In Their Own Words:
Therapists Who Support a Client's Right to Explore Sexual Attraction Fluidity Respond to Questions Posed by Lesbian, Gay, and Bisexual Therapists

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Abstract

In the current politicized climate concerning professional therapies that allow sexual attraction fluidity exploration (SAFE-T), meaningful dialogue between psychotherapists who support and oppose change-oriented goals is quite rare. Recently, a group of lesbian, gay, and bisexual therapists proposed a list of six questions they wished therapists who engaged in SAFE-T would answer. In order to promote understanding and the exchange of ideas over this subject, I submitted these questions to several therapists who have extensive experience working with clients who report unwanted same-sex attractions (SSA) and may desire to pursue change. Questions addressed interventions and theory associated with SSA change, accounting for potential harms of SAFE-T, and the effects of minority stress. In a concluding section, some common themes among respondents were highlighted along with the significance of these themes for clarifying controversies that currently exist regarding SAFE-T.

Keywords: SAFE-T, sexual attraction change, therapy.

In the current professionally and politically volatile climate that surrounds the practice of sexual attraction fluidity exploration in therapy (SAFE-T)[1], there are few opportunities for clinicians who work in this area to respond in their own words to questions that reflect the concerns of lesbian, gay, and bisexual (LGB) mental health professionals. When such a group of LGB therapists[2] provided a short list of questions they wished to pose to clinicians who provide SAFE-T, I sensed this could be such an opportunity for needed professional exchange. I then set out to contact several therapists who are experienced clinicians in this area and invited them to briefly share their own beliefs and practices in response to the questions. A few of these clinicians declined to participate out of concern for their professional standing. All were offered the option of responding in an anonymous fashion to protect their identity, and some participated only on this basis. A total of nine therapists who utilize SAFE-T provided responses to the questions. Below is some general information about each of these invited respondents, who have a combined 160 years of clinical experience in this area of practice:

Joseph Nicolosi, Ph.D.; Psychologist and Director of the Thomas Aquinas Psychological Clinic in Encino, California. He is the founder of Reparative Therapy, a form of SAFE-T. For 30 years he has worked almost exclusively with men with unwanted homosexuality.

Paul Popper, Ph.D.; Psychologist in independent practice in San Francisco, California. He has provided SAFE-T to men for 24 years.

Jane Doe #1, Psy.D.; Psychologist residing in the USA who has served both men and women for 15 years.

John Doe #1, Ph.D.; An American-trained psychologist who has practiced SAFE-T with men for 9 years.

Michael Davidson, Ph.D.; Psychologist residing in the United Kingdom who has 7 years of SAFE-T experience working with men.

Janelle Hallman, Ph.D.; Counselor, Educator, and Assistant Professor at Denver Seminary who has 25 years of serving women in this area.

David Pickup, M.A.; Marriage & Family Therapist practicing in Dallas, Texas, and Los Angeles, California. He has provided SAFE-T in the form of reparative therapy to men for 8 years.

Carolyn Pela, Ph.D.; Marriage & Family Therapist in the Department of Behavioral and Social Sciences at Arizona Christian University in Phoenix, Arizona. She has provided SAFE-T to women for 25 years.

John Doe #2; Ph.D.; Psychologist, Marriage & Family Therapist, and Clinical Social Worker. He has worked primarily with men in the USA for 18 years providing SAFE-T.

Questions

1. **Which interventions do you use if a person wants to change and/or reduce her or his sexual attractions to the same sex? Would those same methods work on any same-sex attracted individual?**

Nicolosi: I use psychoanalytic, affect focus, object relations, EMDR, trauma theory, neuro-biology, and mindfulness meditation-based interventions. The exact selection of approaches would be dependent upon the person and where the person is in treatment.

Popper: I would explore their motivations for coming to therapy, for whom they are doing it and why. I clarify that doing it for others, even for God, does not lead to attraction change in my experience. This is often followed by several years of exploration of their dependent/compulsive/depressive/anxious personality traits, which in this clinician's experience most often correlate with SSA in clients who do not identify with their SSA and look for change towards a more complementary intimate partnership with a female. Initially therapy focuses on mirroring clients' pain connected to the formative experiences associated with their dependent, compulsive/anxious/depressive traits, often connected with their inability to connect with their father and other male peers. Later the focus will include pointing out to them the choices they make in the present, when they run away from that pain in their unique individual pattern,

often through compulsive sexual acting out. As they feel more autonomous and set more appropriate boundaries, their relationships with male peers become more balanced, more mutual and more fulfilling, and often simultaneously the same-sex strivings start to decrease in intensity and frequency.

Regarding the second question, I do not work with folks who choose to live out their same-sex attractions (SSA), so from my clinical experience, I do not know. I would guess that some folks living out their SSA, if engaged in therapy resolving similar personality issues of dependence, etc., would surprisingly find some opposite-sex attractions (OSA) appear in their experience that was not present before.

Jane Doe #1: To answer the second question first: As in all therapy, no one method/intervention works for all clients. The interventions I use depend on the client, their goals (which aren't always clearly to change or reduce sexual attractions), and concerns related to the same-sex attractions (SSA). For example, if the client believes childhood sexual abuse had a part to play in the development of their SSA, the interventions I recommend will be different than if the person has never experienced childhood sexual abuse, or if the person doesn't believe their past sexual abuse played a part in the development of their SSA.

Regarding the first question: It is rare that a client comes in *only* and *resolutely* to change or reduce sexual attractions to the same sex. More often, my clients say they are coming to therapy because of mental health difficulties or other difficulties in their lives. Their same-sex attractions might be related to their primary reasons for seeking treatment or they might be a focus later in therapy. As for interventions, these are common: (1) following my client's lead in what they want to talk about, when they want to talk about it, and how they want to talk about it; (2) allowing my client space to talk about their SSA (many of my clients haven't yet come out) without pressing them toward a particular direction/behavior/decision; (3) addressing complicating factors such as family of origin relationships, faith and values, sexual stigma, desire to have a spouse and family, etc. that impact the person's experience and decisions; (4) reducing shame interventions (identifying a shame cycle, developing skills to exit shame); (5) reducing risk interventions (if the client is involved in risky behavior); (6) teaching

emotional regulation skills, such as DBT skills; (7) teaching and practicing relationship skills and building a supportive community; (8) addressing ambivalence; and (9) Sexual Identity Therapy interventions.

John Doe #1: I look for the emotional meaning behind the attraction. Often times this is elicited by asking the patient what he thinks about himself in relationship to the person he feels an attraction towards. Once that thought is obtained (i.e., "I am inferior," "I am a weak man"), I use two interventions: body work (a form of affect-focused therapy), and EMDR. In both cases there is a focus on past experiences (i.e., traumas) that contributed to the formation of this thought. Usually before I do these interventions, I will introduce some cognitive behavioral techniques including the triple column technique so that a person can more quickly identify and name the cognitive distortions that he falls prey to. In this technique I have the client identify a negative automatic thought, and then by identifying the cognitive distortion behind it arrive at a rational self-assessment. These distortions may or may not directly relate to his same-sex attraction, but often contribute to his self-perception, and I believe that any work that helps the client improve his self-perception will also help the individual with his same-sex attraction.

Davidson: Talking therapies, and some action techniques. Usually this involves behaviour modification – reducing behaviours that appear to the client to be harmful: PMO (Pornography, masturbation, orgasm) link is explored and work is done to understand dopamine addiction. Action techniques revolve around role training—especially in relation to trauma work—in order to discover alternative responses. Our work is about enhancing client self-esteem and teaching assertiveness through assertiveness training. I try to get a feel for a client's "Social Atom." When there are high levels of internet pornography, we work on building real relationships and other socialization goals, such as increasing communication skills in terms of making friends. Work is usually done to de-erotise same-sex connections and demystify "sameness." We explore "difference" versus "sameness" models of romance. We also do work on labeling—deconstructing binary model concepts—notions such as "orientation" (versus "patterning").

Hallman: Most women who experience incongruence between their same-sex sexuality and faith convictions do not necessarily come to therapy to "change" their sexual attractions. They come to therapy because of the confusion, conflicting thoughts and emotions, and general stress that this existential reality presents. They seek to stabilize their internal world, understand their sexual attractions and same-sex relationships (meaning making), work on their lives in terms of broader issues or past trauma, establish a primary identity based on their belovedness and unique self versus their sexuality, understand themselves as a unique and special woman, challenge their religious beliefs, establish safe and healthy community, etc. I therefore offer standard psychotherapy following the theories and techniques that are evidence-based or widely accepted as effective for these types of issues. After engaging in this type of work, many clients experience shifts in their cognitions, emotionality, relationality, spirituality, and sexuality (such as a reduction in the intensity of their attraction to certain women).

For clients who initially come to therapy with the explicit request (or rather hope) to "change" their sexual orientation, I remain in a mode of assessment to determine the source of this request. Many times women feel pressure from their families or churches to "change," fear the loss of these relationships should they act on their same-sex attractions, or experience deep shame over the belief they are flawed or an abomination to God. This request therefore often arises out of fear or shame. When this is the case, I direct therapy towards their very real and legitimate fears or probable internalized shame. It is often during this phase of therapy that a woman realizes there are broader issues to discuss. Her original goal of "changing" typically falls by the wayside.

There are no techniques that I use (or am even aware of) that can directly "change" a person's sexual orientation. Sexual orientation (at least for women) is an integrated aspect of a person's development and sense of self and therefore does not present as an isolated characteristic that can be simply "changed." Nevertheless, not all people will necessarily formulate a primary or typological identity around their sexuality. This is true for many of my clients. While they continue to be primarily sexually attracted to women, they choose to identify as heterosexual based on their belief that this was God's original purpose for their sexuality.

Pickup: I primarily use a psychodynamic approach, with added Cog-B methods. These methods, which are professionally accepted methods that have been used for decades, would benefit any same-sex attracted individual. However, depending on the client's personality traits and preferences, narrative, client-centered and holistic approaches can also be beneficial.

Pela: First, there are no special interventions—this is not a special type of therapy. I am a Narrative Therapist who happened to have the opportunity to collaborate with clients who present with goals related to their sexuality, including distress and discomfort with SSA experiences.

I'm guessing that the long answer—that is, a detailed explanation of Narrative Therapy interventions—is not appropriate for this investigation. But, to provide a clue—for this presenting concern (distress and discomfort related to SSA)—I would begin with a protocol of inquiry that helps me understand what it is about SSA that is concerning the client. Given the current cultural narrative, this concern might be that the client has introjected the current narrative that SSA is somehow intrinsic to her identity. This has been a common concern in my work with college-aged women who have become involved in a same-sex sexual relationship and have become convinced by the popular mantra that they are now a lesbian-for-life. They often present with depression and despondency, believing that they have no choices about their future relationships and sexuality. Most of the women who I have collaborated with have expressed a desire to be free from the boundaries and limitations of the narrative that sexual attraction is intrinsic to one's identity.

The client and I also need to uncover more information about the experiences, beliefs, and values that they associate with the label, SSA. I want to know what attributions they associate with SSA. This is a highly collaborative process and requires the client (not the therapist) to identify the meaning of the problem. The client's story about SSA is more important than mine, or Freud's for that matter (although it's okay for the therapist to have a metanarrative).

The question identifies the client's goal as desiring to "change and/or reduce" her SSA. This gives me an explicit label for the problem. Labeling the problem with a label salient to the client is essential. The client's goals are more important to me than my goals for her. Narrative therapy takes a

radical stand for the self-determination of the client. Narrative therapy proceeds from here by discovering the influence of the problem in her life. Since the question identifies SSA as the problem, I want both of us to explore how SSA has disrupted her life and caused her distress with the utmost detail. This is a clarifying process—it allows us to discover if SSA is actually the problem, or perhaps she will discover a different problem in the process.

Narrative therapy is best known for the externalization and the personification of the problem. This is accomplished through the use of language that extricates the problem from within the client. This begins with my first conversation with a client. In this case SSA is not who she is—nor would OSA be who she will become (again—the goal implied in the question). Rather, SSA is externalized through the use of personifying language so we can see the complexity of the relationship that she has with SSA.

Later, we identify exceptions to the problem, all the while externalizing the problem from the core identity of the client. By seeking the exceptions to the problem, we uncover an alternative story that is congruent with the client's chosen values-identity to the cultural narrative about SSA. Through this process the client's sexuality is restored as her own and no longer dictated by a culturally mandated narrative. This allows the client to explore relationships and romantic experiences that were previously off limits.

This is leaving us halfway through the process of therapy—this is not a comprehensive "treatment plan" but is meant to give the reader a sense of the interventions used by a Narrative therapist when working with someone with the identified presenting problem.

John Doe #2: My interventions include EMDR, CBT for Impulse Control Habits (e.g., Schwartz Four Step), assertiveness training, referral for Twelve-Step group support, meditative breathing, journaling, and help for co-occurring difficulties as appropriate. *No* method works for everyone who has the same presenting concern, whether unwanted SSA or any other issue. Sometimes, it is not so much the "attraction" itself but compulsive or otherwise habitual behaviors which clients want to change (e.g., same-sex pornography use).

2. Which interventions do you use if a person wants to be sexually attracted to the opposite sex when previously the person never felt any sexual attractions to the opposite sex? Which interventions do you use if the person experiences sexual disgust or aversion (not emotional aversion) toward having sex with the opposite sex?

Nicolosi: I would likely be working on past trauma in the form of psychological education, EMDR, body work, and mindfulness regarding the client's mother and other significant, dominant woman. Those same methods listed above to increase opposite-sex attractions.

Popper: Once clients are experiencing more autonomy, genuine mutuality, and satisfaction in their male relationships, it is time to explore if there is a part of them which resonates, however vaguely, with a potential partnership with a woman, whether in a sensual, affectional, or friendship context. As this area is explored, most often mother-related issues surface in all kinds of forms, along with other historical material related to relationships with females, along with sexual abuse history, etc. As the client risks experimenting with approaching females as a male looking for a complementary partner, the childhood pain related to formative relations with females begins to emerge, along with the survival narratives to avoid this pain. Here, the work is to learn to not identify with the childhood narratives connected to the pain, but choose to acknowledge other concurrent inner responses in the present as they are experienced with female companions, and allow their reality to sink in. These responses may, for example, be expressed as nurturing touch, fun playtime together, and sensual impulses.

Jane Doe #1: This specific example has not presented itself in my clients. The clients who have wanted to be more sexually attracted to the opposite sex typically have some element of attraction toward the opposite sex to begin with. In addition, the clients who feel disgust or aversion toward having sex with the opposite sex have not had a goal of increasing their opposite-sex attractions. Typically those clients' goals are related to their own self-development (e.g., feeling comfortable in their own body, identity development, reducing shame, managing anxiety, etc.). But to be clear, I have never used aversion therapy with any of my clients (same-sex attracted or otherwise).

John Doe #1: In these cases I will do EMDR around a woman the man would like to feel an attraction towards. The themes that usually emerge from these sessions revolve around feeling insufficient in the eyes of a woman. This sometimes leads to EMDR around past memories where these beliefs took root.

Davidson: I would work to understand the depth and nature of the aversion and understand the nature of the aversion and the extent to which it is emotional. I would be more comfortable in working with the emotional aversion. Regarding the physical aversion, I would check the age-appropriateness of any events that had contributed to or were associated with the aversion's beginning. Exposure of post-pubescent "sex education" materials to pre-pubescent children might be an issue. I would check the safety measures that might need to be in place to address this—is there a supportive opposite-sex partner who might work with this in terms of incremental exposure to areas that the client is averse to. Psychodrama is useful in symbolizing areas that are distasteful and can be instructive through the stepping in and out of any action to mark what the client brings out.

Hallman: I do not utilize interventions to "make a woman" feel attracted to men. Frankly, most women I work with have no interest in being with a man. They simply long to live a fulfilling life as a single, strong, and centered woman or to be in a healthy same-sex relationship that is not fraught with emotional dependency. Obviously for the latter group, some shift in their religious beliefs surrounding homosexuality has usually occurred.

Some of my clients, however, present as more bisexual. They have experienced attraction to men in the past or even currently. Yet many of these women have nevertheless been solely sexually active with women. They therefore lack the opportunities and experiences in relating to men romantically and sexually. These women often do request to work through the obstacles that might prevent the openness to and cultivation of long-term relationships with men. This might include (1) challenging negative core beliefs, such as "Men only want one thing," or "No man will ever want to be with me"; (2) challenging any fears associated with intimacy with men that may have been learned or formed out of past disappointments; (3) healing from past trauma that involved men; or (4) dealing with her sense of

immaturity in terms of relating with men romantically (such as recognizing social cues or knowing how to do the flirtation dance).

In summary, therapy is not so much directed towards attempting to instill something new into the client, but is directed towards resolving or reframing potential obstacles or restrictions that prevent the client from reaching her goals for personal growth, development, and expansion of her personhood, as well as the full expression and manifestation of all aspects of her true and unique self.

Pickup: I use the same interventions as I noted for the first question. To date, every client who wants this therapy has discovered that their non-attractions to the opposite sex are "hiding" earlier trauma to their gender identity. So, we work on the fulfillment or healing of their gender identity, which results in their reports of how good it feels to be authentic and whole in their own gender. When my clients feel their own wholeness, and when they feel complementarianism with the opposite sex, these clients report a development of sexual attractions to the opposite sex. This does not always happen. Some men are very happy living an authentic life without moving on to women. For those that feel disgust, I have always discovered an underlying, frequently unconscious, issue with the opposite sex from childhood. Psychodynamically, we work on resolving this issue so that the disgust can resolve itself automatically.

Pela: As to the first part of the question, I am very skeptical of this story—"I have never had sexual attraction to the opposite sex." In fact, I'm skeptical of any "never" or "always" narrative. Again, using a Narrative Therapy protocol, I look for unique outcomes (this would take place later in the therapy process). Generally, this process of looking for incidents of OSA is preceded by empowering the client over the limited introjected cultural narrative that they have come to therapy with—the story that SSA is who they are, etc., and by that time there is less of an investment in maintaining the "I have never. . ." story. They don't need it to maintain their core identity if SSA has been successfully externalized. As an aside, I have at times discovered that a Hollywood-style story of what attraction to the opposite sex looks like has limited their "seeing." If we look outside of that limiting, shallow paradigm, the story of attraction to the opposite sex will have room to emerge in their lives.

Regarding the second part of the question, this protocol assumes the client's desire to overcome the disgust and aversion. The client will first need to clarify the values/beliefs and desires at the heart of the choice to attempt to overcome these experiences. Congruent with Narrative Therapy, discovering the story around the disgust and aversion is an essential first step. A common theme that I have found for women who experience disgust and aversion related to opposite-sex sex is previous experiences of sexual abuse from a man, or witnessing their mothers' abuse. They have often witnessed or experienced suppression, degradation, and exploitation of women within opposite-sex sexual relationships. Further, parallel stories about women in healthy egalitarian-complementary sexual relationships have been occluded by this dominant oppressive story. In my experience of working with women, emotional and physical attraction are strongly synthesized; so, I believe helping them find exceptions to their stories about male-female emotional/romantic relationships is helpful in addressing the disgust/aversion. They may also be able to identify times when they were not disgusted by the thought of sex with a man. As mentioned earlier, the process of accepting these exceptions to their story usually comes later in therapy after their identity is no longer overwhelmed by the oppressive story that they are their erotic attractions.

John Doe #2: My answer is the same as the one I gave for the first question.

3. What are the theoretical assumptions underlying the above interventions?

Nicolosi: Homosexuality is a symptom of past shame trauma regarding one's gender. The result is a fear of actualizing the client's natural assertion that includes gender expression.

Popper: Accepting without shame that to a greater or lesser degree, we all carry residues of our childhood pain and the connected narratives inside of us. We often react to situations in the present identifying with those childhood narratives, which back then assured our survival, but in the present do not allow us to experience life as it is happening to us. And learning to not go along with the default identifications with the childhood survival narratives, but to identify with the adult experience and perspective, in which we exist as separate, autonomous human beings with our own thoughts, feelings,

and desires that need to be heard and respected too. As I stated above, folks who are ambivalent about their SSA and look for help towards reaching a capacity towards a more complementary relationship with a female, usually show the residues of childhood issues, which they coped with through developing dependent personality characteristics. I have not mentioned that many of these folks also exhibit an inborn temperamental baseline of great sensitivity, which reduces their chances of thriving in typical culturally defined maleness, which often is judged by their fathers and peers, contributing to their childhood issues.

Jane Doe #1: I'm guided by the ethical ideals of respecting my client's autonomy and avoiding imposing my values on them. I assume that I don't know what is best for the client, but that they have to figure that out for themselves. I also assume that my pressuring them in one direction or another (e.g., to reduce or affirm their same-sex sexuality) is not helpful. Some interventions are based on the research that's been done on sexual identity development and the various stages that sexual minorities commonly progress through, and how some individuals disidentify with a gay identity. I use a cognitive model of shame (though my interventions for shame address emotions, relationships, and behaviors as well). One assumption I have (that seems backed by research) is that shame is not only caused by sexual stigma, but may be present prior to experiencing sexual minority stress.

My theoretical assumptions include the understanding that humans are relational at their core and that in order to endure suffering, a network of support is necessary. I also understand the need for similar others, which can be difficult when the similarity is hidden. I also understand that my client's sexuality is housed within their relationality, and often addressing relational deficits (if present) can be helpful.

John Doe #1: Mainly, that homosexuality is a reaction to feeling disconnected from men. It is not a sexual problem but a developmental one. It represents the symptom of some other underlying condition. However, each story is a little bit different.

Davidson: My basis is psychodrama psychotherapy, by which I understand that the Director (therapist) plays a facilitative role to assist the client (in contract) to work on specific areas of concern. The action of working through alternative responses, reworking scenes (perhaps of traumatic experience where appropriate) making use of role play, role reversal, spiraling, mirroring (travelling backwards or

forwards in time) can be helpful in concretizing the work. Making use of the group strength where possible and identifying the "tele" (i.e., the rapport) operating between participants can be helpful.

Hallman: I operate from a psychodynamic approach attempting to honor all aspects of a client's personhood, experiences, and autonomy and self-determination. I am supremely client-centered. For clients who continue to remain in the tension of same-sex sexuality and conservative religious beliefs, this is not an easy task. Both the client's sexuality and religion must be honored and validated. I aim to reduce the shame and guilt that may be promulgated by either or both of these important aspects of a woman's life. There is no shame in having same-sex attraction, and there is no shame in holding to a conservative religious ethic. Shame tends to fragment a woman's sense of self. Most of my clients are looking for an integrated sense of self, even in light of the tension between their sexuality and religion. To honor my clients' goals in this regard, therapy, at its core, must be seeped in empathy. Empathy is what can shift a shame-based identity and provide the basis for an identity founded on worth and a sense of belonging. I therefore operate from a deeply attuned, empathic, and compassionate stance in an effort to provide a safe environment in which my clients can freely explore, question, challenge, grow, experiment, and apprehend the life that they can equally enjoy and celebrate before God.

Pickup: There are no a priori assumptions by my therapy. However, every client who wants change therapy reports two basic assumptions. First, they do not believe they were born gay. Second, they believe there were traumatic causes of their homosexual feelings originating in childhood that are centered on severe gender identity inferiority and severely unmet needs for love, affection, affirmation, and approval by major same-sex role models. With these assumptions, psychodynamic techniques reveal the truth of these wounds since they automatically come up as clients are relieved of their repression of trauma. Affect interventions, which can be a psychodynamic tool, give rise to the grief, anger, and inferiority that they discover are below their homoerotic attractions. These assumptions lead to one of the primary principles of Reparative Therapy, which is to resolve and get rid of any shame for having homosexual feelings.

Pela: I think I have articulated these assumptions throughout the questionnaire because I believe that good therapeutic interventions are inextricably connected to the theoretical assumptions of the originating theory, and these assumptions should be identifiable throughout the therapeutic process. However, a couple of additional points may be helpful to provide a broader foundation. Narrative Therapy holds to a collaborative approach where the clients determine their goals. The therapist's knowledge does not trump the client's—rather, they come together and share their views of the problem, checking out the saliency of their views for the other, each step of the way. In direct contrast to Narrative practice is the common formulaic response, as revealed in LGBT clinical literature, of assuming and subsequently projecting "internalized homophobia" onto the client as the probable explanation for her distress.

Another assumption is the belief that individuals often accept stories about themselves that others have told them along the way—stories are created in community—in relationship. Especially when individuals are hurt, vulnerable, or confused, they gravitate to cultural stories to find anchors—but these stories are sometimes limiting and are sometimes in conflict with the client's values and beliefs. Narrative Therapy seeks to help the client to become identity-congruent with their beliefs and values and allows them to question the often limiting assumptions posed by the stories that they have adopted.

Narrative Therapy is built on a social constructionist theory and fits well with Michel Foucault's understanding of the dangers of allowing our sexual experiences (attractions, desires, behaviors, thoughts) to become our identity. The reduction of our identity to support any cultural narrative limits the richness of the individual's narrative and limits their options to live a life according their preferred values.

John Doe #2: SSA, like OSA, are bio-psycho-social phenomena, which are learned. People choose whether, when, and how to gratify both same-sex and opposite-sex attractions. The gratification of such desires leads to their being strengthened and to their recurring more often. Abstinence, self-assertion, and working on "core issues" help a person manage or otherwise resolve unwanted SSA, as well as problematic OSA.

4. **How do you account for the reports of specific harms found in the research literature, including reports of misrepresenting themselves, by some consumers who have attempted to change their sexual orientation?**

Nicolosi: To date there has not been a systematic assessment of harm other than individual reports, which are mostly unsubstantiated.

Popper: There is subjective experience of harm in any form of therapy, especially when the hoped-for goals of the therapy are not accomplished to the client's expectations. That is why according to ethical practice, change is not promised to SSA clients who come to explore the possibility of change for themselves. Since some people do change after exploring childhood issues, like the ones mentioned above, my contract with the client is that as you, the beginning client, walk this journey out with me you will see for yourself how much change, if any, is possible for you.

Jane Doe #1: I am familiar with several studies regarding the specific harms found in scientific literature. Some articles have found evidence of possible harm, other articles concluded that there wasn't an inherent harm based on attempting sexual orientation change. I am also familiar with an article attempting to show harm that was done in this type of work, but the authors then had to change the intended title/focus of the article, because they did not find the harm they thought they would find, and in fact, some participants gained benefits from the therapy. Finally, I am familiar with the risks of psychotherapy as a general practice and from my understanding of the "specific harms" found in the research literature, I understand them to be not wholly different.

In order to minimize the risk of harm, I follow suggestions offered in research literature, such as advanced informed consent, addressing motivations for attempting to change one's experience of their sexual orientation (particularly shame-based motivations), and assisting clients in areas that are more amenable to change, such as sexual identity. I work hard on not imposing my own beliefs on my clients and stay attuned with his or her experience so I can be sensitive to what it is they desire.

As far as misrepresentation, I am sorry for the fact that people have felt pressure to present themselves in a way that is not authentic to their true experience. In general, authors frequently suggest that prevalence figures for all conditions are underestimated because people do not report their true experience. Misrepresentations are common phenomena for humans, and not limited to studies on sexual minorities. I also wonder if the questions posed by scientists have not been broad enough to encompass the full experience of a person's sexuality, which has been shown to be incredibly complex (e.g., not limited to physical attractions) and fluid over time for many individuals. This may account for some of what is termed here as "misrepresentations."

John Doe #1: There is an agenda in the psychological community to prove that this therapy is harmful. My experience has been that this therapy is not more harmful than any other sound psychological treatment. The psychological community has published numerous studies endorsing gay affirmative therapy with few participants, less than reliable sampling procedures, and data based on retrospective self-reports. However, those studying the possibility of change have to comply with the most rigorous standards, and even then, most likely face rejection of their submission in any event.

When someone comes to us in tremendous pain, as is the case with SSA, our natural inclination as well-intentioned therapists is to want to take that pain away. It is crucial that despite their urgency for help, we do not commit to things that we cannot reasonably give them. We cannot say we can definitely take it away. (I don't!) Also, many who are desperately seeking relief may only be willing to accept 100% total change and may want it so badly that they almost hear their therapist promise it. We must get the client's advanced informed consent to therapy where we tell them the potential risks and benefits involved as we should ethically do with any other therapy we perform.

Davidson: If this was raised in therapy, I would spend time looking at the research. So if it's the recurring Shidlo and Schroeder (2002) reference, I'd look at the internal stated limitations of the piece that are often ignored, and also the nature of the population group sampled—the way it was selected; I'd point out the statistical anomalies of the piece that indicate people were actually helped on average by the therapy that is in question in terms of a sense of connection and well-being.

Hallman: I have never ever supported the sensationalized claim that "Anyone can or should try to change their sexual orientation." This indeed is false advertising. I have been aware of some misinformed therapists making this claim to unsuspecting and vulnerable clients. This clearly can be very damaging and, I would suspect, has done great harm to folks. I am very frank in communicating to clients who initially come to me to "change" their sexual orientation. I say very plainly that I do not know *how* to do such a thing but that I can offer a safe place in which they can explore *why* they want to change or engage in standard psychotherapy for the many factors that are present in their life that might be adding to the stress or felt urgency to "change" their sexual orientation.

Over the years, I am also aware that some clients maintained a secret hope that their sexual orientation would "change," even after requesting and setting their goals to stabilize their internal world, understand their sexual attractions and same-sex relationships (meaning making), work on their lives in terms of broader issues or past trauma, establish a primary identity based on their belovedness and unique self versus their sexuality, understand themselves as a unique and special women, challenge their religious beliefs, or establish safe and healthy community, etc. Some have shared their disappointment with me, and while not claiming they were directly harmed by me, they nevertheless still experienced sentiments of harm due to their powerful disillusionment and questioning of the time and money spent in therapy. In other words, these clients were not necessarily harmed by false advertising or any direct therapeutic attempt to "change" their sexual orientation, but by an often held unconscious hope that "change" would happen. Nevertheless, this harm is still real and concerning.

Pickup: Who does this mean, "misrepresenting themselves"? Does this refer to the client or the therapist? In my experience, in reviewing the cases of harm put forth, whether in articles or in testifying before state legislatures, I've found almost all reports of harm come from unlicensed "therapists." To date, all the reports of harm, or extreme harm, such as "labor camps," or shaming episodes have no documentation to back them up. Licensed therapists do not force their views on clients. If the therapist is licensed and well trained, they show all clients unconditional positive regard. I am not aware of any research literature in which a valid study has shown harm. There were studies that obviously

demonstrated harm 35–50 years ago, such as electroshock or aversion therapies, but these are long gone. There has not been one ethical complaint to any licensed board concerning SOCE in any state for approximately the last 40 years. The American Psychological Association (2009) reported in their Task Force Report on SOCE that there is no proof of harm in the research literature (pp. 82–83). Also, many of these testimonials of harm are coming from religious "camps," but I have not found documentation of these as well. Other groups, such as men's experiential weekends, do not promise change. They emphasize security in one's own gender and meeting same-sex emotional needs. These men sign release forms as well. Also, if some men decide they are gay and want to pursue that, they are shown compassion and understanding.

Pela: Having reviewed the literature extensively as a background for conducting a quantitative, longitudinal, clinical, outcome study, and in agreement with APA (2009) task force report on the topic, I find little to no evidence supporting the contention that people seeking assistance to influence their sexual attractions are harmed by professional psychotherapy more than the general psychotherapy population. On the contrary, the research that I am conducting demonstrates that the reduction in suicidality, depression, and anxiety is statistically significant when men seek psychotherapeutic support for distress related to their SSA. Their relationships with close family and friends, and functioning in social situations are greatly enhanced while in therapy for their distress.

There is anecdotal evidence that people seeking help to change their SSA from non-professionals can experience deterioration. This is particularly evident when the claims for the possibility of change are exaggerated by the service provider.

John Doe #2: First, all approaches to "psychotherapy" for any presenting concerns have been shown to result in "deterioration" or unwanted and uncomfortable—sometimes explicitly "harmful"—consequences for *some* clients. Second, reports of harm in the literature typically do not differentiate between professional and non-professional caregivers attempting to help persons with unwanted SSA. I think it is likely that mental health professionals who give appropriate informed consent and use state-of-the-art psychotherapeutic interventions will not provide care that results in "reports of specific harms." As

with all psychotherapies, some clients may not manage or resolve their difficulties to the extent that they would like to, regardless of their own motivation to change and the skill and experience of their therapist. Also, if clients leave therapy before they reach a clear termination place, they may experience an unfortunate, perhaps avoidable, degree of discomfort as a result.

5. How do you assess and treat the effects of minority stress on your clients who are attracted to the same sex?

Nicolosi: Among the responsibilities of the therapist is to listen to symptoms of stress and assist the client in reducing those stresses. The process of reduction of stress is to determine if they are intrinsic to the condition or if they are an internalized self-criticism from a hostile environment.

Popper: I spend a lot of time exploring the motivation of the client for change and whether it is mostly motivated by minority stress or other outside pressure, because those motivational factors (i.e., wanting to move away from pain) do not lead to SSA change through the journey I guide my clients through, at least in my experience. As I stated, above, some part of the client has to resonate a bit with moving toward females for affection, nurturance, and eventually sensual touch. This resonance often appears only after the client has achieved some level of autonomy and the ability to set boundaries for himself.

Jane Doe #1: In my advanced informed consent form, I ask the client about their motivations for seeking therapy focused on same-sex sexuality. The responses include elements related to minority stress (such as "lack of social support as an LGBTQ person" and "discrimination"). As the client is willing, we address the nature of these motivations and work to identify what is sexual prejudice. In addition, as the client and I work together, I highlight when minority stress might be a factor in what they are facing.

In terms of treatment, we work to find a supportive community and use psychoeducation to talk about what constitutes safe community. We use cognitive therapy to address cognitive distortions and shame-based beliefs (which often relates to internalized homophobia). Since most of my clients identify

as spiritual, the client might wish to work on a nuanced spiritual understanding that is more accurate than perhaps he or she had learned earlier in his or her spiritual journey. Grief work and boundaries are common when important, on-going relationships contain elements of sexual prejudice.

Davidson: By "minority issues" I am assuming this revolves around prejudice and "homophobia," "xenophobia," or "islamophobia." I try to assist in the process of broadening connections, and encourage the development of skills that might enhance "cross- and inter-cultural competence" by encouraging the client to look at their achievements (in coming to the UK and entering an English language university, for example). I might share some of the findings of the Dutch international business machines (IBM; Hofstede, Pedersen, & Hofstede, 2002) research looking at such things like the differences between "paternal" and "matriarchal" societies, monochrons and polychrons; societies that value "text" and those that don't—how the interface between different hierarchies relate to different cultures coming into focus. Several short papers I wrote around this for university teachers are still helpful to me—on culture shock, etc. (http://www.nottingham.ac.uk/pesl/internationalisation/documents/).

Hallman: This is a significant focus of my therapy. However, many of my clients find it hard to face the difficult realities that are often presented within their Christian families, churches, communities, and sacred scriptures. It requires patience and acceptance to provide the time and space for a woman to admit to her disappointment and hurt surrounding experiences involving discrimination, moralizing, legalism, rejection, isolation, stigmatization, or victimization from the hands of Christians. Therefore, while I may intentionally direct a client into these discussions, I honor her ability to articulate, process, and integrate these difficult aspects of her world and experience. These experiences obviously trigger shame (and fear), so simultaneous shame-related work must be undertaken while these realities are discussed. Many of these disappointments and experiences must be processed before a woman is able to make a fully informed choice on how to move forward with the integration of her sexuality and religious identity. (NOTE: Sadly, it is this type of work that is now carelessly referred to as "reparative or conversion therapy." Just because a client is engaged in long-term therapy and remains in tension between

her sexuality and religious convictions, they are not necessarily seeking or receiving "reparative therapy.") The specific terms, such as heterosexism, internalized homophobia, sexual stigma, and minority status, are typically too clinical or political for my clients to benefit from; nevertheless, we unpack their meaning and their appearance within their lives.

Pickup: If this question means the stress of being treated as a minority, I discover this in the first session when the client has filled out a client history form. I work with these clients to get rid of any feelings or cognition of shame-based messages that have been put onto them by others. I also work with them to build up their self-esteem regardless of what others think about them. I help them to accept themselves for who they truly are (which they define) or for whatever they are feeling.

Pela: From my perspective, minority stress is a result of a group of cultural narratives that limit, oppress, and at times promote discrimination and abuse of cultural groups identified as minorities. Cultural narratives of oppression are routinely investigated in Narrative Therapy since these stories are often influential in the development of the clients' personal unhelpful story. Of particular concern regarding the clients that I have collaborated with is the story about "ex-gays." (I do not encourage my clients to identify according to their former or current erotic attractions, but this is an identity that some present with.) This minority group is maligned by everyone from the groups identifying as LGBT activists to Evangelical Christian groups promoting the current narrative that our erotic attractions are a core of our identity and that at best we should seek a celibate lifestyle if we experience SSA. This narrative often goes so far as implying that LGBT-identified people require a different theological system (Gay Theology) to be reached by the Gospel. As far as I am aware, this is the first time a special system of theology has been written for a minority group. The fact that LGBT-identified religious leaders are contributors to the development of the perspective that LGBT-identified people are so different that they need a special theology just for them is astounding.

John Doe #2: I ask clients about their presenting concerns. This includes both the internal and external sources, and effects of "minority stress." Sometimes, such incidences prove to be occasions of

traumatic familial and/or peer experiences which are treated as described in my answers to questions 1 and 2 above.

6. **How do you help someone who wants to be celibate and/or married to someone of the opposite sex, who has a moderate to high sex drive, but who cannot act on her or his sexual/romantic feelings for the same sex?**

Jane Doe #1: If the person's therapeutic goal is to remain celibate or married to someone of the opposite sex, but they continue to have a moderate to high sex drive towards the same sex, we would follow the interventions recommended in Sexual Identity Therapy. These help a person manage their sexual/romantic feelings in a way that is congruent with their values/goals. As an example, the person would chart the course of their same-sex sexual/romantic feelings in order to understand what influences them (e.g., loneliness, hormonal cycles, physical closeness). Learning what influenced the sexual/romantic feelings can lead the client to ideas of how to address what is going on (if possible). Another angle is to help the client normalize this experience, and help them find others who experience similar struggles (gay or straight).

Of note, one of my clients that fits this description found that being on a particular birth control pill tempered her moderate to high sex drive (she believed it was due to the shift in hormones). This is not something I recommend to other clients, but it caught my attention.

John Doe #1: Living with competing feelings is actually a good thing. It's called life. Diabetics have to make difficult choices when they look at a nice sugary danish. They have competing conflicting feelings, and they need to make a hard choice. It tastes good, but it's not good for them. And they have to choose whether they will make a decision from a place of strength or weakness. And life is full of these moment-to-moment decisions. I have a couple of hours: Do I spend time at work or with my kids? Should I choose the more fulfilling job with less money or go for the better paying but less meaningful position? As psychologists, sure, we try to minimize the intensity of these conflicts, but not to eradicate them. This

is because we realize that conflicts can't always be eradicated. We recognize that conflicts are a healthy—albeit painful—part of life, essential for personal growth. What does any therapy purport to do anyway? In this therapy, we help men who have chosen to work on their SSA, reduce it when they can, and live happily—happily and in integrity with their values, and yes, even if that means navigating competing—at times powerful—feelings in their life. After all, that would mean we help people deal with conflicts. We help people deal with life.

I will encourage people to meet their needs for same-sex connection in healthy ways, such as non-sexual intimacy with other men. This looks different to different men but often team sports can be beneficial, or taking the risk of disclosing something personal to a male friend. It is also important to get the client to become more like his projection, and develop traits that he is attracted to. In other words, become the kind of man he is attracted to. When lust plays a big role, I will also refer to SA programs. SA programs reinforce that sex, unlike food and water, is not a necessity for survival, and that acting out on one's sexual fantasies in the pleasure-saturated world we find ourselves in, is not the recipe for a happy life.

Davidson: I would focus on the issue of performance anxiety and look at the cultural shifts that have taken place over the years enhancing the hyper-sexuality of particularly western culture. If the client is an "international" client, we spend time comparing and contrasting "traditional" values with the philosophical position of the current climate in Western Europe. I would make sure that the values towards celibacy or marriage are properly owned by the client and not those of other significant others (siblings, a church, etc.). I would also challenge any spiritual misconceptions of celibacy and distinguish between "chastity" and "celibacy," the latter of which I take in Christian thinking to be an exclusive term relating abstaining (by special giftedness) from complementary opposite-sex monogamous relationships. If the client was not from a faith background, I would work from whatever values framework they presented and look at the design/evolution of male and female. I would also explore the symbolism of erotic love in the spiritual or symbolic world view of the client in front of me.

Hallman: This is the thousand-dollar question and possibly presupposes that chastity or fidelity is a ridiculous or less than beneficial lifestyle. Outside of religious settings, I can see why chastity makes little sense. The sex act is beautiful, powerful, fun, and pleasurable. It brings a sense of oneness and belonging, especially when there is an emotional connection between the two lovers. Sex is part of God's design, and it makes sense that we would want it. Within religious settings, sexuality is understood as a sacrament. Sexual union is meant to reflect the intimate and pleasurable union between God and us, and therefore serves a transcendent purpose. It is not *all* about our pleasure. Chastity then, within Christian settings, is indeed seen as an act of sacrifice to be taken by singles *and* marrieds who are within sexless or loveless marriages (which, I might add, is far more common than most people realize), for the purpose of honoring God's transcendent purpose for sex. But it is also seen as an act of service and dedication to God and others. For people who are committed to chastity (again whether married or single, gay or straight), it is within their service and abandonment to God that beauty, fun, pleasure, oneness with God, others and self, and belonging are cultivated and hopefully enjoyed.

For women, having sex is not the drive behind longing to be in a same-sex relationship; it is the desire and longing for companionship. Very few women "act out" on their same-sex attraction to merely satisfy their sex drive. They reach out for the sake of being in a relationship. This is why I do not impose an agenda on my Christian clients with respect to how they live and identify or disidentify with their sexuality. It is up to them to make decisions for their life and well-being. Many of my clients have come to peace with their Christian beliefs and sexuality by understanding the scriptures differently than they did when they started working with me. They believe that God knows about and is even sovereign over their sexual orientation and thereby makes provision for a full and healthy life by blessing a monogamous, committed gay relationship. Some come to this conclusion after they have entered a loving gay relationship. By remaining open to my clients' choices and decisions, my clients can avoid the polarization that is often created when individuals are explicitly told (or ordered) what they can or can't do. An individual cannot fully own their decision (which I believe is a healthy thing to do) if they are not allowed the full and frightening freedom to choose from all possible options, good or bad, right or wrong.

God gives each of us this type of freedom. Life is difficult. God was wise in giving us not only freedom, but also grace.

Pickup: In the case of celibacy, I work on their self-esteem and fulfilling their potential in the most important areas of their lives in which their energies can be spent. I also look for reasons why they are celibate and whether those reasons demonstrate consistency with their belief systems, and if not, to help them see their irrational cognitions in order to grow more authentically that fits their belief system.

For those married to the opposite sex, I explore their belief system to help them discover whether they believe they are genetically gay, or whether they believe there were emotional or abuse issues that caused their homosexual feelings. In my experience, almost everyone discovers they were not born gay, so we look for emotional and cognitive issues that created these feelings. This can sometimes include sexual abuse. For men in this situation, they have found that unresolved gender and/or mother wounds from their upbringing have negatively affected their feelings toward their wives. In effect, they unconsciously repeat their mother issues with their wives, so we work on resolving these deeply affective issues to help the client feel self-confident and less trapped by these issues with female role models, which can lead to greater feelings and actions of intimacy with their wives.

Pela: I'm not sure what the client's goal would be in this case. The question implies that the goals of these clients are self-evident. Never assume the client's goals for them. Also problematic: the question assumes that I would approach helping an OS married client in a similar way to helping a celibate client. That is possible, but hard to imagine.

John Doe #2: Along with the answers to Questions 1 and 2, appropriate referrals for peer group support and, if a religious or spiritual person, to persons and groups who can provide religious or spiritual resources which may help them honor their personally chosen celibate or marital state.

Concluding Observations on Participants' Responses

In reviewing these responses, a few concluding observations seem justified. I note them here in no particular order of importance.

1. **SAFE-T takes no singular theoretical or practical manifestation.** This sample of experienced therapists report a wide variety of approaches to assisting clients who may pursue change in their SSA. Psychodynamic perspectives are common, but these may be augmented by insights from such modalities as information processing (EMDR), experiential (psychodrama), and cognitive modalities. Other approaches take a mostly different direction, such as narrative therapy or sexual identity therapy. Of interest is that these latter approaches were found more among therapists who work with women, suggesting that somewhat divergent clinical models have emerged out of the clinical experiences of therapists assisting different genders. This significant diversity of standard therapeutic modalities practiced by these therapists make it difficult to understand how legal bans on SAFE-T can be enforced as a prohibition of therapy per se. In practice, such bans are more likely to function simply as legal intimidation for therapists of clients who might wish to pursue the goal of SSA change.
2. **Emphasis on understanding client motivations.** Nearly all of these clinicians indicated the importance for ethical practice of carefully evaluating client motivations for SAFE-T. These professionals expressed awareness and concern that a client's goal of SSA change could be the result of coercive pressure from family or religious communities rather than the product of an autonomous and self-determined choice. Establishing a client-centered and self-determined goal of SSA change appears to be foundational for any subsequent therapeutic process involving SAFE-T. Such a practice orientation does not seem to comport well with portrayals of SAFE-T as an inherently coercive and therapist- determined process.
3. **Same-sex attractions are usually not the focus.** Often these therapists would note that they did not primarily focus on the client's SSA, but rather on other aspects of the client's experience that are presumed to influence the development and fluidity of SSA. Rather than change being something the therapist does to the client, change appears to be conceptualized as occurring naturally for some (but not all) clients, accompanying their own personal growth in general

identity (i.e., sense of a cohesive and relationally capable self) and sex-consistent gender identity along with the resolution of relevant traumatic experience.

4. **The centrality of shame**. The client experience of shame appears to be a core component for therapeutic intervention within a SAFE-T paradigm. To an extent SAFE-T and gay affirmative therapists share the belief that a clients' shame regarding their SSA must be diminished therapeutically to promote mental health. There is evidence from participants' responses that clinicians who engage in SAFE-T acknowledge that shame can derive from social stigma related specifically to SSA. However, unlike some gay affirmative therapists, many SAFE-T clinicians also appear to allow for the possibility that experiences not specific to client SSA or gender identity (such as attachment trauma) can create shame, which they believe may be the most clinically compelling source of shame for understanding the SSA client's psychological experience. This difference may also influence divergent conceptions of client acceptance of their SSA. SAFE-T approaches appear to encourage clients' acceptance of the reality of their SSA in a self-compassionate rather than punitively judgmental way. Such a shift away from shame appears to be viewed as a step toward opening possibilities for SSA change associated with identity development or at least for the adoption of identities not based primarily on experiences of SSA. This is in contrast to the general gay affirmative perspective where clients' shame is conceived as primarily SSA related and therefore shame reduction is predicated not only on eliminating punitive self-judgment but also on clients' acceptance and enactment of their identity as gay.

Constructive professional exchange among mental health practitioners with opposing viewpoints concerning therapy assisted-change in SSA is almost non-existent in contemporary professional circles. I sincerely hope that the present compilation of responses from therapists who are sympathetic to SAFE-T to questions posited by GLB therapists constitutes a small but significant departure from this norm. When SAFE-T therapists are given the opportunity to speak for themselves rather than be caricaturized by others, these therapists appear to share with all professional clinicians a desire to assist clients toward their self-determined goals in an ethically sound manner utilizing established methodologies that

minimize the potential for harm. There are clearly some significant differences in understanding the effects on SSA of factors such as identity development, trauma resolution and shame reduction between SAFE-T and gay affirmative approaches. These are issues which certainly beg for the production of bipartisan, collaborative research specific to the population of clients who report unwanted SSA. Unfortunately, the current professional and political climate strongly precludes such research. Until this changes, the best we may be able to do is create space for alternate voices to be aired. As participant responses made evident, such space should include the voices of therapists who practice SAFE-T.

Notes

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

[2]The questions were posed by Lee Beckstead, PhD.; Jerry Buie, LCSW; and Jim Struve, LCSW, GLBT members of the Reconciliation and Growth Project, a group of eight mental-health practitioners from across the sociopolitical spectrum who since March of 2013 have met for ongoing dialogue to increase understand of their different viewpoints and establish an inclusive and comprehensive therapeutic approach.

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