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Contents

Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy[i]

Alliance for Therapeutic Choice and Scientific Integrity

Task Force on Guidelines for the Practice of

Sexual Attraction Fluidity Exploration in Therapy (SAFE-T)[ii]

Salt Lake City, Utah

Many significant developments have occurred in the field of same-sex sexuality in the decade since the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) introduced the first edition of its Practice Guidelines (ATCSI, 2010). These developments necessitated that the guidelines be updated to address the professional and legal realities that face therapists who assist individuals in exploring the fluidity of their unwanted same-sex attractions and behavior. The revised Guidelines incorporate the now preferred language of sexual attraction fluidity exploration in therapy[1] (SAFE-T) as the most accurate description of contemporary professional clinical intervention with these individuals. Therapists are therefore encouraged to adopt this new language in their work as an umbrella term for a variety of specific mainstream approaches utilized by individual clinicians (Rosik, 2017a).

Clinical intervention with individuals who wish to explore the degree of fluidity of their unwanted same-sex attractions and behavior continues to generate controversy. Within the left-of-center sociopolitical environment, which currently dominates academia and mental health associations (Al-Gharbi, 2018; Cummings, O'Donahue, & Cummings, 2009; Duarte, Crawford, Stern, Haidt, Jussim, & Tetlock, 2015; Honeycutt & Freberg, 2017; Inbar & Lammers, 2012; Jussim, Crawford, Anglin, & Stevens, 2015; Redding, 2001, 2013; Wright & Cummings, 2005), individuals who pursue and/or report enhanced heterosexual functioning through psychotherapy may have their experiences

[1] SAFE-T can be defined as the client-centered exploration of sexual attraction fluidity among clients reporting unwanted same-sex attractions utilizing established psychotherapeutic modalities.

of change marginalized or invalidated. One development which has tended to marginalize the clinical exploration of sexual attraction fluidity has been the production by professional psychological associations of resolutions, position statements, and practice guidelines related to therapeutic approaches to sexual orientation (e.g., American Psychological Association, 2009, 2012; Gamboni, Gutierrez, & Morgan-Sowada, 2018). While there is much helpful information in these documents with which clinicians should be familiar, they are nonetheless limited by their lack of diverse professional perspectives (Ferguson, 2015; Yarhouse, 2009). Specifically, they often appear to be produced by partisan committees whose members do not generally share the goals, values, or worldviews of many clients who seek assistance in exploring the degree to which their unwanted same-sex attractions and associated feelings, fantasies, and behaviors may be subject to psychotherapy-assisted fluidity.

This document is intended to provide educational and treatment guidance to clinicians who affirm the right of clients to explore the fluidity of their unwanted same-sex behavior and attractions. The specific goals of these guidelines are twofold: (a) promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who pursue SAFE-T regarding their unwanted same-sex attractions and behavior and (b) provide information that corrects stereotypes or mischaracterizations of SAFE-T and those who seek it.

Given that the very right of clients to pursue SAFE-T continues to be questioned within mental health associations (American Psychological Association, 2009, 2012; Gamboni et al., 2018; Kaplan et al., 2009; Yarhouse & Throckmorton, 2002) and is increasingly the focus of legislative and other legal prohibitions (Dubrowski, 2015; Rosik, 2017b), the ATCSI Board determined that an update to their earlier practice guidelines (ATCSI, 2010) was warranted. Members of the original task force were contacted and invited to participate in this revision. Those able to participate were joined by others invited to participate in this reconstituted task force due to their specific areas of expertise. A revised draft document of the original guidelines was completed and then sent out for review to the ATSCI board and selected members of the association's professional membership. Subsequent feedback was then considered and, where deemed beneficial, incorporated into the final version of the revised SAFE-T practice guidelines.

The term *guidelines* refers to statements which suggest or recommend specific professional behavior, endeavors, or conduct for clinicians. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. By contrast, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by clinicians. Thus, practice guidelines are not mandatory, exhaustive, or applicable to every professional and clinical situation. These guidelines should not be construed as replacing accepted principles of psychotherapy but rather as supplementing them. Nor are these guidelines intended to serve as a standard of clinical care. Instead, they are meant simply to reflect the state of the art in the practice of psychotherapy with same-sex attracted clients who desire to engage in SAFE-T. These guidelines are organized into three sections: (a) attitudes toward clients who pursue SAFE-T, (b) treatment considerations, and (c) education.

Attitudes Toward Clients Who Pursue SAFE-T

Guideline 1. ***Clinicians are encouraged to recognize the complexity and limitations in understanding the etiology of same-sex attractions.***

The standard opinion in the field of the behavioral sciences is that the causes of human behavior are multifactorial (Jannini, Blanchard, Camperio-Ciani & Bancroft, 2010; Rutter, 2006). Similarly, there is a general consensus that the etiology of homosexuality is multifactorial (e.g., Gallagher, McFalls, & Vreeland, 1993; Kleinplatz & Diamond, 2014; Otis & Skinner, 2004; Rosario & Schrimshaw, 2014; Sanders et al., 2014) as are the reasons that cause some people to view their same-sex attractions and behaviors as unwanted (cf. Guideline 3). Historically, a large variety of approaches to intervention have been followed, and there have been vastly different individual theories of etiology. This arose because many approaches yielded sufficiently adequate outcomes for counselors, therapists, and their clients and hence tended to be adopted as the sole and sufficient explanation of origin. The strongest childhood correlate of an adult same-sex orientation is that of clinical Gender Dysphoria, which has been associated with subsequent homosexuality in 50% or more of cases in longitudinal studies (e.g., Zucker & Bradley, 1995). However, the low prevalence of full-fledged Gender Dysphoria among those who experience same-sex attractions means that this explanation only applied in a minority of cases, although subclinical gender identity concerns may be more common.

Sociological research has not shown any one environmental, family, or social factor as predominant in production of same-sex attractions for the majority of gay- and lesbian-identified people. The exhaustive work of Bell, Weinberg, and Hammersmith (1981) considered all known factors to that date and concluded each could only be numerically responsible for a small fraction of the causation. This was confirmed by the work of Van Wyk and Geist (1984). However, the sociological factors taken together were statistically significant (Whitehead, 2011a), and this was mostly not an artifact of presumed stability of same-sex attractions from adolescence to adulthood. Deliberate choice also seems to be another quite minor factor (Whitehead, 2013).

Biological research does not show one predominant cause; indeed most influences have been numerically minor, though many individual correlations have achieved statistical significance (Abbott, 2010; Bogaert, 2007; James, 2006; Martin & Nguyen, 2004; Meyer-Bahlburg, Dolezal, Baker, & New, 2008; Lalumiere, Blanchard, & Zucker, 2000; Rahman, Kumari, & Wilson, 2003; Sanders et al, 2014; Whitehead, 2014). The degree of concordance of sexual orientation in twins is the result of multiple influences, whether known to researchers or not, and twin studies suggested that multiple individualistic responses predominate to a degree that had not been expected (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Hershberger, 1997; Langstrom, Rahman, Carlstrom, Lichtenstein, 2010; Santtila, Sandnabba, Harlaar, Varjonen, Alanko, & von der Pahlen, 2008; Whitehead, 2011b). A general context for the biological causes is the strong academic emphasis on plasticity of neural processes (Pascual-Leone, Amedi, Fregni, & Merabet, 2005), in which the brain is constantly reprogramming itself, partly in reaction to environmental events. Although this should not be presented as making any desired behavioral change easy, it can certainly be legitimately presented as

an argument against the impossibility of fluidity and change.

Therefore, there is a particular need and responsibility for clinicians to take client histories seriously and to not impose on all clients' particular etiological theories even if they have been clearly applicable in individual cases (c.f. Guideline 6). On the other hand, a client may deny for psychological reasons events or processes which to the clinician are obvious causes, and it may be legitimate to confront the client if this is present. A balance must therefore be struck between taking clients' histories very seriously, and retaining therapeutic objectivity. There is also a special need for peer consultation and broadening one's understanding by collating influences which clients have found important. Although no overwhelmingly predominant factors are likely to be found, several broad themes are already known, which may contribute to the endpoint of same-sex attraction and behavior. In no particular order these include, but are not limited to, sexual abuse (Jones, 2006; Mustanski, Kuper, & Greene, 2014), conditioning from childhood sexual experience (Beard et al., 2013; Hoffman, 2012; O'Keefe et al., 2014; Pfaus, 2012), relationships with parents (Francis, 2008; Frisch & Hviid, 2005; Udry & Chantala, 2005), relationships with same-sex peers (Bem, 1996), political solidarity (Rosenbluth, 1997; Whisman, 1996), and atypical gender characteristics (mental or physical/biological) (Zucker & Bradley, 1995).

Discretion is thus necessary in comprehending the etiology of same-sex attractions in any particular client, as is suggested by leading mental health organizations now being noncommittal on the issue (APA, 2008a; Rosario & Schrimshaw, 2014). Nevertheless, a broad but unified understanding of these diverse influences might be found in viewing same-sex attractions and behavior as a developmental adaptation to less-than-optimal biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition.[2] Furthermore, this adaptation may be distressful to some individuals in light of their values and/or because it frequently results in behavioral practices that place participants at risk for mental illness and physical disease (cf. Guidelines 3, 8, and 12). Given the complexity of this topic, clinicians who work with clients reporting unwanted same-sex attractions and behavior must be even more concerned about, and committed to, contributing data for research, subject to the usual confidentiality requirements. This would help broaden our understanding of the etiology of same-sex attractions and behaviors.

Guideline 2. ***Clinicians strive to understand how their values, attitudes, and knowledge about homosexuality affect their assessment of and intervention with clients who present with unwanted same-sex attractions and behavior.***

When individuals enter into psychotherapy and express conflicted feelings, thoughts, or values about their same-sex attractions, or any other issues, clinicians engage them from their own values and biases. These values inform the choice of theories, techniques, and attitudes clinicians utilize in their efforts to help these clients explore their presenting issues (Blow, Davis, & Sprenkle, 2012; Jones, 1994; Meehl, 1993; Midgley, 1992; O'Donohue, 1989; Redding, 2001).

[2] An example of such genetic predisposition occurs when a girl, through her genetic inheritance, is attractive to boys and hence more likely to become pregnant as a teenager. This is a weak and indirect effect because many other cultural and situational factors are involved in determining whether she has early sexual intercourse and those influences usually predominate.

Professional mental health associations have historically recognized this principle in their ethical guidelines, which call upon clinicians to be aware of their own belief systems, values, needs, and limitations and how these factors affect their work (e.g., American Association of Marriage and Family Therapy, 2015; American Psychological Association, Ethical Principles, 2017). In this context, the professions have encouraged clinicians to exercise reasonable judgment and ". . . take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices" (e.g., American Psychological Association, 2017, Ethical Principles, Principle D, p. 4). In addition, mental health associations have also recognized that sexuality and religiosity are important aspects of personality (American Psychological Association, 2008b). Clinicians are encouraged to be aware of and respect cultural and individual differences, including those pertaining to religion and sexual orientation, when working with clients for whom these dimensions are particularly salient (American Psychological Association, 2017, Ethical Principles, Principle E; cf. Guideline 3). This is particularly pertinent because surveys suggest that those who come for therapy tend to be much more religious than average (Santero, Whitehead, & Ballesteros, 2018).

Clinicians are encouraged to be aware that their meetings with clients, wherein the clients' presenting problem is their need to clarify conflicted attitudes toward the same-sex attractions they experience, represents a microcosm of the conflicts which are being played out in culture within the spheres of morals, laws, and psychological definitions about the nature and position of homosexuality in our society. Clinicians need to be aware that historically, same-sex attractions and behavior were thought of as a moral issue (i.e., sin) by theologians and laypersons, as a legal problem by legislators (i.e., a crime), and only later as a psychological phenomenon (i.e., a psychic disturbance) (Katz, 1976). Same-sex attractions and behaviors were, and to a significantly lesser extent are still, seen or experienced in our culture as moral failures to be judged (Gallup, 2018), criminal acts to be prosecuted (Posner & Silbaugh, 1996; Rubenstein, 1996), often stigmatized and discriminated against (Eskridge & Hunter, 1997; Herek, 2010; Rubenstien, 1996), and until 1974, as a disorder in and of itself to be treated (American Psychiatric Association, 1972).

The last few decades have brought about accelerating changes in the moral valuation, legal status, and psychological description of homosexuality (Twenge, Sherman, & Wells, 2016). The latter was reflected by the removal of homosexuality in and of itself from the category of a pathological condition from the DSM in 1973 by the American Psychiatric Association (APA, 1973). At this time the legitimacy, effectiveness, and ethicality of change-oriented intervention also came into question. This, in turn, led to most mental health associations asserting that homosexual orientation and/or attractions could never be modified (e.g. American Psychological Association, 2008a). Within this exclusively gay-affirmative position, the presumed and prescribed optimal outcome of therapy for clients ambivalent about their attractions to the same gender is developing and achieving acceptance of and identification with their sexual desires.

Clinicians who continue to practice SAFE-T believe change in terms of sexual attraction fluidity is possible and available for many highly-motivated clients, for whom the goal of therapy is the lessening of their same-sex attraction, the development

and increase of their opposite-sex attractions and identification, or, short of that, achieving a stable identification with an abstinence-based life (ATCSI, 2009; Byrd & Nicolosi, 2002; Santero et al., 2018). Other clinicians can identify with both of these positions. They look at the goals of change and the goals of the gay affirmative stance as possible and ethical without an exclusive value commitment to either one as they counsel a client with ambivalence about same-sex attractions as the presenting problem (Throckmorton & Yarhouse, 2006).

As clinicians attempt to approach the task of assessment, informed consent, and goal-setting, an additional obstacle needs consideration: to define the complexities of sexual orientation and its development. Many social scientists share an interactionist perspective, which postulates that sexual orientation is shaped for most people through the complex interaction of biological, psychological, and social factors (cf. Guideline 1). There is a lack of consensus about how best to measure and what constitutes the central components or dimensions of sexual orientation (e.g., attractions, behavior, fantasies, identification, or some combination of these elements) (Beaulieu-Prevost & Fortin, 2014; Kinnish, Strassberg, & Turner, 2005; Moradi, Mohr, Worthington, & Fassinger, 2009; Sell, 1997; Throckmorton & Yarhouse, 2006). This leads to further problems with measuring reliability and estimating prevalence rates (Byne, 1995; Laumann, Gagnon, Michael, & Michaels, 1994; Stein, 1999). In addition, after December 1973, when homosexuality in and of itself was no longer categorized as a disorder, the research on the possibility of changing unwanted same-sex attractions substantially decreased from the professional literature (Jones & Yarhouse, 2007).

Along with considering the above, clinicians are encouraged to reflect on the following potential biases they may encounter as the exploration of a client's issues begins (Rosik & Popper, 2014). Clinicians who have adopted a primarily gay-affirming stance tend to focus on that portion of the research literature which emphasizes a lack of difference in pathology between individuals with same-sex attractions and the rest of the population, attributing most symptomology that differentiates the two populations to internalized negative messages about homosexuality and external minority stressors (Gonsiorek, 1991; Hatzenbuehler, 2009; Meyer, 2003), although the direct effects of perceived discrimination generally account for less than 10% of the variance in health differences (Pascoe & Richman, 2009). They may ignore the possible etiological significance of social and developmental factors, such as a higher incidence of childhood sexual abuse, particularly for men (Eskin, Kaynak-Demir, & Demir, 2008; Fields, Malebrance, & Feist-Price, 2008; Friedman et al., 2011; James, 2005; Stoddard, Dibble, & Fineman, 2009; Tomeo, Templer, Anderson, & Kotler, 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). They may also ignore the potential for discrimination to occur within LGB communities (Matsick & Rubin, 2018). They might emphasize mostly the methodological limitations in the research literature, which indicate the possible efficacy of change intervention (Gonsiorek, 1991, American Psychological Association, 2009), even though there appears to be no satisfactory measure of sexual orientation (or its change) in the literature (Jones & Yarhouse, 2007; Moradi et al., 2009). They are likely to dismiss the research into psychodynamic and other theories which can be used to support change interventions (American Psychological Association, 2009;

Bell et al., 1981) based on methodological limitations, ignoring the fact that the quality of these studies, although not impressive by contemporary standards, was nevertheless "state of the art," sufficient to merit publication in respected professional journals. Moreover, the early research that supported the possibility of fluidity and change is comparable to other studies on homosexuality in the literature of the time that are still held in good repute (Jones & Yarhouse, 2007) and referenced uncritically in contemporary discussions about change-oriented treatment (cf. American Psychological Association, 2009), most likely because they support a favored sociopolitical point of view.

Furthermore, clinicians holding strong gay-affirming positions may tend to emphasize clinical literature which describe examples of harm (e.g., disappointment in not achieving complete elimination of unwanted same-sex attractions) in the course of SAFE-T and may take a position that conducting such therapy is clearly unethical and harmful (Drescher et al., 2016; Gonsiorek, 2004; Mahler & Mundle, 2015; Murphy, 1992; Tozer & McClanahan, 1999; Worthington, 2004). They may maintain this view even when clients explicitly desire to change their unwanted same-sex attractions and/or behavior (Gonsiorek, 2004). These clinicians may take the position that clients cannot establish realistic therapeutic goals for themselves nor make a truly voluntary decision to develop their heterosexual potential, assuming that such a desire can only be a reflection of an oppressive and prejudicial society (Tozer & McClanahan, 1999). They may discount the reality that many clients who want to explore the possibility of fluidity in their unwanted same-sex attractions and behaviors experience significant conflict between their religious beliefs and their sexual attraction to members of the same sex (Beckstead & Morrow, 2004; Haldeman, 1994, 2004; Yarhouse & Tan, 2004) and that some of these clients perceive their religious affiliation as the most stable aspect of their identity (Johnson, 1995; Koening, 1993). Some clinicians have even equated agreeing to help someone develop their heterosexual potential as analogous to agreeing to help an anorexic lose weight (Green 2003) or having sex with clients (Drescher et al., 2016). They may tend to espouse the immutability of sexual orientation, basing this conclusion on unsubstantiated biological research as its foundation, a conclusion that is rapidly becoming scientifically untenable (Byrd, 2010; Diamond & Rosky, 2016; Garnets & Peplau, 2001; Hu, Xu, & Tornello, 2016; James, 2005; Manley, Diamond, & van Anders, 2015; Stein, 1999; Yarhouse & Throckmorton, 2002).

Some clinicians who engage in SAFE-T for unwanted same-sex attractions and behaviors may overly interpret the likelihood of the possibility and extent of probable fluidity, oversimplifying or overselling the process of change according to their preferred (often psychodynamic) theory (Rosik & Popper, 2014; cf. Guideline 6). They may not take into account sufficiently the uniqueness of a particular client's history of same-sex or opposite-sex interest/arousal/behavioral patterns and underestimate the possible harm that may result from such oversimplification (Rosik & Popper, 2014), such as causing clients to feel misunderstood and misrepresented (Beckstead, 2001; Drescher et al., 2016; Haldeman, 2002; Shildo & Schroeder, 2002; Shildo, Schroeder, & Drescher, 2001). They may be tempted to ignore the reality that only a minority of clients with unwanted same-sex attractions achieve complete change towards heterosexual capacity and functioning, even though they face enormous social sanctions throughout their lives (Green, 2003; Santero et al., 2018).

SAFE-T clinicians might also minimize the research on the effect of social pressures and internalized societal attitudes toward homosexuality as possibly contributing to the symptomatology of the client (Di Placido, 1998; Maylon, 1982; Mays & Cochran, 2001; Meyer & Dean, 1998; Newcomb & Mustanski, 2010; Shildo, 1994; Szymanski, Kashubeck-West, & Meyer, 2008) as well as research suggesting that gay-identified men and women identifying as lesbians who report lower internalized homophobia will present with less symptomatology (Meyer & Dean, 1998; Szymanski et al., 2008). Some clinicians who engage in SAFE-T might automatically assume that the outside pressures experienced by clients to move away from their unwanted same-sex attractions are congruent with clients' value systems and should be honored, without a deeper exploration of the issues (Green, 2003; cf. Guideline 9). Some of these clinicians may suggest fluidity and change in unwanted same-sex attractions to clients as potential relief from a pathological condition when it would be more helpful to look at it as a "clinical problem" (Engelhardt, 1996; cf. Guideline 6), especially for clients who are leaning towards integrating a gay identity and who experience a focus on pathology as unhelpful (Liddle, 1996) or as harmful in various ways (Shildo & Schroeder, 2002), or for clients who have been made vulnerable by repetitive, traumatic anti-gay experiences (Haldeman, 2002).

Both gay-affirmative and change-oriented clinicians, especially if they are actively involved in the cultural debate surrounding the moral, legal, and psychological position of homosexuality in our society, may be vulnerable to dismissing the need for referring clients. This may be a risk particularly when, during the goal setting process, it becomes clear that the value position of the counselor is in clear conflict with the client's goals (Haldeman, 2004; Liszez & Yarhouse, 2005). A need to refer may arise due to a counselor's inability to identify with religiously based identity outcomes (Throckmorton & Welton, 2005) or with the less sexually monogamous norms of a significant portion of the gay culture (Levine, Herbenick, Martinez, Fu, & Dodge, 2018; Bepko & Johnson, 2000; Bonello & Cross, 2010; Laumann et al., 1994; Martell & Prince, 2005; Mercer, Hart, Johnson, & Cassell, 2009; Prestage et al., 2008; Shernoff, 1999, 2006; Spitalnick & McNair, 2005). Or they may find it objectionable to refer clients to a needed supportive community whose values they do not accept (Yarhouse & Brooke, 2005).

Clinicians who adopt a primarily more flexible position than either gay-affirmative or SAFE-T clinicians are less likely to have their therapeutic interactions be influenced by the above potential biases during the initial phase of assessment, informed consent, and goal setting (Throckmorton & Yarhouse, 2006). Yet these therapists also may tend to wait too long to encourage a client to move out of contemplative ambivalence, thus losing opportunities to help a client experiment with new behaviors, attitudes, and adaptations (Rosik & Popper, 2014). This could be due to a clinician's own ambivalences toward the possibility of therapy-assisted fluidity or to not being able to fully identify with the sexual value system of the gay or conservative religious subcultures (Bepko & Johnson, 2000; Rosik, 2003a).

Clinicians who are not engaged in offering SAFE-T may not appreciate fully the experience of clinicians who are such providers, who often find that effective working alliance can come into play only when the counselor and client both view unwanted same-sex attractions from similar value positions (Blow et al., 2012). From this perspective, their more flexible position

of addressing the therapeutic needs of both change-seeking and gay-affirmative clients can dilute the power of the alliance and leave the client feeling incompletely understood and incompletely supported (Nicolosi, Byrd, & Potts, 2000; Rosik, 2003a, 2003b). When working with adolescents, in addition to the above considerations, gay-affirmative and SAFE-T clinicians may need to exercise extra caution, being aware that at this developmental stage the experience of sexual identification is more fluid, and therefore adolescents may experience pressure towards resolution as unhelpful (Cates, 2007; McConaghy, 1993; Remafedi, Resnick, Blum, & Harris, 1992; Savin-Williams, 2005; cf. Guideline 11).

Mental health professionals are in conflict on how best to help the unique individual who enters psychotherapy expressing conflicted feelings, thoughts, or values about their same-sex attractions and behavior (Rosik & Popper, 2014). Since conservative and traditional views are presently underrepresented in the mental health profession (Duarte et al., 2015; Redding, 2001), there is serious risk that a counselor's response to clients wanting to explore potential fluidity will be negative. Therefore, there is merit in clinicians being familiar with a range of therapeutic options for clients who experience religious and sexual identity conflicts, including those that validate a client's decision to develop heterosexual potential (Beckstead & Morrow, 2004; Haldeman, 2004; Rosik, 2003a; Throckmorton & Yarhouse, 2006). It is recommended that clinicians consider these options as part of a reflective, ethical practice.

Guideline 3. ***Clinicians are encouraged to respect the value of clients' religious faith and refrain from making disparaging assumptions about their motivations for pursuing SAFE-T.***

Research indicates that the majority of individuals who present to clinicians with unwanted same-sex attractions are motivated in part by deeply held religious values (Jones & Yarhouse, 2007; Nicolosi et al., 2000; Santero et al., 2018; Spitzer, 2003). However, studies consistently report that mental health professionals are less religious than the general population across several dimensions of participation and belief (Bergin & Jensen, 1990; Delaney, Miller, & Bisono, 2007; Neeleman & King, 1993; Shafranske & Cummings, 2013). A lack of familiarity with religious beliefs and values in general—and those of the client in particular—can negatively affect the course and outcome of interventions with clients whose faith motivates the pursuit of SAFE-T for unwanted same-sex behaviors and attractions (Ruff & Elliott, 2016). Respect for religion as a dimension of diversity within psychology underscores the need for attention to this risk (Benoit, 2005; Rosik & Popper, 2014; Yarhouse & Burkett, 2002; Yarhouse & VanOrman, 1999).

While religious motivations should not be immune from scrutiny in the context of psychotherapy, clinicians need to be extremely cautious about pathologizing the religious values which may prompt a client to pursue SAFE-T. A lack of conservative and religious representation among mental health professionals relative to general population estimations (Delaney et al., 2007; Redding, 2001; Shafranske & Cummings, 2013) suggests that the danger of clinicians misinterpreting or invalidating the motives of religious and conservative clients is considerable (Ruff & Elliott, 2016). One way in which such therapeutic misattunement occurs is when religious beliefs that motivate clients to pursue SAFE-T for unwanted same-sex attractions are too

quickly and uniformly labeled as internalized homophobia (Herek, Gillis, & Cogan, 2009; Sowe, Taylor, & Brown, 2017). Persons who prioritize their traditional religious identities above their sexual attractions can and do experience many benefits from such faith commitments, which may outweigh the challenges (Barringer & Gay, 2017; Walker & Longmire-Avital, 2013). Differences in moral values between therapists, counselors, and their religiously identified clients concerning sexuality can easily become the object of clinical suspicion, with the tacit and inappropriate assumption that the counselor's values are superior to and should override those of the client (Haidt & Hersh, 2001; Kendler, 1999; Miller, 2001; O'Donahue & Caselles, 2005; Rosik, 2003a, 2003b, 2007a, 2007b).

Clinicians can benefit by examining the role that worldview similarity, particularly with regard to moral epistemology, plays in their attitudes toward clients who request assistance in developing their heterosexual potential. For example, six domains of moral concerns have been identified across cultures: 1) concerns for the suffering of others; 2) concerns about unfair treatment, inequality, and justice; 3) concerns about having liberty restricted; 4) concerns related to obligations of group membership (e.g., religious identification); 5) concerns related to social cohesion and respect for tradition and authority; and 6) concerns related to physical and spiritual purity and the sacred (Graham et al., 2013; Graham, Haidt, & Nosek, 2009; Haidt, 2012; Haidt & Graham, 2007, 2009; McAdams, Albaugh, Fauber, Daniels, Logan, & Olson, 2008). The first three moral domains focus on the individual as the center of moral value, with an aim of protecting the individual directly and teaching respect for individual rights. The other three domains emphasize the value of groups and institutions, attempting to bind individuals into roles and duties for the good of society.

The research of Haidt and his colleagues has indicated that conservative persons tend to utilize all six of these domains in their moral thinking, whereas liberal/progressive persons tend to rely much more on the first two concerns for their moral intuitions. These differences can lead liberally minded people to misunderstand the moral concerns of conservative individuals more than the latter misconstrue those of the former (Graham, Nozek, & Haidt, 2012). Furthermore, the moral concerns of conservative individuals regarding group loyalty, respect for authority and tradition, and purity/sacredness tend to be rejected by liberal persons (including mental health professionals) and deemed immoral when perceived to be in conflict with their emphasis on harm, rights, and justice. Respectful awareness of such differences can promote a positive therapeutic environment for clients pursuing SAFE-T for their unwanted same-sex attractions and behavior due to religious or other morally motivated reasons.

Another means of marginalizing religious belief within the general practice of psychology has been to bifurcate psychology and religion, to deem religiously motivated SAFE-T as essentially a religious pursuit which has no place in a science-based clinical practice (Silverstein, 2003; American Psychological Association, 2009). This perspective creates a strict demarcation which is not supportable given the enormous overlap between the fields in their philosophical and anthropological areas of inquiry, e.g., theories of human nature (Auger, 2004; Bain, Kashima, & Haslam, 2006; Jones, 1994; O'Donahue, 1989). Furthermore, it may represent some degree of philosophical naivety or professional hubris in that the empirical methods of psychology contain their own "innate"

values and are also influenced by the value assumptions of researchers (Fife & Whiting, 2007; Slife, 2006, 2008; Slife & Reber, 2009, 2012; Slife, Starks, & Primosch, 2014). These methods are not theologically or philosophically neutral nor do they enable research to proceed without the application of interpretive biases of some sort, particularly when investigating value-laden subjects such as the pursuit of SAFE-T. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). Conversely, established religious and theological traditions are not bereft of a degree of objective and empirical validation, in that when they have not become corrupted by power they have displayed practical validity and utility for understanding and directing human behavior for hundreds if not thousands of years (e.g., Stark, 2005).

A professional stance that endorses dialogue between religion and psychology is to be preferred over one that situates them in opposition to one another in order to place certain religiously motivated therapeutic goals outside the domain of mental health practice (Gregory, Pomerantz, Pettibone, & Segrist, 2008). Clinicians are therefore encouraged to utilize the insights from social science to inform and guide rather than obstruct and proscribe their clinical practice with religiously identified clients who pursue change-oriented intervention.

Guideline 4. ***Clinicians strive to respect the dignity and self-determination of all their clients, including those who seek to change unwanted same-sex attractions and behavior.***

Professional clinicians ascribe to the general ethical principle of individual autonomy and self-determination (e.g., Principle E: Respect for People's Rights and Dignity; American Psychological Association, 2017). Clinicians are encouraged to avoid viewing individuals who pursue SAFE-T for their unwanted same-sex attractions, same-sex behaviors, or sexual identity as an exception to this general ethical principle. Likewise, professionals strive to view clients as fully capable of pursuing self-determination or able to respond in an autonomous manner to the source of their distress (Byrd, 2004). Clinicians act in an ethical and humane manner and provide a valued service to clients when they respect a client's right to self-determination and autonomy to select SAFE-T for unwanted same-sex attractions and behavior (Benoit, 2005).

A focus on self-determination and autonomy does not relegate this ethical consideration above others in addressing the provision of change-oriented interventions (APA, 2009; Drescher et al., 2016). However, this ethical issue is often stressed in the literature relevant to SAFE-T precisely because it is the ethical guideline most directly impacted by the threat of professional and legal restrictions on such care. Restricting client self-determination to pursue SAFE-T on the basis of a lack of empirical efficacy, even if accurate, should in fairness commence a professional prohibition on many other experimental and unsupported treatment modalities that are currently practiced (Barnett & Shale, 2013; Pignotti & Thyer, 2009). A significant case in point is "recovered memory therapy" (RMT), with which the APA dealt in a vastly more lenient and nonpartisan manner than it did with so-called "sexual orientation change efforts," in spite of RMT having more clearly established harms and much less empirical basis than SOCE (Rosik 2017c). Nor does the limiting of client

autonomy appear to be warranted by the potential for harm in exploring the fluidity of unwanted same-sex attractions. No harm has been definitively linked to such exploration as a whole (APA, 2009; Santero et al., 2018), and harms that could be imagined can likely be resolved by suitable practice guidelines such as those offered here.

Clients enter therapy with values that guide their goals for therapy. Whether religious or personal, such values may lead individuals to seek change interventions for unwanted same-sex attractions and behavior. In treatment settings, professionals respect the autonomy and right of self-determination of individuals who pursue SAFE-T for unwanted same-sex attractions and behavior as well as those individuals who do not desire such goals. Clinicians refrain from persuading clients to select goals and interventions that are contrary to their personal values (American Psychological Association, 2008a; Haldeman, 2004).

Professionals support the principle that individuals are capable of making their own choices in response to same-sex attractions and promote autonomy and self-determination by: a) acknowledging a client's choice or desire to pursue SAFE-T for unwanted same-sex attractions and behavior, b) exploring why these attractions and behaviors are distressing to the client (Jones & Yarhouse, 2007), c) addressing the cultural and political pressures surrounding choices in response to same-sex attractions, d) discussing the range of professional therapies and resources that are available (Jones & Yarhouse, 2007), e) providing understandable information on outcome research related to change interventions (ATCSI, 2009), and f) obtaining informed consent for treatment (Rosik, 2003a; Yarhouse, 1998a; cf. Guideline 5).

Value conflicts with the broader culture may be experienced by consumers who opt for gay-affirmative interventions. However, the more sociopolitically liberal and secular worldview of licensed clinicians heightens the probability that value conflicts in the clinical setting are more likely to occur among clients who desire that SAFE-T be a therapeutic option. The clinician's commitment to respecting client autonomy and self-determination may be especially tested when working with individuals reporting unwanted same-sex attractions and behavior. Clinicians risk violating the client's right to autonomy and self-determination when they attempt to deny a client the opportunity to engage in SAFE-T, view the client as incapable of making choices among intervention options, or withhold information about a full range of therapeutic choices. Such violations of client rights may risk harm to the client (Byrd, 2004).

Treatment Considerations

Guideline 5. ***At the outset of treatment, clinicians strive to provide clients with accurate information on SAFE-T processes and outcomes, sufficient for informed consent.***

Clinicians from all the mental health professions provide clients with informed consent at the beginning of treatment (e.g., American Psychological Association, 2017, Ethical Standards 3:10 & 10.01; American Association for Marriage and Family Therapy, 2015, Ethical Standard 1.2; National Association of Social Workers, 2017). Ethically, those who serve clients with unwanted same-sex feelings and behaviors—or any psychological, behavioral, or relational concerns—offer accurate information both about the process of SAFE-T and the kinds and likelihood of changes that may be possible.

Adequate informed consent is an important part of therapeutic "Beneficence and Nonmaleficence," whereby clinicians ". . . strive to benefit those with whom they work and take care to do no harm . . . [and] seek to safeguard the welfare and rights of those with whom they interact professionally . . ." (APA, 2017, General Principle A, p. 3). Informed consent also encourages and expresses clinical "competence," in which clinicians "provide services . . . with populations and in areas only within the boundaries of their competence." Clinicians inform their clients about their clinical "education, training, supervised experience, consultation, study, or professional experience," through which competence was developed (APA, 2017, Ethical Standard 2.01, p. 5).

Clinicians engaged in SAFE-T with clients may properly acknowledge that the perspective of the therapist's professional association regarding same-sex attractions and behaviors, and therapy to address them, may be different from, or opposed to, the perspective of the therapist and the perspective of the client. As appropriate, clinicians may want to discuss the specifics of those differences with the client and include a statement regarding them as part of their consent process.

Since 1973, homosexuality itself has no longer been diagnosed formally as pathological (American Psychiatric Association, 1973; APA, 1975). Although most professional associations no longer consider homosexuality to be a diagnosable or treatable condition (American Psychiatric Association, 2013), related co-occurring conditions with theoretical and empirical links to non-heterosexuality remain valid foci of diagnosis and therapeutic care. As even gay-identified scholars have asserted, "The developmental issues that contribute to 'the persistent and marked distress' about one's sexual orientation are valid areas of investigation" (Morin & Rothblum, 1991, p. 3). This also holds true when examined within the context of SAFE-T for unwanted same-sex attractions and behavior. Contrary to current attitudes explicit or implicit in the professional and lay media, "regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence" (Monachello, 2006, p. 56). When clinicians help clients distressed about their same-sex attractions and behavior, they are being ethically responsible, respecting "the dignity and worth of all people, and the rights of individuals to . . . self-determination" (American Psychological Association, 2017, General Principles, Principle E, p. 4).

In helping clients resolve unwanted same-sex behavior and attraction, clinicians are mindful that the phenomena of male and female homosexuality and the related concept of "sexual orientation" (i.e., the gender(s) of the persons to whom one is sexually and/or affectionately attracted and experiences love and/or sexual arousal) are not universally defined, fixed, discrete, one-dimensional constructs (Beaulieu-Prevost & Fortin, 2014; Weinrich & Klein, 2002; Worthington & Reynolds, 2009). A person's perceived or self-declared sexual orientation may or may not be consistent with actual sexual behaviors, thoughts, or fantasies (Korchmaros, Powell, & Stevens, 2013; Schneider, Brown, & Glassgold, 2002). Moreover, clients' responses to unwanted same-sex experiences may vary from obsessive anxiety that they—or a dependent family member—may develop same gender sexual attractions, to feeling but never having acted upon such attractions, to having gratified them in a single, occasional, habitual or even addictive manner.

Clinicians will assess the nature of their clients' actual experience of unwanted

same-sex feelings, thoughts, and behaviors as part of informing the clients of possible treatment outcomes and developing a mutually agreed-upon plan for intervention. Such assessment will explore the possible presence of many co-occurring medical, psychological, behavioral, and relational difficulties which either contribute to and/or may be consequences of a client's unwanted same-sex attractions or behaviors (cf. Guideline 8). Some research findings indicate the average client will have three difficulties within these domains to some extent (Santero et al., 2018). Unlike other therapeutic settings, there is a tendency for more substance-related issues for the women, and more mood-related issues for the men. (Whitehead, 2010). Evidence is that self-esteem, social functioning, depression, self-harm, suicidality, substance abuse will all move in positive directions during SAFE-T, and most do so markedly. Religiosity among clients who engaged in SAFE-T remains at very high levels even several years after therapy has concluded (Santero et al., 2018).

Clinicians also will assess the nature of their clients' spiritual and religious involvement and motivation in order to respect their clients' rights, dignity, and need for self-determination (cf. Guidelines 3 and 4). Appropriate referrals for allied medical, mental, and/or pastoral healthcare may be an appropriate component of informed consent and goal setting (cf. Guidelines 8 and 12). The therapist should consider whether support groups are available or desirable. Other recommendations for client involvement may include non-erotic same-sex friendship and spiritual support. Clients involved in SAFE-T have found strongly positive benefits in these activities with almost no negative effects. (Santero et al., 2018).

When discussing the possibilities for change, it is important to explain that as with any intensive course of intervention, achievement of significant fluidity and change in unwanted same-sex attractions and behaviors requires sufficient motivation, hard work and patience, with no guarantees of "success" (Haldeman, 1991, 1994, 2001). The mean number of hours engaged in SAFE-T reported by Santero and colleagues (2018) was 80. But when discussing the possibilities of successful changes, it is heartening to note that successful intervention has been reported in the clinical and scientific literature for the past 135 years. In over 150 reports spanning the end of the 19th century through the beginning of the 21st, successful change(s) in sexual attractions, thoughts, fantasy, and/or behaviors from same-sex to opposite-sex have been documented (ATCSI, 2009; Byrd & Nicolosi, 2002; Phelan, 2014; Santero et al., 2018). One rule of thumb which continues to be supported by research and experience over many decades is that among individuals who pursue psychological care with a clinician skilled in SAFE-T, one third experience no change, one third experience some change, and one third experience profound change. But of those exclusively same-sex attracted, two thirds experienced some attraction to the opposite sex for the first time (Santero et al., 2018).

Reports of change range in size from single client case studies to group studies with hundreds of clients. The various therapeutic paradigms used for the purposes of SAFE-T have included psychoanalysis (Bieber, Dain, Dince, Drellich, & Grand, 1962; MacIntosh, 1994) and experiential or other psychodynamic approaches (Berger, 1994; Nicolosi, 2009; Pela, Sutton, & Nicolosi, 2018; Santero et al., 2018); hypnosis; behavior and cognitive therapies (Bancroft, 1974; Birk, Huddleston, Miller, & Cohler, 1971; Throckmorton, 1998); sex therapies (Masters & Johnson, 1979; Pomeroy, 1972; Schwartz & Masters, 1984);

group therapies; religious-mediated interventions (Jones & Yarhouse, 2007, 2011); pharmacology; combinations of therapies (Karten & Wade, 2010; Pela et al., 2018; Santero et al, 2018); and others. A number of meta-analyses also demonstrate that intended fluidity and change in feelings and behaviors is a realistic goal for persons with unwanted attractions to the same sex (Clippinger, 1974; James, 1978; Jones & Yarhouse, 2000; Byrd & Nicolosi, 2002). This list is not exhaustive (cf. ATCSI (2009) for a comprehensive list of reports for each paradigm). In addition, SAFE-T clinicians frequently provide orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices.

As part of fully informing clients and obtaining informed consent, SAFE-T clinicians are encouraged to emphasize in their discussions with clients and in their consent forms that their therapeutic work does not include practices such as aversion therapy, "shock" therapy, any form of physical or emotional intimidation, therapist-imposed goals, or other similar practices or methods, regardless of what label may be attached to them. Advocates of proposed legal prohibitions on therapy have attempted to portray such practices as widespread and suggest that they are somehow necessarily or unavoidably involved in any professional therapy that may address unwanted feelings of same-sex attraction or unwanted behaviors. Such portrayals are untruthful. No SAFE-T clinician would engage in any such practice, and clinicians should leave no question or room for doubt in the client's mind in this regard (cf. Guideline 7).

Clinicians who engage in SAFE-T are further encouraged to communicate to clients that they do not practice so called "conversion therapy," sexual orientation change efforts (SOCE), or any other therapy that is purported to focus on orientation change. SAFE-T clinicians do not attempt to change the client's sexual orientation or gender identity; however, they uphold clients' rights to pursue fluidity and change of any aspect of their identity, attractions, behaviors, or personality. Throughout the therapy process, therapists involved in SAFE-T provide acceptance, support, and understanding to clients and facilitate clients' coping, social support, and identity exploration and development.

While no approach to therapy for any presenting concern—including unwanted same-sex attraction or behavior—has been shown to enable clients to meet all of their therapeutic goals, the clinical and scientific literature to date has shown the potential for fluidity and change to varying degrees. Many—but not all—clients have been either observed by their therapists or have reported themselves that they experienced fluidity of their unwanted same-sex attractions and behaviors in a desired direction as well as changes related to presenting concerns (ATCSI, 2009).

It is not uncommon that clients who report and/or are assessed as having made a significant transition from same-sex to opposite-sex attraction, cognition, fantasy, and behavior, may re-experience same-sex feelings or thoughts, albeit at a less intense level than before SAFE-T. Of course, there may be exceptions. Even when clients have not achieved all they had hoped for when beginning therapy, many report satisfaction with what they have achieved (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003), and some clients who describe their experiences in therapy as "harmful" also may characterize them as "helpful" (Shildo & Schroeder, 2002). Also, as with therapy in general (Lambert & Ogles, 2004), along with documented intervention success, some recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted

same-sex attractions may be expected (cf. Guidelines 7 and 12). However, the percentage of clients who believe they have benefitted is very similar to outcomes in other fields of psychotherapy (Santero et al., 2018), and statistical effect sizes are similar. Similarly, the low degree of alleged harm is comparable. Therapists should nevertheless judge carefully the ability of clients to withstand hostile attitudes from others regarding their pursuit of SAFE-T, and may need to recommend limited exposure to such environments. Activists opposed to SAFE-T clients' goals may aggressively interrogate them to a degree rarely seen in other therapy fields.

Critics of the clinical and scientific literature documenting successful SAFE-T outcomes—or the lack thereof—accurately point out the absence of truly randomized outcome studies. Another criticism of the literature is the lack of clear definition of the meaning of terms like "sexual orientation," "homosexuality," "heterosexuality," and "change." As noted previously, since the American Psychiatric Association's 1973 decision to no longer diagnose homosexuality as a mental disorder, there have been fewer reports of research on the development of and interventions for unwanted same-sex attractions and behavior. However, as Spitzer (2003) noted, a truly randomized study with controls is probably logistically impossible.

Such criticism does not negate that for over a century, clinical and scientific evidence has persistently demonstrated that fluidity of unwanted same-sex attractions and behaviors can be facilitated within a therapeutic setting and that clients who seek such exploration are not invariably harmed when doing so. A substantial number of persons who have sought SAFE-T from professionals representing various theoretical paradigms and psychotherapeutic approaches to address unwanted same-sex attractions have successfully pursued their goals of diminishing the frequency and strength of these attractions, reducing or eliminating same-sex behaviors, and enhancing their experience of opposite gender sexual attractions (Nicolosi et al., 2000; Phelan, 2014; Santero et al., 2018). Reduction in frequency may be about an order of magnitude overall (i.e., about 10 times less than original levels), but many achieve far greater reductions (Santero et al., 2018).

Lambert & Ogles (2004) observed that "helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship characterized by trust, warmth, understanding, acceptance, kindness and human wisdom" (pp. 180–181). As with therapy for all presenting concerns, giving satisfactory informed consent when beginning to counsel persons who want to resolve unwanted same-sex attractions and behavior not only is ethical but also may be expected to facilitate the development of more effective, therapeutic relationships.

Guideline 6. ***Clinicians are encouraged to be aware of the legal environment in their state or local jurisdiction with respect to the presence of therapy bans and to seek competent legal counsel as appropriate under the circumstances.***

Since 2012 various state and municipal governments have enacted statues or promulgated ordinances or regulations aimed at prohibiting at least some clients from pursuing fluidity and change of unwanted same-sex attractions and behaviors within a psychotherapy setting (Dubrowski, 2015; "List of jurisdictions banning conversion therapy for minors,"

2018; Rosik, 2017b; Sandley, 2014). Despite claims of egregious and widespread harms that are the purported motivation for such bans, there have been no formal actions against any licensed therapists by any regulatory authorities in these or other jurisdictions (Drescher et al., 2016). This suggests that the primary aim of these laws or regulations may be to intimidate clinicians who would assist a client in the client's personal goal to explore the potential fluidity of unwanted same-sex attraction and behaviors. Further, clinicians in these jurisdictions should be aware that these bans have handed a potential weapon to activists who are looking for disgruntled clients who are willing to make an example of their former therapists. Therefore, while excellence in practice should be the goal of all therapists who engage in SAFE-T, those in jurisdictions that have therapy bans may also need to obtain the assistance of competent local legal counsel to evaluate the effect and implications of any restrictions that have been enacted or promulgated.

The SAFE-T concept and approach offers an accurate description of therapies that allow for fluidity of unwanted same-sex attractions and behaviors. The practice of SAFE-T is, by definition, one that only utilizes contemporary mainstream therapeutic modalities in assisting clients who request assistance in identifying and resolving issues that might prevent a greater heterosexual adaptation (cf. Guideline 7). Clients with unwanted SSA often present with their own understandings about the origins of their same-sex attractions, and it is best to utilize the moral, religious, and psychological language of clients in initial discussions about their same-sex attractions and behaviors. SAFE-T needs to be client-centered, and clinicians must exercise care not to pressure clients toward adopting the etiological and moral perspective of either the therapist *or* the therapist's professional association (Benoit, 2005; Rosik & Popper, 2014).

Clients who believe, for example, that their history of childhood trauma or relational disruption may have contributed to their nonheterosexuality can be reassured there is research evidence consistent with their experience (Beard et al. 2013; Bickham et al. 2007; O'Keefe et al. 2014; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2009). They can also be informed that fluidity of sexual attractions and behaviors is common rather than atypical, especially for women but also for men (Diamond, 2008a, 2016; Dickson, Paul, & Herbison, 2003; Dickson, van Roode, Cameron, Paul, 2010; Far, Diamond, & Boker, 2014; Hu, Xu, & Tornello, 2016; Katz-Wise, 2015; Katz-Wise & Hyde, 2015; Katz-Wise, Reisner, Hughto, & Keo-Meier, 2016; Moch & Eiback, 2012; Ott, Corliss, Wypij, Rosario, & Austin, 2011; Ott et al., 2013; Savin-Williams & Ream, 2007). Moreover, there is evidence that such fluidity is influenced by relational and environmental contexts that are commonly addressed in the therapeutic process (Manley, Diamond, & van Anders, 2015; Santero et al., 2018). It is no small irony that the APA and other professional organizations acknowledge that no single factor or set of factors is known to definitively determine same-sex attraction (APA, 2008a) while simultaneously maintaining that they are certain all of these factors are simply normal and positive (APA, 2009; Mustanski, Kuper, & Greene, 2014).

Clinicians engaged in SAFE-T recognize that therapist-initiated recommendations for superficial external alterations of the client's gender presentation and role behavior are unlikely to address deeper emotional, relational, and/or identity issues (Santero et al., 2018). SAFE-T is a process that recognizes addressing deeper issues may (or

may not) affect a particular client's unwanted same-sex attractions. For example, sufficient resolution of underlying attachment wounds may promote client-initiated interest in such adjustments of gender presentation.

Another important aspect of SAFE-T practice is the clinician's regular acquisition of client feedback about their therapy experience. This review can be done in session and client perceptions should be documented in the progress notes, whether of satisfaction or dissatisfaction. Occasional use of more objective measures of client satisfaction and progress are also recommended (e.g., the OQ-45 survey; Lambert et al., 2004). Points of perceived dissatisfaction would need to be addressed and documented, including adjustments in the therapy process and goals or even referral to a different therapist if requested.

Clients with nonheterosexual identities who enter therapy may have done so for reasons unrelated to their sexual orientation and may have no interest in SAFE-T. Therapists therefore do not inject a discussion of SAFE-T or the fluidity of same-sex attraction and behaviors into their clinical work without an explicit client-initiated request and the undertaking of a fully informed consent process. Therapists are also encouraged to educate clients concerning their clinical approach to unwanted same-sex attractions and behaviors through both written consent forms and in-session discussions. A similar educative process may be utilized to address possible benefits and risks of SAFE-T as well as the range of potential outcomes with and without treatment (Rosik & Popper, 2014).

SAFE-T clinicians do not promise or guarantee, whether explicitly or implicitly, a change in sexual orientation or even shifts in unwanted same-sex attractions and behaviors. Therapists should exercise caution to make sure clients do not feel blamed if they do not experience their desired level and direction of sexual attraction fluidity. This is particularly important in religious settings where there may be implicit or explicit expectations for change that may be unrealistic. Meichenbaum and Lilienfeld (2018) offer 19 signs of psychotherapy "hype" that are good reminders of ways therapists may undermine their credibility. Indicators of hype may include exaggeration of claims of treatment effectiveness, excessive appeal to authorities or "gurus," and claims that treatment "fits all people." For these reasons, a thorough and scientifically grounded discussion concerning the occurrence of fluidity and change combined with a regular review of the therapy process is very important.

In therapeutic practice, SAFE-T clinicians are encouraged not to specifically target same-sex attractions or sexual orientation generally as a focus of treatment. In fact, large majorities of male clients who pursue SAFE-T reported their pursuit of fluidity and change was most benefited by developing non-erotic relationships with same-sex peers, understanding emotional needs and issues, meditation and spiritual work, and learning to maintain appropriate boundaries (Santero et al., 2018).

Guideline 7. ***Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when serving clients with unwanted same-sex attractions.***

Every counselor uses psychotherapeutic approaches which may be reasonably expected to offer clients help in dealing with their presenting problems (beneficence) and to avoid or minimize potential harm (nonmaleficence). Professional clinicians who utilize SAFE-T in their work with clients to address unwanted same-sex

attractions and behaviors are trained in one or more of the theoretical approaches and techniques practiced currently in the mental health professions. Clinicians use accepted psychological approaches to help clients deal with common co-presenting problems, including depression, anxiety, shame, unresolved distress originating from family of origin, sexual and emotional abuse, relationship difficulties, lack of assertiveness, and compulsive and addictive habits. Clinicians also seek supervision and additional training as dictated by their clients' needs and their own professional development (cf. Guideline 13).

It has been suggested by critics that one possible outcome of SAFE-T for unwanted same-sex attraction has been the development of a negative attitude towards homosexuality or gay and lesbian persons (e.g., Drescher et al., 2016; Haldeman, 1991, 1994). This caution about potential harm or criticism of reported harm must be understood in the context of any therapeutic process. Such intervention often leads a client to become more aware of depression, anxiety, and other emotions leftover from the recent or distant past. In the short-term, as clients are helped to practice sexual or other (e.g., substance use) sobriety, they may experience an increase in their "feeling" of depression, anxiety, etc.

An increase in unpleasant feelings may not be an indication of "harm," but an opportunity to deal with feelings formerly numbed by mood-altering behaviors (e.g., sexual gratification), relationships (e.g., codependency), substances (e.g., alcohol or drugs), or other paraphernalia (e.g., pornography). Clients who terminate any therapy before underlying emotional issues or compulsive behavior patterns are effectively resolved will undoubtedly feel worse than when they began therapy. Also, to the extent that persons with same-sex desires are engaged in sexual compulsions or experience other psychological or relational difficulties, a high recidivism rate, such as is found when treating substance abuse and other habits, may not be unrealistic.

In general, SAFE-T for unwanted same-sex attractions and behavior has been shown to be helpful for a number of clients and has not been shown to be invariably harmful (Santero et al., 2018). Authors who clearly oppose such intervention and who caution that it sometimes is, can, or may be harmful, nonetheless recognize that it is not always so (Haldeman, 2001; Schroeder & Shildo, 2002; Shildo & Schroeder, 2002). Even when disappointed with not changing their same-sex thoughts, feelings, fantasies, and/or behaviors as much as they had hoped, clients have reported satisfaction with the changes they did achieve and that the counseling process was at least somewhat helpful (e.g., Nicolosi et al., 2000; Santero et al., 2018; Shildo & Schroeder, 2002; Spitzer, 2003). While a client's dissatisfaction is a possible and unfortunate consequence of any therapy, such dissatisfaction is not inherently "harmful" and may be minimized by the responsible practice of timely and accurately informed consent (cf. Guideline 5). Such practices would include a discussion that fluidity and change in unwanted same-sex attractions, thoughts, and behavior during therapy occur on a continuum. Some clients seem to experience profound fluidity and change, other's a moderate amount, and still others little or none (ATCSI, 2012).

Regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients. As Lambert (2013) writes, while psychotherapy has proven to be highly effective "for many clients," "psychotherapy can and does harm a portion of those (adults and children) it is

intended to help" (p. 192). Clients who are especially more likely to "deteriorate while participating in treatment" (p. 192) commonly begin therapy with a severe "initial level of disturbance," e.g. borderline personality disorder (Lambert & Ogles, 2004, p. 177). "[C]lients with comorbid problems (also) are less likely to do well." Depending on the primary diagnosis, comorbidity for personality disorders, depression, substance abuse, and psychiatric diagnoses all have been shown to negatively impact treatment outcomes (Bohard & Wade, 2013, p. 227). In addition, clients whose clinicians may lack empathy, underestimate the severity of their problem, or who experience significant, negative countertransference may also be at greater risk for deterioration (Mohr, 1995).

Finally, in light of current research and professional ethics, some long outdated interventions for unwanted same-sex attractions and behavior are not recommended. These include shock therapy and other aversive techniques, so-called reparenting therapies, and coercive forms of religious prayer (including exorcisms). Overall, research to date has shown that clients participating in SAFE-T to address unwanted same-sex attractions or behaviors are not invariably harmed by doing so (APA, 2009; Pela et al., 2018; Santero et al., 2018). Any negative consequences attributed to engaging in SAFE-T have not been shown to outweigh the benefits claimed by those who have found such exploration helpful. Unfortunately, most mental health associations like the APA, both in the United States and in Europe, unfairly warn the general public that clients who pursue fluidity and change in their unwanted same-sex attractions and behaviors through professional therapy have the potential to be harmed. This happens even though the mental health associations themselves admit that historical and recent research does not support their warning (APA, 2009; Sutton, 2014).

Guideline 8. ***Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions which often accompany same-sex attractions and offer relevant treatment services to help clients manage these issues.***

In the psychological care of clients with unwanted same-sex attractions and behavior, it is strongly encouraged that clinicians fully assess each with a detailed history and examination, paying particular attention to the potential presence of associated psychopathological conditions. While often limited by restricted samples, lack of controls, and/or indeterminate causal pathways, studies of mental health morbidity among adults reporting same-sex partners consistently suggest that lesbians, gay men, and bisexual individuals may experience excess risk for some mental disorders by comparison with heterosexual individuals (Cochran & Mays, 2009; King et al., 2008; Semlyen, King, Varney & Hagger-Johnson, 2016). Cochran, Sullivan, and Mays (2003) indicate that gay-bisexual men showed higher prevalence of depression, panic attacks, and psychological distress than heterosexual men; lesbian-bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women in the same study. Other comparisons may be found in Whitehead (2010). Quantitative estimates of length of relationship (Whitehead, 2015/16) suggest a mean length of 4.7 (±2) years, which itself leads to depression that is also associated with frequent short heterosexual relationships (Davila et al., 2009). In addition, several studies have suggested that bisexuals often have even worse health outcomes than gay and lesbian persons (Ross, Salway, Tarasoff, MacKay, Hawkins, & Fehr, 2018), although

this conventional wisdom has been challenged of late (Savin-Williams & Cohen, 2018). This excessive risk of co-occurring psychopathology needs to be at the forefront of the clinician's mind when working with individuals with same-sex attractions, whether wanted or not.

A key issue in the area of health is the assessment of risk and its subsequent management. In mental health terms, this invariably involves a risk assessment for self-harm and suicide. Research has demonstrated evidence of a strong association between suicide risk and same-sex attractions and behavior (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Eskin et al., 2005; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008; Ploderl & Fartacek, 2005; Ploderl & Tremblay, 2015; Remafedi, French, Story, Resnick, & Blum, 1998). Using data from the *National Comorbidity Survey*, Gilman, Cochran, Mays, Hughes, Ostrow, and Kessler (2001) found that people reporting same-sex partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual peers. This finding has been consistent in studies of young people (Rimes, Shivakumar, Ussher, Baker, Rahman & West, 2018; Russell & Joyner, 2001) and adults (Remafedi et al., 1998) and has also been noted in Holland and Sweden, countries with a comparatively tolerant attitude to homosexuality. Dutch men with same-sex attractions and behaviors and Swedes in same-sex marriages are still at a much higher risk for suicidality than their heterosexual counterparts (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016; de Graaf, Sandfort, & ten Have, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Often sex addiction co-occurs with same-sex behavior (Bothe et al., 2018; Dodge, Reece, Herbenick, Fisher, Satinsky, & Stupiansky, 2008; Guigliamo, 2006; Kelly, Bimbi, Nanin, Izienicki, & Parsons, 2009; Parsons, Kelly, Bimbi, DiMaria, Wainberg, & Morgenstern, 2008; Quadland & Shattls, 1987), and it has been defined as follows: "Contrary to enjoying sex as a self-affirming source of physical pleasure, the addict has learned to rely on sex for comfort from pain, for nurturing or relief from stress" (Carnes, 1992, p. 34). This often has roots in childhood and adolescence with up to 60% of people who present with sex addiction having been sexually abused before reaching adulthood (Griffin-Shelley, 1997). Individuals reporting same-sex attractions and behavior also appear to have a higher prevalence of sexual abuse, particularly among women (e.g., Bebbington et al., 2009; Doll, Joy, Bartholow, & Harrison, 1992; Eskin et al., 2005; Friedman et al., 2011; Mustanski, Kuper, & Greene, 2014; Paul, Catania, Pollack, & Stall, 2001; Tomeo et al., 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). It is therefore imperative that clinicians take a full and detailed history from each client. Since clients with same-sex attractions commonly report other addictive behaviors, a thorough history should include assessment of other common addictive behaviors such as pathological gambling (Granta & Potenzab, 2006) and substance misuse (Branstrom & Pachankis, 2018; Goldbach, Fisher, & Dunlap, 2015; Ploderl & Tremblay, 2015; Roth et al., 2018; Ueno, 2010), both for prescribed, illicit and over-the-counter medicines, in addition to sex addiction.

When clinicians have completed a full assessment which screens for active psychopathology, they must also take care not to practice in a clinical area where they are not competent (APA, 2017, Ethical Standard 2). If active psychopathology is detected, then where clinically necessary it should be addressed through multidisciplinary consultation or by referral to an appropriate service (cf. Guideline 12).

Guideline 9. ***Clinicians strive to understand the difficult pressures (e.g., culture, religious community) which clients with unwanted same-sex attractions confront.***

The societal pressures that surround clients who present with unwanted same-sex attractions cannot be understated. Clinical intervention will benefit from a careful appraisal of the multiple contexts from which these clients come and the normative attitudes toward homosexuality found in each milieu. The cultural context of these clients includes their ethnic heritage, and differences in perspectives on homosexuality by ethnic background must be considered. For example, clients coming from African-American or Hispanic backgrounds often live in communities that have traditional and more uniformly negative views of homosexuality (Greene, 1998; Herek & Gonzalez-Rivera, 2006; Martinez & Sullivan, 1998; Schulte & Battle, 2004; Vincent, Peterson, & Parrott, 2009).

Another critical dimension is the religious background of these clients, since many who seek interventions for unwanted same-sex attractions and behavior often come from conservative faith communities (Haldeman, 2002, 2004; Nicolosi et al., 2000; Rosik, 2003a; Schulte & Battle, 2004; Santero et al., 2018; Spitzer, 2003). Most of these individuals will have previously adopted a value framework from their religious background which views homosexual behavior as immoral. Some religiously conservative clients will have grown up hearing theologically based condemnatory remarks about homosexuality from some religious authorities whom may—or may appear to—lack compassion for their struggle, or even assert they have deliberately chosen their attractions and/or are totally irredeemable.

A third environment worthy of careful evaluation is the family context of clients (Yarhouse, 1998b). The attitude of parents and heterosexual spouses toward clients' same-sex attractions is perhaps the most immediate factor that can exert influence on the mindset of those seeking change. Clients may receive a variety of messages from family members, ranging from gay affirmation to loving disapproval to outright rejection and distancing (Freedman, 2008; Pachankis, Sullivan, & Mora, 2018; Ryan, Huebner, Diaz, & Sanchez, 2009). The extent to which clients have disclosed their unwanted same-sex attractions to family members will also affect clients' clarity concerning how their loved ones might respond. The effects of ethnicity and religious identity certainly can overlap with family considerations and may intensify a sense of reluctance to acknowledge, explore, and seek therapy for unwanted same-sex attractions. Clients' proximity to these contexts should also be considered, as clients coming immediately from non-affirming backgrounds may not have been as reflective about their decision to pursue change as clients who report having once lived a gay identity but now wish to dis-identify with it.

The early assessment of these contexts is important in evaluating clients' preparedness to enter into SAFE-T. The more clients come from ethnic, religious, and family backgrounds which are non-affirming of homosexuality, the greater the burden is upon clinicians to ensure that clients are acting in a reasonably self-determined manner as they seek intervention. This important precaution is not to assert, as some have done (Davison, 2001; Drescher et al., 2016; Murphy, 1992), that clients from these backgrounds can never autonomously enter into SAFE-T with the goal of

modifying unwanted same-sex attractions and behaviors. In fact, Santero and colleagues (2018) found societal pressures were quite minor. However, while individuals do make rational and free choices to identify with the moral values and behavioral codes of conduct for sexual expression inherent in homosexually non-affirming contexts (Yarhouse & Burkett, 2002), it cannot be assumed that this is always the case. Exploring with clients the attitudes and beliefs toward same-sex attractions and behavior that dominate their particular cultural and family situation is therefore essential in evaluating the extent to which they have genuinely taken ownership of their decision to explore the degree to which their attractions may be subject to fluidity and change.

Guideline 10: ***Clinicians are encouraged to acknowledge and accommodate the unique experiences of women who experience SSA***.

Most of what has most recently been written about women's same-sex attraction experiences are conclusions drawn from research with self-selected, openly identified lesbian and bisexual women (Diamond, 2003, 2017). Despite these limitations, there are some conclusions that can be drawn from the research, particularly in contrasting the experiences of men and women with SSA. Men and women experience different neurobiological, cultural, and political influences on their sexual development (Savin-Williams & Diamond, 2000; Diamond, 2003a, 2017). These differences result in contrasts between men and women in their accounts of the development of SSA (Diamond, 2003a) and the differences in the exploration and experience of sexual attraction fluidity.

Women's romantic attractions start with emotional and relational intimacy more consistently than men (Diamond, 2003a; Diamond, 2003b; Diamond, 2008a; Savin-Williams & Diamond, 2000). While men may also experience increased sexual attraction as the result of emotional intimacy, women's same-sex attraction experiences almost always move from emotional bonding to sexual attraction, and are sometimes followed by sexual behavior (Diamond, 2000). Although women may have an earlier awareness of attractions and admirations for other women, they tend to "come out" only after they become sexually involved with another woman (Diamond, 2008a). Also, in contrast to men, women's first same-sex attraction experiences are virtually never with a stranger, while men report that 25% of the time their first same-sex sexual experience is with a stranger (Diamond, 2000). These findings about the differences between SSA men and women parallel the differences between men and women's sexuality, in general.

Women have a larger range of sexual attraction fluidity potential (Diamond, 2016; Katz-Wise & Hyde, 2015; Savin-Williams & Diamond, 2000). Most women who experience SSA also experience OSA (Diamond, 2017). Diamond (2003b) found that 2/3 of lesbian-identified women have had male partners within the last 5 years. Additionally, she reports that 27% of the lesbian-identified women in her study had dis-identified as lesbians. Some women who reject a lesbian identity choose to live heterosexually, while others have simply chosen to reject an erotic-attraction identity altogether (Savin-Williams & Diamond, 2000). Such dis-identification should not be presumed to be an indication of shame or incomplete psychosocial development, particularly for conservatively religious women (Hallman, Yarhouse, & Suarez, 2018; see Guideline 3). Sexual attraction identities limit and distort the complexities of sexuality and may result in a forced

identity that is rejected during developmental maturity. Many more mature women see themselves and their sexuality as more complex than the current cultural narrative of an essential, immutable identity based on erotic attractions.

Historical clinical accounts of women experiencing distress related to their SSA are grounded in a Classical Psychoanalytic understanding of the development of women's sexuality. This view frames the development of SSA in women in terms of unresolved penis envy or, more moderately, as maternal attachment issues (Siegel, 2015). However, these limited conclusions regarding the etiology of SSA in women have proved to be inadequate as reflected in recent research that has found the development of same-sex attraction to vary widely from woman to woman (Diamond, 2017). Consequently, SAFE-T clinicians addressing the distress of women with unwanted SSA are encouraged to recognize that clinical intervention will require a more individualized and informed client-centered approach.

Guideline 11. ***Clinicians are encouraged to recognize the special difficulties and risks which exist for youth who experience same-sex attractions.***

Research suggests that first attraction to the same or opposite sex has occurred by age 10 for 50% of the population (Hamer, Hu, Magnuson, Hu, & Patterson, 1993; Whitam & Mathy, 1986), but there is an unusually wide range, and some are still essentially asexual until their late teens in spite of the highly sexualized cultural climate in the West. Adolescents still have developing neurology (Sisk & Zehr, 2005), including brain development, and lack mature judgment, although they are at or near their physical peak in late teenage years. This period is occupied by finding what mature possibilities may exist for them and evolving an identity by experimenting with a wide range of experiences. Sexual initiation is usually during this time (Floyd & Bakeman, 2006).

For adolescents, the simple mature, accurate estimate of risk is often not perceived to be real. They tend to underestimate familiar risks and overestimate the possibility of remote risk. The risk of HIV is clearly underestimated by mature people, but adolescents' estimation of risk is less realistic still, although their risks are not much less than those of adults (Lock & Steiner, 1999). Unfortunately, teenagers may be reluctant to listen to input about this. In view of the above, responsible clinicians will offer more directive guidance to youth than to more mature clients, particularly when estimates of risk are unrealistic. This may involve more mentoring than for a mature client or referral to those who can mentor.

Statistical surveys show there is considerable sexual experimentation of types which are mostly not followed up in adulthood and are therefore far from definitive (Laumann et al., 1994). Change of various types continues to take place even as adults (Diamond, 2016; Diamond, Dickenson & Blair, 2017; Katz-Wise & Hyde, 2015; Katz-Wise et al., 2016; Kinnish et al., 2005). Clinicians should be aware that adolescents may prematurely decide they have a particular sexual orientation and hence should be warned against hasty conclusions. A very significant proportion of young women are most comfortable with the "unlabelled" sexual orientation category (Diamond, 2008b). Conversely, they might be told that with strong motivation, experiencing fluidity and change may be easier than as an adult.

Annually, about 42% of youth are exposed, willingly or unwillingly, to Internet pornography. Hence, over a few years this

exposure is almost universal (Wolok, Ybarra, Mitchell, & Finkelhor, 2007), so its effects should be monitored. Quite unrealistic ideals may be absorbed by these youths. Alternatively, compulsive or addictive use of gay pornography may lead a young person to assume that he is gay when he is merely compelled or addicted to sexual gratification.

Surveys show that some adolescents reach a conclusion about their sexuality, are distraught about what they perceive be the consequences, and are at highest risk of suicide immediately before disclosure to anyone (Paul, Catania, Pollock, Moskowitz et al., 2002; Wang, Ploderl, Hausermann, & Weiss, 2015). Therapists should be particularly aware of the fragility of such clients, who tend to be those without social support. Suicide risk among youth with same-sex attractions decreases 20% each year self-labeling as gay is delayed (Remafedi, Farrow, & Deisher, 1991). Although causal links are not clear, it is prudent to encourage the deferring of self-labelling (Rimes et al., 2018). Clinicians should also consider carefully whether disclosure of the client's struggle to unaware family and friends is in the client's best interests (Rosario, Schrimshaw, & Hunter, 2009; Ryan et al., 2009; Wang et al., 2015; cf. Guideline 9). Many who disclose their homosexuality to unsympathetic family join the ranks of the homeless and are further at risk for drug use, prostitution, and violence (Tyler, Whitbeck, Hoyt, & Cauce, 2004). The reactions of peers at this age can be brutal (brutality tends to peak in the adolescent years) probably because they have less empathy than younger or older groups. There is still intense pressure from peers to conform to stereotypical gender roles.

The male client (but not so much the female client) will probably report rejection and discrimination as central elements of intervention by others (Friedman et al., 2011; Hershberger & D'Augelli, 1995). Fathers can be a primary and potent focus of reported rejection, particularly among men (Pachankis et al., 2018). Therapists should be aware that this experienced rejection may be more perceived than actual but, nonetheless, have real effects for clients (Burgess, Lee, Tran, & van Ryn, 2007). The literature suggests emotional and avoidance coping styles may account for perceived rejection, perhaps more than objective circumstances in some cases (Burgess et al., 2007; Gold, Feinstein, Skidmore, & Marx, 2011; Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009). Thus, an individual's coping style may need examination by therapists. Co-occurrence of standard DSM conditions is much higher for such clients than in others and should be assessed (Fergusson, Horwood, & Beautrais, 1999). Among conditions which should be checked are substance abuse (Branstrom & Pachankis, 2018; Ploderl & Tremblay, 2015; Ross et al., 2018; Sandfort et al., 2001; Trocki, Drabble, & Midanik, 2009; Ueno, 2010), antisocial behavior (Fergusson et al., 1999), depression (Cochran et al., 2003; Gonzales & Henning-Smith, 2017; Ploderl & Tremblay, 2015; Ross et al., 2018), impulsivity (Puckett, Newcomb, Garofalo, & Mustanski, 2017), compulsivity (Dodge et al., 2008), and borderline personality disorder (Marantz & Coates, 1991; Sandfort et al., 2001).

Education

Guideline 12. ***Clinicians make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religiously oriented resources that can support clients in their pursuit of attraction fluidity and change.***

Unwanted same-sex attractions and behaviors often co-occur with formally diagnosable or otherwise evident medical, psychological, behavioral, and relational difficulties (cf. Guideline 8). Therefore, clinicians make reasonable efforts to familiarize themselves with relevant medical, psychological, behavioral, and relational approaches to healthcare. Clinicians keep their knowledge current about health psychology and related issues of behavioral health. They refer clients to specialists when the care of co-occurring influences is outside of their scope of practice. These include general health habits (e.g., diet, exercise, relaxation, sleep, etc.), relevant psychotropic medications and their interactive effectiveness with psychotherapy (Forand, DeRubeis, & Amsterda, 2013; Preston & Johnson, 2018), ways to enhance compliance with medical directives, and the timeliness of partial and inpatient hospitalization (Creer, Holroyd, Glasgow, & Smith, 2004; Thase & Jindal, 2004).

At times, addressing clients' co-occurring medical or psychiatric difficulties may have greater priority than serving their intentions to address unwanted same-sex attractions or behaviors. Psychological care may become an important support to enable clients to comply with other medical directives. At other times, treating medical or psychiatric difficulties may enable clients to engage in psychological and spiritual interventions more effectively. Additional adjunctive interventions may include referring for psychoeducation (e.g., individual or group substance abuse counseling) and to couple, family, and group therapy, as well as peer-support groups, when clients need and are able to benefit from therapeutic relational and group interaction. Referrals also may be expedient for helping clients deal with co-occurring sexual, substance abuse, eating disorders, or other compulsive or addictive behaviors (Forand et al., 2013; Lambert & Ogles, 2004).

When helping parents respond to concerns about children with gender confusion, incongruence and distress, including gender dysphoria or unwanted same-sex attractions, the practice of—or referral for—parent education and family therapy especially may be indicated (Lundy & Rekers, 1995; Rekers, 1988, 1995; Zucker & Bradley, 1995). Therefore, clinicians are prepared to make referrals to other healthcare professionals to obtain primary, sequential, alternative, combined, or adjunct medical or mental health assistance in a timely way.

In addition, clinicians serving clients who seek to address unwanted same-sex attractions and behaviors also prepare themselves to offer their clients directly or to refer them for pastoral care. Such clients often have religious or spiritual beliefs, practices and social interactions which offer motivation and support for their desired changes (cf. Practice Guidelines 3 and 4). Therefore, clinicians make reasonable efforts to assess their clients' religious beliefs, moral values, and spiritual practices to support clients' utilization of appropriate spiritual and religiously oriented resources to achieve intended changes (Collins, 2006; Richards & Bergin, 2000; Wilson, 1988[3]).

Clinicians wisely recognize that, in general, religion can be beneficial to psychological and interpersonal health, more "intrinsic" ways of being religious appear to be healthier, and clients who are more religiously devout tend to "prefer and trust

[3] Wilson's (1988) book is one of 28 volumes in the *Resources for Christian Counseling* series, which is edited by Gary R. Collins. The series' authors address how Christian psychotherapists and professional counselors may serve Christian clients who are dealing with a variety of issues, including self-esteem, depression, anxiety, anger, marriage and family difficulties, special needs of children, family violence and abuse, eating disorders, substance abuse and addiction, and ACOA issues. The notable, last book in this series is authored by the series' editor (Collin, 1988).

clinicians with similar beliefs and values" (Gregory et al., 2008; Richards & Bergin, 2005, p. 307). Also, the use of spiritual or religious-inspired aides such as prayer (Wright, 1986), meditation (Benson, 2015; Benson & Stark, 1997; Proctor & Benson, 2011), forgiveness (Enright, 2012; Enright & Fitzgibbons, 2014), and twelve step groups based on spiritual principles (Burlingame, Strauss, & Anthony, 2013; Friends in Recovery, 2009; Hemfelt, Minirth, Fowler, & Meier, 1991; Marich, 2012) have been shown to be therapeutically effective as part of or as an adjunct to clinical intervention (Richards & Bergin, 2004, 2005).

Studies of clients with unwanted same-sex attractions and behavior who have used spiritual aides, religious activities, and pastoral counseling, whether as adjuncts to psychotherapy or apart from therapy, often report positive results (Jones & Yarhouse, 2007, 2009, 2011). Even when clients did not change as they had intended, research designed to elicit reports of intervention failure, harm, or dissatisfaction from religiously mediated efforts to change nevertheless yielded a few participants who asserted that the process was helpful (Shildo & Schroeder, 2002). Research designed to elicit reports of intervention success or satisfaction with their participation yielded substantially more favorable reports (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003). The more rigorous the research design, the more clearly results have shown that spiritual/religious/pastoral counseling approaches by themselves have been able to reduce or eliminate unwanted same-sex attractions and behaviors for some individuals (Jones & Yarhouse, 2007, 2011; Yarhouse, Burkett, & Kreeft, 2002). Clients tend to try a wide variety of methods and find almost all helpful (Santero et al., 2018).

Guideline 13. ***Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who request SAFE-T, and seek continuing education, training, supervision, and consultation to improve their clinical work in this area.***

The literature on homosexuality is at first sight an academic field like any other, even though it might be thought slightly more active than many as a few new references accumulate almost every day. However, this is deceptive. Same-sex attraction is not an isolated clinical entity. A very wide range of conditions are co-occurrent with it, and it is necessary for clinicians to have a reasonable knowledge of these conditions, or at least be able to recognize them readily and refer clients on as necessary (cf. Guideline 8). This greatly increases the responsibility of clinicians to become and keep current with the literature.

Research has generally shown that persons reporting same-sex attractions and behavior (mainly the male representatives) have much greater prevalence of pathology than the general population. The consistency of these findings counterbalances to some degree the methodological limitations. Prevalence disparities have been reported or can be inferred in several areas: depression (Ross et al., 2018), suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007), violence (Coxell, King, Mezey, & Gordon, 1999; Friedman et al., 2011; Owen & Burke, 2004), antisocial behavior (Fergusson et al., 1999), substance abuse (Branstrom & Pachankis, 2018; Pakula, B., Shoveller, J., Ratner, P. A., & Carpino, R., 2016; Rhodes, McCoy, Wilkin, & Wolfson), injury (Batejan, Jarvi, & Swenson, 2015), rumination (Timmins, Rimes, & Rahman, 2017; Wang & Borders, 2017), suicidality (de Graaf et al., 2006; Hottes et al., 2016; King et al., 2008; Peter et al., 2017; Ploderl

& Tremblay, 2915; Rimes et al., 2018), more sexual partners (Laumann et al., 1994; Mark, Garcia, & Fisher, 2015; Mercer et al., 2009; Parsons, Starks, Gamarel, & Grov, 2012; Pawlicki & Larson, 2011; Rhodes et al., 2009), paraphilias (fisting) (Crosby & Mettey, 2004), being paid for sex (Schrimshaw, Rosario, Meyer-Bahlburg, Scharf-Matlick, Langstrom, & Hanson, 2006), sexual addiction and hypersexuality (Bothe et al., 2018; Dodge et al., 2004; Parsons et al., 2008; Satinsky et al., 2007), personality disorders (Zubenko, George, Soloff, & Schulz, 1987), and psychopathology (Gonzales & Henning-Smith, 2017; Sandfort et al., 2001). It is difficult to find a group of comparable size in society with such intense and variable co-occurring pathology.

As a rule of thumb, many of these characteristics have prevalence rates about three times those reported in the general population, sometimes much more. A check of any medical database shows that articles dealing with conditions which co-occur with homosexuality are far more frequent than those restricted to homosexuality alone. The former may outnumber the latter by nearly ten times. This means it is not enough to read about homosexuality alone, but the much greater number of co-associated articles must also be read. Thus, the other fields add to understanding significantly. In addition, the references to HIV are extensive, and it is quite possible this condition will co-occur. Even if HIV infection is under control, the prevalence of various cancers in AIDS patients is about 20 times greater than in the general population (Galceran et al., 2007). A clinician may well encounter clients with such medical needs and discover therapeutic issues which must be addressed.

SAFE-T for unwanted same-sex attractions and behavior is controversial in a manner that is seldom experienced today for other types of presenting concerns. As a result, there is a potentially increased risk for the clinician of unanticipated legal consequences (Hermann & Herlihy, 2006; Rosik, 2017b; cf. Guideline 6), a greater potential complexity of therapy, and therefore a greater need than average to stay current in the field and be aware of the latest implications of research and good practice. Clearly, it may be necessary to understand the consequences on the client's psyche of having one of the associated medical conditions, or one of the common political attitudes, such as strong rejections of society's attitude toward homosexuality.

This need is also greater because the therapeutic modalities though which SAFE-T is provided are numerous and there is no consensus on the best approach. This again means an unusual need to be aware of other intervention strategies and theoretical approaches, as well as a willingness to adopt useful insights and previously successful techniques (cf. Guideline 7). Alongside this, the varieties of experience in clients are significantly diverse (e.g. Otis & Skinner, 2004; Santero et al., 2018). This readily demands a greater versatility of response from the clinician and more reading of the clinical and research literature than usual.

Much of the literature pertaining to homosexuality is at risk of being irrelevant because it is associated with the political and advocacy aspects of the topic. The remainder of the relevant literature involves many widespread fields, including genetics, physiology, sociology, urban anthropology, and of course psychotherapy. Thus, clinicians must strive to locate relevant material in unusually diverse fields. This material is also often unusually attention-grabbing for the media, and clients are more likely than usual to read it and require comment. Their clinicians should be prepared. It is probably worthwhile that clinicians use a service on the Internet to

alert them when relevant material is published (e.g., PubMed).

Focused events such as seminars, conferences, etc. are more important than usual because SAFE-T approaches for unwanted same-sex attractions and behavior are not as widely known and practiced as counseling for other conditions, which increases the need for collegial consultation. It is assumed in all the above that clinicians attempt to keep current in the psychological disciplines in general, with the usual accompanying need for continuing education.

Applications and Conclusion

These guidelines were developed with multiple purposes in mind and ideally will have many applications. First, the guidelines are intended to address the needs of clinicians. They provide guidance from experienced clinicians specifically to colleagues who are currently practicing or who are considering the use of SAFE-T to help clients address unwanted same-sex attractions and behavior. As such, these guidelines encourage excellence in practice that, when followed, should limit the risk of harm and expand the probability of favorable outcomes for clients seeking some measure of fluidity and change. The guidelines will serve to educate clinicians by providing an entry point into aspects of the professional literature that may be underreported or misrepresented by national mental health associations.

Second, these guidelines inform consumers who currently are receiving or considering the pursuit of SAFE-T for their unwanted same-sex attractions and behaviors. The guidelines provide a broad evaluative framework which these clients can utilize to help determine if the clinical services they receive are being provided in a sufficiently professional and ethical manner. Consumers of SAFE-T may find value in discussing these guidelines with their clinicians. Discussing them early in treatment as part of the informed consent process may facilitate planned short-term and long-range goals for the psychological care they are going to receive.

The social scientific and medical information made available through these guidelines may also benefit consumers as they weigh the benefits and risks of SAFE-T in comparison to therapeutic approaches that endorse the embracing of a gay or lesbian identity. In this way, these guidelines can contribute to a more fully informed and autonomous decision-making process by clients regarding what clinical approach—if any—they may choose for responding to their unwanted same-sex attractions and behavior (Rosik & Popper, 2014). Periodically and at the end of a course of treatment, clinicians may also use these guidelines to assess the therapeutic progress that has been achieved by clients and to review and renegotiate any remaining goals. As is true for all approaches to psychological care for any presenting problem, an initial and ongoing clarity of purpose and goals shared by clients exploring fluidity and their clinicians enables the therapeutic alliance to be more cooperative and effective.

Finally, these guidelines can assist mental health associations and graduate training programs in facilitating a balanced and informed discussion about SAFE-T and associated practices. These guidelines complement the existing professional literature pertaining to psychological care for those with unwanted same-sex attractions and behavior by their non-dismissive focus on SAFE-T that may facilitate fluidity and change. The guidelines may thus encourage more individuals within these associations and universities to engage in valuable dialogue, education, and

research about the place such interventions have in the array of therapeutic responses to unwanted same-sex attraction and behavior. The guidelines also may provide interested clinicians and students an opportunity to become educated about the professional practices of responsible clinicians who practice SAFE-T.

Mental health associations have emphasized the importance of client autonomy and self-determination within a therapeutic environment that honors diversity. This respect for diversity should oblige clinicians to give as much weight to religious belief and traditional values as to sexual identity (Benoit, 2005). Within the contemporary milieu of psychological practice, this especially needs to be emphasized when addressing the choices clients make about how to approach their unwanted same-sex attractions and behavior. When conducted in a manner consistent with these practice guidelines, SAFE-T deserves to be made available to clients who seek it.

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[i] The original guidelines were adopted by the Board of Directors of the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) on October 25, 2008. This updated version was adopted by the ATCSI Board on June 22, 2018, and replaces the earlier guidelines document.

[ii] These revised guidelines were developed by the Alliance Practice Guidelines Task Force (PGTF). The PGTF chair was Christopher H. Rosik, Ph.D. (Link Care Center & Fresno Pacific University). The PGTF members included Shirley Cox, DSW (Brigham Young University); Carolyn Pela, Ph.D., LMFT (Arizona Christian University & Fuller Theological Seminary); Paul Popper, Ph.D. (independent practice, San Francisco, CA); Phil Sutton, Ph.D. (independent practice, South Bend, IN); and Neil Whitehead, Ph.D. (research scientists, Lower Hutt, New Zealand). Others who contributed to the development of these guidelines were Julie Hamilton, PhD, LMFT (independent practice, West Palm Beach, FL); Geoff Heath, J.D. (U.S. Department of the Interior, Washington, D.C. (Retired)); Joseph Nicolosi, Jr. (The Breakthrough Clinic, Westlake Village, CA); David Pruden, MA (Utah State University); and Robert Vazzo, LMFT (independent practice, Culver City, CA, and Las Vegas, NV).

Requests for copies of these guidelines should be addressed to the Alliance for Therapeutic Choice and Scientific Integrity, 307 West 200 South, Suite 3001, Salt Lake City, UT 84101, or can be ordered by phone at 1-888-364-4744, or online at http://therapeuticchoice.com.

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The Breakthrough Clinic

Westlake Village, California

Trauma and addictions are similar in that they both induce emotionally dysregulated trance states of altered consciousness (Miller, 2012; Shapiro & Forrest, 1997). Trauma invokes this trance state with negative, painful affect, and addiction invokes it with positive, pleasurable affects. Iraq war veterans and rape victims know this all too well when they are presented with reminders of their traumas. Addicts can often recall with vivid detail the "rush" of their first experience getting high with such clarity that it almost feels like it is happening in the present. This is not just true for drug abuse. This phenomenon can be observed with behavioral addictions like gambling addiction and sexual addictions. The resolution of these trance states can often be achieved by reintegrating the client's core affects and unmet relational needs. The Reintegrative Protocol™ aims to achieve this. The focus of this paper will specifically examine the protocol's application within the context of treating males presenting with same-sex attractions and will provide instructions for using self-compassion as a method of trauma resolution, as well as instructions for EMDR-trained psychotherapists who wish to use EMDR as a method of trauma resolution.

Introduction

The Reintegrative Protocol™ is a simple and versatile clinical treatment of trauma and addiction for males and females. In the following example, I will specifically illustrate how the Reintegrative Protocol™ would be applied to males with same-sex attractions they wish to explore and will include optional EMDR instructions for therapists qualified to use EMDR therapy. Therapists not trained in EMDR therapy may use the mindful self-compassion version.

A substantial volume of empirical evidence supports the psychological benefits of mindful self-compassion, for example, its demonstrated safety and efficacy in the treatment of a variety of clinical symptoms, particularly in mitigating negative responses to unpleasant events (Leary, Tate, Adams, Allen, & Hancock, 2007), the association between childhood maltreatment and

subsequent emotional regulation difficulties, and problem substance use (Vettese, Dyer, Li, & Wekerle, 2011). It is also linked with increased psychological well-being (Neff, Kirkpatric, & Rude, 2007).

A growing body of empirical research also supports the safety and efficacy of EMDR therapy for resolving a variety of clinical disorders. Twenty-four randomized controlled trials now support the positive effects of EMDR therapy in the treatment of emotional trauma and other adverse life experiences relevant to clinical practice (Shapiro, 2014), and the American Psychiatric Association has recommended EMDR therapy for many patients (APA, 2004). EMDR therapy is widely viewed as an integrative approach with other therapeutic modalities (Shapiro, 2002). According to EMDR therapy, overwhelming, dysregulating experiences in the client's life disrupt the ability of the client's nervous system to adaptively process, encode, and store information related to the traumatic event, leading to the client's trauma-induced irrational maladaptive negative cognitions, propensity toward addictions, and other PTSD symptoms (Shapiro & Forrest, 1997). The systematic implementation of bilateral stimulation (most commonly administered through bilateral eye movements) is believed to contribute to the client's adaptive reprocessing of these traumatic events, and as a result, the client's negative cognitions, propensity toward addiction, and other PTSD symptoms often resolve (Shapiro & Forrest).

With proper EMDR therapy, changes in the client's affects and cognitions are common, with no ideological influence from the therapist. For example, a therapist believing the client's fear of heights is irrational never needs to argue with or in any way coerce the client into the therapist's own belief about what heights constitute a danger to the client. In proper EMDR therapy, rather than debate with the client about whether his fear of heights is appropriate or not, this topic can be bypassed by allowing the client to reach his own conclusions as the trauma-induced components of the client's memories and triggers resolve—any fears which remain after the reprocessing are considered ecologically sound. Examples of this were noticed by the creator of EMDR therapy, Francine Shapiro, when she noted that "EMDR would not desensitize a person's negative feelings if they were appropriate to the situation" (Shapiro & Forrest, 1997, p. 25). Adaptive affects, such as fear about being too close to a cliff remained, while inappropriate, maladaptive affects (for example, the feeling of terror induced by simply being exposed to the word "cliff") spontaneously dissolved.

This method of reprocessing is of great significance when the client and therapist discuss such an important topic as sexuality. Religion, societal pressure, self-image, and health concerns all come into play.

Reintegrative Therapy™ as Distinct from So-called "Conversion Therapy"

When LGBT political activists hear about a therapy which changes sexuality, they often assume it is so-called "conversion therapy"—a broad, ill-defined term used to describe efforts that "seek to change an individual's sexual orientation" (see S.B. 1172, 2011–2012). Reintegrative Therapy™ itself and this protocol are categorically separate from "conversion therapy" or "sexual orientation change efforts" (SOCE) for several fundamental reasons.

First, the goal of Reintegrative Therapy™ is to treat trauma and addictions. Changes in sexuality are a byproduct, not the goal. As a consequence, Reintegrative Therapy™ and the Reintegrative Therapy Association (a 501(C)3 non-profit organization) take no

stance as to whether homosexuality should be considered a mental disorder. Second, Reintegrative Therapy™ methods are employed with no distinctions or modifications related to the client's or therapist's gender or sexual orientation. Providing a client with same-sex attractions the exact same protocol as a client with heterosexual attractions helps bypass the complicated ethical and religious "landmines" related to the religiously and politically charged topic of sexuality. The client is free to come to his own conclusions about his sexuality. No ideological dogma by the therapist needs to be introduced in order for the protocol to work.

Third, Reintegrative Therapy™ employs only established, evidence-based treatment approaches (such as mindful self-compassion and EMDR), the same approaches used by other clinics throughout the world that seek to treat trauma and addiction (as opposed to "conversion therapies," which seek to change sexual orientation).

Avoiding the Pitfalls of "Conversion Therapy"

The Reconciliation and Growth Project (see ReconciliationAndGrowth.org/guidelines), an organization of mental health professionals and academics from diverse sexual identity and religious backgrounds, seeks to foster "dialogue among people with differing perspectives on faith-based values and sexual and gender diversity." Among them is Lee Beckstead, Ph.D., a member of the APA's Task Force on Appropriate Therapeutic Responses to Sexual Orientation. The organization highlights four specific interventions they consider to be inherently unethical and potentially harmful when addressing sexuality, gender, and faith:

1. Fostering expectations of a specific sexual orientation or gender identity outcome
2. Using direct or indirect coercion
3. Basing interventions on bias, unfounded theories, or prejudice
4. Limiting the exploration of sexual orientation, gender and faith identity, and expression possibilities

Though Reintegrative Therapy™ is a sexual orientation–neutral approach, designed to treat trauma and addiction for males and females regardless of the client's sexual orientation, male clients with same-sex attractions have reported decreases in their same-sex attractions and, for some clients, increases in their heterosexual attractions as a byproduct of its use, so this particular article will illustrate the protocol's use when applied to a male in this population.

The Reintegrative Protocol™, when properly applied, allows both client and therapist to bypass every one of the four ethical problems which may arise in "conversion therapy." The client and therapist do not need to try to change the client's attractions—the protocol involves exploring the client's attractions from a neutral stance of curiosity and then seeking to resolve the trauma memories that lie beneath with standard trauma treatments. The use of a treatment protocol means the client and therapist do not need to adhere to any particular ideology or causal model about sexuality, nor do they have to posit any particular moral, political, or religious stance on the topic. The protocol-driven approach reduces and can even eliminate the therapists' ideological influence in the client's treatment.

The Reintegrative Protocol™'s four-phase approach consists of history and evaluation, preparation, assessment, and

reintegration. After describing the steps involved in each phase, I conclude this article with some theoretical discussion of the protocol's approach.

Phase 1: History and Evaluation

1. Obtain history, frequency, and context of the client's symptoms (for behavioral addictions, this is the addictive behavior).

2. Evaluate the client for safety factors that determine whether he has the coping skills and integrative capacity to manage potentially high levels of negative feelings. If the client is too fragile for trauma or addiction work, supportive psychotherapy and instruction in calming and stabilization skills would be in order until the individual is prepared for more direct and challenging psychotherapeutic work, such as this protocol.

Phase 2: Preparation

3. Explain the Reintegrative Protocol™ and how complex emotions can sometimes lie beneath our traumas and addictions, and how self-compassion can help with their resolution. If EMDR therapy may be appropriate, information about EMDR therapy for processing disturbing memories can be provided.

Phase 3: Assessment

4. Identify the specific element of the target behavior that has the most emotional intensity associated with it. For sexual behaviors, this would be the peak moment of the client's most powerful sexual fantasy (Figure 1).

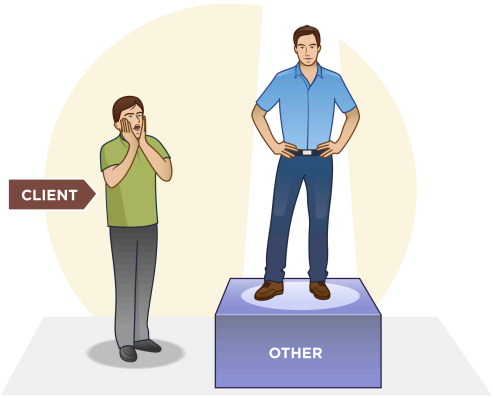

Fig. 1 Examining activating event.

The therapist would inquire: *"Tell me about the sexual fantasy or experience that you want to work on. Tell me about it in as much detail as you're willing to give me."*

The client may respond: *"This ideal man performs oral sex on me, as he praises me."* Or, *"I'm having sex with two men I've just met. Their only desire is to meet my every need."*

5. Identify the specific feelings associated with the most powerful moment of the sexual experience and allow the client to experience this feeling as intensely as he can. Time must be taken for him to carefully identify the feeling he gets from this (i.e., *powerful, bonded, worthy, wanted*). It is very important that he knows his therapist is accepting of him so that he can enter the sexual trance state during this moment, and it is crucial that the therapist be truly accepting of this part of his client. If the client is vague or unable to discuss his sexual fantasy or his feelings associated with it, this is likely an indicator of significant client shame. In order for the client to make productive use of this protocol, he must be able to join the therapist in maintaining a mindful stance of openness, acceptance, and curiosity about his sexual thoughts and feelings. Therefore, the therapist may need to spend extra time, even several sessions if necessary, in this phase of

the protocol, both modeling for the client and supporting him in developing understanding and non-judgmental curiosity about his sexual fantasy and the feelings he associates with it. Sexual abuse victims often have difficulty with this if their sexual fantasy relates to an abuse memory, so it can often be helpful to provide psychological education about how complex, conflicting feelings often emerge after a trusted caregiver becomes sexually abusive.

6. Once the client is visualizing the peak moment of his sexual fantasy and allowing himself to intensely experience its associated emotion, ask the client to imagine taking a stance of being outside of himself in the third person and look deeply and directly into his own eyes and notice what he sees (Figure 2).

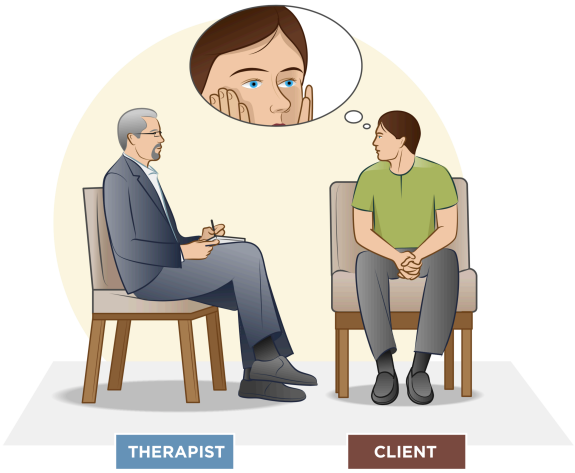

Fig. 2 Identifying and acknowledging the associated feelings.

Therapist: "*Go outside of yourself in the third person and look in at yourself, directly into your own eyes. Take your time and just notice what you see in him"* [speaking as if the client's eyes were in the third person].

The therapist must be careful to move slowly at this point, asking open-ended questions if needed. It is crucial that the client is allowed to come to his own conclusions, at the pace that works for him. This is not a time for analysis or interpretation of his answers.

As the client imagines being outside of himself and peering steadily into his own eyes, exploring what affects are inside, his only job is to "let whatever happens, happen" (Shapiro, 2002, p. 38) with no moral judgment or pressure from the therapist as to what he should see.

The therapist may need to gently and repeatedly draw the client's attention back to the visualization of looking deeply into the client's own eyes to help the client maintain that gaze. The therapist must be steadfast in gently guiding the client back to peering deeply into his own eyes. With a stance of openness, curiosity, and gentleness, the therapist may inquire:

What are you seeing in his eyes?
What do you think he's wanting?
What do you think he's hoping he'll get from this?
What feeling do you see behind the feeling you just mentioned?

The client's awareness of his emotional motivations likely presents itself in a specific order: (1) sexual fantasy trance, (2) underlying emotional desire (craving), and (3) the originating unmet need, which is the result of the individual's early emotional trauma and experiences of neglect (Figure 3).

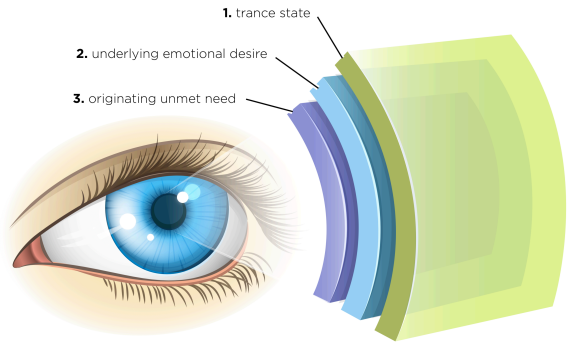

Fig. 3 Transcending the trance state through gaze inversion.

7. Once the client is able to see and experience the originating unmet need, ask him to associate back to an earlier memory from the third-person perspective (Figure 4).

Therapist*: What's an earlier time he's felt this way? What happened in his life that caused him to feel this way in the first place?*

The client will likely associate an important memory which relates to his unmet emotional need:

"*I'm alone on the playground, and everyone is ignoring me.*" Or, *"I remember my mom shouting at me, and I was afraid of her.*"

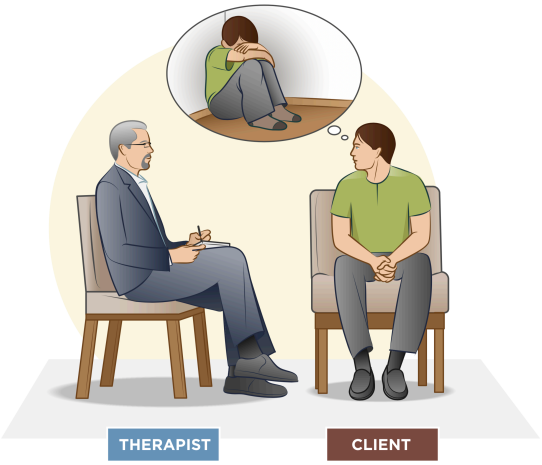

Fig. 4 Associating back to historical experiences.

Spontaneous associations to childhood memories occur with no prompting from the therapist, particularly with clients who have used this protocol with their therapists several times.

If memories are identified, the therapist has a choice point: He or she can now shift directly into EMDR therapy phase three (assessment) by identifying the images, negative cognitions, positive cognitions, etc., and then continue to phases 4–7 for memory reprocessing. For EMDR–trained therapists, the following steps of this protocol are not needed, since the therapist may continue from this point with EMDR therapy's standard protocol. If EMDR therapy is not suitable, then continue with the following steps (below) and use mindful self-compassion to process the trauma(s) instead of switching to the EMDR standard protocol.

Phase 4: Reintegration

8. Once the client has identified the earlier trauma memory, begin to resolve it using mindful self-compassion. At this point, the therapist asks the client, who is still in the third-person observer state, to access feelings within himself of compassion toward his younger self (Figure 5):

Fig. 5 Feeling and expressing self-compassion.

"Look deeply into the eyes of your younger self. Can you see the need in him?

If you take in a deep breath and open your heart toward him, look directly into his eyes. What do you feel inside yourself when you see his unmet needs?"

As the client gains access to his own feelings of care and compassion, the therapist then encourages him to express that compassion toward his younger self:

"If that feeling inside you could express itself toward him, what would you do or say?"

For some clients who have difficulty accessing feelings of compassion, this difficulty can often be remedied by the therapist asking the client how he would treat his own child in that moment:

"Look deeply into his eyes. If you had a son whom you really loved and that child was in this situation, how would you feel toward him? How would you feel if you really opened your heart toward your child in that moment?"

The client may initially report feeling overwhelmed by the pain of the child, stating that he cannot possibly give the child what he needs. This objection is typically voiced by clients who have low self-worth, believing they have little of value to offer others. This roadblock is easily addressed with brief education and encouragement from the therapist. The client needs to be taught that, although children can be easily hurt, they can also be easily reassured with a small amount of compassion from a benevolent caregiver. The therapist can continue:

"See if you can offer him (the client's younger self) the compassion that you do *have. You don't have to solve all of his problems right now, and you'll be surprised how far your care will go for him."*

Once the client is able to access this sense of care and compassion and openness toward his imagined child, the therapist can ask him to now express this toward his younger self:

"If that feeling there in your heart felt really free to express itself in that moment, what would you say or do toward your younger self?"

Clients typically are moved to care for their younger selves, holding, guiding, and listening. As his younger self (which holds onto the original unmet needs) is cared for, brought close and "reintegrated" with the observing, caring adult self, the therapist might facilitate this process by asking the client:

"In that moment, look deeply into the eyes of your younger self. What does he know about himself in that moment? What does he know about you in that moment?"

Clients who are able to feel and express their compassion toward their younger selves in the memory will often respond by saying something like:

"He knows he's acceptable." And, *"He knows I'll always be there for him."*

The development of self-compassion can sometimes require frequent intentional efforts. This is something the ancient tradition of mindfulness has taught us.

9. Ask the client to go back to the original sexual fantasy or memory identified in phase 3.

Therapist: *"What is your emotional reaction to this original scene now?*

What do you know about it now, that you didn't when we began?

What do you think is the connection between the sexual fantasy and the memory we worked on?"

By this point, the client has very likely lost his sense of unrealistic idealization of the other person in the fantasy, lost his shame about himself for having the sexual desire in

the first place, and gained insight into the true motivations behind his sexual feelings and behaviors. He likely experiences himself and the other person as equals and is less likely to experience the original sexual fantasy/memory as affectively dysregulating (Figure 6).

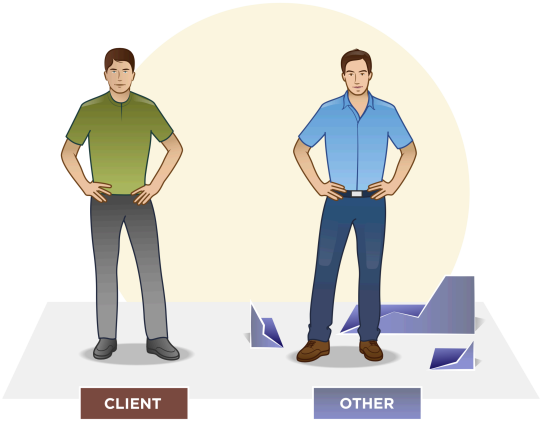

Fig. 6 Revisiting and reassessing the activating event.

Discussion

Clients who have difficulty feeling and expressing self-compassion likely did not receive much compassion from their caregivers when they were young, contributing to their core unmet need and leading them to instead enact self-criticism toward their younger selves. Sexuality change in the client as a result of this process occurs as a byproduct of resolving the core unmet need (the third and deepest layer of Figure 3), and is not the goal of the treatment itself. This is distinct from general forms of "conversion therapy," which seek to modify the sexuality (the most superficial layer of Figure 3). Sexuality change is "conversion therapy's" goal, not its byproduct. In this protocol, no effort whatsoever is made to modify the client's sexual fantasy. The change only occurs on the deepest layer (layer 3—originating unmet need), which often causes layer 1 (sexual trance state) to simply disappear as a byproduct of the resolution of layer-3 dynamics. This has a wide variety of applications—clinicians have reported notable success in treating symptoms of Posttraumatic Stress Disorder, Other Specified Disruptive, Impulse-Control and Conduct Disorder, and a variety of paraphilia disorders with consistent use of the protocol.

In our experience of working with men who report same-sex attractions, at the end of phase 3, the client will virtually always spontaneously recall a moment of profound shame and attachment loss, typically at the hands of other hostile and rejecting males, causing the client's masculine strivings to be disabled and "cauterized" by the painful trauma.

Clients during phase 3 of this protocol who, for example, report sexual fantasies in which they feel "bonded" will likely spontaneously associate back to memories of being "rejected" after inverting their gaze through their own eyes. Likewise, clients reporting sexual fantasies of feeling "powerful" in phase 3 will typically report experiences of feeling "powerless" and "stuck" when they invert their gaze. This phenomenon is consistent across the behavioral spectrum—a gambler who has a rush of the feeling of "winning" will often spontaneously associate back to memories of "losing." Binge eaters wishing to explore their bingeing behavior often spontaneously associate back to moments of emotional deprivation and "emptiness." When applied to men with same-sex attractions, this clinical observation has led many clinicians to view the client's presenting material as a compensatory phenomenon—an attempt to restore affect dysregulation and sense of identity—and therefore remediate the effects of affectively dysregulated symptoms created by trauma and neglect experiences during the client's developmental years.

With regard to male clients with same-sex attractions, gay affirmative theorists have traditionally posited that this phenomenon can be explained by the theory that the boy was rejected by his father and peers for being born gay, i.e., the client's homosexuality was present from birth, and the boy was rejected by other males, either consciously or unconsciously as a result of this. In contrast, reparative therapy has postulated that traumatic rejection from the father and same-sex peers originally blocked the boy's masculine strivings, and due to this traumatic shame and attachment loss, the client unconsciously developed reparative attempts to meet these unmet attachment needs in the form of same-sex attractions. Gay-affirmative theorists and reparative therapy theorists therefore posit reverse cause-and-effect explanations.

Fortunately, this protocol allows the client and therapist to side-step this cause-and-effect question. Regardless of the source of the client's homosexuality, he is now able to access and resolve his early trauma using this protocol. Resolving underlying trauma with self-compassion is beneficial to the client, making this exercise a worthy therapeutic intervention for clinicians who approach the topic of sexuality from many vantage points.[1]

The protocol-driven approach reduces and at times even eliminates the therapists' ideological influence in the treatment. This protocol, when properly applied, prevents the therapist from leading the client to a specific conceptualization of the causality of his behavior. The inversion of the trance-like feeling will cause the underlying trauma memories to "auto-select" and come to the surface of the client's awareness. It should be noted that, in my experience, clients with same-sex attractions, regardless of their various cultural and religious backgrounds, are very likely to spontaneously associate to painful memories of shame and attachment loss from other males. These clients who repeatedly use this protocol with Reintegrative Therapy™ clinicians commonly notice that the compulsive, risky elements of their sexuality are the first to diminish as they become aware of their underlying unmet emotional needs and resolve them through self-compassion and/or EMDR.

To avoid so-called "implicit aversion" (non-verbal or otherwise unacknowledged elements of coercion that may be at play), clients are encouraged to inform their therapists right away if they notice themselves feeling any sense of judgment or coercion from their therapist. A competent therapist can collaboratively work with the client to resolve this, and should do so before moving forward with this protocol. The client's experience of an open, accepting therapeutic alliance is the foundation for productive therapeutic work, as well as the understanding that clients have the right to set their own therapy goals, and to change those goals when they wish.

It is significant to note that clients consistently report the realization that their emotional states of compassion and shame are diametrically opposed to one another. As they grow in their capacity to give and receive compassion, they notice less shame in their everyday lives.

Lastly, clients who feel overwhelmed by seeing negative affect in their own eyes during phase 3 may benefit by viewing their own eyes from a distance. Viewing the eyes

[1] For more information, including further resources to assist therapists with this protocol, visit www.reintegrativetherapy.com

from a distance allows for more gentle acknowledgment and resolution of the negative affect, without overwhelming and dysregulating the client during the process.

Cautions and Contraindications

Two cautions and possible contraindications for this protocol should be noted. Individuals who have obsessive compulsive disorder (OCD) may need additional preparation to benefit from this protocol, as the protocol requires sustained attention on an emotionally charged topic without lapsing into the ritualized mental activities brought on by OCD, something with which OCD sufferers have difficulty (Hershfield, J., & Corboy, T., 2013). Untreated OCD may need to be treated in phase 2 of this protocol, and may take several months or longer, depending on how quickly the OCD symptoms can be diminished to a degree that the individual is able to successfully use the protocol. Males with same-sex attractions may be far more likely to have OCD (Sandfort, de Graaf, Bijl, & Schnabel, 2001). Though the implications of this topic are outside the discussion of this article, it is important to acknowledge that clients often benefit greatly from evidence-based OCD treatment, such as "The Mindfulness Workbook for OCD" (Hershfield, J., & Corboy, T. 2013) during phase 2 of this treatment protocol. The mindful self-compassion exercises help prepare the client for the self-compassion work in phase 4.

Clients who are gay-identified should be informed that the use of this protocol, particularly when used repeatedly, may lead to decreases in their same-sex attractions, and perhaps increases in their opposite-sex attractions as a byproduct. Many clients who are gay-identified, but wish to explore their attractions in a neutral way, and to resolve any traumas they may discover, do not see this potential shift in their sexuality as a negative side-effect. Though they often give consent for their sexuality to possibly shift on its own to whatever that result may be, it is only fair and responsible for the therapist to inform the client of this possibility before the repeated use of this protocol.

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Surviving Gay Activism in Graduate School: A First-Person Account

Andrew Rodriguez[i]

Pottstown, Pennsylvania

This first person narrative chronicles my story as a graduate student in a clinical psychology program in the mid-Atlantic United States, who faced discrimination from the school for my support and involvement in therapeutic help for individuals with unwanted same-sex attraction. I had provided lay counseling to same-sex attracted men for several years prior to beginning my graduate school training. Though I had been transparent about my experiences throughout my academic career and received no complaints from my internship site or clients, near the completion of my degree the administration suspended and then dismissed me for my views. I recount the tactics and arguments my opponents used, how I obtained support and resisted the discrimination, and offer insights for aspiring students, counselors, and other interested parties.
Keywords: *discrimination, graduate school, homosexuality, gay activism*

Andrew,

The program has become aware that you are providing and advertising services directed at people "leaving homosexual ifestyles," healing/recovering from homosexuality, and addressing "unwanted same sex attraction." We are VERY concerned about this, and we need you to discontinue your internship IMMEDIATELY. Please schedule a meeting with us as soon as possible to discuss this. Monday or Tuesday next week look to be possible for some of us. I have CCd your supervisors both on site and on campus so that they are aware that your internship work must stop immediately. (Dr. S., personal communication, June 25, 2015)

That was the email I received from the coordinator of master's field placement at my university, on the fateful day of June 25, 2015—just four weeks away from finishing my internship and graduating with my master's of science in Clinical and Counseling Psychology. I had been a student at this graduate school of psychology in excellent standing since January 2012. My entire experience was arduous and draining: working full-time at a highly stressful administrative job, then driving to three-hour classes twice a week, while also running a support group for men at my alma mater; serving in youth ministry at my church, and barely getting the hours I needed at my internship site. Nearly all of my classmates from my cohort, who were

able to take three classes each session while working just part-time, had graduated and moved onto their careers a year previous. The end for me was imminent; I could barely wait for my freedom. And then this email arrives.

My Prior Background

How did I get to this point? The field of recovery for unwanted same-sex attraction (SSA) was one I entered through a different path than most counselors. I believe the vast majority of therapists begin exploring this type of work after they have already been in practice for some time, usually precipitated by encountering certain clients with this presenting concern. However, by the time I entered graduate school, I had six years of training and lay counseling experience in this area. In 2006, I was fortunate to complete my undergraduate internship at Day Seven Ministries, a Christian counseling center in Lancaster, PA, which at the time was a member ministry of Exodus International, the umbrella organization for various Christian ministries for people looking for help with unwanted SSA, though Day Seven dealt with an array of sexual issues beyond homosexuality. Regarding this particular ministry, the modalities used were Christian-focused 12-step recovery, cognitive-behavioral, insight-based, and trauma-sensitive. Beyond just the typical clerical work involved in most undergraduate internships, I participated in their recovery groups and a couple intake assessments.

The topic of sexual and gender identity conflicts had interested me for some time, as demonstrated by my research projects even before this internship. I also had some personal stakes in the matter; though I myself had never experienced SSA, I had an assortment of family and friends with SSA—some embracing a gay identity, some struggling in secret, and some openly and actively fighting to overcome it in some way. The existence of therapies to assist people with the latter goal excited me, and in my internship, I found living examples of effective and beneficent help at work.

Upon returning to campus after the internship, I cofounded a support and recovery group for men at my school dealing with past trauma, sexual addiction, and unwanted same-sex attraction. Starting this group is a story in itself, considering that there were no counseling services on campus back then and the administration was not so keen on allowing anything, especially not something for this population. Nevertheless, I persevered, even receiving some aid from my internship site to launch it. I continued leading this group after graduating, all while continuing to study books and articles on related topics and develop my own curriculum.

Allow me to make it clear the type of work I was doing in this group and in my lay counseling. As stated, this group was never exclusively for same-sex attracted individuals, though they composed on average half of the men in the group each school year. Therefore, the core curriculum focused on topics applicable to the majority of men in the group: accountability for goals and undesired behavior, emotional regulation, processing emotional wounds, forgiveness, conflict resolution, shame and guilt, grief, identity and self-worth (particularly from a Christian perspective), addiction, understanding a biblical model of masculinity and development, and sexuality. A couple of the men opted to see me during school breaks for continued mentorship. I never made claims—especially not guarantees—that following the group process would result in changes in one's sexual attractions. I was aware of therapeutic approaches to attempt changes in attractions, and I understood their theoretical

concepts; however, as I was not adequately trained in these approaches, we did not make same-sex attraction change a stated goal of the group (or my individual counseling) for the individuals with unwanted SSA. And with my members being college students, I soon realized their efforts for self-improvement would be in competition with the demands of school, so in general I tempered my expectations for the types of changes we would see in the group. It also should be noted that I never made any effort to convince the group members to adopt my view of sexuality or sexual ethics. The members with SSA came to the group already convinced that homosexual behavior and identity were incompatible with their commitment to Christianity. With all of these considerations, our main focus in the group was to assist the other members in living congruently with their religious convictions, while also exploring past emotional wounds and their global effects on their lives. The members may have come to identify contributing factors to the development of their SSA or other issues, but we ultimately kept discussion focused on one's responsibility in the present, as well as resolving one's shame through a revelation of God's grace. That is not to say that this type of ministry approach could not result in changes in one's attractions as a consequence of inner healing and pursuing chastity. I frequently encouraged the men to continue the work begun in the group after they left the school. Some went on to embrace a gay identity and enter into gay relationships, some have maintained their original convictions and celibacy, and some continued with individual counseling or mentoring (some of whom are now in heterosexual marriages).

Definitions and Background of This Field

There are a number of terms for the multiple forms of intervention for individuals with unwanted same-sex attraction. The mainstream media tends to label them all conversion or reparative therapies—both misnomers, as they do not take into account the distinction between religious lay counseling and professional therapies, as well as the actual goals of each approach. Sexual orientation change efforts (SOCE) is perhaps a more appropriate umbrella term for all efforts to reduce or change unwanted same-sex attraction, behavior, and identity—including secular and religious, professional and lay, trained and untrained. Complaints about the ineffectiveness and risk of harm more often than not fail to make the distinction between inadequately trained lay counseling and professional therapy approaches. I will most often refer to professional therapy to include treatment performed by either licensed mental health professionals (LMHPs) or unlicensed professionals who still have some type of a master's degree or higher in counseling, thereby qualifying both types as trained professionals. The unlicensed professionals will typically be found in private practice or a non-profit organization (such as a religious ministry) where insurance is not accepted.

Religious ministries that address unwanted same-sex attraction are traditionally called ex-gay ministries, a term I consider inadequate because it does not account for the existence of clients with SSA who never identified as gay nor even engaged in homosexual relationships. The various member ministries of Exodus International, such as the one at which I had interned, often contained a combination of support and recovery groups as well as individual therapy, while some ministries offered just group support (which may or may not be facilitated by a trained therapist).

The Exodus ministry at which I had interned employed as counselors only professionals with a master's degree or higher, while some of their support groups were facilitated or co-facilitated by non-professionals. Some of these groups followed a modified 12-step recovery model, which is commonly peer-led. I must also note that counseling by non-professionals is not necessarily unethical or ineffective, though I concede that they run a greater risk for unprofessional conduct. Nevertheless, Jones and Yarhouse (2009) conducted a longitudinal study of participants in Exodus ministries and found results across a spectrum. Significant reduction or elimination of SSA and development of opposite-sex attraction was the minority result (23%), but still a showed to be a possibility. Spitzer (2003) had interviewed 200 participants who believed SOCE were helpful for them, and based on their retrospective self-reports, there was a shift from 46% of the men being exclusively same-sex attracted before intervention to 17% having exclusive opposite-sex attraction after intervention.

Of the professional approaches to unwanted same-sex attraction and homosexuality, there are two main camps: change-oriented therapies and Sexual Identity Therapy (Rosik & Popper, 2014). Change-oriented therapies have been called many terms. Both professional and non-professional interventions often get mislabeled as conversion therapy or reparative therapy, the latter of which is a specific form of professional change-oriented therapy, developed by Joseph Nicolosi as a synthesis of psychodynamic and other trauma-informed therapies. It is one of several approaches, but it is the most prevalent among change-oriented therapists. In the spirit of finding a unifying and exclusive term for all professional change-oriented therapies, the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI, hereafter identified as the Alliance) introduced in 2016 the term Sexual Attraction Fluidity Exploration in Therapy (SAFE-T) (Rosik, 2016), which I will use for these approaches going forward. Sexual Identity Therapy, developed by Mark Yarhouse and Warren Throckmorton, attempts to circumvent the controversy over efforts to change sexual attractions by remaining agnostic regarding the etiology of SSA and focusing the therapy on assisting clients with their choices to make their identities and behaviors congruent with their sincerely held religious beliefs (ISSI, n.d.).

The persistent message of SOCE and SAFE-T opponents, which has inundated and indoctrinated the whole culture, has been that therapy to modify or just cope with unwanted SSA is both ineffective and harmful. As a researcher and journal editor, Walter Schumm (2015) recalls frequent rejection of conservative approaches to sexual orientation by students, other scholars and publishers, lawyers, judges, and potential employers. The topic has become so toxic that most clinicians, researchers, and teachers do their best to disassociate from it, even if they personally take issue with the tenets of LGBT activism. On October 5, 2015, Albert Mohler, president of the Southern Baptist Convention, called reparative therapy a superficial response to homosexuality, misconstruing it as a simplistic attempt to convert someone categorically from homosexual to heterosexual (Sanders, 2015). Harvest USA, an ex-gay ministry in Philadelphia, adamantly denies doing reparative therapy, decrying it and confusing it with other types of therapy largely in the past that relied on behavior modification and aversive techniques (Black, n.d.).

The criticisms of SOCE and SAFE-T are largely unfounded or grossly exaggerated. Mainstream media outlets that mention conversion therapy or reparative therapy are

quick to state matter-of-factly that these therapies have been discredited. However, in its task force report, the APA (2009) even admits that there is insufficient scientifically rigorous data to conclude whether or not SOCE are harmful or effective. Nevertheless, the report's conclusion still cautions against these therapies, stating that they pose a risk for harm. And even though the task force's report has been used by several states to ban therapy for minors, the report acknowledges that published research on SOCE among children is lacking (p. 42). There have been only a couple studies reporting harm, the chief amongst them being Shidlo and Schroeder's (2002) retrospective interviews with former SOCE counseling clients, with the majority of the claims of harm being increased psychological distress—not physical torture or overt shaming, as the popular culture would have one believe.

Furthermore, the APA's conclusion that the data on SOCE and SAFE-T are inconclusive concerning efficacy and beneficence completely dismisses decades of research, case studies, and anecdotal evidence that affirms the benefits and safety of professional therapy for unwanted same-sex attraction. Though no published study has sought a random population from which to assess the treatment success of SAFE-T, Phelan, Whitehead, and Sutton (2009) argue that existing positive outcome research should not be so easily dismissed. An ATCSI retrospective survey of 882 participants in SAFE-T reported that 34.3% experienced change in orientation. Whereas prior to therapy 67% considered themselves exclusively homosexual, post-therapy only 12.8% saw themselves as exclusively homosexual (Nicolosi, Byrd, & Potts, 2000). Byrd and Nicolosi (2002) completed a meta-analytic review of 14 outcome studies, finding that treatment for homosexuality was 79% more effective compared to alternative therapies or control groups. Berger (1994) documented several case studies that demonstrated change occurring along a continuum. Lee Beckstead, typically an opponent of SAFE-T, even found in a small study of 20 participants that though they experienced no change in SSA, they reported greater self-acceptance and well-being, which is contrary to the accusation that this therapy increases shame (Beckstead, 2001). Phelan's book (2014), *Successful Outcomes of Sexual Orientation Change Efforts*, provides an overview of the decades of beneficial professional treatment for unwanted homosexuality.

I had been well aware of the hostility toward those who go into this field for years—as well as the hostility toward those who have made efforts to avoid conflict by opting out of gay-affirmative therapy. In the summer of 2010, two cases of students in counseling graduate programs faced expulsion for holding to traditional, biblical views of sexuality. At Eastern Michigan University, Julea Ward referred out a gay client to another colleague because her convictions precluded her from providing the gay relationship counseling the client was seeking. The school required she complete a remediation program and change her beliefs or be expelled (Starnes, 2010). At Augusta State University in Georgia, Jennifer Keeton's expression in and out of class that she adheres to Christian beliefs regarding sexuality and gender identity was apparently enough for the school to require she undergo a re-education program or be expelled (Schmidt, 2010). Her case against the school was thrown by a federal judge two years later (Rudow, 2012). In December, 2012, after Julea Ward appealed a federal judge's verdict in 2010 to uphold Eastern Michigan University's decision, the school reached a settlement with her, which was touted as a victory by her legal team at

the Alliance Defense Fund (Lederman, 2012).

My Experiences in Graduate School

Eventually, it came time for me to obtain my master's in counseling so I could do this work full-time. I chose this particular institute because it offered specialization tracks in addiction, trauma, and marriage and family—all areas related to the work I do. The theoretical orientation of its clinical psychology program was psychodynamic, which I knew was foundational to reparative therapy, which I was hoping to learn in the future. And as a self-described "inclusive Catholic university," I figured they would be at least tolerant of my religious convictions.

As I entered the admissions process, I came to terms with a looming dilemma: would I try to hide my involvement in the field of homosexual recovery so I could quietly earn my degree and then enter the field professionally? Or would I risk academic and career suicide and be open about my convictions and experiences? I resolved that my integrity is the one commodity I cannot spare, no matter the consequences. If I ever found myself embattled, I was confident that the truth would be on my side—the truth that I had been honest since day one. As a Christian, I know that my ultimate judgment will be before God, and not a council of ideologically corrupt men. That security afforded me freedom to be disclosive when the topic would come up in my classes.

And the topic came up immediately and then throughout my time as a student. In my admissions paperwork, I stated where I did my undergraduate internship. A quick look on Day Seven's website would easily show their affiliation with Exodus even after Exodus North America collapsed in 2013, or just show the types of sexual issues they address. In my admissions interview, Dr. T. (the then-head of the psychology department) asked me which types of clients I would not treat, to which I explained how my moral convictions would prohibit me from endorsing sinful and destructive choices, such as homosexual behavior or having an affair. Instead, I would offer to help the client explore their options and the emotional roots of such issues. The very same question came up early in my first semester in a reflection paper for Dr. H.'s theories of counseling course.

Once my first session of classes began, it immediately became clear that this was a very liberal Catholic university. The overwhelming majority of my professors were neither Catholic nor Christian. One professor was transgender. Some were very outspoken liberals, or they were at least unaccustomed to interacting with conservatives. The students were a bit more mixed, but being a conservative Christian with firm traditional convictions on sexuality squarely placed me in a minority viewpoint. This became quite evident in my first semester's Theories of Counseling class when the professor decided to open the conversation one day by disparaging recent comments Kirk Cameron made about homosexuality on Piers Morgan's television show, and then attacking reparative therapy. I had to present that evening, but before speaking about my assignment, I chose to share about my knowledge of reparative therapy and do what I could to dispel myths, which led to a robust discussion. Fortunately—though the professor and another student strongly opposed me—because I had demonstrated my intelligence and maturity in prior class discussions, the majority of the class wanted to hear what I had to say. (A similar discussion occurred a year or so later in my Adolescent Therapy course.)

Also in my first year, in my Techniques of Counseling class by Dr. D., I revealed my

involvement in this field. We were assigned a journal that we had to turn in near the end of the course. During that time, my church was blessed to host a seminar by Sy Rogers, one of the early leaders of Exodus International, who used to attend the same church in Florida as my pastor. My wife and I had the tremendous honor of having breakfast with Sy and his wife, Karen, and I then journaled about the experience. When I received the journal back from Dr. D. on the last day of class (personal communication, July 23, 2012), she wrote a question: "Have you thought of how your values re: homosexuality might play a role in the way you counsel your clients? Particularly those that are struggling w/ the coming out process?"

I include all of these stories because when I received that email from Dr. S. (the director of master's field placement), and in the subsequent inquisition, they claimed ignorance about my involvement in this type of work. And yet numerous professors were made aware, and if they truly considered me a danger to the field of psychotherapy because of my convictions and practice, why did they not present their concerns earlier? After the department head, Dr. T., left during my first year, he was replaced by a board of a few different faculty members, one of whom was Dr. D. herself. And most damning of all is a story about Dr. S., who taught my group therapy course just before beginning my internship. One written assignment was to reflect upon a guest speaker at the university, Greg Boyle from Homeboy Industries. I wrote,

> Finally, I appreciated Boyle's comments about our call not necessarily to be successful but to be faithful, even if we do not arrive at the outcomes people expect. This standard is particularly relevant to the population with which I work: men with sexual struggles (such as sexual addiction or unwanted same-sex attraction). When it comes to these issues—above all others—the world demands to an unreasonable degree that the only acceptable outcome of counseling be categorical change. But the members of my group understand that their purpose is to honor God and be faithful to his standards no matter the degree of change they experience. The world does not agree with this nor tolerate it. And so I can definitely relate to the hostility Boyle experienced for the first 10 years of his ministry to gang members.

And as proof that Dr. S. actually read this paragraph, he handwrote (personal communication, circa March 16, 2014) right next to it the following: "Your empathy and caring sensitivity is very apparent in your writing. Excellent work!" The irony from my position of hindsight certainly does not escape me.

I never learned the reason for the about-face. Dr. S. and I were previously on such good terms that he was looking into helping me publish one of my papers from the group therapy class. Nevertheless, Dr. S. and the other faculty involved in the discrimination against me remained stalwart in their claims that they had no prior knowledge of my involvement in SOCE.

The Impetus for the Email

I was able to surmise the likely impetus of the email I received, which was later confirmed by Dr. S. when we met. As I stated, I had a rather trying internship experience at a private group practice. My site supervisor, Dr. C., is a self-described "neo-Freudian psychoanalyst with strong Jungian leanings." And though my training

was in psychodynamic therapy, I was not so quick to dismiss other approaches and I was interested in integration, which led to various theoretical conflicts between Dr. C. and me, especially when he would largely base my evaluations on my number of "verbal units" (any vocalizations from the therapist, including minimal encouragers, questions, and statements) in a given session since the ideal psychoanalyst rarely speaks. Ultimately, after hearing of so many such stories, Dr. S. decided to look up Dr. C.'s profile online. And while he was perusing the counseling center's website, he saw my profile, which had the following biography:

> I believe changes and growth are always possible. But in some areas, wounds and unhealthy thinking and patterns of relating to others, God, and ourselves can hold us back. This process can be hard work and I am eager to help you with it. For those who are seeking a Christian approach, I believe in a biblical integration of cognitive-behavioral, psychodynamic, family systems, Adlerian, and reality therapies. I have worked with individuals dealing with childhood trauma (typically sexual or physical abuse), sexual addiction, and those leaving homosexual lifestyles and coping with unwanted same-sex attractions. I have also co-facilitated a kids play therapy group. I am looking forward to broadening my experiences at [my internship site], particularly with families and children. In addition to counseling, I work part-time with my wife as a youth pastor.

The mention of key words like "unwanted same-sex attractions," "homosexual lifestyles," and "change" (even though I used the latter in the broadest sense) he found alarming and sufficient to immediately stop the work I was doing with my clients. It is particularly noteworthy that the concern derived solely from Dr. S. alone, as opposed to some complaint against me from any clients or my internship site. I was well aware of cases of religious graduate student interns persecuted for opting to refer out clients referred to them for gay-affirmative therapy. But this was not the case with me; there was no inciting incident. In fact, the *only* client I was seeing with unwanted SSA was a pre-existing group member that chose to continue with me at internship site during the summer (a detail Dr. S. did not even investigate even when we met). None of the clients I obtained through the site were dealing with homosexuality, nor did the topic even arise.

Finding Support

Some very encouraging events occurred after I received Dr. S.'s email. First, I contacted Dr. C., my site supervisor. Whereas prior to this moment we struggled to connect on a personal level, I now saw a different side to him—a fiercely protective one. He and the rest of counseling practice demonstrated their support to me. Next, I informed my pastor, Bob Levins, of True North Christian Church (Trappe, PA). Without hesitation, the whole church rallied behind me. Some members even offered to provide me a lawyer for my first meeting with the school. And most providential of all was the timing of the whole ordeal because the day following the email, I was long-scheduled to travel to Lancaster, PA, for the Restored Hope Network's conference.

Restored Hope Network is the umbrella organization for ex-gay ministries that was formed prior to Exodus North America's 2013 implosion. I was following them online for some time, wishing I would be able to attend one of their conferences, but

they were normally too far out west for me. But, I can only conclude that it was by God's design, for 2015 the conference would be in my old hometown. And I just so happened to receive the threatening email from Dr. S. the day before the conference. There was no better place to be that Friday, June 26, receiving encouragement from other workers in this field as they heard my very fresh story, and especially as we also got the news that very day about the US Supreme Court's decision regarding gay marriage. I was blessed to meet some of my heroes in the field, such as Andrew Comiskey, as well as a client from my undergraduate internship nearly ten years ago, who was present to share his testimony. As a non-denominational Protestant going to a Catholic University with a very liberal faculty, I was also amazed to learn how many Catholics in the area were actually my allies.

At the conference, I met a new hero of mine, Dr. Mike Davidson, from the United Kingdom. He had a much more severe story of persecution for his work, and yet remained completely humble and steadfast. He also is a member of the Alliance, which I had known only as NARTH before then. He offered to connect me with former Alliance president Dr. Christopher Rosik, which started a very helpful email correspondence.

The First Meeting with the School

In Dr. S.'s email, he requested to meet immediately, but I advised him I needed more time to seek appropriate counsel, which should have been a hint to him that I was securing a lawyer. I met with Dr. S. and my advisor (whom I had not previously met), Dr. K. , on Tuesday, July 7. To their apparent surprise, I arrived with a lawyer. However, they informed us that, as professors, the school prohibited them from meeting with a lawyer without the school's own lawyer present. They offered to reschedule, but they also assured me that this meeting was just to gather information and no decision would be made then. Instead, they would report to the other program coordinators, Dr. N. and Dr. D., as well as the dean of the graduate school. I chose to dismiss my lawyer and meet with them on my own. I was confident that I would need to do only two things: point out that my admissions record shows I was open about my history of involvement in the ex-gay ministry field, and explain how I was not practicing any sort of bizarre or inherently harmful therapy, but just applying what I had been learning to a unique client population that had goals to live congruently with both their belief systems and biological design.

After some exchanges about why we had to delay this first meeting, I made my first point, to which they responded by stating that they did not look up my admissions packet. They had no interest in verifying that the school had indeed accepted me and kept me this long as a student with the knowledge of my beliefs and experiences regarding homosexuality. Instead, they had numerous questions about my beliefs, my history of involvement in this field, and why I started doing this type of work. (Perhaps all of my previous professors, one of whom was my main inquisitor, believed that with enough time I would be fully indoctrinated, and so they did not see the need to call me in for questioning sooner.) They especially had questions about hypothetical situations, but not about the work I was actually doing, particularly as part of my internship. Again, I was seeing only one client at my internship with unwanted SSA, and I had already been working with him for five years through my group. It was clear that their main concern was the type of therapy I might do after graduating.

They asked if I was familiar with the American Counseling Association's informed consent process and ethical guidelines regarding this type of work (lumping together all forms of help for SSA clients that are not gay-affirmative). I explained that I knew the informed consent process must include disclaiming any guarantees of change in sexual attraction, and that if at any point they change their minds on pursuing this type of work, they can just let me know and I can help them obtain more appropriate care. They asked for outcome studies of the efficacy of this type of therapy. I stated that there are not many studies available, but I did point them to a longitudinal study Mark Yarhouse and Stanton Jones performed that followed participants of different Exodus ministries (which would include a variety of therapeutic and religious modalities) years after their involvement in Exodus. The results demonstrated sustained change in attraction distributed across a continuum, though the participants who experienced the greatest degree of change were in the minority (Jones & Yarhouse, 2009).

They were concerned that I was not following the ACA's guidelines to inform clients of the potential for harm. I disputed them on this point because I know the data is nonexistent or at least inconclusive in proving that reparative therapy by licensed professional therapists directly causes harm to clients. They could provide no proof themselves. Dr. S.'s rebuttal was a classic fallacy call to authority, reminding me that all of the professional organizations agree that it is potentially harmful, "so who are you as a student with just one year of supervised experience to say otherwise?" Dumbfounded though I was by this remark, I reminded him of the number of clinicians who have been doing this work much longer than me, and of the entrenched bias in the professional organizations like the American Psychological Association and its task force report on therapies for unwanted SSA (APA, 2009).

Besides, I was not actually doing reparative therapy, nor was I claiming to do so, and yet they continued to make the assumption that I was. So I took a moment to correct their understanding and explain that there are a few approaches to assisting clients with conflicts over same-sex attraction: their gay-affirmative approach, Nicolosi's reparative therapy (and other change-oriented approaches or SAFE-T), and Yarhouse and Throckmorton's Sexual Identity Therapy, which focuses only on change in identity and behavior but not attraction. I told them that though I agree with the developmental model upon which reparative therapy is based, I was not trained in that approach, so my work has been to help individuals live congruently with their sincerely held values which conflict with the pull to embrace a gay identity and behavior. They asked what this type of therapy looks like, to which I answered that it is no different than the very techniques in which I have been trained.

The inquisition increased with a litany of irrelevant questions. What about homosexuality among animals? What about the apology Alan Chambers (the final president of Exodus North America) made to the LGBT community, and his decision to shut down the ministry? What about JONAH (the Jewish ex-gay ministry in New Jersey), which had just lost its case for consumer fraud? It was clear to me that they were not interested in the ethics of the work I was actually doing, but they were most interested in attacking my beliefs, a fight I was all too eager and ready to join.

By the end, their questions turned to my personal goals and aspirations as a therapist. Would I continue to do this type of work? As a Christian therapist, I intend to treat a variety of concerns from a biblical

worldview, but I hope to make this an area of specialty. And then came the question that was the clincher: "But what if it became illegal?" I pointed out how it currently is not illegal and that there is no just reason to make it so. Any legal prohibition would itself be unethical, for it would not be respecting a client's right to self-determination and basic freedom of speech between client and therapist. But Dr. S. pressed the hypothetical scenario, so I declared that if the state decided to outlaw any approach that was not gay-affirmative, then I would be forced into a position to practice civil disobedience.

As my interrogation came to a close, I asked some questions about my status and why I was not allowed even in my internship class. I was considered "functionally suspended" until a decision was made. Then I summarized that this whole issue was a conflict over our ideologies, and not over anything I have done. Dr. S. agreed.

The Decision to Terminate My Internship

After the meeting, I got to work updating people and making appeals for aid. I contacted Archbishop Chaput, who wrote a letter on my behalf, though we both knew the school was not under his jurisdiction. Dr. Rosik from the Alliance sent me a journal article delineating the different approaches to unwanted SSA (Rosik & Popper, 2014), which I forwarded to the department heads. I wrote to the board myself as well, not trusting Dr. S. and Dr. K. to represent my side to the other members accurately.

On July 14, just over a week after our meeting, I received the following email from the dean of the graduate school:

Dear Mr. Rodriguez,

On behalf of [the college], I want to reply to your questions about returning to your internship and graduating.

According to item 9 in the Clinical Experience Affiliation Agreement (attached), the College has the right and responsibility to suspend or terminate any students from the Clinical Experience whose behavior is a serious violation of the College's formal policies. In accord with the terms of that agreement, we are notifying you that your internship [. . .] is terminated.

Your ethical violations of the College's formal policy include but are not limited to offering a form of counseling that is not supported by research, is contrary to professional standards and codes of ethics (American Counseling Association (ACA) Code of Ethics, 2014, section C.7. Treatment Modalities; American Psychological Association (APA) Policy Statement on Evidence-Based Practice in Psychology, 2005) as well as College policies, and is unlike anything taught in your graduate program at this College. Further, you did not disclose the fact that you were offering this form of counseling in supervision with your faculty supervisor at this College.

Dismissal from field placement due to a serious ethical violation is grounds for dismissal from this College's Master's Program in Clinical and Counseling Psychology.

However, the College is willing to offer you a remediation plan that will permit you to graduate after its terms are met. The College will permit you to withdraw from your current internship, which would give you a grade of W on your transcript, and undertake a new internship at a

different site in accord with the terms of a remediation plan.

Please let me know if you wish to meet with faculty in your program to review the details of a proposed remediation plan for your consideration.

You are welcome to contact me with questions or concerns. We wish you well as you consider how you would like to proceed.

Make note of a few aspects of this letter. She speaks of a form of counseling I was performing without naming it. The insinuation is clearly that I was practicing some form of therapy, such as reparative therapy, with the stated goal to change a client's sexual attractions from homosexual to heterosexual. It is abundantly obvious that everything I shared at my meeting was misconstrued and misrepresented. What exactly was I doing that was not supported by research? All I was doing, as I stated in the meeting, was applying commonly accepted therapeutic techniques—which I learned at this university, my internship, and over the years prior to and outside my graduate school education—to assist members of a minority population in a way respectful of their values. So, are they in effect implying that the psychodynamic and family systems techniques they teach are not supported by research? How about the Rogerian, cognitive-behavioral, and dialectical behavioral techniques I learned from various other trainings; are they insinuating that they are not supported by research? No, they are assuming—despite having no evidence—that I was practicing some bizarre, dangerous form of counseling, which is how they wrongly perceive reparative therapy—which I was not actually performing.

Evidently, the dean was either extremely obtuse or willfully dishonest, or both. There was no basis to claim that what I was doing was "unlike anything taught in [my] graduate program," unless she means that I was not following the ideological doctrine they had hoped to implant in me by this point in my education. A forthright admission would be that they disagreed with *how* I was using my clinical training—not that I was veering from it, which is also to say that they believe they should have control over a client's stated goals regarding his sexual identity and behavior.

And the bonus rationale for terminating my internship—that I failed to inform my internship class teacher that I was offering help for unwanted same-sex attraction—was both false and irrelevant. I mentioned repeatedly in class that I had a biography on my internship site's website; if my professor was curious about my biography, it was publicly available. I saw no need to mention the single SSA client I had in my class because the case was quite manageable at the time. There was no requirement in the class that I provide a description of each client in my caseload. Therefore, if I was experiencing no difficulties with my clients, there was nothing to share. Regardless, the specific wording in the letter was a way to sidestep an admission of the school's awareness of my open involvement in this field of work. As I demonstrated earlier, I made known my work repeatedly throughout my academic career; it just so happened to be the case that I did not see the need to mention it at my internship class. But Dr. S. , the very head of the internship program, should have remembered knowing about my work from prior experience with me—a fact he never acknowledged in the course of my debacle. (Dr. D., one of the department heads, also knew.)

And then their so-called remediation plan, to re-do an entire year's worth of

internship work, was a ridiculous affront to me. Considering I was just four weeks away from finishing, and the fact that the school should have intervened far sooner in my career there if they considered my convictions incompatible with their program, the wiser course of action would have been to allow me to finish, graduate me, and then update their policies to be explicit about this topic. I was certain I sent a clear message that I was unwilling to be bullied, so I was disappointed by their decision, but my resolve was strong.

Defending Myself with Legal Counsel

I thank God that my case was quickly accepted by the Independence Law Center, a religious liberty legal ministry specifically for Pennsylvania. Jeremy Samek and Randy Wenger were eager to help me, and over the next four months they provided me with sound counsel and prevented me from making rash decisions. However, it is important and helpful to note that they were completely new (though of course sympathetic) to the type of work we do in this field and unfamiliar with the legal and systemic challenges we face. I consider this a sign that we need to do a much better job of informing and familiarizing the public as well as targeted parties (such as lawyers, legislators, school administrators, and churches) with our field. I have found that the common conservative may argue for the protection of traditional marriage but he/she is still reticent to support our therapies because the myths about harm and lack of benefit have infiltrated his/her consciousness. In their effort to keep me focused on the main goal of graduating, Jeremy and Randy were also determined to resolve my case diplomatically and quietly; it received absolutely no media attention, which I regret. Ultimately though, we were able to reach a settlement without going to court so that I could indeed graduate, and this I do not regret.

Along with my lawyers, I met with the school one more time. This meeting included the board members, Dr. S., and the school's lawyer. The exact details of that discussion I am under obligation not to disclose. I can say that I was advised to refrain from speaking as much as possible and allow Jeremy and Randy to attempt negotiation. Despite their sincerest efforts at diplomacy, they shared with me during a break how surprised they were by the level of hostility coming from the other side. The meeting ended with my lawyers offering some form of a compromise, but we had to wait over a month for a decision, which was immensely frustrating. As it turned out, what delayed their response was that they took it upon themselves to still try to find a new internship site for me in the local area. But of course, to each site they contacted they shared their version of events—that I committed ethical violations at my previous site—so naturally, each site refused to accept me. And so, after amassing a number of rejections and possibly blacklisting me, the school decided that they did not want me to return as a student at all.

And here is how I was able to still graduate with my master's from the same school that was expelling me. In Pennsylvania, one needs 48 credits for a master's in counseling. However, for licensure, one needs 60 credits. The extra 12 credits one may choose to complete at once while in graduate school or complete after graduation and prior to testing for licensure. I was on track for 60 credits, but my plan was to finish my internship, graduate with one course remaining, which I would later take after paying off some school debt. Upon my expulsion, the school's offer was to grant me my degree for the 48 credits earned, and then transfer over the remaining credits to another university. However, they

would not count the hours earned toward my internship during that final session in the summer, which really left me in a bind, as I searched for a sympathetic school that would accept me without requiring I re-do work. My salvation came from Cairn University, who graciously accepted me and enabled me to finish all of my coursework for licensure in the spring of 2016.

Reflections and Recommendations

Upon reflecting on this whole ordeal and the array of interactions with the college, I have identified some points that may be of use for colleagues and hopeful students. What became increasingly apparent to me was the utter lack of reasoning behind the LGBT agenda in academia and psychology. And yet they hold the bulk of power in these areas; therefore, a dismissive attitude is less than prudent.

They attempted to make the case that it is inappropriate for a graduate student to have a biography posted at all. And to list areas of experience is equivalent to claiming expertise in an area. I never claimed expertise, and a plain reading of my biography would not suggest it either. Should a biography not include professional and personal experiences that inform readers of my familiarities and values? The school officials appeared to make the assumption that any counseling experience and trainings received prior to or outside of my courses were nonexistent. Their objection to listing the types of people with which I have worked was an obvious mask for their bias against the type of work I was doing, for I am certain there would have been no objection if I stated in my biography that I (hypothetically) worked for years as a technician at a drug and alcohol rehab; they would not red flag that as a claim to substance abuse expertise.

They also repeatedly referred to my biography as an advertisement, with the implication that I was seeking out clients to put through conversion therapy. This was a rather ludicrous perspective because it is perfectly reasonable to expect a therapist to market himself (especially at a small group practice where I had to rely on myself to build my own caseload) and to include in his marketing some biographical data. But to label the biography an advertisement in and of itself is dishonest because it was posted only on the practice's website (along with all of the other therapist's biographies) and not sent out to other media outlets. Furthermore, it is erroneous to conclude that I was advertising reparative therapy (however one understands it) just by mentioning my experiences. I also noted that I had used to co-facilitate a children's play therapy group, yet I had no intention of running such a group at the practice. What I am selling in the biography is myself and my attributes that potential clients may care to know in order to determine the type of therapist I am. I described myself as a Christian therapist, while understanding how that designation is broad and clients bring an array of assumptions to their expectations for it. Among conservative Christians, one's stance on sexuality has become a sort of litmus test; so by stating my work in this field, I provided some insight into the type of Christian I am.

The most important insight gleaned from reflection upon the school's opposition to me was their conflation of all forms of therapy for unwanted same-sex attraction that were not gay-affirmative. This point is critical for Sexual Identity Therapists to comprehend. When the APA's Task Force on *Appropriate Therapeutic Response to Sexual Orientation* (2009) report was released, Mark Yarhouse and Warren Throckmorton's Sexual Identity Therapy (SIT) framework was affirmed at some

points throughout the paper, particularly parts that advised against encouraging the "coming out" process for individuals in certain circumstances. However, I am convinced that my story demonstrates how any confidence that the SIT approach would be politically safe was premature. In my meeting with Dr. S. and Dr. K., I explained the different approaches for unwanted SSA and then clarified that though I may agree with the developmental model underlying reparative therapy, my praxis was in line with SIT. Changing sexual attraction was never a stated goal in my group or individual work. Instead, just as I worded it in my biography, I assisted clients in coping with the attractions and with their choices to leave homosexual lifestyles (patterns of sexual behaviors and relationships). Just as with the tenets of SIT, I explained in my meeting that my role was to help Christian clients live congruently with their faith, which includes its values, goals, and sexual ethics. What soon became quite evident was that none of these distinctions mattered to the school. The goals of my clients were in contradiction to their own ideology, and therefore they deemed our work unethical and harmful. If there is any existing enmity between SAFE-T therapists (reparative therapists and others) and SIT-oriented clinicians, my case should serve as a call to unite in realization that we all face the same existential threat.

The school's final rationale for opposing me was their belief that I would be a future danger to the field of psychology and so they had a moral obligation to thwart my career, especially when I declared that I would be open to civil disobedience if a client's right to self-determination was threatened. The irony is manifold because the psychology establishment is making judgments outside of its jurisdiction. In my meeting, Dr. K. and Dr. S. informed me that science has already proven that homosexuality is a good and normal expression of sexuality. I had to remind them that such a claim is a philosophical and moral assertion that materialistic science is unable to make. Nevertheless, without indisputable proof that reparative therapy or SIT are harmful, they are on a crusade to protect clients by trampling on client rights. And here is the next irony: the establishment removed homosexuality as a disorder but still believes it should have the say in how it is addressed—having their cake and eating it too, as we would say. If it is not a disorder, and just a matter of personal ethics (especially when we live in such a pluralistic society), then how it is addressed should be determined by the client's preference. And its non-designation as a disorder does not preclude its qualification to be a treatment concern. People can obtain licensed professional counseling for an array of nondiagnosable issues. For example, a client coming solely for marital concerns is not necessarily diagnosable, but they can still see a therapist (even if the insurance may not reimburse), and whether or not the treatment plan should gear toward seeking a divorce or reconciliation is not dictated by the APA; it is determined by an agreement between the values and goals of the client and therapist.

And the final irony is that their efforts to impede me from entering this field only served to propel me more into it. Through my correspondence with Dr. Davidson and Dr. Rosik, I came into contact with multiple other members of the Alliance, all of them offering support in various ways, which was incredibly encouraging. One of the highlights of my life was receiving a phone call from the late Dr. Joseph Nicolosi and subsequently receiving the 2015 Dr. Nicolosi Award for Student Excellence. He also enlisted my aid in one of his research projects, summarizing journal articles to be included in a comprehensive review of the

evidence on homosexuality. I am now an Alliance member and am receiving the necessary training to provide professional help for clients who do wish to explore potential change in sexual attraction. And once I secured my degree and finished my coursework at Cairn in 2016, I was hired as a therapist at Day Seven Ministries, the very counseling center at which I interned as an undergraduate that began my whole journey into this field of helping individuals with unwanted same-sex attraction.

Specific Advice to Students

I hesitate to give advice to students—partly because of the uniqueness of my experience, but also because I predict my advice will not be palatable to many people, perhaps not even some members of the Alliance. I hope the example I have demonstrated makes my advice quite evident: speak the truth. I do not recommend this lightly.

After my lawyers and I met with the school and it became increasingly more apparent that they would not decide in my favor, I began inquiring with some Christian universities in case I would have to transfer. In a meeting with several professors and administrators at one of these schools, I recounted my story. One of the professors told me it was unwise of me to include in my biography my experience in working with men with unwanted same-sex attraction, and essentially that I brought my expulsion upon myself. I am certain that there are people reading my account who share his sentiments. Respectfully, I disagreed with him. Granted, if my goal was only to survive graduate school unscathed, I definitely was unwise—for I knew that every time I spoke up in class or wrote about my convictions and work I was risking academic (and possibly career) suicide.

This professor, a director of a small Christian counseling practice, explained that his practice is willing to work with clients who have unwanted SSA but they would never advertise that they address this concern. I consider this almost as great a travesty as the multiple forms of discrimination against our profession and clientele. How will potential clients seeking professional help know where the help is? Our practice has not yet been outlawed entirely, so we ought to work while it is still day. Why are my colleagues working in the daytime as if it is night?

A year after my ordeal in graduate school, my resolve to speak the truth no matter the consequences was further encouraged by an unlikely source. A psychology professor from the University of Toronto, Jordan Peterson, posted a video on YouTube decrying a proposed bill, C-16, that would compel speech by use of transgender and non-binary people's preferred pronouns (Peterson, 2016). I say unlikely because it is well known how left-leaning Canada is, and how left-leaning the psychology world is; so I found it quite inspiring that a psychology professor from Canada was speaking out against the agenda of the radical left and the overreach of LGBT activism. Even more inspiring is how consistent Peterson was being with the content of his lectures (many of which he had already been posting on YouTube) over the years. I have found that Peterson has been echoing much of the same counsel Scott Peck had been giving since the 1970s and 1980s with his seminal work *The Road Less Traveled* (2002 [original version 1978]) and then *People of the Lie* (1983).

Both of these clinicians had been concerned with the nature of human evil; Peterson, in particular, has been studying the development of totalitarian regimes and the role of ideology. Both understood that reality by nature is suffering, but deceit and malevolence are what make it unbearable. Both concluded that the solution to

oppressive hierarchies and human malevolence was at its core theological and spiritual. They realized that the alternative to pathological ideology was in individual growth, by each person taking responsibility and speaking the truth—in both words and actions. As Peck said, "Mental health is an ongoing process of dedication to reality at all costs" (2002, p. 50), and "For truth is reality. That which is false is unreal" (2002, p. 44). And after Peterson's original video on Bill C-16 sparked a wildfire of controversy, he appeared in a caravan of videos online preaching about the importance and power of speaking the truth, that the capacity for speech is divine. Speaking truth is what brings order to chaos. "The truth is what redeems the world from Hell" (Manning Centre, 2017). Peterson often cites Solzhenitsyn's *Gulag Archipelago* (1974, 1975, 1978), noting how Solzhenitsyn came to realize how he himself contributed to the rise of the Soviet Union and its atrocities simply by remaining silent. Therefore, Peterson's (2018) eighth rule for life is to tell the truth—or at least, do not lie.

The following are some practical suggestions for total dedication to truth in the university. If your professors or classmates assert that SOCE and SAFE-T are ineffective or harmful, first ask that they define their terminology, especially when they use terms like "conversion therapy" and "reparative therapy." Then require that they provide the evidence—and not just citations but what the studies actually demonstrated. Familiarize yourself with the research, particularly the studies that show the effectiveness of SAFE-T, so that you can correct misinformation. If you are still uncertain yourself about the value of SAFE-T, then remember that the APA has admitted that there is not enough data to determine whether or not this therapy is effective or harmful. Use that concession as grounds to challenge the sentiment that the verdict is in; instead, appeal to true scientific minds by calling for more sophisticated research to be conducted. And if you personally benefited from SOCE or SAFE-T, share your story (however, I caution against doing so if you are still early in your recovery process). Objectors will be at a disadvantage in trying to rebut you, and you may also be influential in eroding their prejudices.

As a student (whether in graduate school, college, or even grade school), or even as a professional, you may believe that it is not safe to speak up or take a stand for truth, that you will finally speak up once you are in a position of power. By then, it may be too late. And you will eventually realize that it is never truly safe to speak the truth. Some people have heard my story and told me it felt like a nightmare. Others rejoiced with me because it ultimately ended well for me. However, I was prepared for it to not end well for me. Even now, as I prepare for licensure and as the public sentiment and laws in the West continue to turn against our work, I understand that I am not entirely out of the woods yet and may never be.

If you are to speak the truth, there are some things to keep in mind. First, "we must always hold truth, as best we can determine it, to be more important, more vital to our self-interest, than our comfort" (Peck, 2002, p. 50). Total dedication to truth requires a willingness to be challenged (Peck, 2002), as well as a willingness to let go of the consequences (Manning Centre, 2017). When I briefly faced the dilemma of whether or not to be open about this aspect of my life, I was not just choosing how I would present myself in graduate school; I was choosing a trajectory for my life. With every lie or withholding of truth that we come to accept, we grow more comfortable with living in a false reality (Peterson, 2018) until we get to the point of being a mass of prisoners with just a few armed guards. We could overthrow them, but everyone is too

scared to be the first one shot. In speaking up, you act in the faith that nothing brings a better world into being than the stated truth. Yes, you risk paying a price for speaking up, but it will never be safe to *not* speak either, to not advocate for client rights, to not demand scientific integrity and inquiry. If you find yourself outed—whether it was on your terms or not—then consider it an opportunity to stand your ground. Do not apologize for holding unpopular beliefs or even just desiring to investigate the facts on homosexuality and SAFE-T. Instead, practice articulating your beliefs, even if they are still in the process of formulation and they are open to revision. The benefit of speaking the truth is that your ideas as well as the ideas of others can be corrected where necessary (Peck, 2002; Peterson, 2018). I understand that telling the truth may result in your own sacrifice, but speak the truth you must. And consider the outcome (whatever it may be) to be the best possible outcome.

Secondly, do not believe that you are alone. When you speak up, you will discover allies and you will inspire others to also take a stand. I was overwhelmed by the support I received—from my family, my church, my clients and group members, my internship site, my lawyers, my employer, the Restored Hope Network, the Alliance, and various other therapists I knew. You may even find unlikely allies. The current sociopolitical zeitgeist is one in which classical liberals and libertarians are now joining forces with conservatives. There were people who heard my story who expressed disagreement with my values but were reasonable enough to acknowledge how the school wrongly discriminated against me and my clients.

Finally, if you speak the truth, do so with wisdom. The more you understand your life's mission, the more accurately you can calculate risks. Whether or not I completed graduate school, I still had a secure job to provide for myself and my wife, not to mention I have other talents I could find a way to monetize. And even if I could not obtain my degree, I would not be deterred from continuing to do lay counseling in some form or another. I encourage you to network and establish a support system in advance of any potential conflicts. Identify and utilize advocacy groups, such as the ATCSI and Equality and Justice for All. Familiarize yourself with the various constitutional and religious liberty legal funds. I recommend consulting lawyers as soon as you realize your rights or your clients' rights may be in danger by your school.

In hindsight, do I regret being open about my work in this field? No. After so much time to reflect, I have no regrets. However, I have some suggestions for what might have benefited me without sacrificing my honesty and integrity. Once the administration changed after my first semester, perhaps I should have initiated contact with the new administration and explained my story to ascertain if it would cause any conflict going forward. I suppose that I would have needed any answer to be in writing in case I would need it as defense. Beyond that, I am at peace with my conduct and decisions throughout my entire graduate school career. And I am eager to share my story in hope that it will bring courage to others.

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Preparing a Foundation for the Curtailment of Religious Liberty: New Research Targets Conservative Religious Beliefs on Same-Sex Sexuality

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A recently published study (Sowe, Taylor, & Brown, 2017) appears to move psychology's attack on conservative religious beliefs about same-sex sexuality to a new level. The study appeared in the American Psychological Association affiliated journal, *American Journal of Orthopsychiatry*. In what follows, I will outline the study's methodology and findings with extensive quotations from the authors, ending with a critical review of the conclusions and implications drawn by these researchers.

Study Overview

As is common to nearly all research in the area of health disparities among sexual orientations, Sowe et al. ground their study exclusively on the minority stress theory. In this view, disproportionately high rates of mental and physical distress among LGB populations are exclusively attributed to the disproportionately prejudicial social conditions they experience. However, this study forges new ground by focusing specifically on traditional Christian beliefs regarding same-sex sexuality as a key source of that disproportional prejudice, noting that anti-gay prejudice is frequently religious-based. Further, the authors contend that religious anti-gay prejudice negatively impacts not just LGB individuals within conservative religious contexts, but also LGB and even heterosexual persons outside these churches who are simply exposed to or anticipate being exposed to anti-gay doctrine. As Sowe et al. assert,

> Indeed, from a minority stress perspective, it would be erroneous to assume that religious anti-gay prejudice is purely a "religious" phenomenon—that is, of

> consequence only to religious sexual minorities. Although nonreligious LGB individuals may be less likely than their religious counterparts to attend a place of worship or internalize anti-gay doctrines, they may nonetheless *experience* (or *expect* to experience) homonegativity from religious individuals and groups they encounter. (p. 692, authors' emphases)

The sample for this study consisted of 1,600 individuals (1,215 of whom self-identified as White) recruited through Amazon Mechanical Turk ("MTurk"), an online crowd-sourcing platform comprising a diverse pool of more than 500,000 anonymous participants available to take surveys in exchange for modest payments. The final sample, described as being nationally representative, consisted of 600 opposite-sex attracted (heterosexual), 716 both-sex attracted (bisexual), and 284 same-sex attracted (SSA) individuals. Key measures in this study were developed by the authors, including ones to measure religion-sexuality conflict, homonegative prejudice, and experiences of abuse.

Univariate analyses revealed that most of the outcome variables were positively skewed, meaning that most of the respondents were endorsing low levels of the variable, which is a violation of normality assumptions. As a result, the authors could not use multiple regression methods, but chose to transform these variables and treat them as ordinal data, collapsing them into ordered response categories for ordinal or binary logistic regression.

Findings indicated that exposure to religious anti-gay prejudice predicted poorer mental health outcomes among LGB respondents. LGB participants had greater anxiety, depression, stress, and shame. Higher religious prejudice was also associated with more occasions of verbal and physical assault whether or not the LGB person identified as religious. With this finding, the authors begin a rather breathtaking generalization of their findings:

> . . . [T]he current study is among the first to demonstrate that religious anti-gay prejudice—measured across a variety of life domains beyond faith community contexts—is associated with a range of harmful outcomes among LGB persons generally and not only among those who are religious. This finding makes sense from a minority stress perspective, given that both religious *and* nonreligious individuals may be exposed to—or expect to experience—religious anti-gay prejudice from religious people in their lives. Hence, regardless of whether or not LGB persons possess any religious beliefs of their own, they may nonetheless be harmed via stress processes involving *experiences* and *expectancies* of religious-based rejection. In addition to these processes, religious LGB individuals may also be harmed when they *internalize* the homonegative religious doctrines they have been exposed to, which may generate distressing intrapersonal conflict. (p. 697, authors' emphases)

Sowe et al. proceed to discuss their finding that the effects of religious prejudice were largely observed to be independent of sexual orientation, as exposure to such anti-gay prejudice predicted poorer outcomes among all respondents, including heterosexuals.

> This finding is particularly remarkable as it suggests that the adverse effects of anti-gay religious exposure may extend not only beyond *religious* sexual minorities but also beyond *sexual minorities* themselves. In this way anti-gay religious exposure may have the potential to harm everyone—which is consistent with the findings of a small number of studies suggesting that individuals of all orientations may be adversely affected by anti-gay social conditions. (p. 697, authors' emphases)

The study did find that religious anti-gay prejudice was unrelated to suicidal thoughts and behaviors, though the authors speculate that reducing exposure to religious homonegativity might still bolster LGB resiliency with regard to suicide. Finally, the authors note that religious prejudice was unrelated to drug and alcohol abuse, which they acknowledge supports the notion that substance abuse among LGB persons may be more strongly related to aspects of the gay subculture than to the experience of prejudice.

In what will surely be most disconcerting to Christian traditionalists (and by inference to conservative adherents of other faiths) are the implications drawn by Sowe et al. from their research. These implications are broad-based and pertain to licensed therapists, pastoral counselors, clergy, denominational leaders, religious universities, and para-church organizations with conservative moral views regarding same-sex behavior. Here, I will again let the authors speak for themselves in order for interested readers to gauge the seriousness of these claims for themselves.

> Moreover, the measurement of prejudice in the current study was not restricted to overt and hostile forms of anti-gay aggression, but was based upon the disapproval of same-sex sexuality. Results therefore suggest that aside from overt religious abuse, a basic *lack of approval* of same-sex sexuality among religious others may jeopardize the wellbeing of sexual minority—and potentially heterosexual—individuals. In this way, the religious-based disapproval of homosexuality may amount to more than a harmless expression of religious beliefs, instead operating as a distinct form of oppression with potential psychological consequences. Ironically then, attempts to demonstrate love and tolerance toward homosexuals while continuing to "hate the sin" of homosexuality may undermine the objectives and mental health obligations of religious pastoral care. Such deficits in care may explain why LGB persons who seek help from religious advisors appear to be more likely to attempt suicide than those who do not seek help at all (Meyer et al., 2015). Religious leaders, chaplains, counselors, and clinicians should therefore be aware that good-intentioned approaches to care that exclude the affirmation of same-sex attraction might instead perpetuate psychological harm and identity conflict. (p. 699, authors' emphases)

Finally, in the most overt reference to religious liberty, the authors suggest that religious freedoms taken for granted by religious conservatives are in need of reconsideration.

> Prejudice may be further facilitated through exemptions to anti-discrimination policies that allow religious businesses and institutions to deny employment, academic enrollment, or the provision of goods and services to sexual minority individuals. The current findings suggest that policies purporting to protect religious freedoms are likely to do so at the expense of sexual minority wellbeing, insofar as these policies legitimize expressions of prejudice on the basis of anti-gay religious beliefs. (p. 699)

Sowe et al. then summarize their conclusions in a manner that religious conservatives will certainly perceive as having ominous overtones.

> . . . "hating the sin" of homosexuality cannot be viewed merely as an innocuous expression of faith. Rather, homonegative religious exposure may be of greater health and mental health concern than is conventionally recognized, potentially undermining the wellbeing of both religious and nonreligious LGB persons as well as their heterosexual counterparts. . . . Taken together then, the findings of the current study imply that both broad and substantial harm may ensue when religious bodies and faith adherents—including clinicians and pastoral care workers—espouse, and expose others to, anti-gay religious ideology. (p. 700)

Critical Comments on Sowe et al.

There is no doubt that conservative religious communities can improve their approach to and interactions with non-heterosexual persons, and research that could help promote increased sensitivity is indeed welcome. However, to be most useful in this regard, such research needs to demonstrate understanding and sensitivity to both LGB and religiously conservative communities, and on this count Sowe et al. largely fails. The authors offer broad and speculative generalizations from their findings that give the impression of a conclusion in search of data. Certainly, when depicting historic religious teachings as health hazards and implicitly advocating for the suspension of religious freedom to live out these teachings, researchers should proceed only with great circumspection, nuance, and humility in their claims (Rosik, Griffith, & Cruz, 2009). This is all the more necessary given the methodological limitations of this research, which I describe below.

First, it has to be remembered that these are self-report data, and Sowe et al. mention this, if only in passing. Hence, the reports are of *perceived* anti-religious prejudice. This does not mean that they do not have some merit, but it does signify that as perceived experiences they are subject to a host of mediating and moderating influences that have been identified in the literature (e.g., attachment and coping styles, rejection sensitivity) that were not assessed in this study. It is also worth observing that the most objective of the outcome variables, suicidal behavior and drug and alcohol abuse, were not found to be associated with anti-gay religious prejudice. Responsible researchers would acknowledge these limitations and call for further research, offering practice and policy implications only with extreme tentativeness that recognizes other interpretations and alternatives (cf. Vrangalova & Savin-Williams, 2014, for some examples of alternate explanations for health disparities).

Second, although the authors claim a nationally representative sample, their use of the MTurk survey format and platform attracts an almost certainly non-representative sample of any particular population other than the tautological population of "people who participate in MTurk surveys." Furthermore, MTurk workers may misrepresent themselves, which could create additional distortion in research findings (Wessling, Huber, & Netzer, 2017). Hence, the extent to which the study's findings can be generalized to LGB, Christian, past Christian, and conservative religious populations is uncertain. Advocating for the blanket curtailment of religious liberty on the basis of one sample with questionable generalizability creates the appearance of activism and not science.

Third, as noted earlier, several of the outcome measures, including the central predictor of the study, religious prejudice, were developed by the authors. As such, there is no way to be certain of the psychometric quality of these scales and whether they are reliable and valid for assessing the constructs they purport to measure. The only reported psychometric information on the religious prejudice measure was the internal reliability index (i.e., Cronbach's alpha), which at .81 was adequate but not spectacular.

Fourth, the findings are grounded in correlational statistics, and as such cannot determine causality between variables. The authors attempt to play down this limitation by alluding again to minority stress theory as a rationale for their assumed causal pathway from prejudicial experiences to mental and physical distress. Still, it remains hard to scientifically justify restrictions on something as basic as religious liberty in the absence of supportive longitudinal data examining a variety of theoretical causal models (cf. Vrangalova & Savin-Williams, 2014).

Fifth, and perhaps most concerning, was the distributional properties of the study data. Sowe et al. reported that most of their outcome measures were positively skewed, and apparently so extensively that normal data transformations were still not sufficient to maintain the data as a continuous measurement and allow their preferred regression method. What this could mean, for example, regarding the religious prejudice measure is that respondents in this sample reported experiencing low levels of religious anti-gay prejudice generally, and these responses had to be put into an ordinal format that was less tied to the anchors of the scale.

In the case of religious prejudice, the participants were asked to rate the extent of disapproval of same-sex sexuality they felt existed among nine groups of people spanning several life domains, including family, friends, coworkers, and faith communities. The scale anchors for these ratings were *0 = no, not at all* and *4 = yes, to a very large extent*. In this case the positive skew might signal that differences in experiences of perceived prejudice from these groups could be the difference between *no, not at all* and *yes, to a slight extent* (note that the meanings of scale points "*1" and "2"* were not provided by the authors). Such a relatively small magnitude of difference, if confirmed, would constitute an unacceptable and scientifically irresponsible basis for Sowe et al.'s broad conclusions and implications.

The authors somewhat astonishingly did not provide basic descriptive information (means and standard deviations) for any of their variables, so this concern cannot be ruled out. In fact, on multiple occasions I requested this information (as well as the dataset) from the lead author and received no response. This is not in keeping with

APA research guidelines for data requests by other professionals and mirrors the earlier experience of Regnerus (2017), casting some doubt on the integrity of this study and other research in this field.

By way of summary, and taking a wide-angle lens on this topic, it appears to me that Sowe et al.'s research is perhaps the most overtly hostile to date toward non-affirming conservative religious beliefs about same-sex sexuality. However, the appearance of studies that take a similar, if slightly more subdued, line of reasoning is growing at a fast pace (cf., Barnes & Meyer, 2012; Crowell, Galliher, Dehlin, & Bradshaw, 2015; Garrett-Walker, J. J., & Torres, V. M., 2017; Shilo & Savaya, 2012; Sowe, Brown, & Taylor, 2014). It would be naïve for religiously conservative clinicians, pastors, and other leaders to think this will not soon find its way into professional, legal, and judicial proceedings concerned with the intersection of LGB rights and religious liberties. Faith-based counselors and conservative religious leaders who distanced themselves from efforts to contest therapy bans may now find such bans were merely the canary in the proverbial coal mine. It seems very unlikely these individuals will be able to hide from the social and policy implications of research that declares their historic Judeo-Christian sexual ethic to be a severe threat to the health and wellbeing of LGB persons. In fact, this concern appears borne out by recent developments in California, where the state legislature has declared any financial transactions (even those with pastors or other faith-based non-professionals) involving an individual's pursuit of fluidity and change in unwanted same-sex attractions or behaviors to be fraud subject to costly civil lawsuits (California Family Council, 2018).

Psychology has an increasingly abysmal record of partisan activism in research arenas that have clear and desired political and policy implications (Duarte, Crawford, Stern, Haidt, Jussim, & Tetlock, 2015; Ferguson, 2015). Sowe et al.'s work appears to be a fair example of this concern, as evidenced by their rather cavalier overgeneralization of findings from a single study to the conservative religious community as a whole, despite limitations necessitating scientific humility. Religious conservatives should anticipate this developing literature will play a prominent, if unjustified, role in the challenges ahead for religious liberty.

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Recently Published Research Counters Claims of Widespread Harm and Ineffectiveness of Sexual Attraction Fluidity Exploration in Therapy (SAFE-T)

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An online survey of 125 men in the USA who had been or still were engaged in sexual fluidity exploration in therapy (SAFE-T) with licensed mental health professionals has recently been published in the peer-reviewed journal *Linacre Quarterly*. The study by Santero, Whitehead, and Ballesteros (2018) had participants rate their experiences of change, harm, benefit, and type of intervention at three intervals: before, during, and (where applicable) after their therapy experience.

Participants were asked to report on their experience of sexual attraction and their sexual identity, as well as Kinsey scale ratings (from exclusively homosexual to exclusively heterosexual). Also assessed was the duration, effectiveness, and harmfulness of 17 specific therapeutic techniques, the type of provider, and the number of sessions/hours/meetings participants attended. Change was measured in terms of the frequency of homosexual and heterosexual fantasy, desire for intimacy, and kissing and sex. Change in the degree of self-reported sexual attraction and Kinsey scale scores were also evaluated. Separate measures of helpfulness and harmfulness for each of the 17 specific therapeutic techniques was assessed. Variables measuring mental health changes, positive and negative, were assessed for self-esteem, depression, social functioning, suicidality, self-harm, and substance abuse.

Santero et al.'s sample of men had a mean age of 40, median income of $63,000, and 89% reported some variety of Christian identification. Fifty-four percent of the participants were single, 46% married, and 42% had children. Fifty-eight percent had completed therapy, while 42% were still in therapy at the time of assessment. In terms of motivations for pursuing SAFE-T, 64% reportedly entered therapy for faith-based reasons, 12% desired to strengthen their marriage, and 10% aspired to heterosexual marriage. Countering the narrative that SAFE-T clients are routinely coerced into therapy, 4% of the sample cited extreme

dislike of the gay culture they experienced, and 3.2% cited family pressures.

Results

Utilizing chi-square and sign test statistics, the authors checked the reliability of their effect sizes and confidence intervals through Monte Carlo methods. In terms of SAFE-T effectiveness, Santero and colleagues found that 68% of the men reported reductions in their same-sex attractions and behavior as well as an increase in their opposite-sex attractions and behavior. Among the men who had finished their therapy, these changes endured for a median of three years after therapy was completed and loss of therapy gains were generally not observed. Regarding the occurrence of categorical change, 14% of the sample reported change from exclusive homosexuality to exclusive heterosexuality. Two-thirds of participants had more heterosexual attraction and less homosexual attraction after receiving SAFE-T. Specific professional therapy modalities were only recalled by 20% of participants, and the only modality recalled by more than one participant was cognitive/behavioral therapy, of which 16 participants found helpful and two found harmful.

SAFE-T participants reported the most helpful therapy interventions were:

- Developing non-erotic relationships with same-sex peers (87% reported this as helpful)
- Understanding better the causes of your homosexuality and your emotional needs and issues (83%)
- Meditation and spiritual work (83%)
- Exploring linkages between your childhood and family experiences and your SSA (76%)
- Learning to maintain appropriate boundaries (76%)

Participants reported that the most harmful interventions involved:

- Going to the gym (16%)
- Imagining getting AIDS (covert aversion—13.6%)
- Stopping homosexual thoughts (12.8%)
- Abstaining from masturbation (10.4%)

Based on their rating system, Santero et al. indicate that the grouped negative impact of SAFE-T on mental health issues was slight. Meanwhile, the median results for the positive impact of SAFE-T were:

- Self-esteem: Markedly helpful
- Social functioning: Markedly helpful
- Depression: Moderately helpful
- Self-harm: Markedly helpful
- Suicidality: Markedly helpful
- Substance abuse: Extremely helpful

Significant increases in self-esteem and social functioning as well as decreases in depression, self-harm, suicidality, and substance abuse were reported among participants who had completed therapy.

Only one participant reported extreme negative effects (i.e., for suicidality and self-harm). Most participants reported net degrees of harm that were "none to slight." About 75% reported net harm in only one (varying) category out of the six. Most percentages of participants reporting harm were below 10%. Ninety-eight percent of the sample reported active faith, suggesting that SAFE-T resulted in very little loss of religious faith.

Conclusions

Santero et al. conclude that change in same-sex attractions and behaviors from SAFE-T is likely to some extent. They observe that

"If 'unlikely to be successful' (American Psychological Association, 2009a) means only a 14% success rate for very profound change, many lay religious individuals will still feel this worth trying" (p. 12). They also concur with a growing scientific consensus that "The concept of the immutability of sexual attraction must be rejected" (p. 12). The authors also conclude that change in comorbid traits (self-esteem, depression, suicidality) through SAFE-T is likely to a large extent. Based on their findings related to a number of SAFE-T interventions, they suggest that evidenced-based advice to clients is that many types of SAFE-T may be helpful, so they recommend that consumers try a large range of interventions.

Concerning harm, Santero et al. observe that the rates of effectiveness and deterioration or harmfulness for SAFE-T appear to be similar to what is reported in psychotherapy for other conditions. They add that "The degree of change of the comorbid problems was sufficiently high that for them a fair summary would be 'likely to change to a large extent during SOCE [SAFE-T]" (p. 12). Based on their findings, Santero et al. offer a not-so-gentle rebuke to the American Psychological Association:

> Given the results of this survey, the current recommendation by the American Psychological Association (2008) that "ethical practitioners refrain from attempts to change individuals' sexual orientation" is itself unethical, at least for lay religious men. A re-evaluation would at minimum spark motivation to conduct studies with best possible research methodology, so that SOCE [SAFE-T] can be better evaluated and improved further. The bottom line is that individuals with unwanted same-sex attraction have the fundamental right to seek strengthening of opposite-sex attraction, and this should be fully respected. Through their change efforts, they are likely to see at least some change and help with unrelated mental issues, and they have a right to know this. (p.14)

Study Strengths and Limitations

As is the case for any research, Santero et al.'s study has limitations that should be mentioned. Similar to all prior SAFE-T research, this study relies on retrospective self-reports of change and harm and, despite recruiting for participants from therapy contexts, is not definitively able to disentangle professional from non-professional care providers. Moreover, the sample is admittedly unrepresentative in that (1) Joseph Nicolosi, Ph.D., was the main contact for all the therapists who advertized the research project to clients; (2) the authors did not obtain dropout rates during therapy; and (3) participants were highly religious, well-educated, higher SES, Caucasian, Protestant, and American. Thus, the findings from this study, while suggestive, cannot be generalized to all non-heterosexual clients. The authors also astutely observe that the changes in SSA reported by participants may not be acceptable to church authorities, especially for participants who might seek a leadership role in their church or synagogue.

The authors also noted several strengths of their research. The sample size was sufficient to obtain stable statistical results. Santero et al. assessed for both those who benefited from SAFE-T and those who did not. In addition, half of the sample was post-therapy, allowing for a three-year median follow-up. Finally, the inclusion of Roman Catholics, Jews, and LDS men suggest

results are applicable to the broader faith community.

Final Comment

Proponents of clients' rights to pursue SAFE-T owe a significant debt to Santero, et al. for the courage and perseverance it must have taken to finally have their research published. Their study suggests that sample recruitment is especially critical in this research domain and that pessimism toward SAFE-T within organized psychology may be the result of a largely uniform reliance on LGB-identified or LGB-allied researchers, venues, and consumers. This lack of diversity within the field of study should lead to a healthy skepticism concerning the definitiveness of prior claims about SAFE-T's ineffectiveness or risk of serious harms. As Chamber, Schlenker, and Collisson (2012) caution, "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). With the advent of Santero et al.'s research, SAFE-T proponents have a valuable tool for differentiating between SAFE-T opponents who are ideologically closed partisans and those who are curious social scientists open to what may be learned from exceptional findings.

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A Review and Summary of Walter Schumm's

Same-Sex Parenting Research: A Critical Assessment

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Same-Sex Parenting Research: A Critical Assessment is authored by Walter R. Schumm, Ph.D., professor in the Kansas State University *School of Family Studies and Human Services*. Dr. Schumm has conducted research on gender identity, sexual identity, sexual attraction, and same-sex relationships and parenting since 1999. He has published 39 scholarly articles on GLBT topics (cf. Appendix A in Schumm's book for a list). In *Same-Sex Parenting Research,* Schumm masterfully accomplishes three goals. First, Schumm explains how quality, ethical research *is* done. Second, Schumm reviews what social science research to date *does*—and does *not*—tell us about same-sex parenting (SSP). Finally, he examines and critiques the use of social science research concerning SSP in society.

I. An analysis of how social science research has been and ought to be conducted.

Schumm's first goal is the heart and soul of this book. This first section alone could be published as a research primer. It is invaluable to *all* readers in that it defines *what* science is and *how* science should be conducted, including the need for investigators to suspend their worldview biases in the process. Schumm explains that he wrote *Same-Sex Parenting Research* "to show how research (on SSP and *any* issue) can be studied in greater depth and detail than often done"—i.e., in a genuinely scientific manner. This goal includes teaching future researchers in general, and graduate students in particular, to improve their scientific research methodology and "become much

better at assessing scientific literature and engaging it with deeply critical thinking." He also hopes that "even a few newspaper or other media reporters"—and dare we add, judges, politicians, and social policy activists—"might catch some of this scientific spirit with respect to their own investigations" (p. 14–15).

In Chapters 1–3 and Appendix D, Schumm gives particular attention to *how* "honest" research in general, and SSP in particular, ought to be done. A sampling of some of Schumm's comments from these introductory is warranted. In Chapter 1 (*Background*), in addition to offering an overview of the book and its organization, he describes his concern about the cultural and specific SSP–focused "threats" to the conduct of genuine science. He discusses his perception that "scholarly caution" has been "abandoned" and "honest" social science "compromised" on this topic.

In Chapter 2 (*Social Science Theory*), Schumm reviews a number of theoretical areas relevant to the study of SSA. These include concerns about contemporary cultural struggles over the meaning of "Traditional Sexual Morality," "marriage," and happiness." He also stresses the need to distinguish between "harm" and "difference." In effect, well designed and executed studies that conclude children with SSP experience no harm may still reveal "significant" differences between children raised by same-sex and heterosexual parents. For example, children who are raised by same-sex parents *do* appear to develop non-heterosexual feelings, thoughts, behaviors and identities more often than do children raised by opposite-sex parents (see Chapters 8–10 in Part 3). Schumm clarifies that whether such scientifically documented differences are equated with harmfulness depends upon the reigning cultural worldview, not upon science. Science merely reveals what is; science alone cannot and does not dictate what should be done. The latter falls within the moral and philosophical realm not the scientific.

A particular gem of Chapter 2 is Schumm's discussion of the relevance of the *Time Preference Exchange Theory* (TPEX). This is a "mathematical model of morality," which is important to consider when interpreting the results of research on human behavior. In this model, "delayed gratification" (i.e., making "choices based to some extent on how long it will take for the rewards or costs they expect to occur") is studied under four different *time preference* "decisions." For example, Type A decisions "result in positive outcomes in both the short and the long run for everyone concerned," while Type D involve both short- and long-term negative outcomes. Type B decisions result in "positive *short-term* benefits but often have *long-term* negative outcomes." A decision classified as Type C "involves short-term sacrifices or costs but yields long-term positive benefits," sometimes posthumously. Type B & C decisions are more likely to be culturally and morally controversial, while Types A & D are not. Schumm applies the TPEX Model to heterosexual versus SSP and other relevant issues (cf. pp. 33–42).

In Chapter 3 and Appendix D, Schumm reviews methodological issues that impact the quality of research and the strength of its conclusions. With regard to SSP research, both pro and con, he mentions two notable limitations that must be corrected. In national samples of US citizens, how the government codes "same-sex" leads to very ambiguous interpretations of the data. In such studies, "same-sex" does not necessarily reflect only those who identify as LGBT. Heterosexual identifying individuals may constitute a same-sex household. Examples include but are not limited to, for example, a mother and daughter, or two brothers. In addition, when a person is asked to name her or his "sexual orientation" (SO), given the ambiguity of this

term, it is not possible to know how similar are those who so self-identify. Schumm recommends that when researchers try to assess a person's SO, that a person is asked to clarify if this includes same-same attractions, thoughts, behaviors, and identity. For example, a parent who identifies as "gay/lesbian" and who does *not* engage in same-sex sexual gratification behaviors is likely very different from a parent who *does*.

Like a good scientist, Schumm also includes *Future Research* sections, in which he suggests studies to clarify questions not adequately answered by existing research. For example, Schumm describes the need for "equivalence" between groups in order to definitively assess whether there are any significant differences between them. Studies comparing children raised by lesbian parents with those raised by heterosexual commonly are inadequate because the "convenience samples" of lesbian parents in general are better educated, wealthier and report fewer adult psychological difficulties than do the heterosexual parents. Similarly, he questions the validity of relying solely upon parent evaluations of their children, rather than objective measures of the children's well-being, in order to offset parents' "social desirability" or potential intent to impress the researcher.

In his critique of reviewers of SSP literature, Schumm questions why most tend to cite *only* older studies which support their pre-conceived conclusion, and typically fail to mention studies which either contradict or fail to replicate the pro-SSP studies. Schumm points out this may occur due to ignorance, intent to deceive or capitulation to judicial, political, or social activists. Ultimately, what matters, Schum argues, is that readers develop a healthy "skepticism" when reviewing studies and literature reviews of culturally/politically charged topics, like same-sex marriage or SSP.

For example, he exhorts readers to "be *skeptical*" (emphasis in original) if "a so-called scientist argue(s) that every piece of research ever done by anyone in any country has supported their view of the world" (p. 47). Or, "be *skeptical*" when either a scientist is unable "to point to research that is for and against a particular conclusion for a given research question" and/or "cannot point to research or a researcher with whom they disagree without somehow feeling obligated to "discredit" that researcher" (p. 48). Or, "be *skeptical* . . . (w)hen you hear a so-called scientist state that research is simple and clear, without much in the way of complexity," instead of being willing to "dig deep" and "not be content with superficial analyses of what may be very complicated" (p. 50). Or, "be *skeptical* . . . when public viewpoints are dismissed by a presumably elite group of scientists who presume they know better than everyone else" (i.e., when they dismiss "common sense") (p. 51).

To his credit, Schumm "walks his talk" in his writing. While he disputes the oft heard claim that science reveals "no differences" between same-sex and opposite sex parents, and the children they raise, he presents all of the available studies, *including* those that do not support his position. His analysis of the work of authors who hold a divergent view is respectful even in the face of suffering ad hominem attacks from some of those same authors. In addition, he makes it a point to alert readers to where *he* is conjecturing, often writing, "It is possible (*speculation* only) that . . ." (p. 88, emphasis in original).

II. WHAT social science research <u>does</u> and does <u>not</u> reveal about same-sex parenting (SSP).

Schumm details what is and is not known about SSP in Parts 2–5 of *Same-Sex Parenting Research.* Most of these chapters (4–12) are organized in the following

manner. He first summarizes *what is claimed* to be true about the relevant topic concerning SSP. Then, he reports *what actually is known*. Schumm accomplishes this as he critiques the methods used by the commonly cited research and literature reviews, then applies the same analysis to relevant studies that are often omitted. After reviewing what *has* been claimed and what responsible science actually *reveals*, Schumm details the *Limitations* of all of the studies, recommends *Future Research* to clarify remaining questions, and then summarizes *Conclusions to date.* Part 2 focuses upon what is known of same-sex parents. It tackles such questions as *How Many Same-Sex Couples Are Raising Children; Family Stability; Same-sex Parents as Sexual Abusers,* and the *Values and Behaviours*[1] *of same-sex parents*. Part 3 addresses what is known about the children of same-sex parents in terms of their *sexual orientation*, *gender identity*, and *gender roles*. Part 4 reviews what is known about the children of same-sex parents in terms of their mental health and related issues, including *mental health* in general, *drug and alcohol abuse, educational attainment, crime and conduct problems, sexuality, self-control/delayed gratification,* and *other child outcomes*. Part 5 is unique in that it considers the claim that same-sex marriage has no *negative consequences.*

III. The (mis)use of the social science to meet SSP judicial, legislative, and social policy goals.

After acknowledging that he is "a scholar, not a lawyer or a politician," Schumm explains that it is the purpose of his book—and the purpose of social science in general—to directly "address issues of fact and social science theory," *not* to answer "legal or political questions" (p. 53–54). At the same time, he comments throughout the book when he perceives that the particular author of either a study or a review of the study appears to be sacrificing the scientific method to the demands of "SSP advocacy." Schumm likewise comments when it appears that judges, legislators, and/or social policy activists have misinterpreted or misused well-publicized research or reviews which appear to support their apparent goals, while ignoring research which does not.

Throughout his book, Schumm shares some personal encounters in which he was confronted with the misuse and misrepresentation of SSP social science research. The prominence given to political agendas and group think that he encountered in these cases remains particularly discouraging for those dedicated to rigorous social science and discovering truth. Schumm's comments in Appendix C (*Fair Fight?*) and Appendix E (*Lessons Learned at Trial(s)*) are particularly worth reading.

For example, he describes the different set of rules by which "progressive" vs. "conservative" social science expert witnesses had to play in the State of Florida trial regarding SSP. He notes that while the judge had ordered each "side" to prepare and provide beforehand a complete statement of their summary of the research, for examination by the other side, this order was not enforced fairly. While Schumm did as ordered, the "progressive" side provided nothing. So, while the "progressives" could painstakingly review the "conservative" case before it was presented, the "conservatives" had no idea what case the "progressives" would make, until they made it during the actual hearing. And, the judge simply allowed the "progressives" to get away with their noncompliance to his order with no

[1] Some words, like "behaviour," reflect British English spellings of the words, since *Same-Sex Parenting Research: A Critical Assessment* was published in the UK.

penalty and with the advantage of being able to prepare their rebuttal while the "conservatives" couldn't—an (Un)*Fair Fight* indeed!

In Chapter 2 (*Social Science Theory*, p. 37–41), Schumm discusses the practical personal and cultural consequences of "legalized" same-sex marriage and parenting. *In the past, cultural, legislative, and judicial recognition and respect for the "*biological . . ., as well as social differences, between men and women," led them to recognize and reward:

> the inherent sacrifices that biology and society virtually forced upon heterosexuals, especially those who wanted children, and were open to providing them with various forms of compensation for those risks, costs and limitations on their freedoms." But by deciding to reward everyone equally, regardless of the risks, costs or loss of freedoms, the courts, in my assessment, have created inequality (in terms of legal benefits relative to risks and costs) for the many in order to create an apparent equality of outcomes for a few (p. 39).

Schumm comments further that the courts'—and legislatures'—effective denials of:

> the costs and risks of *heterosexuality* may well have the effect of turning *heterosexuals* and their children into the actual "second-class citizens" in terms of no longer getting the respect (or legal support) they deserve for the extra risks they take and costs they assume . . . relative to homosexuals . . ., ultimately for the sake of society's long-term outcomes." (p. 39, *emphases* added)

> Another way of looking at such issues is the "playing by the same rules" approach. . . . [S]ame-sex couples . . . want the same benefits as heterosexual couples but want to play (and biologically can play) by different rules because for them, there are no risks of pregnancy. Thus, they don't want to play by the same rules or take the same risks, but they want the same benefits of the game. (p. 40)

On a more personal note, in the Prologue, Schumm first mentions that "[t]here are many people to whom I owe much gratitude for encouraging me in my life and even in the production of this book." Then he adds: "I hesitate to mention them by name lest they come under attack for having any association with me. Some very Christian scholars have gone out of their way to avoid any association with this book because of the stigma or discrimination they fear (p. 13)." Later in the book, he writes: "Some may think that I am opposed to same-sex marriage because I am a conservative or because I am somehow 'religious'" (p. 40). He clarifies: "[M]y view is that my primary concern is when courts create inequality by treating things that are different as if they were the same in terms of short and long-term costs, risks, and benefits" (p. 40-41).

Schumm recounts unprofessional ways in which apparently "progressive" social scientists have attempted to marginalize his own work (Appendix B: *Discredited?*). Unfortunately, Schumm and other social scientists attempting to be authentically scientific in their research on SSP are not alone in receiving unpleasant, ill-founded criticism. Researchers and professionals in other professions likewise have received irresponsible personal and professional attacks because of the counter-cultural,

politically incorrect implications of their work.[2]

While Schumm acknowledges his Christian faith, he clearly documents that his criticism of the mainstream claims regarding SSP is rooted in science—not his religion. At the same time, he deftly discusses "theoretical" and "moral" issues that result in acrimonious debate due to a clash of worldviews—namely Christianity and secular humanism. Competent scientists of all faiths and worldviews must have a place in the public arena or else public debate is unacceptably biased. This point has been made before.[3]

Final Remarks

Sadly, the art and science of medicine and mental health, like our culture, have fallen prey to moral relativism and political correctness. In *Same-Sex Parenting Research*, Walter Schumm painstakingly reminds us of the qualities which authentic, responsible scientists must possess in order to produce rigorous, trustworthy scientific results about *any* topic, and SSP *in particular*. Schumm's book is an excellent review of *all* of the research on SSP—such as it is—which clearly documents that, in fact, same-sex parents and the children whom they raise are significantly different in important ways from opposite sex parents and their children. For these reasons, *Same-Sex Parenting Research* warrants a close read by all.

Certainly, the members of the Alliance's Public Education; Ethics, Family & Faith; and Research Divisions—and non-members who support these Divisions' concerns and goals—will find Walter Schumm's book of particular interest. Also, college students, professors, researchers, mental and medical healthcare professionals, laypersons, and involved judicial, legislative, political and social policy professionals—*all* who are concerned about both the *what* and the *how* of "honest," truly professional research in the area of SSP and any concern of the social sciences—are encouraged to get a copy and read. Even those with no interest in SSP would walk away a better person by reading the first three chapters, for they would learn how social science *is* and *ought* to be conducted. To paraphrase a well-used saying, for any professional or lay person genuinely interested in reading a book about <u>what</u> we know about SSP and <u>how</u> we *do*—or *can*—know it, *Same-Sex Parenting Research* is <u>the</u> book for you!

References

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[2] For example, Dr. Jodi Gilman, M.D., assistant professor at Harvard University's *Center for Addiction Medicine*, has received "hate mail" for daring to study and publish politically and culturally "incorrect" research showing the differences between the brains of users and non-users of marijuana and the harm caused by its use (Sushrut Jangi, MD, 2015).

[3] Abbott and Byrd (2009) are academics who have written from an explicitly Christian worldview about how to encourage and support persons who want themselves or their loved ones to develop a heterosexual "sexual orientation." In their writing, Abbott and Byrd offer an important perspective about the validity of Christian-based approaches in particular to studying, reporting, and intervening in such areas of human concern. They assert the need for both professional and non-professional readers to:

> understand that all people—including scientists, mental health professionals, and educators—have overarching worldviews that guide their theories and direct their interventions into the physical and psychological realms of human life. Our worldview, which includes Christian ideas and principles, is no less legitimate than theirs; it's just different! It should be accepted on equal footing with other major worldviews. Our Christian viewpoint is one of many, but is not an illegitimate stepchild to the nonreligious or secular worldviews that dominate psychology, education, and mental health (p. 8).

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A Review and Analysis of *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture*

by Mark A. Yarhouse

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Introduction

This paper is a review and analysis of *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture,* authored by Mark A. Yarhouse (2015a). I also offer suggestions about complementary and supplemental readings and resources. Some of the authors of this additional material are mental-health professionals, while others are para- or non-professional, including pastoral caregivers and lay caregivers.

Dr. Yarhouse states in the Introduction that he wrote *Understanding Gender Dysphoria* because "there is a need for a resource that is written from a Christian perspective and is also informed by the best research we have to date, as well as seasoned with compassion for the person who is navigating gender dysphoria" (p. 10). Through this book, he has attempted to offer, in particular, professionally and pastorally sound wisdom to persons who experience *gender incongruence* (Yarhouse & Burkett, 2003) and also to youth ministers who try to help their charges to better understand themselves and to act morally and maturely as sexual human beings (Yarhouse & Hill, 2013).

Yarhouse has studied empirically the experiences of persons who self-identify as "transgender." His studies include learning how persons' perceiving that they *are*—that they self-identify as—*transgender* and engaging in transgender activities and behavior have affected their relationships with God *as* Christians and *with* other Christians (Carr & Yarhouse, 2014; Carr, Yarhouse & Thomas, 2014; and Yarhouse & Carr, 2012). Strictly speaking, persons who experience *gender dysphoria* commonly are struggling with what often are qualitatively different issues than many who fit under the "transgender umbrella," and Yarhouse has given the topic of *gender dysphoria*, as well as the formally diagnosed *Gender Dysphoria,*

particular attention in *Understanding Gender Dysphoria* (Yarhouse, 2015a; 2015b).[1]

After describing an anecdote of meeting a certain "male-to-female transgender person" who was also a "conservative Christian," Yarhouse comments that "[t]his experience, together with other personal and professional experiences, led my research group to a series of trainings and consultations around gender dysphoria and eventually the decision to conduct the study of the experiences of transgender Christians" (p. 10). He notes that discovering the sincerely held faith of these persons—sometimes apparently in spite of and at other times because of dealing with gender dysphoria—"was humbling to me as a Christian and a researcher" (p. 11). He invites readers to reflect upon the results of his empirical study in particular, as well as "a broader research literature . . . and other anecdotal accounts." His goal is to help readers "to gain greater insight into the experiences of persons who navigate gender dysphoria, recognizing that there is no one story that can capture the range of experiences that exists today" (p. 11).

I. Gender Incongruence and Distress—Gender Identity Disorder (GID)—*Gender Dysphoria*

In Chapter 1, entitled *Gender Identity, Gender Dysphoria and Appreciating Complexity*, Yarhouse introduces readers "to the language, categories, and key terms associated with the topic" of distressful gender incongruence, i.e. *gender dysphoria* (p. 11). He defines "a person's sex" as his or her "physical, biological and anatomic dimensions of being male or female and a person's "gender" as the "psychological, social and cultural aspects of being male or female" (p. 16). Over several pages, Yarhouse clarifies and distinguishes *biological sex, primary sex characteristics, secondary sex characteristics, gender, gender identity* and *gender role* (p. 17). Several Tables on page 18 offer useful distinctions, such as the *Physical/Biological/Anatomical Facets of Being Male or Female,* in terms of *Chromosomes*, *Gonads*, *Sexual Anatomy,* and *Secondary Sex Characteristics*. He further explains the binary distinctions for *Biological Sex* (male or female), *Gender Identity* (man or woman), and *Gender Role* (masculine or feminine), as well as the exceptions to these binary differences, i.e., *Intersex*, *Androgyny*, and *Outside Cultural Norms*, respectively (p. 18).

The fundamental and foundational definition for the book concerns the meaning of the more common condition of *gender dysphoria* and the diagnosis of the rarer phenomenon of *Gender Dysphoria* (lower and upper case spelling intentional). Yarhouse writes: "Gender identity concerns—or . . . gender dysphoria—refers to experiences of gender identity in which a [man's] psychological and emotional sense of [himself] as female, does not match or align with [his] birth sex as male." Or, when a woman's psychological or emotional sense of herself as male does not match or align with her birth sex as female. In other words, "gender dysphoria [is] the experience of having a psychological and emotional identity as either male or female, and that your psychological and emotional identity does not correspond to your biological sex" (p. 19).

There is a perceived incongruity or mismatch between one's biological sex and one's psychological or emotional identity (e.g., a person is born one biological sex but

[1] Note that whenever Yarhouse mentions *gender dysphoria* (lower case), he is referring to the *distress* which commonly accompanies the experience of *gender incongruence*, the mismatch between a person's biological or "assigned" (see below for further clarification) sex and his or her perceived, felt and/or intended gender. When he mentions *Gender Dysphoria* (upper case), he is referring to formal DSM-5 diagnosis.

feels the psychological or emotional identity of the other, opposite sex). So, in gender dysphoria, a biological female perceives or feels herself to be or have the psychological or emotional identity of a male, and a biological male, perceives or feels himself to have or be the psychological or emotional identity of a female. This "perceived incongruity" between one's birth or biological sex and one's perceived or felt gender or sex can be the source of deep and ongoing discomfort (i.e. psychological or emotional distress or dysphoria). When persons' experiences of "gender incongruence"—the misalignment of one's "birth sex and psychological sense of gender"—causes "them significant distress or impairment, they may meet criteria for the [formal, professional] *diagnosis* of Gender Dysphoria" (p. 19).

On pages 20–21, Yarhouse again makes important distinctions and clarifications, while defining another long list of words. These include *gender dysphoria, transgender, cisgender, gender bending, cross-dressing, third sex* or *third gender, transsexual, male-to-female, female-to-male, genderfluid, genderqueer, drag queen, drag king, transvestism,* and *intersex*. A crucial word to know is *transgender*, which "is an umbrella term for the many ways in which persons might experience and/or present and express (or live out) their gender identities differently form people whose sense of gender identity is congruent with their biological sex" (p. 19, 21).

At the end of this first chapter, Yarhouse mentions two themes that he repeats often later in the book. First, he sees "value in encouraging individuals who experience gender identity conflicts to resolve the conflicts in keeping with their birth sex if possible." Also, he recognizes "the potential value in managing the gender identity conflict or concern through the *least invasive means* (recognizing surgery as the most invasive step toward expression of one's internal sense of identity)" (p. 25, emphasis added).

II. Challenges for (Evangelical) Christian Leaders, Pastors and Laypersons

In the Second Chapter entitled *A Christian Perspective on Gender Dysphoria,* Yarhouse advises that there

> is a need to balance between two hazards when we turn to the Bible to inform our discussion about gender dysphoria. The one hazard is to look to Scripture for answers it is not prepared to provide. The other hazard is to fail to critically reflect on the socio- cultural context in which we live and make decisions about gender identity and dysphoria (p. 30).

Yarhouse advises Christian leaders, pastors, and laypersons that while gender dysphoria, if significantly disabling, is "a mental health issue that is a diagnosable condition," i.e., Gender Dysphoria. But they

> . . . might not view mental health issues and moral issues in the same way as the broader culture views these issues. It might not be enough to just point to a diagnostic manual for confirmation that an issue is strictly a mental health concern and that it has nothing to do with moral and ethical considerations." (p. 30).

In this respect, understanding that the presence of a diagnosable mental health condition may help explain, but does not excuse or condone, the otherwise unacceptable behavior.

After discussing biblical passages which frequently are cited—sometimes properly and helpfully, sometimes not—in response to

concerns about a person's gender dysphoric feelings or behavior, Yarhouse describes the value in considering "The Four Acts of the Biblical Drama." He "tries to think about sexuality and gender in the context of God's redemptive plan for creation," whose four acts are "*creation, the fall, redemption* and *glorification*." After describing these acts in some detail, Yarhouse explains that "a Christian explanation of the biblical drama" offers "an understanding of sin (which also) brings with it a corresponding affirmation of the *inherent goodness of creation"* (p. 45).

Along with observing and understanding "the goodness of our physical existence and ourselves as gendered persons," he advises recognizing and distinguishing the "different aspects of our sexuality: *gender sexuality, erotic sexuality* and *genital sexuality*" (p. 36). Yarhouse encourages the valuable reflection on God's purpose in creating two sexes and teasing out "the meaningful differences between men and women . . . from our sociocultural context." He further asserts that "the view that 'gender enables unity'" between man and woman is important to consider (p. 36).

Yarhouse notes that an authentic Christian perspective of human beings describes and explains both the inherent goodness of man and woman—and men and women—and that this "goodness is *tainted and incomplete in some ways*" (p.45, emphasis in original).

> Christians recognize that we are marred by the fall—we are broken, incomplete and disordered persons. However, the reality of redemption and the hope of resurrection tells us never to give up and that God's grace is sufficient to cover all of what we may encounter (including our own wrongs) if we are in a right relationship with God (p. 45–46).

III. Four Frameworks or Lenses for Perceiving and Conceptualizing Gender Identity Concerns

In Chapter 2, Yarhouse discusses a theme which he frequently repeats in later chapters. He perceives that there are three different frameworks or lenses for perceiving and conceptualizing gender identity concerns. These include the *integrity* framework, the *disability* framework, and the *diversity* framework. And Yarhouse recommends that persons, especially Christians and others who are committed to the *integrity* framework, adopt a fourth: the *integrated* framework, which combines the best of the insights of the other three.

The *integrity* framework "views sex and gender and, therefore, gender identity conflicts in terms of 'the sacred integrity of maleness or femaleness stamped on one's body' (Gagnon, 2007)". By contrast, the *disability* framework considers 'gender dysphoria . . . with reference to the mental health dimensions of the phenomenon." As Yarhouse points out, "a preference for seeing the diagnosis of Gender Dysphoria as a disability of some kind still raises many questions about etiology, prevention, maintenance, and treatment and care" (p. 480). Professionals and non-professionals who view their difficulties primarily through the "lens of disability" may seek palliative care (such as adopting cross-gender dress) or medical interventions (such as hormonal treatments and amputational and plastic surgery), which integrity lens persons understandably find problematic (p. 49).

By contrast, the *diversity* framework views "transgender issues . . . as something to be honored or revered, . . . as reflecting an identity and culture to be celebrated as an expression of diversity." Yarhouse perceives that there are *strong* and *weak* forms of this framework. Diversity *strong* formers, "a small but vocal (and often vey well-educated)

group, often call "for the deconstruction of norms related to sex and gender." Such persons reportedly "wish to recast sex as *just as socially constructed* as gender" (emphasis in original). Diversity *weak* formers, by contrast, focus "primarily on identity and community" (p. 50). Those who adhere to the *weak* form of the diversity framework prioritize the needs of the strugglers for support in answering fundamental, existential questions about their "identity ('Who am I?') and (their) community ('Of which community am I a part?')" (p. 51) or, "To—or with—whom do I belong?"

Christians—as well as, arguably, all persons who genuinely are trying to seek the truth and be of good will—are challenged on the one hand to reject the *strong* from of the diversity framework which clearly is committed to undermining (i.e., deconstructing) the Judeo-Christian and philosophical reality, culture and lifestyles of "sex and gender." Others who may object to this framework include those influenced by pre-Christian (e.g., Chabad-Lubavitch Media Center and Jewish Institute for Global Awareness) and a-religious (i.e., philosophical) perspectives (Rice, 1999; Sullivan, n.d.). On the other hand, Christians, et al. are challenged to learn from the *weak* side diversity framework about the need for and the ways of providing "meaning-making structures for identity and community" for persons suffering with gender incongruence and distress (p. 53).

Finally, Yarhouse describes and recommends for Christians a fourth lens for viewing gender dysphoria: the *integrated* framework. He writes: "My concern is that any of one of these three frameworks—to the exclusion of the best the others have to offer—will likely be an inadequate response for the Christian community." He encourages all readers, especially Christians, to "identify the strengths of each framework and apply to how we approach"—and serve—"the person who is navigating this terrain" of gender incongruence and distress (p. 53).

IV. Phenomenology, Prevalence, Causes, Prevention and Treatment of *Gender Dysphoria*

Throughout *Understanding Gender Dysphoria,* Yarhouse repeatedly calls on professionals (academic and clinical); church leaders; theologians and pastors; public officials; those who experience gender confusion and related distress, including *Gender Dysphoria*, and their families, friends and others with whom they may have contact to consider gender dysphoria with *humility*. Specifically, he invites and challenges all to a *humble* (i.e., honest and realistic) acceptance about what *is* – and is *not* – known about gender dysphoria (and *Gender Dysphoria,* case and italicizing intentional). Also, Yarhouse encourages all whose lives are involved with serving those with gender confusion and related distress to consider how best to help them, including seeking, offering and providing medical, mental health and pastoral remedies which are the "least invasive" as possible (e.g., cf. p. 123–124).

In Chapters 3–5, Yarhouse focuses primarily on the Causes, Phenomenology and Prevalence, and the Prevention and Treatment of Gender Dysphoria, respectively. Overall, he does a masterful job of, in his words, *humbly* reviewing what professionals in contemporary mental and medical health arts and sciences know *and do not know* about what causes—or at least influences—the development of gender incongruence and distress, in general, and *Gender Dysphoria*, in particular.

Yarhouse's *humble* answer to the question (and title of Chapter 3): "What Causes Gender Dysphoria?" is simple and direct. "The most concise answer to the question of causation is this: *we do not know*

what causes gender dysphoria. The reality is that while there are several theories for the etiology of gender dysphoria, the cause(s) is still unknown" (p. 61, emphasis in original). Complicating an accurate understanding of causation are three issues.

First, there is a wide continuum of perceptions, feelings, and behaviors which may be involved. These include the experiences of gender incongruence and distress themselves, as well as a range of behaviors, which may include suffering or acting out privately, as well as more public "cross-dressing, gender-bending, male-to-female transgenderism, female-to-male transgenderism, and so on" (p. 65). Second, "[m]ost of the research on causation has focused on the experience of transsexual persons whose cross-gender identification is profound" and who "typically identify as the other gender and may decide at some point to pursue hormonal treatment and/or sex-reassignment surgery" (p. 65). And third, each of these phenomena may have "its own specific cause(s). It may very well be that there are multiple pathways to the same endpoint (*equifinality*)" (p. 65, emphasis in original).

Yarhouse comments on the differences among the many kinds of degrees of gender incongruence, co-related distress, and their expressions, noting that "transgender" has been used as a heterogenous "umbrella" term which offers more ambiguity than clarity (cf. p. 61–66) And, he describes and mentions the limitations of the major theories of causation of "transgenderism." Specifically, these are Brain-Sex Theory, including the *prenatal hormone* and the *neuroanatomic brain differences* hypotheses; Blanchard's Typology, which attempts to categorize "distinct subtypes of transsexuals based on" persons' preferred object of "sexual attraction/orientation" (p. 74); and various Multifactorial Models with an emphasis on Psychosocial Factors.

Along with a "We do not know" humility about the etiology/causation of phenomena variously entitled *gender incongruence*, *gender identity concerns*, and *transgenderism*, Yarhouse wisely discusses the concepts of "*equifinality* and *multifinality*. *Equifinality* says that there could be multiple pathways to the same outcome. . . . *Multifinality* says that a group of people could have the same factors as part of their history but have different outcomes" (p. 79). As he tries to clarify what truths concerning causation may be gleaned from the theories and research which he reviews, Yarhouse comments "that a weighted interactionist model of etiology would consider contributions from both nature and nurture, from both biology and environment without giving too much weight at this point to any one unifying theory." (p. 80).

While not ruling out the possibility of a primarily biologically based causation for some people, he speculates that given the current state of research and the

> . . . wide range of gender variant presentations, . . . [f]or less severe gender identity presentations, perhaps the biological contributions take the form of temperamental and personality differences or sensory reactivity, followed by environmental conditions and social learning, among other factors, including but not limited to parental preferences, indifferences, reinforcement and modeling (Meyer-Bahlburg, 2002, p. 372, referenced in text)" (p. 80).

Relevant to the phenomenology and prevalence, as well as the causation, of gender incongruence, is Yarhouse's observation that "there are so many variations in experience and presentation that knowing one transgender person tells you very little about transgender persons as a

group." Also important, particularly for persons of faith challenged to respond to their own or another's experience of gender incongruence, is answering the question: "What is volitional here?" He offers for reflection his observations that while a "person can choose to engage in cross-gender behavior," his or her "experience of *true gender dysphoria* . . . is not chosen, nor is it a sign of willful disobedience, personal sin, nor the sin of his parents as such" (p. 81).

Overall, Yarhouse's distinguishing between gender incongruence and distress (GInDi), in general, and *Gender Dysphoria* (DP) in particular, highlighting that GInDi occurs on a continuum, and reporting that a DSM-5 diagnosis of GD is a truly rare condition, are significant and noteworthy contributions. Yarhouse's efforts to educate Evangelical Christian pastors and other religious leaders about the implications of the valid knowledge and wisdom of the contemporary mental and medical health arts and sciences for Evangelical Christians also are commendable. Hopefully this scientific knowledge and professional wisdom will be studied and used to guide pastoral practice as appropriate.

V. More Humility Is Needed by Medical and Mental Health Arts and Science Professionals

Yarhouse has done a scholarly and thoughtful job of discussing the subjects of *gender incongruence distress* and Gender Dysphoria from the perspectives of the contemporary Medical and Mental Health Professions and Evangelical Christianity worldviews. While Yarhouse has written "a lot," no book can say "everything," and more deserves to be said.

For example, in spite of prior explanations (Whitehead 2000, 2011) which clearly explain that there is insufficient evidence to assert that gender incongruent and dysphoric—let alone transgender—persons are simply "born that way," research and media commentary to the contrary continue. To illustrate, a recent study (Spizzirri et al., 2018) comparing "treatment-naïve or hormone-treated transgender women" led to public media commentary touting the "born that way" hypothesis (Fernandez, 2018; Jackman, 2018). Other commentary questioning whether people really are transgender and what the research actually and reasonably shows also has appeared (Brown, 2018).

In his efforts to communicate what is generally valid—and perhaps wise to consider in the cases of particular persons—about the *Disability* and *Diversity* frameworks, Yarhouse may have offered more respect than some of the promoters of these frameworks deserve. For example, the worldview and motives of the American Psychiatric Association[2], which was ultimately responsible for composing and publicizing the DSM-5, which included officially retiring the diagnosis of *Gender Identity Disorder* (GID) and replacing it with *Gender Dysphoria* (GD), warrant careful scrutiny.

James Phelan (2014) writes that while advocates of those who publicly promote the practice of gender non-conforming behaviors

> . . . wanted to normalize the condition of gender nonconformity, and felt that mental diagnosis was stigmatizing, they still wanted a formal diagnosis instituted so individuals could have access to [i.e., health insurance and other companies and financial supporters would pay for] cross-sex hormones, gender reassignment

[2] Among non-professionals, the American Psychiatric Association and the American Psychological Association are often confused. Also, each commonly refers to themselves as the "APA." From this point, any use of the initials "APA" will mean the American *Psychiatric* Association.

surgery and social and legal transition (e.g. defense for transgender people who have experienced discrimination based on their gender identity).

Advocates criticized psychiatry for pathologizing transgenderism and so they pressured the APA to change the name. The APA admits that its change was to be sensitive to special interests [sic] groups, rather than as a result of overwhelming empirical and field data to support changing the diagnosis of GID [Gender Identity Disorder]. This pattern was generally the case for many areas of the DSM-5 (Allen, 2010)" (p. 14–15).

It is sobering to realize that at the same time it was changing the diagnosis of GID to GD, in the initial printing of the DSM-5, the APA either changed significantly the criteria for diagnosing disorders of human sexuality or declined to diagnosis them, without having sufficient research or clinical experience as justifications for these decisions.[3]

VI. The Ethics of (Non)Invasive Medical Treatments for Teens and Youths with Gender Dysphoria (GD)

In reviewing in Chapter 5 the "cutting edge" professional wisdom on the Prevention and Treatment of Gender Dysphoria (GD), Yarhouse clearly reminds readers about the "value in encouraging individuals who experience gender identity conflicts to resolve the conflicts in keeping with their birth sex if possible." He also sees "potential value in managing the gender identity conflict or concern through the *least invasive means"* (i.e., avoiding—as increasingly invasive—hormonal treatment, plastic surgery, and amputation surgery). Yarhouse clearly espouses compassion and empathy for those who experience and struggle with gender dysphoria, which he perceives as the beneficial contributions of the Disability Framework. And he understandably promotes a "choose the lesser of two evils" ethic when helping strugglers find ways to best *manage*—when they have exhausted their efforts to *resolve*—their gender identity distress.

Yarhouse's perspective is wisely supplemented by other expressions of professional and social activist concerns, which assertively challenge contemporary medical and mental healthcare responses to gender incongruence, GD, and transgenderism/transsexualism. Various medical and mental health organizations *do* support the mission of those strugglers and would-be overcomers of gender identity confusion, gender incongruence and distress, and Gender Dysphoria, who want to manage and resolve their difficulties from an Integrity perspective.

[3] For 60 years (1952–2012), the APA officially diagnosed *pedophilia* as an unhealthy psycho-sexual deviation. As with the change in the definition and diagnosis of gender incongruence and distress from Gender Identity Disorder to Gender Dysphoria, similar changes occurred with the definitions and diagnoses of the "paraphilias," particularly "pedophilia." In effect, in the DSM-5's initial publication, persons were not considered diagnosable and treatable for having a *pedophilic disorder* unless they were either distressed about desiring, imagining or acting this way, or had gotten in trouble for doing so. Thankfully, in the text revision of the DSM-5, the APA amended the diagnosis for *pedophilia* to the DSM-IV-TR (APA, 2000) criteria (APA, 2013c). *Pedophilic disorder* is again diagnosable if the person engages in a *pedophilic* act, *even* if he or she is *not* distressed about having imagined, wanting to or having done so, or in trouble for having done so. It is unclear whether the professional trustworthiness of the APA is more questionable due to APA's initial formulation of the DSM-5 diagnosis or its relatively hasty response to "revise the text" in response to "public"—not "professional"—outcry. Also, while the APA identified a number of *sexual dysfunctions* in the DSM-5, "hypersexuality" was not one of them, even though the mental health field has been formally treating *sexual compulsion*, including *sexual addiction,* for over 30 years (Carnes, 1992, 2001, 2015). Ironically, there are many diagnoses in the DSM-5 concerning sexual gratification, which cover unsatisfactory attempts to achieve sexual orgasm or non-pleasurable, including painful, experiences while attempting to do so. But there is *no* diagnosis for persons experiencing "clinically significant impairment or distress" due to engaging in too much sexual activity (i.e. *hypersexuality)* (Grant, 2018; Reid & Kafka, 2014).

For example, the American College of Pediatricians (ACPeds)[4] and its members are explicitly committed to science and the natural moral law principle of "first do no harm." ACPeds has persistently confronted the aggressive, pro-transgender agenda currently dominating mainstream medicine. This organization has warned that many current practices and promotion of *gender ideology* are harming children (Cretella, Van Meter & McHugh, 2017). The ACPeds President has confronted the "suppression of debate" about genuinely humane, medical and mental healthcare responses to gender dysphoria in children (Cretella, 2016) and the large-scale abuse of children, which has resulted from the infiltration of "transgender ideology" into pediatrics (Cretella, 2017).

And, in the ACPeds' *Scribit Veritas* blog, the anonymous Dr. Veritas (January 30, 2017) asserts from an unabashedly *integrity*-based perspective:

> Gender does matter! . . . Though the world we live in may try to blur the lines of gender and confuse children and adults on the importance of their own biological gender, we must continue to help our children see the importance of their being male or female. Gender is not something that should be changed; it is something innate in ourselves . . . an essential characteristic of our identity as human beings.

This blogger explains "why gender matters" by quoting the four foundational principles underlying a monograph by the Australian *National Strategic Summit on Marriage, Family & Fatherhood* (n.d.), which outlines and is entitled: *21 Reasons Why Gender Matters***.** These principles include:

1. Gender differences exist; they are a fundamental reality of our biology and impact our psychology. Our maleness and femaleness is a key aspect to our personhood.
2. Acknowledging, rather than ignoring (or worse denying), gender differences is the only intellectually honest response to this reality.
3. Gender differences are complementary; individuals, our collective humanity, and society as a whole, all benefit from masculine and feminine characteristics. We are better for having men with a clear understanding of their masculinity and women with a clear understanding of their femininity.
4. Gender identity confusion does exist in a small minority of individuals. It is a painful pathology and warrants a compassionate response. However it is not the "normative" experience and is not therefore a paradigm upon which to drive social policy and institutions.

ACPeds actively networks with other medical organizations who share common concerns about how the transgender/transsexuality promotion movement has negatively influenced medical and mental healthcare. Some of these organizations are more explicitly proactive about these concerns and have accessible materials on their websites (see the Alliance for Therapeutic Choice and Scientific Integrity and the Christian Medical & Dental Association), while others (Association of American Physicians & Surgeons and Catholic Medical Association) as of this writing, do not (Cretella, 2018). The NARTH

[4] Website contact information for medical and pastoral ministry organizations listed in this and subsequent sections of this book review may be found in the list of *Resources for Persons with Gender Dysphoria, Families and Churches* at the end.

Scientific Advisory Committee (2007) likewise engaged in a critical review of the Kenneth Zucker research on gender identity disorders in children and adolescents, and NARTH's successor organization, the Alliance for Therapeutic Choice and Scientific Integrity, has a number of Integrity framework supportive documents listed on its website.

Particular psychiatrists also have publicly challenged the medical/mental healthcare establishment's promotion of hormonal and surgical responses to the concerns of persons with gender dysphoria. Dr. Paul McHugh (2016) asserts that the drastic physical changes which result from transgender surgery are *not* the solution for persons with gender dysphoria because they do *not* address the psycho-social troubles which underlie this condition. And psychiatry professor Dr. Corradi (2016) has likened the current influence of and preoccupation with "transgenderism" in contemporary medical/mental healthcare as a "mass hysteria." Feminist activists likewise have challenged the practical implications of the "politics of transgenderism" (Jeffreys, 2014; Pela, 2016). Also, Littman (2017) and Marchiano (2016, 2017a, 2017b & 2017c) have called attention and suggested responsible responses to the current "rapid onset (of) Gender Dysphoria" in adolescents and young adults.

VII. The Need for Humility by Christian Pastors, Leaders, and Professionals

It is valuable and important that Yarhouse writes from an integrated Christian professional and scholarly mental health perspective. In *Understanding Gender Dysphoria*, Yarhouse clearly proposes that Christians take seriously the formal prescriptions and proscriptions of medical and mental healthcare researchers and professionals about gender dysphoria (and Gender Dysphoria). But more caution about the need for the book's readers to consider how valid are these pronouncements would also have been welcome.

It should be recognized that at least one theologian, Robert Gagnon (2009), whom Yarhouse cites in his book, has publicly questioned the validity—or at least wisdom—of some of Yarhouse's attempts to accommodate the Evangelical Christian worldview and practices with the professional/scientific. Responding to Yarhouse's summary of his book (2015a) in *Christianity Today* (2015b, 2015c), Gagnon (2015) offers public commentary on and criticism of some of Yarhouse's assumptions and recommendations in *First Things*. After Yarhouse (2015d) responds to Gagnon's comments in the same journal, Gagnon (2016b) responds directly to Yarhouse's. For example, Gagnon (2015) acknowledges that Yarhouse is "well-intended" and clearly wants all members of the church, including himself, "to be loving to persons experiencing this distress." Yet Gagnon asserts that "it is possible to be sensitive, gentle, and loving without forcing the church to act as if the lie is the truth." Gagnon wonders if—as a "Christian *psychologist*" (emphasis added)—Yarhouse may be trying too hard to "accommodate" a person's needs to have the church "be sensitive, gentle, and loving." Gagnon voices concern that this may force "the church to act as if the lie is the truth."

Gagnon also wonders if Yarhouse seems too ready to have "the church abandon the 'culture wars' . . . [and] stop combating society's efforts to persuade vulnerable children in the schools that one's perceived "gender" need not correlate with one's biological sex." Space limitations prevent a thorough discussion of their interchange, but readers are strongly encouraged to read these articles in their entirety. It is worth noting that Gagnon writes elsewhere, during the time of

his interchange with Yarhouse, that "God *isn't* transgender" (2016a) and that "the Bible *does* reject 'transgender behavior'" (2016c, emphases added).

Moving on, Yarhouse notes that persons accustomed to guiding their thoughts and behavior about gender incongruence and distress from the Integrity framework may abandon it when "the voice of science speaks." This is an example of a "Both . . . And." When an area of human concern is studied scientifically and clinically, it is important and proper BOTH that the proper method of scientific and clinical study be used AND that the worldview(s) of the researchers be clearly explained. This way, the meaning of the results of the research and any recommendations may be properly understood and evaluated in terms of their validity and possible limited generalizability or applicability to persons who were not directly studied.

Chamber, Schlenker and Collisson (2012) caution professionals, researchers, and the lay public that to "the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). There does appear to be a contemporary tendency by lay or professional persons who espouse a secular scientific or professional worldview, especially concerning human sexuality, to discredit researchers or professionals who interpret scientific or clinical data from a Christian or other faith-based worldview. This is simply unacceptable, as well as frankly nonprofessional and unscientific (Abbott & Byrd, 2009; Cummings, O'Donohue & Cummings, 2009; Wright & Cummings, 2005). This perspective is important because society as a whole, and too many of its members in particular, seem often to regard the pronouncements of the medical and mental health arts and sciences as a "professional gospel" (i.e., beyond criticism). The secular and atheistic—or at least agnostic—worldview, underlying many of the scientific and professional papers and pronouncements by so many of the leading national and international medical and medical healthcare professions, researchers and professionals, too often goes unnoticed—and therefor un-critiqued. If "the doctor(s) have spoken," nonprofessionals, or professionals with a particular "theistic" worldview, may feel or be intimated from questioning or debating the findings or professional "wisdom" being promoted—let alone the underlying philosophical assumptions and, at least implicit, worldview beliefs.

Abbott and Byrd (2009) remind the healthcare community—and the nonprofessionals who try to hear and heed what the professionals report and prescribe or proscribe as healthy or unhealthy—that the Christianity is also a legitimate "worldview." As long as Christian scholars and healthcare professionals conduct and report their research responsibly and serve their patient and clients ethically, the broader healthcare researcher and practitioner community must respect their views. Non-professionals, particularly Christians, must consider the possibility that pronouncements by clearly secular—if not anti-religious—researchers and professionals may be biased in ways which may undermine the validity and applicability of their views. Of course, the same may be true of faith-based scholars and clinicians as well.

VIII. Supplementary Resources for Persons Experiencing *Gender Dysphoria* and Their Families Who Want to Live within a Christian or Other Integrity-Based Worldview

Many readers of this book, especially those who are guided most by the *integrity* framework and who *do* want to resolve their gender identity conflicts "in keeping with their birth sex"—or help others to do so—may wish to seek additional, more assertively *integrity*-based resources to help them. Such persons may include non-professional evangelical and other Christians, all non-professional seekers of the truth and persons of good will, and professional and pastoral caregivers of whatever faith orientation. Commonly, they want alternatives to current "politically/culturally correct" professional and religious approaches and resources which celebrate transgender/transsexual lifestyles, including the more "invasive" hormonal and surgical interventions which allow persons to appear to resemble their non-biological sex. As worthwhile as are the case studies and examples which Yarhouse provides, other sources provide additional ones which nonprofessional, non-pastoral strugglers, especially those for whom the *integrity* framework is primary, may find helpful. The *Help4Families* ministry and the writings of its founder and director, Denise Shick (2014, 2016, in press), offer many personal glimpses and practical responses to the challenges which *gender incongruence distress* and GD offer to both strugglers and their families.[5] So do the *Walt Heyer Ministries* and the affiliated *Sex Change Regret* website. Heyer has written many articles on the possible pathways and experiences of persons who are considering or hoping to leave behind a transgender identity and lifestyle (Heyer, 2016). Morabito (2014) likewise has written about the reality of "sex-change regret." The *Restored Hope Network* and *Courage/EnCourage Apostolate* websites also are Christian ministries which offer material on their websites in support of persons who want to manage and hopefully resolve their difficulties within an Integrity-based framework.

IX. Concluding Thoughts

Throughout *Understanding Gender Dysphoria*, Yarhouse offers important advice to parents, pastors, medical and mental health professionals, and those who themselves struggle with gender incongruence and distress, the rare diagnosis of *Gender Dysphoria*, and transgender/ transsexuality lifestyle concerns. While respecting what he calls the three frameworks through which concerned persons may perceive the continuum of phenomena dealing with gender dysphoria, he calls for a fourth, *Integrative* framework, which attempts to combine the best of the three. Specifically, Yarhouse invites and challenges the full range of caregivers and the strugglers themselves to respect the latter's needs: to recognize and value the intrinsic, essential, created goodness of their biological-based maleness or femaleness (*Integrity* framework); for empathy and compassion (*Disability*); and for identity/esteem and community/belonging/ fellowship (*Diversity*). Finally, Yarhouse advises all caregivers to listen to and try to understand strugglers, and to help them cope with their distress through the least invasive strategies possible.

[5] Amazon (n.d.) on its author page, quotes Denise Sick, as follows:

> Sometimes people think if they pray or wish hard enough, their transgender tendencies will just disappear. This is an unrealistic expectation. It is not reasonable to expect an overnight change in the area of gender or sexual confusion. The problem takes years to develop. The restoration likewise takes a lengthy healing and restorative process-and some very hard work-which typically involves years of serious commitment.

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Resources for Persons with Gender Dysphoria, Families and Churches

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