

Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior¹



Task Force on Practice Guidelines for the Treatment of Unwanted Same-Sex Attractions and Behavior²

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Introduction

Clinical intervention for those who desire to change their unwanted same-sex attractions and behavior is an increasingly controversial subject. Within the sociopolitical environment that currently dominates mental health associations (Cummings, O'Donahue, & Cummings, 2009;

¹ These guidelines were adopted by the National Association for Research and Therapy of Homosexuality's Board of Directors on October 25, 2008, and reaffirmed upon subsequent revisions prior to publication in October, 2010.

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Redding, 2001; Wright & Cummings, 2005), individuals who pursue and/or report greater heterosexual functioning through psychotherapy may have their experiences of change marginalized or invalidated.

One possible reason for such marginalization is the increasing number of resolutions, position statements, and practice guidelines produced by professional psychological associations that are related to therapeutic approaches to sexual orientation (e.g., American Psychological Association, 2000, 2009). While these documents contain much helpful information with which clinicians should be familiar, they are nonetheless limited by their lack of diverse professional perspectives (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 changing unwanted same-sex attractions and associated feelings, fantasies, and behaviors.

This document is intended to provide educational and treatment guidance to clinicians who affirm the right of clients to pursue change of unwanted same-sex behavior and attractions. The specific goals of these guidelines are twofold: (1) to promote professional practice that maximizes positive outcomes and reduces the potential for harm among clients who seek change-oriented intervention for unwanted same-sex attractions and behavior, and (2) to provide information that corrects stereotypes or mischaracterizations of change-oriented intervention and those who seek it.

The very right of clients to pursue change-oriented intervention continues to be questioned within mental health associations (American Psychological Association, 2009; Kaplan et al., 2009; Yarhouse & Throckmorton, 2001, 2002). As a result, the Alliance for Therapeutic Choice and Scientific Integrity Board and Scientific Advisory Committee concluded

that the development of guidelines by and for clinicians who actually engage in this practice is urgently needed. A practice guideline task force was subsequently formed to develop this document. An initial draft document was sent for review to the Board and the association's professional membership; all feedback was considered and, where deemed beneficial, incorporated into the final version of the practice guidelines.

The term *guidelines* refers to statements that 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 and are intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by clinicians. Because practice guidelines are not mandatory, exhaustive, or applicable to every professional and clinical situation, they should be used to supplement accepted principles of psychotherapy, not to replace them.

The guidelines outlined in this document are not intended to serve as a standard of clinical care. Instead, they simply reflect the state of the art in the practice of psychotherapy with same-sex-attracted clients who want to decrease homosexual functioning and/or increase heterosexual functioning. These guidelines are organized into three sections: (a) attitudes toward clients who seek change, (b) treatment considerations, and (c) education.

Attitudes Toward Clients Who Seek Change

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

The standard opinion among behavioral scientists is that the causes of human behavior are multifactorial (Rutter, 2006). There is also general consensus that the etiology of homosexuality is multifactorial (e.g., Gallagher, McFalls, & Vreeland, 1993; Otis & Skinner, 2004), as are the reasons that cause some to view their same-sex attractions and behaviors as unwanted (cf. Guideline 3).

Over time, there have been vastly different theories about etiology, and a broad variety of approaches to intervention have been used. Theories about the origin of same-sex attraction have often been adopted when a particular approach proved adequate—leading a counselor, therapist, or client to draw a particular conclusion about what “caused” the attraction. The strongest childhood correlate of an adult same-sex orientation is that of clinical Gender Identity Disorder, which has been associated with subsequent homosexuality in 50 percent or more of cases in longitudinal studies (e.g., Zucker & Bradley, 1995). However, the low prevalence of full-fledged Gender Identity Disorder among those who experience same-sex attractions means that this explanation likely applies in only a minority of cases, although subclinical gender identity concerns may be more common.

Sociological research has not shown any one environmental, familial, or social factor as a predominant factor in same-sex attractions for the majority of gay and lesbian people. The exhaustive work of Bell, Weinberg, and Hammersmith (1981) considered all known factors to that date and concluded that 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). Biological research does not show one predominant cause; in fact, most influences have been numerically minor, though many individual correlations have achieved statistical significance (Bogaert, 2007; James, 2006; Lalumiere, Blanchard, & Zucker, 2000; Martin & Nguyen, 2004; Meyer-Bahlburg,

Dolezal, Baker, & New, 2008; Rahman, Kumari, & Wilson, 2003). The degree of concordance of sexual orientation in twins is the result of multiple influences, whether known to researchers or not, and twin studies suggest that multiple individual responses predominate to a degree that had not been expected (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Hershberger, 1997; Langstrom, Rahman, Carlstrom, & Lichtenstein, 2008; Santtila et al., 2008).

Therefore, clinicians need to take client histories seriously and not impose on all clients any particular etiological theories, even if those theories have been clearly applicable in other cases. On the other hand, a client may for psychological reasons deny events or processes that to the clinician are obvious causes; in such cases, it may be legitimate to address this with the client. A balance must be struck between taking client histories very seriously and retaining therapeutic objectivity. It is also important to consult peers and to increase understanding by collating influences that clients have found important.

Although no overwhelmingly predominant factors are likely to be found, several broad themes are already known to potentially lead to same-sex attraction and behavior. In no particular order, these include but are not limited to sexual abuse (James, 2005; Wilson & Widom, 2010), relationships with parents (Francis, 2008), relationships with same-sex peers (Bem, 1996), political solidarity (Rosenbluth, 1997; Whisman, 1996), and atypical mental or physical/biological gender characteristics (Zucker & Bradley, 1995).

Discretion is necessary in exploring the etiology of same-sex attractions in any particular client, as is suggested by the fact that leading mental health organizations are noncommittal about etiology (American Psychological Association, 2008a). 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 predisposition³. Such an adaptation and the resulting same-sex attraction may distress some people either because it violates their values and/or because the subsequent behaviors may place them at risk for mental illness and physical disease (cf. Guidelines 7 and 11).

Given the complexity of this topic, clinicians who work with clients who have 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. These contributions would help broaden everyone's understanding of the etiology of same-sex attractions and behaviors.

Guideline 2. Clinicians are encouraged 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 are impacted by their own values and biases as they engage these clients. A clinician's values and biases help determine the theories, techniques, and attitudes used to help these clients explore their presenting issues (Jones, 1994; Meehl, 1993; Midgley, 1992; O'Donohue, 1989; Redding, 2001).

³ 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 on 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, 2001; American Psychological Association, 2002). More recently, clinicians have been encouraged 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” (American Psychological Association, 2002, Ethical Principles, Principle D, pp. 1062–1063). Mental health associations have also recognized that sexuality and religiosity are important aspects of personality (American Psychological Association, 2008b)—and 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, 2002; cf. Guideline 3).

A client whose presenting problem is a need to clarify conflicted attitudes toward same-sex attractions represents a microcosm of the moral, legal, and psychological conflicts regarding homosexuality in our society. Clinicians need to be aware that, historically, same-sex attractions and behavior were considered as a moral issue (sin) by theologians and laypersons, as a legal problem (crime) by legislators, and only later as a psychological phenomenon (psychic disturbance) by clinicians and others (Katz, 1976). Same-sex attractions and behaviors were—and to a significantly lesser extent still are—seen or experienced in our culture as moral failures to be judged (Gallup, 1998; Schmalz, 1993); criminal acts to be prosecuted (Posner & Silbaugh, 1996; Rubenstein, 1996); behaviors to be stigmatized and discriminated against (Rubenstein,

1996; Eskridge & Hunter, 1997); and, until 1974, disorders in and of themselves that needed to be treated (American Psychiatric Association, 1972).

The last few decades have brought about significant changes in the moral valuation, legal status, and psychological description of homosexuality. The change in description was reflected when in 1973 the American Psychiatric Association removed homosexuality in and of itself as a pathological condition from the DSM. At this time the legitimacy, effectiveness, and ethicality of change-oriented interventions 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, 2000, 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 change-oriented counseling believe change is possible and available for many highly motivated clients who want to lessen their same-sex attraction, develop and increase their opposite-sex attractions and identification, or achieve stability within an abstinence-based life (Byrd & Nicolosi, 2002; NARTH, 2009).

Other clinicians can identify with both of these positions. When counseling a client with ambivalence about same-sex attractions, these clinicians look at both the goals of change and the goals of the gay-affirmative stance as possible and ethical without an exclusive value commitment to either one (Throckmorton & Yarhouse, 2006).

As clinicians approach the task of assessment, informed consent, and goal setting, they need to consider the complexities of sexual orientation and its development (cf Guideline 1). Many social scientists share an interactionist perspective 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 to best measure sexual orientation and what constitutes its central dimensions, be they attractions, behavior, fantasies, identification, or some combination of these elements (Kinnish, Strassberg, & Turner, 2005; Moradi, Mohr, Worthington, & Fassinger, 2009; Sell, 1997; Throckmorton & Yarhouse, 2006). This leads to further problems with estimating prevalence rates and measuring the reliability of sexual orientation (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, research on the possibility of changing unwanted same-sex attractions became much less prevalent in the professional literature (Jones & Yarhouse, 2007).

Along with considering the above, clinicians are encouraged to reflect on some specific potential biases they may encounter when they start exploring a client's issues. Clinicians who have adopted a primarily gay-affirming stance tend to focus on research literature that emphasizes a lack of difference in pathology between individuals with same-sex attractions and the rest of the population—research that attributes differences between the two populations to internalized homophobia and external stressors (Gonsiorek, 1991). 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, 2005; Fields, Malebranche, & Feist-Price, 2008; James, 2005; Stoddard, Dibble, & Fineman, 2009; Tomeo, Templer, Anderson, & Kotler, 2001; Wilson & Widom, 2010). They might also emphasize the methodological limitations in the research literature that indicate the possible efficacy of change intervention (American Psychological Association, 2009; Gonsiorek, 1991), 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 that 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” and good enough to merit publication in respected professional journals. Moreover, the early research that supported the possibility of 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), probably because they support a favored sociopolitical point of view.

Furthermore, clinicians with a strong gay-affirming position may tend to emphasize clinical literature that describes examples of harm—such as disappointment in not achieving complete sexual reorientation—in the course of change-oriented therapy and may decide that conducting such therapy is clearly unethical and harmful (Gonsiorek, 2004; Murphy, 1992; Tozer & McClanahan, 1999; Worthington, 2004). They may maintain this view even when clients explicitly say they want to change their unwanted same-sex attractions and/or behavior (Gonsiorek, 2004). These clinicians may believe that clients cannot establish realistic therapeutic goals for themselves nor make a truly voluntary decision to develop their heterosexual potential, assuming that clients want to change only because they have been oppressed and discriminated against by society (Tozer & McClanahan, 1999). They may discount the reality that many clients who want to explore the possibility of change experience significant conflict between their religious beliefs and their same-sex attraction (Beckstead & Morrow, 2004; Haldeman, 1994, 2004; Yarhouse & Tan, 2004), and that religious affiliation may be the most stable aspect of a

client's identity (Johnson, 1995; Koenig, 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). They may tend to espouse the immutability of sexual orientation, basing this conclusion on unsubstantiated biological research—a conclusion that remains premature (Garnets & Peplau, 2001; James, 2005; Stein, 1999; Yarhouse & Throckmorton, 2002).

Biases may impact clinicians on the other side of the issue as well. Clinicians who practice a primarily change-oriented intervention approach to unwanted same-sex attractions may overly interpret the likelihood and extent of probable change, oversimplifying or overselling the process of change according to their preferred (often psychodynamic) theory. They may not take into sufficient account the uniqueness of a particular client's history of same-sex or opposite-sex interest/arousal/behavioral patterns, and they may underestimate the possible therapeutic harm that may result from such oversimplification (Buxton, 2004), such as causing clients to feel misunderstood and misrepresented (Beckstead, 2001; 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 toward heterosexual capacity and functioning, even though they face enormous social sanctions throughout their lives (Green, 2003).

Change-oriented clinicians might also tend to minimize the research on the effect of social pressures and internalized societal attitudes toward homosexuality as possible factors contributing to a client's symptoms (DiPlacido, 1998; Maylon, 1982; Mays & Cochran, 2001; Meyer & Dean, 1998; Shildo, 1994). They might also minimize research suggesting that homosexual men and women who report lower internalized homophobia generally have fewer

related problems (Meyer & Dean, 1998). Some clinicians who practice primarily change-oriented intervention might automatically assume that outside pressure to move away from unwanted same-sex attractions is congruent with clients' value systems and should be honored, and might as a result neglect a deeper exploration of the issues (Green, 2003; cf. Guideline 8). Some of these clinicians may suggest to clients that change in unwanted same-sex attractions would be potential relief from a pathological condition when it would be more helpful to look at it as a "clinical problem" (Engelhardt, 1996)—especially for clients who are leaning toward integrating a gay identity and who find a focus on pathology unhelpful (Liddle, 1996) or harmful (Shildo & Schroeder, 2002), or for clients who have been made vulnerable by repetitive, traumatic anti-gay experiences (Haldeman, 2002).

There are also biases that affect both gay-affirmative and change-oriented clinicians. Both—especially if they are actively involved in the cultural debate surrounding the moral, legal, and psychological aspects of homosexuality in society—may dismiss the need to refer 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; Lischez & Yarhouse, 2005). Clinicians may need to refer if they are unable 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 (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). A clinician may also find it objectionable to refer clients to a needed supportive community whose values the clinician does not accept (Yarhouse & Brooke, 2005).

Clinicians who adopt a primarily more flexible position than either gay-affirmative or change-oriented clinicians are less likely to be impacted by these sorts of biases during the initial phase of assessment, informed consent, and goal setting (Throckmorton & Yarhouse, 2006). Yet these therapists 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 (Buxton, 2004). This could be due to a clinician's own ambivalences toward the possibility of change or to the clinician 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 do not exclusively offer change-oriented intervention may not fully appreciate the experience of clinicians who do and who often find that effective working alliances can come into play only when the counselor and client both view unwanted same-sex attractions from similar value positions. 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). In addition to the above considerations, gay-affirmative and change-oriented clinicians working with adolescents may need to exercise extra caution: at this developmental stage, the experience of sexual identification is more fluid, and adolescents may experience pressure toward resolution as unhelpful (Cates, 2007; McConaghy, 1993; Remafedi, Resnick, Blum, & Harris, 1992; Savin-Williams, 2005; cf. Guideline 9).

Mental health professionals are in conflict on how best to help individuals who enter psychotherapy expressing conflicted feelings, thoughts, or values about their same-sex attractions and behavior. Since conservative and traditional views are presently underrepresented

in the mental health profession (Redding, 2001), there is serious risk that a counselor's response will be negative toward a client who is leaning toward change. Because of that, it is important for clinicians to become familiar with a range of therapeutic options for clients who experience religious and sexual identity conflicts, including options 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 change-oriented interventions.

Research indicates that the majority of people 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; 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). 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 change in same-sex behaviors and attractions. Respect for religion as a dimension of diversity within psychology underscores the need for attention

to this risk (Benoit, 2005; Buxton, 2004; Yarhouse & Burkett, 2002; Yarhouse & VanOrman, 1999).

Religious motivations should not be immune from scrutiny in psychotherapy, but clinicians need to be extremely cautious about pathologizing religious values that may prompt a client to attempt to modify unwanted same-sex attractions and behavior. A lack of conservative and religious representation among mental health professionals compared to the general population (Delaney et al., 2007; Redding, 2001) suggests a considerable danger of clinicians misinterpreting or invalidating the motives of religious and conservative clients. One way in which that occurs is when religious beliefs that motivate clients to modify their unwanted same-sex attractions are too quickly and uniformly labeled as internalized homophobia (such as Herek, Gillis, & Cogan, 2009). 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 ask for help developing their heterosexual potential. For example, five 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 related to obligations of group membership (such as religious identification); 4) concerns related to social cohesion and respect for tradition and authority; and 5) concerns related to physical

and spiritual purity and the sacred (Graham, Haidt, & Nosek, 2009; Haidt & Graham, 2007, 2009; McAdams et al., 2008). The first two 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 in binding individuals into roles and duties for the good of society.

The research of Haidt and his colleagues (2001, 2007, 2009) has indicated that conservative people tend to utilize all five of these domains in their moral thinking, while liberal people tend to rely much more on the first two concerns. These differences can lead liberal people to misunderstand the moral concerns of conservative individuals more than conservatives misconstrue the concerns of liberals. Furthermore, the moral concerns of conservative individuals regarding group loyalty, respect for authority and tradition, and purity/sacredness tend to be rejected by liberal individuals (including many mental health professionals)—who, in fact, consider those concerns immoral if they seem to be in conflict with their own emphasis on harm, rights, and justice. Respectful awareness of such differences can promote a positive therapeutic environment for clients who, for religious or other morally motivated reasons, pursue change in their unwanted same-sex attractions and behavior.

Another means of marginalizing religious belief within the general practice of psychology has been to completely separate psychology and religion—to deem religiously motivated psychotherapeutic attempts to change unwanted same-sex attractions and behavior as essentially religious pursuits that have no place in a science-based clinical practice (American Psychological Association, 2009; Silverstein, 2003).

This perspective creates a strict demarcation that is not supportable given the enormous overlap between psychology and religion in their philosophical and anthropological areas of inquiry, such as theories of human nature (Auger, 2004; Bain, Kashima, & Haslam, 2006; Jones, 1994; O'Donahue, 1989). This perspective can also represent some degree of philosophical naïveté or professional hubris, since 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). 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 change-oriented interventions. Conversely, established religious and theological traditions are not bereft of a degree of objective and empirical validation; when they have not become corrupted by power, they have been valid and useful for understanding and directing human behavior for hundreds, if not thousands, of years (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 to 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, 2002). Clinicians are encouraged to avoid viewing individuals who seek to change their unwanted same-sex attractions, sexual orientation, 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, 2008). In harmony with that attitude, 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 when the client seeks change interventions for unwanted same-sex attractions and behavior (Benoit, 2005).

A focus on self-determination and autonomy does not elevate this ethical consideration above others in addressing the provision of change-oriented interventions (American Psychological Association, 2009). However, this ethical issue is often stressed in the change-oriented literature precisely because it is the ethical guideline most directly impacted by the threat of professional restrictions on such care. Restricting client self-determination to pursue change-oriented intervention on the basis of a lack of empirical efficacy, even if accurate, should in fairness make clinicians stop using many other experimental and unsupported treatment modalities that are currently practiced. Nor does the limiting of client autonomy appear to be warranted by the potential for harm in change-oriented interventions. No harm has been definitively linked to such interventions as a whole (American Psychological Association, 2009),

and potential harm can likely be resolved by suitable precautions such as those offered in these guidelines.

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 seek change interventions for unwanted same-sex attractions and behavior, as well as those individuals who do not desire such interventions. Clinicians are encouraged to refrain from persuading clients to select 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 seek intervention 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 choice in response to same-sex attractions; d) discussing the available range of professional therapies and resources (Jones & Yarhouse, 2007); e) providing understandable information on outcome research related to change interventions (NARTH, 2009); and f) obtaining informed consent for treatment (Rosik, 2003a; Yarhouse, 1998a; cf. Guideline 5).

Value conflicts with the broader culture are more likely to be experienced by clients 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 pursue change-oriented interventions. The clinician's commitment to respecting client autonomy and self-determination may be especially

tested when working with people 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 change interventions, 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, 2008).

Treatment Considerations

Guideline 5. At the outset of treatment, clinicians strive to provide clients with information on change-oriented processes and intervention outcomes that is both accurate and sufficient for informed consent.

Clinicians from all of the mental health professions provide clients with informed consent at the beginning of treatment (e.g., American Psychological Association, 2002, Ethical Standards 3:10 & 10.01; American Association for Marriage and Family Therapy, 2001, Ethical Standard 1.2; National Association of Social Workers, 2000). 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 change and the kinds and likelihood of changes that are possible.

Adequate informed consent is an important part of therapeutic “beneficence and nonmaleficence” through which 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” (American Psychological Association, 2002, General Principle A, p. 1062). Informed consent also encourages and expresses clinical “competence,” through which

clinicians “provide services . . . with populations and in areas only within the boundaries of their competence.” Clinicians inform their clients about the clinical “education, training, supervised experience, consultation, study, or professional experience” that contributed to their competence (American Psychological Association, 2002, Ethical Standard 2.01, p. 1063).

Since 1973, homosexuality itself has no longer been formally considered to be pathological (American Psychiatric Association, 1973; American Psychological Association, 1975). But distress concerning sexual orientation is still a diagnosable, treatable condition under the category *Sexual Disorder Not Otherwise Specified* (American Psychiatric Association, 2000), and some instances of unwanted same-sex attractions may fall under this category. As even gay-identified scholars have asserted, developmental issues that contribute to a person’s distress about her or his sexual orientation are valid topics for research (Morin & Rothblum, 1991).

This also holds true when considering intervention 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). Clinicians who help clients distressed about their same-sex attractions and behavior are being ethically responsible, respecting “the dignity and worth of all people, and the rights of individuals to . . . self-determination” (American Psychological Association, 2002, General Principles, Principle E, p. 1063).

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”—the gender(s) of the persons to whom one is sexually and/or affectionately attracted and with whom one experiences love and/or sexual arousal—are not universally

defined, fixed, discrete, one-dimensional constructs (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 (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 that either contribute to and/or may be consequences of a client's unwanted same-sex attractions or behaviors (cf. Guideline 9). 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 health care may be an appropriate component of informed consent and goal setting (cf. Guideline 8).

When discussing the possibilities for change, it is important to explain that, as with any intensive course of intervention, achievement of significant change(s) of unwanted same-sex attractions and/or behaviors requires sufficient motivation, hard work, and patience, with no guarantees of "success" (Haldeman, 1991, 1994, 2001). 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 125 years. More than 150 reports spanning the end of

the nineteenth century through the beginning of the twenty-first have documented successful change(s) in sexual attractions, thoughts, fantasy, and/or behaviors from same-sex to opposite-sex (Byrd & Nicolosi, 2002; NARTH, 2009; Throckmorton, 2002).

While not an exhaustive list, reports of change range in size from single-client case studies to group studies involving hundreds of clients. The various therapeutic paradigms used have included psychoanalysis (Bieber, Dain, Dince, Drellich, & Grand, 1962; MacIntosh, 1994) and experiential or other psychodynamic approaches (Berger, 1994; Nicolosi, 2009); 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; religiously mediated interventions (Jones & Yarhouse, 2007); and various combinations of therapies (Karten & Wade, 2010), among others. Non-theory-driven, serendipitous change has also been reported in response to psychotropic medication and brain injury (Golwyn & Sevlie, 1993; Jawad, Sidebothams, Sequira, & Jamil, 2009). A number of meta-analyses have demonstrated that intended change in feelings and behaviors is a realistic goal for many persons with unwanted attractions to the same sex (Byrd & Nicolosi, 2002; Clippinger, 1974; James, 1978; Jones & Yarhouse, 2000). See NARTH (2009) for a comprehensive list of reports for each paradigm.

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 change to varying degrees. Many—but not all—clients have either been observed by their therapists or have reported themselves to have experienced desired changes in “sexual orientation” and related presenting concerns (NARTH, 2009).

Clients who report a significant transition and/or who are assessed as having made a significant transition from same-sex to opposite-sex attraction, cognition, fantasy, and behavior not uncommonly re-experience same-sex feelings or thoughts, though at a less intense level than before intervention. Of course, there may be exceptions. Even when clients do not achieve all they had hoped to when beginning therapy, many report satisfaction with what they have achieved (Nicolosi et al., 2000, 2008; Spitzer, 2003), and some clients who describe their therapy experiences as “harmful” may also characterize those experiences as “helpful” (Shildo & Schroeder, 2002). As with therapy in general (Lambert & Ogles, 2004), documented intervention success is often accompanied by some recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted same-sex attractions (cf. Guidelines 6 and 10).

Critics of the clinical and scientific literature documenting successful therapeutic outcomes—or the lack thereof—accurately point out the absence of truly randomized outcome studies (American Psychological Association, 2009). Another criticism of the literature is the lack of clear definition of terms such as *sexual orientation*, *homosexuality*, *heterosexuality*, and *change*. As noted previously, there has been much less research focusing on the development of and interventions for unwanted same-sex attractions since the American Psychiatric Association’s 1973 decision to no longer diagnose homosexuality as a mental disorder

Such criticism does not negate that, for more than a century, clinical and scientific evidence has persistently demonstrated that unwanted same-sex attractions and behaviors are often treatable and that clients who seek intervention are not invariably harmed when receiving intervention. A substantial number of people who have sought help from professionals representing various theoretical paradigms and psychotherapeutic approaches have diminished

the frequency and strength of same-sex attractions, reduced or eliminated same-sex behaviors, and enhanced their experience of opposite-gender sexual attractions (Nicolosi et al., 2000; Spitzer, 2003). While some clients may report change in sexual orientation identity only—labeling themselves as ex-gay without an accompanying change in the direction or intensity of sexual attractions (American Psychological Association, 2009)—research does support the occurrence of change in the behaviors, attractions, and fantasies associated with sexual orientation per se (Jones & Yarhouse, 2007; Spitzer, 2003). Since the question of change in sexual orientation identity versus sexual orientation is definitionally complex and does not lend itself to an either/or dichotomy, clinicians are encouraged to be cognizant of this issue without adopting a dogmatic all-or-nothing approach.

Doubt that same-sex attractions and behavior can change has arisen in part because of the desertion of psychological and clinical principles in favor of sociological surveys. This constitutes a significant methodological problem. The traditional psychological treatments arose in a discipline where individual change was monitored and interpreted and taken as an indicator of ways therapy could be improved. Change that was satisfactory to the client was the criterion. However, in a situation (germane to many interventions) in which a minority of clients experience significant change, some experience minimal change, and some experience no change, the illegitimate sociological average would say the therapy does not work.

To illustrate this point, imagine an intervention that helps only 10 percent of clients, but for that 10 percent the intervention is brilliantly successful. The intervention fails for the other 90 percent. The sociological average of all these cases would indicate that the intervention has no effect at all. That conclusion is false and neglects the traditional prime role of the individual.

It may be that many of those who say change is impossible have been unable to change themselves—so they assume their experience is like that of all who pursue change. This would be invalid reasoning, but it may contribute to attempts by professional organizations to explicitly or implicitly discredit change-oriented interventions or otherwise discourage their use (American Psychological Association, 2009).

Lambert & Ogles (2004) observed that “helping others deal with depression, inadequacy, anxiety, 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 those who want to resolve unwanted same-sex attractions and behavior is not only ethical but also may be expected to facilitate the development of more effective, therapeutic relationships.

Guideline 6. Clinicians are encouraged to utilize accepted psychological approaches to psychotherapeutic interventions that minimize the risk of harm when applied to clients with unwanted same-sex attractions.

Every counselor uses psychotherapeutic approaches that 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 work with clients to resolve unwanted same-sex attractions and behaviors are trained in one or more of the theoretical approaches and techniques currently practiced 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 professional development (cf. Guideline 11).

It has been suggested by critics that one possible outcome of counseling for unwanted same-sex attraction has been the development of a negative attitude toward homosexuality or homosexuals (e.g., 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 left over from the recent or distant past. In the short term, as clients are helped to practice sexual or other (such as substance use) sobriety, they may experience an increase in their "feeling" of depression, anxiety, and other problems.

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 (such as sexual gratification), substances (such as alcohol or drugs), or other paraphernalia (such as pornography). Clients who terminate any therapy before effectively resolving any underlying emotional issues or compulsive behavior patterns 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 may not be unrealistic—similar to what is found when treating substance abuse and other habits.

In general, interventions for unwanted same-sex attractions and behavior have been shown to help a number of clients and have not been shown to be invariably harmful

(Throckmorton, 1998, 2002). Even authors who clearly oppose such intervention and who caution that it may be harmful nonetheless recognize that it is not always so (Haldeman, 2001; Schroeder & Shildo, 2002; Shildo & Schroeder, 2002). Even clients who are disappointed by failure to change their same-sex thoughts, feelings, fantasies, and/or behaviors as much as they had hoped have reported satisfaction with the changes they did achieve, and they regard the counseling process as at least somewhat helpful (e.g., Nicolosi et al., 2000; Shildo & Schroeder, 2002; Spitzer, 2003; Throckmorton, 2002). 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 accurate informed consent (cf. Guideline 5).

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, especially those who begin therapy with a severe "initial level of disturbance," such as borderline personality disorder (Lambert & Ogles, 2004, p. 177). Clients who experience significant negative countertransference or whose clinicians may lack empathy or underestimate the severity of their problem may also be at greater risk for deterioration (Mohr, 1995).

Finally, in light of current research and professional ethics, some 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.

Overall, research to date has shown that clients participating in efforts to change unwanted same-sex attractions or behaviors are not invariably harmed by doing so. Any negative

consequences attributed to experiencing change-oriented interventions have not been shown to outweigh the benefits claimed by those who have found the interventions helpful.

Guideline 7. Clinicians are encouraged to be knowledgeable about the psychological and behavioral conditions that often accompany same-sex attractions and to offer or refer clients to relevant treatment services to help clients manage these issues.

When treating clients with unwanted same-sex attractions and behavior, it is strongly encouraged that clinicians do a complete assessment that includes a detailed history and examination. Clinicians should be particularly alert to the potential 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 higher risk for some mental disorders when compared to heterosexual adults (Cochran & Mays, 2009; King et al., 2008). Cochran, Sullivan, and Mays (2003) found that gay and bisexual men showed higher prevalence of depression, panic attacks, and psychological distress than heterosexual men; lesbian and bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women in the same study. This excessive risk of co-occurring psychopathology needs to be at the forefront of a clinician's mind when working with individuals who report same-sex attractions, whether wanted or not.

A key issue in health care is risk assessment and management; in mental health terms, it is important to assess the risk of self-harm or suicide. Research has demonstrated a strong association between suicide risk and same-sex attractions and behavior (Eskin et al., 2005; King

et al., 2008; Ploderl & Fartacek, 2005; Remafedi, French, Story, Resnick, & Blum, 1998). Data from the National Comorbidity Survey found that people with same-sex partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual peers (Gilman et al., 2001). This finding has been consistent in studies of both young people (Russell & Joyner, 2001) and adults (Remafedi et al., 1998). Such suicidal feelings may not be only the result of prejudice or societal pressures; even in Holland, a country with a comparatively tolerant attitude to homosexuality, men with same-sex attractions and behaviors are at a much higher risk for suicidality than heterosexual men (de Graaf, Sandfort, & ten Have, 2006).

Sex addiction often co-occurs with same-sex behavior (Dodge et al., 2008; Guigliamo, 2006; Kelly, Bimbi, Nanin, Izienicki, & Parsons, 2009; Parsons et al., 2008; Quadland & Shattls, 1987). Instead of “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 type of addiction often has roots in childhood and adolescence; as many as 60 percent of people who seek treatment for sex addiction were sexually abused before reaching adulthood (Griffin-Shelley, 1997). Clients with same-sex attractions commonly report other addictive behaviors as well, including pathological gambling (Granta & Potenzab, 2006) and substance abuse of prescribed, illicit, and over-the-counter medications. A thorough history should include assessment for these and other common addictive behaviors.

Individuals reporting same-sex attractions and behavior also appear to have suffered a higher prevalence of sexual abuse (Doll, Joy, Bartholow, & Harrison, 1992; Eskin et al., 2005; Paul, Catania, Pollack, & Stall, 2001; Tomeo et al., 2001; Wilson & Widom, 2010). It is therefore imperative that clinicians take a full and detailed history from each client.

While clinicians should complete a full assessment to screen for active psychopathology, they must also take care not to practice in a clinical area where they are not competent (American Psychological Association, 2002). If active psychopathology is detected, it should be addressed through multidisciplinary consultation or by referral to an appropriate service where clinically necessary (cf. Guideline 11).

Guideline 8. Clinicians strive to consider and understand the difficult pressures from culture, religion, and family that are confronted by clients with unwanted same-sex attractions.

The societal pressures that surround people with unwanted same-sex attractions cannot be understated. Careful appraisal of the multiple contexts from which these clients come and the normative attitudes toward homosexuality found in each milieu will benefit clinical intervention.

One pervasive dimension is culture, which includes ethnic heritage and the varying perspectives on homosexuality common to each ethnicity. 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; Spitzer, 2003). Most of these individuals will have previously adopted from their religious background a value framework that considers homosexual behavior as immoral. Some

religiously conservative clients will have grown up hearing homosexuality condemned by religious authorities who may—or may appear to—lack compassion for their struggle.

A third dimension 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 the factor that can likely exert the most immediate influence on the mind-set of those seeking change. 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. Clients may receive a variety of messages from family members, ranging from gay affirmation to loving disapproval to outright rejection and distancing (Freedman, 2008).

The effects of ethnicity and religious identity can overlap with family considerations and may intensify a sense of reluctance to acknowledge, explore, and seek therapy for unwanted same-sex attractions. An important factor is client proximity to these contexts; clients coming immediately from nonaffirming backgrounds may not have been as reflective about their decision to pursue change as clients who report having once lived a gay identity but who now wish to change that identity.

The early assessment of these contexts is important in determining how ready a client may be for interventions oriented toward change. Clients from ethnic, religious, and family backgrounds that do not affirm homosexuality need to be assessed carefully to make sure they 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; Murphy, 1992), that clients from these backgrounds can never autonomously enter into therapy with the goal of attempting to change unwanted same-sex attractions and behaviors. But while people do make rational and free choices to identify with the moral values and behavioral codes of conduct for sexual expression

inherent in homosexually nonaffirming contexts (Yarhouse & Burkett, 2002), it cannot be assumed that this is always the case. Therefore, it is essential to explore with clients the attitudes and beliefs toward same-sex attractions and behavior that dominate their particular cultural and family situation as part of evaluating the extent to which they have genuinely taken ownership of their decision to pursue change.

Guideline 9. Clinicians are encouraged to recognize the special difficulties and risks that exist for youth who experience same-sex attractions.

Research suggests that in 50 percent of the population, first attraction to the same or opposite sex has occurred by age ten (Hamer, Hu, Magnuson, Hu, & Pattatucci, 1993; Whitam & Mathy, 1986)—but there is an unusually wide age range during which those first feelings of attraction occur. Some are still essentially asexual until their late teens in spite of the highly sexualized cultural climate in the West.

Even when experiences with attraction occur, they may not be “reliable.” Neurology—including that of the brain—continues to develop throughout adolescence (Sisk & Zehr, 2005), so teens generally lack mature judgment, even though they are at or near their physical peak in their late teens. Many use the late teen years to explore what mature possibilities may exist for them and to then evolve an identity by experimenting with a wide range of experiences. Sexual initiation usually occurs during this time (Floyd & Bakeman, 2006).

A mature estimate of risk does not conform to reality during adolescence. Teens 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,

even though their risk of infection is not much less than that of adults (Lock & Steiner, 1999). Unfortunately, teenagers may also be reluctant to listen to input about such risks. Consequently, responsible clinicians will offer more directive guidance to youth than to more mature clients, particularly when a client's estimate of risk is unrealistic. This type of guidance may involve more mentoring than for a mature client or referral to someone who can mentor the client.

Statistical surveys show that adolescents participate in considerable sexual experimentation, much of which is not followed up on in adulthood—and, therefore, those types of experimentation can be considered far from definitive (Laumann et al., 1994). Changes of various types continue to take place even during adulthood (Kinnish et al., 2005). Consequently, 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 “unlabeled” sexual orientation category (Diamond, 2008); conversely, they might be told that, with strong motivation, change may be easier during adolescence than during adulthood.

Each year, about 42 percent of youth are exposed, either willingly or unwillingly, to Internet pornography; over the period of a few years, almost all youth get exposed (Wolok, Ybarra, Mitchell, & Finkelhor, 2007), so the effects of such pornography should be monitored. Youth may absorb quite unrealistic ideals as a result, and may even draw incorrect conclusions; for example, 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 adolescents who reach a conclusion about their sexuality and who are distraught about its perceived consequences are at highest risk of suicide immediately before

they disclose their “secret” to anyone (Paul et al., 2002). 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 percent each year they delay labeling themselves as gay (Remafedi, Farrow, & Deisher, 1991). Although causal links are not clear, it is prudent to encourage teens to wait for some time and maturity to take place before they label themselves as gay.

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; cf. Guideline 8). Many who disclose their homosexuality to unsympathetic family join the ranks of the homeless and then become 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 teens have less empathy than younger or older people. Brutality can also occur because there is still intense pressure from peers to conform to stereotypical gender roles during adolescence.

Male adolescents will probably report rejection and discrimination by others much more than female adolescents will (Hershberger & D’Augelli, 1995). Such rejection may be more perceived than actual but can have real effects for clients. The literature suggests that, in some cases, emotional and avoidance coping styles may account for perceived rejection more than the actual circumstances do (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2009). Therefore, it is wise to examine an individual’s coping style.

Co-occurrence of standard DSM conditions is much higher for such clients than others (Fergusson, Horwood, & Beautrais, 1999), so clients should be checked for, among others, substance abuse (Sandfort, de Graaf, Bijl, & Schnabel, 2001; Trocki, Drabble, & Midanik,

2009), antisocial behavior (Fergusson et al., 1999), depression (Cochran et al., 2003), compulsivity (Dodge et al., 2008), and borderline personality disorder (Sandfort et al., 2001).

Education

Guideline 10. *Clinicians are encouraged to make reasonable efforts to familiarize themselves with relevant medical, mental health, spiritual, and religious resources that can support clients in their pursuit of change.*

Unwanted same-sex attractions and behaviors often co-occur with formally diagnosable or otherwise evident medical, psychological, behavioral, and relational difficulties (cf. Guideline 7). Therefore, clinicians should make reasonable efforts to familiarize themselves with relevant approaches to health care that address applicable areas of difficulty.

It is essential for clinicians to keep current about health psychology and related behavioral health issues and to refer clients to specialists when care is outside their scope of practice. These health issues include, but are not limited to, how to improve general health habits (such as diet, exercise, relaxation, and sleep.), the use of relevant psychotropic medications and understanding of their interactive effectiveness with psychotherapy, ways to enhance compliance with medical directives, and how to determine when partial and inpatient hospitalization is indicated (Creer, Holroyd, Glasgow, & Smith, 2004; Thase & Jindal, 2004).

Addressing clients' co-occurring medical or psychiatric difficulties may sometimes have greater priority than helping them resolve 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 (such as individual or group substance abuse counseling) or referring to couples therapy, family therapy, group therapy, or peer-support groups when clients need and are able to benefit from therapeutic relational and group interaction. Referrals also may help clients successfully deal with co-occurring sexual abuse, substance abuse, eating disorders, or other compulsive or addictive behaviors (Lambert & Ogles, 2004).

Parents who are concerned about children with Gender Identity Disorder or unwanted same-sex attractions might be referred for parent education and family therapy (Lundy & Rekers, 1995; Rekers, 1995; Zucker & Bradley, 1995). Clinicians are encouraged to be prepared to make referrals to other health-care professionals so clients can receive primary, sequential, alternative, combined, or adjunct medical or mental health assistance in a timely way.

In addition, clinicians serving clients who seek to resolve unwanted same-sex attractions and behaviors are also encouraged to be prepared to offer their clients pastoral care, either directly or by referral. Religious or spiritual beliefs, practices, and social interactions can offer motivation and support for a client's desired changes (cf. Guidelines 3 and 4). Clinicians should therefore make reasonable efforts to assess their clients' religious beliefs, moral values, and spiritual practices and be prepared to support clients' utilization of appropriate spiritual and religiously oriented resources to achieve intended changes (Richards & Bergin, 2000).

Clinicians should 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 clinicians with similar beliefs and values" (Gregory et al., 2008; Richards & Bergin, 2005, p. 307). Also, the use

of spiritual or religiously inspired aides such as prayer, forgiveness, meditation, and twelve-step groups based on spiritual principles have been shown to be therapeutically effective as part of or as an adjunct to clinical intervention (Benson, 1996; Enright & Fitzgibbons, 2000; 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 separate from therapy—report positive results (Jones & Yarhouse, 2007). Even when clients did not change as they had intended, some asserted that the process was helpful, even when the research was designed to elicit reports of intervention failure, harm, or dissatisfaction from religiously mediated efforts to change (Shildo & Schroeder, 2002). When the research was designed to elicit reports of success or satisfaction with their participation, substantially more were favorable (Nicolosi et al., 2000, 2008; 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 (Jones & Yarhouse, 2007; Yarhouse, Burkett, & Kreeft, 2002).

Guideline 11. Clinicians are encouraged to increase their knowledge and understanding of the literature relevant to clients who seek change, and to seek continuing education, training, supervision, and consultation that will improve their clinical work in this area.

The literature on homosexuality is at first glance an academic field like any other, even though it might be considered slightly more active because new references accumulate almost every day. That view is deceptive, though: Same-sex attraction is not an isolated clinical entity.

A very wide range of conditions occur with it, and clinicians need to have a reasonable knowledge of these conditions—or at the very least be able to recognize those conditions readily and refer clients to others as necessary (cf. Guideline 7). This greatly increases the responsibility of clinicians to keep current with the literature.

Research has generally shown that people reporting same-sex attractions and behavior (mainly the men who have been studied) have much greater prevalence of pathology than the general population. The consistency of these findings counterbalances to some degree the methodological limitations. These differences in prevalence have been reported or can be inferred in several areas: suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007); violence (Coxell, King, Mezey, & Gordon, 1999; Owen & Burke, 2004); antisocial behavior (Fergusson et al., 1999); substance abuse (Rhodes, McCoy, Wilkin, & Wolfson, 2009; Sandfort et al., 2001; Trocki et al., 2009); suicidality (de Graaf et al., 2006; King et al., 2008); more sexual partners (Laumann et al., 1994; Mercer et al., 2009; Rhodes et al., 2009); paraphilias, or so-called fisting (Crosby & Mettey, 2004); being paid for sex (Schrimshaw et al., 2006); sexual addiction (Dodge, Reece, Cole, & Sandfort, 2004; Parsons et al., 2008; Satinsky et al., 2008); personality disorders (Zubenko, George, Soloff, & Schulz, 1987); and psychopathology (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 there are many more articles—generally ten times as many—dealing with conditions that co-occur with homosexuality than articles restricted to homosexuality alone. It is not enough to read about homosexuality alone, then, but it is essential to read the much greater

number of co-associated articles and to benefit from the understanding these articles make possible.

References to HIV are extensive in the literature, and it is quite possible this condition will co-occur with same-sex behaviors. Even if HIV infection is under control, the prevalence of various cancers in AIDS patients is about twenty times greater than in the general population (Galceran et al., 2007). A clinician may well encounter clients with these kinds of medical needs and will need to address appropriate treatment issues.

Psychotherapeutic intervention for unwanted same-sex attractions and behavior is controversial in a way that is seldom experienced today for other conditions. As a result, clinicians face the risk of unanticipated legal consequences (Hermann & Herlihy, 2006), deal with more complex therapy, and have a greater-than-average need to stay current in the field and be aware of the latest implications of research and good practice.

This kind of intervention is also exceptionally complex. Clinicians need to understand the consequences to the client's psyche of having an associated medical condition or suffering strong rejection because of attitudes toward homosexuality.

The varieties of change-oriented counseling are numerous, and there is no consensus on the best approach. This requires clinicians to be aware of other intervention strategies and theoretical approaches and to be willing to adopt useful insights and previously successful techniques (cf. Guideline 6). Alongside this, the variety of experiences among clients is significantly diverse (Otis & Skinner, 2004), which demands a greater versatility of response from the clinician and greater familiarity with the research literature.

Much of the literature pertaining to homosexuality is at risk of being irrelevant because it is associated with the political aspects of the topic. The remainder of the relevant literature

involves many widespread fields, including genetics, physiology, sociology, urban anthropology, and psychotherapy. Thus, clinicians must strive to locate relevant material in unusually diverse fields. Clinicians also need to be prepared for the fact that clients often read this same material and want to discuss it. It is probably worthwhile that clinicians use a service on the Internet—such as PubMed—to alert them when relevant new material is published.

Focused events such as seminars and conferences are more important than usual because change-oriented interventions for unwanted same-sex attractions and behavior are not as widely known and practiced as counseling for other conditions; as a result, collegial consultation becomes more important. Finally, it goes without saying that clinicians must 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 and provide specific guidance from experienced clinicians to colleagues who are currently practicing or who are considering the use of change-oriented interventions for 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 change. The guidelines also serve to educate clinicians by providing an entry point into aspects of the professional literature that may be underreported by national mental health associations.

Second, these guidelines inform consumers who are receiving or considering therapeutic intervention to change their unwanted same-sex attractions and behaviors. The guidelines provide a broad evaluative framework that helps these clients determine if the clinical services they receive are being provided in a sufficiently professional and ethical manner. Consumers of change-oriented intervention may find value in discussing these guidelines with their clinicians. Discussing them early in treatment as part of the informed consent process may facilitate planning of both short-term and long-range goals.

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 problem, the most effective therapeutic alliance occurs when there is initial and ongoing clarity of purpose and goals shared by clients seeking change and their clinicians.

The social, scientific, and medical information made available through these guidelines may also benefit consumers as they weigh the benefits and risks of pursuing change-oriented intervention in comparison to therapeutic approaches that endorse or embrace a gay or lesbian identity. In this way, these guidelines can contribute to a more fully informed and autonomous decision-making process by clients who want to know what clinical approach—if any—they want to use for their unwanted same-sex attractions and behavior.

Finally, these guidelines can help mental health associations and graduate training programs facilitate a balanced and informed discussion about change-oriented intervention. The guidelines complement the existing professional literature pertaining to psychological care for those with unwanted same-sex attractions and behavior by their nondismissive focus on change-oriented intervention. 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 change-oriented clinicians.

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 guidelines, change-oriented intervention deserves to be made available to clients who seek it.

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