

# **Guidelines for the Practice of Sexual Attraction Fluidity Exploration in Therapy<sup>1</sup>**

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Sexual Attraction Fluidity Exploration in Therapy (SAFE-T)<sup>2</sup>  
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Many significant developments have occurred in the field of same-sex sexuality in the decade since the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) introduced the first edition of its Practice Guidelines (ATCSI, 2010). These developments necessitated that the guidelines be updated to address the professional and legal realities that face therapists who assist individuals in exploring the fluidity of their unwanted same-sex attractions and behavior. The revised Guidelines incorporate the now preferred language of sexual attraction fluidity exploration in therapy<sup>3</sup> (SAFE-T) as the most accurate description of contemporary professional clinical intervention with these individuals. Therapists are therefore encouraged to adopt this new language in their work as an umbrella term for a variety of specific mainstream approaches utilized by individual clinicians (Rosik, 2017a).

Clinical intervention with individuals who wish to explore the degree of

fluidity of their unwanted same-sex attractions and behavior continues to generate controversy. Within the left-of-center sociopolitical environment, which currently dominates academia and mental health associations (Al-Gharbi, 2018; Cummings, O'Donahue, & Cummings, 2009; Duarte, Crawford, Stern, Haidt, Jussim, & Tetlock, 2015; Honeycutt & Freberg, 2017; Inbar & Lammers, 2012; Jussim, Crawford, Anglin, & Stevens, 2015; Redding, 2001, 2013; Wright & Cummings, 2005), individuals who pursue and/or report enhanced heterosexual functioning through psychotherapy may have their experiences of change marginalized or invalidated. One development which has tended to marginalize the clinical exploration of sexual attraction fluidity has been the production by professional psychological associations of resolutions, position statements, and practice guidelines related to therapeutic approaches to sexual orientation (e.g.,

American Psychological Association, 2009, 2012; Gamboni, Gutierrez, & Morgan-Sowada, 2018). While there is much helpful information in these documents with which clinicians should be familiar, they are nonetheless limited by their lack of diverse professional perspectives (Ferguson, 2015; Yarhouse, 2009). Specifically, they often appear to be produced by partisan committees whose members do not generally share the goals, values, or worldviews of many clients who seek assistance in exploring the degree to which their unwanted same-sex attractions and associated feelings, fantasies, and behaviors may be subject to psychotherapy-assisted fluidity.

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

Given that the very right of clients to pursue SAFE-T continues to be questioned within mental health associations (American Psychological Association, 2009, 2012; Gamboni et al., 2018; Kaplan et al., 2009; Yarhouse & Throckmorton, 2002) and is increasingly the focus of legislative and other legal prohibitions (Dubrowski, 2015; Rosik, 2017b), the ATCSI Board determined that an update to their earlier practice guidelines (ATCSI, 2010) was warranted. Members of the original task

force were contacted and invited to participate in this revision. Those able to participate were joined by others invited to participate in this reconstituted task force due to their specific areas of expertise. A revised draft document of the original guidelines was completed and then sent out for review to the ATSCI board and selected members of the association's professional membership. Subsequent feedback was then considered and, where deemed beneficial, incorporated into the final version of the revised SAFE-T practice guidelines.

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

## **Attitudes Toward Clients Who Pursue SAFE-T**

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

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

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

Biological research does not show one predominant cause; indeed most influences have been numerically minor, though many individual correlations have achieved statistical significance (Abbott, 2010; Bogaert, 2007; James, 2006; Martin & Nguyen, 2004; Meyer-Bahlburg, Dolezal, Baker, & New, 2008; Lalumiere, Blanchard, & Zucker, 2000; Rahman, Kumari, & Wilson, 2003; Sanders et al, 2014; Whitehead, 2014). The degree of concordance of sexual orientation in twins is the result of multiple influences, whether known to researchers or not, and twin studies suggested that multiple individualistic responses predominate to a degree that had not been expected (Bailey, Dunne, & Martin, 2000; Bearman & Bruckner, 2002; Hershberger, 1997; Langstrom, Rahman, Carlstrom, Lichtenstein, 2010; Santtila, Sandnabba, Harlaar, Varjonen, Alanko, & von der Pahlen, 2008; Whitehead, 2011b). A general context for the biological causes is the strong academic emphasis on plasticity of

neural processes (Pascual-Leone, Amedi, Fregni, & Merabet, 2005), in which the brain is constantly reprogramming itself, partly in reaction to environmental events. Although this should not be presented as making any desired behavioral change easy, it can certainly be legitimately presented as an argument against the impossibility of fluidity and change.

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

gender characteristics (mental or physical/biological) (Zucker & Bradley, 1995).

Discretion is thus necessary in comprehending the etiology of same-sex attractions in any particular client, as is suggested by leading mental health organizations now being noncommittal on the issue (APA, 2008a; Rosario & Schrimshaw, 2014). Nevertheless, a broad but unified understanding of these diverse influences might be found in viewing same-sex attractions and behavior as a developmental adaptation to less-than-optimal biological and/or psychosocial environments, possibly in conjunction with a weak and indirect genetic predisposition.<sup>4</sup> Furthermore, this adaptation may be distressful to some individuals in light of their values and/or because it frequently results in behavioral practices that place participants at risk for mental illness and physical disease (cf. Guidelines 3, 8, and 12). Given the complexity of this topic, clinicians who work with clients reporting unwanted same-sex attractions and behavior must be even more concerned about, and committed to, contributing data for research, subject to the usual confidentiality requirements. This would help broaden our understanding of the etiology of same-sex attractions and behaviors.

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

When individuals enter into psychotherapy and express conflicted feelings, thoughts, or values about their

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

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

than average (Santero, Whitehead, & Ballesteros, 2018).

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

The last few decades have brought about accelerating changes in the moral valuation, legal status, and psychological description of homosexuality (Twenge, Sherman, & Wells, 2016). The latter was reflected by the removal of homosexuality in and of itself from the category of a pathological condition from the DSM in 1973 by the American Psychiatric Association (APA, 1973). At this time the legitimacy, effectiveness, and ethicality of change-oriented intervention also came into question.

This, in turn, led to most mental health associations asserting that homosexual orientation and/or attractions could never be modified (e.g. American Psychological Association, 2008a). Within this exclusively gay-affirmative position, the presumed and prescribed optimal outcome of therapy for clients ambivalent about their attractions to the same gender is developing and achieving acceptance of and identification with their sexual desires.

Clinicians who continue to practice SAFE-T believe change in terms of sexual attraction fluidity is possible and available for many highly-motivated clients, for whom the goal of therapy is the lessening of their same-sex attraction, the development and increase of their opposite-sex attractions and identification, or, short of that, achieving a stable identification with an abstinence-based life (ATCSI, 2009; Byrd & Nicolosi, 2002; Santero et al., 2018). Other clinicians can identify with both of these positions. They look at the goals of change and the goals of the gay affirmative stance as possible and ethical without an exclusive value commitment to either one as they counsel a client with ambivalence about same-sex attractions as the presenting problem (Throckmorton & Yarhouse, 2006).

As clinicians attempt to approach the task of assessment, informed consent, and goal-setting, an additional obstacle needs consideration: to define the complexities of sexual orientation and its development. Many social scientists share an interactionist perspective, which postulates that sexual orientation is shaped for most people through the complex interaction of biological, psychological, and social factors (cf. Guideline 1). There is a lack of consensus about how best to measure

and what constitutes the central components or dimensions of sexual orientation (e.g., attractions, behavior, fantasies, identification, or some combination of these elements) (Beaulieu-Prevost & Fortin, 2014; Kinnish, Strassberg, & Turner, 2005; Moradi, Mohr, Worthington, & Fassinger, 2009; Sell, 1997; Throckmorton & Yarhouse, 2006). This leads to further problems with measuring reliability and estimating prevalence rates (Byne, 1995; Laumann, Gagnon, Michael, & Michaels, 1994; Stein, 1999). In addition, after December 1973, when homosexuality in and of itself was no longer categorized as a disorder, the research on the possibility of changing unwanted same-sex attractions substantially decreased from the professional literature (Jones & Yarhouse, 2007).

Along with considering the above, clinicians are encouraged to reflect on the following potential biases they may encounter as the exploration of a client's issues begins (Rosik & Popper, 2014). Clinicians who have adopted a primarily gay-affirming stance tend to focus on that portion of the research literature which emphasizes a lack of difference in pathology between individuals with same-sex attractions and the rest of the population, attributing most symptomology that differentiates the two populations to internalized negative messages about homosexuality and external minority stressors (Gonsiorek, 1991; Hatzenbuehler, 2009; Meyer, 2003), although the direct effects of perceived discrimination generally account for less than 10% of the variance in health differences (Pascoe & Richman, 2009). They may ignore the possible etiological significance of social and developmental factors, such as a

higher incidence of childhood sexual abuse, particularly for men (Eskin, Kaynak-Demir, & Demir, 2008; Fields, Malebranche, & Feist-Price, 2008; Friedman et al., 2011; James, 2005; Stoddard, Dibble, & Fineman, 2009; Tomeo, Templer, Anderson, & Kotler, 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). They may also ignore the potential for discrimination to occur within LGB communities (Matsick & Rubin, 2018). They might emphasize mostly the methodological limitations in the research literature, which indicate the possible efficacy of change intervention (Gonsiorek, 1991, American Psychological Association, 2009), even though there appears to be no satisfactory measure of sexual orientation (or its change) in the literature (Jones & Yarhouse, 2007; Moradi et al., 2009). They are likely to dismiss the research into psychodynamic and other theories which can be used to support change interventions (American Psychological Association, 2009; Bell et al., 1981) based on methodological limitations, ignoring the fact that the quality of these studies, although not impressive by contemporary standards, was nevertheless “state of the art,” sufficient to merit publication in respected professional journals. Moreover, the early research that supported the possibility of fluidity and change is comparable to other studies on homosexuality in the literature of the time that are still held in good repute (Jones & Yarhouse, 2007) and referenced uncritically in contemporary discussions about change-oriented treatment (cf. American Psychological Association, 2009), most likely because they support a favored sociopolitical point of view.

Furthermore, clinicians holding strong gay-affirming positions may tend to emphasize clinical literature which describe examples of harm (e.g., disappointment in not achieving complete elimination of unwanted same-sex attractions) in the course of SAFE-T and may take a position that conducting such therapy is clearly unethical and harmful (Drescher et al., 2016; Gonsiorek, 2004; Mahler & Mundle, 2015; Murphy, 1992; Tozer & McClanahan, 1999; Worthington, 2004). They may maintain this view even when clients explicitly desire to change their unwanted same-sex attractions and/or behavior (Gonsiorek, 2004). These clinicians may take the position that clients cannot establish realistic therapeutic goals for themselves nor make a truly voluntary decision to develop their heterosexual potential, assuming that such a desire can only be a reflection of an oppressive and prejudicial society (Tozer & McClanahan, 1999). They may discount the reality that many clients who want to explore the possibility of fluidity in their unwanted same-sex attractions and behaviors experience significant conflict between their religious beliefs and their sexual attraction to members of the same sex (Beckstead & Morrow, 2004; Haldeman, 1994, 2004; Yarhouse & Tan, 2004) and that some of these clients perceive their religious affiliation as the most stable aspect of their identity (Johnson, 1995; 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) or having sex with clients (Drescher et al., 2016). They may tend to espouse the immutability of sexual orientation, basing this conclusion on

unsubstantiated biological research as its foundation, a conclusion that is rapidly becoming scientifically untenable (Byrd, 2010; Diamond & Rosky, 2016; Garnets & Peplau, 2001; Hu, Xu, & Tornello, 2016; James, 2005; Manley, Diamond, & van Anders, 2015; Stein, 1999; Yarhouse & Throckmorton, 2002).

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

SAFE-T clinicians might also minimize the research on the effect of social pressures and internalized societal attitudes toward homosexuality as possibly contributing to the symptomatology of the client (Di Placido, 1998; Maylon, 1982; Mays & Cochran, 2001; Meyer & Dean, 1998; Newcomb & Mustanski, 2010; Shildo,

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

Both gay-affirmative and change-oriented clinicians, especially if they are actively involved in the cultural debate surrounding the moral, legal, and psychological position of homosexuality in our society, may be vulnerable to dismissing the need for referring clients. This may be a risk particularly when, during the goal setting process, it becomes clear that the value position of the counselor is in clear conflict with the client's goals (Haldeman, 2004; Liszez & Yarhouse, 2005). A need to refer may arise due to a counselor's inability to identify with religiously based identity

outcomes (Throckmorton & Welton, 2005) or with the less sexually monogamous norms of a significant portion of the gay culture (Levine, Herbenick, Martinez, Fu, & Dodge, 2018; Bepko & Johnson, 2000; Bonello & Cross, 2010; Laumann et al., 1994; Martell & Prince, 2005; Mercer, Hart, Johnson, & Cassell, 2009; Prestage et al., 2008; Shernoff, 1999, 2006; Spitalnick & McNair, 2005). Or they may find it objectionable to refer clients to a needed supportive community whose values they do not accept (Yarhouse & Brooke, 2005).

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

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

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

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

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

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

While religious motivations should not be immune from scrutiny in the context of psychotherapy, clinicians need to be extremely cautious about pathologizing the religious values which may prompt a client to pursue SAFE-T. A lack of conservative and religious representation among mental health professionals relative to general population estimations (Delaney et al., 2007; Redding, 2001; Shafranske & Cummings, 2013) suggests that the

danger of clinicians misinterpreting or invalidating the motives of religious and conservative clients is considerable (Ruff & Elliott, 2016). One way in which such therapeutic misattunement occurs is when religious beliefs that motivate clients to pursue SAFE-T for unwanted same-sex attractions are too quickly and uniformly labeled as internalized homophobia (Herek, Gillis, & Cogan, 2009; Sowe, Taylor, & Brown, 2017). Persons who prioritize their traditional religious identities above their sexual attractions can and do experience many benefits from such faith commitments, which may outweigh the challenges (Barringer & Gay, 2017; Walker & Longmire-Avital, 2013). Differences in moral values between therapists, counselors, and their religiously identified clients concerning sexuality can easily become the object of clinical suspicion, with the tacit and inappropriate assumption that the counselor's values are superior to and should override those of the client (Haidt & Hersh, 2001; Kendler, 1999; Miller, 2001; O'Donahue & Caselles, 2005; Rosik, 2003a, 2003b, 2007a, 2007b).

Clinicians can benefit by examining the role that worldview similarity, particularly with regard to moral epistemology, plays in their attitudes toward clients who request assistance in developing their heterosexual potential. For example, six domains of moral concerns have been identified across cultures: 1) concerns for the suffering of others; 2) concerns about unfair treatment, inequality, and justice; 3) concerns about having liberty restricted; 4) concerns related to obligations of group membership (e.g., religious identification); 5) concerns related to social cohesion and respect for tradition and authority; and 6) concerns related to

physical and spiritual purity and the sacred (Graham et al., 2013; Graham, Haidt, & Nosek, 2009; Haidt, 2012; Haidt & Graham, 2007, 2009; McAdams, Albaugh, Fauber, Daniels, Logan, & Olson, 2008). The first three moral domains focus on the individual as the center of moral value, with an aim of protecting the individual directly and teaching respect for individual rights. The other three domains emphasize the value of groups and institutions, attempting to bind individuals into roles and duties for the good of society.

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

Another means of marginalizing religious belief within the general practice of psychology has been to bifurcate psychology and religion, to

deem religiously motivated SAFE-T as essentially a religious pursuit which has no place in a science-based clinical practice (Silverstein, 2003; American Psychological Association, 2009). This perspective creates a strict demarcation which is not supportable given the enormous overlap between the fields in their philosophical and anthropological areas of inquiry, e.g., theories of human nature (Auger, 2004; Bain, Kashima, & Haslam, 2006; Jones, 1994; O'Donahue, 1989). Furthermore, it may represent some degree of philosophical naivety or professional hubris in that the empirical methods of psychology contain their own "innate" values and are also influenced by the value assumptions of researchers (Fife & Whiting, 2007; Slife, 2006, 2008; Slife & Reber, 2009, 2012; Slife, Starks, & Primosch, 2014). These methods are not theologically or philosophically neutral nor do they enable research to proceed without the application of interpretive biases of some sort, particularly when investigating value-laden subjects such as the pursuit of SAFE-T. As noted by Chambers, Schlenker, & Collisson (2013), "To the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). Conversely, established religious and theological traditions are not bereft of a degree of objective and empirical validation, in that when they have not become corrupted by power they have displayed practical validity and utility for understanding and directing human behavior for hundreds if not thousands of years (e.g., Stark, 2005).

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

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

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

A focus on self-determination and autonomy does not relegate this ethical

consideration above others in addressing the provision of change-oriented interventions (APA, 2009; Drescher et al., 2016). However, this ethical issue is often stressed in the literature relevant to SAFE-T precisely because it is the ethical guideline most directly impacted by the threat of professional and legal restrictions on such care. Restricting client self-determination to pursue SAFE-T on the basis of a lack of empirical efficacy, even if accurate, should in fairness commence a professional prohibition on many other experimental and unsupported treatment modalities that are currently practiced (Barnett & Shale, 2013; Pignotti & Thyer, 2009). A significant case in point is "recovered memory therapy" (RMT), with which the APA dealt in a vastly more lenient and nonpartisan manner than it did with so-called "sexual orientation change efforts," in spite of RMT having more clearly established harms and much less empirical basis than SOCE (Rosik 2017c). Nor does the limiting of client autonomy appear to be warranted by the potential for harm in exploring the fluidity of unwanted same-sex attractions. No harm has been definitively linked to such exploration as a whole (APA, 2009; Santero et al., 2018), and harms that could be imagined can likely be resolved by suitable practice guidelines such as those offered here.

Clients enter therapy with values that guide their goals for therapy. Whether religious or personal, such values may lead individuals to seek change interventions for unwanted same-sex attractions and behavior. In treatment settings, professionals respect the autonomy and right of self-determination of individuals who pursue SAFE-T for unwanted same-sex attractions and

behavior as well as those individuals who do not desire such goals. Clinicians refrain from persuading clients to select goals and interventions that are contrary to their personal values (American Psychological Association, 2008a; Haldeman, 2004).

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

Value conflicts with the broader culture may be experienced by consumers who opt for gay-affirmative interventions. However, the more sociopolitically liberal and secular worldview of licensed clinicians heightens the probability that value conflicts in the clinical setting are more likely to occur among clients who desire that SAFE-T be a therapeutic option. The clinician's commitment to respecting client autonomy and self-determination may be especially tested when working with individuals reporting unwanted same-sex attractions and behavior. Clinicians risk violating the

client's right to autonomy and self-determination when they attempt to deny a client the opportunity to engage in SAFE-T, view the client as incapable of making choices among intervention options, or withhold information about a full range of therapeutic choices. Such violations of client rights may risk harm to the client (Byrd, 2004).

## **Treatment Considerations**

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

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

Adequate informed consent is an important part of therapeutic “Beneficence and Nonmaleficence,” whereby clinicians “. . . strive to benefit those with whom they work and take care to do no harm . . . [and] seek to safeguard the welfare and rights of those with whom they interact professionally . . .” (APA, 2017, General Principle A, p. 3). Informed consent also encourages and expresses clinical “competence,” in

which clinicians “provide services . . . with populations and in areas only within the boundaries of their competence.” Clinicians inform their clients about their clinical “education, training, supervised experience, consultation, study, or professional experience,” through which competence was developed (APA, 2017, Ethical Standard 2.01, p. 5).

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

Since 1973, homosexuality itself has no longer been diagnosed formally as pathological (American Psychiatric Association, 1973; APA, 1975). Although most professional associations no longer consider homosexuality to be a diagnosable or treatable condition (American Psychiatric Association, 2013), related co-occurring conditions with theoretical and empirical links to non-heterosexuality remain valid foci of diagnosis and therapeutic care. As even gay-identified scholars have asserted, “The developmental issues that contribute to ‘the persistent and marked distress’ about one’s sexual orientation are valid areas of investigation” (Morin & Rothblum, 1991, p. 3). This also holds true when examined within the context of SAFE-T for unwanted same-sex attractions and behavior. Contrary to current attitudes explicit or implicit in the professional and lay media,

“regardless of pathology, cultural trends, or current political rhetoric, mental health issues for homosexuals remain clinically significant and, like all others, must be addressed by the clinician with competence” (Monachello, 2006, p. 56). When clinicians help clients distressed about their same-sex attractions and behavior, they are being ethically responsible, respecting “the dignity and worth of all people, and the rights of individuals to . . . self-determination” (American Psychological Association, 2017, General Principles, Principle E, p. 4).

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

Clinicians will assess the nature of their clients’ actual experience of unwanted same-sex feelings, thoughts,

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

Clinicians also will assess the nature of their clients' spiritual and religious involvement and motivation in order to respect their clients' rights, dignity, and need for self-determination (cf. Guidelines 3 and 4). Appropriate referrals for allied medical, mental, and/or pastoral healthcare may be an appropriate component of informed consent and goal setting (cf. Guidelines 8 and 12). The therapist should consider whether support groups are available or desirable. Other recommendations for client involvement may include non-erotic same-sex friendship and spiritual support. Clients involved in SAFE-T have found strongly positive benefits in

these activities with almost no negative effects. (Santero et al., 2018).

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

Reports of change range in size from single client case studies to group studies with hundreds of clients. The various therapeutic paradigms used for the purposes of SAFE-T have included psychoanalysis (Bieber, Dain, Dince, Drellich, & Grand, 1962; MacIntosh,

1994) and experiential or other psychodynamic approaches (Berger, 1994; Nicolosi, 2009; Pela, Sutton, & Nicolosi, 2018; Santero et al., 2018); hypnosis; behavior and cognitive therapies (Bancroft, 1974; Birk, Huddleston, Miller, & Cohler, 1971; Throckmorton, 1998); sex therapies (Masters & Johnson, 1979; Pomeroy, 1972; Schwartz & Masters, 1984); group therapies; religious-mediated interventions (Jones & Yarhouse, 2007, 2011); pharmacology; combinations of therapies (Karten & Wade, 2010; Pela et al., 2018; Santero et al., 2018); and others. A number of meta-analyses also demonstrate that intended fluidity and change in feelings and behaviors is a realistic goal for persons with unwanted attractions to the same sex (Clippinger, 1974; James, 1978; Jones & Yarhouse, 2000; Byrd & Nicolosi, 2002). This list is not exhaustive (cf. ATCSI (2009) for a comprehensive list of reports for each paradigm). In addition, SAFE-T clinicians frequently provide orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices.

As part of fully informing clients and obtaining informed consent, SAFE-T clinicians are encouraged to emphasize in their discussions with clients and in their consent forms that their therapeutic work does not include practices such as aversion therapy, “shock” therapy, any form of physical or emotional intimidation, therapist-imposed goals, or other similar practices or methods, regardless of what label may be attached to them. Advocates of proposed legal prohibitions on therapy have attempted to portray such practices as widespread and suggest that they are somehow necessarily or unavoidably involved in any professional therapy that may

address unwanted feelings of same-sex attraction or unwanted behaviors. Such portrayals are untruthful. No SAFE-T clinician would engage in any such practice, and clinicians should leave no question or room for doubt in the client’s mind in this regard (cf. Guideline 7).

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

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

It is not uncommon that clients who report and/or are assessed as having made a significant transition from same-sex to opposite-sex attraction, cognition,

fantasy, and behavior, may re-experience same-sex feelings or thoughts, albeit at a less intense level than before SAFE-T. Of course, there may be exceptions. Even when clients have not achieved all they had hoped for when beginning therapy, many report satisfaction with what they have achieved (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003), and some clients who describe their experiences in therapy as “harmful” also may characterize them as “helpful” (Shildo & Schroeder, 2002). Also, as with therapy in general (Lambert & Ogles, 2004), along with documented intervention success, some recidivism during or following the treatment of compulsive or addictive sexual and/or other disorders co-occurring with unwanted same-sex attractions may be expected (cf. Guidelines 7 and 12). However, the percentage of clients who believe they have benefitted is very similar to outcomes in other fields of psychotherapy (Santero et al., 2018), and statistical effect sizes are similar. Similarly, the low degree of alleged harm is comparable. Therapists should nevertheless judge carefully the ability of clients to withstand hostile attitudes from others regarding their pursuit of SAFE-T, and may need to recommend limited exposure to such environments. Activists opposed to SAFE-T clients’ goals may aggressively interrogate them to a degree rarely seen in other therapy fields.

Critics of the clinical and scientific literature documenting successful SAFE-T outcomes—or the lack thereof—accurately point out the absence of truly randomized outcome studies. Another criticism of the literature is the lack of clear definition of the meaning of terms like “sexual orientation,” “homosexuality,” “heterosexuality,” and

“change.” As noted previously, since the American Psychiatric Association’s 1973 decision to no longer diagnose homosexuality as a mental disorder, there have been fewer reports of research on the development of and interventions for unwanted same-sex attractions and behavior. However, as Spitzer (2003) noted, a truly randomized study with controls is probably logistically impossible.

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

Lambert & Ogles (2004) observed that “helping others deal with depression, inadequacy, anxiety, and inner conflicts, as well as helping them form viable relationships and meaningful directions for their lives, can be greatly facilitated in a therapeutic relationship characterized by trust, warmth, understanding, acceptance, kindness and

human wisdom” (pp. 180–181). As with therapy for all presenting concerns, giving satisfactory informed consent when beginning to counsel persons who want to resolve unwanted same-sex attractions and behavior not only is ethical but also may be expected to facilitate the development of more effective, therapeutic relationships.

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

Since 2012 various state and municipal governments have enacted statues or promulgated ordinances or regulations aimed at prohibiting at least some clients from pursuing fluidity and change of unwanted same-sex attractions and behaviors within a psychotherapy setting (Dubrowski, 2015; “List of jurisdictions banning conversion therapy for minors,” 2018; Rosik, 2017b; Sandley, 2014). Despite claims of egregious and widespread harms that are the purported motivation for such bans, there have been no formal actions against any licensed therapists by any regulatory authorities in these or other jurisdictions (Drescher et al., 2016). This suggests that the primary aim of these laws or regulations may be to intimidate clinicians who would assist a client in the client’s personal goal to explore the potential fluidity of unwanted same-sex attraction and behaviors. Further, clinicians in these jurisdictions should be aware that these bans have handed a potential weapon to activists who are looking for disgruntled clients who are willing to make an example of their former therapists. Therefore, while

excellence in practice should be the goal of all therapists who engage in SAFE-T, those in jurisdictions that have therapy bans may also need to obtain the assistance of competent local legal counsel to evaluate the effect and implications of any restrictions that have been enacted or promulgated.

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

Clients who believe, for example, that their history of childhood trauma or relational disruption may have contributed to their nonheterosexuality can be reassured there is research evidence consistent with their experience (Beard et al. 2013; Bickham et al. 2007; O’Keefe et al. 2014; Roberts, Glymour, & Koenen, 2013; Wells, McGee, & Beautrais, 2011; Wilson & Widom, 2009). They can also be informed that fluidity of sexual attractions and

behaviors is common rather than atypical, especially for women but also for men (Diamond, 2008a, 2016; Dickson, Paul, & Herbison, 2003; Dickson, van Roode, Cameron, Paul, 2010; Far, Diamond, & Boker, 2014; Hu, Xu, & Tornello, 2016; Katz-Wise, 2015; Katz-Wise & Hyde, 2015; Katz-Wise, Reisner, Hughto, & Keo-Meier, 2016; Moch & Eiback, 2012; Ott, Corliss, Wypij, Rosario, & Austin, 2011; Ott et al., 2013; Savin-Williams & Ream, 2007). Moreover, there is evidence that such fluidity is influenced by relational and environmental contexts that are commonly addressed in the therapeutic process (Manley, Diamond, & van Anders, 2015; Santero et al., 2018). It is no small irony that the APA and other professional organizations acknowledge that no single factor or set of factors is known to definitively determine same-sex attraction (APA, 2008a) while simultaneously maintaining that they are certain all of these factors are simply normal and positive (APA, 2009; Mustanski, Kuper, & Greene, 2014).

Clinicians engaged in SAFE-T recognize that therapist-initiated recommendations for superficial external alterations of the client's gender presentation and role behavior are unlikely to address deeper emotional, relational, and/or identity issues (Santero et al., 2018). SAFE-T is a process that recognizes addressing deeper issues may (or may not) affect a particular client's unwanted same-sex attractions. For example, sufficient resolution of underlying attachment wounds may promote client-initiated interest in such adjustments of gender presentation.

Another important aspect of SAFE-T practice is the clinician's regular acquisition of client feedback about their

therapy experience. This review can be done in session and client perceptions should be documented in the progress notes, whether of satisfaction or dissatisfaction. Occasional use of more objective measures of client satisfaction and progress are also recommended (e.g., the OQ-45 survey; Lambert et al., 2004). Points of perceived dissatisfaction would need to be addressed and documented, including adjustments in the therapy process and goals or even referral to a different therapist if requested.

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

SAFE-T clinicians do not promise or guarantee, whether explicitly or implicitly, a change in sexual orientation or even shifts in unwanted same-sex attractions and behaviors. Therapists should exercise caution to make sure clients do not feel blamed if they do not experience their desired level and direction of sexual attraction fluidity. This is particularly important in religious settings where there may be implicit or

explicit expectations for change that may be unrealistic. Meichenbaum and Lilienfeld (2018) offer 19 signs of psychotherapy “hype” that are good reminders of ways therapists may undermine their credibility. Indicators of hype may include exaggeration of claims of treatment effectiveness, excessive appeal to authorities or “gurus,” and claims that treatment “fits all people.” For these reasons, a thorough and scientifically grounded discussion concerning the occurrence of fluidity and change combined with a regular review of the therapy process is very important.

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

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

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

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

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

An increase in unpleasant feelings may not be an indication of “harm,” but an opportunity to deal with feelings formerly numbed by mood-altering behaviors (e.g., sexual gratification), relationships (e.g., codependency), substances (e.g., alcohol or drugs), or other paraphernalia (e.g., pornography). Clients who terminate any therapy

before underlying emotional issues or compulsive behavior patterns are effectively resolved will undoubtedly feel worse than when they began therapy. Also, to the extent that persons with same-sex desires are engaged in sexual compulsions or experience other psychological or relational difficulties, a high recidivism rate, such as is found when treating substance abuse and other habits, may not be unrealistic.

In general, SAFE-T for unwanted same-sex attractions and behavior has been shown to be helpful for a number of clients and has not been shown to be invariably harmful (Santero et al., 2018). Authors who clearly oppose such intervention and who caution that it sometimes is, can, or may be harmful, nonetheless recognize that it is not always so (Haldeman, 2001; Schroeder & Shildo, 2002; Shildo & Schroeder, 2002). Even when disappointed with not changing their same-sex thoughts, feelings, fantasies, and/or behaviors as much as they had hoped, clients have reported satisfaction with the changes they did achieve and that the counseling process was at least somewhat helpful (e.g., Nicolosi et al., 2000; Santero et al., 2018; Shildo & Schroeder, 2002; Spitzer, 2003). While a client's dissatisfaction is a possible and unfortunate consequence of any therapy, such dissatisfaction is not inherently "harmful" and may be minimized by the responsible practice of timely and accurately informed consent (cf. Guideline 5). Such practices would include a discussion that fluidity and change in unwanted same-sex attractions, thoughts, and behavior during therapy occur on a continuum. Some clients seem to experience profound fluidity and change, other's a

moderate amount, and still others little or none (ATCSI, 2012).

Regardless of theoretical orientation or treatment modality, some psychological or interpersonal deterioration or other negative consequences appear to be unavoidable for a small percentage of clients. As Lambert (2013) writes, while psychotherapy has proven to be highly effective "for many clients," "psychotherapy can and does harm a portion of those (adults and children) it is intended to help" (p. 192). Clients who are especially more likely to "deteriorate while participating in treatment" (p. 192) commonly begin therapy with a severe "initial level of disturbance," e.g. borderline personality disorder (Lambert & Ogles, 2004, p. 177). "[C]lients with comorbid problems (also) are less likely to do well." Depending on the primary diagnosis, comorbidity for personality disorders, depression, substance abuse, and psychiatric diagnoses all have been shown to negatively impact treatment outcomes (Bohard & Wade, 2013, p. 227). In addition, clients whose clinicians may lack empathy, underestimate the severity of their problem, or who experience significant, negative countertransference may also be at greater risk for deterioration (Mohr, 1995).

Finally, in light of current research and professional ethics, some long outdated interventions for unwanted same-sex attractions and behavior are not recommended. These include shock therapy and other aversive techniques, so-called reparenting therapies, and coercive forms of religious prayer (including exorcisms). Overall, research to date has shown that clients participating in SAFE-T to address

unwanted same-sex attractions or behaviors are not invariably harmed by doing so (APA, 2009; Pela et al., 2018; Santero et al., 2018). Any negative consequences attributed to engaging in SAFE-T have not been shown to outweigh the benefits claimed by those who have found such exploration helpful. Unfortunately, most mental health associations like the APA, both in the United States and in Europe, unfairly warn the general public that clients who pursue fluidity and change in their unwanted same-sex attractions and behaviors through professional therapy have the potential to be harmed. This happens even though the mental health associations themselves admit that historical and recent research does not support their warning (APA, 2009; Sutton, 2014).

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

In the psychological care of clients with unwanted same-sex attractions and behavior, it is strongly encouraged that clinicians fully assess each with a detailed history and examination, paying particular attention to the potential presence of associated psychopathological conditions. While often limited by restricted samples, lack of controls, and/or indeterminate causal pathways, studies of mental health morbidity among adults reporting same-sex partners consistently suggest that lesbians, gay men, and bisexual individuals may experience excess risk for some mental disorders by

comparison with heterosexual individuals (Cochran & Mays, 2009; King et al., 2008; Semlyen, King, Varney & Hagger-Johnson, 2016). Cochran, Sullivan, and Mays (2003) indicate that gay-bisexual men showed higher prevalence of depression, panic attacks, and psychological distress than heterosexual men; lesbian-bisexual women showed greater prevalence of generalized anxiety disorder than heterosexual women in the same study. Other comparisons may be found in Whitehead (2010). Quantitative estimates of length of relationship (Whitehead, 2015/16) suggest a mean length of 4.7 ( $\pm 2$ ) years, which itself leads to depression that is also associated with frequent short heterosexual relationships (Davila et al., 2009). In addition, several studies have suggested that bisexuals often have even worse health outcomes than gay and lesbian persons (Ross, Salway, Tarasoff, MacKay, Hawkins, & Fehr, 2018), although this conventional wisdom has been challenged of late (Savin-Williams & Cohen, 2018). This excessive risk of co-occurring psychopathology needs to be at the forefront of the clinician's mind when working with individuals with same-sex attractions, whether wanted or not.

A key issue in the area of health is the assessment of risk and its subsequent management. In mental health terms, this invariably involves a risk assessment for self-harm and suicide. Research has demonstrated evidence of a strong association between suicide risk and same-sex attractions and behavior (Arnarsson, Sveinbjornsdottir, Thorsteinsson, & Bjarnason, 2015; Eskin et al., 2005; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008; Ploderl & Fartacek, 2005; Ploderl

& Tremblay, 2015; Remafedi, French, Story, Resnick, & Blum, 1998). Using data from the *National Comorbidity Survey*, Gilman, Cochran, Mays, Hughes, Ostrow, and Kessler (2001) found that people reporting same-sex partners have consistently greater odds of experiencing psychiatric and suicidal symptoms compared with their heterosexual peers. This finding has been consistent in studies of young people (Rimes, Shivakumar, Ussher, Baker, Rahman & West, 2018; Russell & Joyner, 2001) and adults (Remafedi et al., 1998) and has also been noted in Holland and Sweden, countries with a comparatively tolerant attitude to homosexuality. Dutch men with same-sex attractions and behaviors and Swedes in same-sex marriages are still at a much higher risk for suicidality than their heterosexual counterparts (Bjorkenstam, Andersson, Dalman, Cochran, & Kosidou, 2016; de Graaf, Sandfort, & ten Have, 2006; Sandfort, de Graaf, Bijl, & Schnabel, 2001).

Often sex addiction co-occurs with same-sex behavior (Bothe et al., 2018; Dodge, Reece, Herbenick, Fisher, Satinsky, & Stupiansky, 2008; Guigliamo, 2006; Kelly, Bimbi, Nanin, Izienicki, & Parsons, 2009; Parsons, Kelly, Bimbi, DiMaria, Wainberg, & Morgenstern, 2008; Quadland & Shattls, 1987), and it has been defined as follows: “Contrary to enjoying sex as a self-affirming source of physical pleasure, the addict has learned to rely on sex for comfort from pain, for nurturing or relief from stress” (Carnes, 1992, p. 34). This often has roots in childhood and adolescence with up to 60% of people who present with sex addiction having been sexually abused before reaching adulthood (Griffin-Shelley, 1997). Individuals reporting

same-sex attractions and behavior also appear to have a higher prevalence of sexual abuse, particularly among women (e.g., Bebbington et al., 2009; Doll, Joy, Bartholow, & Harrison, 1992; Eskin et al., 2005; Friedman et al., 2011; Mustanski, Kuper, & Greene, 2014; Paul, Catania, Pollack, & Stall, 2001; Tomeo et al., 2001; Wilson & Widom, 2010; Xu & Zheng, 2015). It is therefore imperative that clinicians take a full and detailed history from each client. Since clients with same-sex attractions commonly report other addictive behaviors, a thorough history should include assessment of other common addictive behaviors such as pathological gambling (Granta & Potenzab, 2006) and substance misuse (Branstrom & Pachankis, 2018; Goldbach, Fisher, & Dunlap, 2015; Ploderl & Tremblay, 2015; Roth et al., 2018; Ueno, 2010), both for prescribed, illicit and over-the-counter medicines, in addition to sex addiction.

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

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

The societal pressures that surround clients who present with unwanted same-sex attractions cannot be

understated. Clinical intervention will benefit from a careful appraisal of the multiple contexts from which these clients come and the normative attitudes toward homosexuality found in each milieu. The cultural context of these clients includes their ethnic heritage, and differences in perspectives on homosexuality by ethnic background must be considered. For example, clients coming from African-American or Hispanic backgrounds often live in communities that have traditional and more uniformly negative views of homosexuality (Greene, 1998; Herek & Gonzalez-Rivera, 2006; Martinez & Sullivan, 1998; Schulte & Battle, 2004; Vincent, Peterson, & Parrott, 2009).

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

A third environment worthy of careful evaluation is the family context of clients (Yarhouse, 1998b). The attitude of parents and heterosexual spouses toward clients' same-sex attractions is perhaps the most

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

The early assessment of these contexts is important in evaluating clients' preparedness to enter into SAFE-T. The more clients come from ethnic, religious, and family backgrounds which are non-affirming of homosexuality, the greater the burden is upon clinicians to ensure that clients are acting in a reasonably self-determined manner as they seek intervention. This important precaution is not to assert, as some have done (Davison, 2001; Drescher et al., 2016; Murphy, 1992), that clients from these backgrounds can never autonomously enter into SAFE-T with the goal of modifying unwanted same-sex attractions and behaviors. In fact, Santero and colleagues (2018) found societal pressures were quite

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

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

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

Women's romantic attractions start with emotional and relational intimacy

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

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

conservatively religious women (Hallman, Yarhouse, & Suarez, 2018; see Guideline 3). Sexual attraction identities limit and distort the complexities of sexuality and may result in a forced identity that is rejected during developmental maturity. Many more mature women see themselves and their sexuality as more complex than the current cultural narrative of an essential, immutable identity based on erotic attractions.

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

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

Research suggests that first attraction to the same or opposite sex has occurred by age 10 for 50% of the population (Hamer, Hu, Magnuson, Hu, & Patterson, 1993; Whitam & Mathy,

1986), but there is an unusually wide range, and some are still essentially asexual until their late teens in spite of the highly sexualized cultural climate in the West. Adolescents still have developing neurology (Sisk & Zehr, 2005), including brain development, and lack mature judgment, although they are at or near their physical peak in late teenage years. This period is occupied by finding what mature possibilities may exist for them and evolving an identity by experimenting with a wide range of experiences. Sexual initiation is usually during this time (Floyd & Bakeman, 2006).

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

Statistical surveys show there is considerable sexual experimentation of types which are mostly not followed up in adulthood and are therefore far from definitive (Laumann et al., 1994). Change of various types continues to take place even as adults (Diamond, 2016; Diamond, Dickenson & Blair, 2017; Katz-Wise & Hyde, 2015; Katz-Wise et al., 2016; Kinnish et al., 2005). Clinicians should be aware that

adolescents may prematurely decide they have a particular sexual orientation and hence should be warned against hasty conclusions. A very significant proportion of young women are most comfortable with the “unlabelled” sexual orientation category (Diamond, 2008b). Conversely, they might be told that with strong motivation, experiencing fluidity and change may be easier than as an adult.

Annually, about 42% of youth are exposed, willingly or unwillingly, to Internet pornography. Hence, over a few years this exposure is almost universal (Wolok, Ybarra, Mitchell, & Finkelhor, 2007), so its effects should be monitored. Quite unrealistic ideals may be absorbed by these youths. Alternatively, compulsive or addictive use of gay pornography may lead a young person to assume that he is gay when he is merely compelled or addicted to sexual gratification.

Surveys show that some adolescents reach a conclusion about their sexuality, are distraught about what they perceive be the consequences, and are at highest risk of suicide immediately before disclosure to anyone (Paul, Catania, Pollock, Moskowitz et al., 2002; Wang, Ploderl, Hausermann, & Weiss, 2015). Therapists should be particularly aware of the fragility of such clients, who tend to be those without social support. Suicide risk among youth with same-sex attractions decreases 20% each year self-labeling as gay is delayed (Remafedi, Farrow, & Deisher, 1991). Although causal links are not clear, it is prudent to encourage the deferring of self-labelling (Rimes et al., 2018). Clinicians should also consider carefully whether disclosure of the client’s struggle to unaware family and friends is in the client’s best interests (Rosario,

Schrimshaw, & Hunter, 2009; Ryan et al., 2009; Wang et al., 2015; cf. Guideline 9). Many who disclose their homosexuality to unsympathetic family join the ranks of the homeless and are further at risk for drug use, prostitution, and violence (Tyler, Whitbeck, Hoyt, & Cauce, 2004). The reactions of peers at this age can be brutal (brutality tends to peak in the adolescent years) probably because they have less empathy than younger or older groups. There is still intense pressure from peers to conform to stereotypical gender roles.

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

Midanik, 2009; Ueno, 2010), antisocial behavior (Fergusson et al., 1999), depression (Cochran et al., 2003; Gonzales & Henning-Smith, 2017; Ploderl & Tremblay, 2015; Ross et al., 2018), impulsivity (Puckett, Newcomb, Garofalo, & Mustanski, 2017), compulsivity (Dodge et al., 2008), and borderline personality disorder (Marantz & Coates, 1991; Sandfort et al., 2001).

## **Education**

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

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

Holroyd, Glasgow, & Smith, 2004; Thase & Jindal, 2004).

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

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

In addition, clinicians serving clients who seek to address unwanted same-sex attractions and behaviors also prepare

themselves to offer their clients directly or to refer them for pastoral care. Such clients often have religious or spiritual beliefs, practices and social interactions which offer motivation and support for their desired changes (cf. Practice Guidelines 3 and 4). Therefore, clinicians make reasonable efforts to assess their clients' religious beliefs, moral values, and spiritual practices to support clients' utilization of appropriate spiritual and religiously oriented resources to achieve intended changes (Collins, 2006; Richards & Bergin, 2000; Wilson, 1988<sup>5</sup>).

Clinicians wisely recognize that, in general, religion can be beneficial to psychological and interpersonal health, more "intrinsic" ways of being religious appear to be healthier, and clients who are more religiously devout tend to "prefer and trust clinicians with similar beliefs and values" (Gregory et al., 2008; Richards & Bergin, 2005, p. 307). Also, the use of spiritual or religious-inspired aides such as prayer (Wright, 1986), meditation (Benson, 2015; Benson & Stark, 1997; Proctor & Benson, 2011), forgiveness (Enright, 2012; Enright & Fitzgibbons, 2014), and twelve step groups based on spiritual principles (Burlingame, Strauss, & Anthony, 2013; Friends in Recovery, 2009; Hemfelt, Minirth, Fowler, & Meier, 1991; Marich, 2012) have been shown to be therapeutically effective as part of or as an adjunct to clinical intervention (Richards & Bergin, 2004, 2005).

Studies of clients with unwanted same-sex attractions and behavior who have used spiritual aides, religious activities, and pastoral counseling, whether as adjuncts to psychotherapy or apart from therapy, often report positive results (Jones & Yarhouse, 2007, 2009, 2011). Even when clients did not change

as they had intended, research designed to elicit reports of intervention failure, harm, or dissatisfaction from religiously mediated efforts to change nevertheless yielded a few participants who asserted that the process was helpful (Shildo & Schroeder, 2002). Research designed to elicit reports of intervention success or satisfaction with their participation yielded substantially more favorable reports (Nicolosi et al., 2000, 2008; Santero et al., 2018; Spitzer, 2003). The more rigorous the research design, the more clearly results have shown that spiritual/religious/pastoral counseling approaches by themselves have been able to reduce or eliminate unwanted same-sex attractions and behaviors for some individuals (Jones & Yarhouse, 2007, 2011; Yarhouse, Burkett, & Kreeft, 2002). Clients tend to try a wide variety of methods and find almost all helpful (Santero et al., 2018).

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

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

on as necessary (cf. Guideline 8). This greatly increases the responsibility of clinicians to become and keep current with the literature.

Research has generally shown that persons reporting same-sex attractions and behavior (mainly the male representatives) have much greater prevalence of pathology than the general population. The consistency of these findings counterbalances to some degree the methodological limitations. Prevalence disparities have been reported or can be inferred in several areas: depression (Ross et al., 2018), suicidal risk-taking in unprotected sex (van Kesteren, Hospers, & Kok, 2007), violence (Coxell, King, Mezey, & Gordon, 1999; Friedman et al., 2011; Owen & Burke, 2004), antisocial behavior (Fergusson et al., 1999), substance abuse (Branstrom & Pachankis, 2018; Pakula, B., Shoveller, J., Ratner, P. A., & Carpino, R., 2016; Rhodes, McCoy, Wilkin, & Wolfson), injury (Batejan, Jarvi, & Swenson, 2015), rumination (Timmins, Rimes, & Rahman, 2017; Wang & Borders, 2017), suicidality (de Graaf et al., 2006; Hottes et al., 2016; King et al., 2008; Peter et al., 2017; Ploderl & Tremblay, 2015; Rimes et al., 2018), more sexual partners (Laumann et al., 1994; Mark, Garcia, & Fisher, 2015; Mercer et al., 2009; Parsons, Starks, Gamarel, & Grov, 2012; Pawlicki & Larson, 2011; Rhodes et al., 2009), paraphilias (fisting) (Crosby & Mettey, 2004), being paid for sex (Schrimshaw, Rosario, Meyer-Bahlburg, Scharf-Matlick, Langstrom, & Hanson, 2006), sexual addiction and hypersexuality (Bothe et al., 2018; Dodge et al., 2004; Parsons et al., 2008; Satinsky et al., 2007), personality disorders (Zubenko, George, Soloff, & Schulz, 1987), and psychopathology

(Gonzales & Henning-Smith, 2017; Sandfort et al., 2001). It is difficult to find a group of comparable size in society with such intense and variable co-occurring pathology.

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

SAFE-T for unwanted same-sex attractions and behavior is controversial in a manner that is seldom experienced today for other types of presenting concerns. As a result, there is a potentially increased risk for the clinician of unanticipated legal consequences (Hermann & Herlihy, 2006; Rosik, 2017b; cf. Guideline 6), a greater potential complexity of therapy, and therefore a greater need than average to stay current in the field and be aware of the latest implications of research and good practice. Clearly, it may be

necessary to understand the consequences on the client's psyche of having one of the associated medical conditions, or one of the common political attitudes, such as strong rejections of society's attitude toward homosexuality.

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

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

Focused events such as seminars, conferences, etc. are more important than usual because SAFE-T approaches

for unwanted same-sex attractions and behavior are not as widely known and practiced as counseling for other conditions, which increases the need for collegial consultation. It is assumed in all the above that clinicians attempt to keep current in the psychological disciplines in general, with the usual accompanying need for continuing education.

## **Applications and Conclusion**

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

Second, these guidelines inform consumers who currently are receiving or considering the pursuit of SAFE-T for their unwanted same-sex attractions and behaviors. The guidelines provide a broad evaluative framework which these clients can utilize to help determine if the clinical services they receive are being provided in a sufficiently professional and ethical manner. Consumers of SAFE-T may find value in

discussing these guidelines with their clinicians. Discussing them early in treatment as part of the informed consent process may facilitate planned short-term and long-range goals for the psychological care they are going to receive.

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

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

encourage more individuals within these associations and universities to engage in valuable dialogue, education, and research about the place such interventions have in the array of therapeutic responses to unwanted same-sex attraction and behavior. The guidelines also may provide interested clinicians and students an opportunity to become educated about the professional practices of responsible clinicians who practice SAFE-T.

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

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## Endnotes

<sup>1</sup>The original guidelines were adopted by the Board of Directors of the Alliance for Therapeutic Choice and Scientific Integrity (ATCSI) on October 25, 2008. This updated version was adopted by the ATCSI Board on June 22, 2018, and replaces the earlier guidelines document.

<sup>2</sup>These revised guidelines were developed by the Alliance Practice Guidelines Task Force (PGTF). The PGTF chair was Christopher H. Rosik, Ph.D. (Link Care Center & Fresno Pacific University). The PGTF members included Shirley Cox, DSW (Brigham Young University); Carolyn Pela, Ph.D., LMFT (Arizona Christian University & Fuller Theological Seminary); Paul Popper, Ph.D. (independent practice, San Francisco, CA); Phil Sutton, Ph.D. (independent practice, South Bend, IN); and Neil Whitehead, Ph.D. (research scientists, Lower Hutt, New Zealand). Others who contributed to the development of these guidelines were Julie Hamilton, PhD, LMFT (independent practice, West Palm Beach, FL); Geoff Heath, J.D. (U.S. Department of the Interior, Washington, D.C. (Retired)); Joseph Nicolosi, Jr. (The Breakthrough Clinic, Westlake Village, CA); David Pruden, MA (Utah State University); and Robert Vazzo, LMFT (independent practice, Culver City, CA, and Las Vegas, NV).

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

<sup>3</sup>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.

<sup>4</sup>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.

<sup>5</sup>Wilson's (1988) book is one of 28 volumes in the *Resources for Christian Counseling* series, which is edited by Gary R. Collins. The series' authors address how Christian psychotherapists and professional counselors may serve Christian clients who are dealing with a variety of issues, including self-esteem, depression, anxiety, anger, marriage and family difficulties, special needs of children, family violence and abuse, eating disorders, substance abuse and addiction, and ACOA issues. The notable, last book in this series is authored by the series' editor (Collin, 1988).