


# Resolving Distress Between **FAITH-BASED VALUES & SEXUAL AND GENDER DIVERSITY**

A Guide for Mental Health Professionals





This is a living document. We will continue to revise it based on feedback. For example, we recognize the need to incorporate more fully transgender and intersex experiences.


To contribute feedback, visit:

**[ReconciliationAndGrowth.org](https://ReconciliationAndGrowth.org)**

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As mental health professionals and academics, we believe there is a need for clear rules and guidelines to govern the ethics of any treatment protocol. Current governance of therapies addressing sexual orientation is vague and polarized. Therefore, we seek to define a set of standards and practices that are ethical and fair in order to provide guidance for individual mental health providers, provide a framework of ethical practices to guide professional and licensing boards in regulating the work of mental health providers, and de-escalate the polarized battles around legislation and litigation regarding these matters.

## INTRODUCTION AND PURPOSE

Events locally, nationally, and internationally have heightened the pain and conflict for individuals and families regarding same-sex attractions and/or non-traditional gender, as well as all sexual and gender minorities. The authors are a group of mental health professionals and academics who represent a wide spectrum of faith-based and ideological positions. The following document is the product of hundreds of hours of deliberation over the course of several years starting in March 2013. During that time, the members of our group have met twice monthly to find and clarify common ground and to identify “do no harm” approaches for working with clients who hold faith-based beliefs and who experience emotional distress related to non-traditional gender and/or same-sex attractions.<sup>1</sup>

The diverse composition of our group attests to our ability to engage in collaborative dialogue. For example, several members of our group have been recipients of therapeutic efforts and/

or activities to bring about changes to their sexual orientation. Some believe harm was done to them because of those interventions; others of our group report positive outcomes from their experiences with these interventions. Some members of our group have provided therapy to help individuals experience shifts in sexual orientation; some members of our group have been opponents of such therapy.

All of the people participating in this process operate independently and do not necessarily represent the viewpoints of their various affiliations.

Since our process has been collaborative, the following material also includes input from other contributors holding a variety of viewpoints. We welcome any feedback about how to refine this document.

Your critique and feedback can be submitted at:

[ReconciliationAndGrowth.org](https://www.ReconciliationAndGrowth.org)

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<sup>1</sup> Information about distress regarding paraphilias and attractions to children or adolescents are beyond the scope of this document. Those working or struggling within these areas can determine if and how the following issues and recommendations apply to them.

## THE THERAPISTS AND ACADEMICS LEADING THIS CONVERSATION INCLUDE:



**Lee Beckstead, PhD**  
Private Practice, Aspen Grove  
Counseling; American Psychological  
Association's task force on  
"Appropriate Therapeutic Responses  
to Sexual Orientation"



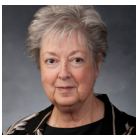
**David Matheson,  
MS, CMHC**  
Private Practice; Co-Founder, People  
Can Change; Co-Developer, Journey  
Into Manhood Experiential Workshop



**Jerry Buie, MSW, LCSW**  
Private Practice, Pride Counseling;  
Faculty, University of Utah School of  
Social Work



**Candice Metzler,  
MSW, CSW**  
PhD Candidate, Social Work,  
University of Utah; U of U College of  
Social Work Bridge Training Clinic;  
Executive Director, Transgender  
Education Advocates of Utah



**Shirley Cox, PhD, LCSW**  
Retired Faculty, Brigham Young  
University School of Social Work;  
Board, Foundation for Attraction  
Research



**David Pruden, MS**  
Executive Director, Alliance for  
Therapeutic Choice and Scientific  
Integrity; Adjunct Faculty, Utah State  
University



**Lisa Tensmeyer Hansen,  
MS, LMFT**  
PhD Candidate, MFT, Brigham Young  
University; Private Practice, Provo  
Center for Couples and Families



**Marybeth Raynes,  
MS, MSW, LCSW, LMFT**  
Private Practice, Crossroads  
Psychotherapy; Co-Editor, *Peculiar  
People: Mormons and Same-Sex  
Orientation*



**Ty Mansfield, PhD, LMFT**  
Private Practice; Co-founder/Board,  
North Star International; Adjunct  
Faculty, Brigham Young University,  
Utah Valley University



**Jim Struve,  
MSW, LCSW**  
Private Practice; Co-Founder/  
Coordinator, LGBTQ- Affirmative  
Psychotherapists Guild of Utah

As mental health professionals and academics, we believe there is a need for clear rules and guidelines to govern the ethics of any treatment protocol. Current governance of therapies addressing sexual orientation and non-traditional gender is vague and polarized.

Therefore, we seek to define a set of standards and practices that are ethical and fair in order to:

1. provide guidance for individual mental-health providers,
2. provide a framework of ethical practices

to guide professional and licensing boards in regulating the work of mental health providers, and

3. de-escalate the polarized battles around legislation and litigation regarding these matters.

We believe that legislation without an ethical practice framework informed by ideologically diverse perspectives increases divisiveness and polarization within our communities. This may have the unintended consequence of forcing unethical providers underground, thereby creating a “prohibition-like” environment, contributing to fewer appropriately trained providers, and leaving consumers at the risk of seeking services from untrained or fraudulent providers.

Therefore, we propose this booklet as a working document of principles and practices based upon our collective understanding of the current research, clinical literature, and our various professional codes of ethics. We are aware that more work is needed to make this document comprehensive and inclusive. For example, we realize that the term “same-sex” leaves out individuals who do not identify with a binary sex, such as individuals who fall within the intersex and transgender spectrums. Also, avoiding harm requires

a broader acknowledgment and inclusion of people and experiences that exist outside narrow constructions of sex, gender, sexuality, religiosity, and spirituality.

## THE DEFINITIONS WE USE ARE THE FOLLOWING:

**Sex:** An assigned biological sex at birth. Assigned sex refers to the medical determination of the body’s assumed sex as male or female at the time of birth.

**Gender:** Cultural meanings constructed around individual behavior, personal identity, and/or social roles. Gender refers to an internal experience (gender identity) and/or an external experience (gender expression).

**Sexuality:** A person’s erotic and romantic feelings, expression, and identity.

**Religiosity:** The adherence to beliefs, practices, and rituals of a religion.

**Spirituality:** The experience of connection with something divine or transcendent.

The continued use of terminologies such as “reparative,” “conversion,”

“sexual orientation change efforts,” and “affirmative” therapies fuels adversarial tensions among people with different perspectives about sexual orientation and gender identity. This obscures the substantial common ground between diverse perspectives. We advocate leaving such language behind in favor of language that focuses on resolving the individual’s distress with their sexual attractions and/or gender identity and fosters their ability to thrive.

peer-led community leaders, other lay helpers, and family members who seek to be supportive. These documents were written with the intention of wide distribution in the hope that they might stimulate further dialogues regarding the nuances and complexities of same-sex attraction and sexual/gender identity development within the context of faith-based values and beliefs.

The authors of this document began to discover our common ground when our diverse group moved beyond these historical labels. This allowed us to create a Peacemaking Dialogue Skills protocol to help therapists assist families and others in resolving their interpersonal conflicts regarding these issues. These peacemaking skills represent the process we have used to discuss our differences and can be found at:

### [ReconciliationAndGrowth.org](https://ReconciliationAndGrowth.org)

While the current document and the Peacemaking Dialogue Skills protocol were prepared to meet the needs of licensed professionals, these principles and practices apply to a broader audience. This audience might include pastoral counselors and paraprofessionals, such as life coaches,

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<sup>2</sup> The third-person plural pronouns “they,” “them,” and “their” in some instances are used in this document as third person singular pronouns to avoid the use of gendered pronouns and include individuals who are gender non-binary.



## PEACEMAKING DIALOGUE SKILLS

### FOUNDATIONAL SKILLS

Approach conflict with the intention of goodwill and compassion. Value what you learn. Embrace optimism and confidence in the possibility of a win-win solution.

### DIALOGUE SKILLS FOR MANAGING CONFLICTS: S-U-D-S

#### **S: SAFETY**

Identify what each person needs to feel safe to discuss the issues. Practice making respectful statements. Identify common-ground hopes, values, and ideas. Set limits on the negative.

#### **U: UNDERSTANDING**


Follow what the other person is saying; keep their perspective in mind. Repeat or rephrase the other person's ideas or feelings that you do not understand. Validate by expressing, "I can see how that would be meaningful to you." Clarify respectfully if you feel that the other person does not understand.

#### **D: DIALOGUE**

Take turns carefully expressing one idea or feeling at a time. Share your perspective while holding the other's viewpoint in mind. State when you agree with another's idea while understanding that your differences may remain. Empathize by expressing, "If I were in your shoes, I would feel the same way." Do not try to fix the differences or argue or debate. The process is more important than conformity.


#### **S: STRATEGIES**

Build ideas together to integrate differences. Search for more options that take both or several viewpoints into account. Restore justice and fairness; hear the hurts; make amends.



The continued use of terminologies such as “reparative,” “conversion,” “sexual orientation change efforts,” and “affirmative” therapies fuels adversarial tensions among people with different perspectives about sexual orientation and gender identity. This obscures the substantial common ground between diverse perspectives. We advocate leaving such language behind in favor of language that focuses on resolving the individual’s distress with their sexual attractions and/or gender identity and fosters their ability to thrive.





We call upon society to move beyond adversarial strategies and focus on fostering respectful dialogue and a shared commitment to facilitate individual self-determination and to do no harm.

## SELF-DETERMINATION AND DO NO HARM

In response to the continuing polarizations regarding same-sex attractions and non-traditional gender, we propose an alternative approach. We call upon families, mental health professionals, lawmakers, professional organizations, religious communities, and individuals to move beyond adversarial strategies and focus instead on collaborative efforts that foster respectful dialogue and a shared commitment to two core mandates of ethical mental health services:

1. facilitate individual self-determination;
2. do no harm.

broad spectrum of sexual and gender identities and expressions. This requires an understanding of and respect for sexual and gender minorities as well as religious, spiritual, and other ideological values of individuals and communities. Ethical care involves working within the client's value system to enhance the client's well-being. Ethical care may also involve exploring with the client any assumptions and values that may be causing unintended distress or harm.

To reduce the risk of therapist-caused

The ethical principle of self-determination requires that each individual be seen as a whole person and be supported in their right to explore, define, articulate, and live out their own identity.

The ethical principle of self-determination requires that each individual be seen as a whole person and be supported in their right to explore, define, articulate, and live out their own identity. For that reason, it is essential to acknowledge the

harm, it is essential to understand several basic principles. First, and most importantly, a person is not mentally ill, developmentally delayed, or addicted simply because they experience same-sex attractions or non-traditional gender. We acknowledge that shifts

A variation of this section was published as an op-ed in the *Salt Lake Tribune* on November 28, 2015, as "Time has come for a new paradigm in gender/sexuality debate."

in sexuality and gender identity can and do occur for some people. We believe it is unethical to focus treatment upon the assumption that a change in sexual attractions or gender identity will or should occur. Second, it is important to accept that a person's desire to bring their life into harmony with closely held religious beliefs may very well be their possible and desired outcome of treatment.

We encourage all interested parties in this debate to move beyond the battle lines of exclusion, legislation, and litigation, and we invite all parties to create bridges for collaborative engagement with those who are perceived as the "other." We believe that this respectful process will offer hope and an effective route to resolve distress associated with same-sex attractions and non-traditional gender.

Our group has also focused on moving beyond the historical impasse found within our communities of prioritizing science over religion or religion over science. This hierarchical and binary thinking shuts down dialogue and collaboration. We assert that a more constructive way of resolving these issues is to consider that both science and religion have relevance.

Both religion and science may contribute significant meaning and guidance to families and individuals

who are distressed about these issues. We encourage those helping this population to intentionally value the contributions of both religion and science. This type of affirming environment may allow for blended and integrated approaches to reduce distress.





Context is crucial when determining if a therapeutic intervention will cause harm when addressing distress related to same-sex attractions, gender identity, and faith issues.



## ASSUMPTIONS AND PRACTICES THAT MAY INCREASE HARM AND/OR CLIENT DISTRESS

Context is important when determining if an intervention will cause harm. Context can involve the setting, provider role, and unique client variables (e.g., personal history, trauma history, client values). An example of concern about the setting is that initiating religious rituals within a religious setting is appropriate but could be harmful when initiated by a licensed mental health provider (LMHP) because the ritual may impose values not shared by the client. An example of concern about provider role is that an ecclesiastical leader may legitimately offer religious guidance that may be inappropriate coming from a mental health professional. An example of concern about client variables is that a touch on the shoulder could be interpreted by an individual as comforting or as a boundary violation. The client's interpretation of the intervention must never be assumed.

There is an inherent power differential between practitioner and client in any perceived clinical setting. In these kinds of helping relationships, the practitioner has a responsibility to maintain professional standards that protect the client from any abuse of therapeutic power.

Historically, different levels of physical

contact have been utilized in a variety of clinical settings. However, the use of physical contact has been controversial in addressing distress related to same-sex attractions, gender identity, and faith issues. Therefore, it is essential for the LMHP to be aware of transference and countertransference issues regarding touch, holding between practitioner and client, and nudity in session. Within a clinical or community setting, an individual may experience the impact of any physical intervention in a manner that is vastly different from the intention of the provider who was delivering that intervention. Such dynamics have a very high risk of being exploitative and are contrary to accepted practices of professional therapists. These behaviors bypass any consideration about abuses of power, may overlook trauma dynamics within an individual's history, and confuse the boundaries between practitioner and client or between community leader and member.

Some interventions are inappropriate regardless of context because of the inherent impact on the client. For example, harm has been reported when highly religious, sexual and gender minority clients are (a) pressured to identify one way or another and thus

reject and/or suppress core aspects of self, (b) misinformed about realistic outcomes regarding their sexuality, gender, and social and religious impacts, (c) misled with unsubstantiated theories and treatments, (d) blamed for not being able to change their sexual orientation and thus internalize treatment failure, (e) reinforced in a belief that either identifying as religious or as lesbian, gay, bisexual, or transgender (LGBT) must be avoided, and (f) restricted from education or exploration regarding a wide range of options. Such practices have been described as resulting in increased anxiety, depression, anger, addictions, and suicidality.

We propose that any mental health intervention that includes the following is inherently unethical and potentially harmful when addressing sexuality, gender, and faith:

### 1. **Fostering expectations of a specific sexual orientation or gender identity outcome:**

Clients present with their own unique hopes and therapeutic goals. Believing and expecting that there is only one acceptable outcome has the potential for harm. LMHPs must work without any assumption of what the final outcome will or should be for the individual.

### 2. **Using direct or indirect coercion:**

Interventions that use aggression, deprivation, exclusion, fear, inappropriate guilt, isolation, punishment, shame, or any aversive techniques lack scientific evidence for long-term effectiveness and have the

potential to cause significant harm.

### 3. **Basing interventions on bias, unfounded theories, or prejudice:**

Examples include:

- Assuming a person is mentally ill, developmentally delayed, or addicted simply because they experience same-sex attractions or a non-traditional gender.
- Imposing a sexual identity on a client based on the client's attractions or experience (assuming a heterosexually married person with strong same-sex attractions must be bisexual, for example).
- Imposing a gender identity on a client that is based on the client's assigned sex at birth (for example, assuming a person assigned a male sex at birth must identify with a male gender identity). An individual's assigned sex at birth does not necessarily imply a "correct" or "natural" corresponding gender identity.
- Assuming that addressing a client's history of sexual trauma, gender issues, or dysfunctional family dynamics will necessarily result in a change in sexual orientation. A client's distress may decrease and shifts may occur in their sexuality or gender identity when a variety of environmental factors are attended to in therapy, but that does not inevitably imply such issues have caused their sexual orientation or gender.
- Assuming that all same-sex attracted individuals are in fact heterosexuals who have sexualized their emotional needs.
- Assuming that all people who identify with a gender identity other than their assigned sex at birth are really just people who are "confused" or only "fantasize" they are a particular gender.

We propose that any mental health intervention that includes the following is inherently unethical and potentially harmful when addressing sexuality, gender, and faith:

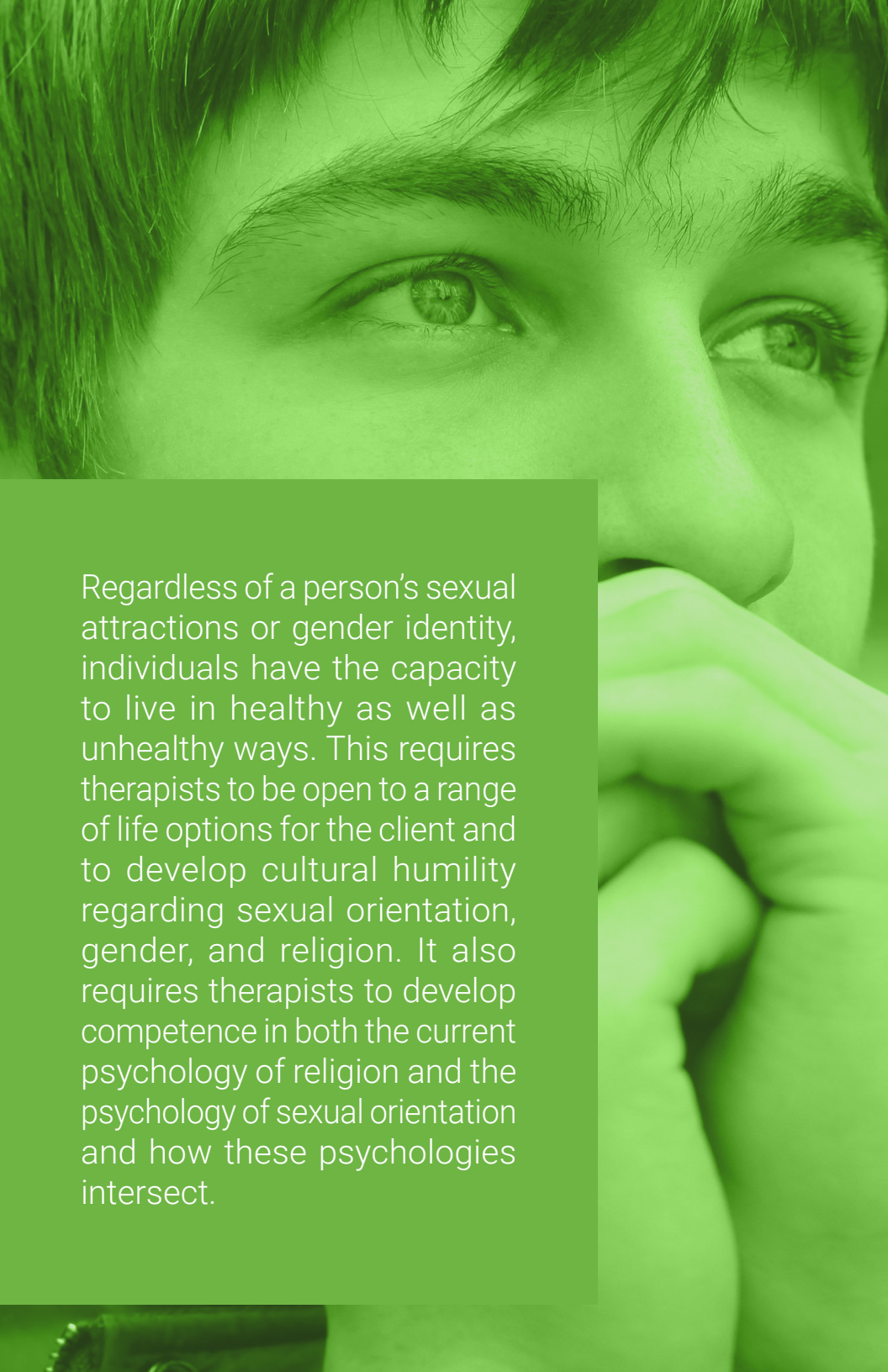
1. Fostering expectations of a specific sexual orientation or gender identity outcome.
2. Using direct or indirect coercion.
3. Basing interventions on bias, unfounded theories, or prejudice.
4. Limiting the exploration of sexual orientation, gender, and faith identity and expression possibilities.

- Assuming that same-sex attractions and relationships cannot be healthy.
- Assuming that a person who identifies with a gender other than their assigned sex at birth cannot thrive or be healthy.

**4. Limiting the exploration of sexual orientation, gender, and faith identity and expression possibilities:**

- Pressuring the client directly or indirectly to live only one option has the potential for a variety of harms.
- Clients should feel safe to explore the many relationship options available to them (e.g., other-sex relationship/marriage, same-sex relationship/marriage, celibacy, a single life, etc.)

- Intentionally misgendering the client or insisting the client adhere to gender roles and behaviors associated with their assigned sex at birth may potentially inflict a variety of harms on the client.
- Faith identity and development is unique to each person. Assuming that all should or will believe a certain way may damage the capacity for authentic faith expression in that person.
- Clients should feel safe to explore their sexuality, gender, and faith and not be restricted from pursuing their own healthy identity development.



Regardless of a person's sexual attractions or gender identity, individuals have the capacity to live in healthy as well as unhealthy ways. This requires therapists to be open to a range of life options for the client and to develop cultural humility regarding sexual orientation, gender, and religion. It also requires therapists to develop competence in both the current psychology of religion and the psychology of sexual orientation and how these psychologies intersect.

## THERAPEUTIC PRACTICES THAT SUPPORT CLIENT SELF-DETERMINATION

Regardless of a person's sexual attractions or gender identity, individuals have the capacity to live in healthy as well as unhealthy ways.

This document recommends therapy options in order to:

1. increase overall mental health and functioning,
2. decrease client distress, and
3. invite the client to examine and modify unhealthy expressions of sexuality, gender, and/or faith.

These goals require therapists to be open to a range of life options for the client and to develop cultural humility regarding sexual orientation, gender, and religion. This also requires therapists to develop competence in both the current psychology of religion and the psychology of sexual orientation and how these psychologies intersect. They should also become aware of current ethical therapy practices. A therapist should consult their supervisor, seek peer supervision, and make appropriate referrals when indicated. With appropriate training and management of biases, mental health providers can be more effective in facilitating the following interventions. As a result of our ongoing dialogue, we encourage mental health providers to practice within the following treatment

guidelines:

1. Recognize distinctions between biological sex and gender identity.
  - a. Consider biological (chromosomal, physiological, anatomical) sex and how it relates to sex assigned at birth, gender identity, and social roles. Discrepancies can occur between biological sex and sex assigned at birth (e.g., a child may develop anatomically as female and thus be assigned as “female” at birth but be chromosomally male [XY]).
  - b. Be aware that binary definitions of sex and gender can be problematic for individuals whose personal experience of sex and gender is non-binary (e.g., a biological female may experience masculine and feminine social traits at different times in her life, or an individual may be sexually or romantically attracted to another person irrespective of that person's sex characteristics or gender).
  - c. Explore how the person's experience of biological sex influences gender identity (e.g., how a person perceives their body may influence how they define their gender and sexuality).
  - d. Assess potential incongruence between body image and perceived cultural norms (e.g., gender

inferiority, body shame, and gender identity).

2. Assess the role of spirituality and religion in the client's life.

- a. Understand and respect the importance of religion and spirituality in the lives of clients, to provide/offer meaning, tradition, culture, identity, community, health, satisfaction, and diversity.
- b. Recognize how a therapist's attitudes and level of knowledge about spirituality and religiosity influence assessment and treatment, and avoid any potential to favor religious over mental health treatment goals or vice-versa.
- c. Manage religious biases through a conscious awareness of the dynamics of power and transference. Understand how these dynamics may blur boundaries between clients and their religious leaders as well as between clients and their selected mental health professionals.
- d. Avoid possible imposition of religious or anti-religious beliefs or values on the client and the potentially harmful, unethical, and unprofessional practice of debating religious doctrines and beliefs with clients.
- e. Seek to understand the client's religious and spiritual:
  - relationship with God or divinity,
  - identity development,
  - goals and motivations,

- experiences of conflict,
- strengths and strategies for managing distress, and
- perceptions of doctrine, policies, teachings, and messages related to sex, sexuality, and gender.

3. Assess the role of sexuality and the impact of sexual attractions on the client's life. Acknowledge that clients may present with varieties of sexuality (e.g., exclusive attractions, mostly other-sex attracted, mostly same-sex attracted, equally attracted to men and women, person-centered sexuality, asexual orientation, etc.).
4. Understand and respect the importance of sexuality in the lives of clients as a domain of meaning-making, tradition, culture, identity, community, health, satisfaction, and diversity.
5. Recognize how therapists' and researchers' attitudes and level of knowledge about attractions and sexual identity formation influence assessment and treatment.
6. Understand that while clients may experience same-sex attractions (SSA) as a problem, SSA does not constitute a "mental disorder." A person is not mentally ill, developmentally delayed, or addicted simply because they experience same-sex attractions.
7. Understand that many individuals who present for therapy with conflicts around their sexuality may experience accompanying mental and emotional disorders. It is important

- to differentiate the potential mental-health concerns from the person's sexual orientation.
- a. Recognize that some people who have experienced sexual trauma may reenact unresolved aspects of their trauma abuse through sexual and/or abusive behaviors.
  - b. Differentiate with clients which feelings and behaviors are due to posttraumatic stress.
8. Conduct a review of the client's sexual and interpersonal history. Help clients consider the impact of these experiences on their sexuality, while being cautious about making causal inferences.
  9. Understand that the experience of sexual attraction and gender is a complex reality for many people without imposing any etiological explanation. Consider asking each client what their understanding is for why they experience same-sex attractions and/or a non-traditional gender. This understanding may create a respectful dialogue about the variety of etiological explanations for attractions and gender, while highlighting the unique development for the client and what type of distress the client is experiencing.
  10. Differentiate between the person's sexual attractions and aversions (if any), orientation, behavior, and identity.
  11. Understand that people do not choose their sexual attraction.
  12. Assess the impact of stigma, prejudice, bias, and minority stress.
    - a. Explore the effects of stigma and minority stress, including the influence of social, familial, religious, political, and cultural beliefs. Be especially aware of how social privilege and oppression impact an individual's self-concept, distress, coping skills, and opportunities.
    - b. Explore how they perceive and manage distress due to being a minority.
    - c. Recognize how stigma and cultural expectations influence a client's therapeutic goals.
  13. Explore with clients their level of openness with others. Assess the effects of nondisclosure, concealment motivation, and concealment behaviors (e.g., lying about being same-sex attracted; avoiding contact with same-sex attracted, lesbian, gay, bisexual, and transgender individuals; and being vigilant to conceal stigmatized status) on the client's self-concept, acceptance concerns, mood, and life satisfaction.
  14. Assess and respond to the following issues as needed: shame, perfectionism, anxiety, depression, pornography use, addictions, relationship issues (e.g., with peers, family, religious leaders), sensitivity to rejection, obsessions, rumination, passivity, codependence, grief, and past trauma.
  15. Recognize that a client with obsessive-compulsive disorder may ruminate on

fears of being gay that have no basis in actual same-sex attractions. Also, a client who is questioning gender identity may initially present with concerns about sexual orientation. Or others who are heterosexual, particularly adolescents, may confuse feelings of same-sex curiosity or affection with homosexuality.

- a. Assess what it is about same-sex attractions, gender, and/or faith that concerns the client. What is their understanding of what would be helpful to them?

## SUGGESTED TREATMENT INTERVENTIONS

To counter and prevent harm and increase the likelihood of benefit, the following therapeutic treatment approaches are suggested. They are not intended as a treatment-plan template, and mental health providers must use discretion regarding when, how, and with whom they employ any specific technique. We also recognize that many other appropriate therapeutic interventions may exist.

1. Utilize professionally accepted psychotherapeutic interventions.
2. Provide information on potential therapeutic outcomes and risks that is both accurate and sufficient for informed consent. Be aware that expectations and outcomes may need to be reassessed during the course of therapy.
3. Utilize treatment approaches that are inclusive, respectful, and compassionate to a wide spectrum of clients' personal experiences.
4. Strive to understand the unique problems and risks that exist for youth who experience distress associated with their sexuality and/or gender.
5. Discuss how sociocultural factors (e.g., race, economic status, geographic status, privilege, minority stress) impact this client's experience. Assist clients to develop competence in dealing with minority stress.
6. Recognize that client sexual and gender self-identity and self-labeling is diverse, may be fluid, and may include not labeling oneself. Know the label and language each client prefers you to use in discussing their experiences as well as how they define that usage.
  - Sexual self-identities could include same-sex attracted, straight or heterosexual, nonheterosexual, lesbian, gay, bisexual, queer, pansexual, asexual, etc.
  - Gender self-identities could include transgender, gender non-conforming, genderqueer, bigender, androgynous, etc.
  - Similarly, recognize that client values, behaviors, and relational choices may vary within all of these self-identities.
  - Consider asking each client which sexual/gender identity labels they previously used that they no longer use, how they feel about other identity labels, and what feels congruent and possibly incongruent about their current identity label.
7. Be conscious of and in harmony with clients' wishes and desires around



- exploration. Ask clients the level of exploration they are willing to consider (e.g., being curious; examining issues from diverse viewpoints; reducing prejudice; developing awareness, acceptance, and understanding) regarding each concern in their life.
8. Be cautious about encouraging clients to engage in behaviors that may be contrary to their values or emotional development.
  9. Help determine realistic ways to integrate the multiple and intersecting areas of their life to increase health and well-being.
  10. Examine possible emotional consequences, benefits, losses, and long-term outcomes of decisions they are considering.
  11. Explore means of resolution of client distress with their gender, gender roles, and/or gender expressions.
  12. Address issues of shame, guilt, anxiety, depression, and/or addiction due to potential incongruence between body image and self-esteem, and perceived cultural norms (e.g., gender inferiority, body shame, and gender identity).
  13. Explore with clients their level of openness with others about sexual and gender identity.
  14. As appropriate, encourage healthy self-disclosure to safe individuals at first and eventually to all others who may need to know the depth and extent of past or current feelings of SSA and gender identity. Therapists may assist clients in exploring the pros and cons of these various levels of disclosure as well as help clients develop skills to deal with potentially negative responses both before and after they may occur.
  15. Help clients understand that opening up to others need not necessarily be a universal “coming out” process in order to obtain needed support. Thoughtful disclosure may help prevent clients from getting locked into labels and identities before they are clear about what fits best for them.
  16. Make reasonable efforts to familiarize yourself with relevant, reliable, and trustworthy professional, online, and community resources that can support clients in their self-determined goals.
  17. Encourage clients to identify and access increased social support that is congruent with their values, goals, and self-concept. Exploring diverse community groups may help clients determine for themselves which match their needs, as they examine their feelings regarding such groups.
  18. Explore with clients their spirituality and religiosity.
    - a. As appropriate, consider fostering the use of positive religious/spiritual practices (such as experiencing “sacred moments”) and coping skills that have had value and meaning for the client.
    - b. Consider with clients the value of seeking spiritual confirmation for their life path.
    - c. Explore the degree to which the client desires to live in harmony with the doctrinal teachings and policies of their religion regarding sex, sexuality, and gender.
  19. Explore the extent, timing, benefits and risks of potential disclosure to spiritual or religious community and leaders.
  20. Explore with clients their experience of sexuality.
    - a. Invite clients to examine thoughtfully their sexual attractions and values as opposed to dismissing or compartmentalizing them.

- b. Explore with clients their motivation for abstaining from or engaging in sexual relationships, and assist them to differentiate between internal and external sources of those motivations. Assist the client to assess which options will be most healthy and sustainable for them.
21. Help clients understand that fearfully turning away from or suppressing sexual attractions can increase distress and disconnection.
  22. Assist clients to reduce shame and fear associated with their sexual attractions. The person might then experience more support, calmness, feelings of empowerment, and increased capacity to make informed decisions about their sexuality and social circumstances.
  23. Assist the client to explore their various attachment needs and the intensity of their desires, emotions, attractions, aversions, sex drive, and behaviors in considering sexuality, sexual identity, and life options.
  24. Help clients identify and prioritize their short- and long-term needs for emotional intimacy, deep connection, and bonding with same-sex and opposite/other-sex individuals.
  25. Help clients acknowledge and process grief and loss that arise from decisions regarding conflicting values.
  26. Assist the client to examine their various attachment needs and the intensity of their desires, emotions, attractions, aversions, sex drive, and behaviors in considering sexuality, sexual identity, and life options.
  27. Recognize that resolving sexual attraction distress will not resolve all relationship issues. Additionally, recognize that any type of intimate relationship is not a panacea for resolving life difficulties.
  28. Additionally, consider whether there is a role or need for sexual and romantic intimacy.
    - a. Consider how they plan to respond to any needs for romance, sexual expression, companionship, and family.
    - b. Assist them to consider the possibilities for intimacy and emotional connection in a variety of relationships, while also positively adapting to potential losses and opportunities that may be associated with celibacy.

## SUGGESTED RELATIONSHIP-ORIENTED TREATMENT INTERVENTIONS

When assisting clients who are in, or are seeking, a heterosexual relationship, it is important to consider the following guidelines:

1. Understand that faith-based individuals who experience or have experienced same-sex attractions may pursue a heterosexual relationship for a number of reasons. Examples of some of those may be that the person has:
  - a. external expectations that may be based on religion or culture;
  - b. internal values, such as deeply held spiritual beliefs, desire for companionship, parenthood, or community inclusion;
  - c. a belief that a committed heterosexual partnership will foster shifts in sexuality or sexual orientation;

- d. fallen in love with a person of the other sex;
  - e. experienced shifts in their sexuality and are interested in a heterosexual relationship.
2. Assess the client's level of aversion (if any) to emotional, romantic, physical, and sexual intimacy with someone of the other sex.
  3. Differentiate erotic aversion from anxiety about emotional closeness.
  4. Assess how clients can most positively experience their sexuality (e.g., orientation, arousal, identity) within the other-sex relationship and throughout the lifespan.
  5. Counsel with them regarding the importance and timing of full disclosure of vital aspects of their lives, personalities, and levels of attractions and aversion (if any) to a prospective other-sex partner.
  6. If a client experiences intense same-sex longings, examine with them the difficulties this can likely create in the other-sex relationship. Explore with clients when and how to be transparent about these factors with a current or prospective partner. Address any fears in doing so.
  7. Focus on developing relationship skills to increase intimacy, satisfaction, and sustainable relationships.

To assist clients who are in, or are seeking, a same-sex relationship, it is important to consider the following guidelines:

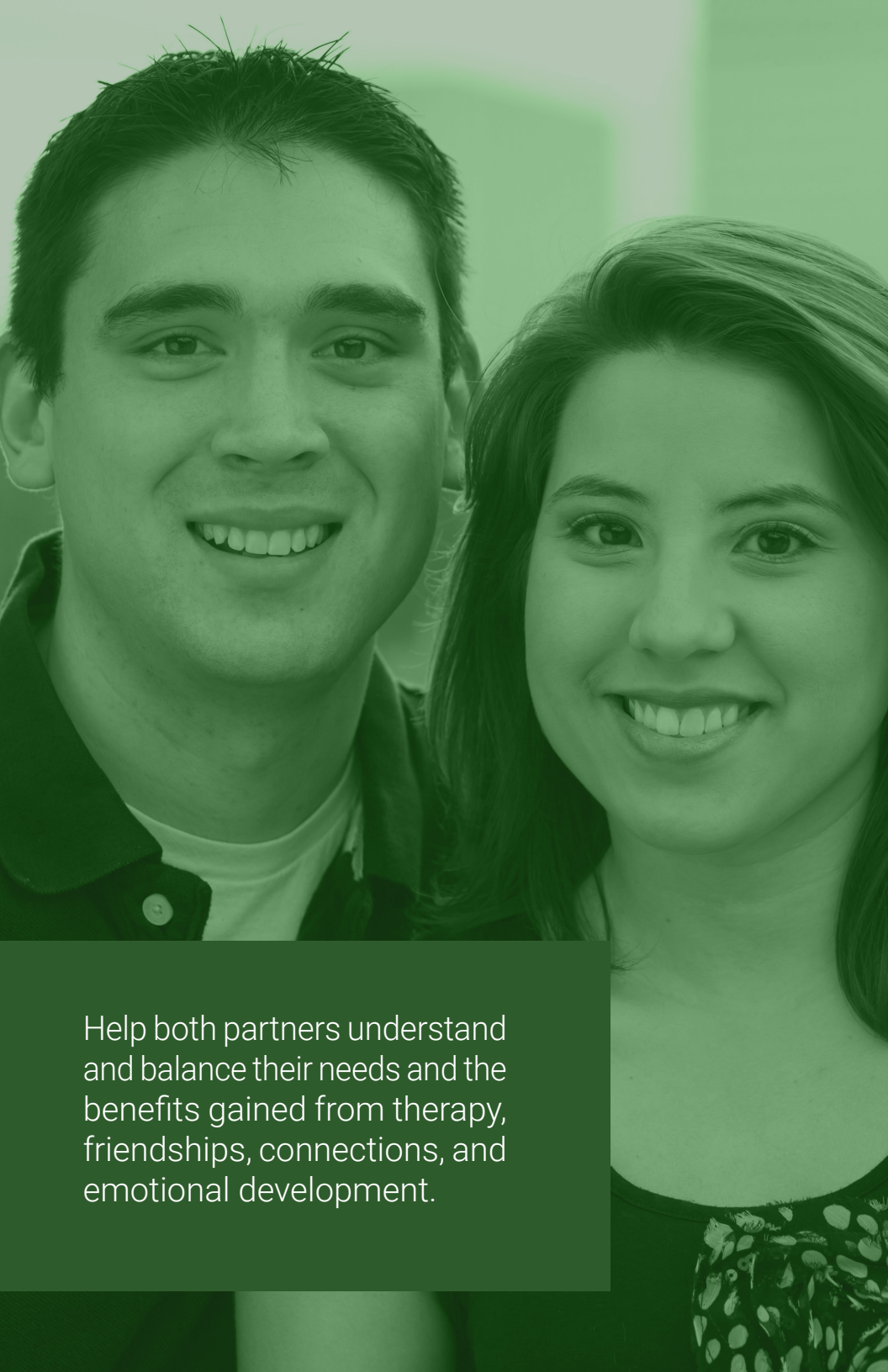
1. Explore the benefits and potential

losses associated with their decision. These could include effects on their participation and membership in faith-based institutions as well as their family and social connections, over which they may have no control.

2. Examine which aspects of their religious/spiritual identity and experiences (e.g., values, beliefs, ethics, rituals) they want to retain or need to replace in developing their same-sex relationship.
3. Focus on developing relationship skills to increase intimacy, satisfaction, and sustainable relationships.

To assist clients who choose celibacy, consider the following guidelines:

1. Help them define and determine their level of desired celibacy, considering their boundaries regarding sexual desires and behaviors with self or others.
2. In light of their choice of celibacy, explore how they plan to respond to any needs for romance, sexual expression, companionship, and family.
3. Assist them to explore the possibilities for intimacy and emotional connection in a variety of relationships, while also positively adapting to potential losses and opportunities that may be associated with celibacy.
4. Explore how to develop a positive solitude as they also meet their relationship needs through reciprocal social support. Help them to find enjoyable activities that are important to them and are emotionally fulfilling.



Help both partners understand and balance their needs and the benefits gained from therapy, friendships, connections, and emotional development.

## CONSIDERATIONS FOR PARTNERS


Whether married, engaged, dating, or otherwise committed, partners of those with some degree of distress with same-sex attraction may need guidance and support. Consider the following suggestions:

1. Help both partners explore their individual commitment to their relationship, including how varying levels of commitment may affect each other and the relationship.
2. Highlight the fact that SSA issues and stigma must be addressed in order for a sustainable, meaningful relationship to be built.
3. Encourage both partners to not accept responsibility for each other's attractions or behaviors. Partners run a risk of personalizing the other's attractions, wants, and needs and may feel inadequate about what they cannot change. Explore what type of behavioral changes are reasonable to request.
4. Highlight the important role of both partners in supporting mutually desired change in their relationship.
5. Help both partners become educated about and understand SSA and stigma. For example, many of the points in this document may be helpful.
6. Help partners understand that punishing, threatening, bribing, or preaching to their partners will not motivate their partner nor increase intimacy, and that this is not healthy for either partner. Help them understand the limited nature of their ability to affect their partner's sexuality.
7. Advise partners of the potential value of their own individual counseling to help them effectively adjust to their current situation and to the changes that may develop as their partner undergoes their own therapy.
8. Encourage partners to talk with someone they trust to get needed support. Spiritual or faith leaders, family members, friends, or professionals may be consulted.
9. Help the couple understand their interactional patterns, both strengths and problems—only some of which may be linked to dealing with same-sex attractions.
10. Examine with both partners if any beliefs or internalized stigma about SSA, bisexuality, gender, and/or faith may be affecting their distress and/or limiting their ability to develop a close relationship.
11. Explore and develop areas of shared beliefs and values to help bridge conflicts between sexuality and faith.
12. When a partner experiences betrayal (e.g., a breach in relationship fidelity or change in religious beliefs), help partners process conflicted feelings about and toward the other to help them understand their partner's feelings, motivations, behaviors, and

needs.

13. Help partners understand that forgiveness does not mean forgetting, condoning, or absolving their partner of responsibility for unacceptable behavior and that it is a complex process toward resolution.
14. Help partners explore how they can care for themselves emotionally, physically, socially, and spiritually, and help them implement plans to do so.
15. Help both partners understand and balance their needs and the benefits gained from therapy, friendships, connections, and emotional development.





Understand that unconditional love, forgiveness, respect, empathy, autonomy, dialogue, and support from parents and family are effective ways to resolve family distress.



## CONSIDERATIONS FOR PARENTS AND FAMILIES

Parents and families of SSA/LGBT individuals may need guidance and support under the direction of a licensed mental health professional. Consider the following suggestions:

1. Normalize family members' reactions and needs (e.g., sense of loss, desire for information, coming to terms with difference between hopes and reality and doctrine and practice).
2. Understand that unconditional love, forgiveness, respect, empathy, autonomy, dialogue, and support from parents and family are effective ways to resolve family distress.
3. Reinforce the vital role that the family plays in providing protection, safety, positive socialization, self-esteem, and connection for all its members.
4. Help the family understand that they will go through a process of adjustment. Family members may need to address stigma, stereotypes, disclosures, various types of loss, emotional processing, and resolution.
5. Counsel parents and family to remember that SSA is just one part of the individual's experience. This one aspect of experience need not dominate the relationship or the conversations with the individual.
6. Advise parents and family members to seek mutually enjoyable activities, common feelings, and shared values, while also seeking to understand the individual's experience with same-sex attraction. Ask simple questions and strive to listen without judgment, checking in to ensure clear understanding.
7. When misunderstandings occur, maintain compassionate engagement, negotiate how to resolve those misunderstandings, and then try again. Families may need support and training in how to communicate and sustain positive emotional connections, even during interactions that involve conflict. One conversation will not solve everything. Leave the door open for ongoing dialogue.
8. Encourage parents and families not to preach, threaten, shame, blame, or alienate. They could instead strive to understand and show their love for the family member. Help families accept that they have no power to alter the individual's sexuality and very limited power to shape their identity and life goals. On the other hand, they have great ability to influence positive outcomes, such as the individual feeling loved, accepted, and safe within the family.
9. Encourage parents to seek help and support as needed from their support network (for example, family members, friends, faith community and faith leaders).
10. Examine with family members how their negative reactions to their child's

SSA/LGBT identity may negatively influence their child's physical and mental health. In contrast, explore how openly talking with their child about their SSA/LGBT identity may increase their child's wellbeing.

11. Examine if any beliefs or internalized stigma about SSA, bisexuality, gender, and/or faith may be affecting family members' distress and/or limiting their ability to develop a close relationship with each other.
12. Explore and develop areas of shared beliefs and values to help bridge conflicts between sexuality and faith.
13. If the family member is involved in a same-sex relationship, explore how parents and families react to situations that arise. Assist them to make plans for how they will deal with predictable events, such as whether or not to include the partner in family marriages, religious events, reunions, holidays, and other family activities.
14. Reassure parents and family members that they do not need to alter family practices or compromise spiritual or religious values to accommodate behaviors that conflict with their religious beliefs. However, explore with them how to maintain their identity while offering the SSA/LGBT family member respect and individuality. Similarly, encourage parents and family members to find a balance between boundary setting and a commitment to inclusion, love, and connection.



The principles and practices outlined in this booklet are primarily relevant to mental health professionals but may apply to a broader audience. For those seeking therapy, consider interviewing counselors and therapists to see if their approach is consistent with these guidelines.

This document recommends therapy options in order to:

1. increase overall mental health and functioning,
2. decrease client distress, and
3. invite the client to examine and modify unhealthy expressions of sexuality, gender, and/or faith.

The authors are a group of licensed professionals and academics who represent a wide spectrum of faith-based and ideological positions. This document is intended to provide guidance in conducting ethical interventions and reducing the potential for harm. We recommend that these interventions be conducted under the care of a licensed mental health professional trained in these principles.



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