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Gay-affirmative Therapy and Emerging Integrative Solutions

Working with Ego-dissonant Gay Male Clients

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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, the treatment of choice was conversion therapy, which aimed to treat the "condition" (homosexuality) by changing an individual's homosexual orientation to heterosexual. In recent years, as public opinion has shifted towards 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 offer a limited, exclusionary choice to either reject or accept one's sexual orientation. This dichotomised approach may not serve all clients who seek help in dealing with conflicts regarding sexual orientation. This two-part article begins with a review of gay-affirmative therapy: its history, the developing relationship between the mental health profession and homosexuality, and key concepts of practice from different theoretical perspectives. Secondly, emerging integrative solutions, including a sexual identity management model, are examined 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 unique needs of different individuals.

In my practice I see many individuals who seek help in exploring aspects of their sexuality. The environment in which I work adopts a gay-affirmative philosophy that disavows treatments based upon therapeutic modifications of sexual orientation, and views homosexuality as a normal variation of human sexuality.

While some gay individuals experience relatively little conflict over their sexuality, others experience a host of challenges resulting from an inability to resolve perceived irreconcilable differences between personal values and sexual feelings. For these individuals, same-sex attraction is experienced as confusing or unwanted, responses that can stem from holding traditional values regarding marriage and family, or religious beliefs that view homosexuality as unnatural and immoral. These conflicts are not restricted solely to individuals who are in the initial stages of the "coming out" process, but can also affect those who openly acknowledge their same-sex attraction and identify as gay.

Guided by a gay-affirmative approach that tackles biased socialisation and internalised homophobia, therapy may assist conflicted gay clients to achieve a sense of self-acceptance and pride. Yet there are a few whose dissonance is so persistent and fundamental that it causes them to consider sexual reorientation as a plausible resolution to their distress. At such times, the very professionals they turn to for assistance may also be in conflict over how best to help (Throckmorton & Yarhouse, 2006).

Matt (a pseudonym) is a gay man in his mid-thirties who was raised in a conservative Christian home. He recalls having always been attracted to men rather than women, and "came out" to his parents in his early twenties. Despite some sadness that he had disappointed his parents by being gay, Matt has generally felt loved and supported by his family. After several short-term relationships, Matt settled into a happy, long-term relationship of ten years with another man. Matt enjoys a rewarding career and has a close circle of friends both in and out of the gay community. On entering therapy, Matt described a conflict between his homosexuality and a desire to have children of his own. This, combined with his Christian faith, which does not support same-sex attraction, created an underlying gnawing angst that often made him question his gay identity and lifestyle.

C1: I realise on the one hand that this is who I am, and I love Luke. If I just think of that, I'm fine. But, then the whole doubt thing creeps in.

T1: Doubt?

C2: Like maybe I've got it wrong. Maybe, I'm just convincing myself I'm happy, maybe I can change.

T2: You're being pulled in two opposite directions.

C3: More like torn apart—like these two parts of my life just can't go together.

Despite sensitive inquiry and exploration into possible determinants stopping Matt from achieving a sense of self-cohesion and identity integration (i.e. biased socialisation

and condemnatory religious convictions), his dissonance persisted. Even with insight into how formative influences contributed to his core belief system and values, he remained unresponsive to a gay-affirmative approach. It seemed that where Matt was experiencing a powerful conflict, any suggestion that he might consider accepting his sexuality only seemed to activate the opposing side and increase his level of distress.

My experiences with Matt caused me to wonder whether certain conflicted gay clients might not benefit (initially or at all) from gay-affirmative therapy.[1] In examining the problems that beset people who struggle with their sexual orientation, I wondered if it was right to assume that the only way to alleviate their distress was to help them to work towards accepting their homosexuality. Should therapists automatically view such clients as only suffering from internalised homophobia and heterosexism,[2] and thereby downplay or override personal values, attitudes, and/or religious beliefs? Is there a way to work with such clients without either endorsing homophobic treatments or negating opposing values and beliefs? If so, how do we as practitioners respect these two seemingly conflicting expressions of the client's identity as legitimate aspects of diversity?

For those who struggle to accept their same-sex attraction and who experience their homosexuality as ego-dissonant,[3] the literature is clearly split between two therapeutic approaches, both offering a "cure". Each position tends to respond with a limited, exclusionary choice to be either an "out" gay or an "ex" gay; to accept or reject one's sexual orientation. On the one hand, there are those who argue that some variety of treatment—whether formal conversion therapy conducted by a professional practitioner or a self-help, "ex-gay" group—should be available for those who experience their same-sex attractions as incompatible with competing values or beliefs (Throckmorton, 2002; Yarhouse & Burkett, 2002).

On the other hand, proponents of gay-affirmative therapy consider antigay social stigma and internalised homophobia, not sexual orientation, to be the primary motivator for those seeking to change their sexual orientation. These authors (e.g., Liddle, 1996; Schidlo & Schroeder, 2002) highlight the potential harms to those who attempt conversion therapy and question the justification and ethical basis for sexual reorientation when homosexuality is no longer considered a mental illness. They also expound compelling reasons for a gay-affirmative approach, including social justice, preserving autonomy, promoting esteem, and ensuring professional commitment to diversity.

These dichotomised treatment options may not serve all clients who seek help in dealing with conflicts regarding sexual orientation. While gay-affirmative therapy has been advanced as the approach most likely to benefit the majority of ego-dissonant gay clients, a few individuals, like Matt, end up in therapy embroiled in attempts to resolve the internal dissonance that causes their distress and prevents their achieving emotional congruency and identity cohesion (Meyer, 1995). Emerging integrative solutions aim to help such individuals. Each approach has positive aspects that recognise something essential to the client: the endorsement of sexuality, and personal beliefs or values respectively.

Philosophical underpinnings of gay-affirmative therapy

Anthropologists (e.g., Greenberg, 1988; Weinrich & Williams, 1991) have documented that homosexuality is a universally occurring phenomenon. In some cultures it is approved of and encouraged, with homosexuals awarded leadership roles and even status as spiritual leaders. Over the last three centuries, religion, medicine, law, and politics have had the greatest influence on sexuality, primarily in Western societies. These professions came to view homosexuality as sinful, sick, and illegal, resulting in attempts by the mental health profession to treat the "condition" by changing an individual's homosexual orientation to heterosexual (Weeks, 1985). More recently, a shift in opinion has caused psychology to dramatically develop and expand its capacity to recognise human diversity. Changes to legislation, such as with New Zealand's Homosexual Law Reform Act (1986), have significantly contributed towards increasing tolerance and acceptance of gay, lesbian, bisexual, and transgender people within our society.

Essentialism has grown to become the most popular philosophical perspective on the causation of sexual orientation, and in part informs the worldview of most gay-affirmative therapists. Its biomedical view suggests that sexual categories—homosexual, bisexual, heterosexual—describe an inner essence or core of a person that is both ahistorical and acultural (Throckmorton & Yarhouse, 2006). Thus, homosexuality is regarded in a similar way to one's race, gender, or eye-colour: as a biological characteristic that defines something different about those in one category from those in another. Sexual orientation is something one is born with and, therefore, attributable to nature (DeLamater & Hyde, 1998; Houston, 2006; Karten, 2006).

The mental health profession and homosexuality

Over the last sixty years, homosexuality has been conceptualised by the American Psychiatric Association as a mental disorder, as a possible disorder in the case of the *DSM-III* ego-dystonic homosexuality, and as neutral as it relates to the mental status of an individual when it was removed from the *DSM* (*The Diagnostic and Statistical Manual of Mental Disorders*) by the APA in 1973. Davies and Neal (1996a) explain that this controversial decision resulted from social science research, influenced by black and feminist civil rights protests, which reflected the new social values of egalitarianism.

Bieschke, McClanahan, Tozer, Grzegorek and Park (2000) identified three primary studies that signalled a shift from the assumption of homosexuality as a psychopathology to current views of gay mental health. In the first two studies, Kinsey and colleagues (1948; 1953) provided empirical data on the incidence of homosexuality, which they portrayed as a normal variation of human sexuality. Findings contradicted assumptions that sexuality was a dichotomous phenomenon: heterosexual and homosexual; rather, sexuality encompassed a continuum, with more people experiencing same-sex attraction than had previously been believed. These studies reported that 37% of males had as adults engaged in same-gendered sexual contact to orgasm. Rothblum (1991) criticised sampling methods as over-representing college students, prisoners, and urban gay communities, and therefore not accurately reflecting the general population. However, similar cross-cultural studies by Sell, Wells and Wypij (1995) reported that 7–12% of people in large random samples throughout France, Europe and America "admitted" to having homosexual sex more than once. The authors claim these figures were conservative, as some people were likely to underreport same-sex behaviour due to social pressures.

In a third study, Hooker (1957) conducted a landmark survey that established, under blind analysis using psychological testing, that no difference could be found in the mental health status of homosexual and heterosexual men. Outcomes indicated that homosexual men were as well-adjusted as heterosexuals—a remarkable finding, given the extremely negative attitudes held by the public and the mental health profession at the time. Similar evidence from the ranks of psychiatry also came from the work of Szasz (1977) and Halleck (1971, as cited in Silverstein, 1991).

It is difficult to pinpoint the first instance of a therapy not based on the belief that homosexuality was a form of psychopathology. However, the formation of gay counselling centres in the early 1970s marked the most significant step in providing

an alternative form of therapy for gay people who were experiencing emotional distress but did not want to change their sexual orientation (Silverstein, 1991). Practitioners in these centres chose to affirm the client's homosexuality and then proceeded to work with the person. Publications raised awareness about the therapeutic needs of gay individuals, and professionals started using the term "gay-affirmative psychotherapy." This suggested that homosexuality was an acceptable lifestyle and that therapists should attempt to "provide corrective experiences to ameliorate the consequences of biased socialization" (Malyon, 1982, p. 62).

Since then, all major mental health associations, including the American Psychiatric Association (APA, 2000), the American Psychological Association (APA, 1997), the American Counseling Association (ACA, 1998) and the New Zealand Association of Psychotherapists (2002), have issued statements reiterating their official positions that homosexuality is not a mental disorder, and have warned of the potential harm in attempting sexual reorientation. In 1985, Division 44 was formulated within the American Psychological Association,[4] and a British equivalent—the Lesbian and Gay Psychology Section—was officially founded in 1998 within the British Psychological Society (BPS).

In 1991, the American Psychoanalytic Association, once renowned for its discriminatory policies against homosexual members, issued a non-discriminatory statement regarding the acceptance of homosexual candidates and the promotion of training and supervising analysts in their affiliated institutes (Bergmann, 2002). Since then, an increasing number of writers have openly advocated a gay-affirmative stance (e.g., Cornett, 1995; Harrison, 2000; Isay, 1989; Lewes, 1988). Currently, the American Psychological Association is embarking on the first review of its ten-year-old policy on counselling homosexuals, a step that gay-affirmative activists hope will end with a denunciation of any attempt by therapists to change sexual orientation. A final report from the task force is expected towards the end of 2008 (Crary, 2007).

Gay-affirmative therapy: key concepts, treatment approaches and research

Gay-affirmative therapy views homosexuality as non-pathological, valuing heterosexuality and homosexuality as equally desirable, valid, and potentially healthy. Resting on the assumption that affirming responses from others assist individuals to see themselves as having positive self-worth (Harrison, 2000), gay-affirmative therapy represents a special range of psychological knowledge that considers homophobia and heterosexism, as opposed to homosexuality, as a major pathological variable in the

development of gay men. Gay-affirmative therapy uses traditional psychotherapeutic methods but proceeds from a non-traditional perspective (Malyon, 1982).

While the skills and understandings of most theoretical schools can be assimilated with gay-affirmative concepts, adjustments are necessary to some of the more traditional schools of psychotherapy. As a result, Cass (1979) developed the Homosexual Identity Formation (HIF) model, integrating both psychological and sociological perspectives of gay identity development into six stages: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. This model set the groundwork for future gay-identity development models (Marszalek & Cashwell, 1999; Troiden, 1984), which emphasise movement across the stages from less acceptance to more acceptance, and involve a paradigm shift engendering changes in emotions, cognitions, and behaviours, similar to minority-identity development models (Perez & Amadio, 2004). Fassinger and Miller's (1996) findings supported the validity of Cass's theory, with 90% of participants aligning themselves to the appropriate phases of development.

When working with gay clients, some authors contend that it is not enough for therapists simply to offer Rogers' (1951) "core conditions" (genuineness, unconditional regard, and empathy), nor is it sufficient to have a sound grasp of psychodynamic or cognitive-behavioural principles (Chernin & Johnson, 2003; Davies, 1996; Malyon, 1982; Marszalek, Cashwell, Dunn & Jones, 2004; Perez & Amadio, 2004; Rubinstein, 2003; Shannon & Woods, 1991). Clients in conflict regarding their sexual orientation face unique challenges and, as with any special population, a counsellor helps facilitate and educate through raising awareness about the nature and origin of their distress. On the other hand, a defensively counter-homophobic therapist who assumes that there is nothing different or problematic about an individual's sexual orientation can inadvertently discourage a client from talking about the painful feelings that go along with being in a minority that is ignored, ridiculed, despised, and persecuted. Such a dismissive acceptance of difference can be as counter-therapeutic as rejection of it could be (McWilliams, 1996).

Harrison (2000) synthesised the findings from 33 papers into an integrated model of gay-affirmative therapy that recognises that many gay men who have moved through the "coming out" process towards self-acknowledgment will have experienced being rejected or marginalised. With this expectation embedded in their belief structure, Harrison assumes that such men will face the same fears in seeking professional help. Thus, Harrison's model has at its core a non-pathological view of gay people, the

therapist's role being to challenge oppression in the form of heterosexism and internal/external homophobia. This involves empowering clients and acting as their advocate. A therapist, therefore, requires an understanding of the potential effects of social stigma, and inquires as to the client's experience. Additionally, practitioners need to be familiar with the particular issues presented by gay clients, i.e. addictive disorders, isolation, anxiety, depression, and low self-esteem (Shannon & Woods, 1991), and to develop competence in using a range of therapeutic interventions.

Fundamental to gay-affirmative therapy is the belief that clients may benefit from having gay therapists who self-disclose their sexuality and act as role models. However, studies show that gay-affirmative experiences are not dependent on therapists' sexuality, and suggest that heterosexual clinicians can develop their knowledge about gay lifestyles and resources and, in some cases, offer increased objectivity and the advantage of a different perspective from the client's (Moon, 1994; Pixton, 2003; Rochlin, 1981).

Traditionally, for those working from a psychotherapeutic perspective, it was thought that to disclose sexual orientation would interfere with the development of the transference. However, as long as a gay therapist is aware of the possibility of a countertransferential need to establish a sense of social alliance through one's client, and that such information by the analyst is in the service of the client, "all transference paradigms will eventually be established" (Meyer, as cited in Isay, 1991, p. 208).

Finally, Harrison (2000) emphasises the need for practitioners to fully explore their own homophobia and be comfortable with their own and their clients' sexuality, endeavouring to develop self-awareness of personal limitations in working with a gay client group. Therapists' unrecognised prejudice or misinformation regarding sexual orientation can risk exacerbating clients' distress. In assessing Harrison's (2000) model overall, it needs to be noted that Friedman (1991) previously criticised some of the literature Harrison used in his analysis, however, and claimed it only focused on the healthier side of the spectrum and did not include those with severe and enduring mental illness.

Gay-affirmative theorists believe any explicit or implicit attempts at changing an individual's sexuality will inevitably injure homosexuals' self-esteem (Cornett, 1995; Davison, 1991; Drescher, 2002; Isay, 1986; McWilliams, 1996; Phillips, 2004; Tozer & McClanahan, 1999). Silverstein (as cited in Davison, 1991) argues that, "to suggest that a person comes voluntarily to change his sexual orientation is to ignore the powerful environmental stress, oppression if you will, that has been telling him for years that

he should change" (p. 144). Where is the "free choice" for those homosexuals who are racked with internalised guilt, self-hate, and discrimination? These authors believe it is more ethical to let a client continue to struggle honestly with their identity than to collude, even peripherally, with a practice that is discriminatory, oppressive, and ultimately ineffective.

Psychoanalytic and psychodynamic approaches

In "Three essays on the theory of sexuality," Freud (1905) separated sexual behaviour from gender, thus founding a radical and invaluable way of thinking about diversity of sexual experience and expression. However, Freud recognised that Oedipal theory,[5] which was central to his project concepts, depended on maintaining what Sinfield (as cited in Davies & Neal, 1996a) called "the cross-sex grid," which refers to bipolar explanations of genders and sexualities as "opposite" to one another. The cross-sex grid had its origins in 19th-century Victorian dominance and oppression by the heterosexual family mode of all possible other modes. Although Freud acknowledged his own inability to completely enter this new discourse, it is this early concept of the separation of human sexuality from gender that has formed the basis of the work of many gay-affirmative psychoanalytic writers (Davies & Neal, 1996a; Isay, 1986; Izzard, 2000; Roughton, 2002; Rubinstein, 2003).

Schwartz (1995) divides psychoanalytic writing into two groups. The first proposes a genetic model of homosexuality based in psychobiology and endocrinology that sees sexual orientation as biologically determined. In studies of twins, Kallman (1952) and Ekert, Bonchard, Bohlen and Heston (1986) found a significantly greater preponderance of homosexual behaviour in monozygotic than dizygotic twins. Pillard and Weinrich (1986) also reported that gay men have significantly more homosexual or bisexual brothers (22%) than do heterosexual men (4%). Scientific research by gay geneticist Le Vay (2003) has attempted to find a "gay gene" and, despite inconclusive results to date, continued research has fuelled the writings of genetic theorists such as Friedman and Downey (1993). While not ruling out the importance of the early environment in the development of sexual object choice,[6] these authors suggest a genetic predisposition in the origin of sexuality. However, this theoretical perspective leaves out mobility of object choice (Schwartz, 1995).

The second, larger group of psychoanalytic writers (e.g., Isay, Lewes, Cornett, O'Connor & Ryan, and Rubinstein) emphasises the prevalence of homophobia in society, within the psyche and in the consulting room. Lewes (1988) retains classical

developmental ideas and offers a new interpretation of the Oedipus complex. By exploring the vicissitudes of identification and object of desire, Lewes describes twelve equally valid outcomes (six homosexual, six heterosexual) rather than one "successful" heterosexual outcome.[7] Other postmodernist writers, i.e. O'Connor and Ryan (1993), claim the Oedipus complex is obsolete and creates a view of sexuality that is fixed for life, whereas Schwartz (1995) argues for a severing of the tie altogether between the erotic and the gendered body. Goldsmith (2001) rejects the notion of a "negative Oedipal" explanation for the homosexual boy, suggesting instead that the configuration of father as love object and mother as rival is the normative experience for the homosexual boy and should be considered his positive triangulation experience. To avoid confusion in terms, Goldsmith proposes the name "Orestes complex," after the Greek figure who murdered his mother to avenge the death of his father.

Isay (1986, 1987, 1989) believed that sexual object choice precedes the development of gender identity. This is based on substantive research identifying homoerotic fantasies in gay men from the ages of three, four, and five years, with all subjects reportedly having felt "different" from other boys. He proposed that this experience of being different and an outsider becomes a screen for conflicted preconscious same-sex fantasies. Isay conceptualises this period as analogous to the Oedipal stage of heterosexual boys, except that the primary sexual object appears to be their fathers. He asserts that the period of childhood homoerotic sexual attachment to the father is when a boy acquires his homosexual identity, stating: "I see no evidence either in the nature of the transference or in the nature of the sexual object choice of these men of a defensive shift in erotic interest from their mothers to their fathers" (Isay, 1986, p. 474). Isay reworked Freudian theory, suggesting that a distant relationship between a father and his homosexual son was not the cause of the homosexuality, but the result of the father's discomfort with his son's difference. Ensuing consolidation of homosexual identity often occurs later than in heterosexual identity development due to internalised social restraints, causing a homosexual to deny his sexuality with greater vigour. Continuing conscious recognition and subsequent integration of the homosexuality throughout adulthood culminates in enhanced self-esteem, a greater sense of wellbeing and, usually, increased productivity (Isay, 1986).

Cornett (1995) has developed an approach grounded in trauma theory and self-psychology. Utilising Kohutian principles, he recognised the deleterious effects of biased socialisation that cause narcissistic injuries and selfobject failures, and acknowledged resistances where gay men's hope for acceptance has been overshadowed

by experiences of rejection and alienation. From this perspective, the therapist becomes a consistent, soothing, and mirroring selfobject for the developing "gay-self", generally buried beneath layers of culturally fostered self-deception, and offers a relationship that affirms that authentic self. This seeks to preserve the positive selfobject transference in which the client feels understood, held, and affirmed, and in which the stalled psychological growth might be resumed (Stansfield & Younger, 2006).

Peterkin and Risdon (2003) underscore the importance of eliminating the therapist's power base in therapy, suggesting that therapists who practise from an expert-centred modality should consider its implications. In such practice, a therapist's power, silence, and knowledge are central to the creation of transference. Many gay men in the past have experienced the silence, knowledge, and power of society, culture, and religion as persecutory. Therefore, a traditional analytic stance of rigid neutrality can be experienced as re-traumatising by certain gay clients and may need to be moderated. Lebolt (1999) supports Cornett's view that a more actively affirming stance in psychotherapy helps counter the effects of homophobic upbringing. However, Izzard (2000) argues that psychoanalytic neutrality is more helpful than affirmation, even when working with gay clients.

Psychodynamic approaches to working with ego-dissonant gay clients rely not only on the clients' understanding of society's prejudicial and discriminatory influences but also on the analysis of family background and dynamics. In terms of object relations, Rubinstein (2003) suggests that the avoidance-approach pattern of the rapprochement stage (Mahler, 1972) might be characteristic of gay individuals who are unable to accept their sexual orientation and experience a permanent position of emotional conflict. On feeling close to another man, they are happy, hopeful, and stay with him ("shadowing"). Yet, on realising that the relationship has the potential to succeed, they regress and avoid, since intimacy is threatening for them ("darting away"). Once they have escaped, they feel alleviated and free from the last complication, only to feel lonely and miserable again. Loneliness pushes them into a new romance with the same disastrous consequences. The reason for their rejection is an underlying self-hatred for not being the men that their family, and society, expected of them.

Cognitive-behavioural therapy approaches

In contrast to Ellis' (1959) older, rational-emotive therapy, which comes from a more heterosexist position, Beckian (1976) cognitive-behavioural therapy (CBT), according to Gray (2000), is based on a stance of humanistic empiricism, has no explicit tradition

of pathologising homosexuality, and takes a morally neutral standpoint on sexuality. CBT acknowledges the role of environmental factors and looks at maladaptive coping patterns as "survival strategies," rather than being due to some psychopathology of the client. The CBT approach emphasises that the one thing all gay men have in common is that they are taught to be ashamed of their sexual desire (Gray, 2000).

"Early maladaptive schemas," which are unconditional, self-perpetuating, dysfunctional (leading to distress), triggered by the environment, and linked to high affect, are believed to be established in the first few years of life (Young, 1990). These are hypothesised as being the persistent, dysfunctional core beliefs that are thought to underlie enduring psychological problems. They include fundamentally held views of the self as worthless, bad, unlovable, or unacceptable. Schema-focused cognitive therapy has particular relevance for working with gay clients, as feeling "different" is a central theme of many gay men's early experiences. Gay people often experience attack and erosion of self-worth linked to their growing awareness of being part of a stigmatised group. Members of a minority group may develop negative schema that interfere with their capacity to function and enjoy life and, in particular, relationships. There is limited research into the prevalence of early maladaptive schemas in gay individuals; however, a study by Rivers (1995), demonstrating a significant relationship between homophobic bullying and later relationship difficulties, supports the hypothesis that many gay people show evidence of strong negative schema.

CBT explores clients' beliefs about their sexuality and its formation, and then employs cognitive restructuring techniques to challenge their negative belief systems. With gay clients, treatment is often longer, with greater emphasis placed on the relationship, as the presence of entrenched negative schema impedes or prevents the development of the therapeutic alliance. Psychodrama and Gestalt techniques can be employed and integrated into an explicit CBT framework to confront self-defeating schema. Empirical evidence supports the effectiveness of CBT for many clinical problems including self-acceptance and identity-integration (Gray, 2000; Marszalek et al., 2004).

Group therapy approaches

A central theme within a gay-affirmative approach is that the "problem" needs to be reformulated in terms of self-acceptance (Smith, 1985). Once individual psychotherapy has brought about initial movement towards self-acceptance, group therapy

can be beneficial in helping the client progress to a more adaptive adjustment to homosexuality in the area of peer socialisation.

Group therapy is an effective method for consolidating sexual identity and promoting peer-identification in both gay- and mixed-group therapy (Lebolt, 1999). Participation in gay groups may increase clients' awareness of the diversity of gay people and help individuals learn to deal with the vicissitudes of being gay. Participants more advanced in self-acceptance and self-disclosure may model healthy behaviour for those not as far along the path to full adaptive functioning. Lebolt added, "The use of group dynamics to challenge and confront dilutes the transference directed towards the solo therapist and promotes self-reliance" (p. 402). In mixed groups, clients experience their issues as human, rather than exclusively gay, which helps them develop the skills and self-confidence required to integrate into the predominantly heterosexual environment. The level of integration may vary depending on the individual's subculture. For example, Māori clients might need to overcome feelings of alienation or confusion about connection with whānau and iwi, requiring therapists to acknowledge and work alongside communal or extended family groups (Durie, 2003). With mixed-group therapy, lessons learned from the development of feminist therapeutic practice, which confronts the hegemony of straight white males in the social and epistemological arena, have been valuably integrated (Milton & Coyle, 1999).

Religious programmes

"There is no more divisive subject in any denomination today than the issue of homosexuality" (Culbertson, 2000, p. 190). Mahaffy (1996) found that the main source of conflict in many gay people was early religious identity (pre-coming-out). Studies show that over two-thirds of gay people have felt that in order to accept their sexuality, they had to reject religion (Mahaffy, 1996; Schuck & Liddle, 2001; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). This has caused the anti-religion backlash that exists in the gay community. Yet for some individuals, it is easier to come out as gay in their communities of faith than it is to come out as religiously orientated in the gay community (Haldeman, 2002). In their quest to be simultaneously gay and Christian, these individuals often experience conflict, as well as feelings of guilt, shame, depression, self-loathing, and suicide ideation.

Increasingly, literature from emergent religious groups calls for a more sensitive and constructive attitude towards gay Christians seeking pastoral assistance. Many

authors disagree with traditional interpretations of homosexuality in the Bible (Culbertson, 2000; Gomes, 1996; Helminiak, 2000; Miner & Connoley, 2002; Scroggs, 1983; Wink, 1999). They argue it is not the authority of the Bible they challenge but the authority of the culture of interpretation, which they feel has evolved from an obsolete, patriarchal tradition that served to legitimise its doctrinaire prejudices. This has resulted in scholars addressing the hermeneutical problem of how to translate the content of ancient texts into the language and life-context of 21st-century individuals. More recently, some denominations have become more accepting of gay members of their congregation, or splinter groups have opted to cut off from mainstream churches in order to cater to members normally ostracised because of their sexuality.[8] These gay-affirmative religious groups have advocated that committed gay relationships are equally able to fulfil "God's design for creation," and aim to help clients explore their sexuality and religious identities, evaluate their conflicts, and come to individual resolutions and choices. Rodriguez and Ouellette (2000) found that 72% of participants attending gay-friendly congregations reported less internalised homophobia, a reduction of anxiety around their conflict, and signs of increased mental health, wellbeing, and identity-integration.

Stuart (1997) suggests that in considering spiritual core values, religiously conflicted gay individuals must start with their own experience, from which revelation occurs. Helminiak (2000) describes this "core of spirituality as basic integrity where spiritual development is translated into affirming oneself rather than being bound by religious expectations" (p. 441). Research indicates that participants claim the main resolution to their conflict lies in the alteration or re-education of their core belief system. This was achieved by considering themselves spiritual (an intrinsic belief system), rather than religious (an external institutionalised authority), and involved reinterpreting previously damning biblical texts and the reappropriating of scripture by those who felt excluded from it (Barret & Barzan, 1996; Rodriguez & Ouellette, 2000).

Queer therapy

There is a growing body of literature on this relatively new perspective that has emerged from gay-affirmative philosophy. Over the past two decades, gay-affirmative therapists have been narrowing the perceived differences between gays and straights as a necessary tactic to achieve a degree of acceptance within the field of mental health. Queer ideology shifts the focus away from similarities, towards recognising the important differences (Roughton, 2002). "Queer therapy" represents a rainbow

coalition of non-normative sexualities that extends the politics of sexuality beyond sex and sexual minorities to include anything countercultural. "Queerness depends on identificatory alliances; with a coming together through the embracing and welcoming and opening up of difference, rather than the closing down of identity" (Stansfield & Younger, 2006, p. 6).

Evaluation and critique

Growing empirical evidence shows the efficacy of a gay-affirmative approach (Hogan, 2002; Lebolt, 1999; Marszalek, 1999; Milton & Coyle, 1999; Miranda, 1986; Tozer & Hayes, 2004), and research suggests that most contemporary therapists prefer to provide gay-affirmative therapy over alternative treatments (Kilgore, Sideman, Amin, Baca & Bohanske, 2005; MacIntosh, 1994). However, much of the literature remains anecdotal, and further empirical research is needed to evaluate the effectiveness of the various conceptual approaches to working with gay clients.

Phillips, Ingram, Smith and Mindes (2003) highlight the consistently low percentage of gay empirical and theoretical publications in mainstream journals, and note that 54% of 119 articles they reviewed were based on empirical studies. Of those, the majority were survey/analogue studies and most used convenience samples. Forty-eight per cent of the empirical articles failed to provide theoretical frameworks for their hypotheses. Bowman (2003) asserts, "Articles created from inductive reasoning alone do not tell the whole story, as they often do not provide a framework with which to explain the findings" (p. 67). In addition, Bieschke et al. (2000) note researchers' tendency to use white, educated men as participants, a sampling that is not reflective of all gay men. Further qualitative studies are needed with a more diverse gay population—in particular, bisexual, transgender, and people of colour—to explore empirically their experiences of affirmative psychotherapy.

The American Psychological Association (1992) calls its members to respect "the fundamental rights, dignity, and worth of all people … including those due to … religion … [by] respecting the rights of others to hold values, attitudes, and opinions that differ from their own" (p. 5). Yarhouse (1998) argues that gay-affirmative practitioners may be comfortable with more liberal expressions of spirituality, while fundamentalist expressions of religion often appear to be overlooked as an aspect of diversity. Gay-affirmative therapists are called upon to take seriously the experiences of religious clients, refraining from encouraging an abandonment of their spiritual traditions in favour of a more gay-affirmative doctrine or from discouraging the

exploration of alternative options. Such an approach can impose sexual orientation over religiosity, neglecting the primary task of integrating all aspects of identity (Haldeman, 2002).

Developmentally, heterosexual adolescents may experiment with homosexuality but remain predominantly heterosexual, just as homosexual adolescents experiment with heterosexuality but remain predominantly homosexual (Isay, 1989). Gay-affirmative therapists need to venture discerningly in order to distinguish the struggling homosexual client from the heterosexual client who is confused about his or her sexuality because of a phase they may be going through. Viewing all clients as suffering from internalised homophobia limits access to approaches that might facilitate unbiased inquiry and exploration, exacerbating clients' distress.

The identities of gay men vary as widely as any other group in society. They may share a common journey of self-acceptance, but the map for each individual on that particular journey is unique (Younger, 2007). In an attempt to affirm and validate clients, gay-affirmative therapy runs the risk of stifling the plurality of sexual meaning-making. A "blanket" approach aimed solely at supporting those who experience homosexuality as ego-dissonant may deprive individuals of the opportunity to make radically different sense of their experiences. If gay-affirmative therapy is to be generative, then it must be prepared to be objectively critical and facilitative of the process of unique meaning-making. Simply validating the perspective of the client, where that perspective and its implications are the cause of their distress, is obviously problematic (Cross, 2001).

Summary

Gay-affirmative therapists assert that the target of change is not the individual, but rather the culture. They argue that if there were no discrimination against gay people, there would be no need for gay-affirmative psychotherapy. However, in a society where gay men continue to experience prejudice and oppression, this model provides a way of healing familial and social wounds. Current research indicates that gay-affirmative therapy helps the majority of people who experience their homosexuality as ego-dissonant to achieve an increased sense of identity integration and wellbeing. Yet there is a small group of individuals 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. A later, companion article will explore some of the emerging integrative

solutions appearing in the literature, which offer more flexible possibilities for productive therapeutic work with these clients.

Notes

1. Gay-affirmative therapy in this context refers to an approach also known as "pink therapy" (Davies & Neal, 1996b), which established itself in the 1970s in reaction to pathologising views of homosexuality at the time.
2 The cultural assumption that all people are or would want to be heterosexual (Chernin & Johnson, 2003).
3 Ego-dissonant describes individuals who struggle to integrate their same-sex attraction with competing aspects of their identity. Dissonance stems from the words "dis", meaning "lack of" or "apart", and the Latin "sonans", meaning "sound" or "accord". Together they describe a "discord" or "lack of agreement or consistency" with the ego or conscious "I" (Harper, 2001).
4 The American Psychological Association's Division 44 is psychology's focal point for research, practice, and education on the lives and realities of lesbian, gay, bisexual, and transgender people.
5 Refers to the Oedipal complex where, between the ages of three and five, the child feels sexual desire for the parent of the opposite sex and desires the death of the parent of the same sex.
6 The act of selecting a person or a type of person as love-object. A distinction is drawn between an infantile object-choice and a pubertal one, with the former pointing the way for the latter.
7 Lewes (1988) described twelve different possible Oedipal constellations for the boy, depending upon whether his attachment is anaclitic or narcissistic, whether he takes himself or his father or mother as object, whether this mother is phallic or castrated, whether he identifies with father or (phallic or castrated) mother, and whether his own sexual stance is passive or active.
8 Dignity/USA (Catholic), Integrity (Episcopal), Metropolitan Community Church (Interdenominational), Evangelicals Concerned, More Light (Presbyterian), and Association of Welcoming and Affirming Baptists.

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