White Paper on Sexual Orientation Change Efforts

Texas Counseling Association

&

Texas Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling

Authors

(In alphabetical order)

Faith G. Harper, PhD, LPC-S (TALGBTIC President)

Beck Munsey, PhD, LPC-S, NCC (TALGBTIC Senator)

Jacqueline Parsons, PhD, LPC (TALGBTIC President-Elect),

Lisa Pearson, MA, MRE, LPC-S (TALGBTIC Director)

Adrian Warren, PhD, LPC-S (TALGBTIC President Emeriti)

Reviewers

(In alphabetical order)

Joseph E. Green, Chase G. Jones, Esq., Larry Parsons, MA, Aaron Sapp, M.D., and Edwin Tamayo, M.D.

Citation Information:

Texas Association of Lesbian, Gay, Bisexual and Transgender Issues in Counseling (2014). *White paper on sexual orientation change efforts*. Austin, TX: Author.

Abstract

In this white paper the leadership of the Texas Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (TALGBTIC) outline the position of TALGBTIC and the Texas Counseling Association (TCA) on sexual orientation change efforts (SOCE). An analysis of the available literature indicated that SOCE are at best ineffective and at worst remarkably harmful to clients. It is the position of TCA and TALGBTIC that SOCE are unethical practices. Additionally, the authors review the history of SOCE and current best practices for helping clients deal with internalized inconsistencies between their sexual orientation and spiritual identities.

Keywords: SOCE, sexual orientation change efforts, reparative therapy, conversion therapy, homosexuality, sexual orientation, lesbian, gay, bisexual, sexual minorities, religion, spirituality

White Paper on Sexual Orientation Change Efforts

In June of 2014, the President of the Texas Counseling Association (TCA) tasked the leadership of the Texas Association of Lesbian, Gay, Bisexual, & Transgender Issues in Counseling (TALGBTIC) to write a white paper that both explicates the history of sexual orientation change efforts (SOCE) and the more appropriate treatment strategies (grounded in evidence-based practice) for individuals seeking therapy specific to their sexual identity concerns. This final product is a reflection of the most recent thought and literature on the subject.

There have been many character traits throughout history which have been considered detrimental, undesirable, or outright evil. Homosexuality is not the only trait, even in modern times, which falls within these categories. In fact, until the late 1970s left-handedness was also considered deviant. Researchers have shown that while most people are right-handed, some are truly left-handed, some are mixed-handed, and some are ambidextrous. Researchers trying to figure out the causality of handedness have found that heredity accounts for about a quarter of the individuals who are left-handed (McManus, 2003). Besides genetics, other factors that seem to correlate with left-handedness include prenatal hormone exposure, prenatal vestibular asymmetry, and prenatal ultrasound usage.(Wang, 2011).

The current cultural norm regarding handedness is that it is simply one of the myriad of unique traits we may or may not be born with. There is no rightness or wrongness associated with handedness, it just exists. However, this was not always the case. For centuries, left-handed individuals have been considered at best a curiosity and at worst an affront to God (Harris, 1990). The left side (and therefore left-handedness) was considered evil and unlucky in many cultures throughout history. The Sanskrit word for “left” is the same as the word “wicked.”

Many other languages have dual meaning words, or root words, that associate left handedness with that which is bad or wrong. The word “right” on the other hand, has always been associated with what is true, and good, and correct. The right hand of God is the favored side. Within the Muslim culture (and within some other cultural groups) the right hand is used for clean and sanitary purposes, implying that the left hand is dirty. In some countries, children are still forced into right-handedness (mainland China) and in others this practice was only recently discontinued (Taiwan).

While these past beliefs and practices do not speak to our current understanding and experience of handedness, there are still many struggles that left-handed individuals face, even for individuals who do not live in countries where they are forced to use their right hand. There are multiple psychiatric and developmental disorders that have higher prevalence among left-handed people. For example, ADHD, dyslexia, and thought disorders are all much more likely to occur among the left-handed (Wang, 2011).

This may be because, in reality, we live in a right-handed world. The way the spaces we live and work are set up and the equipment we use in them are also designed for right-handed people. While there is no appreciable difference in intelligence among righties and lefties, there appears to be a slower learning curve for lefties, as they have to learn to navigate a world not designed for them (Wang, 2011).

While scientists have started paying particular attention to what causes individuals to be born left-handed instead of right (Wang, 2011), the answer is currently unknown. They have ideas, but just do not know why some people are born different. *If you change handedness to sexual orientation and gender identity, we can see the problem in relationship to SOCE.*

The human predisposition to categorize others and proceed to rank them based on these categories is a fundamental aspect of how our brains work. As we learn more about the human experience, we find that it is time to discount some of these categories as irrelevant. However, some of these belief systems continue to be part of our common dialogue and daily experience solely because we believed them to be true for so long that they have become culturally embedded. Sometimes people cannot turn off their filters that help to determine what they consider right and wrong when newer information does not mesh with past learning experiences.

With this paper, TALGBTIC was given the opportunity to review and summarize both the history of SOCE as well as the current understanding of the possible impact of SOCE on the mental health and well-being of individuals. While many people have some awareness of SOCE, in the summer of 2014 it became a politically charged issue in the state of Texas, thus requiring a formal response on the part of Texas licensed mental health clinicians.

It is important within the framework of this paper to define the term *sexual orientation change efforts* as used in the above paragraph. Many other terms have been used to describe the methodologies employed to change the sexual orientation of individuals who do not identify as heteronormative. The term *reparative therapy*, often used within mainstream media, is associated with the specific psychoanalytic SOCE techniques utilized by Elizabeth Moberly and Joseph Nicolosi (1991). Other terms associated with SOCE include *conversion therapy* and *reorientation therapy* and refer to the myriad of techniques employed by clinicians attempting to facilitate sexual orientation change with their clients.

The terms *reparative therapy*, *conversion therapy*, and *reorientation therapy* are problematic. Cultural anthropologist Franz Boas made a fascinating discovery when studying American Indian languages in 1911. He noted a bi-directional flow between thought and

language. That is, how we think informs how we speak and how we speak *changes* how we think. It is our contention that using the above terms implies that the techniques utilized by therapists attempting to guide a client through sexual orientation change are, in fact, therapeutic. Researchers have demonstrated that these techniques are not only ineffective, but known to cause significant harm. Therefore, if we use the term therapy in conjunction with SOCE, even in disagreement, we are identifying it within the same category as the evidence-based practices therapists employ to promote healing, recovery, and wellness.

SOCE in Texas

Early in the summer of 2014, two newspapers in the state of Texas received the newest draft of the Texas GOP's political platform. The 2014 Texas Republican Party Temporary Platform Committee Report (which can be read in its entirety here) states:

> Homosexuality must not be presented as an acceptable alternative lifestyle, in public policy, nor should family be redefined to include homosexual couples. We believe there should be no granting of special legal entitlements or creation of special status for homosexual behavior, regardless of state of origin. (p. 13)

The language is interesting. They explicitly state homosexuality is not acceptable *regardless of the state of origin.* Therefore they are making room for the idea that homosexuality has a genetic component, but it is still an unacceptable behavior or lifestyle. The question, then, becomes how do we be not-gay?

The platform then endorses sexual orientation change efforts (SOCE) as a means of correcting this aforementioned *alternative lifestyle:*

> We recognize the legitimacy and value of counseling which offers reparative therapy and treatment to patients who are seeking escape from the homosexual lifestyle. No laws or executive orders shall be imposed to limit or restrict access to this type of therapy. (p. 13)

This statement may be a direct response to political leadership within the State of California, which recently banned reparative therapy. When signing the bill into law, California Governor Jerry Brown termed sexual orientation change efforts as "quackery" (Levs, 2012, para. 1). A federal appeals court upheld the law in August of 2013 (Elias, 2013). New Jersey followed suit, (another decision recently upheld in federal court; Stemple, 2014) with Republican Governor Chris Christie stating he was signing the bill based on the research he had been presented, noting that "efforts to change sexual orientation can pose critical health risks, including, but not limited to, depression, substance abuse, social withdrawal, decreased self-esteem and suicidal thoughts" (Cavaliere, 2013, para. 4).

As of the writing of this paper, opponents of SOCE in Washington D. C. are working to have the practice outlawed within the district itself; Council Member Mary Cheh stated, "Many children who have participated in conversion therapy suffer from increased risk for suicide, depression, anxiety, shame and self-hatred….by adopting this legislation, we will send a strong message that the District does not believe our LGBT children are sick" (Davis, 2014, para. 6).

While the promotion of SOCE is part of the Texas GOP platform, we are aware that this is in no way a politically partisan issue; therefore, our response is not intended to be politically polarizing. Fiscal conservative strategies do not equate with social conservatism, and even social conservatism does not equate with automatic approval of SOCE. Within the state of Texas, two Republican groups (the Log Cabin Republicans and the Metroplex Republicans; Wolfson, 2014) have been vocal advocates for gay marriage and opponents of SOCE. Throughout the country,

individuals fighting to discredit SOCE have been decidedly bipartisan, as noted by the above statements cited from both Jerry Brown and Chris Christie.

Additionally, Rick Perry (current Texas governor as of the writing of this paper, therefore de facto public face of the Texas GOP platform) has not come out in obvious support of SOCE. Perry recently went on record comparing homosexuality to alcoholism, stating per Wolfson (2014) “I may have the genetic coding that I’m inclined to be an alcoholic, but I have the desire not to do that, and I look at the homosexual issue the same way.” However, when pressed to further elaborate on this statement at a fundraising event, Perry stated “I don’t know. The fact is, we’ll leave that to the psychologists and doctors to decide” (Wolfson, 2014).

Other national professional organizations (consisting of the aforementioned psychologists and doctors, as well as other therapeutic professionals) have already released reviews of SOCE research along with position statements indicating that sexual orientation change efforts are not appropriate therapeutic goals. However, as clinical practioners who live and work within the state of Texas, we add our voice formally to the discussion.

The Texas Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (TALGBTIC), a division of the Texas Counseling Association (TCA) is comprised of expert treatment providers. Division members are licensed professional counselors with graduate degrees (along with students pursuing a graduate degree and licensure in the same field). The individuals who wrote this statement are licensed clinicians, licensed board supervisors, and professors in counseling departments throughout the state of Texas. Additional support for our work here was provided by both physicians and attorneys also within the state of Texas, in order to further ensure the validity of our research and statements.

Do No Harm: The Case Against Sexual Orientation Change Efforts

As with any important debate, knowing the history of a movement often defines its future. The development of SOCE within the relatively young history of therapeutic practice is an important one. The media popularization of SOCE 75 years ago mirrored many of the ongoing debates we are currently experiencing in the state of Texas. Understanding the context for the emergence of SOCE as a formal intervention is an important part of our response to the current debate.

A History of Sexual Orientation Change Efforts

Contrary to popular belief, early therapeutic professionals did not herald sexual orientation change efforts as a promising treatment for individuals who identified as homosexual. Freud, the father of psychoanalysis, felt that the best he could do was help cultivate any heterosexual interest possibly present within an individual, rather than extinguish homosexual desire (Lewes, 1988). In 1935, Freud was asked to treat a young man whose mother had great concerns regarding his sexuality. Freud's (1935) response was thus:

> I gather from your letter that your son is a homosexual...it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development. By asking me if I can help [your son], you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies, which are present in every homosexual; in the majority of cases it is no more possible. It is a question of the quality and the age of the individual. The result of treatment cannot be predicted. (p. 423)

Not until later were SOCE spearheaded by psychoanalysts (including Freud's own daughter, Anna) as an appropriate treatment goal. The most prominent voice in favor of SOCE was Edmund Bergler, beginning with his 1938 publication of "Preliminary Phases of the Masculine Beating Fantasy" in *Psychoanalytic Quarterly*, a response to Freud's "A Child is Beaten" (Lewes, 1988). Throughout the 1940s and 1950s, Bergler operated not only in opposition to the father of the analysis movement to which he subscribed, but to the work of Alfred Kinsey, who ascribed to homosexuality the role of being a normal variant of human sexuality (Terry, 1999).

Bergler, who based much of his theory on his analysis of fictional literature written by individuals identified as homosexual, led a movement promoting SOCE by focusing his writings within popular media targeting the general public (Lewes, 1988). This bears repeating. Edmund Bergler's theory that homosexuality was a treatable, learned behavior came from him reading literature written by authors thought to be gay and analyzing the characters contained therein. This was the basis of his research and his influence was enormous. In 1952, the first edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-I) was published, and homosexuality was classified as a mental disorder.

Between the death of Freud in the late 1930s and the popularization by Bergler, SOCE was considered a common and accepted form of treatment for several decades (Drescher, 1998). Despite the research published by Alfred Kinsey (Terry, 1999) and Evelyn Hooker (1957) the acceptance of SOCE persisted. It was not until the Stonewall Riots of 1969 that the fight against SOCE became a political policy agenda item for many LGBTQ activists (Bayer, 1987).

The Evidence Against Sexual Orientation Change Efforts

Significant research has been done regarding both the efficacy of SOCE and the possibility that it can cause harm to some participants. A total review of this research is beyond the scope of this paper and is already widely available through multiple media resources (many of which are noted in the reference section and/or hyperlinked throughout the text of this paper). However, a brief review of the lack of evidence to support SOCE, along with the continued findings that SOCE efforts have caused significant harm to many participants, does merit review in order to provide context to our discussion. It is important to note that the American Psychological Association's 2009 *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* is the baseline analysis on SOCE, from which the contributors to this paper operate.

Perhaps the Southern Poverty Law Center (2014) summarized the findings best with this statement, issued on their website:

> People who have undergone conversion therapy have reported increased anxiety, depression, and in some cases, suicidal ideation. The devastating consequences of conversion therapy are why the Southern Poverty Law Center is dedicated to ending this practice and defending the rights of individuals harmed by it.

Haldeman (2002) noted a long list of potentially deleterious effects from SOCE, such as struggles with intimacy, loss of sense of masculinity, depression, and sexual dysfunction. Hein and Matthews (2010) found a multitude of negative effects associated with SOCE, including mental health diagnoses such as post-traumatic stress disorder, depression, and anxiety, as well as other characteristics that are at odds with mental wellness, such as avoidance of intimacy, sexual dysfunction, feelings of demasculinization, lack of self-confidence, lack of self-efficacy, shame, guilt, and other self-destructive behavior. Perhaps most telling in their research were the

number of individuals who reported suicidality as a result of their SOCE experiences. Morrow and Beckstead (2004) concurred with the findings of depression and suicidality, *as well as noting higher instances of internalized homophobia within their research participants*.

A study by Shidlo and Schroder (2002) reported that a majority of the 202 subjects they interviewed had experienced overall negative effects from the therapy, including depression, loss of self-esteem, experiencing thoughts of suicide, and suicide attempts. They described erectile dysfunction (as well as other sexual dysfunctions), along with recurring images based on the aversion therapies that were used (these aversion therapies sometimes included electric shocks to the genitals and induced vomiting during homoerotic imagery).

Opponents of SOCE are steadfast in their belief that these therapies constitute child abuse when practiced on minors. Ryan Kendall, a survivor of SOCE states, "Let me be perfectly clear: conversion therapy is junk science that kills children" (Gaffney & Lewis, 2014, para. 4). Young (2006) stated that 60% of violence toward sexual minority children occurs in their own homes. Young described several types of child abuse toward sexual minority youth, including physical abuse, being thrown out of their homes, being denied parental financial support, and being forced into SOCE. Parents who practice some of the more extreme forms of the treatment, such as aversion and emetic "therapies" are increasingly being prosecuted for child abuse (Young, 2006).

Dr. Tim Eustace, an openly gay Democrat in the New Jersey General Assembly who spearheaded the movement that made reparative therapy illegal in New Jersey, agreed. He has described reparative therapy as "an insidious form of child abuse" (Associated Press 2014, para. 2).

As evidenced by clinical accounts, as well as reported suicides, SOCE can be extremely harmful, especially to children. Having a mental health professional label a child's sexual

attraction as wrong and abnormal contributes to problems rather than alleviates them. Ford (2002) cited depressed thoughts and self-destructive urges. Panozza (2013) as well as Jenkins and Johnston (2004) wrote of the dangers of teaching children to hate themselves as well as anyone who is not heteronormative. Teaching children to reject different expressions of sexuality becomes a de facto consequence of the therapy. Bright (2004) also described various types of psychological distress resulting from SOCE; additionally, he pointed out that the practitioners of these techniques frequently misinform and/or lie to clients, which is a different type of harm. In fact, the potential negative repercussions of SOCE are so widely known that mental health professionals have started devising strategies for facilitating the recovery of LGB adolescents who have been harmed by these therapies (Hein and Mathews, 2010). When reviewing the literatures associated with this topic, we noticed that the treatment for trauma associated with SOCE is more recent based on publication dates, but the body of literature is growing.

Since 1974, numerous professional associations for medical and mental health practitioners have published policies discouraging or prohibiting their members from practicing SOCE, because these protocols are not evidence-based and may cause great harm to the client (American Medical Association, 2007; American Academy of Family Physicians, 2007; American Nurses Association, 2001; American Psychiatric Association, 2000; American Psychological Association, 2009; National Association of Social Workers, 2000; Bright, 2004; Hein and Mathews, 2010). One recent example is the Association of Christian Counsellors, which in 2014 banned its members from using SOCE “in the interest of public safety” (Association of Christian Counsellors, 2014, p. 2). One common thread unites each of these policies: SOCE should be discouraged because it damages the health of the client.

One of the most famous examples of this movement away from the use of SOCE comes from Dr. Robert Spitzer, whose famous study, published in 2001 in the Archives of Sexual Behavior, was the basis of the National Association for Research and Therapy of Homosexuality's (NARTH) arguments in favor for reparative therapy (NARTH, 2009). Arana's (2012) article, which included an interview with Spitzer, gave voice to his regret:

> "In retrospect, I have to admit I think the critiques [of my study] are largely correct. The findings can be considered evidence for what those who have undergone ex-gay therapy say about it, but nothing more."
>
> He said he spoke with the editor of the Archives of Sexual Behavior about writing a retraction, but the editor declined. (Repeated attempts to contact the journal went unanswered.)
>
> Spitzer said that he was proud of having been instrumental in removing homosexuality from the list of mental disorders. Now 80 and retired, he was afraid that the 2001 study would tarnish his legacy and perhaps hurt others. He said that failed attempts to rid oneself of homosexual attractions "can be quite harmful." He has, though, no doubts about the 1973 fight over the classification of homosexuality.
>
> "Had there been no Bob Spitzer, homosexuality would still have eventually been removed from the list of psychiatric disorders," he said. "But it wouldn't have happened in 1973."
>
> Spitzer was growing tired and asked how many more questions I had. Nothing, I responded, unless you have something to add. He did. Would I print a retraction of his 2001 study, "So I don't have to worry about it anymore." (para. 38-42)

Spitzer, in a follow-up to that interview, sent the following letter to Dr. Ken Zuker, a letter that was later published on the website TruthWinsOut.com (Becker, 2012). Spitzer wrote:

> Several months ago I told you that because of my revised view of my 2001 study of reparative therapy changing sexual orientation, I was considering writing something that would acknowledge that I now judged the major critiques of the study as largely correct. After discussing my revised view of the study with Gabriel Arana, a reporter for American Prospect, and with Malcolm Ritter, an Associated Press science writer, I decided that I had to make public my current thinking about the study. Here it is.
>
> Basic Research Question. From the beginning it was: "can some version of reparative therapy enable individuals to change their sexual orientation from homosexual to heterosexual?" Realizing that the study design made it impossible to answer this question, I suggested that the study could be viewed as answering the question, "how do individuals undergoing reparative therapy describe changes in sexual orientation?" – a not very interesting question.
>
> The Fatal Flaw in the Study – There was no way to judge the credibility of subject reports of change in sexual orientation. I offered several (unconvincing) reasons why it was reasonable to assume that the subject's reports of change were credible and not self-deception or outright lying. But the simple fact is that there was no way to determine if the subject's accounts of change were valid.
>
> I believe I owe the gay community an apology for my study making unproven claims of the efficacy of reparative therapy. I also apologize to any gay person who wasted time and energy undergoing some form of reparative therapy because they believed that I had

proven that reparative therapy works with some “highly motivated” individuals. (para 2-5)

Spizter’s humble and public retraction is an important one. It removes any remaining gravitas regarding NARTH’s position that SOCE is an evidence-based practice. And it allows us to focus on the more ethical treatment alternatives.

While the Texas Administrative Code (TAC) does not explicate a position on SOCE in any regard (either speaking to it as a potential treatment modality or deeming it dangerous and illegal), it is important to note that most licensed practitioners ascribe to the ethical standards and codes associated with their federal and/or state parent association. Ethical codes are a consistent touchstone within the healing professions.

There is a significant difference between mandatory ethics and aspirational ethics. Mandatory ethics are those which have laws attached with legal ramifications for any lack of adherence. Aspirational ethics are what we associate with best practice of our chosen profession. There may not be a legal basis for the aspirational ethical practice, but there is often a moral one. Our job, ultimately, is to care for the wellness of the clients we serve. Laws provide a basic framework for *not doing harm*. Ethical standards fill in the gaps that laws do not cover, encouraging us to go beyond the basics. Ethical guidelines are what help us do *good.* The following information serves to unpack our ethical standards as licensed practitioners in order to align them with the need to value our clients’ belief systems and personal wellness journeys.

Ethical Standards of Care

Mental health organizations have continued to promote the wellbeing of all individuals, including sexual and gender minorities. Taking homosexuality out of the Diagnostic Statistical Manual (DSM) in 1973 is indicative of the shift in thinking about homosexuality brought on by

the LGBTQ political movement that started with the Stonewall riots of 1969. The message was clear: homosexuality should not be seen by the therapeutic community as a mental health disorder. The DSM (currently in its 5th revision) is a tool of communication between clinical practitioners; therefore, it is used across mental health disciplines. When licensed mental health practitioners diagnose a client they are treating, they typically do so from the DSM.

Within the state of Texas, many community mental health centers are moving toward using the World Health Organization's (WHO) medical classification system known as the International Statistical Classification of Diseases and Related Health Problems. Currently in its 10th revision, the tool commonly referred to as the ICD-10 has gone a step further than the DSM by not just removing homosexuality as a diagnosis, but including the statement that "sexual orientation by itself is not to be regarded as a disorder" (WHO, 2008).

Additionally, multiple professional organizations dedicated to the ethical practice of mental health treatment, physical health treatment, and/or the healthy educational development of youth have either released a formal statement of opposition to SOCE practices, or have endorsed publications warning of the possible dangerous consequences of SOCE. These associations include:

- American Academy of Pediatrics
- American Academy of Physician Assistants
- American Association for Marriage and Family Therapy
- American Counseling Association
- American Medical Association
- American Psychiatric Association
- American Psychological Association

- American School Counselor Association
- American School Health Association
- Interfaith Alliance
- National Association of Social Workers
- National Association of School Psychologists
- National Association of Secondary School Principals
- National Education Association
- School Social Work Association of America

The American Psychological Association has been one of the most vocal advocates on promoting the dissemination of accurate information regarding the harmfulness of SOCE, including their "Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts" (APA, 2009) and the multi-coalition publication they spearheaded entitled "Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel" (also available in Spanish; Just The Facts Coalition, 2008).

The American Psychiatric Association concurs. The organization originally responsible for adding homosexuality as a classifiable mental health disorder in the first DSM manual has since become one of the strongest advocates for safe, affirming, and integrative therapy for LGBTQ individuals. The American Psychiatric Association (2014) posted this statement on their website in celebration of LGBT Pride Month:

> There is no published scientific evidence supporting the efficacy of "reparative therapy" as a treatment to change one's sexual orientation, nor is it included in the APA's Task Force Report, Treatments of Psychiatric Disorders. More importantly, altering sexual orientation is not an appropriate goal of psychiatric treatment. Some may seek conversion

> to heterosexuality because of the difficulties that they encounter as a member of a stigmatized group. Clinical experience indicates that those who have integrated their sexual orientation into a positive sense of self-function at a healthier psychological level than those who have not. “Gay affirmative psychotherapy” may be helpful in the coming out process, fostering a positive psychological development and overcoming the effects of stigmatization. A position statement adopted by the Board in December 1998 includes the following:
>
> *The American Psychiatric Association opposes any psychiatric treatment, such as “reparative” or “conversion” therapy, which is based upon the assumption that homosexuality per se is a mental disorder, or based upon a prior assumption that the patient should change his/ her homosexual orientation* [italics in original article]. (para 10-11)

However, despite the fact that homosexuality has not been a classifiable diagnosis for over 40 years and is continuously rejected by various professional mental health organizations, some politicians, churches, and mental health professionals continue to promote SOCE, conduct research regarding SOCE, and provide it as a form of therapy services.

With this position paper, the Texas Counseling Association (TCA) adds its voice to the many mental health organizations weighing in against the practice of any counselor or school counselor in Texas providing SOCE to clients or students. Counselors within TCA ascribe to the ethical codes of the parent organization, the American Counseling Association (ACA). Ethical practice is informed by these codes, updated in March of 2014. One of the core professional values of the counseling profession is that of “honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social

and cultural contexts" (ACA, 2014, p. 3). Sexual orientation change efforts are not in keeping with these values, nor are they congruent with many of the other ethical obligations.

Professional Responsibility

Counselors are required to conduct treatment from a specific theoretical orientation: "When providing services, counselors use techniques/procedures/modalities that are grounded in therapy and/or have an empirical or scientific foundation" (ACA, 2014, p.10). While SOCE practitioners may use some aspects of evidenced-based theoretical orientations (behavioral and cognitive techniques), the overall treatment plan is not recognized as an appropriate treatment option for counselors. According to Miville and Ferguson (2004), SOCE is simply too wide-ranging in scope, with too many treatment plans being offered and no standardized treatment.

Avoidance of harm. One of the fundamental principles of ethical behavior is to "do no harm" to our clients. The American Counseling Association (2014) goes beyond that in discussing harmful practices: "Counselors do not use techniques/procedures/modalities when substantial evidence suggests harm, *even if such services are requested*". [Italics added.] We have seen that SOCE potentially induce psychological harm (depression, suicide, anxiety, etc.) and may reinforce negative views on homosexuality. SOCE efforts may even reinforce self-hatred over past experiences or past/current feelings. (APA, 2010, p.v.; Anderson & Handelsman, 2010; Cramer, Golom, LoPresto, & Kirkley, 2008). Based on those ethics, a division of ACA, the Association of Lesbian, Gay, Bisexual, Transgender Issues in Counseling (ALGBTIC) stated in their competencies for working with Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Ally individuals (LGBQQIA; ALGBTIC has published separate competencies for working with transgendered individuals, and those competencies can be found here):

> Understand that attempts to "alter," "repair," "convert," or "change" the affectional orientations or gender identities/expressions of LGBQQ individuals are detrimental or may even be life-threating, are repudiated by empirical and qualitative findings, and must not be undertaken. When individuals inquire about previous noted techniques, counselors should advise them of the potential harm related to these interventions and focus on helping individuals to achieve a healthy, congruent affectional orientation or gender identity/expression. Counseling approaches that are affirmative of these identities and realities are supported by empirical findings, best practices, and professional organizations such as ACA and APA. ALGBTIC, 2014, p.5)

Note that the statement above even warns counselors against referring clients to conversion therapy programs. It is important to help clients through affirmative counseling treatment instead of conversion therapy.

Discrimination or multicultural issues. Considering American culture vis-à-vis acceptance of gender and sexual minorities, we see that there are still many individuals who continue to support discrimination against this population. There are still protests against same-sex marriage, antidiscrimination laws, etc. Sexual orientation change therapists believe that homosexuality is pathological and needs to be cured; they do not embrace it in any way. But according to ACA code of ethics:

> …counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital/ partnership status, language preference, socioeconomic status, immigration status, or any basis proscribed by law. (ACA, 2014, p.9)

Following the statement above is likely to help clients to feel accepted in the counseling office and able to process their concerns with any counselor in the profession, even if society can be judgmental.

False or deceptive statements. By promoting a treatment that can "cure" homosexuality, SOCE programs and treatment facilities fall into another ethical violation. They fail to notify clients of the lack of empirical evidence for such treatment - an unethical practice by the standards of most mental health organizations in America. "When advertising or otherwise representing their services to the public, counselors identify their credentials in an accurate manner that is not false, misleading, deceptive, or fraudulent" (ACA, 2014, p.9). Not disclosing the risks of SOCE or telling individuals struggling with their sexual orientation or gender identity about programs to "cure" them may constitute a misrepresentation of one's services and/or credentials. In mental health, counselors discussing the therapeutic process talk about "making progress in treatment" or "finding a stable place to move forward," not cures. Ultimately, SOCE efforts go against several ethical principles established by the American Counseling Association. For counselors, it is important to continue to advocate for the wellbeing of clients and help them affirm their identity and expression, whatever that may be.

Given the inefficacy and ethical risks associated with the practice of SOCE, we acknowledge the fundamental challenge in affirming client identity when it may be those competing identities that are causing the distress and driving the individual to seek counseling. There are multiple facets to all human experiences and sometimes these facets do not align or reinforce each other. This can happen when religious and/or spiritual practices are at odds with sexual orientation.

The debate about the "wrongness" of homosexual identity and concomitant homosexual practice is often based in religion. The belief that homosexuality or non-heteronormative sexual contact is immoral and/or harmful based on religious writings or principles has continued to be promoted by some religious groups and mental health professionals (Haldeman, 2002; Yarhouse & Throckmorton, 2002). Despite research and ethical standards to the contrary, there remains a market for SOCE and there are mental health practitioners continuing to provide these services. It would be both unfair and ill-advised not to contextualize the continued promotion of SOCE within the religious context from which it developed.

Religion and Sexual Orientation Change Efforts: A Historical Perspective

We understand that it is likely out of compassion that some Texas counselors wish to offer SOCE. A patient struggling with the cognitive dissonance (Scanzoni & Mollenkott, 1994) resulting from a perceived incompatibility of faith and sexual orientation or gender identity may seek relief from that interior dissonance through mental health services. Counselors will readily empathize with the accompanying shame, guilt, and fear of negative judgment and rejection (both divine and human) and want to help. But, as we have seen, there is evidence that SOCEs are ineffective and even harmful. This means that it may be unethical to practice such interventions. Additionally, several researchers have noted the likely ethical problems with the practice of SOCE from the standpoint of justice and advocacy responsibilities. (Haldeman, 2002)

It is interesting to note that the use of SOCE may also be objectionable on religious grounds, insofar as they reinforce denial or invalidation of an individual's deep relational needs. Daniel Maguire (the Roman Catholic professor of theology and ethics at Marquette University) as quoted in McNeill (1995) once stated:

> The desire for a significant other with whom we are uniquely conjoined is not a heterosexual but a uniquely human desire. The programmatic exclusion of gay persons from the multiple benefits of erotic attraction, which often opens the way to such a union, is arbitrary, harmful, and cruel, and therefore sinful.(p. 86)

Because we must validate all of the relational needs of those we serve, it is important to acknowledge that profound human needs are *also* met by spirituality, religious affiliation, and faith practice. As Yarhouse (2002), a researcher in mental health and an advocate of allowing for SOCEs in certain cases, reasonably asserts, setting an agenda for a counseling patient that affirmed *LGBT identity* at the cost of *faith identity* would be unethical and cruel. Going further, Haldeman (2002, p. 264), an opponent of the use of SOCE in all instances, concluding his 2002 article in *Professional Psychology: Research and Practice* and citing the APA guidelines on the subject, asserts the twin responsibilities of mental health clinicians both to "actively counter the misrepresentations of some conversion therapists who [peddle] prejudicial notions of sexual orientation to fearful and confused potential clients," and to attend to and respect religious identity and its associated choices in those patients. Haldeman remarks in the same article that while "attempting to combat scriptural references to homosexuality with psychological knowledge about the subject is like trying to have a conversation in two different languages [that] does not mean we should turn away from the conversation" (p. 264). Indeed. In this section of our paper, we attempt that conversation.

The majority of Americans identify as Christian, and among these individuals, the majority consider themselves Evangelical Christians (Sweeney, 2005). The Merriam-Webster dictionary online defines Evangelical Christians as a "sect or group… emphasizing salvation by faith in the atoning death of Jesus Christ through personal conversion, the authority of Scripture,

and the importance of preaching as contrasted with ritual" (Merriam-Webster, 2014). While some mainline Christians, Jews, Muslims, and non-Evangelical Christians who identify as sexual or gender minorities may seek to "repair" their orientation or gender, research demonstrates that many of those requesting SOCE from mental health professionals are past or present members of conservative Evangelical Christian communities (Haldeman, 2002; Shidlo, 2002).

The seeking of SOCE by Evangelicals may arise partly from their movement's historical teachings about the authority and appropriate use of scripture. A distressed patient from that tradition may state that he/she/ze feels shame, guilt, and fear of divine judgment and retribution regarding their relational and gender orientation because "the Bible says it's a sin." While it is neither ethical nor appropriate under most circumstances to teach or inculcate religious ideas or practices in professional counseling, holding a basic knowledge of the history, literature, and traditions influencing our patients will likely make our work more effective and compassionate. This will be especially important with those struggling to integrate what they perceive as conflicting components of human fulfillment: the relational and the spiritual.

All traditions within Christianity (and Judaism, from which Christianity derived), revere the Bible as the principal written source for living a life of faith and morality. The Episcopalian (American Anglican) "Articles of Religion," for example, (appearing in The Book of Common Prayer and in the language of the original 1549 prayer book; Society of Archbishop Justus, 2007), affirm that "Holy Scripture containeth all things necessary to salvation: so that whatsoever is not read therein…is not required of any man."

Christian religious understanding of the authority of scripture has evolved over the centuries. Gnuse (1985) has identified patterns of such understanding as falling among four basic types: verbal, social, non-textual, and soteriological (salvation history). Of those types, typical of

the Protestant movement in the Renaissance was the belief in the *verbal inspiration* of biblical texts. This meant that "God [is] the principal author who directs the intellect of the writer infallibly" (Gnuse, 1985, p. 25); and it followed for them that "if God is perfect, and God is revealed in the Bible, the Bible must be perfect" (Gnuse, 1985, p. 25). Furthermore, it seemed to believers in the strict verbal inspiration of the Bible that "since not lying entails total and absolute accuracy, and common sense tells us that accuracy is the same for all people everywhere, then Scripture must be accurate in all its details" Gnuse, 1985, p. 25).

The new emphasis on the primacy of scripture typical for early Protestants was, in effect, a substitute for a newly absent Roman Catholic hierarchy (Gnuse, 1985). Later, especially in the 19th and 20th centuries and in light of archaeological and historical findings, mainstream theologians and biblical scholars would develop other approaches to the question of biblical authority. These included the inspiration of ideas, the inspiration of individuals, social inspiration, salvation history, and existentialism for discerning scriptural authority for the use of biblical texts to live by and to reflect on reality (Gnuse, 1985). Evangelicals, by contrast, tended to keep to a strict or limited verbal inspirational model.

The Evangelical movement began within Protestant churches in Europe and America in the late 18th century, but quickly led to splintering away from the original churches (as well as intragroup splitting), and a departure from many of the structures of tradition and hierarchy in Catholicism, Anglicanism, and Lutheranism. This left a lively mix of passionate and extemporaneous preaching, individual fervor, and the quick development and spreading of new ideas…particularly about forms of church leadership and the use of and interpretation of the scriptures. As noted, however, in the midst of that vigorous growth, American Evangelicals, descendants of 18th –century Great Awakening Protestants, continued to embrace at least to

some degree the “verbal inspirational” ideas of scriptural authority noted above (Sweeney, 2005; Gnuse, 1985).

Evangelicals succeeded very well in attracting membership in the New World, building large communities of the faithful, a growth trend that has continued (Sweeney, 2005). Their initial growth was probably aided by several factors: the early disestablishment of state churches in the US (Sweeney, 2005); Evangelical sects’ relative simplicity and fluidity of governance with no elaborate hierarchical governing structure or requirement for clergy to be trained in traditional seminaries; and the mobility deriving from those conditions. The Evangelical emphasis on a personal, individual relationship with God; the reading and study of scripture by laypersons; and the permitting of spontaneous, associative, and creative interpretation of texts in preaching, also helped increase their appeal and accessibility to large numbers of both Americans and individuals in other countries. In addition, beginning in the twentieth century, Evangelicals’ extremely effective use of mass media has further extended their reach (Sweeney, 2005).

In contrast with Catholics and non-Evangelical Protestants of the nineteenth, twentieth, and twenty-first centuries, conservative Evangelical churches and their theologians have typically allowed themselves relatively little latitude in scholarly criticism of biblical texts, claiming the infallibility and, sometimes, the scientific and historical inerrancy of the Bible (Gnuse, 1985; Sweeney, 2005). These beliefs have at times conferred on Evangelical practitioners a fixed understanding of the meaning and significance of certain texts and of their identity as a “Christian” (Bartoli, & Gillem 2009; Scanzoni & Mollenkott 1994).

This historical lens on the evolution on the Evangelical movement suggests an explanation for the fact that LGBTQ individuals from the Evangelical faith system may believe that their sexual or gender identity is immoral or wrong based on teachings about the texts that

were the basis of their faith formation. Many Evangelical Christian followers believe they must be both heterosexual and gender normative in order to be Christians and part of the religious community with which they wish to remain connected. We can see how this can sometimes lead to confusion and even fear in people within those traditions attempting to come out as LGBTQ. And indeed Bartoli & Gillem (2009), identifies a struggle with the cognitive dissonance that may arise between an individual's sexual or gender minority orientation on one hand, and his/her/hir understanding of God's will (as reflected in certain biblical texts) on the other.

The challenge of such cognitive dissonance in this context was probably first identified by theologians Scanzoni and Mollenkott in their book *Is the Homosexual My Neighbor?* (1994). It is a useful term borrowed from sociologists Festinger, Riecken & Schachter (1957). First published in the seventies, Scanzoni and Mollenkott (1994, p. 53) suggested that "a clash occurs in our minds when two pieces of information are hard to reconcile." We may then, she says, attempt various means of "quieting the inner tension," perhaps by perhaps by seeking or recommending mental health treatment and/or prayer "for deliverance from homosexuality" (p. 54). Bartoli,& Gillem, (2009, p. 204) likewise consider individuals' "conflict between their religious beliefs and sexual orientations" to be the source of the emotional pain driving such individuals to "privilege or deny" *either* their religious or their sexual/gender identity. Persons caught in such emotional pain, often Evangelical Christians, are precisely those most likely to request "repair."

So Bartoli & Gillem (2009), as well as Scanzoni and Mollenkott (1994) would locate a conversion therapy candidate's "presenting problem" in the identity conflict of the individual rather than in his/her/hir orientation, gender, or religious affiliation. Scanzoni and Mollenkott (1994) conclude that the solution is in believers' affirming the Christian mandate (part of the

moral systems of other faiths as well, of course) to “love one’s neighbor as oneself” by declining to engage in the rejection of minorities based on fear, ignorance, prejudice, and uninformed use of religious texts. In their article in that vein, Bartoli & Gillem (2009, p. 205) proposed a model “depolarizing the conflict, decreasing the anxiety and depression associated with it, and aiding clients in feeling more hopeful about exploring solutions that won’t entail a radical compromise of their core well-being.” Scanzoni & Mollenkott (1994) offers compassionate solutions from an explicitly theological and pastoral perspective, while Bartoli & Gillem (2009) suggests concrete steps that a professional counselor might take in assisting a patient to resolve interior cognitive dissonance between received religious ideas and a developing relational identity. Both implicitly reject SOCE.

The clinical community’s helpfulness to religiously conservative LGBTQ clients is not only hampered thus far by advocacy and acceptance of SOCE, there is also the problem of prejudice against and ignorance about religious faiths and their practitioners. Several researchers have noted the antireligious attitudes in both mental health clinician circles and in LGBT communities at large. Cramer, Golom, LoPresto, & Kirkley (2008) are troubled by the apparent conflict between counseling research and religion, and feel it probably has negatively impacted efforts to address the SOCE controversy and to offer effective treatment to all individuals who identify as LGBTQ. Their solution: “Leaders of scientific organizations must begin to address the issue of religious-based [SOCE]. It is possible to incorporate client views of faith into [LGBTQ - Affirmative Therapy] treatment. Achieving this harmony, however, requires individual work by the client *and clinician* as well as conversation and action on a grander scale by APA and religious organizations” (Cramer, Golom, LoPresto, & Kirkley 2008, p. 111;

emphasis added). Of course, this extends to the other professional counseling organizations as well, and could perhaps be considered multicultural counseling.

Note the call for individual effort by both "client and clinician" in the quote above. In connection with that idea, we might circle back to the APA Guidelines on this subject referenced earlier: "[Clinicians and researchers] are encouraged to be familiar with the resources (including but not limited to faith-related literature and groups) from different faith traditions in their communities that are affirming and welcoming of lesbian, gay, and bisexual people" (APA, 2014, p. 21). This echoes one of the *Competencies for Addressing Spiritual and Religious Issues in Counseling*, from the American Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 2009, p. 2):

> (5.) The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer.

This parallels the American Association for Multicultural Counseling and Development (AMCD, 1996, p. 3), who, in their *AMCD Multicultural Counseling Competencies*, call for counselors to "[seek] consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate."

In line with the leaders of ACA and APA, we believe that a knowledge of religious resources (such as local ministries that are affirmative of the LGBTQ community) is integral to competent therapeutic practice. As part of following ethical counseling principles and practice, counselors may wish to acquire an understanding of religious thought and practice in general, perhaps through some of the resources mentioned above.

As we have seen, counselors are ethically required to have a solid working knowledge about the multiple cultural groups to which our clients may belong. Sexual and gender minority persons of a religious conservative background being one such cultural cluster group. Another resource for enhancing one's knowledge of contemporary religious thought about sexual minority religious experience is *queer theology*. This term was coined in the early eighties by Robert Goss in *Jesus Acted Up: A Gay and Lesbian Manifesto* (as cited in Cheng, 2011). By incorporating contemporary perspectives on gender and sexual identity along with other groundbreaking movements in religious thought (such as recent developments in feminist and environmental theology), queer theology offers contemporary analysis regarding religion. It may be another helpful resource for religious members of the sexual and gender minority community and the therapeutic professionals helping them.

By increasing our understanding of religious and cultural values in general, and those of our clients in particular, we believe that therapeutic professionals will be better equipped to offer effective and compassionate care.

Best Practices for Treating Clients Seeking SOCE

If the evidence is overwhelming that SOCE are not only ineffective, but may be harmful to religiously conservative LGBT patients in distress, what are our clinical options? A number of professional and pastoral counselors have taken some first steps in developing ways to be of assistance to religious LGBT persons struggling to integrate their multiple identities. (Beckwith and Morrow; McNeill, 1995.)

Kenneth Burr, for example, is a gay Evangelical Christian minister and marriage and family therapist who in his book *Coming Out, Coming Home* (2009) discusses his personal journey in enhancing his knowledge about scripture and about himself as he successfully

integrated his relational and religious identities. He then suggests a model for helping others to make such a journey, which includes, among other types of interventions, providing assistance in finding a supportive community including allies from other groups such as heterosexuals and gender-traditional persons, and wherein one can be open about one's spirituality and sexual/gender identity, finding caring, acceptance, and belonging (pp. 139-150).

John McNeill is a psychotherapist and former Catholic priest who was defrocked for his homosexuality and affirmative stance on sexual minorities in the Church. In his book *Freedom, Glorious Freedom* (1995), he calls for reform in clinical practice, in the Church, and in our greater culture. He states that his personal experiences have demonstrated that "we gay people were born into an unchangeable gay orientation, we must live out that reality to the best of our ability, [and] we have a desperate need to understand our lives and experience in a positive spiritual context." (McNeill, 1995, 4) Similar to Burr (2009) , McNeill believes that therapy itself become a touchstone of congruence, "a place where we are free without judgment or condemnation to talk about our deepest spiritual life, our longings, our fears, and our needs, and to get those needs authenticated in a deep exchange between our real self and the real self of the other person." (McNeill, 1995, p. 78)

Among the published clinical research, one of the most encompassing works is Bartoli and Gillem's (2009) *Continuing to Depolarize the Debate on Sexual Orientation and Religion: Identity and the Therapeutic Process,* referenced earlier. Drawing on the literatures of the psychology of religion, feminism, and multiculturalism and using illustrative clinical examples, the authors invite clinicians to avoid pushing patients to "solidify one aspect of identity at the expense of another" (p. 206), and instead to allow for the development of an understanding of the psychological functions of the individual's belief systems as well as the interaction or

"intersecting" of all aspects of his/her/hir identity, including ethnicity, gender identity, etc. Additionally, they encourage the clinician to be aware of his/her/hir own potential values conflicts, as well as the possible social justice implications of their work. The authors then offer case studies that illustrate an identity integration that does not seek to "corner" an individual into choosing between spirituality and sexuality.

Another helpful clinical perspective on the integration process is suggested by Borgman (2009) in her qualitative study of the spiritual development of LGBT allies. All of her sample population were heterosexual, gender-traditional (cisgender) psychotherapists or educators who belonged to Evangelical Christian communities and who became active allies of the LGBT communities. Borgman studied how individuals moved a negative view of non-normative sexual and gender identity to a position of alliance and advocacy for change. Factors such as the subjects' ability to examine and revise their understandings of God, Christ, moral teachings, and beliefs about sexual orientation, as well as to "apply a historical –cultural perspective" to Biblical texts, driven by "the need for congruence and integrity in life" (Borgman, 2009, p. 513 were correlated with their development as moral persons and as religious LGBT allies. These factors may be of use when assisting patients with similar relational/religious conflicts.

Appropriate alternatives to SOCE within the clinical literature, which are both effective and ethical, are developing rapidly. The consensus among experts is that a clinical understanding and acceptance by the therapist of these two important aspects of a client's identity are integral to the therapeutic process.

The experiences of aforementioned LGBT clinicians and allies of the LGBTQ community from conservative backgrounds affirm the value of access to general social support as well as theological, pastoral, scriptural, and clinical resources for individuals to achieve such

integration. In order to offer such support, counselors will thus need to avail ourselves of information pertaining to LGBTQ development and models of healthy psychological and relational functioning in a heterosexist society, as well as background information about religious thought, both contemporary and historical.

We have seen that the integration of sexual and religious identities is possible in the context of a safe and effective counseling relationship. We saw that Bartoli and Gillem (2009) made note of two cases in which that was achieved for LGBTQ indentified clients, while Borgman (2009) did the same for allies. Both Burr (2009) and McNeill (1995) then demonstrated how LGBT persons even within the least affirming religious milieu can find their way to a life and an identity in which they both retain their faith and embrace their affectional orientation. It is clear that such integration does not require individuals to renounce their religious beliefs or values. As clinicians who explore those religious values and self-knowledge with our patients, we certainly must notice and acknowledge our own countertransference "rumblings" should they arise, as they are likely to do at times with regard either to sexual orientation/gender identity or religious ideas.

Regardless of the treatment protocols (delineated above) from which we work, there are certain clinical recommendations that we put forth for all therapeutic professionals. Often position papers of this sort advise clinicians on what to avoid doing, but do not focus on the alternatives they should utilize instead. The following recommendations are best practices indicated in the literature, supported by the mandatory ethics dictated by the Texas Administrative Code and the aspirational ethics defined by the American Counseling Association.

Clinical Recommendations

Regardless of their personal positions on religion and sexuality, it is vitally important for counselors to consider the spiritual diversity of their clients (APA, 2009; ASERVIC, 2009). Many clients seeking counseling for sexual orientation change efforts (SOCE) are fervent in their spiritual devotion and are truly struggling to find a way to bring congruence to their spiritual and sexual identities. It is important for counselors to have a thorough understanding not only of issues generally viewed as LGBQQIA, but also the intersecting identities of culture and religion (ALGBTIC, 2013).

Counselors who have an inordinate fear or hatred of SOCE could do just as much harm to their clients as counselors who blindly embrace change efforts. By focusing on the change therapies themselves—and the clinicians who employ them—rather than the reasons clients seek SOCE, counselors risk significant hindrances to understanding their clients' motivations and identities (APA, 2009).

Simplistic responses to clients seeking SOCE, such as "I don't practice reparative therapy; sorry" dismiss the clients' lived experiences of spiritual and sexual incongruence and could be considered tantamount to doing professional harm. Rather, counselors should become competent in both sexual orientation development models (e.g., Cass, 1979) and spirituality development models (e.g., Fowler, 1981). Such an intersection of competence is necessary for adequately handling incongruities in intersection of identity. While there are certain general skills that all competent counselors use with clients struggling with incongruence, individuals seeking SOCE require a sensitive clinician with a more specific skill set. The 2009 APA report included five domains for clinicians working with clients seeking SOCE. We have reviewed each of these strategies below and included any new literature specific to this work that has been published since the release of the APA report.

Acceptance and Support

While various therapeutic techniques will be applicable across the course of treatment, there is no evidence to suggest that a healthy integration of identities will happen in brief therapy. The APA (2009) suggested a strongly client centered approach (Rogers, 1957) emphasizing not only congruence, but empathy and unconditional positive regard as well as the firm belief that client already has the answers he or she needs. Ultimately, the client will have to navigate a path between a sexual and spiritual identity that is uniquely theirs, not one suggested by the clinician. This type of work requires the client to be in the driver's seat at all times. The clinician's job is to sit in the back seat and provide navigational support, as needed.

As some in-depth studies have shown (Wampold, 2000), the therapeutic relationship is the primary change agent in counseling. The importance of a client's first impression of their counselor cannot be understated. Deeply religious clients will be able to ascertain the spiritual beliefs of their counselors. If counselors hold negative biases against religion/spirituality in general, or specific religious/spiritual beliefs and practices, then their clients will likely view that as a rejection of their spiritual identity.

It is imperative, then, that counselors work through their own countertransference regarding religion. The key to building the therapeutic relationship for clients seeking SOCE is for the counselor to hold both the sexual and spiritual identities as equally important and to model that juxtaposition without cognitive dissonance. While practitioners of SOCE err on the side of rejecting the sexual identity, other counselors run the risk of erring in the other direction through the rejection of spiritual identity. Any denial of the client's identity by the clinician is ultimately detrimental to the well-being of the client and the therapeutic relationship.

This is not to say that all clinicians have to have a similar religious/spiritual belief system as their clients or any belief system at all. It is to say that any issues we walk in the door with regarding religion and spirituality are something we are aware of so we do not impose them on the client. Clients will often ask a clinician about their religious/spiritual identity in hopes of parsing this out. Every clinician has to develop an answer with which he/she/ze feels comfortable. Many clinicians use a statement that honors and respects the client's spiritual path without detailing much of their own, knowing that the real question being asked is *are you OK with who I am?* A statement such as "I can tell that being_____ is an important part of who you are, and it has contributed to many of the wonderful things that you have accomplished in your life. Even if we attended the exact same church, we would likely have a different relationship with God [or other higher power]. The important thing is that we respect each other's spiritual journey, and I have enormous respect for yours."

Assessment

While many counselors may not consider assessment as integral to their practices as psychologists do, there are a few ways that assessments can directly benefit clients seeking SOCE. Counselors should consider a light assessment battery beginning with positive assessments such as the VIA Survey of Character Strengths (Peterson & Seligman, 2004) and/or the Hope Scale (Staats, 1989). Additionally, there are a multitude of tools that we may not consider formal assessments highlighting the intersections of identity within each client, such as spiritual genograms. It is important to remember that many counseling interventions also concomitantly operate as an assessment. By using such tools to draw out their clients' focus on culture, values, religious beliefs, family context, and personality, counselors will be more able to diminish the acute affective symptoms of spiritual/sexual incongruence. This shift in focus

makes the *process* of assessment therapeutic in and of itself. The fact that it provides the clinician and client with useful information often becomes a secondary gain.

Active Coping

The individual creativity and personality of the counselor is most important when it comes to working with clients to develop coping strategies. It has been suggested in the literature that, ultimately, all theoretical approaches are equally viable (Wampold, 2000). Therefore, there are no specific techniques or stylistic approaches that the TALGBTIC board feels that we should recommend. This flexibility allows us multiple strategies to facilitate the active and intentional deepening of the therapeutic relationship. Counselors can and should use any combination of cognitive (e.g. mindfulness-based cognitive-behavioral therapy, dialectical behavior therapy, and/or a narrative approach to therapy); emotion-focused (e.g. existential therapy, gestalt therapy, and work around non-finite/disenfranchised grief); or religious counseling (e.g. directing counseling to exploring all the other aspects of the clients' religion other than stances on sexuality) strategies that fit their theoretical orientation and worldview as well as the needs and personality of the client. Assessment tools, as mentioned above, can help facilitate the discovery of the right approach, or even encourage the clinician to refer the client to another clinician who may be a better match for the client's needs.

Spiritual Counseling

We want to re-emphasize the importance of being able to work deeply within the context of clients' spiritual traditions, values, and understanding. Bozard & Sanders (2011) offered the Goals, Renewal, Action, Connection, and Empowerment (GRACE) model of addressing the spiritual/religious needs of LGB clients. While the authors noted that the model was designed for clients whose belief system is congruent with Christian faith traditions, it may be adapted to

clients from other faiths. Over the course of several sessions counselors review clients' histories and goals regarding religion; work to renew spiritual hope; decide upon and execute actions (which may include considering the coming out process, in these instances); connecting with God and a faith community; and, ultimately, encouraging and celebrating client empowerment throughout the process.

In addition to exploring their own religious countertransference, counselors need to improve their competence regarding spirituality and counseling in general. Counselors should review the ASERVIC competencies; attend continuing education opportunities related to spirituality; or read books and articles related to spirituality/religion and counseling (e.g. West, 2000). Also, counselors should familiarize themselves with LGBTQ resources relating to spirituality (Chellew-Hodge, 2008; Helminiak, 2000; and McNeill, 1996)

Social Support

Counselors also need to expand their familiarity with the LGBTQ community and the resources in their local areas. Find points of contact with religious organizations that are gay-affirming or encourage clients to develop safe, non-romantic relationships with other people who have struggled with intersections of identity. Counselors will also need to spend time exploring LGBTQ stigma within the community and help clients determine safe times and places to "come out" and when to stay "closeted". (APA, 2009).

Identity Exploration and Development

Finally, it is important for counselors to work with clients on exploring the intersection of all their identities—not only spiritual and sexual. By developing healthy identities including gender, ethnicity, disability, socioeconomic status, mental health, and age, counselors help clients decrease a sense of false dichotomy between sexual and spiritual identity. As clients

begin to view themselves as either sexual or spiritual and instead see themselves as multifaceted individuals with a variety of honorable identities, the cognitive dissonance surrounding spirituality and sexuality should begin to diminish. As the acute pain caused by this incongruity is lessened, clients will have more internal resources to advance their progress through therapy and holistic identity development.

Conclusion

We write this position paper knowing that the debate regarding ethical treatment of LGBTQ individuals seeking counseling is a complex one. It has been shown that SOCE are not curative, but neither are the alternatives. If these efforts were curative, the debate would have been settled long ago. We write this position paper in honor of the difficult journey many clients and clinicians face when seeking wellness and congruence. We know what does not work, and we know there are many things that can help. But we also are aware that what works is developed within the context of a counseling relationship and cannot be quantified outside of it. Counseling is a dance replete with mis-steps and sometimes mis-chosen partners.

We wrote this paper to honor the important undertaking of working with LGBTQ clients seeking wellness. We offer a context to our history and suggestions for the present and future.

References

American Academy of Family Physicians. (2007). *Reparative therapy*. Retrieved from http://www.aafp.org/about/policies/all/reparative-therapy.html

American Counseling Association. (2005). *ACA code of ethics.* Alexandria, VA: Author. Retrieved from http://www.counseling.org/Resources/CodeOfEthics/TP/Home/CT2.aspx

American Nurses Association. (2001). *Code of ethics for nurses.* Retrieved from http://nursingworld.org/mainmenucategories/ethicsstandards/codeofethicsfornurses.aspx

American Psychiatric Association (2014). *LGBT-sexual orientation*. Retrieved from http://www.psychiatry.org/lgbt-sexual-orientation

American Psychiatric Association. (2000). *Therapies focused on attempts to change sexual orientation (reparative or conversion therapies): Position statement*. Retrieved from http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2000_ReparativeTherapy.pdf

American Psychological Association. (2009). *Report of the American Psychological Association task force on appropriate therapeutic response to sexual orientation.* Washington, DC: Author. Retrieved from http://www.apa.org/pi/lgbc/publications/therapeutic-resp.html

American School Counselor Association. (2004). Ethical standards for school counselors. Alexandria, VA: Author. Retrieved from http://www.schoolcounselor.org/files/ethical%20standards.pdf

American School Counselor Association. (2007). *The professional school counselor and LGBTQ youth.* Alexandria, VA: Author. Retrieved from http://asca2.timberlakepublishing.com//files/PS_LGBTQ.pdf

American Medical Association (2007). *AMA policy regarding sexual orientation.* Retrieved from http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page

Anderson, S. K., & Handelsman, M. M. (2010*). Ethics for psychotherapists and counselors: A proactive approach.* Malden, MA: Wiley-Blackwell.

Arana, G. (2012). My so-called ex-gay life. *American Prospect Longform.* Retrieved from http://prospect.org/article/my-so-called-ex-gay-life

Associated Press (2014, August 30). *Chris Christie signs New Jersey ban on gay conversion therapy.* Retrieved from http://www.politico.com/story/2013/08/chris-christie-gay-conversion-therapy-new-jersey-95666.html#ixzz3C2B0uPPe

Association of Christian Counsellors (2014). *ACC statement to its members.* Retrieved from http://www.accuk.org/pdfs/ACC%20statement%20to%20its%20members%20January%202014.pdf

Association for Lesbian, Gay, Bisexual & Transgender Issues in Counseling. (2009). *Competencies for counseling gay, lesbian, bisexual and transgender (LGBT) clients.* Alexandria, VA: Author. Retrieved from http://www.algbtic.org/competencies.html

Association for Spiritual, Ethical and Religious Values in Counseling. (2009). *Competencies for addressing spiritual and religious issues in counseling.* Alexandria, VA: Author. Retrieved from http://www.aservic.org/competencies.html

Bartoli, E., & Gillem, A. (2008). Continuing to depolarize the debate on sexual orientation and religion. *Professional Psychology: Research and Practice, 39,* 202-209. doi: 10.1037/0735-7028.39.2.202

Bayer, R. (1987), *Homosexuality and American psychiatry: The politics of diagnosis.* Princeton, PA: Princeton University Press.

Becker, J. M. (2012, April 25). EXCLUSIVE: Dr. Robert Spitzer apologizes to Gay community for infamous 'Ex-Gay' study. *Truth Wins Out.* Retrieved from http://www.truthwinsout.org/news/2012/04/24542/

Boas, F. (2011). *The mind of primitive man.* Retrieved from http://www.yale.edu/glc/boas/MindOfPrimitiveMan.pdf

Borgman, A. (2009). LGB allies and Christian identity: A qualitative exploration of resolving conflicts and Integrating Identities. *Journal of Counseling Psychology, 56,* 508-520. doi: 10.1037/a0016691

Boswell, J. (1980). *Christianity, social tolerance, and homosexuality: Gay people in Western Europe from the beginning of the Christian era to the fourteenth century.* Chicago, Illinois: University of Chicago Press.

Bright, C. (2004). Deconstructing reparative therapy: An examination of the processes involved when attempting to change sexual orientation. Clinical Social Work Journal, 40, 457. doi: 10.1007/s10615-004-0543-2

Bright, C. (2012). 'Deconstructing reparative therapy: An examination of the processes involved when attempting to change sexual orientation': Erratum. *Clinical Social Work Journal, 40*, 457. doi:10.1007/s10615-012-0418-x

Bozard, R. L. & Sanders, C. J. (2011). Helping Christian Lesbian, Gay, and Bisexual clients recover religion as a source of strength: Developing a model for assessment and integration of religious identity in counseling. *Journal of LGBT Issues in Counseling, 5,* 47-74. doi: 10.1080/15538605.2011.554791

Burr, K. (2009). *Coming out, coming home: Making room for Gay spirituality in therapy*. New York, NY: Taylor and Francis Group.

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*, 219-235. doi: 10.1300/j082v04n03_01

Cavaliere, V. (2013, August 13). New Jersey bans gay conversion therapy. *Reuters.* Retrieved from http://www.reuters.com/article/2013/08/19/us-usa-gaytherapy-newjersey-idUSBRE97I0JC20130819

Chellew-Hodge, C. (2008). *Bulletproof faith.* San Francisco, CA: Jossey-Bass.

Cheng, P. (2011). *Radical love: An introduction to Queer theology.* New York, NY: Seabury Books.

Cramer, R. J., Golom, F. D., LoPresto, C. T. & Kirkley, S. (2008). Weighing the evidence: Empirical assessment and ethical implications of conversion therapy. *Ethics and Behavior, 18*, 93 – 114.

Davis, A. (2014, June 10). D.C. Council weighs ban on gay-conversion therapy for minors. *The Washington Post.* Retrieved from http://www.washingtonpost.com/local/dc-politics/dc-council-weighs-ban-on-gay-conversion-therapy-for-minors/2014/06/10/c572e6b8-efe9-11e3-bf76-447a5df6411f_story.html

Drescher, J. (1998). *Psychoanalytic therapy and the Gay man.* Hillsdale, NJ: The Analytic Press.

Elias, P. (2012, August 29). California gay conversion therapy ban upheld by federal court. *Huffington Post.* Retrieved from http://www.huffingtonpost.com/2013/08/29/california-gay-conversion-therapy-ban_n_3837922.html

Embry, L. (2012, August 27). “Conversion therapy": Therapy that isn't. *Los Angeles Times.* Retrieved from http://sd28.senate.ca.gov/news/2012-08-27-los-angeles-times-op-ed-conversion-therapy-therapy-isn-t#sthash.lJaObGQr.0MCnfTNJ.dpuf

Evangelical (n. d.). In Merriam-Webster’s online dictionary. Retrieved from http://www.merriam-webster.com/dictionary/evangelical

Festinger, L.& Riecken, H. (1956/2012). *When prophecy fails.* New York, NY: Start Publishing.

Ford, J. G. (2002). Healing homosexuals: A psychologist's journey through the Ex-Gay movement and the pseudo-science of reparative therapy. *Journal of Gay and Lesbian Psychotherapy, 5(*3/4), 69-86. doi:10.1300/J236v05n03_06

Fowler, J. W. (1981) *Stages of faith: The psychology of human development and the quest for meaning.* San Francisco, CA: Harper Collins.

Freud, S. (1935). Anonymous (Letter to an American mother). In E. Freud (Ed.), The letters of Sigmund Freud (pp. 423-424). London, England: Hogarth Press, 1960.

Gaffney, S., and Lewis, J (2014, August 13). Taking on conversion therapy in Texas. *Huffington Post.* Retrieved from http://www.huffingtonpost.com/stuart-gaffney/taking-on-conversion-therapy-in-texas_b_5495156.html

Gay and Lesbian Medical Association (2013*). Compendium of health profession association LGBT policies.* Retrieved from http://www.glma.org/_data/n_0001/resources/live/GLMA%20Compendium%20of%20Health%20Profession%20Association%20LGBT%20Policy%20and%20Position%20Statements.pdf

Gay, Lesbian and Straight Education Network. (2009). *Inside Texas schools: The experiences of LGBT students* (GLSEN Research Brief). New York: Author. Retrieved from http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1392-1.PDF

Gnuse, R. (1985). *The authority of the bible: Theories of inspiration, revelation, and the canon of scripture.* Mahwah, NY: Paulist Press, 1985.

Haldeman, D. (2002). Gay Rights, patient rights: The implications of sexual orientation conversion therapy," *Professional Psychology: Research and Practice, 33,* 260-264.

Harris, L. J. (1990). Cultural influences on handedness: Historical evidence and contemporary theory and practice in S. Coren (Ed.), *Left-handedness: Behavioral implications and anomalies (*pp. 195-253). North-Holland: Amsterdam: The Netherlands.

Hein, L., & Matthews, A. (2010). Reparative therapy: the adolescent, the psych nurse, and the issues. *Journal of Child & Adolescent Psychiatric Nursing, 23,* 29-35. doi:10.1111/j.1744-6171.2009.00214.

Helminiak, D. A. (2000). *What the Bible* really *says about homosexuality.* Tajique, NM: Alamo Square Press.

Hooker, E. (1957), The adjustment of the male overt homosexual. *Journal of Projective Techniques, 21,* 18-31. doi: 10.1080/08853126.1957.10380742

Jenkins, D., & Johnston, L. B. (2004). Unethical treatment of Gay and Lesbian people with conversion therapy. *Families in Society: The Journal of Contemporary Social Services, 85*(4), 557-561. doi: 10.1606/1044-3894.1846

Jones, S., & Yarhouse, M. (2011). A longitudinal study of attempted religiously mediated sexual orientation change. *Journal of Sex and Marital Therapy, 37,* 404-427. doi: 10.1080/0092623x.2011.607052

Just The Facts Coalition (2008). *Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel.* Retrieved from http://www.apa.org/pi/lgbt/resources/just-the-facts.pdf

Levs, J. (2012). California governor OKs ban on gay conversion therapy, calling it 'quackery.' *CNN.* Retrieved from http://www.cnn.com/2012/10/01/us/california-gay-therapy-ban/

Lewes, K. (1988). *The psychoanalytic theory of male homosexuality.* New York, NY: Simon and Schuster.

McManus, Chris (2003). *Right hand, left hand.* Beverly Hills, CA: Phoenix Paperbacks.

McNeill, J. J. (1995*). Freedom, glorious freedom: The spiritual journey to the fullness of life for Gays, Lesbians, and everybody else.* Boston, MA: Beacon Press.

McNeill, J. J. (1996). *Taking a chance on God.* Boston, MA: Beacon Press.

Miville, M. L. & Ferguson, A.D., (2004). Impossible "choices": Identity and values at a crossroads. *The Counseling Psychologist. 32,* 760-770.

Moberly, E. and Nicolosi, J. (1991). *Reparative therapy of male homosexuality: A new clinical approach.* Oxford, England: Roman & Littlefield.

Morrow, S. L., & Beckstead, A. (2004). Conversion therapies for same-sex attracted clients in religious conflict: context, predisposing factors, experiences, and implications for therapy. *The Counseling Psychologist, 32,* 641-650. doi: 10.1177/0011000004268877

National Association for Research and Therapy of Homosexuality (2009).

2009 scientific report confirms 125 years of observation on homosexuality. Retrieved from http://www.traditioninaction.org/HotTopics/a02z_020_NARTH.html

National Association of Social Workers (2000). *Position statement: "Reparative" and "conversion" therapies for Lesbians and Gay Men.* Retrieved from http://www.socialworkers.org/diversity/lgb/reparative.asp

National Board for Certified Counselors. (2005). *NBCC Code of Ethics.* Greensboro, NC: Author. Retrieved from http://www.nbcc.org/AssetManagerFiles/ethics/nbcc-codeofethics.pdf

Peterson, C., & Seligman, M. E. P., (2004). *Character strengths and virtues: A handbook and classification.* New York, NY: Oxford University Press.

Republican Party of Texas (2014). *Temporary platform committee report.* Retrieved from https://www.documentcloud.org/documents/1182339-temporary-platform-committee-report.html

Rogers, Carl (1951). *Client-centered therapy.* Cambridge, Massachusetts: The Riverside Press.

Scanzoni, L., & Mollenkott, V. (1994). *Is the homosexual my neighbor? A positive Christian response.* New York, NY: HarperCollins.

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*(3), 249-259. doi: 10.1037//0735-7028.33.3.249

Society of Archbishop Justus (2007). *Articles of religion.* Retrieved from http://anglicansonline.org/basics/thirty-nine_articles.html

Southern Poverty Law Center (2014). *Conversion therapy*. Retrieved from http://www.splcenter.org/conversion-therapy

Staats, S. R. (1989). Hope: A comparison of two self-report measures for adults. *Journal of Personality Assessments, 53,* 366-375. doi: 10.1207/s15327752jpa5302_13

Stemple, J. (2014). New Jersey 'gay conversion therapy' ban is upheld. *Reuters*. Retrieved from http://www.reuters.com/article/2014/09/11/us-usa-gaytherapy-newjersey-idUSKBN0H622620140911

Sweeney, D. (2005). *The American evangelical story: A History of the movement.* Ada, MI: Baker Academic

Terry, J. (1999). *An American obsession: Science, medicine and the place of homosexuality in modern society.* Chicago, IL: Chicago University Press.

Texas Administrative Code: Educator's Code of Ethics. Retrieved from http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=3&ti=19&pt=7

Texas Statutes: Education Code. Retrieved from http://www.statutes.legis.state.tx.us/

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates

Wang, S. (2011). The health risks of being left-handed lefties face chance of ADHD, other disorders; brain wiring holds clues. *The Wall Street Journal.* Retrieved from http://online.wsj.com/news/articles/SB10001424052970204083204577080562692452 5

West, W. (2000). *Psychotherapy and spirituality: Crossing the line between therapy and religion.* Thousand Oaks, CA: Sage Publications

World Health Organization (2008). International Statistical Classification of Diseases and Related Health Problems 10th Revision Retrieved from http://apps.who.int/classifications/icd10/browse/2010/en

Yarhouse, M,, & Throckmorton, W. (2002). Ethical issues is attempts to ban reorientation therapies," *Psychotherapy: Theory/Research/Practice/Training, 39,* 66-75. doi: 10.1037//0033-3204.39.1.66

Young, S. (2006). Does reparative therapy really constitute child abuse: A closer look. *Yale Journal of Health Policy Law and Ethics, 163.* Retrieved from http://heinonline.org/HOL/LandingPage?handle=hein.journals/yjhple6&div=7&id=&page=

APPENDIX A
Other Recommended Reading

Dibble, S.L., & Robertson, P.A. (2010). *Lesbian Health 101: A Clinician's Guide*. San Francisico, CA: UCSF Nursing Press.

Dworking, S.H., & Pope, M. (2012). *Casebook for Counseling Lesbian, Gay, Bisexual, and Transgender Persons and Their Families*. Alexandria, VA: American Counseling Association.

Helminiak, D. A. (2000). *What the Bible really says about homosexuality*. Tajique, NM: Alamo Square Press.

Hood, R. W., Hill, P.C., & Spilka, B. (2003). The psychology of religion. New York, NY: Guilford Press.

Kort, J.(2008). *Gay affirmative therapy for the straight clinician: The essential guide*. New York, NY: W.W. Norton & Company Inc.

Johnson, T. (2000). Gay spirituality. Los Angeles, CA: Alyson Publications.

McLaren, B. D. (2007). Everything must change: Jesus, global crises, and a revolution of hope. Nashville, TN: Thomas Nelson.

Mizock, L., & Fleming, M.Z. (2011). Transgender and gender variant populations with mental illness: Implications for clinical care. *Professional Psychology: Research and Practice, 42*, 208-213.

Page, E. (2007). Bisexual women's and men's experiences of psychotherapy. In B.A. Firesten (Ed.), *Becoming visible: Counseling bisexuals across the lifespan* (pp.52-71). New York, NY: Columbia University Press.

Panozzo, D. (2013). Advocating for an end to reparative therapy: Methodological grounding and blueprint for change. *Journal of Gay and Lesbian Social Services, 25*, 362-377.

Rix, J. (2010). *Ex-Gay no way.* Forres, Scotland: Findhorn Press.

Shelton, M. (2011). *Gay Men and Substance Abuse: A Basic Guide for Addicts and Those Who Care for Them*. Center City, MN: Hazelden.

Wattles, J. (1996). *The golden rule.* New York, NY: Oxford University Press