

# Gay-affirmative Therapy and Emerging Integrative Solutions

## Working with Ego-dissonant Gay Male Clients

Andrew Kirby

### *Part Two*

#### Abstract

A dichotomy exists in the literature in relation to treating ego-dissonant gay clients who struggle to reconcile their same-sex attraction with opposing values and beliefs. Historically, conversion therapy was the treatment of choice, which aimed to treat the “condition” (homosexuality) by changing an individual’s homosexual orientation to heterosexual. In recent years, as public opinion has shifted toward increased tolerance and acceptance of homosexuality, gay-affirmative therapy has gained popularity and advanced as the modality most likely to benefit the majority of ego-dissonant gay clients. However, each position has tended to respond with a limited, exclusionary choice: to either reject or accept one’s sexual orientation. This dichotomised treatment option may not serve all clients who seek help in dealing with conflicts regarding sexual orientation.

The first instalment of this two-part discussion appeared in the *New Zealand Journal of Counselling*, vol. 28(2), and reviewed gay-affirmative therapy: its history, the developing relationship between the mental health profession and homosexuality, and key concepts of practice from different theoretical perspectives. In this second instalment, emerging integrative solutions appearing in the literature are examined, including a sexual identity management model, and a Kleinian perspective is offered as a way of working with individuals who are unable to accept, change or integrate competing aspects of their identity. This study recognises that each approach caters, to some degree, to the uniquely different needs of individuals.

This article, the second in a two-part series, continues to explore the issue of working with ego-dissonant gay male clients. In the first part of this series, the author examined gay-affirmative therapy, recognising that this relatively new approach, which values and endorses individuals' sexual orientation, has advanced to become the modality of choice for most clinicians working with individuals who struggle to accept their sexuality. Whereas historically, conversion therapy attempted to change one's sexual orientation, many contemporary gay-affirmative therapists assert that the target of change is not the individual, but rather, culture.

Current research suggests that gay-affirmative therapy helps most of those who experience their homosexuality as ego-dissonant to achieve an increased sense of identity, integration and wellbeing. Yet there are others who value all aspects of their identity equally, and do not wish or are not ready to choose a conventional gay-affirmative approach for fear that their sexuality might be validated at the expense of competing values or beliefs, such as holding on to traditional values regarding marriage and family, or religious doctrines that view homosexuality as unnatural and immoral. The ongoing debate about whether one should accept or reject one's sexuality has rendered dichotomous explanations insufficient for such clients, for whom neither conversion therapy nor gay-affirmative therapy seems appropriate. In this article, emerging integrative solutions which cater to the needs of this minority of ego-dissonant gay clients are examined. Following this review, a Kleinian model is proposed as a way to think about and work with clients who are unable to resolve perceived irreconcilable differences between sexual feelings and opposing personal values and beliefs.

### **Is change of sexual orientation really possible?**

Complicating this area of research is disagreement about what sexual orientation actually is. While essentialism and social constructionism fuel the nature versus nurture debate over the aetiology of homosexuality, research does not yet clearly support one particular perspective. Some researchers (Gonsiorek, Sell, & Weinrich, 1995; Spitzer, 2003) have attempted to examine sexual orientation change; however, no consensus about accurate assessment and measurement of sexual orientation has been reached. If theorists are uncertain as to what sexual orientation is, then it is understandable that there is disagreement as to whether or not it can be changed (Yarhouse & Burkett, 2002).

Worthington (2004) cautions against the tendency to fall into simplistic or dualistic

thinking about sexuality, and argues that dichotomous notions of sexual orientation must be challenged. Distinguishing between sexual orientation, sexual identity, and sexual orientation identity creates clearer understandings of how patterns of sexual behaviour, affiliation and identification might change, even significantly, over time. Current research does not support the idea that persons can convert their core sexual orientation, and data indicate that individuals have been unable to change their core sexual arousal patterns, regardless of how hard they tried (Gonsiorek et al., 1995). Thus, *perceived* sexual identity and sexual orientation identities have been the focal points of most individuals' reports in research (Phillips, 2004).

Increasingly, contemporary conversion therapists acknowledge that their target of change is sexual identity and that sexual orientations are essentially immutable (Yarhouse, 1998). They defend the practice without trying to establish the pathology of homosexuality, appealing instead to the individual preferences of those who are dissatisfied with their sexual dispositions (Murphy, 1992).

### **Thoughts about depolarising the debate**

The American Psychological Association (1992) calls on clinicians to respect individuals' diverse aspects of identity; however, the Association does not address situations where competing aspects of identity collide. So what is meant by this request for "respect"? Respect in this sense does not mean therapists have to agree with every belief, value, or expression of the client, but rather to respect why clients choose to accept and engage in the various expressions that reflect their identity (Yarhouse & Burkett, 2002)—for example, understanding why a conservatively religious gay person chooses not to engage in same-sex behaviour.

Haldeman (2004) notes that the depth with which religious identity can be embedded in the psyche cannot be underestimated, and can serve as a central organising aspect of identity that some individuals cannot relinquish. Psychology is in no position to negate clients' religious or other affiliations. Respecting a conservative religious person's view of homosexuality is not tantamount to supporting inappropriate heterosexism: "There is a difference between moral evaluation of same-sex behaviour as volitional conduct and prejudice against another for his or her race or sex. Some gay-affirmative theorists (e.g., Stein) acknowledge this distinction" (Yarhouse & Burkett, 2002, p. 238). These writers postulate that the middle ground is perhaps to recognise that in a diverse and pluralistic society, gay-affirmative therapy, reorientation therapy, and alternative approaches may all be viable options.

While these options might suit persons who feel they have a choice—such as bisexuals, and individuals who identify as heterosexual but engage in homosexual behaviour—there are serious problems with this position for gay people, not least of which is that the situation is fraught with ethical malpractice risks (Gonsiorek, 2004). Gonsiorek challenges the assumptions underlying the idea of “unlimited client choice.” Clients struggling with issues around sexual orientation could make treatment requests based on naïveté, immaturity, interpersonal coercion and social pressure, social desirability, misinformation, personal psychopathology, misunderstanding, curiosity, or any number of other factors. It is a therapist’s professional responsibility to ensure that clients are provided with enough information about recommended treatment options and appropriate ethical practice to be able to give informed consent. “It is nonsense to assert that, in requests for conversion therapy, respect for diversity requires that psychology abdicate these complex duties and considerations” (Gonsiorek, 2004, p. 755).

Furthermore, Beckstead and Morrow (2004) argue that the benefits gained by participants in sexual reorientation could have been experienced in therapies other than conversion therapies, and the potential risks of harm are significant. In honouring the ethical principle, “First, do no harm,” and harm seems likely, “we have an ethical obligation to investigate the actual risk to patients *before* offering them an intervention” (Herek, 2003, p. 439).

A key issue that explains why the present debate resists resolution is that conservative religious ideologies are typically based on values from a separate philosophical paradigm (faith-based), which can be incompatible with principles of scientific inquiry and professional psychological practice. Conversion therapies seek to legitimise the use of psychological techniques and behavioural science to enforce compliance with theology and religious orthodoxy. In other words, conversion therapists are asking psychology to endorse and sanction the theologically based creation of psychological distress in gay individuals. Avoiding polarisation is a worthy goal, but not at any price. “The stakes in the ‘conversion therapy’ controversy are high: psychology’s soul is in peril” (Gonsiorek, 2004, p. 758).

Miville and Ferguson (2004) raise the issue of “choice” when an individual is “caught between conflicting social worlds” (p. 767). To ensure optimal psychological functioning, psychotherapists need to continue working on alternative ways to help clients as they navigate conflicts to achieve the highest level of identity synthesis possible. Thus, some authors (Beckstead & Morrow, 2001; Haldeman, 2004; Throckmorton

& Yarhouse, 2006) have proposed integrative models to tackle the complexities of often-conflicting aspects of sexual identity and competing values or beliefs, such as religiosity. These do not presume a direction for the religiously conflicted gay person but instead enable the individual to explore and, if need be, change fundamental core aspects of identity without subscribing to either conversion therapy or gay-affirmative therapy. Integrative models also provide guidelines to practitioners “who wish to facilitate clients setting their own therapeutic agenda, often in the face of social pressure in one direction or another” (Haldeman, 2002, p. 268).

### **An integrative model**

Emerging integrative solutions share the view that all aspects of an individual’s identity are worthy of respect and that the therapeutic goal is “to assist the client in finding a solution in which different components will find some place at the table” (Gonsiorek, 2004, p. 752). For clients who are both gay and conservatively religious, therapy cannot focus solely on one of those aspects, but must work to integrate both if it is to be beneficial and effective. Conflict resolution, for example between homosexuality and religiosity, is an endeavour of psychotherapeutic practice and consistent with gay-affirmative perspectives. However, this approach differs in that, instead of a client and therapist agreeing that the goal is to help the client integrate a gay identity, this model advocates a discernment process. It should be noted that some contemporary gay-affirmative therapists do operate from such a perspective.

Haldeman (2004) proposes three general stages to an integrative approach: *assessment*, *intervention*, and *integration*. Assessment involves evaluating the client’s current sexual behaviour and fantasy life, including a thorough investigation of the existential implications of the person’s sexual orientation, and psychosocial forces that might affect the way his sexual identity and expression are viewed. Advanced informed consent<sup>1</sup> provides the framework for eventual goal development whereby the client may come to his own direction. Worthington (2004) raises concerns of potential ethical malfeasance where highly polarised proponents on either side of the debate might adopt only those aspects of their approach that are consistent with and confirm previously held biases.

Following assessment comes a choice point for the client. This might lead to the goal of “prioritising” one identity element over another, and strategies employed in the intervention phase are dependent on the identified direction of treatment. Often a psycho-educational/experimental phase ensues, in which the individual is involved

in social or affiliative exploration, or “trying on” the chosen lifestyle. Alternatively, the task of the therapist may be to facilitate an “integration” of the competing elements of identity. Rawls (1971) describes a similar process—“reflective equilibrium”—beginning with considered judgements (intuitions) arising from a “sense of justice” that is a source of both moral judgement and moral motivation. If our judgements are in some way conflicted, we proceed by adjusting our various beliefs until they are in equilibrium, meaning they are stable, not in conflict, and provide consistent practical guidance. For example, a gay man in therapy moves towards integrating a gay identity and so relinquishes his conservative home community of faith for a more inclusive, gay-friendly religious environment, or the other way around.

Often conflicts contain a “should” side saying, “Do this,” and a “want” side saying, “I don’t want to.” Although never addressing this particular issue, Yontef’s (1995) concept of the Gestalt two-chair approach is useful for gay clients faced with this type of conflict. The client role-plays both sides, speaking from the “should” side and then the “want” side, switching back and forth until some integration has been reached. Integration occurs because both sides begin to see some sense in the other side. “Changes in the ‘should’ side particularly facilitate integration because the should side moves from talking in ‘shouldistic’ language to expressing hopes and fears” (Bohart, 1995, p. 125). Instead of, “You shouldn’t be gay,” it says, “I’m worried [that] if you’re gay, you’ll never be happy.” However long this intervention phase lasts, the therapist needs to provide support and resources when requested, but acts as neither cheerleader nor sceptic.

Haldeman’s integration phase presents a resolution of the conflict. Information gathered during intervention leads the individual to determine a course that will most likely embrace the previously conflicting elements of identity. This is an informed and fully conscious choice, and the client, supported by the therapist, can access the necessary resources to make this a realistic integration. This final phase also provides an opportunity to review and evaluate the entire process. The therapist’s task with such individuals is not to provide advice or direction but a safe holding environment, in which the client is free to explore the many challenging questions associated with identity conflicts. Freud (1918) emphasised the importance of such a client-centred approach:

*We refused most emphatically to turn a patient who puts himself into our hands in search of help into our private property, to decide his fate for him, to force our own ideals upon him, and with the pride of a Creator to form him in our own*

*image and see that it is good...we cannot accept [the] proposal either—namely that psycho-analysis should place itself in the service of a particular philosophical outlook on the world and should urge this upon the patient for the purpose of ennobling his mind. In my opinion, this is after all only to use violence, even though it is overlaid with the most honourable motives. (p. 164)*

### **The sexual identity management model**

But what of an individual who, after careful examination, still feels committed to exploring sexual reorientation? Even with data indicating that conversion therapy is not a legitimate solution to this complex problem, therapists would be hard-pressed to deny individuals the treatment or spiritual interventions they seek. Throckmorton and Yarhouse (2006) have proposed strategies of sexual identity management under specific conditions, in which a client maintains adherence to his personal values and/or faith and, while recognising same-sex attractions, develops ways to control or avoid unvalued sexual behaviour. Goals may include attempting to change sexual orientation, aspiring to celibacy, or managing homoerotic impulses and feelings in the context of a heterosexual identity. This might be achieved by expanding social networks and specific settings to those supportive of the desired sexual identity, or avoiding sexual behaviour until there is significant level of comfort with and desire for this activity. With this approach, it is essential that therapists continually monitor the impact that sexual identity interventions have on their clients' mental and emotional status.

Sexuality and religion are two issues most capable of eliciting emotional responses for both client and therapist. Given these complexities, it is vital that therapists examine and re-examine their own feelings, beliefs, experiences, values, and assumptions, and be especially vigilant that their feelings about either or both of these areas do not lead to countertransference reactions that could exacerbate clients' confusion. Therapists' behaviours that could be an extension of countertransference are usually expressed as prejudice against clients who are considering a possible course of action. In the case of therapists who find themselves disappointed by a client's choices, or feel challenged about maintaining facilitative neutrality in the face of a client choice, referral should be made.

### **The negative therapeutic reaction**

Friedman and Downey (1995) speculate on a clinical subgroup of conflicted gay clients in the context of what Freud (1923) termed the "negative therapeutic reaction."<sup>2</sup>

Certain types of transference reaction—frequently a manifestation of unconscious guilt, sometimes reinforced by unconscious envy—make some clients unable to accept supportive gay-affirmative interventions. They envy the therapist for being free of the tormenting conflicts from which they suffer and may experience any primary love object as destructive. These clients seem “wrecked by success” and have difficulty allowing others to be helpful to them, with histories of being success-avoidant and undermining relationships with others. Psychodynamic assessment reveals early childhood feelings of self-hate, “which [were] condensed into internalised homophobic narratives conducted during later childhood” (Friedman & Downey, 1995, p. 107).

Treatment strategies generally need to then move from supportive psychotherapy to a more uncovering approach. A supportive approach with ego-dissonant gay clients who express self-hatred for being gay, for no logical reason, might encourage individuals to express, rather than attempt to suppress, their sexuality. In contrast, an uncovering approach seeks to explore with clients their negative feelings about the representation of themselves as homosexual. Instead of confrontation, clarification, and psycho-education, an exploratory approach would more likely present a relatively unstructured, although empathic and accepting, therapeutic stance to facilitate regression and transference distortion. Often, symptoms represent relationships with lost objects from childhood, and, over time, the therapist would attempt to alter the balance between the client’s unconscious wishes and fears through interpretation and other techniques. If symptoms are embedded in a self-destructive character pathology, treatment is likely to be lengthy and arduous, and the treatment outcome uncertain.

### **A Kleinian model**

There are a handful of clients for whom none of the above models will work; their wish to maintain both sides—sexuality and opposing values/beliefs—means that neither a comfortable resolution of the conflict nor a choice of a side seems possible (Haldeman, 2004). With this in mind, it may be helpful to elaborate on Klein’s (1946) concept of the paranoid-schizoid and depressive positions<sup>3</sup> as a possible way to think about and work with individuals who are unable to integrate or choose between these competing aspects of their identity. These clients often split off conflicting aspects of themselves in a defensive manoeuvre aimed at protecting idealised fantasies of how life “should” be. In the early stages of the therapeutic process, these clients are in the paranoid-schizoid position, characterised by persecutory anxiety. Splitting allows the individual to keep contradictory feelings and impressions separate, so that they can hate



and love safely, without their good parts being destroyed by their perceived bad parts. This, however, inhibits the individual's ability to be congruent.

If, in time, assessment reveals that all other treatment options are unsuitable, the therapist explores with the client how it might be for them to tolerate the paradox created by their conflict, or, as the person moves into the depressive position, they themselves find that matters appear differently. A shift occurs as the conflicted individual becomes able to tolerate ambivalence and, thus, to integrate both the loved and hated aspects of themselves. This painful but more realistic move to the depressive position is characterised by sadness, longing, and grieving. As the ego's tolerance for its aggressive impulses increases, its need for splitting and projection decreases, persecutory anxiety diminishes, and the ideal and persecutory aspects are allowed to come closer. In this instance, the paradox must be accepted, not resolved. For some ego-dissonant gay clients, helping them learn to increase their capacity to "hold" ambivalence might be a realistic goal. For others, this might be an essential step in reaching a place of self-acceptance, facilitating a more favourable response to a gay-affirmative approach in time.

The following vignette attempts to illustrate part of this process. After detailed assessment and examination of his experiences and motives, Matt had still been unable to fully integrate a gay identity.

*C1: Everything points to me accepting it, and yet, there's something that stops me. I just can't take that final step. It just blows everything right out the water, again!*

*T1: You are unable to feel truly settled.*

*C2: Yup. It just seems so futile—like why keep trying? [Client becomes teary]*

*T2: It feels like an impossible position to be in.*

*C3: Yup, there aren't answers are there?... At least not for me.*

*T3: How would it feel if there weren't any answers?*

*C4: It would just feel really... disappointing. [Silence] Other people seem to manage somehow. Why can't I just accept it and be happy?... But I can't.*

*T4: Maybe all you can do right now is accept that there are no answers, and that your faith and being gay is who you are.*

*C5: [Client sighs] It's not what I was hoping for.*

*T5: A resolution to the problem?*

*C6: Yeah, part of me really finds that hard to accept—not having an answer... [Silence] But, in a way, it somehow feels better than constantly fighting what seems an uphill battle that just isn't going anywhere.*

In following sessions, Matt came to grieve the loss of what seemed to be an impossible dream: that of finding a definitive answer to his conflict, which he had spent most of his adult life searching for. Feelings of disillusionment and vulnerability evoked an outpouring of sadness. Yet recognition of and connection with his overwhelming disappointment created a shift beyond his “need” to resolve this paradox. Winnicott (1968) believed that, in this instance, success in analysis must include the “delusion” of failure. This paradox needs to be accepted. From a psychoanalytic perspective, an analyst must be able to accept the role of failure as he accepts all other roles that arise from a client’s neuroses and psychoses. Many analysts have failed in the end because they could not allow a delusional failure, due to their personal need to prove their own skill through “curing” the client.

### **Conclusion**

The initial motivation and somewhat naïve intention of this research was to find a single treatment option for conflicted gay clients that neither endorses homophobic treatments nor negates opposing values and beliefs. What is evident is that people are uniquely individual, and a “one size fits all” approach to these kinds of conflicts is not advocated because the variety and complexity of issues brought by ego-dissonant gay clients defy generalisations. Investigation of the literature reveals that any ready-made, content-bound form of intervention will ultimately disenfranchise the client. Therefore, rather than attempt to synthesise the results from completely different paradigms, the two parts of this study have, consecutively, looked at gay-affirmative therapy and emerging integrative solutions, each of which caters to different needs of individuals.

Current research suggests that the majority of gay clients who struggle to integrate their sexual feelings and personal values or beliefs benefit from gay-affirmative therapy. Using gay-affirmative therapy, clients have come to recognise that their conflicts, stemming from societal prejudices that they have internalised, are symptomatic manifestations of homophobia, heterosexism, insufficient social support and lack of gay role models, social stigma, and the association of a gay identity with negative stereotypes. For gay clients who enter therapy considering sexual reorientation, the goal of gay-affirmative therapy is to help these individuals realistically assess their “impossible dream.” Literature suggests that the ensuing insight and clarity that follow gay-affirmative therapy allow the majority of clients to experience a decrease in their levels of distress and an increase in self-acceptance, identity cohesion, and emotional congruency. Individuals with more advanced gay identities have a lower propensity

to seek sexual reorientation. Furthermore, self-disclosure arising from increased self-acceptance has been shown to decrease ego-dystonicity.

The reciprocal nature of behaviour, psychology, and health has long been recognised, and recent research investigating this relationship has demonstrated the salience of religiosity as a mediator of the therapeutic alliance, client psychological health and wellbeing, and treatment outcomes. Many clients perceive spirituality to be appropriate within therapeutic settings. Fear of their religious beliefs and values not being respected stops some religiously conflicted gay individuals from seeking professional help.

Filling this gap, emerging integrative solutions that give equal credence to an individual's spirituality and sexuality offer alternative treatment options to those who do not wish or are not yet ready to choose between traditional conversion and gay-affirmative psychotherapies. Available literature on integrative models, however, is limited, and largely from a gay-affirmative perspective. More research and discussion are required regarding religious integrative identity models for same-sex attracted individuals and how they reconcile conservative religious doctrines with same-sex attraction.

There are a few remaining individuals for whom none of the three aforementioned modalities work; the conflict—and the wish to maintain both sides of the conflict—mean that neither a comfortable resolution of the sides nor the choice of a side is feasible. A model using Klein's concepts of the paranoid-schizoid and depressive positions has been suggested as a way to think about and work with ego-dissonant gay clients who are unable to accept, change, or integrate competing aspects of their identity. Increasing these individuals' capacity to hold ambivalence can decrease anxiety, eventuating in a shift that can better equip them to tolerate their conflicts. For some, this may be a transitional phase until they are ready, in time, to respond more favourably to a more affirmative approach.

As counsellors and therapists working with this client group, it is important that we ourselves grapple with who we are authentically, with all our competing parts, and come to accept our own identities as rich and complex. By understanding ourselves more fully, we offer hope of providing a relationship to clients that supports them in understanding themselves. Acceptance of our own contradictions enables us to offer clients an environment that allows them to explore and ultimately accept theirs. By remaining open, we can explore with clients how they make sense of, and give meaning to, their individual experiences. We can also appreciate the delicate balance required

in providing a safe, neutral, and holding environment in which clients can fully explore and ultimately make autonomous choices regarding treatment options, while being kept informed of appropriate ethical practice. As effective clinicians, we must be aware of our own contributions—assumptions, reactions, and agendas—and how these can affect therapeutic outcomes. Equally important is the need to be patient in a way that allows us to reflect on how our countertransference—anger, disappointment, feeling challenged, and the narcissistic need to “cure”—might enhance our capacity to understand and meet each client. In this way we can advocate for a society where individuals can be who they are, and be valued for it.

### Notes

1. Advanced informed consent helps the individual understand the effects of their social environment and know what appropriate treatment options are available while therapy remains a value-neutral enterprise (Haldeman, 2004).
2. Freud (1923) describes this phenomenon sometimes occurring during the work of analysis—when the analyst speaks hopefully to the analysand or expresses satisfaction with the progress of treatment, the patient shows signs of discontent and their condition invariably becomes worse.
3. According to Klein’s (1946) theory, during the first year of life the infant develops two “positions”: the “paranoid-schizoid” position, assumed during the first three or four months of life due to the inability of the immature ego to integrate the death and life instincts, and the “depressive” position, which develops when the infant ego is somewhat more mature and better capable of integration.

### References

- American Psychological Association (1992). *Ethical principles of psychologists and code of conduct*. Washington, DC: Author.
- Beckstead, A., & Morrow, S. (2001). *Clients’ experience of sexual reorientation: The process of seeking congruence*. Paper presented at the 109th Annual Convention of the American Psychological Association, San Francisco, CA.
- Beckstead, A., & Morrow, S. (2004). Mormon clients’ experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist*, 32(5), 651–690.
- Bohart, A. (1995). Person-centered psychotherapy and related experiential approaches. In S. Gurman & S. Messer (Eds.), *Essential psychotherapies: Theory and practice* (2nd ed., pp. 107–148). New York: Guilford.

- Freud, S. (1918). Lines of advance in psycho-analytic therapy. In *Standard Edition* (Vol. 17, pp. 157–174). London: Hogarth Press, 1955.
- Freud, S. (1923). The ego and the id. In *Standard Edition* (Vol. 19, pp. 1–66). London: Hogarth Press, 1961.
- Friedman, R., & Downey, J. (1995). Internalized homophobia and the negative therapeutic reaction. *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 23, 99–113.
- Gonsiorek, J. (2004). Reflections from the conversion therapy battlefield. *The Counseling Psychologist*, 32(5), 750–759.
- Gonsiorek, J., Sell, R., & Weinrich, J. (1995). Definition and measurement of sexual orientation. *Suicide and Life Threatening Behavior*, 25, 40–51.
- Haldeman, D. (2002). Gay rights, patient rights: The implications of sexual orientation conversion therapy. *Professional Psychology: Research and Practice*, 33(3), 260–264.
- Haldeman, D. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist*, 32(5), 691–715.
- Herek, G. (2003). Evaluating interventions to alter sexual orientation: Methodological and ethical considerations. *Archives of Sexual Behavior*, 32, 438–439.
- Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis*, 27, 99–110.
- Miville, M., & Ferguson, A. (2004). Impossible “choices”: Identity and values at a crossroads. *The Counseling Psychologist*, 32(5), 760–770.
- Murphy, T. (1992). Freud and sexual orientation therapy. *Journal of Homosexuality*, 23(3), 21–38.
- Phillips, J. (2004). A welcome addition to the literature: Nonpolarized approaches to sexual orientation and religiosity. *The Counseling Psychologist*, 32(5), 771–777.
- Rawls, J. (1971). *A theory of justice*. Cambridge: Harvard University Press.
- Spitzer, R. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior*, 32(5), 403–417.
- Throckmorton, W., & Yarhouse, M. (2006). *Sexual identity therapy: Practice framework for managing sexual identity conflicts*. Retrieved May 17, 2007, from <http://www.wthrockmorton.com/wpcontent/uploads/2007/04/sexualidentitytherapyframeworkfinal.pdf>.
- Winnicott, D. (1968). Thinking and symbol-formation. In C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Psycho-analytic explorations* (pp. 213–216). Cambridge: Harvard University Press.
- Worthington, R. (2004). Sexual identity, sexual orientation, religious identity, and change: Is it possible to depolarize the debate? *The Counseling Psychologist*, 32(5), 741–749.

- Yarhouse, M. (1998). When clients seek treatment for same-sex attraction: Ethical issues in the right to choose debate. *Journal of Psychotherapy*, 35(2), 234–259.
- Yarhouse, M., & Burkett, L. (2002). An inclusive response to LGB and conservative religious persons: The case of same-sex attraction and behaviour. *Professional Psychology: Research and Practice*, 33(3), 235–241.
- Yontef, G. (1995). Gestalt therapy. In S. Gurman & S. Messer (Eds.), *Essential psychotherapies: Theory and practice* (pp. 261–303). New York: Guilford.

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