Introducing the Reconciliation and Growth Project Document:

Clinical Common Ground

for Gender, Sexual, and Faith Diversity

Some clinicians make the mistake of believing that a client should change their sexual orientation and/or gender identity. Other clinicians make the mistake of believing that therapy cannot impact or influence a client's sexual orientation or gender identity.

People have different definitions of sexual orientation. We define it as a persistent pattern of sexual attraction and aversion. This may or may not be consistent with a person's preferred or experienced sexual and romantic expression and identity. People also have different definitions of gender identity. We define it as the way a person interprets and labels their gendered experience and expression in relation to the social environment.

We understand clients may not have had sufficient opportunity to explore their orientation and/or identity before meeting with a clinician.

Although we believe clinicians should not directly attempt to change a person's sexual orientation and/or gender expression, we believe that clinicians should not outrightly refuse or dismiss a client's request for change. We encourage therapists to respect diverse pathways and help clients discover authentic ways of integrating their identity and experiences.

We hope the following gives clinicians ample interventions to help clients explore and expand their experience of and options for their sexuality and gender expression.

We consider this a living document that will evolve and grow over time with feedback and more research and clinical developments.

Clinical Common Ground
for Gender, Sexual, and Faith Diversity

A Reconciliation and Growth Project Statement

When treating clients dealing with sexuality, gender identity, and life purpose/faith/meaning concerns, we recommend the following to promote human flourishing and avoid harm: encourage self-determination, address trauma and minority stress, strengthen individual and interpersonal resilience, and foster healthy human connection.

Encouraging self-determination means that clinicians:

- See the client as multifaceted with the right to explore, define, and live a personal life path without imposing one's worldviews, values, and goals.

  For example: telling clients to leave or stay in their relationship, religion, etc. could harm the client.

- Respect and explore the client's understanding of personal biological, psychological, and social experiences, including how the client navigates identity in such experiences.

  For example: pressuring a client to identify in a particular way or to transition (or not transition) socially or medically could harm the client.

- If a client is seeking letters of support for medical treatment from the clinician, and the clinician is unable to provide them, respectfully disclose this so the client can make a fully informed decision about whether to pursue treatment elsewhere.

  For example: expressing, "Here are my limits. I can support you in [x] and [y] ways. Do you still want to engage in treatment with me, or do you prefer I refer you to someone who may be better aligned with your goals?" In cases where a client chooses to transfer, assist the client in finding suitable alternatives.

- Use language that is respectful to the client. Use a client's pronouns OR if choosing not to use a client's pronouns, do not contest or disparage what the client shares with you about their identity or use of those pronouns.

  For example: the therapist may use the client's requested pronouns, and/or gender-neutral pronouns (e.g. they/them, if acceptable to the client) and/or refer to the client by the chosen name.

- Respect the client's existential, spiritual, religious, and sociopolitical beliefs, experiences, and consequent decisions to participate in institutions that may or may not reflect all the client's values, needs, and goals.

  For example: asking, "What kinds of support and/or growth do you experience in [x] environment\group that is meaningful to you?"

For clients who present with a goal to change their sexual orientation or explore their potential to expand, reduce, or eliminate sexual attractions and behaviors, we recommend the following:

- Assess the client's history, motivations, and desired outcomes, including possible medical assessment to rule out physiological contributors.

- Explore the client's understanding of what "sexual orientation" means to them and their history and emotional distress, if any, around their attractions, behaviors, and identity. Explore with the client any desire they might have to change or expand their sexual expression. Avoid discouraging, dismissing, shaming, and shutting them down in this process, including refusing to help the client.

  For example: avoid saying, "You can't change your sexual orientation; it's been proven to be impossible, so I can't help you with your goals and you just need to learn to be happy with who you are." Instead, say, "While I may not be able to help you change your sexual orientation, I may be able to help you explore and understand your sexual orientation and what relationship options are accessible to you."

- Assess and differentiate between a client's sex drive, sexual orientation, moral aversion, and "out of control" sexual behavior.

- Assess and explore any erotic aversion and differentiate between physiological sexual limit/dislike/disgust, sexual trauma, sexual phobia, pain during intercourse, homonegativity, bi-negativity, transphobia, gender dysphoria, attachment insecurity, lack of sex hormones, sexual indifference, low sex drive, and an asexual orientation.

- Do not introduce or encourage sexual orientation change efforts to a client or discourage or negatively label a client's prior or current personal change efforts.

- Evaluate with the client the safety, potential risks, and sustainability of the client's patterns of behavior, including coping behaviors and change efforts, in relation to self, others, and the client's development, health, and sexuality.

- Explore potential internal and external motivations to change, beliefs driving behaviors and motivations, and ways motivations might be based on internalized narratives and stigma versus personal values, needs, and priorities.

- Hold neutral space so that the client feels free to discover and pursue paths that align with their values, needs, and circumstances.

- Avoid challenging a client's beliefs about their identity or their spiritual path.

- Allow for unfolding potential and spontaneous shifts in sexuality that may occur without the clinician's direction.

- Assess the roles of anxiety and shame in the client's behavior reduction/change goals. Consider with the client how anxiety/shame affects their experiences with these goals and may diminish well-being, perpetuate stigma, and reinforce rather than reduce behavior. Use interventions that reduce anxiety and shame.

- Encourage the client to be expansive rather than avoidant by broadening the client's focus beyond goals of behavior reduction/elimination. Life-affirming goals relevant to sexuality and domains outside of sexuality may include mindfulness, self-acceptance, self-compassion, connection, and resilience.
- Review periodically with the client the impact of the above interventions on their distress, sexuality, and behaviors.

For clients who experience gender distress and are interested in non-medical interventions, we recommend the following:

- Do not encourage or discourage a person from identifying as male, female, or transgender/nonbinary.
- Do not discourage or challenge any particular gendered behavior, expression, or exploration.
- Assess for and distinguish between gender shame/trauma, sexism, transphobia, gender-role dysphoria, gender-body dysphoria, body dysmorphia, depersonalization, derealization and social dysphoria.
- Focus on reducing the effects of gender-minority distress on the client's well-being.
- Promote the client's gender identity development by:
  (a) providing safety for the client to explore personal congruence regarding their gender, gender-body, gender role, and expression;
  (b) providing interventions to address sources of distress, including societal neglect and lack of social safety;
  (c) examining unrealistic, dichotomous/binary, and negative expectations of gender and gender role or other contributors to the client's gender distress;
  (d) supporting the client's autonomy to self-label, including identifying as nonbinary, genderfluid, bigender, etc.; and
  (e) strengthening the client's ability to live positively as a gender minority person, expressing themselves more congruently, and responding assertively to stigma and discrimination.
- Assess the client's history, motivations, and desired outcomes while respecting the client's personal values, needs, and priorities. Explore potential internal and external motivations and beliefs and the possibility that the client's motivations might be based on stigmatized narratives.
- Allow for unfolding potential and spontaneous shifts in gender identity and expression that may occur without the clinician's direction.
- Assess the roles of anxiety and shame in the client's behavior reduction/change goals. Consider with the client how anxiety/shame affect their experiences with these goals and behavior and may diminish well-being, perpetuate stigma, and reinforce rather than reduce the behavior.
- Without dismissing the client's goals, consider broadening the client's focus to include life-affirming goals such as mindfulness, self-acceptance, self-compassion, connection, and resilience.
- Review periodically with the client the impact of the above interventions on their gender distress, identity, and expression.

Avoiding harm means that clinicians:

- Do not coerce, pressure, shame, discourage, or encourage direct changes in identity outcomes.

  For example: suggesting or implying that a client will only have positive mental health if the client pursues or avoids gender transition or if the client pursues or avoids certain relationships could harm the client. Leading a client could harm a client rather than staying with and holding space for the client to explore personal experiences.
- Use approaches that are respectful and compassionate to the various choices a client makes regarding lived experiences.

  For example: check in with the client about potential harms the client might be experiencing from the clinician.
- Obtain education and awareness about how organizational and cultural systems can discourage, devalue, and constrain the client's options for self-determination; in particular, clinicians should be especially aware of how organizations and cultural systems that the clinicians themselves are associated with may influence treatment and impact a client negatively.
- Consider ways the same organizational and cultural systems may be important facilitators of belonging and cooperative relationships for the client. Do not discourage a client from participating in systems or institutions that are valuable to the client and may contribute to the client's well-being.
- Recognize the impact of race/ethnicity and other meaningful identities as they intersect with sexuality, gender, and faith;
- Foster a client's intellectual, emotional, psychological, and social development in ways that honor the client's integrity.
- Convey that the client unconditionally deserves respect, dignity, and love and that the client's worth is not conditioned upon conformity.
- Assert the client's right to organize their values and ethics in a way that may or may not align with the expectations of other persons, institutions, or customs.
- Expand the client's sense of self-determination.

Strengthening Interpersonal Connection and Resilience means that clinicians:

- Help the client relate authentically with others, including identifying the client's strengths, needs, values, and boundaries in relationships and when to conceal and when to disclose aspects of the client's identity.
- Help the client develop skills to address conflict in ways that sustain relationships without jeopardizing the client's integrity and well-being.
- Support the client in recognizing, adding to, and/or strengthening the client's ability to contribute to and engage with relationships, family, institutions, and community.
- Help the client recognize and recruit interpersonal and community resources.
- Deepen the client's awareness of the role of personal needs and values in relationships, the client's own value in these relationships, and others' contributions to the client's well-being.
- Identify people, groups, and communities with shared values, mutual interests, and goals.
- Identify people, groups, and communities who value the client's contributions, even if there are limited shared values.

These approaches are potentially harmful:

Violating professional ethics and guidelines:

- Beginning from a foundational assumption that people are mentally ill or exhibiting a learned, reactive, or addictive behavior if they experience sexual and/or gender diversity and/or a deep devotion to faith;
- Assuming that a client's experience adheres to a one-size-fits-all model or theory;
- Not addressing the effects of minority stress, including prejudice, stigma, discrimination, exclusion, and lack of social safety, mentorship, representation, and/or awareness of positive life options;
- Failing to be aware of healthy life options that may be available within the client's system of values or faith;
- Violating the client's boundaries, such as asking voyeuristic questions, using inappropriate touch or any nudity in sessions, and/or inappropriately disclosing personal information to the client;
- Not addressing the client's potential for creativity, resilience, and community building;
- Not assessing the client's unique experiences with religion, faith, sexuality, and/or gender identity;
- Failing to explore the effects of trauma, including physical, emotional, sexual, and religious abuse and neglect;
- Failing to explore family systems and cultural and ethnic values and/or traditions; and
- Failing to discern the difference between a scope of practice issue and abandoning a client whose identity or life decisions do not align with personal beliefs.

Failing to follow principles of good practice

- Not assessing the potential for suicide or self-harm;
- Not inquiring periodically about the client's feelings regarding counseling–for example, failing to ask if the client feels understood and not making adjustments or appropriate referrals.

Using coercive techniques:

- Using direct or indirect manipulation, pharmacological interventions, or aversive techniques, such as punishment, shame, pain, and shock therapy, to achieve a specific outcome regarding sexual orientation, gender identity, or faith;
- Exploiting the client's vulnerability by asking questions that are voyeuristic, intrusive, or otherwise not relevant to the client's needs.

Fostering expectations of predetermined outcomes:

- Basing treatment on the assumption that a change in sexual orientation or gender identity will or should occur;
- Encouraging expectations of a specific sexual orientation, gender identity, or faith outcome;
- Limiting the client's exploration of sexuality, sexual orientation, gender identity, gender expression, personal values, or faith.

Imposing external values upon the client's belief system:

- Urging the client to discard beliefs about their religion, faith, sexuality, or gender identity;
- Denigrating the quality of life for a client's preferred life path regarding sexual, gender, and faith diversity.

This declaration applies to the spectrum of sexual and gender diversity, whether an individual identifies as lesbian, gay, bisexual, transgender, queer, intersex, asexual, or a different label or chooses not to identify according to sexual attraction or gender experiences.

For this declaration, we used the following terms:

Faith means a person's adherence to beliefs, practices, and rituals of that person's spirituality and/or religion.

For some people, **gender** is based on the degree of (a) resonance, (b) dissonance, and (c) fluidity with embodying male, female, and ambiguous sex characteristics. **Gender-role orientation** is based on the degree of resonance, dissonance, and fluidity of masculine and feminine traits, interests, and behaviors labeled by and related to cultural norms and gendered expectations. For some people, **gender** is not subjective but is based on biological sex.

A person's **gender identity** is self-defined and based on the person's self-knowledge (the internal sense they have about their gender) and how they label and express their gender based on their negative/positive evaluations about gender in general and their experiences of their gender.

Gender-body dysphoria is the distress caused by the incongruence between a person's experience of self and specific sex characteristics of their body. Gender-body dysphoria means a person's physical sexed body and gendered appearance do not align with the gender they perceive themselves to be and want to be perceived as. Gender-body dysphoria is different from body dysmorphia. People with **body dysmorphia** are preoccupied with and distressed about their idealized self-image, function, attractiveness, and/or appearance. In contrast, people with gender-body dysphoria are preoccupied with and distressed about discrepancies between their gender and sex characteristics. People who are dysmorphic can be obsessed with looking at the body part; people who have gender-body dysphoria want to avoid looking at and thinking about that part of their body.

Gender-role dysphoria is the distress caused by the incongruence between a person's experience of self, their gender-role orientation, and social expectations to adhere to a specific gender role.

Minority stress is chronic stress resulting from discrimination, harassment, prejudice, social attitudes, and/or lack of social safety and acknowledgment by a dominant social group. Minority stress can also involve internalized stigma, expectations of rejection, and concealment. Minority stress is not limited to external mistreatment but anticipating being different and not belonging. These are unique stressors that the general population does not experience. Repeated exposure to these stressors can result in mental and physical health disparities. People suffer from minority stress differently depending on their social statuses, privileges, disadvantages, and social contexts. Resilience is important to buffer minority stress but may also be limited in reducing the impact of certain minority stressors.

Sexual orientation means a persistent pattern of sexual attraction and aversion. This may or may not be consistent with a person's preferred or experienced sexual, romantic, and emotional expression and identity.

Sexuality means a person's sexual, romantic, and emotional feelings, expression, and identity.

***Faith, sex, gender identity, and sexuality may be core aspects of a person and/or may be shaped by cultural influences.*