

Sexual identity therapy:  
Practice guidelines for managing sexual identity conflicts

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## ABSTRACT

Sexual and religious 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 guidelines 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 feelings. 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.

### Sexual Identity Therapy:

#### Practice guidelines for managing sexual identity conflicts

Although some gay, lesbian, and bisexual (GLB) individuals experience little, if any, conflicts with their religious identity, others feel distress over conflict between religious beliefs and sexual attractions to members of the same-sex (Beckstead & Morrow, 2004; Haldeman, 2004; Yarhouse & Tan, 2004). Persons 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 religious beliefs 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 religious and 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.

Furthermore, 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 may not profit from a profession that marginalizes 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 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 (Spitzer, 2003; Throckmorton & Welton, 2005).

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 religious belief. We believe these recommendations address the concerns of researchers and psychotherapists from a variety of perspectives.

Prior to outlining the recommendations, let us say what they are not. They are not sexual re-orientation 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 and 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 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 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.

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:

Guideline 1. Psychologists understand that homosexuality and bisexuality are not indicative of mental illness.

Guideline 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.

In addition, a division of the American Counseling Association has adopted competencies for counselors with respect to religiosity 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 clients' therapeutic goals as befits the clients' expressed preference. (Association for Spiritual, Ethical, Religious & Values Issues in Counseling, nd).

Thus, both sexual orientation and religious/spiritual beliefs are recognized by mental health professional bodies as important domains or personal experience. Further, these domains are to be respected and incorporated into therapy as appropriate. However, the principles proposed by these professional associations do not address situations where sexual feelings and religious beliefs collide. The sexual identity therapy guidelines help address issues that arise when clients believe their sexual orientation and religious/spiritual beliefs are in conflict.

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

The guidelines do not stigmatize same-sex eroticism or conservative religious values. The emergence of a gay identity for persons struggling with religious 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, 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 religious 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.” (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 values and beliefs. We believe therapeutic support can provide an invaluable component in finding resolution to conflicts surrounding sexual feelings and religious belief.

## **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 distress. 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 would require appropriate referral.

### **Clinical Picture**

Clinical concern and intervention is warranted when stress or issues concerning sexual orientation becomes 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.

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 conflict between religious beliefs and values and sexual feelings, behavior or identity.<sup>1</sup>

### **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, puts emphasis on the diversity of sexual categories such as homosexual and heterosexual have been across cultures and through history. 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 either heterosexual, homosexual or bisexual because these categories exist. 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 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 belief 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, by 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 afterwards. Thirteen percent of the women and 22% 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 questioned at least 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, current research and theory distinguishes between erotic arousal and romantic attachments (Diamond, 2003). We take sexual identity to refer to a personal identification with sociocultural 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 portrays themselves to the world (Stein, 2001).

For the purpose of these guidelines, we propose that the measurement difficulties surrounding sexual orientation as a concept make it impossible 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 flexibility and change 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.

## **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 permanent 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 confusion concerning sexual identity is common 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.

### **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 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 religious beliefs in favor of support for a gay identity. These are important considerations in assessment since mental health professionals can assist clients by inviting an open discussion of the various motivations that may lead a person to seek professional services.

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 religious identity conflicts? An open-ended question may give the clinician access to this information: 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 formed judgments about same-sex behavior or identity) while others may reflect external motivations (e.g., an ultimatum delivered by one's spouse).

Often clients will disclose conflict between religious beliefs 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 attractions may place other vital aspects of identity at risk. It is also important for therapists to take a neutral stance toward the client's worldview.

### **Phase two: Advanced Informed Consent**

The content of psychoeducation in 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 with 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 clients' experience and provide appropriate responses. In all cases, therapists must provide clients with accurate information to support a client's consent for further intervention.

Informed consent is an important part of providing mental health services to clients. 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).

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 to all subsequent interventions and should cover the following:

1. Hypotheses as to what is causing their distress (including etiology of same-sex attraction, rationale for identity conflict and the subjective experience of distress);
2. Professional interventions available, including success rates and definitions and methodologies used to report and define “success”;
3. Alternatives to therapy, including reported success rates and the relative lack of empirical support for claims of success;
4. Possible benefits and risks of pursuing treatment at this time;
5. Possible outcomes with or without treatment (and alternative explanations for possible outcomes). (Yarhouse, 1998, p. 252).

It is beyond the scope of this article to fully delineate all information that might be needed during this phase. In addition to Yarhouse (1998), 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; 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, 2005; Yarhouse & Brooke, in press; 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; 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)

What is most important during informed consent is to help each client make a truly informed decision about the kinds of goals they might have for treatment and the kinds of services that are available. This can be an involved process when clients frequently ask about change of same-sex attraction and behavior. 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 in treatment. If in therapy a client is not making much headway, it is important (just as in any other treatment program) to revisit treatment goals as to whether they are the best fit for their present needs.

**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 worked through the clarification 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. Therapists should not attempt to persuade clients toward a course of action.

**Referral**

The need for referral can arise for reasons involving therapeutic capability and value conflicts. Therapists rarely conducting 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 even attempts to dissuade clients 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).

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 & 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**

In addition to individual psychotherapy, clients may benefit from a sexual identity therapy group. This is often offered 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 other on one's interpersonal style, a

supportive community that can also provide accountability, and so on (Yarhouse & Brooke, 2005) .

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

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 identity therapy may seem to blend appropriate therapeutic boundaries and are discouraged. For instance, therapists should not engage in dual relationships with clients or provide physical 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 complete a process of 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 include social settings of the desired sexual identity. This may entail limiting 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 are preferred. 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 and avoid 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 for the client's desires and direction. Furthermore, therapists must monitor the impact sexual identity

interventions on the client's mental and emotional status and be prepared to provide basic clinical services or referrals that are indicated. Advanced informed consent principles are active throughout the therapeutic process.

### **Conclusion**

Dilemmas regarding sexual and religious identity are among the most difficult 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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<sup>1</sup> In this paper, we focus most frequently on conflicts deriving from religious conflicts over same-sex attractions. However, there may be occasions when individuals wish to minimize opposite-sex attractions in order to more fully pursue a same-sex identity. All situations should be assessed and responded to in keeping with the individual client's religious/spiritual beliefs, valued sexual identity and therapist's professional identity and competence.