## Impossible "Choices": Identity and Values at a Crossroads


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# Impossible "Choices":
## Identity and Values at a Crossroads

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Nearly 30 years ago, the American Psychological Association (APA) encouraged psychologists to "take the lead in removing the stigma of mental illness . . . associated with homosexual orientations" (Conger, 1975, p. 633). Since that time, scholars, researchers, and theorists have helped inform the profession to work sensitively, responsibly, and ethically with lesbians and gay men in their mental health care (Fassinger, 1991). Much of the research has focused on identity models and the coming-out process (Morin & Rothblum, 1991), allowing researchers, practitioners, and theorists to understand the developmental process an individual may experience in embracing his or her sexual orientation in a society that holds many negative beliefs and stigmas about lesbian, gay, and bisexual (LGB) individuals.

The authors of this issue's major contribution have provided qualitative and quantitative data with which to gain a better understanding of some of the factors that lead same-sex attracted individuals in religious conflict to elect conversion therapeutic practices, and some of the positive and negative outcomes of participating in this type of therapy. Together, the authors provided an introspective and thought-provoking discussion of the complexities of being LGB or same-sex attracted and religiously conflicted. They primarily considered whether conversion therapy had therapeutic value and efficacy, whether it upheld APA ethical guidelines, or whether it was indicated at all, given the profession's stance that homosexuality is no longer considered a "mental disorder." The current series of articles focused on the individual's unique developmental processes regarding both sexuality and religion and sought to provide further illumination not only on the effect of conversion therapy but also on the psychological struggles one may engage in when conflicted about aspects of self and society that are inextricably linked in one's core functioning.

The major contribution provided a number of findings and suggestions that better our understanding about why individuals might seek conversion therapy despite the potential harm it might cause. Morrow and Beckstead

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(2004 [this issue]) described current theories and controversies surrounding this form of therapy, and Tozer and Hayes (2004 [this issue]) showed that religiosity in itself does not necessarily lead an individual to seek conversion therapy. Instead, a confluence of variables involving homonegativity and identity development seems to be at play. Beckstead and Morrow's (2004 [this issue]) research demonstrated that these individuals may seek resolutions to religious conflict and to feelings of shame, isolation, and marginalization about being same-sex attracted. Beckstead and Morrow suggested that rather than considering conversion therapy as a way to resolve religious conflicts, future research may want to explore how factors buffering shame and marginalization may be a preferred treatment intervention to facilitate resolution of these feelings. Haldeman (2004 [this issue]) provided thoughtful suggestions and avenues for treatment that focused on the challenges resulting from conflicting values and questions related to identity. A primary message of the articles in the major contribution is to focus on the individual client's conflicts and needs rather than to apply a "cookbook" approach favoring either sexual orientation or religion.

Each article substantively contributed to the discussion and expansion of future research in the areas of conversion therapy and identity exploration. Nevertheless, additional areas of discussion may be important to the topic. Our reactions to the major contribution focus on three themes: (a) adequate or consistent definitions of conversion therapy and LGB affirmative therapy, (b) issues of oppression and privilege related to race/culture and gender relevant to the current findings, and (c) the need to create models that describe psychological processes leading to a variety of outcomes or resolutions for the individual, each of which may be considered "healthy" or adaptive. The terms *same-sex attraction* (SSA) and *LGB* were used throughout the major contribution. It is important to define these terms specifically because some researchers use them interchangeably, whereas others use them to define distinctions between same-sex behavior and homoerotic feelings, experiences, and identity. In some cases, we use the term *same-sex attraction* in the limited sense, as involving only behavior. We use the term *LGB* as a broader definition that includes homoerotic feelings, community, and relationships among same-sex individuals. We acknowledge that our discussion is far from exhaustive; however, it is our hope that our comments will encourage continued scholarly dialogue, research, and exploration in these areas.

## DEFINITIONS OF THERAPY

Morrow and Beckstead (2004) and Haldeman (2004) provided brief descriptions of conversion therapy and its stated goal of converting homosexual

to heterosexual orientation. Other researchers (e.g., Haldeman, 1994; Shidlo & Shroeder, 2002; Tozer & McClanahan, 1999) describe conversion therapy more extensively. However, we wonder if therapists practicing conversion therapy follow similar goals, processes, and intervention strategies and even achieve similar outcomes. That is, what, if any, methods of conversion therapy are consistently used by therapists? Equally important, what are important differences among these forms of conversion therapy (even among therapists themselves) that might affect outcomes such that a participant is influenced to become either a proponent or opponent of conversion therapy? For example, Tozer and Hayes (2004) and Beckstead and Morrow (2004) do not make clear if or what type of formal training was involved for conducting conversion therapy. Were the majority of therapists pastoral or theologically based therapists or were some at least partially trained within an APA-accredited program? It is conceivable that the similarities and differences among the forms of conversion therapy might have significantly affected the results in the current research. Thus, we suggest that the term *conversion* therapy may be too broad to be meaningfully interpreted, and that further research needs to be conducted on the specific type(s) of interventions and/or techniques that are used that lead to more positive or negative results.

Similarly, we wonder what might be considered LGB-affirmative therapy today. The authors implicitly convey that LGB-affirming therapy is a treatment choice with common or collective interventions that facilitate clients' psychosocial adjustment as LGB-identified individuals. Indeed, while numerous publications call for such therapy with LGB clients (Browning, Reynolds, & Dworkin, 1991; Morrow, 2000; Shannon & Woods, 1991; Tozer & McClanahan, 1999), we wonder if most practicing therapists agree on this type of therapy. There is also a sense in the major contribution that LGB-affirming therapists agree on the best treatment methods for LGB-conflicted clients, and we doubt this is the case. And what of therapists who do not engage in conversion therapy but who are unfamiliar with LGB-affirming therapy? Are there positive outcomes within this treatment modality?

According to many LGB identity theories, beginning with Cass (1979), an individual is considered mentally healthy if he or she is able to renounce stigmatized notions of the LGB community and lifestyle. Can an individual live with discomfort with SSA and still be mentally healthy? More generally, does the term *LGB-affirmative therapy* today capture the bias of some therapists that to be mentally healthy, an LGB individual must be "out" or in the open about this choice—that is, one must always choose an "out" LGB identity at risk of other losses one may incur (religion, family, community)? Helping clients make critical choices is an integral part of LGB affirmative therapy, as well as helping clients understand and articulate the impact of these choices on other aspects of their lives.

## CONTEXT OF IDENTITY

Our primary reactions to the major contribution emanate from exploring the contextually nested nature of therapy itself; that is, context has much to do with how we experience an event. In particular, we identify important contextual issues based on race and gender that affect the meaning of the current findings.

### Racial/Cultural Issues

We make these remarks regarding race and culture with the understanding that these concepts are distinct from each other. Although it is beyond the scope of this article to review these distinctions, our reaction focuses on areas of conceptual convergence with respect to oppression/privilege and values. All authors noted the lack of racially and culturally diverse participants in their samples, despite efforts to recruit these participants, and the authors speculated about why such participants were difficult to access. Furthermore, in one of his case scenarios involving an African American man, Haldeman (2004) describes unique issues facing LGB people of color with respect to racism in the LGB community. We extend these points and emphasize that it is critical to understand how sexuality and religious conflicts are embedded within one's experiences as a racial/cultural being. For people of color faced with multiple challenges based on minority social status, sexual/religious conflicts may be overshadowed by other, larger issues related to maintaining one's racial/cultural communities. These factors must be a major focus of future research extending the current findings.

In addition, there likely are racial/cultural issues affecting the experiences of the participants in the samples of the major contribution. For example, we suspect that racial privilege of the majority of the participants or case scenarios was a significant aspect of these individuals' lives. We are curious to know what it is like to be a member of highly powerful majority groups in the larger society (e.g., White and male) and, at the same time, be a part of a marginalized group (e.g., gay).

Constructing and feeling validated for one's identity is a difficult process, particularly when one's identity is marginalized, loathed, and stereotyped as defective or deficient and having no value. The process of identity construction shares similar themes for many identities (e.g., gender, racial) in which people find themselves at a crossroads as to whether they should embrace, despise, or devalue their identity or remain in conflict. Thus, we encourage future researchers to consider what it was like for participants or clients to embrace an identity that has been harshly marginalized while enjoying many of the privileges that come with belonging to a majority group. For example,

we wonder if some of the religious/LGB identity struggles may have, in part, masked a privilege/oppression struggle. This is not to say that participants did not experience real struggles about being LGB or SSA and holding conservative religious values. We wonder, however, what role privilege might play in first creating the struggle and then in participants' seeking to resolve the struggle.

In sum, we assert that the privileges associated with race and culture must be incorporated in the research paradigm. That is, research incorporating racial/cultural issues should not be limited to oppression issues experienced by people of color. Research methodology needs to integrate aspects of privilege as critical variables that can deepen our understanding of the phenomenon in question, in this case, conflicts between sexuality and religion.

## Gender Issues

Similarly, we were struck by the large number of men in the samples who apparently are drawn to conversion therapy. As noted by Morrow and Beckstead (2004), perhaps issues of fluidity of identity deter women from seeking conversion therapy that forces a choice of label. In addition, oppression factors are likely relevant to potential lesbian and bisexual female clients (many of whom might also identify as feminist) who may not want to participate in therapy or religious institutions that promote patriarchal values and the diminishment of women's roles in the religious community and the larger society. In addition, developmental models of women's gender identity and sexual orientation include a component of understanding oppression in society, and conversion therapy apparently does not. This may be another reason why more women and people of color do not seek conversion therapy. Furthermore, we suggest that men, particularly White men, might be attracted to such therapy because it is likely to benefit them in the larger society.

Examining the intervention strategies used in conversion therapy provides further insight into why women may not participate in this form of therapy. For example, Beckstead and Morrow (2004) discuss strategies for "healthy male bonding," focused on men coming together in sporting activities, as opposed to activities such as "coiffing" for women. It is not surprising that lesbians are not drawn to coiffing and similar activities in significant numbers. Not only might these activities be of little or no interest to potential female clients (even prompting disgust and hostility), such activities also represent traditional gender roles that place women in less powerful, less relevant, and less effective positions in society. On the contrary, sports are symbols of wealth and power in the larger society. It is no wonder that some men are drawn to such activities (one participant described being welcomed into the "club of man," calling up visions of traditional men's clubs whose mem-

bers were often the most powerful men in society). Such strategies of conversion therapy seem to target gender roles and will likely not include or attract women who see themselves in broader terms.

More generally, we wonder if the outcomes of conversion therapy were more related to gender role development than to sexual orientation or identity (Tozer & McClanahan, 1999). It seems the definition of LGB identity in many forms of conversion therapy is boiled down to behaviors with sexual partners (hence the term *same-sex attraction* or SSA). As Morrow and Beckstead (2004) note, this definition seems to reduce sexual orientation to a purely behavioral phenomenon (likely a desired goal of conversion therapy, to enhance its effectiveness). However, for many women, while sexual behavior is clearly a critical aspect of identity or sexual orientation, being a lesbian involves much more, including emotional bonding, types of friendships, political philosophies, and music—that is, finding community. Furthermore, it appeared that many men who benefited from conversion therapy, particularly in Morrow and Beckstead's study, learned how to be in relationships, including friendships, and develop broader or effective ways of interacting with other men instead of leading closeted sexualized lives. This process seems to involve adopting a component of "sacrificing of self," such as adopting a father or husband role. In contrast, women, including lesbian and bisexual women, have many more ways to be social (and not just sexual) with other women and simply may not need this kind of intervention. In addition, many roles in which women engage, particularly in religious settings, necessarily already involve a self-sacrificing component. Women in most religions do not hold positions of authority or status and often provide "supportive" roles in the church. Consequently, as a result of the patriarchal practices that permeate many religious denominations, women may find themselves compartmentalizing their gender and religious selves on an ongoing basis. This may be another reason women were not well represented in the studies.

Although several gender and LGB identity models have been developed, these have often been insensitive to issues of race, ethnicity, age, class, and gender. Models of gender and LGB identity (Reynolds & Hanjorgiris, 2000) have provided useful ways to understand the developmental process of embracing identities, particularly those that have been marginalized and stigmatized; however, the models disregard issues of intimacy, autonomy, and sexual expression (McCarn & Fassinger, 1996). As the findings of Tozer and Hayes (2004) indicate, clearly, sexual orientation identity is relevant to one's seeking of conversion therapy; it is important to know how other identities, as based on gender, for example, might also influence interest in conversion therapy.

As the authors note, women were underrepresented throughout the major contribution, thus limiting generalizability and exploration of the ways that

men and women uniquely express intimacy, same-sex attraction, gender awareness, and sexual orientation identity. This unfortunately repeats a historical pattern for research on gender that has often ignored the interaction of gender with sexual orientation (Morrow, 2003). For example, why did Haldeman (2004) in his very thoughtful article focus only on male clients? What were his assumptions for doing so, and what are the unique issues of resolving religious conflicts that gay or same-sex-attracted men face? Conversely, how should researchers and practitioners specifically apply his suggestions and scenarios to their female clients dealing with sexual/religious conflicts? While we have attempted to suggest ideas on how women experience or are deterred from conversion therapy, we propose that empirical research be conducted to specifically examine unique gender issues lesbian and bisexual women (and men) face in conversion therapy. Current literature continues to marginalize women in terms of research and practice in LGB issues surrounding religion and conversion therapy (Morrow, 2003).

Relatedly, bisexuality as a credible identity for inclusion in the discussion of same-sex attraction was neglected. Many researchers and theorists have not viewed bisexuality as a viable identity in both the gay and lesbian and heterosexual community (Queen, 1996, in Davidson, 2000). Although bisexual individuals embrace both same- and opposite-sex attractions and lifestyles, they also may experience psychological distress as a result of religious conflicts. Their exclusion from the discussion on sexuality and religion perpetuates a marginalized status in both heterosexual and gay and lesbian communities.

## CONTEXT OF RELIGION

It is beyond the scope of our discussion to define religion and to distinguish between religion and spirituality. However, a brief comment about the role and salience of religion in individuals' lives is useful, particularly in light of Tozer and Hayes's (2004) research findings. These authors found that individuals who were intrinsically oriented toward religion and, more to the point, adopted homonegative beliefs were likely to have a propensity to seek conversion therapy. Conversely, individuals who were not intrinsically oriented toward religion and did not adopt homonegative beliefs were not likely to have a propensity to seek conversion therapy. These findings highlight the importance of conducting further research on the specific role religion plays in clients' lives—for example, its potential link with developing homonegativity and with choosing treatment interventions that are appropriate for the client rather than interventions primarily focused on embracing or denouncing same-sex attraction.

## IDENTITY REDEFINED

The major contribution provides a call to the profession to broaden the definition and scope of LGB identity models to be more inclusive of individuals who are in religious conflict with varying degrees of homoerotic feelings. This call is in line with early scholars who examined sexuality in psychology, beginning with Kinsey (Kinsey, Pomeroy, & Martin, 1948, in Haldeman, 1994), who described sexual identity in a fluid way (i.e., most people identify neither as exclusively heterosexual or homosexual). More recent work regarding existing theory and research on LGB people has critiqued its unexamined compartmentalized framework about group memberships based on race, gender, and so on (Bowman, 2003).

Current research poignantly presents the critical ways in which context, identity, and values intersect, sometimes clashing in painful ways. The authors clearly demonstrate that resolutions of these conflicts are unique for every individual. Unfortunately, most psychological identity models typically portray common "coming-out" processes and outcomes without regard to race, gender, social class, age, and religion. The current articles, particularly those by Beckstead and Morrow (2004) and Haldeman (2004), legitimize the idiosyncratic experiences of individuals' coming-out processes and attempt to build a theory or model that is based on these experiences rather than labeling them exceptions to a presumed common healthy or adaptive outcome (i.e., coming out).

Arguably, the search for congruence is a common process that many conflicted LGB people struggle with regarding religion and sexuality. However, it is imperative for psychologists, both researchers and practitioners, to understand that the resolutions of incongruence are as infinite as the number of people who seek them. The key issue is not so much about "coming out" for many people but rather figuring out how one's experiences can become congruent with deeply held belief systems. Therapists need to be open to helping clients move toward their unique resolutions regarding congruence.

One of the assumptions in much of Western philosophy and psychology is the notion that people have "choices" when it comes to religion or the experience of homophobia. We assert that for many individuals, particularly those with collectivistic worldviews (many religions fall in this realm), the issue to resolve is not necessarily about "choice" but about being caught between conflicting social worlds that the individual simply cannot live without (e.g., "faith" or one's family as well as one's sexuality or intimate partner). For many oppressed people (e.g., people of color and women), it is a daily occurrence to "choose" between social worlds in which only a part of one's being can be affirmed or expressed. Living these lives means living with the constant conflict such compartmentalizing inflicts, leading to increased dis-

tance from one's self and emotions. Many people with oppressed experiences based on race, gender, and social class may look to their religious community as a primary buffer against these compartmentalized and diminishing experiences. One's religious community can provide major protections, not only psychologically but also politically and economically. So, for many people, there is not really a "choice" about keeping one's religion; it is more a process of negotiating within this community, along with other communities, to find solace, meaning, and support.

For many participants and clients described in the current series of articles, it is likely that religion was important and perhaps not even a "choice" because religion provided the buffering and the meaning they needed. Additionally, it is important to examine how religion provides not only critical supports but also social status and political and economic access that clients and participants may not want to relinquish.

Identity models need to incorporate the varied ways of healthy resolution of incongruence described in the major contribution. Research paradigms used to investigate identity generally leave it to the individual to reconcile societal portrayals of negative identities. People who have social identities that are mutually stigmatized must reconcile two or more identities that may have equal meaning for them. To ask an individual to separate herself or himself from one or the other identity may be implicitly asking the individual to lead a fragmented life (e.g., whether that life be "out-gay" or "out-religious"). Psychology can and should offer individuals with conflicting and mutually stigmatizing identities more than a "choose one over the other" approach. There is value in the profession calling into question various therapeutic practices and seeking social justice for many oppressed people. However, there is also value in imploring the profession to examine broader models for therapists to practice and understand the complexities of multiple social identities so they may help clients negotiate the challenges of living with such complexities.

We believe the major contribution provides important findings and suggestions relevant to research and practice today with LGB and SSA people. This growing body of research obligates the profession to redefine current approaches of "affirmative" LGB therapy. Such approaches have rightfully demanded that psychologists examine their own negative biases regarding LGB issues, particularly in working with conflicted individuals. We strongly agree with the authors of the major contribution that much of conversion therapy is not theoretically based, is simply harmful and unethical, and promotes anti-LGB bias in the larger society. However, as the authors also note, psychologists must be aware of their own biases regarding the significance of religion in their own lives and those of their clients (Beckstead & Morrow, 2004; Haldeman, 2004). It would be harmful and unethical to negate the

importance of religious values and practices or of other identities or communities that a client or research participant views as central to his or her existence. It is sometimes a difficult but no less healthy or adaptive strategy to "choose" family or religion over an "out" sexual identity as counterintuitive as this may seem for many psychologists. Thus, affirmative therapy for LGB clients must necessarily allow the space for safe dialogue in which the client can identify these strategies without fear of being pathologized or subtly rejected by the therapist.

Of course, we believe that such an approach does not mean psychologists as professionals or as religious beings cannot address oppression and prejudice within our various communities and the larger society or even acknowledge these prejudices to our clients. We can and we must! We recognize the inherent contradictions of both helping a client recognize social prejudices and supporting the same client in negotiating various ways of dealing with these prejudices, including staying connected with a religious community that perpetuates homonegativtiy. At a minimum, we must be aware of our biases in providing support to our clients and follow our ethical guidelines when we believe these biases we are at play (i.e., consult or refer out).

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