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Ethical Treatment For People Who Present With Unwanted Homoerotic Attractions

Guidelines For Therapists

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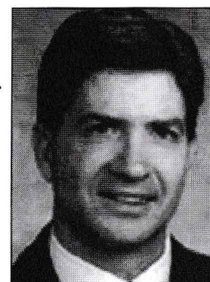
Many people in therapy who have homosexual feelings are in the initial stages of exploring the meaning of these attractions with people they trust.

They wonder what the future holds for them, and if marriage and family can be a reality. They wonder about their place in society—among peers, family, and various communities of people in which they are involved. Some are questioning their faith and values, and wonder how society will respond to them.

A consistent hope for some of these people is that same-sex attractions (SSA) can be reduced or eliminated, and that joyful heterosexual functioning can emerge. These clients tend to look especially to their therapists for assistance, partly because no one else seems to understand the issues involved or exactly how to help. It is an issue that many people, increasingly more publicly, have opinions about, but to which almost no one seems to know how to respond.

This paper is an effort to explore issues related to ethical, therapeutic treatment. Ethical and therapeutic treatment concerns the manner in which a person is treated by the therapist so as to promote trust, mental health, and personal development. At the heart of ethical considerations is how to reduce or eliminate harm, and promote health. Based on available research and clinical stories, I have categorized potential ethical dilemmas and biases of three varieties of therapists—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1) those who help clients with their goals to reduce SSA and where possible, increase heterosexual attraction

2) theoretically non-committed therapists whose beliefs might not agree with aspects of GLB identity or behavior, yet remain skeptical about change, and

3) GLB advocating or affirming therapists whose goal is to assist clients in accepting a GLB identity. My hope is that the issues raised here will spark discussion and deeper pondering of personal bias, so that ethical practices can improve and clients' needs can be met. Although I offer my opinions and biases throughout, the reader is invited to respond to the issues involved. The

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guidelines used to assess ethics and harm are taken from the Code of Ethics for the American Association for Marriage and Family Therapy (2001) and the American Psychological Association (2002).

Ethical Dilemmas And Biases Among Three Types Of Therapists

Category One: Therapists who undertake to assist clients to reduce SSA and promote heterosexual functioning.

It is valuable to understand what may constitute harm from the experience of therapists and men and women who have undergone therapy in an attempt to develop stronger heterosexual attractions. The following problems are cautions to therapists, based on the work of Beckstead (2001), Haldeman (2002), and Shildo and Schroeder (2002).

Therapists who undertake to assist clients to reduce SSA and promote heterosexual functioning may tend to *err* in the following ways, and should consider the ethics involved. These therapists may: **Over-promote heterosexual potential** and over-induce a client to believe that change is possible in every case. Therapists may be guilty of presenting unrealistic goal expectations, and work beyond the client's capacity to incorporate different attitudes and directives. A therapist who does this may be guilty of AAMFT ethics code 1.7, "MFT's do not use their professional relationships with clients to further their own interests." A therapist who presses too hard may neglect to consider co-morbid diagnoses that may constrain changes in sexual development.

Tie personal worth, salvation, or social role viability to heterosexual functioning. Clients of faith have typically thought through the implications of having SSA many times over, and are usually worried and may feel discouraged about not having stronger heterosexual feelings. Such a client may be experiencing a crisis of faith. A therapist may imply "wrongfulness" of homosexuality by his or her approach in a way that the client may internalize that message, believing he is condemned or less socially viable.

Vulnerable clients, at the beginning of therapy, have difficulty distinguishing between self-worth and their homosexual feelings, thoughts, and actions. Too strong of an approach at this phase may confuse a client unnecessarily. Time may be necessary to form a therapeutic alliance, in which the client is assured that her self-worth is not tied to either homosexuality or the direction she may take with these attractions. A strong therapist agenda may preempt a client from feeling safe to contemplate "out-loud," discrepancies in his or her own values, thoughts, and goals.

Prematurely attempt to end clients' ambivalence about their condition, by rushing to goal-setting toward increasing heterosexual feeling. Some clients are past a contemplative stage—they want to work toward greater integration within a GLB framework; others, and perhaps the majority of clients who present for therapy with NARTH members, want to work toward heterosexual functioning. A significant number are pre-contemplative or in contemplation. A therapist who has strong values about heterosexuality may prematurely try to persuade the client into goal setting and action before he or she is ready. Such a client may naively trust the therapist, but not have the emotional or mental solidarity to accomplish what the therapist is asking. This client is likely to feel like a failure and that change is impossible for him.

Unintentionally create a dependent or conditional therapeutic relationship with the client, which can border on exploitation. As clients increase trust in the therapist (who is sometimes perceived as a last

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"Victory on the Bow of a Ship"