**	-.19**
8. Knowledge Skill Combined subscale								--	-.54**
9. MHS Composite Scale									1

** Correlation is significant at the $p< 0.01$ level (2-tailed).

* Correlation is significant at the $p< 0.05$ level (2-tailed).

age, years of post-master's clinical experience, whether or not the participants had worked with a LGB client (0 = No, 1 = Yes), and the total number of LGB clients that the participants had worked with in a clinical setting. These variables were entered using a forward stepwise procedure, which helped to determine if these independent variables were predictors of the belief that it is ethical to refer a client based solely on the client's sexual orientation. For the first step, only years of post-master's clinical experience was found to be a predictor of participants' beliefs that it is ethical to refer a client based solely on the client's sexual orientation (See Table 4 for the *B*, Wald, and Odd Ratio Statistics). In particular, more years of post-master's experience was associated with the belief that it is not ethical to refer a client based on sexual orientation. The regression results indicated the overall model fit for step one was questionable (-2 Log Likelihood = 700.64; Hosmer and Lemeshow Goodness-of-Fit = 5.69) but was statistically reliable in distinguishing between those who believed it is ethical to refer and those that believed it is not ethical to refer ($x^2(1) = 4.19$, $p < .05$). The model that resulted from this first step correctly classified 68.6% of the cases. While the Wald statistic indicated that years of post-master's clinical experience was a significant predictor, the odds ratio for this variable was fairly small. The second block contained the independent variable of interest, in this case, the degree of self-reported clinical competence to work with LGB clients, which was measured by the combined knowledge/skills sub-scale of the R-SOCCS. The logistic regression found that clinical competence was not a good predictor of beliefs about the ethics of referring based on client's sexual orientation and the model was not significant (-2 Log Likelihood = 699.39; Hosmer and Lemeshow Goodness-of-Fit = 6.26; $x^2(2) = 5.44$, $p > .05$). For the second logistic regression, the independent variables were identical to the first and the

dependent variable was have you ever referred a LGB client based solely on the client's sexual orientation. For the first step, none of the variables were found to be predictors of whether participants referred a LGB client based solely on the client's sexual orientation (See Table 5 for the *B*, Wald, and Odd Ratio Statistics). The regression results indicated the overall model fit from step one was questionable (-2 Log Likelihood = 322.23; Hosmer and Lemeshow Goodness-of-Fit = .00) and was not statistically reliable in distinguishing between those who referred a LGB client and those who have not referred a LGB client ($x^2(1) = 3.07$, $p < .05$). The model that resulted from this first step correctly classified 92.4% of the cases. The second block contained the variable that measured the degree of self-reported clinical competence to work with LGB clients. The logistic regression found that clinical competence was not a good predictor of whether participants referred a LGB client based solely on the client's sexual orientation and the model was not significant (-2 Log Likelihood = 314.85; Hosmer and Lemeshow Goodness-of-Fit = 19.58; $x^2(2) = 10.45$, $p > .05$). However, the model continued to correctly classify 92.4% of the cases.

Results for Research Question Two: Homophobia and Decision to Refer

Prior to running the analyses for this research question I examined the descriptive statistics for the primary independent variable, which was self-reported homophobia as measured by the MHS. The mean level of self-reported homophobia was 1.88 (SD = 1.04) with a range from 1.0 to 5.70, with higher scores representing higher levels of homophobia. Thus, on average participants reported relatively low homophobia, however like self-reported clinical competence there was a significant range.

Similarly to the previous research question, the two logistic regressions for this research question only varied in terms of the dependent variable. For the first logistic

Table 4: Regression Coefficients for the Logistic Regression Exploring Clinical Competence and Ethics of Referring a LGB Client

		B	*Wald*	*df*	*p*	Odds Ratio
Step 1						
	Years of Clinical Experience	-0.02	4.19	1	.04	0.98
	Constant	1.13	33.45	1	.00	3.08
Step 2						
	Years of Clinical Experience	-0.02	3.49	1	.06	0.98
	Knowledge/Skill Subscale	-0.11	1.23	1	.27	0.89
	Constant	1.59	11.71	1	.00	4.91

Table 5: Regression Coefficients for the Logistic Regression Exploring Clinical Competence and Whether Clinicians Referred a LGB Client

		B	*Wald*	*df*	*p*	Odds Ratio
Step 1						
	Worked with a LGB	0.90	3.62	1	.06	2.47
	Constant	-2.58	246.75	1	.00	0.08
Step 2						
	Worked with a LGB	0.35	0.45	1	.50	1.42
	Knowledge/Skill Subscale	-0.47	7.38	1	.01	0.62
	Constant	-0.59	0.67	1	.41	0.55

regression the dependent variable was is it ethical to refer a client based solely on the client's sexual orientation. The independent variables were again entered into the logistic regression in two separate blocks. The first block contained the demographic control variables, which are the same as used for research question one. These variables were entered using a forward stepwise procedure, which helped to determine if these independent variables were predictors of the belief that it is ethical to refer a client based solely on the client's sexual orientation. For the first step only years of post-master's clinical experience was found to be a predictor of participants beliefs that it was ethical to refer a client based on the client's sexual orientation (See Table 6 for the *B*, Wald, and Odd Ratio Statistics). The regression results indicated the overall model fit from step one was questionable (-2 Log Likelihood = 704.78; Hosmer and Lemeshow Goodness-of-Fit = 5.90) but was statistically reliable in distinguishing between those who believed it is ethical to refer and those that believe it is not ethical to refer ($x^2(1) = 3.88$, $p < .05$). The model that resulted from this first step correctly classified 68.5% of the cases. While the Wald statistic indicated that years of post-master's clinical experience was a significant predictor, the odds ratio for this variable was fairly small. The second block contained the independent variable of interest, in this case, the degree of self-reported homophobia, which was measured by the combined MHS. The logistic regression found that homophobia was not a good predictor of beliefs about the ethics of referring based on client's sexual orientation and the model was not significant (-2 Log Likelihood = 703.29; Hosmer and Lemeshow Goodness-of-Fit = 2.62; $x^2(2) = 5.37$, $p > .05$).

For the second logistic regression, the independent variables were identical to those in the first logistic regression and the dependent variable was have you ever referred a LGB

Table 6: Regression Coefficients for the Logistic Regression Exploring Homophobia and Ethics of Referring LGB Clients

		B	*Wald*	*df*	*p*	Odds Ratio
Step 1						
	Years of Clinical Experience	-0.02	3.88	1	.05	0.98
	Constant	1.11	32.89	1	.00	3.03
Step 2						
	Years of Clinical Experience	-0.02	3.46	1	.06	0.98
	MHS Composite Score	0.11	1.45	1	.23	1.12
	Constant	0.89	11.23	1	.00	2.43

client based solely on the client's sexual orientation. For the first step no variables were found to be predictors of whether a participant referred a client based solely on the client's sexual orientation (See Table 7 for the *B*, Wald, and Odd Ratio Statistics). The regression results indicated the overall model fit from step one was questionable (-2 Log Likelihood = 322.67; Hosmer and Lemeshow Goodness-of-Fit = .00) and was not statistically reliable in distinguishing between those who have referred a client based solely on the client's sexual orientation and those who have not referred a client based solely on the client's sexual orientation ($x^2(1) = 3.10$, $p > .05$). The model that resulted from this first step correctly classified 92.4% of the cases. While the Wald statistic indicated that whether or not a therapist had worked with a LGB client was nearly a significant predictor, the odds ratio for this variable was small to moderate. The second block contained the independent variable of interest, in this case, the degree of self-reported homophobia, which was measured by the combined MHS. The logistic regression found that homophobia was a good predictor of whether a participant referred a client based solely on the client's sexual orientation and the model was significant (-2 Log Likelihood = 282.88; Hosmer and Lemeshow Goodness-of-Fit = 17.56; $x^2(2) = 42.89$, $p < .05$). The model that resulted from this second step also correctly classified 92.4% of the cases. The Wald statistic indicated that participants' level of self-reported homophobia was a good predictor and the odd ratio was small to moderate.

I calculated an independent samples *t*-test to further explore this significant finding and found that on average individuals who have referred a client based on sexual orientation reported a mean level of homophobia of 2.80 (SD = 1.54), while individuals who have not referred a client based solely on the client's sexual orientation report an

Table 7: Regression Coefficients for the Logistic Regression Exploring Homophobia and Having Referred a LGB Client

		B	*Wald*	*df*	*p*	Odds Ratio
Step 1						
	Worked with a LGB	0.91	3.67	1	.05	2.48
	Constant	-2.58	247.94	1	.00	0.08
Step 2						
	Worked with a LGB	0.36	0.45	1	.50	1.43
	MHS Composite Score	0.79	40.32	1	.00	2.20
	Constant	-4.31	139.65	1	.00	0.01

average level of homophobia of 1.79 (SD = 0.95). A statistically significant difference was found between those who have and have not referred a client ($t(720) = -7.03$, $p < .001$) with those who had referred reporting a higher level of homophobia.

CHAPTER FIVE. DISCUSSION

This chapter is divided into five sections: (1) main findings, (2) limitations, (3) clinical implications, (4) suggestions for future research, and (5) conclusions.

Main Findings

Main Findings for Research Question One

Before discussing the results of the first research question, it seems important to reflect on some of the descriptive statistics reported in the fourth chapter. For instance, a high percentage of the CFTs in this study believe it is ethical to refer a client based solely on the client's sexual orientation (61.7%); however, most of our participants have not actually done it (88.4%). One possible reason therapists believe this practice should be ethical, though have not actually done it, is that they themselves do not feel comfortable with referring a client based on the client's sexual orientation, but are able to think of situations where they believe it would be appropriate. For example, some CFTs may view this practice as ethical because they do not want other CFTs with high levels of homophobia working with LGB clients; thus, this belief could be based on a desire to protect LGB clients. Given the above scenario, the intent behind the belief that it is ethical to refer a client based on the client's sexual orientation comes from a good place; however, given the review of the literature that I performed this referral practice still seems to be a violation of the AAMFT Code of Ethics as CFTs are not to discriminate against a client based upon sexual orientation (Brock, 1998; Woody & Woody, 2001). My hope is that instead of seeing the practice of referring a client based solely on the client's sexual orientation as an ethical practice, CFTs would want to hold each other to a higher standard, which involves gaining additional training to be able to serve all clients. Thus, while as a

profession we would never see it as ethical to take the stance that I do not feel competent to work with women or feel that women are inferior and therefore refer all women, we continue to allow it to be acceptable for this practice to occur for LGB clients (McGeorge & Carlson, 2010).

The first research question explored how experienced clinicians' self-reported levels of clinical competence relate to their decisions to refer a client based solely on the sexual orientation of the client. As discussed in the analysis section, the decision to refer was examined by asking participants if they have ever referred a client based on the sexual orientation of the client, and also, if they believe it is ethical to do so. Years of post-master's clinical experience was the only variable in this logistic regression found to be a good predictor of participants' decision to refer based solely on the client's sexual orientation. In particular, CFTs with more years of post-master's clinical experience were less likely to believe it is ethical to refer a client based solely on the client's sexual orientation. Similarly, CFTs with more post-master's clinical experience were less likely to have referred a client based on the sexual orientation of the client. This could be explained by many factors, one of which is that clinicians who have been practicing longer are probably more likely to have developed a greater understanding of their professional code of ethics. Another possible reason that more years of post-master's clinical experience predicts a lesser likelihood that a therapist has referred a LGB client is that if a therapist has been practicing for a greater number of years, they are provided more opportunities to work with LGB clients, possibly resulting in lower levels of homophobia and greater levels of competence (Green, 1996).

Finally, we found that self-reported clinical competence to work with LGB clients does not predict CFTs' decision to refer a client. This finding suggests that CFTs make their decision to refer or not refer regardless of their level of competence to work with LGB clients. This is interesting because, while one might predict that CFTs who feel less competent to work with LGB clients would be more likely to refer them, this does not appear to be the case given the data used for this study. On average, most CFTs in my sample reported being moderately competent to work with LGB clients. It is interesting to note that those who reported lower competence were no more likely to refer LGB clients nor were they anymore likely to believe it is ethical. Again, there appears to be other factors that must be influencing CFTs' beliefs and practices about referring a client based solely on the client's sexual orientation. For example, some of our participants may not be competent to provide therapy to LGB individuals based on the knowledge/skills subscale, but still chose not to refer a client because they are actually interested in providing services to LGB clients in an effort to alter their sexual orientation as opposed to providing LGB affirmative therapy.

Main Findings for Research Question Two

The second research question explored how experienced clinicians' self-reported levels of homophobia relate to their decision to refer a client based solely on the sexual orientation of the client. It is important to note that on average, participants in this study reported low levels of homophobia. Again, the decision to refer was examined by asking participants if they have ever referred a LGB client based solely on the sexual orientation of the client, as well as if they believe it is ethical to refer based solely on the sexual orientation of the client. Self-reported levels of homophobia do not appear to be a good

predictor of whether or not a therapist believes it is ethical to refer a client based solely on the client's sexual orientation. One explanation for this is that CFTs believe such a referral is ethical for different reasons. A therapist who has low levels of self-reported homophobia, for example, may believe that this practice is ethical because they would not want a homophobic or incompetent therapist working with a LGB client, and therefore would prefer the client to be referred. Other therapists, however, may believe that such a referral is ethical because of their own homophobia. Thus, the belief that it is ethical to refer a client based on the client's sexual orientation could stem from having either positive or negative views of LGB persons, explaining why homophobia is not a good predictor of therapists' beliefs about the ethics of referral practices.

While CFTs' self-perceived level of homophobia does not predict whether or not they believe it is ethical to refer a client based solely on the client's sexual orientation, homophobia does indeed predict whether a therapist has referred a client. An important finding of this study is that therapists who reported higher levels of homophobia were more likely to have referred a client based solely on the client's sexual orientation. Unfortunately this is not a surprise to us because as many researchers have documented, therapists' decisions are very much influenced by personal values (Huber, 1994; Priest & Wickel, 2011). While the influence of personal values on the therapeutic process is clearly documented in the literature, this is the first study to find that homophobia directly impacts clinical decision making related to LGB clients. This finding could be seen as encouraging as CFTs who hold strong negative beliefs about any group of clients probably should not be working with those clients. However, as discussed in the literature review of this thesis, Brock (1998) argued that this behavior of referring based solely on the sexual orientation of

the client is in fact an act of discrimination and thus violates the AAMFT Code of Ethics. This further raises the question about whether clinicians who hold strong negative beliefs about any groups of people should be allowed to practice if those beliefs influence their clinical decision making as found in this study. This question is especially relevant when we consider the AAMFT Code of Ethics, which states that CFTs must not cause clients harm. The literature reviewed in this thesis indicates that a CFT referring a LGB client because of the client's sexual orientation does cause harm (Corey et al., 2007). Thus, considering that principle 1.1 in the AAMFT Code of Ethics does not allow CFTs to discriminate on the basis of sexual orientation and taking into account the harmful effects of referring a client based on the client's sexual orientation, we again must question if CFTs who refer LGB clients based on the client's sexual orientation should be allowed to practice.

Limitations

This study relied on a survey for data collection, and because of this we had a self-selecting population, so those that chose to take this survey are probably different from those who chose not to and the decision to take the survey is likely about having strong feelings about LGB clients either positive or negative. Another limitation of this study is the influence that social desirability may have had on participants' responses, such that some participants may not have felt free to express the depths of their homophobia; however, they were granted complete confidentiality so it is possible that this was not an issue. Lastly, since this is a study of participants' perceptions (i.e., self-reported homophobia, self-reported competence) and not actual behaviors, a limitation arises in that discrepancies are likely present between participants' perceptions of themselves and what

another person might observe in them. For example, participants may perceive themselves as competent to work with LGB persons, though a clinician well-studied in LGB issues may argue otherwise as might an LGB client.

Clinical Implications

This study provides us with clinical implications for CFT training programs, practicing clinicians, and also for the AAMFT. CFT training programs need to further educate students about what the Code of Ethics actually means with regard to not discriminating against clients based solely on demographic qualities (e.g., sexual orientation, gender, race, etc.), thus providing a foundation for what is considered by the AAMFT to be ethical practice and what is considered unethical. It is important that CFTs in training be cognizant of the seriousness of the Code of Ethics and the demands it places on CFTs to not discriminate against groups of clients, because without this awareness there is greater risk that therapists will cause harm to their clients by acting on their own beliefs and values. There are a number of steps that CFT training programs can utilize to train therapists to provide LGB affirmative therapy. For example, Carlson et al. (in press) discuss how teaching students about LGB topics is not enough to help them become affirmative therapists, but that CFT training programs must also make students aware of their own heterosexism and reflect on how their heterosexist biases influence the way they think about LGB clients. Additionally, Carlson and McGeorge (in press) highlight the importance for training programs to adopt specific policies and practices regarding the appropriate treatment of LGB clients, which creates a foundation for what will be expected from student therapists.

The AAMFT Code of Ethics outlines the importance for therapists to provide non-discriminatory services as well as maintain clinical competence (Brock, 1998; Woody & Woody, 2001). This study provides a greater understanding of the ways homophobia and clinical competence can influence therapists' decisions. It is pertinent that therapists continually take notice of and eliminate the ways their own homophobia is influencing how they practice. Some ways for CFTs to address and minimize the influence of their own homophobia are provided by McGeorge and Carlson (2010). For instance, McGeorge and Carlson (2010) provide specific questions for therapists to ask themselves in a process of self-reflection in which they explore their own heternormative assumptions, the privileges they have because they are heterosexual, as well as how their heterosexual identity developed. Additionally, a lack of competence to work with LGB persons should be addressed by CFTs through initiating continued education including reading articles and books that discuss working with LGB clients, and attending trainings or conferences focused on working with LGB clients. Again, CFTs must make continuous efforts to address their own homophobia or lack of competence to work with LGB persons throughout their careers.

It appears problematic that the AAMFT Code of Ethics does not provide clear guidelines on whether or not it is ethical for CFTs to refer LGB clients based solely on the client's sexual orientation. It is clear that CFTs make referrals for various reasons and it is important that the AAMFT be clear about what deems a referral discriminatory, and thus unethical. In summary, the AAMFT needs to be clear about whether referring based on sexual orientation is an act of discrimination and create a policy about the ethics of referring based on the client's sexual orientation or on any other demographic factor. This

provides support for both clarifying the AAMFT Code of Ethics and developing clear guidelines for the ethical treatment of LGB clients as other mental health disciplines have done (ALGBTIC, n.d.; APA Council of Representatives, 2000b).

Suggestions for Future Research

With this present study we were limited to data gathered from quantitative surveys, but it would be interesting to do a qualitative study in order to find out why experienced clinicians believe it is ethical to refer a LGB client based solely on the client's sexual orientation. Some therapists could argue that it would be ethical to refer a LGB client if the therapist has homophobic beliefs in order to avoid causing the client harm, or possibly because they themselves would prefer to not work with LGB clients. Those who think it should not be ethical to refer a client based solely on the client's sexual orientation might argue that this act is discriminatory and that therapists who do not wish to work with LGB clients should not be therapists. There are several possible reasons that therapists believe it is or is not ethical to refer clients based solely on the client's sexual orientation. The best way to learn those reasons would be through a qualitative study that invites both new and experienced CFTs to share their beliefs about the ethics of referring LGB clients. Discovering therapists' reasons for such beliefs about the ethical nature of referring clients based solely on the clients' sexual orientation would provide more information regarding what should be addressed if the AAMFT were to create guidelines about the ethical treatment of LGB clients.

In order to further substantiate the need for clear guidelines on the treatment of LGB clients, this study could be replicated with clinicians from other disciplines that do have clear guidelines for the treatment of LGB clients. This would give us insight as to how

having guidelines around the ethical treatment of LGB clients might influence therapists' beliefs about the ethical nature of referring LGB clients based solely on the client's sexual orientation. Thus, such a study would give us insight to know if the addition of these guidelines would encourage CFTs to have different beliefs regarding the ethical treatment of LGB clients.

Another study that would provide more clarity in the field regarding current practices of therapists working with LGB clients is to conduct a qualitative study asking CFTs what they think the AAMFT Code of Ethics means with regard to working with LGB clients. This would provide a greater understanding of how clinicians interpret the Code of Ethics with regard to LGB clients and what they believe to be ethical and unethical practices. Furthermore, asking specifically about clinicians' practices with LGB clients and whether those practices are informed by their interpretation of the Code of Ethics, by research, or by their own personal values, could potentially provide important implications for training programs as well the AAMFT ethics board. Additionally, in regard to their interpretation of the AAMFT Code of Ethics, researchers could ask if referring a client based solely on the client's sexual orientation is a violation of the non-discrimination clause of the AAMFT Code of Ethics.

Conclusion

The purpose of this study was to explore how experienced clinicians' level of clinical competence and level of homophobia influenced their beliefs about whether it is ethical to refer a LGB client based solely on the client's sexual orientation. Clinical competence was not found to be a good predictor of whether or not a clinician believes it is ethical to refer a LGB client based solely on the client's sexual orientation. We did find,

however, that clinicians' who reported having higher levels of homophobia were more likely to have referred a client based solely on the client's sexual orientation. Additionally, we found that clinicians with more years of clinical experience were less likely to have referred a LGB client based solely on the client's sexual orientation and were also less likely to believe this practice is ethical. Based on the results of this study, we hope that this sparks a discussion about the ethics of referring and provides support for the development of clear guidelines about the ethical treatment of LGB individuals, couples, and families.

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