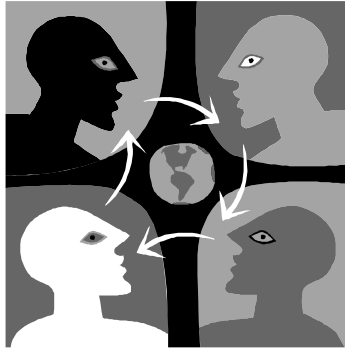


**Sexual identity therapy:  
Practice framework for managing sexual identity conflicts**



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## ABSTRACT

Sexual identity conflicts are among the most difficult faced by individuals in our society and raise important clinical, ethical and conceptual problems for mental health professionals. We present a framework and recommendations for practice with clients who experience these conflicts and desire therapeutic support for resolution. These recommendations provide conceptual and empirical support for clinical interventions leading to sexual identity outcomes that respect client personal values, religious beliefs and sexual attractions. Four stages of sexual identity therapy are presented incorporating assessment, advanced informed consent, psychotherapy and sexual identity synthesis. The guidelines presented support the resolution of identity conflicts in ways that preserve client autonomy and professional commitments to diversity.

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Sexual Identity Therapy:  
Practice framework for managing sexual identity conflicts

Although some gay, lesbian and bisexual (GLB) individuals experience little, if any, conflicts with their sexual identity, others feel distress involving dissonance between sexual feelings and other important personal values and attitudes (e.g., religious beliefs/values) (Beckstead & Morrow, 2004; Haldeman, 2004; Yarhouse & Tan, 2004). People experiencing such conflict often experience a host of problems as the result of being unable to resolve what they perceive to be irreconcilable differences between their values and attitudes and sexual feelings (Schuck & Liddle, 2001; Throckmorton, 2002; Yarhouse, 2005). People who look to mental health practitioners to assist them often find these professionals also in conflict over how best to help.

There has been a recent call for professionals to develop and identify a range of therapy options for clients who experience sexual identity conflicts. For example, Haldeman (2004), in his discussion of these potential conflicts, suggested that “a broader array of treatment models, based on more extensive research, needs to be developed” (p. 714). Similarly, Beckstead and Morrow (2004) concurred that methods should be developed that do not polarize clients or mental health professionals into pro-gay and anti-gay camps.

A variety of conflicts can occur. For instance, Spitzer (2003) found that many of his sexual reorientation research participants wanted to change their sexual feelings to pursue traditional values regarding marriage and family. Many of the participants also desired a more traditional sexuality. Finally, a common source of identity dissonance was conflict between religious beliefs and same-sex attractions.

Haldeman (2004) and Beckstead and Morrow (2004) suggest that psychology should depolarize the debate over conservative religion and same-sex sexual orientation. Clients who are conservative in their religious beliefs may not profit from a psychology profession that marginalizes their beliefs, just as those who hold more gay-integrative religious beliefs will not profit from mental health professionals who marginalize their sexual identity as gay, lesbian or bisexual (Haldeman, 2002; 2004). Data suggest that therapists who do not respect religiously-based identity outcomes are judged as generally

unhelpful by clients (Throckmorton & Welton, 2005), while therapists who suggest conversion therapy to GLB clients<sup>1</sup> who are not conflicted about their attractions are likewise rated as unhelpful (Liddle, 1996).

Some researchers and professionals have expressed reservations about pursuing any therapeutic course with same-sex attracted clients other than a gay-integrative one (Gonsiorek, 2004; Worthington, 2004; Tozer & McClannahan, 1999). Concerns about client harm have led some observers to call for prohibitions on conversion therapies designed to alter a client's sexuality, even if the client desires to pursue this outcome (Gonsiorek, 2004). Some clients have reported negative results from a variety of activities done in the name of reorientation therapy (Shidlo & Schroeder, 2004). However, others have reported benefits from efforts to integrate sexual identity and religious value conflicts in favor of their religious identity (e.g., Spitzer, 2003; Throckmorton & Welton, 2005).

**What is needed are ways to assist clients and therapists as they navigate these difficult conflicts.**

What is needed are ways to assist clients and therapists as they navigate these difficult conflicts. Therefore, we suggest guidelines for those therapists who provide sexual identity therapy, counseling and consultation to clients who are experiencing sexual orientation distress due to issues of personal values. We believe these recommendations address the concerns of researchers and psychotherapists from a variety of perspectives.

Prior to outlining the recommendations, let us define what they are not. They are not sexual reorientation therapy protocols in disguise. Although some investigators (e.g., Spitzer, 2003) have attempted to examine sexual orientation change, numerous criticisms have been leveled at client self-report as a means of assessing such change. Currently, no other means of sexual orientation assessment has found wide acceptance. A consensus about accurate assessment and measurement of sexual orientation would be required in order to empirically test therapies purporting to produce sexual orientation change. At present, such consensus does not exist (Kinnish, Strassberg & Turner, 2005).

Current assessment methods do allow us to ask clients about their perceptions of sexual identity during psychotherapy. Furthermore, we have tools that assess overall

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<sup>1</sup> GLB refers to gay, lesbian and bisexual

client well-being, mental health and satisfaction with how therapy is conducted. To varying degrees, some clients may come to believe change has occurred in their sexuality while some will believe little or no change has occurred. These perceived changes can be examined but we do not view such change as a determinant for the success or failure of sexual identity therapy. Instead, client satisfaction and overall mental health improvement are more efficiently assessed. In any case, we believe guidelines are needed for therapy with clients who experience sexual identity conflict no matter what their beliefs are about sexual orientation and whether it can be altered.

### **Respecting religious and sexual orientation diversity**

Relevant to these guidelines, professional bodies have made various statements valuing both sexual expression diversity and religious diversity. For instance, the American Psychological Association issued guidelines for psychotherapy with GLB clients (APA, 2000). The first two guidelines state:

1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.
2. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.

However, clients holding conservative religious values and attitudes may experience conflict surrounding the implementation of these guidelines. Regarding religious diversity, a division of the American Counseling Association has adopted competencies for counselors with respect to religious values in counseling. In part, the competencies state:

- Competency 7: The professional counselor can assess the relevance of the religious and/or spiritual domains in the client's therapeutic issues.
- Competency 8: The professional counselor is sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client.
- Competency 9: The professional counselor uses a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as

befits the client's expressed preference (Association for Spiritual, Ethical, Religious & Values Issues in Counseling, nd).

Thus, both sexual orientation and personal values and attitudes (in this case, religious/spiritual beliefs) are recognized by mental health professional bodies as important domains of personal experience (see also Pargament & Mahoney, 2005). Further, these domains are to be respected and integrated into therapy as appropriate. However, the principles proposed by these professional associations do not address situations where sexual feelings and personal values and attitudes collide. The sexual identity therapy guidelines help address issues that arise when clients believe their sexual orientation and values and attitudes are in conflict.

**The guidelines do not stigmatize same-sex eroticism or traditional values and attitudes.**

Sexuality and moral values and attitudes are important aspects of personality. However, clients value each of these functions in different ways. We believe that the therapist should not attempt to persuade clients about how to value these dimensions but can assist clients to determine their own valuations.

The guidelines do not stigmatize same-sex eroticism or traditional values and attitudes. The emergence of a gay identity for persons struggling with value conflicts is a possibility envisioned by the recommendations. In addition, the recommendations recognize, as do many gay and lesbian commentators, that some people who have erotic attraction to the same-sex experience excruciating conflict that cannot be resolved through the development of a GLB identity (Haldeman, 2002). Thus, for instance, some religious individuals will determine that their religious identity is the preferred organizing principle for them, even if it means choosing to live with sexual feelings they do not value. Conversely, some religious individuals will determine that their religious beliefs may become modified to allow integration of same-sex eroticism within their valued identity. We seek to provide therapy recommendations that respect these options.

The framework of these recommendations can aid practitioners in helping people arrive at a healthy and personally acceptable resolution of sexual identity and value conflicts. Although consistent with professional guidelines regarding psychological services to GLB and religious clients, these recommendations provide specific guidance

for work with clients who experience same-sex attraction but do not regard themselves as homosexual. Writing about conversion therapy, Haldeman (2002) provides a fitting description of the role of mental health professionals when dealing with areas of value conflict. He notes, “Psychology’s role is to inform the profession and the public, not to legislate against individuals’ rights to self-determination” (p. 263).

Client self-determination is especially important when clients experience value conflicts involving sexuality and religious belief. Psychology cannot provide empirical support for choosing one set of religious beliefs over another. Thus, according to Haldeman (2002),

We must respect the choices of all who seek to live life in accordance with their own identities; and if there are those who seek to resolve the conflict between sexual orientation and spirituality with conversion therapy, they must not be discouraged. It is their choice, in consultation with their therapists and/or pastoral care providers, to develop goals in treatment as they see fit, without undue interference from the practitioner. These goals may amount to attempting to change sexual orientation outright, aspiring to celibacy, or managing homoerotic impulses and feelings in the context of a heterosexual marriage (previously referred to as *sexual identity management*) (p. 263).

Although, as we have noted, these recommendations are not treatment protocols for reorientation therapy, they can provide guidance for practitioners who work with clients who adopt a variety of objectives that address sexual and religious identity conflict.

In short, the recommendations do not presume outcomes for same-sex attracted clients who experience religious conflict. The recommendations support client exploration that may lead to

varying degrees of change in one or more of the foundational aspects of personal identity. The recommendations seek to minimize social pressure from any direction thus allowing clients to set a therapeutic course consistent with their own values and beliefs. We believe therapeutic support can provide an invaluable component in finding resolution to conflicts surrounding sexual feelings and religious belief.

**“Psychology’s role is to inform the profession and the public, not to legislate against individuals’ rights to self-determination”  
- Douglas Haldeman,**

## **Practice guidelines for sexual identity therapy**

### **Treatment objective**

The purpose of these recommendations is to develop professional consensus around appropriate mental health responses to those individuals seeking assistance due to sexual identity conflict. The general objective of interventions in this area should be the synthesis of a sexual identity that promotes personal well-being and integration with other aspects of personal identity (cultural, ethnic, relational, spiritual, worldview, etc.). Therapists should also assess for any mental health issues and problems that might impact the successful resolution of a valued sexual identity. Issues outside of the competence of the therapist require appropriate referral.

### **Clinical picture**

Clinical concern and intervention is warranted when stress or issues concerning sexual orientation become a central conflict in a person's daily experience or interferes with personal identity formation. The Diagnostic and Statistical Manual of the American Psychiatric Association (1994) describes a situation akin to the clinical picture we are outlining. Sexual Disorder Not Otherwise Specified (302.9) includes this description: "Persistent and marked distress about sexual orientation," as does V62.89, which addresses identity and religious conflicts. By noting that psychological services may be useful in such situations, no stigma is directed at either same-sex eroticism or a conservative worldview.

This distress can occur from early adolescence through later adulthood and appears to have many origins. Such distress can stem from experiencing sexual attractions that are confusing or unwanted, feeling erotically attracted to those of the same-sex but emotionally drawn to the opposite sex, feeling emotionally attracted to the same-sex but sexually attracted to the opposite sex, or experiencing conflict between religious beliefs, traditional values or attitudes and sexual feelings, behavior or identity.

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**Theoretical issues surrounding the description of sexual orientation**

Two broad perspectives, essentialism and social constructionism, have been advanced to understand and describe sexual orientation. Essentialism is probably the more prominent view in popular opinion and the biological sciences (Laumann, Gagnon, Michael, & Michaels, 1994; Broido, 2002). In this view, the categories of sexual orientation (e.g., homosexual, bisexual, heterosexual) describe an inner essence or core of a person. For instance, one's sexual orientation is spoken of in the same terms as one's race, gender or handedness. One's sexual orientation is an expression of who one is as a distinct element of personality. In this perspective, sexual orientation is an attribute that defines something different about those in one category as opposed to those who are in a different category.

Social constructionism on the other hand, recognizes that sexual categories such as homosexual and heterosexual have not always existed throughout history. Furthermore, homoeroticism, in particular, is expressed in a variety of ways with different meanings across cultures. This view proposes that individuals construct a view of themselves in the context of the categories available to them in a culture. People tend to think about themselves as heterosexual, homosexual or bisexual because these categories exist and have social roles and expectations associated with them. Essentialist thinking may cause people to discount category discrepant attractions, behaviors and fantasies as being incompatible with the category. A constructionist paradigm predicts the potential of multiple sexual identity trajectories consistent with individual variations in culture, socialization, gender and biology.

While an awareness of these paradigms has relevance for these guidelines, we take no position on the primary causes or factors associated with how or why sexual attractions take the direction they do for all people. The research on this topic is still developing and can only provide a basis for tentative hypotheses regarding causation. However, whatever the causes of sexual attractions might be, these recommendations assume the capability of people to reflect on their experiences of sexuality to the end that they can integrate these experiences into a sexual identity that is consistent with their overall worldview and value system.

### **Epidemiological issues**

Like many issues surrounding sexual orientation, prevalence of various sexual practices and orientations has become a topic of popular and professional interest. However, determining prevalence for sexual orientations has proven to be a difficult task. The task of assessing such information has been driven by political, epidemiological and public health concerns (Laumann, et al, 1994). Our purpose is to provide information to inform discussions with clients about sexual identity.

Establishing a figure for the prevalence of homosexual orientation is complicated by several factors including the reluctance of some people to disclose same-sex attractions and the difficulty in measuring sexual orientation. The fact that negative attitudes exist toward homosexuality may impact the willingness of some survey respondents to report feelings of same-sex attraction. While those who report a gay identity may not be as reluctant, disclosure of same-sex attractions by those who are not gay identified may be underreported.

The difficulties in measurement of sexual orientation are well-documented (Gonsiorek, et al; 1995; Laumann, et al, 1994). They include the lack of a direct physical measurement tool, the reliance on self-report and the inability of researchers to come to consensus about what elements of sexuality form the construct of sexual orientation. Kinnish, et al (2005) noted that “the central components or dimensions of sexual orientation are likewise an unresolved matter” (p. 180). In other words, should sexual orientation be defined by attractions only; by behavior, fantasies and identification; or by some combination of these factors?

Taking into consideration the measurement and theoretical issues raised above, the prevalence of the various sexual orientations is difficult to state. According to Laumann, et al (1994), about 2.4 percent of men and 1.3 percent of women define themselves as homosexual, have same-gender partners and experience same-sex sexual desires. These findings represent people who experience consistency across identity, desire and behavioral expressions of sexuality. However, there are higher percentages of people that experience some expression of same-sex interest. For instance, 3.8 percent of women and 7.1 percent of men reported a homosexual experience since puberty. According to Laumann, et al (1994), 42 percent of men who reported homosexual

behavior said it had occurred before they turned 18 but never afterward. Thirteen percent of the women and 22 percent of the men report at least one same-gender partner since turning 18 but no homosexual desire or identity at the time of the survey. Thus, the stability of aspects of sexual orientation could be confusing for some people. For clients who are questioning their sexual identity, this information can provide a context for their reflection and choices regarding sexual identity integration.

### **Sexual orientation versus sexual identity**

Both terms are used in this paper. We take sexual orientation to describe the pattern of sexual and emotional attractions experienced by a person. We are aware that even within the category of sexual orientation, some current research and theory suggests that erotic arousal and romantic attachments are distinct but related processes (Diamond, 2003). We take sexual identity to refer to a personal identification with socio-cultural categories of gay, straight, bisexual, etc. Biologically-minded researchers often view sexual orientation in an essentialist manner, viewing this construct as descriptive of who one really is, sexually speaking. Such essentialist theorists then view sexual identity as how people portray themselves to the world (Stein, 2001).

For the purpose of these guidelines, we propose that the measurement difficulties surrounding sexual orientation as a construct make it difficult (and in some clinical situations, unnecessary) to assess sexual orientation with clinical certainty. Since self-report is the primary means of assessment, issues of identity are invariably involved. Even if a means were developed to physically determine current sexual orientation, the question of orientation change still would not be settled. Complicating the labeling issue for some clients is the fact that at times romantic attachments, behavioral inclinations and erotic arousal are not concordant (Diamond, 2003; Garnets, 2002). Thus, in sexual identity therapy, the focus is on sexual identity as a construct that incorporates the person's assessment of sexual orientation, emotional preferences and inclinations to engage in sexual activities.

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Having de-emphasized categorical assessment of sexual orientation as a requirement for sexual identity therapy, we are simultaneously aware that, for some clients, exploration of how fluid their sexuality could be is of prime therapeutic interest. In such cases, we believe there can be therapeutic value to clients to engage in assessment of their sexual orientation, both in terms of how they understand sexual orientation and its meaning to them, but also with measures of attraction, both emotional and sexual. In this regard, Klein has developed a broad assessment perspective, examining both same and other-sex attractions and attachments (Klein, 1993). Such assessment may assist clients toward more complete self-awareness which we believe helps facilitate a valued integration of sexuality and values.

### **Overview of clinical considerations**

#### **Working with adolescents**

Adolescents should be dealt with conservatively because sexual identity confusion and change can be more prevalent during the teen years than during adulthood when individuals begin to synthesize their identity (Savin-Williams, 2005). Adolescents should be followed, provided psychotherapeutic support, educated about identity options, and encouraged to attend to other aspects of their social, intellectual, vocational and interpersonal development. Because an adolescent shift in self-reported sexual and religious identities can occur primarily to please family, peers or other adult role models, changes may not persist or reflect a permanency in sexual identity. Clinical follow-up is encouraged.

Parents may bring in teens who are unable to provide legal consent. The role of the therapist here is to take a consultative role. Therapists can point parents and younger teens to research showing that uncertainty and/or confusion concerning sexual identity is not uncommon and that there should be no rush to declare a sexual identity at a young age (Remafedi, 1992; McConaghy, 1993; Savin-Williams, 2005). Clinicians should communicate that an appropriate parental stance is to provide consultation and support for their child and to refrain from shaming children for openly expressing their distress to parents and the therapist. In cases where parents and children are at odds due to sexuality conflicts, clinicians should seek to reduce family conflict and preserve a safe place for both parents and children to work out their relationship.

### **Phases of sexual identity therapy**

There are at least four phases of intervention with someone who is struggling with sexual identity concerns: assessment, advanced informed consent, psychotherapy and social integration to an emerging sexual identity synthesis.

#### **Phase one: Assessment**

As a basic therapeutic stance, we accept the self-report of an individual. We also recognize that individuals may vary in the degree to which they feel duress related to socio-cultural expectations regarding normative sexual identity synthesis. Many people experience pressure from friends, family and religious institutions to curtail same-sex attractions and behaviors. Others may experience pressure to abandon conservative values and beliefs in favor of support for a gay identity. These are important considerations in assessment since mental health

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professionals can assist clients by inviting an open discussion of the various motivations that may lead a person to seek professional services. It is important for therapists to be empathic with respect to the client's worldview. Thus, assessment of motivation for seeking sexual identity therapy comes early in the first meeting. Why is this person seeking professional services? What are they asking for in terms of their sexual identity and personal value conflicts? Open-ended questions may give the clinician access to this information. For instance: What is it about your experiences of same-sex attraction that bring you in to see a clinician? Many experiences may lead to a person seeking such services, and it should not surprise the clinician to hear about many different motivations for services. Some may reflect internal motivations (e.g., a person's informed values and beliefs about same-sex behavior or identity) while others may reflect external motivations (e.g., an ultimatum delivered by one's spouse or church).

Often clients will disclose conflict between traditional values and aspects of sexual orientation. Beckstead and Morrow (2004) describe a model of clients needing to find congruence between religious beliefs and sexual feelings. Some clients may perceive

religious affiliation as being the most stable aspect of their identity (Johnson, 1995; Koenig, 1993). Sexual feelings that are in conflict with religious ideals can produce a sense of difference and distress. An assessment of the consequences of same-sex attractions and a potential gay identity to aspects of ethnic, cultural and occupational identity as well as to familial attachments is vital. Therapists should be open to the possibility that embracing same-sex identity may place other vital aspects of identity at risk.

Still other clients demonstrate more of an extrinsic religiosity that may not represent self-aware and chosen values. Clinicians should assist clients to clarify their values in order to determine their preferred course of action. Therapists should be open to the possibility that a same-sex identity is the least dissonant course. There are many possible factors that may contribute to distress and we emphasize that assessment must be individualized.

### **Phase two: Advanced informed consent**

The content of this phase is quite dependent on what the assessment process reveals about the client's past explorations and attempts to resolve sexual identity conflict. Clients often enter therapy confused about the course of action they wish to pursue having engaged in no prior efforts to explore information and experiences to help resolve their situation. Some clients may be leaning toward a certain course and still others may have already determined the identity direction they would like to pursue. Therapists must assess this dimension of the client's experience and provide appropriate responses. In all cases, therapists must provide the client with accurate information to support a client's consent for further intervention.

Informed consent has become a critical aspect of providing mental health services. Growing out of a consumer-model of service delivery and increased valuing of client autonomy and self-determination, informed consent has emerged as a critical part of establishing treatment goals in therapy (Corey, Corey, & Callahan, 1998; Keith-Spiegel & Koocher, 2000). Therapists should consider a written consent form outlining the issues raised in this section.

Because of the controversies surrounding sexual identity concerns, it is important to take the time to cover relevant topics before clients consent to therapy. This has been

referred to as advanced informed consent to therapy (Yarhouse, 1998). Advanced informed consent is foundational and, at the least, should cover the following:

1. Same-sex eroticism per se is not considered a mental illness by any of the major mental health organizations. This should be communicated by the mental health professional to the client.
2. Questions about what is causing their distress (including etiology of same-sex attraction, rationale for identity conflict and the subjective experience of distress) are frequently asked by clients. Psychologists working with sexual identity clients must stay up-to-date with the relevant research literature. However, we also find that it can be helpful to ask clients how one version of sexual attraction etiology or another would alter, if in any manner, their direction. Such an exercise can assist in clarification of beliefs and values.
3. Professional interventions available include an active focus on same-sex identity, efforts to modify erotic orientation and/or a more integrative approach. Clients should be informed that there are no well-designed, controlled outcome studies of reorientation therapies, gay affirmative therapies or sexual identity therapy. Some research on attempts to change erotic orientation documents participant self-report of modest mental health benefits (e.g., Spitzer, 2003), while other research documents participant self-report of harm (e.g., Shidlo & Schroeder, 2002). Some research finds both outcomes (e.g., Beckstead & Morrow, 2004). As we noted above, research on sexual orientation change per se is hampered by many methodological problems.
4. For some clients, alternatives to therapy may be suggested, including religious-based interventions. Clients need to be made aware that there are few studies on ministry-based approaches (See Erzen, 2006; Wolkomir, 2006). Research showing harm and benefit has tended to collapse all interventions, professional and ministry-based, into one category, thus obscuring what might be helpful and what might be harmful about each approach (Miville & Ferguson, 2004).

It is beyond the scope of this article to fully delineate all information or questions that might be discussed during this phase. In addition to what we have discussed above, clinicians should consult current resources providing a wide range of perspectives and research regarding biological factors and sexual orientation (Bailey, Dunne & Martin, 2000; Bem, 1996, 2000; Byne et al, 2001; Jones & Kwee, 2005; Jones & Yarhouse, 2000; Mustanski, et al, 2005; Rice, Anderson, Risch & Ebers, 1999; Stein, 2001; Wilson & Rahman, 2005), environmental factors and sexual orientation (Bem, 2000; Balsam, Rothblum & Beauchaine, 2005; Dube, 2000; Frisch & Hviid, 2006; Kalichman, Gore-Felton, Benotsch, Cage & Rompa, 2004; Stanley, Bartholomew & Oram, 2005), outcomes of interventions designed to modify sexuality (Beckstead & Morrow, 2004; Nicolosi, Byrd & Potts, 2000; Schidlo & Schroeder, 2002; Spitzer, 2003; Throckmorton, 1998, 2002; Throckmorton & Welton, 2005), various approaches to sexual identity synthesis (Haldeman, 2004; Nicolosi, 1991; Yarhouse & Brooke, 2005; Yarhouse & Burkett, 2003; Yarhouse & Tan, 2004), ethical concerns relating to sexual identity interventions (Gonsiorek, 2004; Miville & Ferguson, 2004; Yarhouse & Throckmorton, 2002), the definition and measurement of sexual orientation (Broido, 2000; Diamond, 2003; Garnets, 2002; Kinnish, Strassberg & Turner, 2005; Klein, 1993; Laumann, Gagnon, Michael & Michaels, 1994; Stein, 2001) and religious and value issues in sexual identity synthesis (Lease, Horne, & Noffsinger-Frazier, 2005; Schaeffer, Hyde, Kroencke, McCormick & Nottebaum, 2000; Schaeffer, Nottebaum, Smith, Dech & Krawczyk, 1999; Schuck & Liddle, 2001; Yarhouse & Burkett, 2002; Yarhouse, Burkett, & Kreeft, 2001).

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What is most important during informed consent is to help clients make a truly informed decision about the kinds of goals they might have for services and the kinds of services that are available. This process and client response should be thoroughly documented. Clinicians may find that this takes more than one or even two sessions to process with some clients. Informed consent is also an ongoing process depending on



how a person is progressing. If clients do not feel they are making much headway, then treatment goals can be re-examined to determine whether they are the best fit for the client's present objectives.

### **Phase three: Psychotherapy**

The informed consent procedures that are listed above have, in various combinations, helped people to find a greater sense of congruence. In the authors' experience, some clients are satisfied with therapy once they work through their questions and concerns via the informed consent phase. Clients may begin to identify ways to live that are consistent with their beliefs and values. For other clients, a specific course may evolve and lead to a specific psychotherapeutic objectives. Therapists should always be prepared to revert to an earlier phase as needed.

Frequently, clients do not choose a direction immediately after the therapist provides detailed information about options. Supportive psychotherapy is indicated while clients are mulling over their options and concerns.

### **Referral**

The need for referral can arise for reasons involving therapeutic capability and value conflicts. Therapists who rarely conduct sexual identity therapy may find their knowledge and skill base challenged by the needs of some clients.

Therapists who find themselves disappointed by a client's choices or who even attempt to dissuade a client from pursuing a particular integrative course should secure consultation and consider referral. Moreover, if a therapist's value position or professional identity (e.g., gay affirming, conservative Christian) is in conflict with the client's preferred direction, the referral to a more suitable mental professional may be indicated (Haldeman, 2004). Therapists considering referral must take care to consider the therapeutic alliance and any institutional difficulties which might occur due to the referral. Referral may generate charges of discrimination and trigger legal or clinical liability exposure in certain cases (Hermann & Herlihy, 2006). When referral seems clinically appropriate, legal counsel and consultation with one's liability insurer should be considered.

Once a client chooses a specific values-based position, matching clients and therapists according to worldview may assist the development of a therapeutic relationship (Fischer, Jome & Atkinson, 1998). Ahn, Kim and Ng (2005) found that “having a shared worldview among clients and counselors, at least in terms of agreeing on the cause of the problem, is important in establishing a good working relationship and helping clients feel understood by the counselors” (p. 11). Thus, where appropriate, referral may enhance the potential for a successful therapeutic alliance.

### **The therapeutic relationship**

The establishment of a reliable trusting relationship with the client is the first step toward successful work as a mental health professional. This is usually accomplished by competent nonjudgmental exploration of the sexual identity issue with the client during the first two phases. Ideally, the clinician's work is with the whole of the person's complexity, not merely a narrow definition of sexual identity. The goal of therapy is to help the person explore and eventually live more comfortably within a sexual identity that is consistent with personal values and beliefs. Even when this goal is attained, mental health professionals should inform the client that psychotherapy may not quickly or permanently eliminate all aspects of sexual identity conflict.

### **Modalities of psychotherapy**

These guidelines do not constitute a new school of psychotherapy but rather a framework for initiating services with clients who experience sexual identity conflict. Many existing schools and techniques of psychotherapy can be applied to specific situations. Therapists who practice within a specific therapeutic model may need to modify some aspects of their frequent practice with sexual identity clients. For instance, since so little is known about the etiology of sexual attractions, therapists who begin by explaining the hypothetic “roots” or causes of same-sex attractions will need to modify such practice to adhere to this framework. Therapeutic techniques should be derived and applied based on an individualized assessment of client need

In addition to individual psychotherapy, clients may benefit from a sexual identity therapy group. This is often offered in a different format (e.g., a 90-minute session) with others who are also sorting out sexual identity concerns. Benefits of group therapy include the opportunity to hear from others who have similar experiences, a safe place to

practice social skills and receive feedback from others on one's interpersonal style, a supportive community that can also provide accountability, and so on (Yarhouse & Brooke, 2005).

The therapist should make it clear that it is the client's right to choose among many options. The client can experiment over time with alternative approaches. Psychotherapy is a collaborative effort. Therapists must be certain that clients understand the concepts of eligibility and readiness because therapists must cooperate in defining clients' problems and in assessing progress in dealing with them.

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Therapists should maintain professional boundaries in the therapeutic relationship. Therapists should follow ethical guidelines of their profession in conducting sexual identity therapy. Some approaches to sexual reorientation may blend appropriate therapeutic boundaries and are discouraged (e.g., Cohen, 2000). For instance, therapists should not engage in dual relationships with clients or provide physical touch or nurturance to clients. Therapists may supervise or oversee the client's involvement in physical contact with others of the client's choosing (friend, family member) during sessions only if the client has given consent. Clients should not be expected to become physically close to other clients in a group therapy situation. Therapists should not refer clients to retreats, support groups or interventions requiring boundary violations as a condition of participation.

#### **Phase four: Sexual identity synthesis**

For many clients the first three phases will be sufficient to enable a choice concerning sexual identity synthesis. Some clients will not continue in psychotherapy but choose to live out this choice with no or intermittent therapeutic support. However, others will continue in therapy to pursue synthesis. Since synthesizing a sexual identity could mean profound personal and social consequences, the decision to do so should be preceded by an awareness of what the familial, vocational, interpersonal, educational,

emotional, economic and/or legal consequences are likely to be. As noted above, professionals have a responsibility to discuss these predictable consequences.

During this phase, clients often explore practical elements of a synthesized sexual identity. This could involve expanding social networks to those supportive of the desired sexual identity. Some clients may decide to limit contact with social networks and settings specific to the undesired sexual identity. Sexual behavior is often avoided until there is a significant level of comfort with and desire for this activity. This is a topic for the client and the therapist to discuss but for the client to decide. In general, social settings that support one's sexual identity integration may fit well within the objectives desired by the client. Therapeutic interventions from a variety of theoretical orientations can be employed to assist clients accept private events (feelings, thoughts, desires), develop self-awareness and pursue valued behavior while avoiding unvalued behavior. Some therapists identify with a particular school of therapy (e.g., cognitive-behavioral or interpersonal) and will implement techniques consistent with that perspective. Other more eclectic therapists may employ a range of interventions to collaboratively address client needs.

Some clients experiment with a sexual identity outcome and decide that this direction is not in their best interest. Such experiences can be of great value. They can assist both the client and the mental health professional in their judgments about how to proceed. Therapists should always be prepared to return to prior phases of therapy as needed.

Therapists have a special responsibility to continually assess the client's desires and direction. Furthermore, therapists must monitor the impact sexual identity interventions have on the client's mental and emotional status and be prepared to provide basic clinical services or referrals when needed. Advanced informed consent principles are active throughout the therapeutic process.

**Conclusion**

Dilemmas regarding sexual identity are among the most difficult and highly polarized faced by individuals in our society. They can potentially lead to depression, anxiety and loss of vitality and happiness, and these conflicts frequently require sensitive professional support from mental health professionals. The present guidelines focus on recommendations that support the resolution of identity conflicts in ways that preserve client autonomy and professional commitments to diversity. A framework is suggested to promote client exploration and synthesis of a valued sexual and personal identity.

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