SEXUAL IDENTITY AND FAITH
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Helping Clients Find Congruence

Mark A. Yarhouse

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To people of faith
who are navigating questions
about their religious
and sexual identities.
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I have spent the past two decades conducting research on and providing therapy services to Christians who experience a conflict between their same-sex sexuality (or sexual identity) and their faith (or religious identity). I served as executive director of the Institute for the Study of Sexual Identity at Regent University, where I have been the Rosemarie S. Hughes Endowed Chair and Professor of Psychology. I have also served as the clinical director of the Sexual and Gender Identity Clinic, which has been a subclinic of the Psychological Services Center. Earlier in my career I collaborated with my mentor, Stanton Jones, on a study of whether people could change their sexual orientation through involvement in Christian ministries. This early work inspired me to explore the conflict Christians often feel when they do not experience a change in sexual orientation but remain convinced of a traditional Christian sexual ethic. In other words, I wanted to study sexual identity development and the experiences of Christians navigating sexual and religious identity conflicts over time. This investigation would lead to several lines of research. Informed by that research, I developed with Warren Throckmorton the Sexual Identity Therapy Framework (see Appendix A), an approach to therapy that serves as an alternative to sexual orientation change efforts (SOCE), and I developed how I provide services, which I refer to as Sexual Identity Therapy (SIT).

I draw upon several theoretical and empirical research projects in this book. The theoretical underpinnings of Sexual Identity Therapy come from an understanding of sexual identity as a construct that develops and can reach synthesis in a person over time. Sexual identity (also referred to as sexual orientation identity) is the label applied to oneself based upon one’s sexual preferences, which sounds
fairly straightforward. But labels people apply to themselves are also informed by the weight a person gives to their gender identity, biological sex, beliefs and values, and so on. Empirical studies of sexual identity development and of milestone events in the formation of sexual identity, especially among Christians, are also foundational to this therapy model (e.g., Yarhouse & Tan, 2004; Yarhouse, Tan, & Pawlowski, 2005). More recent research on sexual identity and faith has included the experiences of sexual minorities at Christian colleges and universities (e.g., Yarhouse, Dean, Stratton, & Lastoria, 2018; Yarhouse, Stratton, Dean & Brooke, 2009), celibate gay Christians (e.g., Yarhouse & Zaporozhets, 2019), and people in mixed-orientation marriages in which one partner is a sexual minority and the other is heterosexual (Yarhouse, Atkinson, Doolin, & Ripley, 2015).

In addition to research, I have also had several professional experiences that inform how I try to navigate potential conflicts between sexual and religious identities. I have spent several years promoting dialogue between people who view the topic of sexual identity differently. In 2000, I chaired a groundbreaking (at that time) symposium at the annual convention of the American Psychological Association (APA), bringing together gay psychologists and Christian psychologists to discuss common ground in treatment options for those who experience sexual and religious identity conflicts. I chaired similar dialogues at the APA on services for adolescents experiencing sexual identity concerns and related topics.

In 2006, I was named senior fellow with the Council of Christian Colleges and Universities to conduct a study of students navigating sexual identity concerns at Christian colleges and universities. The most recent publication from that line of research is Listening to Sexual Minorities, published in 2018 with Janet Dean, Stephen Stratton, and Michael Lastoria. I have been a consultant to the National Institute of Corrections to address issues facing sexual minorities in corrections, whether in adult jails or prisons or in the juvenile justice system. I was also part of a consensus panel from the APA on sexual orientation and gender identity change efforts that convened to provide input to the Substance Abuse and Mental Health Services Administration in
Washington, DC. I currently chair the task force on LGBT+ issues for Division 36 (Psychology and Religion and Spirituality) of the APA.

I also have a small clinical and consulting practice. I have worked with individuals, couples, and families and run groups for people who are navigating sexual and religious identity conflicts. In addition, I have consulted with churches and other Christian organizations. Pastors would call and request staff training on LGBTQ+ issues. Parents would call and ask for help when their teenager came out to them as gay. College-aged students would want to meet to discuss their sexual identity and faith. Youth ministers would call and ask for guidance on how to work with gay and lesbian teens in their youth group. Middle-aged adults would come in having spent 10 to 15 years attempting to change their sexual orientation; since their orientations had not changed, they wondered if I had anything to offer them.

Two groups of clients, in particular, made an impression on me. One group was made up of teenagers who did not want to become straight. They didn’t have a negative response to their same-sex sexuality the way someone a few years older than them might have had. They weren’t sure what they wanted. They knew that their sexuality was important to them. They also knew that their faith was important to them. They wondered how the two could be related to one another.

The other group that stood out to me were adults who had been attempting to change their orientation through involvement in various SOCE. These SOCE might have been ministry approaches or professional therapy; in either case, these adults had been trying for many years to go from gay to straight. They seemed to have been taught that their same-sex attractions originated either from sexual abuse or from unmet emotional needs in relationship to their parents, especially the parent of the same sex. I didn’t think much of these theories for the etiology of same-sex sexuality. The research cited was often older and conducted at a time when certain expressions of psychoanalytic theory were more popular, when the prevailing understanding was that homosexuality was the result of unmet emotional needs that would become sexualized at puberty. I am oversimplifying the theory here, but the quality of the research was limited in my
opinion, and, at least with the people who were coming to see me for help, the SOCE they had undertaken had not delivered what they felt was promised them.

As I mentioned, these experiences with teenagers and with adults who had not experienced change of orientation through SOCE made an impression on me. It was evident to me that there was a need for clinical services that would be respectful of Christian beliefs and values but would avoid some of the potential for disappointment that could come from SOCE. If most people did not experience change of underlying attractions (rather than change of behavior and identity) in SOCE—and if some of those individuals felt they had been led to believe that if they tried hard enough or had enough faith they could be straight (which would reflect a change in underlying attractions)—then where could they go for professional care? There seemed to be a great risk of shame in acknowledging enduring same-sex attractions in a climate that promised change of orientation. Still, many clients who experienced no change in orientation did continue to believe that their religious identity, beliefs, and values could inform their overall understanding of their sexuality, their identity, and their behavior. Their values could set them on a trajectory that could be healthy but not be about becoming straight. Alternatively, these clients could come to change their beliefs and values and find congruence through more mainstream gay identity and relationships. But clients needed a safe therapeutic space to ask questions, explore assumptions, and carve out a path that would work for them. They needed a safe therapeutic space to discuss how their current values had shaped and informed how they viewed their sexuality in ways not understood by many clinicians. Nonreligious clinicians seemed to think they were in denial; religious ministries still wanted to bring them back to an ex-gay narrative. These appeared to be the only options on the table. Where were these clients supposed to receive help?

SIT is an example of what Siang-Yang Tan calls implicit integration. Tan distinguishes implicit integration from explicit integration, a clinical practice that utilizes overtly Christian (or other religious) concepts
to frame therapy. When a clinician practices forgiveness therapy or offers a grace-based approach to marital therapy, these are explicitly integrating Christian constructs into the heart of the therapy. Implicit integration occurs when an approach to therapy fits well with the values of either the client or the therapist (or both), even though that therapy does not explicitly align itself with a value system. It is a protocol that exists as an alternative to existing protocols, especially when those existing protocols might be prone to violate the values of a certain group. In the case of same-sex sexuality, SIT could be offered as an alternative protocol to SOCE and gay affirmative therapy. It would be implicitly integrative.

Throughout this book I will draw on cases I have seen in 20 years of providing therapy to people navigating sexual identity and religious identity conflicts. There are also three full cases from therapy and supervision at the end of the book for reference. I have changed the names and identifying information to protect the identities of clients, but these are real cases of clients I have seen or supervised.

I would like to acknowledge the many students I have had the opportunity to train and supervise in the institute I have codirected with Dr. Olya Zaporozhets, as well as students who have been a part of the more recent specialty subclinic. The discussions that have taken place there have often brought about new insights and perspectives on complex clinical issues. In recent years this has been especially true in discussions with Jennifer Blue, Meredith Cain, Chelsi Creech, Seth Crocker, Matt Fennell, Desiree Frain, Carson Fuhrman, Jessica Grove, Heather Keefe, Matt Komar, Elizabeth Loewer, Joshua Matlack, Kamau Montegut, Julia Sadusky, Tim Stauffer, Nichole Urh, Ethan Weniger, and others in group supervision over the past several years. There are also many colleagues who have collaborated with me over the years and who have shaped my thinking. Conversations with Trista Carr, Janet Dean, William L. Hathaway, Stanton L. Jones, Michael Lastoria, Stephen P. Stratton, and Erica S. N. Tan have been especially meaningful.

This book is intended to reflect a broader and more comprehensive
approach to assessment, advanced informed consent, and therapy. I hope that this approach can equip clinicians to provide services to people who experience a conflict between their sexual and religious identities and to do so in a way that shows respect and cultural competence with reference to both aspects of their personhood.
PART ONE

Overview of Sexual Identity Therapy
Sienna experiences a conflict between her religious identity and her sexual identity. She is looking for a place, a therapeutic relationship, where she can navigate that conflict. It goes without saying that some people do not experience such a conflict between religious and sexual minority identity, or they find ways within their existing support system to navigate that conflict without the aid of therapy. But for Sienna and many others, it can be helpful to have a place to discuss both religious and sexual identity and to work out a coherent sense of identity to move forward in life.

It is worth noting that 89% of adults in the United States say they believe in God, and three fourths (77%) of adults identify with a religion.
(Pew Research Forum, 2015b). Reports of a recent dip in American religiosity cite the rise of the “nones,” or those who hold no religious affiliation, a stance especially prominent among millennials (Pew Research Forum, 2015b). Despite this apparently growing minority view, religion continues to be an important part of many people’s experience in the United States.

When we look at the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, we see a drop in religious affiliation, although most (59%) still adhere to a religion. Similarly, while 71% of the general public identifies as Christian, about half (48%) of LGBTQ+ persons identify as Christian (Pew Research Forum, 2015a).

Andrew Marin (2016) of The Marin Foundation, a not-for-profit that has worked to bridge religious faith traditions, especially Christianity, and the LGBTQ+ community, reported on a study of over 2,000 LGB Christians who were asked about their Christian faith and current religious practices. Most of them (86%) indicated they were raised in a faith community, and just over half (54%) left their faith community after age 18. A little over a third (36%) of LGBT people surveyed reported that they continued their faith practices after age 18, and most of these (about two thirds) continued practicing in theologically progressive faith communities, while about a third continued to practice in theologically conservative faith communities. Also, 80% of LGBT people surveyed indicated they regularly pray (regardless of religious identification or affiliation).

Religion will have varying degrees of impact on a person navigating same-sex sexuality or sexual identity. A shared faith tradition does not mean agreement when it comes to LGBTQ+ experiences. One Christian, for instance, may embrace his same-sex sexuality, view it as blessed from God, and pursue a faith community that shares this perspective. Another Christian may view same-sex sexuality as an experience that God did not intend for her and choose to forego same-sex relationships as a result.

What is particularly important is how clinicians navigate these potential differences with their clients. What does it mean to explore both religious identity and sexual identity in therapy?
Religious Identity and Sexual Identity in Therapy

The approach to care presented in this book is referred to as Sexual Identity Therapy (SIT). It follows the Sexual Identity Therapy Framework (SITF; Throckmorton & Yarhouse, 2006) and has been discussed in various forms for individual (Yarhouse, 2008) and group therapy (Yarhouse & Beckstead, 2011). SIT and the SITF were both cited in the 2009 American Psychological Association (APA) task force report on Appropriate Therapeutic Responses to Sexual Orientation as examples of identity-focused alternatives to sexual orientation change efforts (SOCE). Before we look more at SIT, let’s look at the 2009 task force report.

The task force report was primarily focused on whether SOCE should be considered a viable therapeutic option when a person reports unwanted same-sex attraction. The task force provided a fairly extensive review of the extant research and concluded that “enduring change to an individual’s sexual orientation [is] unlikely” (APA, 2009, p. 4). Interestingly, however, the task force also noted that the support clients received in such therapies had some perceived benefits. For example, when clients attempted to change their orientation, they perceived benefits in approaches that “emphasize acceptance, support, and recognition of important values and concerns” (APA, 2009, p. 4).

At the same time, gay affirmative therapy, which is in many ways the default posture clinicians take toward sexual minorities, may not be a good fit for all clients. In particular, clients who hold conventional religious beliefs and values may not feel the posture of gay affirmative therapy to be a supportive one for their own needs, depending on how such therapy is practiced. Gay affirmative therapy is not so much a protocol as a way of seeing a person’s sexuality. In practice, gay affirmative therapy can at times assume a preferred identity outcome (e.g., gay) and same-sex sexual behavior as a taken-for-granted expression of that identity, in keeping with its assumptions about sexual identity and expression, even though these assumptions are not necessarily shared by every client.

The task force suggests that today’s gay affirmative therapy, what
they refer to as simply “affirmative therapy,” is best practiced in a more open-ended manner, without a fixed outcome:

Although affirmative approaches have historically been conceptualized around helping sexual minorities accept and adopt a gay or lesbian identity . . . , the recent research on sexual orientation identity diversity illustrates that sexual behavior, sexual attraction, and sexual orientation identity are labeled and expressed in many different ways, some of which are fluid. . . . We define an affirmative approach as supportive of clients’ identity development without a priori treatment goals for how clients identify or express their sexual orientations. (APA, 2009, p. 14)

To avoid confusion, I think of this more nuanced approach as “client-affirmative” so as to not conflate it with gay affirmative therapy, which may sometimes be balanced and client-affirmative but is not always practiced in quite this way by all practitioners. SIT is client-affirmative, as will be described in greater detail below. It functions as an alternative both to SOCE and to gay affirmative therapy as it is sometimes practiced.

The task force, even as it expressed concerns about SOCE, raised important considerations about what therapists stood to learn from the SOCE phenomenon. Among these considerations is the suggestion that mental health professions show respect for clients whose traditional religious values may conflict with the values of gay affirmative therapy as it has often been practiced. In other words, while the task force had concerns about SOCE, they also perceived a need for mental health services to create a safe space within which clients could explore beliefs and values that appeared to put their sexual and religious identities in conflict. In my view, such beliefs and values have at times precluded a person from being a good fit for gay affirmative therapy as it has traditionally been practiced.

The task force report concluded that when a client like Sienna presents with a conflict between her religious and sexual identities, clini-
cians are encouraged to utilize client-centered and identity-focused interventions rather than SOCE:

Conflicts among disparate elements of identity play a major role in the conflicts and mental health concerns of those seeking SOCE. Identity exploration is an active process of exploring and assessing one’s identity and establishing a commitment to an integrated identity that addresses the identity conflicts without an a priori treatment goal for how clients identify or live out their sexual orientation. The process may include a developmental process that includes periods of crisis, mourning, reevaluation, identity deconstruction, and growth. (APA, 2009, p. 64)

In addition to being client-centered and identity-focused, the task force report outlined several other qualities they believe should be part of an affirmational approach to care. Such care would also reflect multicultural competence and foster both social support and coping skills.

In light of the conflicts experienced by conventionally religious clients who experience same-sex attraction, and in light of the concerns raised about SOCE, there appears to be a need for more “third way” models of care. The task force described some of the elements of an approach to care that could reflect these benefits without attempting to make gay people straight and cited a number of examples of “integrative and affirmative [or client-affirmative] perspectives” that include the SITF (Throckmorton & Yarhouse, 2006) and SIT (Yarhouse, 2008), among many other approaches (see Beckstead & Israel, 2007; Beckstead & Morrow, 2004; Glassgold, 2008; Haldeman, 2004). What the task force appeared to appreciate were approaches that explored identity rather than attempting to manipulate orientation. They emphasized the value of clinical services that demonstrated respect for religious identity while avoiding some of the pitfalls they saw in SOCE. Taken together, these various approaches suggest that “psychotherapy that respects faith can also explore the psychological implications and impact of such beliefs” (APA, 2009, p. 20).
The task force noted that although there are no empirically supported treatments (EST) for this population, in part because EST are “interventions for individuals with specific disorders” that “have been demonstrated to be effective through rigorously controlled trials” (APA, 2009, p. 14), affirmative care is evidence-based insofar as it integrates the best research we have as a field with clinical wisdom and expertise, in light of a number of client diversity considerations.

SIT is a therapeutic approach that is consistent with the SITF (Throckmorton & Yarhouse, 2006). The SITF provides a kind of scaffolding for people who wish to help clients navigate sexual identity in therapy.

The SITF organizes mental health services into four distinct areas: assessment, advanced informed consent, psychotherapy, and congruence. Assessment includes general mental health concerns as well as a client’s religious background or upbringing, current religious beliefs and values, and sexual identity. Advanced informed consent addresses general consent information (such as the limits of confidentiality) but also broaches the controversies surrounding sexual identity and religion in some detail so that clients have adequate information to decide whether this is the right approach for them. Psychotherapy should reflect a client-affirmative approach and can be based on any number of theoretical orientations; the key is that such therapy leads a person toward congruence, which means that the person’s behavior and sexual identity is in keeping with the person’s beliefs and values.

Any number of therapy models could be consistent with the SITF. SIT is one of those models. Let’s look at a brief overview of the key components of SIT.

**Sexual Identity Therapy**

SIT (Yarhouse, 2008; Yarhouse & Beckstead, 2011) is one approach to providing therapy in keeping with both the SITF and recommendations from the 2009 APA task force. It is considered an alternative to both SOCE and gay affirmative therapy. SIT is for individuals who experience a conflict between their religious and sexual identities. It
follows a theoretical model of, and empirical research on, sexual identity development (Yarhouse, 2001; Yarhouse, Stratton, Dean, & Brooke, 2009), as well as empirical research on the experiences of Christians who identify as gay and those who disidentify with a gay identity or the mainstream LGBTQ+ community (Yarhouse & Tan, 2004; Yarhouse, Tan, & Pawlowski, 2005). SIT is client-affirmative and, in addition to a focus on sexual identity exploration, it reflects a nuanced understanding of both the mainstream LGBTQ+ community and the range of beliefs and values found in religious communities. In terms of core elements, SIT originated with an emphasis on cognitive elements, most notably attributions clients make about their same-sex sexuality in light of their religious faith. Today, SIT, as I practice it, also draws upon narrative elements. In a recent article I described SIT as drawing from “cognitive-behavioral, person-centered, and narrative theoretical orientations and [focusing] on attributional search for sexual identity, navigating religious identity conflicts, and facilitating personal congruence” (Yarhouse & Beckstead, 2011, p. 108).

There are a few steps to SIT. The therapy begins with assessment and advanced informed consent. It is important for the therapist to distinguish SIT both from SOCE—which a client may have participated in previously or be hoping for—and from gay affirmative therapy. There is then often a time of psychoeducation. These are typically the first two to three sessions. After these are completed, much of therapy entails an “attributional search” for sexual identity that involves navigating the principal conflicts the person experiences between that person’s religious and sexual identities. Attributional search refers to how clients make meaning and come to construct purpose out of their same-sex sexuality. The final step is that of personal congruence.

**Figure 1. Sexual Identity Therapy**

![Figure 1. Sexual Identity Therapy](image-url)
Assessment
Assessment and advanced informed consent often occur in tandem. A clinician is collecting initial information at intake and providing information about services. The clinician collects further information through a more thorough assessment, determining if SIT would be a good fit for a client. I will discuss assessment and advanced informed consent in that order, but to treat them as strictly linear would be oversimplifying the process. Also, as we will see, informed consent is obtained at the start of therapy but is returned to throughout the course of therapy.

We will see in subsequent chapters that assessment of both sexual identity and religious identity is important in SIT. It is also important to assess the history of conflict between these two aspects of identity and personhood. Clinicians also collect information on experiences with key milestone events in identity development, such as first awareness of same-sex attractions. If a therapist uses a more narrative approach to SIT, assessment will consider more explicitly how experiences have been informed by “stories” people have heard about same-sex sexuality and what those stories mean to them today.

Advanced Informed Consent
In tandem with a proper assessment, it is important to obtain advanced informed consent for SIT. Advanced informed consent includes going over standard information covered in informed consent as well as detailing common questions people have about sexual orientation and identity, the nature of SIT, and so on. The reason for advanced informed consent is that the topic of sexual identity and the potential conflicts that exist between religious and sexual identities are such that it seems prudent to provide more detailed information to the client so that the client can truly make an informed decision about possible services.

Psychoeducation
There are two common components of psychoeducation. The first is a three-tier distinction between attractions, sexual orientation, and
identity (Yarhouse, 2005). In other words, some people experience same-sex attraction. Many but not all of these individuals experience so much same-sex attraction—and they experience it in a consistent, enduring way—that they would say they are oriented toward the same sex. Still others would adopt a gay identity, either privately or publicly. A gay identity may to some clients simply reflect an account of their sexual orientation, which is the common vernacular today, or a gay identity could reflect a close affiliation with the mainstream LGBTQ+ community and communicate certain beliefs and values.

The second component of psychoeducation is the weight accorded to various aspects of identity. It has been suggested that sexual identity (e.g., identifying as gay, lesbian, or bisexual) is often a reflection of the relative weight a person might give to their sexual preferences, biological sex, gender identity, personal beliefs and values, behaviors, and intentions. In SIT, the therapist discusses the question of relative weight with clients, unpacking which aspects of identity are particularly salient to a client. If a therapist draws more on a narrative approach to SIT, the therapist can also discuss the nature of narrative and how stories about same-sex sexuality can shape a person’s sense of identity.

*Attributional Search*

The next stage of therapy with SIT has to do with attributions and meaning-making, terms which in this context refer to how a person makes meaning out of their experiences of same-sex attraction. Are the attractions signaling who they “really are” as a person? This is one possible attribution, one which is in keeping with what might be thought of as the mainstream LGBTQ+ community. Do the attractions reflect impulses that are a naturally occurring variation but are, in keeping with some Christians’ views of nature, essentially “not the way things are supposed to be”? This attribution reflects a set of assumptions in some conventionally religious communities. Are the attractions themselves sinful, their very existence morally impermissible? This attribution reflects a different set of assumptions found in some conventionally religious communities. These and other attributions are