Family Counseling and Referral with Gay, Lesbian, Bisexual, and Transgendered Clients: Ethical Considerations

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Couple, marriage, and family counselors face unique ethical and practice challenges in their dual commitment to the positive growth and integrity of both the individual and the family system. These challenges may become acute when working with stigmatized and oppressed populations such as gay, lesbian, bisexual, and transgendered persons and their families. A brief case vignette illustrates a range of ethical issues for couple and family counselors working with this client population.

The ethical code of the International Association of Marriage and Family Counselors (IAMFC, 2001) is intended to supplement the ethical code and standards of practice of the American Counseling Association (ACA, 1997) and to help IAMFC members to "protect and advocate for the healthy growth and development of the family as a whole, even as they conscientiously recognize the integrity and diversity of each family and family member's unique needs, situations, [and] status" (IAMFC, 2001, preamble).

This special charge, to serve both the individual and the family, often places the family counselor in complex and challenging situations. This may prove particularly true when the question is asked, What are the ethical responsibilities of IAMFC family counselors who are counseling with gay, lesbian, bisexual, and transgendered[1] (GLBT) clients and couples and their families or considering referral issues for this population? Beyond considerations directly related to family issues, divergent needs and values, therapist bias, homophobia, heterosexism, race, ethnicity, gender, cultural oppression of sexual minorities, and the clash of religious and secular values further complicate the clinical picture. To help clarify these issues, IAMFC members are charged to use the IAMFC (2001) ethical code and the ethical code of the ACA (1997) as decision-making aids:

> Although an ethical code cannot anticipate every possible situation or dilemma, the IAMFC ethical guidelines can aid members in ensuring the welfare and dignity of the couples and families they have contact with, as well as assisting in the implementation of the Hippocratic mandate for healers: Do no harm. (IAMFC, 2001, preamble)

MARC'S DISCLOSURE: A COLLEAGUE'S DILEMMA

Paul, a colleague of yours, calls to consult with you about "Marc," a new client who is nearly 15 years old and has become increasingly withdrawn over the previous year and a half. Marc's father is deeply concerned about his son and has taken him to see Paul, who is employed as a counselor at the Christian Family Counseling Center recommended by his pastor. Your relationship with Paul dates back to a master's program in community and agency mental health counseling you both completed. Paul took an independent study in family systems during his program and subsequently attended several weekend trainings in family therapy. Paul tells you that he has seen Marc individually and with his family.

After three sessions, Paul diagnoses Marc with clinical depression (Marc denies any suicidal ideation) and a possible substance abuse problem related to Marc's marijuana usage. It is during the sixth meeting, an individual session, that Marc feels comfortable enough and trusts his counselor sufficiently to reveal his same-sex feelings of attraction and express his belief that he is gay. "I think I've always known it," Marc says. Marc does not want his parents to know about his marijuana use or his sexuality. Your colleague is concerned about his next session with the family and wonders what course of action he should take. He is uncomfortable dealing with GLBT issues and is considering referring Marc for individual therapy.

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PAUL'S ETHICAL CONFLICTS

Paul has shared with you that during the first family session, he informed Marc and the other members of Marc's family that his primary client was the family as a whole (IAMFC, 2001, Section I.J). Paul believes that Marc's sexuality issues and drug use should be treated within the family system and within a Christian context. However, he is also aware that he may be obligated to hold Marc's disclosures in confidence (IAMFC, 2001, Section II.A.2). Although he believes homosexuality is a sin, Paul is also aware that he should not impose his personal values on Marc (IAMFC, 2001, Section I.F) and that he must be careful that his interactions with Marc do not reflect any form of discrimination because of Marc's sexual orientation (IAMFC, 2001, Section I.G). Paul shares with you that his motivation for choosing to work where he does is based on a desire to help his clients achieve their full potential and help them develop "a philosophy on the meaning, purpose, and direction of life" (IAMFC, 2001, Section I.E). For Paul, this suggests a positive approach to life and living that is based on Christian teachings.

How would you help Paul clarify the issues and decide on an ethically appropriate course of action?

A number of questions arise in this scenario.

Does Paul have an adequate level of clinical competence to practice couple and family counseling? This question may seem almost too obvious, but many master's-level counseling programs focus on individual and group counseling. They provide little in the way of specialized clinical training and supervision in couple and family therapy, leaving graduates unprepared to deal with the ethical complexities and practice challenges of family therapy (Beamish, Navin, & Davidson, 1994). This leaves practitioners such as Paul with the responsibility of seeking adequate postgraduate training and supervised experience before practicing as a couple and family therapist (Scrivner, 1997).

Paul's independent study and his attendance at several weekend workshops may be insufficient preparation for working with families, but you would need to know more about Paul's experiences before advising him. Questions to ask Paul might include, What level of past and present supervision by a qualified family counselor does Paul have? What level of peer review does he have access to? Can Paul state confidently that other couple and family counselors would believe he was qualified to practice? A master's degree in counseling is not necessarily sufficient to qualify Paul to work with families (IAMFC, 2001, Sections III.A and III.C).

Does Paul have the requisite skills, knowledge, and experience to work with GLBT populations? The literature does not identify special therapeutic techniques unique to GLBT persons and their families (Scrivner, 1997). However, a prerequisite to family counseling with GLBT populations is clinical competence in individual therapy with GLBT clients, adequate supervised experience, and thorough knowledge of the sociocultural, clinical, legal, and ethical issues that pertain to sexual minorities (Brown, 1996; Davison, 1991; Dworkin, 1992; Gonsiorek, 1994; Murphy, 1991; Rigby & Sophie, 1990). Although the most recent training standards of the Council for Accreditation of Counseling and Related Educational Programs (2001) mention sexual orientation 13 times, adequate training in this area has been and remains an issue in many counseling and psychology training programs (Bahr, Brish, & Croteau, 2000; Buhrke & Douce, 1991; Fassinger, 1991).

It is important to note that Paul has primarily focused on Marc's sexuality. He has not told you much about Marc's family, his life at school, or how Marc's depression relates to his sexual identity. Marc's presenting problems could be the result of predictable developmental challenges all adolescents face and may not be at all related to his sexual orientation. Many clinicians, like Paul, tend to view homosexuality as the root problem of sexual minority clients, regardless of the presenting problem or the client's opinion (Davison, 2001). This provides a strong example of why Paul has an ethical obligation to develop an awareness of his own biases and values and their potential impact on Marc and his family (IAMFC, 2001, Section III.G), as well as an appreciation for the ways in which the biases and values of the majority culture might affect the family (IAMFC, 2001, Section I.F).

If Marc's issues did revolve around his sexual orientation, questions you may wish to ask Paul might relate to his familiarity with existing models of adolescent personality development that pertain to GLBT youth (Cass, 1979; Troiden, 1989); the types of risks, benefits, expectations, and stressors Marc and his family might face in the coming-out process (Savin-Williams, 1994); and what significant issues Marc might need to be informed about, such as positive role models, internalized homophobia and heterosexism, and HIV and AIDS (Slater, 1988). Family issues might involve Marc's parents' "coming-out" process as the parents of a gay son, altered expectations, and potential feelings of loss, grief, and personal responsibility (Davison, 2001).

At a minimum, Paul needs to be aware that some GLBT teenagers come out to friends, family, and classmates in junior high or high school and report few problems, whereas other GLBT adolescents may feel compelled to conceal their sexual orientation, creating a forced isolation (Martin, 1982), a negative impact on development, and a pattern of denial and deception that may lead to isolation and what may be the worst type of loneliness an adolescent can suffer (Tartagni, 1978). Psychological inhibition in general has also been associated with negative somatic consequences (Pennebaker, 1990), as well as a higher risk of behavioral consequences for GLBT youth, such as harassment, difficulties at school, substance abuse, depression, anxiety, running away, and

increased risk for prostitution and suicide (Gonsiorek, 1988; McCann, 2001; Savin-Williams, 1994). As a counterbalance to the increased mental health risks associated with Marc's being a member of a stigmatized minority, Marc may also experience protective factors found in relationships with GLBT peers, with mentors, and within the GLBT community at large that may mitigate these increased risks (Rothblum, 1994). Is Paul aware of how to help Marc access these resources? Does he know how to help Marc's parents and family access GLBT-affirming resources that could be helpful to them (e.g., Gay, Lesbian, Straight Education Network, 2002; Parents, Families and Friends of Lesbians and Gays, 2002)?

The issue of Paul's competency might still be an issue, even if he had been trained in a certified marriage and family therapy (MFT) master's program. Training and supervision in GLBT issues are not typical of most MFT programs (Scrivner, 1997). Prior to the late 1980s, GLBT issues were virtually invisible in the family therapy literature, with only a single article appearing (Krestan & Bepko, 1980). Even the designation of associations, programs, and courses as "marriage and family" implies an exclusively heterosexual model of partnership and family, whether intentional or not.

Couple and family counseling with GLBT persons and their families may involve complex situations with individuals as well as couples; children from partnerships, present marriages, and previous marriages; spouses and partners and former spouses and partners; multigenerational family members; "family members of choice" not related by blood or marriage; and others (Scrivner, 1997). To work effectively with Marc and his family, Paul needs extensive training and supervision in couple and family counseling, a solid grounding in GLBT issues, and the ability to facilitate interventions that are psychoeducational as well as therapeutic in nature (IAMFC, 2001, Section III.G; L'Abate, 1992).

Is Marc sufficiently competent to explore and make decisions about his sexual identity without involving his parents? Isn't Paul's primary client the whole family, as stated in the IAMFC (2001, Section I.J) ethical code? As Paul is well aware, respect for a client's autonomy is a foundational ethical principle (Kitchener, 1984) and is clearly delineated in the IAMFC (2001) ethical code: "Members respect the autonomy and independent decision-making abilities of their clients" (Section I.C). However, this same section also says, "When working with families with children, counselors respect the parent's autonomy in child-rearing decisions" (Section I.C). Paul is correct that the IAMFC ethical code states that Marc's family as a whole is his primary client (Section I.J), a position he feels is in perfect harmony with his stance as a Christian counselor. However, the code also makes it clear that he cannot divulge information obtained during an individual session (Section II.A.3) except in very specific instances, which do not apply to Marc (Section II.C.1-7).

If Paul reviewed the literature, he would find that absent any special circumstances, most adolescents are considered able to participate in the decision-making processes involved in therapy (Gustafson & McNamara, 1995) and are fully capable of sexual identity exploration (Sobocinski, 1990). Whenever an adolescent is held to be competent, the therapist is obligated to honor his or her autonomy and confidentiality (Swann & Herbert, 1999), which would indicate that Paul is obligated to honor Marc's wishes to keep his confidentiality.

In the future, if Paul has strong feelings about these particular issues, he would do well to anticipate a potential confidentiality conflict and obtain informed consent from all family members about more precise boundaries of confidentiality and disclosure at the very beginning of therapy (IAMFC, 2001, Sections II.D.3 and II.D.4).

Has Paul taken steps to ensure that Marc's confidentiality is fully protected? Agencies may open files on an individual client, then include the family, or vice versa. Insurance considerations often play a role in determining what name goes on the file; access rights to the file may depend on whose file it is. Key questions for Paul might include, How should the paperwork be handled? Do Marc's parents have access to his records? His insurance company? Is Marc aware of the circumstances? Has Paul taken adequate care to safeguard the confidentiality of Marc's records from noncounseling staff and others in the agency (IAMFC, 2001, Section II.E.10-14)?

Is it reasonable to expect Paul to possess competence in GLBT issues? GLBT persons make up an "invisible minority" that may comprise as much as 15% of the population in the United States (Fassinger, 1991). The original estimates of the Kinsey Report in the 10% range (Kinsey, Pomeroy, & Martin, 1948) have been contested on methodological grounds by some researchers (Court & Whitehead, 1996), but whatever the exact percentage, it is highly likely that Marc and his family are far from an isolated example: Paul should expect to encounter a range of GLBT clients and their families in his practice. Because he is ethically forbidden to discriminate against clients on the basis of their sexual orientations (IAMFC, 2001, Section I.G), it is not unreasonable to expect Paul to be adequately prepared and trained to work with GLBT clients.

Does Paul face potential legal or ethical problems if he chooses to refer Marc—or if he continues to counsel with Marc? Paul may well make the case that he lacks the training and experience to counsel with GLBT persons and their families, based on his present qualifications and his consultation with you, and refer (IAMFC, 2001, Section III.A.D). This may place Paul in the difficult situation of stating that he has accepted a counseling responsibility he was not capable of undertaking. Given the number of sessions he has facilitated and his stated discomfort with GLBT issues (not just discomfort relating to his level of skill and training), Paul may be at

risk for possible censure for abandoning his clients (ACA, 1997, Section A.11.a), for having entered into a counseling relationship inappropriately (ACA, 1997, Section A.11.b), and perhaps for discriminating as well (IAMFC, 2001, Section I.G). When Marc's parents ask why Paul is referring them, what will he tell them?

Is it possible that Paul could encounter legal problems if he continues to counsel with Marc in an affirmative manner? As you might share with Paul, couple and family counselors must be aware of legal issues in addition to ethical considerations when counseling with GLBT populations (Leonard, Curry, & Clifford, 1994; Purcell & Hicks, 1996; Rubenstein, 1996). Some states have adopted the ACA (1997) ethical code and standards of practice into law, and the code expressly forbids any form of discrimination on the basis of sexual orientation. For example, Paul could face sanction or suspension of his license for refusing to counsel with a lesbian couple because he objects to their lifestyle. At the other end of the spectrum, according to the National Gay & Lesbian Task Force (NGLTF, 2001a), there are 18 states that still have laws prohibiting sodomy (both same-sex and opposite-sex) and a number of legislatures that are debating bills that specifically target GLBT individuals, couples, and families and seek to further marginalize the status of GLBT persons and their families. Technically, Paul's license could be endangered for working affirmatively with the same lesbian couple—as ethical practice requires.

Paul is ethically obligated to honor and affirm diversity and avoid forcing his clients into any preconceived notion of what a "normal" family should be (IAMFC, 2001, Section I.B). However, he may not receive a great deal of support at the legislative level. At present, there are only 12 states and the District of Columbia that specifically prohibit discrimination on the basis of sexual orientation (NGLTF, 2001b). What happens if the state where Paul—or you—is licensed adopts the ACA (1997) ethical code as law and also has a statute that forbids same-sex relations? Yet another question involves Paul more personally: The IAMFC (2001) ethical code mandates that Paul "openly disclose information in sessions" (Section I.D). Should this also include Paul's sexual orientation? These can be thorny issues for couple and family counselors, challenges that require adequate training, supervision, and consultation.

If Paul does decide to refer Marc, ethical referral requires some kind of verification that the referral therapist is properly qualified to work with GLBT persons and families. Counselors, even counselors who openly share their GLBT sexual orientation, may lack the adequate training and supervised experience and may be subject to the same cultural biases, internalized homophobia, and prejudicial beliefs about individuals and families as any other counselor.

Would referring after one session be ethically appropriate? Is it ethical for Paul to refer Marc because he is uncomfortable working with GLBT clients or disapproves of homosexuality? What are Paul's rights as a person and as a professional? A large part of the problem with referring clients is that they seldom come to the first session, or even the sixth, presenting with clean, clear-cut problems (Davison, 2001). They often begin by talking about what Carl Rogers (1957) so aptly described as the "thing next to the thing," because of a lack of awareness or because they are waiting until a sufficient level of trust has been achieved to permit discussion of embarrassing or painful issues.

As a Christian counselor who declines to work with actively homosexual persons, or attempts to impose his own values on clients, Paul may find himself in a very difficult position legally and ethically. Dr. Mel Witmer (personal communication, November 2001), a professor emeritus from Ohio University who taught ethics for many years, provides a concise description of Paul's dilemma:

> If a GLBT client wants to work on issues that are not primarily related to sexual orientation, I see no ethical, religious, or moral basis for refusing to provide services. Just because I disapprove of the behavior, choosing which "sin" I will work with seems indefensible from most any religious point of view (assuming competency to deal with the goals of the client). If a client has as a goal to go public on sexual orientation and learn to cope with the issues around that lifestyle, or to explore sexual identity, is the counselor who believes it is a serious sin and violation of the laws of God required by professional code to work with the client? What rights does the counselor have? Does the professional code supercede the personal-religious rights of the counselor? If our Code of Ethics does not allow for this and the state licensure law adopts our code or parallels it, then the counselor is in the position of violating state law as well as the professional code of ethics and being reprimanded or suspended.

Aspirational Ethics

Beyond Paul's adherence to any mandatory level of ethical action that is required by the IAMFC and ACA ethical codes, there is also a question of aspirational ethics: striving for the highest ideals of practice. Within this context, you might wish to ask Paul how he believes Marc will react to a referral. Would he interpret Paul's actions as a statement by his counselor that reinforces the bias and prejudice of the dominant culture? Sexual orientation aside, Marc is a depressed adolescent who may be self-medicating with marijuana and who has chosen to share his inner self with a professional counselor he has come to trust. There are few more damaging experiences than having the expectation of help, acceptance, and affirmation and then having it withdrawn. If sexual orientation is a key issue for Marc, that may put an even greater obligation on Paul. This is because it is likely that Marc, like most GLBT adolescents, would be virtually invisible to the people teenagers often turn to for help and guidance: educators and counselors within the school system. These helping professionals, as

well as mental health professionals outside the school system, are frequently unaware of and insensitive to the needs of GLBT youth (Kourany, 1987).

Paul faces some very difficult ethical decisions that his professional codes of ethics can help him to resolve, which he can then incorporate into his life and practice. If he does aspire to the highest practice standard, perhaps one of the best questions you can have Paul ask of himself comes directly from the first section of the IAMFC (2001) ethical code: Do you believe that for Marc and his family, your actions will "promote safety, security, and place-of-belonging in family, community, and society" (Section I.A)?

Part 2 of this series will present additional ethical challenges for IAMFC counselors working with GLBT clients and their families. These challenges will center on the multiple complexities of sexual orientation and the influences of gender, race, ethnicity, custody and assessment issues, conversion therapies, and coming out later in life on the family system.

NOTE

1. The term *gay, lesbian, bisexual, and transgendered* (*GLBT*) is used interchangeably with the term *sexual minorities* in this article. Transgendered persons are included as members of this population; however, a discussion of their unique needs and circumstances is beyond the scope of the present article, which focuses on gay, lesbian, and bisexual persons and their families.

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