Working with Lesbians, Gays, and Bisexuals: Addressing Heterosexism in Supervision*

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Heterosexism is a form of multicultural bias that has the potential to harm both clients and supervisees. Supervisors are encouraged to examine their own heterosexist lens as a first step in providing a safe environment in which supervisees can challenge their own heterosexism. The issue of heterosexism is first discussed from an ethical vantage point. The second section of the article examines four facets of heterosexism (discrimination, lack of knowledge, stereotyping, and insensitivity) and how they might be exhibited by the supervisor in the supervision arena. Special topics discussed in this section include: the possible consequences of "coming out" in the supervisory context; the presence of heterosexism in the foundational family systems theory; the need for recognition of the special family characteristics of lesbians, gays, and bisexuals; the value of personal and professional relationships with persons who are gay, lesbian, and bisexual; common heterosexist stereotypes and research that refutes them; and the use of language. The final section of the article offers suggestions for working with supervisees around these issues.

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SUPERVISEES approach lesbian, bisexual, and gay clients with varying levels of acceptance, comfort, and knowledge. Supervisors approach supervision related to lesbian, gay, and bisexual clients with a similar range of responses. Levels of acceptance and comfort and the acquisition of knowledge are often linked to the presence of heterosexism in the supervisor and the supervisee. Racism, sexism, classism, and heterosexism are all areas that need to be addressed in attending to multicultural bias in the supervisory process. Bisexual, gay, and lesbian clients can be harmed by unexamined heterosexism just as ethnic minority clients can be harmed by unexamined racism (Greene, 1994). Heterosexism is a multicultural bias in that gays, lesbians, and bisexuals constitute a cultural minority and deserve recognition of the unique subculture of which they are members (Pope, 1995). While acknowledging the gravity and the interrelatedness of all issues of bias, I intend to focus on heterosexism in the

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hope that consciousness-raising related to this pocket of bias will also encourage and facilitate examination of other multicultural biases.

HETEROSEXUAL BIAS

Heterosexual bias was first defined by Morin (1977) as the belief system that values the superiority of heterosexuality to lesbian and gay sexual orientations. A task force established by the Board for Social and Ethical Responsibility in Psychology of the American Psychological Association more recently defined heterosexual bias as "conceptualizing human experience in strictly heterosexual terms and consequently ignoring, invalidating, or derogating homosexual behaviors and sexual orientation, and lesbian, gay, and bisexual relationships and lifestyles (Herek, Kimmel, Amaro, & Melton, 1991, p. 958). Heterosexism is an ethnocentric lens through which many cultures have traditionally viewed the world. This heterosexist lens has historically been employed by mental health professionals and social scientists to evaluate, analyze, research, and work in therapy with lesbians, gays, and bisexuals. Specific evidence of the presence of heterosexism in the mental health arena includes the following beliefs: (a) the presumption that heterosexuality is "normal" and "healthy," and that gay, lesbian and bisexual orientations are deviant or pathological (Morin, 1977); (b) the presumption that theories and research findings based on studies of heterosexuals are applicable and generalizable to gays, bisexuals, and lesbians (Kitzinger, 1987); and (c) the presumption that heterosexuality and its accompanying lifestyle provide normative standards against which the lives of lesbians, gays, and bisexuals need to be compared in order to be understood (Goodrich, Rampage, Ellman, & Halstead, 1988).

Greene (1994) notes that lesbian and gay sexual orientations are topics about which most persons socialized in the United States have intense feelings. Yet, this topic has been carefully avoided in formal training programs for mental health professionals (Brown, 1991; Eldridge & Barnett, 1991; Greene, 1994; Markowitz, 1991). It is likely that persons who are not informed regarding issues of sexual orientation will be more susceptible to wearing a heterosexist lens. The issue of bias becomes even more intense when related to the 20th century AIDS epidemic. Herek (1991) presents several connections between AIDS-related stigma and antigay prejudice. Family therapy supervisors are not immune to the influence of the ubiquitous existence of heterosexist bias in the dominant culture.

How do supervisors balance supervision in a way that is respectful and growth-enhancing for the supervisee and at the same time advances the welfare of gay, lesbian, and bisexual individuals, couples, and families? This article will focus on the self-examination of heterosexism by the supervisor, particularly around the issues of discriminatory practices, lack of knowledge, stereotypical thought processes, and insensitivity. I will argue that self-examination is a necessary step in preparing supervisors to work with supervisees around the issue of heterosexism, including those supervisees who hold different values and opinions than their supervisors (Long, in press).

THE SUPERVISORY PROCESS

Ethical Dilemmas

While self-examination of heterosexism on the part of the supervisor may occur as the result of self-awareness of bias, supervisors are often motivated to examine self as a result of interactions within the supervisory process. This awareness might be promoted in several ways: (a) a supervisee who differs from the supervisor in

acceptance of gays, lesbians, and bisexuals; (b) a supervisor who discovers that she or he has inadequate knowledge related to *HIV/AIDS* when advising a supervisee concerning a case; (c) a supervisee who encourages a bisexual client to adopt a straight lifestyle and ignores the fact that the person has identified himherself as bisexual; or (d) a supervisee who believes in trying to convert gays, lesbians, or bisexuals to heterosexuality.

Supervisors are bound by ethical codes that prohibit discrimination or refusal of service to persons on the basis of sexual orientation (AAMFT Code of Ethics, 1991; APA Ethical Principles of Psychologists, 1990; NASW Code of Ethics, 1984). Ethical codes also acknowledge both the influential position of therapists and the right of clients to make their own decisions. Ethical codes provide a foundation from which supervisors can begin their work with supervisees, but ethical codes do not have the answers to all challenging questions. For instance, how does a supervisor respond when a supervisee refuses to work with a gay couple. The supervisor might begin by pointing out to the supervisee that the ethical code prohibits refusal of service due to sexual orientation. The supervisee may then note that the ethical code also states, "Marriage and family therapists assist persons in obtaining other therapeutic services if the therapist is unable or unwilling, for appropriate reasons, to provide professional help" (AAMFT Code of Ethics, 1991, p. 2). One might well wonder what is meant by "for appropriate reasons." Consider the following supervisee responses when asked by the supervisor why they want to refer a gay couple (Long, in press):

1. "I simply cannot work with this couple. I have never even known someone who is gay, and I don't have a clue about how to work with them. I will refer them to someone else."
2. "I cannot condone their lifestyle, but I want to treat them with respect. I feel that I would do them a disservice or possibly cause them harm to work with them, so I am going to make a referral."

When does the supervisor request or allow a supervisee not to see clients who are lesbian, bisexual, or gay? Refusing to work with gays and lesbians because of a lack of knowledge and skill is a very different issue than refusing to work with them because one believes that their lifestyle is immoral (Long, 1994). What does the supervisor need to do or to say in order to assure service to lesbian, bisexual, and gay clients that is not disrespectful or otherwise harmful? What does the supervisor need to do or consider to assure that therapists are encouraged to broaden and examine their own beliefs, skills, and knowledge (Long, in press)?

While the supervisor may believe that exposure to persons who are bisexual, lesbian, or gay would be good training experience for the supervisee who condemns gay and lesbian sexual orientations, the supervisor might also consider the wishes of the clients. In a recent pilot study, six persons, self-identified as gay, lesbian, or bisexual, participated in conversational interviews concerning their perceptions of the therapy experience. This study was conducted using a grounded theory approach to qualitative analysis. As a part of the interview, respondents were asked if they would consider having the services of a therapist who did not condone their lifestyle (Long, Lindsey, Manders, et al., 1993). Their response was a resounding "NO." Supervisors must decide whether they are doing a disservice to gay, lesbian, and bisexual clients by assigning them to therapists who are opposed to their sexual orientation. Supervisors who decide that a supervisee should not be assigned bisexual, lesbian, and gay clients could consider other avenues for introduc-

ing such therapists to this population. One possible option would be allowing supervisees who are aversive to these orientations to observe therapy sessions involving gays, lesbians, and bisexuals from behind the mirror or on videotape, with the permission of the clients (Long et al., 1993).

The issue of lack of knowledge is a much more difficult question to address. In the study mentioned above, participants were asked if they would prefer to work with a therapist who was lesbian, gay, or bisexual as opposed to a therapist who was heterosexual but supportive of their orientation and lifestyle. Overall, the respondents did not believe that the sexual orientation of the therapist was the key issue but, rather, an openness and acceptance of who they were. Only two of the respondents cited topics for which they would prefer a therapist of the same orientation: "coming-out" issues and sexual issues. All respondents noted, however, that they would expect the therapist to have a knowledge base related to bisexual, gay, and lesbian lifestyles, and that they would not continue to see the therapist if a lack of knowledge became apparent (Long et al., 1993). A supervisor who discovers a lack of knowledge on the part of the supervisee can closely monitor the case while broadening the supervisee's knowledge base.

If a supervisor decides that a supervisee should not see particular clients because of a conflict in values, or a fear of doing harm, how might the supervisor proceed? The supervisor must first work with the supervisee on making a referral to another therapist. The supervisee could relay to the client(s) that a referral was being made to a new therapist who was more knowledgeable about gay/lesbian/bisexual issues. The supervisee could then be invited to examine the problematic area. The challenge for the supervisor is to provide a safe and informed context in which this exploration can take place. An initial step in creating this context is for the supervisor to examine her or his own heterosexism.

THE SUPERVISOR'S BIAS

Heterosexism can be exhibited in many ways: outright prejudice or discrimination; ignorance of the special issues of gays, bisexuals, and lesbians; stereotypical thought processes; and insensitivity. The following section will examine each of these facets of heterosexism and how they might be exhibited by the supervisor within the supervision arena.

Discriminatory Practices

A clinical faculty member who has never knowingly supervised a gay, bisexual, or lesbian trainee could ask himherself the following question: "Would gay, bisexual, and lesbian trainees feel comfortable disclosing their sexual preference within the environment of this program setting?" This question is not posed to suggest that trainees should be required to disclose their sexual orientation, but rather to scrutinize the safety of the environment for sharing such information if the trainee chose to do so. Supervisees may refrain from revealing information about their sexual orientation because of perceived and/or experienced heterosexism on the part of supervisors, administrators, the institution, or the community. The program accreditation guidelines of both the National Association of Social Workers and the American Psychological Association include sexual orientation in their antidiscrimination clauses (Council on Social Work Education, 1991; Greene, 1994). Currently, however, the Commission on Accreditation (COA) of the AAMFT does not include sexual orientation in its antidiscrimination clause, which leaves supervisees unprotected in the event of

discrimination (COA Manual on Accreditation, 1991).[1]

Gay, bisexual, and lesbian supervisees who do choose to disclose, open themselves up to the possibility of the following: lowered status due to the stigma attached to their sexual orientation by the supervisor; the burden of "helping" fellow supervisees or supervisors deal with their heterosexism; the possibility of retaliation by administrators who may become privy to this information; unexpected changes in supervisors who may not be as open but who are informed of the supervisee's orientation; concerns that future employers, who may not be as open and accepting, may discover one's sexual orientation; and, particularly for gays and bisexuals, the possible consequences of AIDS-related stigma. Supervisors have a responsibility to make supervisees aware of the potential consequences for public openness. When a supervisee comes "out" to a supervisor, the supervisor should hold this information in confidence unless explicitly instructed otherwise by the supervisee, which gives the supervisee control over who knows the information and when (Long, in press).

"Why would a prospective student who was gay or lesbian decide not to apply to our program?" This question raises many possible avenues for exploration: "Does our program offer diversity in students and in faculty?"; "Is the political climate of our campus and community open to gay, lesbian, and bisexual lifestyles?"; "Would I consider encouraging the hiring of a colleague who was gay, lesbian, or bisexual?"; and "Does our curriculum convey an awareness of gay, lesbian, and bisexual lifestyles and issues?" As Markowitz (1991) contends, "Few graduate programs include required reading on same-sex couples or discussion of homosexuality" (p. 28). How do we account for this exclusion in the face of mandates to the contrary from a variety of accrediting bodies? (See Commission on Accreditation for Marriage and Family Therapy Education, 1991; Committee on Gay and Lesbian Concerns, 1991; Council on Social Work Education, 1991.) If our explanatory narratives include our own actions or inactions, what might we consider doing differently?

Lack of Knowledge

It should be noted that heterosexism is present in much of the foundational family systems theory and in many of the traditional approaches to family therapy (Ault-Riche, 1986; Goodrich et al., 1988). For example, early popular concepts such as: triangulation, fusion, and boundaries have the potential to pathologize when related to the lesbian relationship (Goodrich et al., 1988). While these concepts have the potential to pathologize any relationship, much of the clinical literature addressing lesbian relationships highlights the presence and the pathological aspects of fusion/merger/enmeshment in those relationships (Brown & Zimmer, 1986; Burch, 1982, 1986; Krestan & Bepko, 1980; Roth, 1989; Sharratt & Bern, 1985). Many of these writers acknowledge the influence of gender-role socialization, and the tendency of persons with minority status to bond closely together in order to provide protection from a hostile environment, as key initiators for such characteristics in lesbian relationships (Zacks, Green, & Marrow, 1988). The issue then becomes whether the presence of merger or fusion in a lesbian relationship is seen as pathological, or as having the potential to enhance rather than to restrict personal growth (McKenzie, 1992). Certainly, the theories of women's psychological development generated by Dinnerstein (1977), Chod-

[1] It should be noted that, without the antidiscrimination clause, bisexual/gay/lesbian faculty members and supervisors are also vulnerable.

orow (1978), and Gilligan (1982) have supported the notion that psychological merger can enhance personal growth. The key to promoting growth in the relationship is not to do away with merger, but to allow both parties to find themselves within the merger and then vacillate between merger and separation (McKenzie, 1992; Burch, 1985).

Slater and Mencher (1991) point out that "gay and lesbian families have been the 'poor relations' in family therapy's attention to diversity, receiving little consideration as to their establishment or to the differences and similarities among their life cycle patterns and those of heterosexual families" (p. 375). Recognizing the unique set of family characteristics presented by gay/lesbian/bisexual families can encourage a broader understanding of family diversity. Clinical faculty members who become acquainted with this body of literature will not only expand their knowledge base but also avoid overlooking potential problems and solutions in therapy. Education would also help to prevent insensitivity on the part of the supervisor. Treating gay and lesbian couples as though they were heterosexual couples, and dismissing the fact that they have special concerns, have the potential to convey both insensitivity and discrimination. There is a growing base of literature related to working with gays, lesbians, and bisexuals and their families in therapy, and much of the recent literature focuses on ways to minimalize heterosexism in therapeutic relationships (Brown & Zimmer, 1986; Levy, 1992; Slater & Mencher, 1991).[2]

The best way to increase one's knowledge about lesbians, gays, and bisexuals is to seek out both personal and professional relationships with members of these groups. Recently, in interviews to discuss their therapy experiences, gay and lesbian couples were asked what they would like a therapist to know about being gay or lesbian. Their responses included: the invisibility of our relationship to the majority of persons with whom we come in contact every day; knowledge about the "coming-out" process, including dealing with family and friends and "coming-out" issues in the work environment; knowledge of the history of the gay rights movement; awareness of the major social battles facing gays and lesbians; and an awareness of the effects of homophobic actions—including the fear of being harmed or killed because of one's sexual orientation (Long et al., 1993). One's understanding of these issues greatly increases when one actually knows persons who struggle with these issues on a daily basis.

Stereotypical Thought Processes

Stereotypical thoughts inhibit one's clinical performance and promote heterosexism. Persons who are heterosexist may hold on to stereotypes of gays and lesbians because they are threatened by the notion that gays and lesbians are more similar to heterosexuals than different. Because the stigma of homosexuality is so great in our society, persons want to place themselves as far away from this label as possible (Eldridge & Barnett, 1991). A discussion of some common stereotypes and research that refutes them follows:

Stereotype I: Gays and lesbians are thought not to desire or be capable of permanence in relationships. Research indicates that between 45 to 80% of lesbians and 40 to 60% of gays are involved in steady relationships at any given time (Peplau & Cochran, 1990), and many lesbians and gays establish lifelong partnerships (Blumstein & Schwartz, 1983; McWhirter & Mattison, 1984).

Stereotype II: Gay and lesbian relationships are less satisfactory than heterosexual relationships. When the relation-

[2] A more extensive reading list is available through contacting the author.

ship satisfaction of lesbians and gays is compared to heterosexual couples, few if any differences emerge (Duffy & Rusbult, 1986; Kurdek & Schmitt, 1987; Peplau & Cochran, 1990).

Stereotype III: Lesbians and gays are not effective parents. Harris and Turner (1985/1986) noted that being gay is compatible with effective parenting. Miller, Jacobsen, and Bigner (1981) found that lesbian mothers were more likely to be child-centered in their responses than were heterosexual mothers. Kirkpatrick, Smith, and Roy (1981) found no differences between lesbian and heterosexual mothers in maternal interests, current lifestyles, and child-rearing practices.

Stereotype IV: Children who are raised by gay or lesbian parents will be psychologically damaged in some way (poor social adjustment, sexual identity confusion). Several studies have found no evidence of sexual identity confusion (Golumbok, Spencer & Rutter, 1983; Green, 1982; Kirkpatrick et al., 1981; Patterson, 1994). Green, Mandel, Hotvedt, et al. (1986) found no differences in measures of peer group popularity or social adjustment between children of heterosexual and lesbian mothers. Patterson (1994) found normal social competence among children of lesbian parents and similar levels of behavior problems with children of heterosexual parents.

Stereotype V: Children who are exposed to gays, lesbians, or bisexuals are more likely to be molested. Riveria (1987) and Finkelhor (1986) indicate that molestation is not related to sexual orientation but, rather, results from a fixation on childishness or children as sex objects, that is, pedophiles.

Stereotype VI: All gays are or will be HIV-infected. Even though the AIDS epidemic remains a crisis in the both the gay and straight populations of the United States, the percentage of HIV-infected individuals who are gay or bisexual men has decreased approximately 20% in recent years (Gonsiorek & Shernoff, 1991). Initial data from HIV infection prevention programs indicate a substantial change in behavior, which will likely reduce the numbers of those infected (Kelly, St. Lawrence, Hood, & Brasfield, 1989; Swarthout, Gonsiorek, Simpson, and Henry, 1989).

Stereotype VII: In lesbian and gay couples, one partner usually plays the traditional feminine role while the other usually plays the traditional masculine role (butch/femme role division). Research shows that most lesbians and gays reject traditional masculine-feminine roles as a model for relationships (Blumstein & Schwartz, 1983; McWhirter & Mattison, 1984; Peplau & Amaro, 1982). Currently, most lesbian and gay couples are in "dual-worker" relationships in which neither partner is the sole provider and each partner has economic independence (Peplau, 1991). Examination of the division of household tasks, decision-making processes, and sexual behavior reveals no consistent masculine-feminine patterns; that is, roles seem to be based on skills or interest (Peplau, 1991).

Stereotype VIII: Lesbian, gay, and bisexual orientations are "caused" by patterns of interaction in the family of origin. This stereotype is not supported by studies of community samples. The available evidence suggests that the families of origin of lesbian and gay offspring do not differ significantly from the families of heterosexual offspring (Bell, Weinberg, & Hammersmith, 1981; D'Augelli & Patterson, 1994). In the past, researchers have sought to discover particular family dynamics or structures that would produce lesbian and gay progeny. Laird (1994) writes: "In spite of efforts to blame certain stereotypical family constellations (e.g., the domineering, seductive mother and the passive, peripheral father), research-

ers were not able to link male or female homosexuality to any particular family form" (p. 120).

Resources for research and discussion that confront these and other stereotypes of gays, lesbians, and bisexuals include: Bell and Weinberg, 1978; Bozett, 1989; Gonsiorek and Weinrich, 1991; Greene and Herek, 1994; Kurdek, 1994; and Laird, 1993.

Insensitivity

Supervisors who discriminate, who operate on the basis of stereotypical thought processes, and who remain uneducated about gay and lesbian issues and relationships, are exhibiting insensitive behavior. Like stereotyping, insensitivity is also conveyed through our use of language. Supervisors who refer to gays, lesbians, or bisexuals as sexual inverts or sexual deviants both stigmatize and pathologize the individual's sense of self (Committee on Lesbian and Gay Concerns, 1991). On a very basic level, supervisors who take for granted that clients or supervisees have a heterosexual orientation are dismissing lesbians, gays, and bisexuals, and their relationships. For example, we must be aware of how we word our intake information sheets. How many of the questions even acknowledge the possibility of a sexual/intimate relationship that is anything other than heterosexual?

SUGGESTIONS FOR SUPERVISORS

Supervisors have a commitment to trainees to insure that trainees have adequate knowledge and skills to work with diversity in families. It is not enough simply to say that we recognize multiculturalism. Clinical faculty members must take responsibility for assuring that therapists-in-training have both the theoretical knowledge and the clinical skills to work with gays, lesbians, and bisexuals. Clinical supervisors can provide intensive training related to these issues, for example, in workshops, seminars, and research experiences. However, these issues will be more effectively addressed when they are also dispersed throughout the curriculum rather than discussed only in specially designed courses intended to cover all special populations. Relegating these concerns solely to a special topics course could send trainees the message that clinical faculty give only secondary consideration to gays, lesbians, bisexuals and their families.

The following is a list of suggestions for supervisors who wish to mainstream gay and lesbian concerns into class content as well as in supervision:

1. In class discussions and in supervision, use examples that include gays, bisexuals, and lesbians. Supervisors are encouraged to examine their language for clues that they may be stereotyping bisexuals, lesbians, and gays as abnormal or dysfunctional. For example, when comparing gay or lesbian couples to other family types, parallel terms should be used, that is, comparing lesbian couples with heterosexual couples, as opposed to "normal" couples. Mention that healthy parental units are not always heterosexual, and that the literature indicates that gay and lesbian couples can provide a positive family environment for healthy childrearing (Crawford, 1987; Koepke, Hare, & Moran, 1992; Martin, 1993).

2. When assigning class readings, include works pertaining to gays, lesbians, and bisexuals. Do not assume that readings related to gay relationships can be applied to lesbian relationships. Even though some similarities do exist, McWhirter and Mattison (1988) note that the differences between gay and lesbian couples are as distinct as the differences between heterosexual and same-sex couples. Coursework pertaining to systems theory, ethics, couple's therapy, gen-

der, sexuality, supervision, and so on, all have relevance for discussing issues related to gays, lesbians, and bisexuals.

3. Supervisors can take several approaches in training supervisees to be sensitive to bisexual, gay, and lesbian clients, including role play, the review of tapes for examples of insensitive approaches, and the use of case materials to determine how they might view the case if the clients were lesbian, gay, or bisexual (Dahlheimer & Feigal, 1991; Greene, 1994).

4. Invite openly gay, lesbian, and bisexual therapists to talk with students in classes related to a variety of topics, not just on issues related to sexual orientation.

5. Help students be aware of bias in language both in the classroom and in supervision. Supervisors can point out the necessity of monitoring one's language when eliciting information from clients. For instance, suggesting that a supervisee ask a client, whose sexual orientation is unknown, at what age they first engaged in sexual activity, rather than at what age the client first had sexual intercourse. The supervisor should also caution the trainee not to assume that a client is heterosexual if the client says that he or she is married. Many gay and lesbian couples exchange vows and have wedding ceremonies. Trainees need to also be aware that gays and lesbians often refer to their friendship network as "family," and that for many gays and lesbians this "family" is often as crucial and influential as their family of origin and, at times, even more so.

CONCLUSION

Laura Brown (1991) reminds us that much of what we know about the lives of bisexuals, gays, and lesbians, and much of what we have been able to do for them as helping professionals, has evolved under the shadow of heterosexism. The mental health professions have viewed issues related to gays, bisexuals, and lesbians as marginal and of interest only to those persons who are themselves lesbian, bisexual, or gay. As noted by Brown (1991), when supervisors fail to introduce supervisees to lesbian, gay, and bisexual issues, to the experience of lesbian, bisexual, and gay colleagues, faculty, and clients, to self-examination, and to the raising of consciousness that accompanies these encounters, we allow "the development of professionals who are not only deficient in their ability to work with sexual minorities . . . but in the creation of therapists who are uncomfortable with ambiguities and questions regarding sexuality (p. 237)."

The process of becoming a therapist exposes the trainee's vulnerability and challenges the trainee to examine his or her own personal themes (Satir, 1987). These themes arise from one's own personal history, as well as one's sexual orientation, and will undoubtedly be challenged many times throughout training related to a variety of topics, including issues related to gays, bisexuals, and lesbians. Margolin (1982) suggests that "formal training programs in family therapy provide an arena for discussing specialized ethical concerns" (p. 800). The role of the supervisor is not in dictating what a student's beliefs should be, but, rather, in providing a safe environment for the supervisee to explore her or his beliefs. The supervisor can help to establish a safe environment for this exploration by examining and attending to his or her own heterosexism and by mainstreaming content related to gays, bisexuals, and lesbians throughout the curriculum.

REFERENCES

AAMFT. (1991). *Code of ethics.* Washington DC: American Association for Marriage and Family Therapy.

American Psychological Association. (1990). Ethical principles of psychologists. *American Psychologist 45:* 390–395.

Ault-Riche, M. (1986). A feminist critique of five schools of family therapy (pp. 1–15). In M. Ault-Riche (ed.), *Women and family therapy.* Rockville MD: Aspen Publications.

Bell, A.P., & Weinberg, M.S. (1978). *Homosexualities: A study of diversity among men and women.* New York: Simon & Schuster.

_____, Weinberg, M.S., & Hammersmith, S.K. (1981). *Sexual preference: Its development in men and women.* Bloomington IN: Indiana University Press.

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, sex.* New York: William Morrow.

Bozett, F.W. (ed.). (1989). *Homosexuality and the family.* New York: Harrington Park Press.

Brown, L. (1991). Commentary on the special issue of *The Counseling Psychologist:* Counseling with lesbians and gay men. *The Counseling Psychologist 19:* 235–238.

_____, & Zimmer, D. (1986). An introduction to therapy issues of lesbian and gay male couples (pp. 451–468). In N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy.* New York: Guilford Press.

Burch, B. (1982). Psychological merger in lesbian couples: A joint ego psychological and systems approach. *Family Therapy 9:* 201–208.

_____. (1985). Another perspective on merger in lesbian relationships (pp. 100–109). In L.B. Rosewater & L. Walker (eds.), *Handbook of feminist therapy: Women's issues in psychotherapy.* New York: Springer Publishing Co.

_____. (1986). Psychotherapy and the dynamics of merger in lesbian couples (57–71). In T.S. Stein & C.J. Cohen (eds.), *Contemporary perspectives on psychotherapy with lesbians and gay men.* New York: Plenum Medical Book Company.

Chodorow, N. (1978). *The reproduction of mothering: Psychoanalysis and the sociology of gender.* Berkeley: University of California Press.

Commission on Accreditation for Marriage and Family Therapy Education, American Association for Marriage and Family Therapy (1991). *Manual on accreditation.* Washington DC: AAMFT.

Committee on Lesbian and Gay Concerns. (1991). Avoiding heterosexual bias in language. *American Psychologist 46:* 973–974.

Council on Social Work Education. (1991). *Handbook of accreditation standards and procedures.* Alexandria VA: CSWE.

Crawford, S. (1987). Lesbian families: Psychosocial stress and the family-building process (pp. 195–214). In Boston Lesbian Psychologies Collective (eds.), *Lesbian psychologies: Explorations and challenges.* Chicago: University of Illinois Press.

D'Augelli, A.R., & Patterson, C.J. (eds.). (1994). *Lesbian, gay, and bisexual identities over the lifespan.* New York: Oxford University Press.

Dahlheimer, D., & Feigal, J. (1991). Bridging the gap. *The Family Therapy Networker 15* (1): 44–53.

Dinnerstein, D. (1977). *The mermaid and the minotaur: Sexual arrangements and human malaise.* New York: Harper & Row.

Duffy, S.M., & Rusbult, C.E. (1986). Satisfaction and commitment in homosexual and heterosexual relationships. *Journal of Homosexuality 12:* 1–24.

Eldridge, N.S., & Barnett, D.C. (1991). Counseling gay and lesbian students (pp. 147–178). In N.J. Evans & V.A. Wall (eds.), *Beyond tolerance: Gays, lesbians, and bisexuals on campus.* Lanham MD: University Press of America.

Finkelhor, D. (1986). *A sourcebook on child sexual abuse.* Newbury Park CA: Sage Publications.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge: Harvard University Press.

Golumbok, S., Spencer, A., & Rutter, M. (1983). Children in lesbian and single-parent households: Psychosexual and psychiatric appraisal. *Journal of Child Psychology and Psychiatry 24:* 551.

Gonsiorek, J.C., & Shernoff, M. (1991). AIDS prevention and public policy: The experience of gay males (pp. 230–243). In J.C. Gonsiorek & J.D. Weinrich (eds.), *Homosexuality: Research implications for public policy.* Newbury Park CA: Sage Publications.

_____, & Weinrich, J.D. (eds.). (1991). *Homosexuality: Research implications for public*

policy. Newbury Park CA: Sage Publications.

Goodrich, T.J., Rampage, C., Ellman, B., & Halstead, K. (1988). *Feminist family therapy: A casebook.* New York: W.W. Norton.

Green, R. (1982). The best interests of the child with a lesbian mother. *Bulletin of the American Academy of Psychiatry and the Law 10:* 7–15.

_____, Mandel, J.B., Hotvedt, M.E., Gray, J., & Smith, L. (1986). Lesbian mothers and their children: A comparison with solo parent heterosexual mothers and their children. *Archives of Sexual Behavior 15:* 167–184.

Greene, B. (1994). Lesbian and gay sexual orientations: Implications for clinical training, practice, and research (pp. 1–24). In B. Greene & G.M. Herek (eds.), *Lesbian and gay psychology: Theory, research, and clinical implications.* Thousand Oaks CA: Sage Publications.

_____, & Herek, G.M. (eds.). (1994). *Lesbian and gay psychology: Theory, research, and clinical applications.* Thousand Oaks CA: Sage Publications.

Harris, M.B., & Turner, P.H. (1985/1986). Gay and lesbian parents. *Journal of Homosexuality 12:* 101–113.

Herek, G.M. (1991). Stigma, prejudice, and violence against lesbians and gay men (pp. 60–80). In J.C. Gonsiorek, & J.D. Weinrich (eds.), *Homosexuality: Research implications for public policy.* Newbury Park CA: Sage Publications.

_____, Kimmel, D.C., Amaro, H., & Melton, G.B. (1991). Avoiding heterosexist bias in psychological research. *American Psychologist 46:* 957–963.

Kelly, J.A., St. Lawrence, J.S., Hood, H., & Brasfield, T. (1989). Behavioral intervention to reduce AIDS risk activities. *Journal of Consulting and Clinical Psychology 57:* 60–67.

Kirkpatrick, M., Smith, C., & Roy, R. (1981). Lesbian mothers and their children. *American Journal of Orthopsychiatry 51:* 545–551.

Kitzinger, C. (1987). *The social construction of lesbianism.* London: Sage Publications.

Koepke, L., Hare, J., & Moran, P.B. (1992). Relationship quality in a sample of lesbian couples with children and child-free lesbian couples. *Family Relations 41:* 224–229.

Krestan, J.-A., & Bepko, C.S. (1980). The problem of fusion in the lesbian relationship. *Family Process 19:* 277–289.

Kurdek, L.A. (1994). *Social services for gay and lesbian couples.* New York: Haworth Press.

_____, & Schmitt, J.P. (1987). Relationship quality of partners in heterosexual married, heterosexual cohabiting, and gay and lesbian relationships. *Journal of Personality and Social Psychology 14:* 57–68.

Laird, J. (1993). Lesbian and gay families (pp. 282–328). In F. Walsh (ed.), *Normal family processes* (2nd ed.). New York: Guilford Press.

_____. (1994). Lesbian families: A cultural perspective (pp. 118–148). In M.P. Mirkin (ed.), *Women in context: Toward a feminist reconstruction of psychotherapy.* New York: Guilford Press.

Levy, E.F. (January, 1992). Strengthening the coping resources of lesbian families. *Families in Society: The Journal of Contemporary Human Services,* 23–31.

Long, J.K. (1994). MFT supervision of gay, lesbian, and bisexual clients: Are supervisors still in the dark? *The Supervision Bulletin* (AAMFT) 7(1): 1–2.

_____. (in press). Lesbian, gay and bisexual orientations: Implications for the supervisory process. In C. Storm & T. Todd (eds.), *The complete systemic supervisor: Philosophy, methods and contexts.* New York: Allyn and Bacon.

_____, Lindsey, E., Manders, J., Dotson, D., & Wilson, R. (October, 1993). Training MFTs to work with gay and lesbian couples and families. Workshop presented at the annual meeting of the American Association for Marriage and Family Therapy, Anaheim CA.

Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. *American Psychologist 37:* 788–802.

Markowitz, L.M. (1991). Homosexuality: Are we still in the dark? *The Family Therapy Networker 15*(1): 26–35.

Martin, A. (1993). *The lesbian and gay parenting handbook: Creating and raising our families.* New York: HarperCollins.

McKenzie, S. (1992). Merger in lesbian relationships. *Women and Therapy 12:* 151–160.

McWhirter, D., & Mattison, A. (1984). *The*

male couple: How relationships develop. Englewood Cliffs NJ: Prentice-Hall.

_____, & Mattison, A. (1988). Stages in the development of gay relationships (pp. 161–168). In J. DeCecco (ed.), *Gay relationships.* New York: Harrington Park.

Miller, J.A., Jacobsen, R.B., & Bigner, J.J. (1981). The child's home environment for lesbian v. heterosexual mothers: A neglected area of research. *Journal of Homosexuality 7:* 49–56.

Morin, S.F. (1977). Heterosexual bias in psychological research on lesbianism and male homosexuality. *American Psychologist 19:* 629–637.

NASW. (1984). *Code of ethics.* Washington DC: National Association of Social Workers.

Patterson, C.J. (1994). Children of the lesbian baby boom: Behavioral adjustment, self-concepts, and sex role identity (pp. 156–175). In B. Greene & G.M. Herek (eds.), *Lesbian and gay psychology: Theory, research, and clinical applications.* Thousand Oaks CA: Sage Publications.

Peplau, L.A. (1991). Lesbian and gay relationships (177–196). In J.C. Gonsiorek & J.D. Weinrich (eds.), *Homosexuality: Research implications for public policy.* Newbury Park CA: Sage Publications.

_____, & Amaro, H. (1982). Understanding lesbian relationships (pp. 233–248). In W. Paul, J.D. Weinrich, J.C. Gonsiorek, & M.E. Hotvedt (eds.), *Homosexuality: Social, psychological, and biological issues.* Beverly Hills CA: Sage Publications.

_____, & Cochran, S.D. (1990). A relational perspective on homosexuality (321–349). In D.P. McWhirter, S.A. Sanders, & J.M. Reinisch (eds.), *Homosexuality / heterosexuality: Concepts of sexual orientation.* New York: Oxford University Press.

Pope, M. (1995). The "salad bowl" is big enough for us all: An argument for the inclusion of lesbians and gay men in any definition of multiculturalism. *Journal of Counseling and Development 73:* 301–304.

Riveria, R.R. (1987). Legal issues in gay and lesbian parenting (pp. 199–227). In F.W. Bozett (ed.), *Gay and lesbian parents.* New York: Praeger Publishers.

Roth, S. (1989). Psychotherapy with lesbian couples: Individual issues, female socialization, and the social context (pp. 286–307). In M. McGoldrick, C.M. Anderson, & F. Walsh (eds.), *Women in families: A framework for family therapy.* New York: W.W. Norton.

Satir, V. (1987). The therapist's story. *Journal of Psychotherapy and the Family 3*(1). In M. Baldwin & V. Satir (eds.), *The use of self in therapy.* New York: Haworth Press.

Sharrat, S., & Bern, L. (1985). Lesbian couples and families: A co-therapeutic approach to counseling (pp. 91–99). In L.B. Rosewater & L. Walker (eds.), *Handbook of feminist therapy: Women's issues in psychotherapy.* New York: Springer Publishing Co.

Slater, S., & Mencher, J. (1991). The lesbian family life cycle: A contextual approach. *American Journal of Orthopsychiatry 61:* 372–382.

Swarthout, D., Gonsiorek, J.C., Simpson, M., & Henry, K. (1989). A behavioral approach to HIV prevention among seronegative or untested gay/bisexual men with a history of unsafe behavior (p. 784). *Proceedings of the Fifth International Conference on AIDS,* Montreal, Canada.

Zacks, E., Green, R.-J., & Marrow, J. (1988). Comparing lesbian and heterosexual couples on the Circumplex Model: An initial investigation. *Family Process 27:* 471–484.

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