

When identities collide: providing therapeutic support for individuals with sexual and religious incongruence, ethically.

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Introduction

The established consensus of mental health professionals is that homosexuality is a normal positive variation of human sexual orientation and not a mental disorder (Kinsey, Pomeroy, & Martin, 1948ⁱ; Kinsey, Pomeroy, Martin, & Gebhard, (APA, 1975)ⁱⁱ). Since 1974, the American Psychological Association (APA) “has opposed stigma, prejudice, discrimination, and violence on the basis of sexual orientation and has taken a leadership role in supporting the equal rights of lesbian, gay, and bisexual individuals” (APA, 2005ⁱⁱⁱ). The UKCP, BACP and other UK organisations, have followed this lead.

American studies identify a population of individuals who experience serious distress related to same sex sexual attractions^{iv}. The majority of these subjects report that their religion is extremely important to them (Beckstead and Morrow, 2004^v; Nicolosi, Byrd, & Potts, 2000^{vi}; Shidlo & Schroeder, 2002, Spitzer, 2003^{vii}). They report seeking support from religious and secular professionals to change their sexual orientation, using a variety of methods: behavioural, cognitive, psychotherapeutic and religious. According to gay psychotherapist^{viii} and current candidate for APA chairman^{ix} Haldeman (2004:694^x): “For some, religious identity is so important that it is more realistic to consider changing sexual orientation than abandoning one’s religion of origin”. He argues that “religious affiliation can serve as a central, organizing aspect of identity that the individual cannot relinquish even at the price of sexual orientation. Psychology is in no position to negate this affiliation...”

Findings of APA Task Force on Appropriate Therapeutic responses to Sexual Orientation:

In response to ongoing initiatives by therapists, and religious and social conservatives offering Sexual Orientation Change Efforts (SOCE) the APA appointed the Task Force on Appropriate Therapeutic Responses to Sexual Orientation to review the available research on SOCE and to provide recommendations to the Association. Conflicts in values held by orthodox faith-based organisations on the one hand and LGBT organisations, professional and scientific organisations on the other, make SOCE controversial. The Task Force document distinguishes between ‘*telic congruence*’ in which some individuals choose to live their lives in accordance with personal or religious values and ‘*organismic congruence*’^{xi} meaning that some individuals choose to live with a sense of wholeness in one’s experiential self rather than, primarily with a valuative goal. Other literature (Yarhouse and Burkett 2002:238)^{xii} also highlights dimensions of complexity, debated on both “sides” of the argument in terms of what sexual orientation actually is. ‘*Essentialists*’ argue that it is universal reality; ‘*social constructionists*’ see it as a linguistic category constructed by society to explain a person’s sexual preferences. The APA’s Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts^{xiii} summarises the Task Force findings as:

- (1) There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person’s sexual orientation. Some individuals appeared to learn how to ignore or limit their attractions.
- (2) Although there is insufficient evidence to support the use of psychological interventions to change sexual orientation, some individuals modified their sexual orientation identity (i.e., group membership and affiliation), behaviour, and values.

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They did so in a variety of ways and with varied and unpredictable outcomes, some of which were temporary.

(3) On the basis of the Task Force's findings, the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilising affirmative multiculturally competent and client-centred approaches that recognize the negative impact of social stigma on sexual minorities and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people's rights and dignity.

Despite the above APA Task Force findings, which affirm the need for therapeutic support for this population, and also avoid the condemnation of sexual reorientation treatments per se, the UKCP statement 'On the 'reparative' therapy of members of sexual minorities (Feb 2010)' uncritically brands any attempt by therapists to 'convert' clients from homosexuality to heterosexuality, as irresponsible. Such concerns may reflect Dresher's (2002:86^{xiv}) warnings that "therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient". However the UKCP appears to limit SOCE efforts to 'conversion' therapy (a behaviourist approach), which it conflates with 'reparative therapy', (an affective approach).

Ethical issues in the client autonomy, the "right to choose" and diversity debate

The UKCP's Ethical Principles and Code of Conduct helpfully entreat the psychotherapist to treat their clients "with respect"^{xv}, particularly in relation to "their client's autonomy"^{xvi}. Psychotherapists are to "actively consider issues of diversity and equalities"^{xvii}. It reminds them that "no one is immune from the experience of prejudice, and acknowledges the need for a continuing process of self-enquiry and professional development". Such prejudice, including a therapists's "religious or cultural beliefs", should not adversely affect the way they relate to the client^{xviii}. The same principles underline the importance of providing information about the whereabouts of alternative psychotherapists and the importance of appropriate referrals.

Yarhouse and Burkett (2002) argue the case for religious affiliation and expression as legitimate forms of diversity. Those advocating LGBT rights which demand ethical and competent treatment insist that therapists with religious connections avoid pathologising this population. In the same way it seems unreasonable to pathologise those conflicted in sexual and religious identity as having 'ego-dystonic sexual orientation'^{xix} as the World Health Organisation's ICD continues to do. Again Haldeman (2004:695), when writing about Gay clinicians, actually elucidates the dangers of prejudice on both sides: "Gay clinicians may be particularly at risk for negative counter-transference reactions towards clients with strong conservative religious affiliations, given the issue of conflict between the gay community and the conservative religious world".

What emerges for any ethically practicing psychotherapist, is the need for a critical awareness on the part of the practitioner when faced with clients' dissatisfaction with their same-sex attractions, especially those conflicted in their religious and sexual identities. Just as therapists need to guard against requests for change because of familial, social or religious pressures, therapists also need to be aware that if gay identity is chosen uncritically over conservative religious identity, where anything other than celibacy is recognised, there remains the potential for profound existential loss, quite apart from the loss of family and community support. By the same token, therapists with orthodox values cannot ethically proceed with SOCE if the real inhibitors of a gay identity and practice are prejudice from family, church, synagogue or mosque or the society at large. Gay therapists and their orthodox counterparts are equally vulnerable to prejudicial interventions. An effort to respect

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the interests of clients wishing to integrate their same sex attractions into an LGBT identity or liberal religious framework might be as uncomfortable for a therapist from a conservative religious background as integrating such experiences into a religious framework advocating celibacy, chastity or change, might be to a therapist who is gay integrative. Both will have to consider appropriate referrals if they are unable to walk the journey with their clients authentically. Therapists with conservative religious backgrounds cannot be assumed to be any more of a danger to clients than gay integrative therapists with considerable prejudice against religious conservatism.

Facilitating autonomy and self-determination – the referral

According to Yarhouse and Burkett (2002:238)^{xx} referrals to a gay-integrative therapist should consider doing so if their client:

(a) states this is a goal for treatment; (b) is in his or her normal state of mental health (e.g., has worked through feelings of anger, frustration, or depression following unsuccessful approaches to change orientation or behaviour); (c) has had same –sex experiences (as opposed to fantasy); (d) is motivated by internal factors (e.g., personal values or sense of congruence) or external factors (e.g., peer or subculture pressure); (e) has considered whether he or she has adequate social support and access to friends, family, places of worship, and community services that support such a decision; and (f) is aware of some of the possible benefits of and risks in pursuing gay-integrative therapy at this time.

Haldeman (2004:711) warns against therapist behaviours that could be “extensions of counter-transferences” expressed as prejudice against client choice in considering a path of action in which a therapist could provide “direct or subtle encouragement towards conversion therapy” or “mislead clients about the lives of LGB individuals”. His position is:

If a practitioner feels challenged about maintaining a facilitative neutrality in the face of a client choice, consultation is essential. And if one’s reactions against their religious or LGB individuals are such that the advancement of the therapist agendas cannot be avoided, a referral should be made.

Beckstead and Morrow (2004)^{xxi}, Haldeman (2004), Throckmorton and Yarhouse (2006)^{xxii} all argue for therapeutic opportunities to step outside of the two polarised positions of ‘out-gay’ or ‘ex-gay’ in working with conflicted clients. This is a person-centred approach and aims to reconcile conflict between same sex attraction and religious identity, thus leading clients towards individualised congruent, solutions. Haldeman (2004:692) lists the ethical challenges to those working with sexual minority clients as:

(1) informed consent about treatment; (2) alternative treatments; (3) disseminating accurate clinical and scientific information about sexual orientation; (4) respect for individual autonomy; and (5) protection from bias on the part of the practitioner.

Conservative scholars Yarhouse and Burkett and gay integrative therapist Haldeman appear to agree that the ethical standards – informed consent, accuracy of information, withholding of prejudicial attitude and respect for autonomy are crucial in these cases. This position is what Haldeman (2004:712)^{xxiii} calls “antidogma” where rather than encouraging either a “coming out”, repressing sexuality in the service of religion, or advocating any particular outcome “a treatment framework is offered that enables the client to make decisions himself”.

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Religious belief and the diversity debate

Whilst the American literature focuses on the needs of a multicultural approach to dealing with same-sex attracted individuals conflicted with religious values, the UK literature concentrates on 'diversity and equality'^{xxiv}. Identification with American writers (Browning et al, 2009:192)^{xxv} for example, who urge psychologists to help homosexuals "recognise and validate needs for spiritual community and discover ways to fulfil them" through "alternatives to traditional religion" is probably one approach unlikely to be supported by therapists who identify with organised religion. This distinction between generic 'spirituality' and 'religiosity' clearly diminishes organised religion. However, many of the adherents of religious institutions consider themselves to be finding fulfilment of a legitimate 'spiritual' identity, within organised religion. Generic spirituality should not be pitted against religious traditions if we are to value diversity or have respect for multicultural difference.

To Professor Samuels, UKCP Chairperson, the defence of "conversion therapy" using the grounds of "free speech" is to be rejected as "specious"^{xxvi}. It is unclear whether the use of 'conversion' (in 'conversion therapy') in general use throughout relevant UKCP documents is specifically associated with behavioural change techniques or is a generic term intended to catch any SOCE approach. Efforts to clarify this have not yet been engaged with^{xxvii}. Possibly the reticence of the UKCP to recognise in any of its documentation, SOCE for religious clients or clients motivated to seek this help from a position of 'no faith' represents a position that differs from the trajectory of the APA. The discussion by Bieschke and Dendy (2010: 430^{xxviii}) about trainees having to navigate between their personal values and expectations of the professions is worth noting:

We argue that psychology as a field has employed the assimilation acculturation strategy when it comes to LGB training. The field has foreclosed on an LGB-affirmative stance without a complex discussion of how to deal with competing cultural and religious values. We argue that the assimilation approach often results not only in unexamined, shallow affirmation, but also the marginalization and/or silencing of students and psychologists who are struggling to reconcile their personal religious or cultural values with the expectations of the profession.

Conclusion

I wish to make the case for the minority who experience same sex attractions and seek to change their behaviour, impulses or orientation or who seek to live rich and fulfilling lives and remain celibate. Many wish to do this with the help and support of professionally trained psychotherapists. For these individuals it may be that their religious identity is primary, just as Green (1994:24^{xxix}) reports that for many African American gay men and lesbians their identities as 'African Americans' is primary. Therapists generally do well to be informed about the fact that many homosexual people disagree with the Judeo-Christian teachings about human sexuality, and similarly, that there is a minority of homosexual people who are committed to the orthodox, historical perspectives on the status of same sex attractions and wish to live in conformity to the teachings of their religious communities.

I submit to the readers of this brief paper that the protection of ethical standards and professional conduct in dealing with those conflicted in their religious and sexual identity is best served through appropriate training and professional supervision – and not through the dogmatic refusal of activists to recognise the fundamental dignity of those who differ from them.

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