When Sexual and Religious Orientation Collide: : Considerations in Working with Conflicted Same-Sex Attracted Male Clients

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The debate among scholars and gay activists and religious/political activists about the appropriateness and efficacy of conversion therapy has left out a number of individuals for whom neither gay-affirmative nor conversion therapy may be indicated. The present discussion, through the use of case material, offers considerations for the practitioner who seeks to assist same-sex attracted male clients in the integration of their conflicting religious and sexual selves. Issues of attachment, social and family considerations, religious and spiritual factors, and developing familiarity with the gay community are considered. Ethical considerations of treatment are discussed.

Organized religion has historically taken positions ranging from ambivalent to outright hostile with regard to same-sex orientation (Haldeman, 1996). Nevertheless, it has been argued that some variety of "treatment"—whether formal conversion therapy conducted by a professional practitioner or a self-help "ex-gay" group—should be available for those who experience their same-sex attractions as ego-dystonic and/or incompatible with their religious beliefs (Throckmorton, 2002; Yarhouse and Burkett, 2002). These authors have cited a number of studies suggesting that at least for some individuals, such programs provide a modicum of benefit in terms of change of sexual orientation or adaptation to heterosexuality or celibacy. Proponents of conversion treatments view religious affiliation as an element of diversity potentially as important as other elements (ethnicity, sexual orientation, ability status; Yarhouse, 1998). Bearing in mind ethical considerations such as informed consent, respect for individual values, and accurate transmission of information about psychological science, some writers have advocated for conversion therapy as a legitimate therapeutic option for a number of clients who are dissatisfied with their same-sex attractions (Throckmorton, 2002; Yarhouse and Burkett, 2002).

Conversely, a number of reviews of the conversion therapy literature have questioned the justification for offering such treatments when homosexuality is no longer considered a mental illness (Tozer & McClanahan, 1999). Furthermore, they have found the methodologies of studies purporting to dem-

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onstrate change in sexual orientation to be severely lacking (Haldeman, 1994) and theoretically unsupported (Drescher, 2002). These authors have generally considered antigay social stigma, not sexual orientation, as the primary motivator of those seeking to change their sexual orientation. Data from a recent study of participants who indicated both positive and negative responses to conversion treatments showed that a majority experienced the treatments as harmful (Shidlo & Schroeder, 2002). Finally, the same authors also found that a majority of their participants reported that their conversion therapists had given them prejudicial and misleading information about same-sex sexual orientation and distorted impressions of gay men's normative life experiences, among other possible ethical concerns (Shidlo & Schroeder, 2001). Conversion therapies are often marketed with the notion that sexual orientation is freely chosen and therefore changeable, which, according to some, jeopardizes the civil rights of lesbian, gay, and bisexual (LGB) individuals (Haldeman, 1999).

POLICIES OF MENTAL HEALTH ORGANIZATION

Both proponents and opponents of conversion therapy would probably agree that the psychological and social issues typically brought by the client seeking to change sexual orientation are complex and require the utmost care and attention on the part of the practitioner. Additionally, the numerous psychological and physiological harms experienced by some who have undergone conversion therapy have been documented (Haldeman, 2001; Shidlo & Schroeder, 2002). For these reasons, organized psychology and psychiatry have both developed policies on conversion therapy. Further, the issue is addressed generally in the American Psychological Association's (APA's) Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients (American Psychological Association [APA], Division 44/Committee on Lesbian, Gay and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients, 2000). Psychology's resolution reiterates the fact that homosexuality is not a treatable mental disorder and "opposes portrayals of lesbian, gay and bisexual youth and adults as mentally ill due to their sexual orientation" (APA, 1998, p. 935). The basis of the resolution delineates those aspects of the APA's Code of Ethics (APA, 2002) most likely to provide ethical challenges to those working with sexual minority clients. These include informed consent about treatment, alternative treatments, disseminating accurate clinical and scientific information about sexual orientation, respect for individual autonomy, and protection from bias on the part of the practitioner.

The American Psychiatric Association's (1998) policy warned of the potential risks associated with conversion therapies (depression, anxiety, self-destructive behavior), noting that "therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient" (Drescher, 2002, p. 86). The policy recommended that "ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to first, do no harm" (Drescher, 2002, p. 87). The policy further noted that many conversion therapy patients are misled into believing that all homosexuals are doomed to lives of unhappiness and that conversion therapy often does not present alternative possibilities of dealing with social stigma (APA, 1998).

The APA (2000) adopted Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients in an effort to "assist psychologists in seeking and utilizing appropriate education and training in their treatment of lesbian, gay, and bisexual clients" (p. 4). In the document, Guideline 4 addresses the issue of clients whose discomfort about their homosexuality or bisexuality prompts questions about sexual orientation change. The practitioner is encouraged to remember the misinformation and social prejudice against LGB individuals and that personal prejudice against same-sex sexual orientation expressed by the practitioner is likely to exacerbate the client's distress. This guideline further encourages the practitioner to carefully examine the social context in which the client's discomfort occurs, including social support; to determine the presence or absence of positive LGB role models; and to assess the client's beliefs about homosexuality or bisexuality. The practitioner should not impose personal beliefs or judgments on the client nor should the client be pathologized or otherwise devalued for any aspect of her or his identity.

RELIGIOUS ASPECTS OF IDENTITY INTEGRATION

It has been noted that the vast majority of those seeking sexual orientation change because of internal conflict have strong religious affiliations (Shidlo & Schroeder, 2002; Tozer & Hayes, 2004 [this issue]). The ultimate task of the therapist helping a client resolve internal conflicts about sexuality and religion is the integration of disparate aspects of identity. These profound conflicts render dichotomous explanations insufficient for many clients. Sexual orientation conversion therapy and the personal and social context in which it occurs for most people has been characterized by different polarities (Beckstead & Morrow, 2004 [this issue]). These extend from the internally polarizing effect that religiosity exerts on those seeking to change their sexual orientation to the polarizing and sometimes alienating effect that the gay

community can have on the uninitiated. The depth to which religious identity can be embedded in the psyche cannot be underestimated, although the mechanisms by which this occurs may not be well understood. For some, religious identity is so important that it is more realistic to consider changing sexual orientation than abandoning one's religion of origin. Miranti (1996) suggested that "the spiritual and/or religious dimensions inherent in each individual could possibly be the most salient cultural identity for a client" (p. 117).

Religion and spiritual practice may hold a special meaning for some LGB individuals or for those who struggle with issues of same-sex attraction. Religion offers comfort for a soul in torment. It has been said that the gay soul turns inward for lack of external support and, in so doing, create a rich internal spiritual framework that soothes the anxieties stemming from sexual dissonance with social expectation and heals the wounds of a homonegative world (Haldeman, 1996). For these reasons, 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, however its basis may be viewed. And while many religiously oriented LGB individuals find a home in welcoming and affirming religious traditions, not all disaffected religious homosexuals are able to relinquish their native conservative traditions. The potential losses of family, community, belief system, and core identity are so great that for some who choose conversion therapy, changing or managing sexual orientation is a steep price, but one they choose to pay.

Parenthetically, the relationship between the same-sex attracted individual and some conservative churches and religious organizations is complex. For some doctrinaire religions, homosexuality may be greatly useful. Traditional Christianity, for example, relies on its own polarities to underscore its message. Sin must be identified to foster righteousness. Constructions of morality stand in stark relief against the depravity of immorality; in this regard, homosexuality serves a valuable function. Some conservative religious practices are predicated on extremes, which theoretically lead to salvation or damnation. LGB individuals and the gay rights movement in general serve as a natural flash point for some religious political conservatives (Haldeman, 2002) and stand as a socially acceptable target for scriptural vilification. Some conservative groups identify LGB individuals, along with women's reproductive rights, as a common enemy against which to organize, aggressively supporting campaigns to deny LGB and questioning youth information about sexual orientation or relevant civil rights issues. These are some of the reasons for the antireligion backlash in the gay community. Because of this and the sometimes "foreign" experience of the gay community to the uninitiated, it can be as difficult for some to come out as religious

in the gay community as it is to come out as gay in a community of faith (Haldeman, 2002).

Yarhouse and Burkett (2002) have made the case that religious affiliation and expression are legitimate forms of diversity. Despite what these authors refer to as a recent "dramatic interest" in religion, its psychological underpinnings and existential meanings are still poorly understood by many practitioners. Gay clinicians may be particularly at risk for negative countertransferential reactions toward clients with strong conservative religious affiliations, given the issues of conflict between the gay community and the conservative religious world. Honoring religious experience as a legitimate aspect of identity is the duty of all who work with conflicted clients. Those who have spoken out on behalf of the rights of LGB individuals for competent and ethical treatment insist that therapists in the religious world refrain from pathologizing their LGB clients. So, too, should gay-affirmative practitioners refrain from overtly or subtly devaluing those who espouse conservative religious identities.

A PERSON-CENTERED APPROACH TO RESOLVING INTERNAL CONFLICT ABOUT RELIGION AND SEXUAL ORIENTATION

We have seen that the APA discourages automatic responses on the part of the practitioner when faced with clients who are dissatisfied with their same-sex attractions. Neutralizing one's personal feelings or beliefs in this instance cannot be overemphasized. Many clients do not experience a conflict between their sexual and religious selves or will have decided on a direction prior to seeing a therapist. The present discussion is for the client whose frustration with therapy is born out of competing, seemingly irreconcilable internal differences. For such clients, it may be that neither a gay-affirmative nor a conversion-therapy approach is indicated. Many clients and their therapists have felt a responsibility to fit themselves into one of two polarized positions, "out gay" or "ex-gay" (Beckstead & Morrow, 2004). This discussion is intended to facilitate the development of a person-centered approach so that no client who struggles with these issues is left out.

The person-centered approach to addressing potential conflicts between sexual orientation and religious affiliation is intended to help the client make decisions about his or her life that may involve a number of complex tasks. This approach differs from traditional gay-affirmative therapy; in such therapy, the client and therapist generally agree that the goal is integrating an LGB identity into the overall life experience and facilitating psychosocial adjustment to living as an LGB-identified person. The present model is more

of a discernment process, with goals that may result in a path similar to gay-affirmative therapy but may also be different. There are three general stages of the person-centered approach to reconciling conflict between same-sex attraction and religious orientation: assessment, intervention, and integration. Assessment involves an evaluation of the individual's current sexual behavior and fantasy life. This stage includes a thorough investigation of the existential implications of the person's sexual orientation, as well as the psychosocial forces in the individual's life that would affect the way in which sexual identity and expression are viewed. Therapist and client then collaborate to identify treatment goals and, thus, what interventions are appropriate. Strategies employed in the intervention phase are dependent on the identified direction of treatment, which can vary from case to case. Finally, the integration stage presents a resolution of the conflict between sexual and religious identity. At this point, the client and therapist have an opportunity to review the entire process and to evaluate the integration process. All three stages are illustrated with case material that follows.

The emotional valence associated with both religious and spiritual beliefs and with same-sex attraction is often intense. All the more reason, then, to begin with a careful inquiry about the individual's psychosocial history as well as the meanings associated with religious and sexual expression. As will be seen in the following case discussions, sometimes the primary task of the therapist is to facilitate an integration of the elements of identity in conflict—for example, a same-sex attracted man in therapy moves toward integrating a gay identity and so relinquishes his conservative home community of faith for a more inclusive, gay-friendly religious setting. This may be a paradoxical process of freeing and grieving at the same time—freeing the individual from prior constraint about his sexual orientation, yet grieving the loss of long-held beliefs and family position. It also may be that the therapeutic discernment leads to a goal of prioritizing one identity element over another. Such would be the case if a heterosexual married man experiences strong same-sex attractions but decides to remain in his marriage, actively repressing his homoerotic self and prioritizing his family commitments and attachments.

A "one-size-fits-all" approach to these kinds of conflicts is not advocated, because the variety and nature of issues brought by conflicted clients defies generalities, and an examination of conversion therapies and gay-affirmative therapies is not offered. One must not assume that all who have sought conversion therapy have sustained long-term damage, although it is clear that many who undergo conversion therapies suffer psychological, social, and even physiological harms—either directly following treatment or chronically. The second case will briefly examine some of the therapeutic issues most profitably addressed for practitioners seeking to heal wounded ex-gay

individuals (for a more thorough discussion of such a treatment protocol, see Haldeman, 2001).

Cases will be presented for the purpose of making general observations about the challenges of work in this area as well as illustrating the processes that clients sometimes use to resolve internal conflicts about same-sex attraction and religion. The cases are drawn from the clinical experience of the author, a counseling psychologist in independent practice. It should be noted that although the term *conversion therapy* is often used to describe both professional interventions and ex-gay ministries, in this context, it refers to the former. The author's theoretical orientation is eclectic/humanist and generally involves both insight-oriented and psychoeducational components in most clinical work. His practice is primarily with gay men, many of whom have undergone some form of conversion therapy in an effort to change their sexual orientation and some of whom have been harmed in the process. He has long been a critic of conversion therapies and is a primary contributor to the APA documents mentioned above. At the same time, he respects religious practice and supports clients in making their own decisions about the prioritizing of religion in their lives. This discussion, however, is offered with the recognition that not all who have trod the difficult path of conversion therapy are meant to abandon their faith of origin and live as openly gay persons. The cases themselves are not intended to be representative of the experiences of those who struggle with conflicts in this area, nor are they intended to be generalized to the experiences of women (for which the reader should see Beckstead & Morrow, 2004, and Shidlo & Schroeder, 2002). Throughout the case discussions, every effort will be made to connect ethical considerations to elements of the cases. Finally, some general thoughts about developing a person-centered model of working, as well as implications for training, will be discussed.

Assessment of the Conflicted Client: A Case of Prioritizing

The first task of the practitioner working with conflicted same-sex attracted clients is to carefully assess the motivation behind a request for help in changing sexual orientation or behaviorally managing homoerotic feelings. Above all, the reflexive tendency to agree with or discourage such a change should be avoided. The following two cases illustrate this challenge. The cases encompass the three stages of assessment, intervention, and integration, but each case highlights one particular aspect of the model. In the first case, for example, it is recommended that a therapeutic direction be determined only after significant factors influencing sexual orientation change have been thoroughly investigated.

Phil, age 35, is an African American employed as a midlevel manager in a large corporation. He was raised in a strongly religious family in a large Eastern city and remains close to them, although he lives some distance away. Phil reports that he was aware of "feelings" for boys in early childhood and that these feelings had developed into strong attractions by adolescence. Although he acknowledges the struggle with his homosexual feelings has been life-long, he does not identify as gay. Phil's relationship history with women has been episodic and guilt ridden, particularly as most of these relationships were short-term efforts to dispel his homosexual feelings in conjunction with his extensive, but unsuccessful, involvement with ex-gay ministries. He has disclosed his conflict around sexual orientation to his family, who continue to pray for him but make it quite clear that he will no longer be welcome in their homes should he "give up" and succumb to what they perceive as "the gay lifestyle."

Phil's sexual interaction with men has been limited to furtive, anonymous encounters in public places, typically followed by intense feelings of guilt and shame. He does not identify as gay and feels no connection with the gay community, which he perceives as being dominated by "sissies and perverts." He fears the loss of his family as well as the loss of his conservative religious community, which he views as an extended family. Phil recognizes that unless he is able to manage his homosexual desires, his connection to both is jeopardized. Moreover, he truly believes that his homosexual feelings are a burden to be overcome. He presents for therapy seeking a way to resolve the profound dilemma created by the incompatibility of his values and his familial and community of faith connections with his homosexual feelings. As a result of this dilemma, he has become quite depressed and despondent.

Phil's situation highlights a number of issues common to individuals who are firmly rooted in a family and conservative community of faith. With such clients, the first task is to refrain from making inappropriate assumptions—for example, that Phil needs to overcome his internalized homophobia—or to invalidate his experience. Rather, it is important to assess the relative meanings associated with family, community, and religion. Practitioners strive to identify their biases in therapy and refrain from operating in a way that reflexively supports them. For example, some pastoral counselors might assume that Phil needs to set aside his same-sex desires, even if it would mean a celibate life, in the service of his connection to family and spiritual community. Conversely, some gay-affirmative therapists could conceivably devalue Phil's religious experience and encourage him to stop repressing his same-sex attractions. Neither perspective may be a realistic solution for Phil. His tendency to repress, compartmentalize, and then act out his sexual feelings in questionably healthy ways needs to be examined. The degree to which he projects his own self-loathing onto the gay community should also be

addressed. Furthermore, his competing need for inclusion in family and community of faith need to be validated and explored. Ultimately, if Phil integrates these seemingly disparate elements, it will be because he has embraced all of them.

Phil's attachment to his family and church is strong. He noted that his relationship with his mother is particularly close and that he spends every Sunday with her and his father. Most of his siblings, married and still living in the area, provide an extensive extended family network in which Phil is embraced and valued. Central to his relationship with the family, particularly with his mother, is practicing a conservative Christian faith in the context of a nondenominational church. The faith strictly adheres to heterocentric expectations for its congregants; homosexuality is so far afield from normative expectations that it is almost never mentioned. Similarly, the family no longer inquires about Phil's prospects for marriage. It is as if there is an unspoken agreement that whatever the reason, marriage prospects will not be explored.

The meanings of Phil's family relationships and his connection to his community of faith should not be taken at face value but investigated. Is he attached to this institution out of tradition, fear, genuine love, or a combination? How do Phil's racial and cultural experiences affect his feelings toward his church? Were he to come out, would he risk the loss of these connections? And, if so, what would replace them? Alternatively, should he choose to stay closeted in the service of his religious and familial attachments, will he continue to engage in anonymous sexual encounters? If so, how will he manage the attendant health and legal risks as well as the significant guilt he seems to experience?

Phil's stereotypes of the gay community should also be examined. What experiences form the basis of his impressions? Does he have any gay friends, or is his experience with other gay men limited to anonymous sexual contacts? Does his own internalized antigay prejudice distort his view of gay people? Additionally, Phil voices reasonable concerns about racism within the gay community. As an African American man, he fears what he perceives to be a White-dominated gay culture. These fears are realistic, and it would be unfair to discount them. He voices the concern that were he to let go of his family of origin, he would have difficulty finding a place in the gay community, given his race and his religious affiliation. Finally, there is the question of how to navigate a social environment with which he is totally unfamiliar. Any gay social venue, other than the Internet, would be for Phil a place where he might be spotted by someone who knows him.

It is reasonable to question Phil's view of what it means to be gay. In his case, it became clear that his perspective, including his near-wholesale devaluation of other gay men, was greatly influenced by deeply held religious beliefs that he identifies as contaminating his same-sex attractions. What

consideration might he give to alternative perspectives? After all, he is faced with a choice that requires tremendous sacrifice in either direction. Would he consider social exploration of the gay community in a nonsexual context? Were he to develop a greater sense of comfort with his own sexual self, would that translate into a clearer view of the gay community and a greater level of comfort with it?

A period of education and tentative exploration of the gay community followed. Phil read several self-help books about being gay and reported that even the process of purchasing them proved challenging. He attended several meetings of a support group for Black and White Men Together, became involved in a gay running group, and developed several acquaintances. Additionally, he began attending a Baptist church in his city that was a "reconciling" congregation—meaning that gay, lesbian, bisexual, and transgender individuals were welcomed. His response to this church was positive, particularly because he was able to meet other gay African American men. However, he reported on several occasions that the new church "just didn't feel like home."

At the end of this period of exploration, Phil decided that his initial religious/familial affiliation—and all that it entailed for him—held primary importance over his sexual orientation. He reported that he learned a great deal in the gay community and that his social experiences with gay men were generally pleasant and enabled him to overcome his stereotypes. Nevertheless, Phil indicated that realistically, he felt that he stood to lose everything that was important to him and that "coming out" was a risk he simply could not take. His decision, then, was to return to his community of faith and seek pastoral support for living as a celibate man.

He recognizes that his experiences in ex-gay ministries have been unsuccessful and even socially isolating as an African American. Had he asked for a referral to either a conversion therapist or another ex-gay group; however, it would have been problematic. Psychologists are responsible for offering appropriate referrals (APA, 2002), and conversion therapies offer no accepted treatment formularies or empirical record of success. Furthermore, they can be rife with misinformation and distortion that would surely have exacerbated Phil's tenuously resolved conflict about his sexual self (Shidlo & Schroeder, 2002). Ex-gay ministries have even less to recommend them as a possible referral for Phil, given their operation outside the scope of psychological science.

One option is to seek group resources for individuals seeking to develop their own models of sexual identity management (Beckstead & Morrow, 2004). Such groups are only beginning to be described in the literature. It is hoped that the future will bring more treatment options that do not force a client into an unrealistic choice between sexual and spiritual selves but that sup-

port the individual in carving out a path that may be challenging but ultimately more suitable. Finally, it may be that Phil's religious issues cannot be solved with interventions from psychological science and that he is better served by a gay-affirmative religious group or community such as Evangelicals Concerned. This conservative religious group has chapters in most urban areas and is dedicated to the reconciliation of same-sex orientation and conservative religious affiliation and practice. Finally, there are thousands of "reconciling congregations" throughout the country in a variety of religious denominations that employ pastoral staff whose counsel is not affected by a negative view of same-sex attraction.

Lastly, it is important to consider the possibility that Phil will someday return to psychotherapy. It is not uncommon for individuals with Phil's strong conservative religious family background to come in and out of therapy for an extended period until there is a resolution. The decision to relinquish either sexual expression or emotional security is often followed not with elation but with depression, and the client may require further treatment. These are not short-term cases, generally speaking, and it is essential for the therapist to be both patient with and respectful of the client's decisions regarding religious issues.

Treatment Phase: Psychoeducational Interventions

The following case includes some background and issues similar to Phil's but with a significantly different phenomenology and, thus, a different outcome. Of the three case examples, the therapeutic process described here is most similar to traditional gay-affirmative therapy.

Michael, age 28, comes to therapy following several years spent in ex-gay ministry groups. He reports a background similar to Phil's in its conservative religiosity, although he is Caucasian and was raised in an all-White fundamentalist church. He comes from a farming family in a rural area of the Midwest. Like Phil, there is no doubt that his primary sexual attraction is to men. However, unlike Phil, Michael has had a more rebellious response to the treatments that he sought out when he went away to college. Rather than continue trying different conversion therapy groups, he reports that he has given up because there has been no diminishment in homoerotic feeling despite years of trying.

Michael indicates that his primary history in conversion therapy was behaviorally based. Unlike Phil, who was taught to seek relief from his homoerotic feelings through prayer, Michael reports that he was encouraged to substitute heteroerotic for homoerotic fantasies and to date women. At the same time, he was encouraged to engage in "male bonding" experiences, such as sports. The intent of this approach was to augment normative male

affiliative experiences while boosting his heterosexual component. He was also counseled to avoid going out in public (errands, shopping, and so on) when there was a high likelihood of attractive men being present. He described having a realization, in a supermarket aisle at 11:00 p.m., that he was attracted to many of the men on his basketball team and that his attempts at relationships with women were fraudulent.

He decided at that point to seek a different form of therapy, one in which he might explore what it would be like—and what it would mean—to live as a gay man. Although this recognition was accompanied by some relief, Michael also became anxious about his unfamiliarity with the gay community as well as his prospects for a long-term relationship. He had been told that the lives of gay men were degenerate and solitary. Given the paucity of visible long-term gay couples, there were no data to counteract this misimpression. Michael was also concerned about the reaction his parents would have to his coming out. Although he had moved to a large urban area and was somewhat estranged from his parents, he was not interested in severing ties with them altogether. He came to therapy complaining of feeling "adrift"—considering that he might let go of the hope of someday identifying as heterosexual but not yet being committed to a gay identity or being comfortable in the gay community. Furthermore, he presented with a significant degree of residual shame and self-recrimination for having failed in his efforts at conversion therapy.

Although there are similarities with Phil's history, the therapeutic tasks in Michael's case differ somewhat. Michael comes to treatment with a bit more openness to considering a gay identity. Therefore, initial assessment will focus on his process related to this difficult decision in addition to his personal and family history. This process of inquiry involves confirming and validating his homoerotic and homoaffiliative experience and considering the implications of integrating these into a gay identity. Additionally, the consequences of his attachments to family of origin, should he come out, need to be explored.

There is an extensive literature debating the efficacy of conversion therapy. At the same time, little information is available about helping clients recover from what they consider an unsuccessful conversion therapy experience. It is not known what percentage of people who undergo conversion therapy are harmed by their experiences, but preliminary data suggest that a majority of conversion therapy clients report some negative consequences from their failures in these treatments (Shidlo & Schroeder, 2002). A recent treatment protocol suggests that some of the most common reactions to a failed course of conversion therapy include exacerbated levels of guilt and depression, difficulties in forming relationships with other men, and a generalized sense of "de-masculinization" (Haldeman, 2001). It is essential to

inquire about previous conversion therapy experiences and to carefully assess any psychological and emotional consequences. In some cases, it is necessary to work on healing the shame and depression that commonly follow conversion therapy before moving on to identity integration.

Michael describes his entry into conversion therapy as "a foregone conclusion," given his upbringing. Feeling marginalized as a sensitive child in his practical farm family, Michael resisted the notion of homosexuality as soon as he recognized that he was attracted to boys. He retreated into denial as an adolescent, developing a reputation as a loner as he struggled with the dissonance between himself and the norms of his family and community. As soon as he went away to college, he investigated an ex-gay ministry and began attempting to change his sexual orientation through prayer and group support. When this was unsuccessful, he sought out individual practitioners who practiced conversion therapy.

Michael's initial goal was to expunge homosexual feelings entirely from his consciousness. In time, he came to recognize that this was probably an unrealistic goal; nevertheless, he accepted the common conversion therapy belief that his homosexual feelings would fade in the context of a relationship with the "right" girl. A series of short-term relationships with women was characterized by conflict and frustration resulting from Michael's own ambivalence. His guilt about his homoerotic feelings was significantly exacerbated by the recognition that he was hurting the women with whom he became involved, many of whom blamed themselves for the demise of the relationship. Nevertheless, he continued trying for several years. By the time he had his supermarket "epiphany," Michael's self-loathing for being homosexual was significantly compounded by his shame at having failed at conversion therapy, his fear about what kind of future he would have, and an overarching sense of fear that he was likely to be damned for eternity.

Michael's fears about what his life might be like as a gay man stem directly from the distortion and misinformation about the lives of gay men that he had been subjected to by his religious involvement and his conversion therapists. Such fears need to be acknowledged because they develop during a long period of time and do not disappear overnight. Nonetheless, guilt and shame are neutralized through education and experience. Gonsiorek and Rudolph (1991) described a model of gay identity development that calls for an initial phase of permission. Once the individual abandons resistance, the true (in this case, gay) self may emerge. Although it is important to offer comfort and support for the residual emotional discomfort, it is also important to encourage education through reading and community involvement (similar to the experience of Phil) that accurately depicts the lives of gay, lesbian, and bisexual individuals. A treatment protocol for counteracting the negative emotional sequelae of conversion therapy suggests that depression and inti-

macy avoidance are resolved through integrating gay, lesbian, or bisexual orientation into the overall concept of identity (Haldeman, 2001).

The individual who has been misled about the normative life experiences of lesbian, gay, and bisexual people, as many in conversion therapy apparently are (Shidlo & Schroeder, 2002), needs corrective experiences. These experiences involve developing a network of support, including friends and a connection to community. People with a history of conversion therapy, such as Michael, sometimes fear that gay people are unable to form and maintain successful long-term relationships. Although it is true that such relationships often have little visibility, through community involvement and personal contact, the individual is able to see the range of options available to most LGB individuals. Michael's involvement in community groups was less extensive than was Phil's, owing in part to Michael's shyness. He did make a few close friends, however, which was useful in helping him understand that a long-term relationship, and even children, were not impossible in a redefined concept of "family." Above all, it is incumbent on the therapist to communicate that gay and lesbian individuals face numerous challenges related to social stigma and that these challenges often have an adverse effect on emotional well-being. Apart from this, however, there is no reason to infer any basis for lack of happiness, productivity, or family/relationship status based on factors intrinsic to sexual orientation.

Another significant element in the picture for Michael was his abiding conservative faith tradition. His beliefs of homosexuality as sinful were not only long-held but were intimately connected to his experience of family and community. Just as Michael came to see the conversion therapist as uninformed and prejudiced in the realm of sexual orientation, it can be equally true that clients do not view the mainstream therapist as competent in the area of religion. This variable is critical, for without some kind of adjustment in religious belief, the refugee from conversion therapy cannot fully integrate a gay identity—should that be his choice. And at this point in Michael's treatment, the lack of resolution with regard to his faith concerns prevented any further development of a positive gay identity.

Because religious issues are typically not addressed in models of sexual identity development, it is incumbent on the therapist to consider those issues when working with clients who experience religious conflicts. One option, as seen in Phil's case, is to refer the client to a reconciling or gay-affirming worship community. In Phil's case, the reaction was positive, but it was not sufficient to overcome the conservative religious framework installed in his identity. For Michael, the opposite proved true. His participation in a liberal Episcopal parish—a radical change from his rural White fundamentalist upbringing—proved to be the most significant factor in his ability to progress with the rest of his sexual identity integration. The theological bases of his

religious evolution, together with the fellowship provided by other people of faith who had integrated their sexual and religious orientations, proved a powerful curative element in Michael's development. These were also experiences that could not be supplied in psychotherapy, but they were central nonetheless. Therefore, it is useful for clinicians working with clients in conflict to be aware of local resources that welcome LGB persons of faith and others struggling with sexual and religious orientation.

One day, Michael came to therapy stating, "I am a Christian. I am a gay man. I always thought I couldn't be both. I am both." This was the beginning of Michael's integration of two previously disparate elements of identity and, as a result, of the therapist's ability to help him work on the process of coming out. As he proceeded to make friends and date, he felt increasingly that he was living a double life. His weekly calls to his parents, never a source of great interpersonal connection, felt increasingly strained. He had decided that he would not come out at his workplace and that it was similarly unwise to come out to his family. Still, he felt an ongoing sense of discomfort about this issue and considered the possibility of disclosing his sexual orientation when it "felt right" to do so.

Ultimately, the issue came to the foreground one year with the approaching holidays. Typically, Michael would spend Christmas with his parents, and his siblings and their spouses and children would join them for an extended family celebration. Michael always voiced ambivalence about the holidays, feeling obliged to attend but also feeling emotionally isolated during the event. Michael had started dating a member of his community of faith in the spring, and by autumn, the relationship was serious. He and his boyfriend wanted to spend the holidays together. Michael's boyfriend was willing to go with him to his family celebration on the condition that he disclose the nature of the relationship to his family and that they not masquerade as "friends." Michael decided to write his parents a letter in advance of the holiday, disclosing his sexual orientation and advising them of his new relationship. He explained that he would understand if they did not want to include Michael and his boyfriend in the family holiday celebration but that his coming alone was not an option.

Surprisingly, it was not his parents but Michael's oldest brother who had difficulty with this news. He sent Michael several e-mails castigating him for his selfishness and for adding a stressful burden to their parents, admonishing him about the likelihood that he would suffer in the afterlife. Michael and his brother are still estranged. His connection with his parents is much improved, however; they are able to speak openly about Michael's personal life, and he has sent them reading material and directed them to the local chapter of PFLAG (Parents, Family, and Friends of Lesbians and Gays).

Some lesbian and gay couples consider coming out as serving the same developmental function that marriage does for heterosexuals (Haldeman, 1998). In Michael's case, his depression was significantly relieved, and in time, his sense of diminished masculinity was restored. First, his misconceptions about normative gay life experiences needed to be corrected. Second, he needed to develop a "replacement theology" that would allow him to integrate his sexual orientation into his identity as a person of faith. Third, he needed to spend time getting acquainted with other gay men and with the gay community itself. These activities enabled him to envision, and ultimately experience, a fulfilling life as an out gay man.

Integration Phase: A Case of Sexual Identity Management

An individual's sexual behavior and sexual identity may be congruent or they may be at variance with one another. That is, sexual behavior may directly express the individual's experience of sexual identity (as with a man who identifies as gay in a same-sex relationship), or it may vary. The following case, that of a heterosexually married man who identifies as gay, illustrates another common scenario in which neither "ex-gay" or "out-gay" options are appropriate.

John is a 36-year-old Caucasian, married for 12 years and a father of three. Like the two previous cases, he presents with a history of participation in conversion therapy. Unlike the prior cases, however, John reports that conversion treatments were helpful in enabling him to develop and maintain a heterosexual relationship. John's family of origin knew of his struggles with homosexual feelings and was very supportive of him. Still, he sought out conversion therapy because of a steadfast adherence to his conservative religious upbringing and because he felt strongly that he wanted to be a parent and could not imagine this in other than a traditional heterosexual relationship. In John's early adulthood, images of lesbians and gay men as parents were not nearly as visible as they are today. Nevertheless, given his religious tradition, it is unlikely that he would have considered parenting in the context of a same-sex partnership anyway. John also understood that it was unlikely that he would relinquish all same-sex attractions and disclosed early on to his college sweetheart that he struggled with homosexual feelings. She agreed to pursue a relationship, provided that he refrain from homosexual behavior.

The couple married shortly after they finished college and started a family several years later. They have three children, ages 7, 5, and 2. John reports that he was able to compartmentalize his homoerotic feelings until shortly after the birth of the third child. At that point, he found himself obsessed with men, and he would find reasons to linger in the sauna at his gym, occasionally

engaging in furtive sexual activity. He acknowledges that his primary attraction has always been to men and describes himself as "functionally bisexual" in that he is able to generate and sustain heteroerotic competence with his wife to some degree. Although he reports that his sexual fantasies are primarily about men, John has no interest in leaving his family and coming out. He adores his children and still loves his wife, who is aware of his recent struggles. She is willing to continue the relationship but only on condition that John seek therapy to help contain his homoerotic impulses. John is further troubled by the guilt that accompanies his impersonal same-sex encounters.

Not all individuals in John's situation, of course, choose to stay married nor are all heterosexual spouses agreeable to the arrangement. Some spouses, for example, have no foreknowledge of their mates' homoerotic feelings because of their mates' shame and their belief that the "right woman" will expunge their homoeroticism. Still other spouses fear that as soon as the children are independent, their same-sex attracted mates will leave. But for those in John's situation, a therapeutic approach that enables the individual to separate feeling and impulse from behavior may be indicated. Such approaches are often referred to as *adaptation therapy* or *sexual identity management*, and they are cognitive-behavioral strategies that enable the individual to monitor and neutralize homoerotic feelings. Such a strategy has recently been described in detail (Yarhouse, 1998).

Many heterosexual spouses struggle with the knowledge of a partner's same-sex extramarital sexual activity. Frequently, maintaining a heterosexual relationship is contingent on the gay spouse's ability to avoid acting on homoerotic impulses. This involves identifying factors that lead to homoerotic arousal and working in whatever ways possible to limit them. In John's case, this meant refraining from using the sauna at his gym, contracting with his therapist to avoid the park where he would seek anonymous sexual encounters, and monitoring his use of the Internet for the purpose of meeting sexual partners. It did not mean denying the existence of such feelings, however. Previously caught in a cycle of denial, pressure, impulse dyscontrol, and guilt, it was important that John directly acknowledge his homoerotic feelings. They do not vanish simply because they are not acted on; to the contrary, they seem to gain added potential for mischief if suppressed.

The other important issue in sexual identity management involves sexual expression. It is not adequate, or desirable, for an individual simply to refrain from expressing homoerotic feelings. The individual must decide if he or she will express them in some form—typically, autoerotically—or if this is too disruptive. Other nonsexual alternatives involve support groups for heterosexually married gay men and a broad array of social and interest groups that welcome men of any sexual orientation. Furthermore, the married individual

must take responsibility for a certain level of heterosexual interaction with the spouse. This is much more realistic if the individual has a bisexual component or has experienced at least some heteroerotic feelings. In John's case, he had an extensive heterosexual history prior to marriage and acknowledged an ongoing heteroerotic response to his wife. Without this, it is far less likely that such an individual can succeed in a heterosexual relationship—or that the individual's partner can be satisfied.

At least for now, John has been able to resolve his issues about being a man with strong homoerotic impulses who lives in a heterosexual marriage. He has been able to successfully avoid homosexual acting-out and has been able to channel his sexual energy into a sexual relationship with his wife that both describe as adequate to good. Ultimately, the greatest reinforcer has been his deepened sense of identity as a father in a heterosexual relationship. John is, by all reports, an excellent dad who is extremely involved with his children. He feels proud of the fact that the way he lives his life expresses the primary importance he places on his role as a father. As is often the case, however, his wife carries the most ambiguous burden. Although she did not attend therapy sessions, John reports that she feels anxious and insecure about John's true attractions and, as a result, about their future. This is understandable, and it was recommended that the couple enter therapy to address some of her concerns. In a relationship where the children are central, what will happen when the children are gone? Will she be reason enough for John to remain in the marriage after years of containing his homosexuality? As John enters midlife, will he ultimately tire of the strain of so many years of internal sexual repression?

There are no easy or obvious answers here other than to see why celibacy is so often advocated for religiously oriented people who are struggling with their sexual orientation. Suffice it to say, heterosexual marriage is not a realistic choice for all men like John or for their wives. For the former, it requires considerable dedication to family, skill at compartmentalizing sexual impulses, and some heteroeroticism. Their wives require an ability not to see themselves as failed women because of their husbands' attraction to other men as well as a tolerance for ambiguity in the extreme. Regardless, it may ultimately be the right choice for some couples; as a result, it is necessary to offer them some therapeutic resource.

GENERAL IMPLICATIONS FOR TREATMENT

These cases are but three examples of the ways in which religious and sexual orientation can intersect. They are not meant to be representative of all

men who struggle with these issues, nor are they intended to be typical of the population who stand at this often-challenging crossroads. We have no examples reflecting the experiences of women who struggle with these issues. At present, no data exist that would demonstrate the relative frequency of these conflicts, given the extreme difficulty of conducting any reasonably random survey research in this area. Outside the debate about the efficacy of conversion treatments (Haldeman, 1994; Tozer & McClanahan, 1999), no data exist that would determine the relative numbers of individuals who have already resolved the "religion versus sexuality" question one way or the other prior to presenting for therapy.

From these examples, however, some general considerations might be drawn that have some utility when applied to the wide variety of cases involving a conflict between religious and sexual orientation. Most important are the ethical aspects of this issue, outlined in APA's (1998) resolution on Appropriate Therapeutic Responses to Sexual Orientation. Of primary concern is respecting the values and life experience of the client and upholding the client's right to self-determination. This means that the therapist must maintain a facilitative stance and be particularly vigilant that personal values do not negate the client's experience of religion or sexuality. The first two cases deal with clients who come to therapy with strong conflicting feelings and do not know how they are going to be resolved.

The first phase of treatment, assessment, serves to lay the groundwork for eventual goal development. It is a value-neutral enterprise. In both cases, a careful inquiry precedes developing a framework in which the client may come to his own direction—recognizing, of course, that the initial choice of direction may change, as it did for Phil. In any case, when the individual is experiencing significant distress about pressure from family and/or religious institutions, the therapist must not demean the client's history as something to be "overcome." The initial phase of the work involves helping him to understand the effects of his social environment and to make choices about possible options for his future based on his own goals. Had the therapist adopted an antireligious stance, Phil's inner conflict might have been exacerbated rather than resolved. In his case, of course, after deciding to explore life as a gay man, he chose to return—at least for now—to his community of faith. A therapist supports this free agency, recognizing that Phil's struggle is an unfolding process.

Deliberately misinforming the client about the normative life experiences of LGB individuals, although apparently widespread among conversion therapists (Shidlo & Schroeder, 2002), violates the spirit of value neutrality and is a potential source of ethical malfeasance. Unfortunately, most practitioners of conversion therapy operate outside the ethical mandates of any orga-

nization. Nevertheless, this author has found that a number of clients' conflicts are rooted in simply being misinformed about what it means to live as an LGB individual. Equally disturbing is the knowledge that often, therapists do not tell clients with conflicts about sexuality and religion that alternatives to conversion therapy exist or that conversion therapies themselves are not considered to have a high probability of success (Shidlo & Schroeder, 2002).

Following assessment comes a choice point: How does the client work toward the goals he has developed? Does he proceed with an investigation of developing an LGB identity, return to an original community of faith, or devise yet a different path? Should he wish to prioritize his religious orientation, community resources have been mentioned that may serve as helpful adjuncts to alternatives with which he is already familiar. If he chooses, even temporarily, to investigate the LGB community and "try on" a gay identity, a psychoeducational/experimental phase ensues in which the individual explores living as a gay person to the extent that he feels comfortable. This may not require an actual "coming out" process but may involve social and affiliative explorations like Phil's and Michael's. However long this period lasts, the therapist must be careful to provide support and resources when requested to do so but act as neither cheerleader nor skeptic for exploring life in an unfamiliar gay community. John's case was somewhat different in that the goal-setting phase led to the decision to remain in his marriage and not explore the possibility of developing a gay identity. In his case, the experimental phase focused on management strategies for acknowledging his homoeroticism but containing it in ways that were ego-syntonic.

The third phase of treatment with these clients has been described as the integration phase. At this point, the information gathered in Phase 2 has led the individual to determine the course that will most likely embrace the two previously conflicting elements of identity. In Phil's case, the integration results in a return to his community of faith and the choice to seek spiritual support for living as a celibate man. Although he recognizes that this means suppressing or somehow managing his ongoing homoerotic feelings, he feels confident that he has engaged in a process that enables him to see this as an informed and fully conscious choice. He further believes that he can access the necessary resources to make this a realistic integration. Michael's integration involves beginning the coming-out process and a transition to a different religious community—again, after a period in which his experience validates this decision. John chooses a path that enables him to resolve the tension between his sexuality and his identity as a person of faith and a father and husband. This is a challenging direction, but he leaves treatment with considerable resources to manage his sexual identity so that it feels less like a conflict and more like the free choice that it is.

RELATED CONSIDERATIONS: COUNTERTRANSFERENCE, TRAINING, AND MULTIPLE IDENTITIES

Religion and sexuality are two of the issues most capable of eliciting emotional responses for both client and therapist, and their intersection intensifies this capacity. It is essential that the therapist working with clients who have conflicts regarding religion and sexuality be especially vigilant that their feelings about either or both of these areas do not lead to countertransferential reactions that could exacerbate the client's confusion. Therapist behaviors that could be an extension of countertransference are generally expressed as prejudice against a client's considering a possible course of action. For the religious client, a therapist could discourage the expression or investigation of faith-based options when the therapist believes that the client needs to overcome his religiously induced internalized homophobia and come out. For the client who is struggling with his sexual orientation, a therapist could provide direct or subtle encouragement toward conversion therapy or, in extreme situations, mislead the client about the lives of LGB individuals. Countertransferential reactions may be overt and verbal, or they may be subtle and nonverbal. In either case, 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 either religious or LGB individuals are such that the advancement of therapist agendas cannot be avoided, a referral should be made.

In considering these issues, psychologists in training are advised to recognize the limits of their own neutrality and to examine their own biases relative to both religion and sexuality. The ethical standards that apply to work in this area—informed consent, accuracy of information, withholding of prejudicial attitude, and respect for autonomy—must be emphasized in training. The past few years have seen an increase in the availability of training materials about LGB issues and generally greater inclusion of LGB issues in training curricula. Including this particular area of conflict, although it may not represent a large portion of the therapy-seeking LGB population, poses interesting clinical challenges for the therapist in training.

Of particular concern are students trained in religious institutions or those with religious backgrounds who are trained in mainstream institutions. Although we may like to think that there is always a "common ground" from which conflicts between sexuality and religion can be resolved, this is not always the case. APA's accreditation policy provides for an exemption so that some religiously affiliated training institutions can discriminate on the basis of sexual affiliation. In another case, an intern under the author's supervision reported her intent to advise a client to seek conversion therapy, even though

it was not his stated desire. These are potential ethical breaches and should be identified as such. The elements of both sexual orientation and religious expression cannot always be equally honored in the diversity equation. Religion—and the enormous social and institutional power behind it—used in the coercion or oppression of a person struggling with his or her sexual orientation is ethically contraindicated. Similarly, the person (such as Phil) who chooses to prioritize his religion over his sexuality should not be impeded from so doing.

Although few aspects of identity can seem as potentially mutually exclusive as religion and sexual orientation, it may be possible to apply the considerations from this discussion to other sometimes-conflicting aspects of identity. Sexual orientation and age, for example, often require a series of compromises and priorities in a social sense—both for LGB youth and LGB elders. Young people struggling with coming-out issues are often vulnerable because of the lack of social and familial support as well as challenges with academic and social competence. Similarly, LGB elders are often socially marginalized within the LGB community itself, feeling invisible in what is sometimes perceived as a youth-oriented culture. Furthermore, medical and social support resources for LGB people later in life can be scarce, although that may change as the gay baby boomers age. Bisexual and transgender persons can also experience their own sense of distance within the context of the gay community. They are viewed by many as not really "belonging"—bisexuals because of their periodic heterosexual privilege, transgender people because of the sense that theirs is an issue of gender identity, not sexual orientation. Finally, LGB persons of color have found that the sometimes-conflicting norms of the gay community and their cultural communities can be difficult to navigate (Greene, 1994).

SUMMARY

The debate about the justification for and efficacy of conversion therapy has bypassed those individuals for whom neither conversion nor traditional gay-affirmative therapies are appropriate. This discussion has highlighted some of the complexities that neither of the dominant positions adequately addresses. The treatment philosophy is antidogma; rather than encourage either "coming out," repressing sexuality in the service of religious belief, or advocating for any particular outcome at all, a treatment framework is offered that enables the client to make decisions for himself. The concepts used here are intended to be applicable to each specific case by thoroughly examining the histories, experiences, and existential aspects of the individual's sense of sexuality and religious affiliation. The above cases show that

the dissonance between sexual and spiritual orientation frequently raises dilemmas for which there may be no adequate answers. The individual who is able to successfully integrate sexuality and spirituality is indeed fortunate. Many clients, however, ultimately come to a crossroads involving difficult sacrifices in one direction or another. In general, the therapist's task with such individuals is to provide not wisdom, advice, or direction but a safe holding environment in which the client is free to explore the many challenging questions associated with identity conflicts. Further, it is the therapist's responsibility to provide accurate information and to suggest alternative courses of action.

The practical and ethical ramifications for the sexually/spiritually conflicted client are considerable. For example, if gay identity is expressed to the exclusion of a conservative religious background, the potential losses of family and community are not easily replaced, especially for the individual unfamiliar with the gay community. And these losses may pale in contrast with the profound existential loss of a religious institution whose doctrine provided meaning and comfort but whose doors are not open to noncelibate, same-sex-attracted individuals. Similarly difficult challenges face the individual who chooses religious expression instead of same-sex attraction. The repression of same-sex feelings for the individual seeking to live in a heterosexual or celibate manner can exact a great psychic toll.

Additionally, the therapist faces unique challenges with clients in this situation. Many therapists may have difficulty sanctioning any course of action that subverts one part of identity for another. Some believe that it is easier to find a new religious affiliation than to change or repress one's sexual orientation; thus, they will attempt overtly or subtly to guide the client in this direction. This may be an inappropriate choice for the individual as well as a disruptive element in the therapeutic environment. Similarly, some religious counselors may be at risk for ignoring their client's realities because of a scripturally induced rigidity about the way in which people should live their lives.

We live in a time of unprecedented visibility for LGB individuals, their families, and their life concerns. In an age where sodomy laws are struck down, gay marriage is judicially sanctioned, openly gay individuals are elevated to the bishopric, and gay men appear on television to offer lifestyle advice to their straight brothers, it seems as though the gulf between the LGB community and mainstream society is narrowing markedly. Nonetheless, the codification of antigay attitudes on the part of powerful religious institutions invariably instills in some individuals profound discomfort with their sexual orientation. Psychology's responsibility is not to contravene its own database or its own policies by supporting treatments founded in the conception of lesbian, gay, and bisexual people as mentally ill or incapable of fulfilling, pro-

ductive lives. Nor, however, should psychology deny individuals the right to therapeutic support in making the accommodations necessary to living lives that are consonant with their personal values. To this end, a broader array of treatment models, based on more extensive research, needs to be developed. Until the world is free of antigay bias and prejudice, we need to be as responsive as possible to all people that are affected by it.

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