A Review of *Sexual Identity & Faith: Helping Clients Find Congruence* (2019)

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Mark Yarhouse is arguably the most influential Christian voice in the field of sexual orientation and gender identity. He is an accomplished scholar who has attempted with general success to bridge the sometimes cavernous divide between secular professional and Christian worldviews as pertains to sexual minorities. While most of his books have been addressed to a Christian lay audience, this is not the case with *Sexual Identity & Faith*. The intended audience for this work are licensed Christian and other conservatively religious practitioners and non-religious licensed therapists who work with religious populations. This book is an expanded follow-up to his initial 2006 paper

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(co-authored with Warren Throckmorton) outlining their Sexual Identity Therapy (SIT) framework for working with often conflicting sexual and religious identities of clients.

The Sexual Identity Therapy Framework

Positioning of SIT

Yarhouse positions SIT as a "third way" approach between sexual orientation change efforts (SOCE), which he generally dismisses, and gay-affirmative therapy (GAT) approaches, toward which he seems generally more sympathetic while clearly acknowledging potential limitations for Christian clients. He describes SIT as "client-affirmative" with a focus on sexual identity exploration that provides a nuanced understanding of both mainstream LGBTQ+ and religious communities (p. 7). As Yarhouse developed and practices SIT, it is primarily cognitive-behavioral, person-centered, and more recently narrative in its theoretical orientation. SIT has four primary phases: assessment and advanced consent, psychoeducation, attributional search for identity, and personal congruence. Yarhouse treats each of these phases in detail.

Assessment and Advanced Consent

SIT commences with a detailed assessment process focusing on both sexual and religious identities of the client, as well as the history of any conflict between these identities. Clinicians are encouraged to assess the clients' awareness, development, and any synthesis of same-sex sexuality. Furthermore, Yarhouse stresses the value of assessing a number of common milestones in clients' potential formation of their sexual identity, such as first disclosure of same-sex attractions (SSA), private adoption of a gay identity, and first engagement in same-sex behavior. Religious identity of clients must also be assessed, with an aim of obtaining a better sense of clients' religious faith as it relates to and informs their same-sex sexuality. Such assessment should include clients' motivations and expectations for pursuing therapy. Yarhouse also recommends, and wisely, I believe, that therapists conduct ongoing assessment of the therapy process. He provides an extensive Quality of Life instrument (pp. 32–36) he uses for periodic assessment with clients.

The SIT assessment phase also includes advanced informed consent: "Advanced informed consent should include discussion of what is causing the client's difficulties, professional treatment options and paraprofessional alternative, possible benefits and risks of treatment, and possible outcome without treatment" (p. 38). This discussion may include a statement about the APA's position on same-sex sexuality and theories of etiology for SSA. Regarding etiology, Yarhouse generally adopts the APA's stance, which indicates research does not support any one theory of sexual orientation development and that multiple factors are likely to converge and "provide a 'push' in the direction of same-sex sexuality" (p. 41). The range of possible treatment options are briefly outlined. Yarhouse correctly observes, "Some professionals provide GAT, which is itself not so much a protocol as a posture toward being gay" (p. 44). GAT typically has the goal of helping the client live openly and with integrity as a gay person. SOCE, according to Yarhouse, is an attempt to change clients' sexual orientation, and there is broad consensus that these practices are unethical and, for minors, now illegal in many states. As a result, SOCE currently is more likely to occur in faith-based ministries. Then Yarhouse adds (p. 44):

> It should be noted too that the primary potential benefit of SOCE approaches may be simply the opportunity for the

> client to explore their identity and find social support while learning adaptive coping in a context that honors their religious perspectives (APA, 2009). These benefits are precisely the emphasis of SIT and related "third way" approaches to clinical practices today.

The author concludes his discussion of advanced informed consent by acknowledging the difficulty some therapists will have with clients whose ultimate choices surrounding their identity conflict will lead them to a ". . . resolution that does not align with the clinician's own values. . . . How difficult will it be for you to present a range of options to clients without setting up one option as the one you prefer?" (p. 49).

Psychoeducation and Attributional Search

Yarhouse identifies two primary components of psychoeducation as the second stage of SIT. He discusses with clients his three-tier distinction between sexual attractions, sexual orientation, and gay identity. This is a very helpful differentiation about which Yarhouse goes into some detail (pp. 60–66). I would certainly concur in recommending all clinicians working in this area to be familiar with this distinction when providing psychoeducation to same-sex attracted clients. The other component of this stage is working with clients to have them "weigh" the relative importance they give to several parts of their experience. These parts include the strength of their same-sex sexuality, current and past sexual behavior, and personal beliefs and values.

The third SIT stage of attributional search for identity refers to ". . . how a person makes meaning of their experience of same-sex attraction" (p. 11). Yarhouse describes this middle stage as a cognitive search for meaning wherein clients are helped by the therapist to ". . . make sense of their same-sex sexuality and begin to develop a meaning-making structure that will help them thrive and achieve congruence" (p. 80). Two examples of milestone attributions are when clients initially attribute meaning to same-sex sexuality and when they assess the meaning of the word "gay" in relation to themselves. Here the therapist listens to the sense-making stories (i.e., attributions) that are embedded in how clients think about their sexuality and attempts to understand how they see their sexuality through interpretive lenses. Yarhouse identifies three such lenses through which clients may view LGBTQ+ issues: the diversity lens, the disability lens, and the sacred lens.

The author's discussion of these lenses is very useful to both clinician and client. In the diversity lens, persons with SSA are viewed as part of the LGBTQ+ community, and their sexuality should be recognized and celebrated. This is the lens of GAT. The disability lens assumes because SSA is not the normative sexual experience, it is ". . . either the result of something not functioning properly or evidence of sexuality not being as it should" (p. 85). Here same-sex orientation can be a variation in nature and not likely to change, but sexual impulses are not seen to justify engaging in same-sex sexual behavior. Finally, in the sacred lens clients view the same-sex sexuality as a variation occurring in nature and regard it with concern as it violates something sacred. They may see their sexuality as an indicator of spiritual deficiency, hence

> . . . whereas the disability lens treats same-sex attractions as an enduring reality . . . the sacred lens regards them as something that must be contended against, that must be healed. Requests for SOCE often

> come from adherents of the sacred lens, in my experience. (p. 47)

Yarhouse notes that therapists need not uncritically accept the lens clients have adopted and can explore with clients the benefits and drawbacks of each lens. However, he cautions, "Clinicians do not adjudicate among the underlying philosophical and theological views that undergird different lenses, but rather help our clients become more aware of how they are seeing their sexuality . . ." (p. 91).

In this stage Yarhouse also helps clients identify narratives that may have come to dominate and influence their lives. He describes two main scripts, one derived from traditional religious communities and the other from mainstream LGBTQ+ communities (pp. 94–102). The "Shame script" includes four tenets involving (1) SSA as a departure from who people are meant to be, (2) moral culpability not just for sexual behavior but also for experiencing SSA, (3) SSA signals a willful disobedience against God, and (4) centering life on Christ will free you from SSA. This is in contrast to the "Gay script," which Yarhouse characterizes as including (1) SSA is a categorical distinction between (LGB and heterosexual) types of people, (2) SSA signals your fundamental nature as a person, (3) sexual attractions are the core of your identity and sense of self, and (4) sexual behavior is morally permissible and an expression of identity and who you really are. Yarhouse rightly cautions that these scripts are not universal within either religious or LGBTQ+ communities and warns against stereotyping.

Personal Congruence

In the SIT approach, congruence is conceptualized as ". . . the bringing together of one's belief/values and one's behavior/identity" (p. 133). Preparatory to this congruence, clients may need to identify and remove the constraints that experiences and dominant narratives may have placed upon them that interfere with the goal of congruence. Yarhouse notes that the life stories of clients are often influenced by relationships and cultures in which they live, which can limit the way clients experience their life stories through "proscriptive" and "prescriptive" constraints. Within SIT, ". . . a proscriptive constraint places a limit on what a person can share, drawing a line between what is and is not allowed to be mentioned"; whereas a prescript constraint ". . . insists that certain questions be asked only in a prescribed manner and allows only for a prescribed conclusion" (p. 107). Although constraints can derive from both religious and mainstream LGBTQ+ communities, the SIT process is the same.

> [Clients] can then acknowledge the existence of the constraints and decide how they want to respond to them. They can consider the impact of adhering to the constraints placed on them and decide whether they wish to concede to a particular constraint or to reject it. If they choose to reject a constraint, they could use therapy to learn how to respectfully communicate that rejection and explore alternatives to the proscriptions or prescriptions being communicated. (p. 107)

In subsequent chapters, Yarhouse describes the technique of "interviewing the concern," assisting clients to identify the chapters in their lives, and the importance of working with clients to help them develop a counternarrative to the narrative that gave rise to their identity conflict. He observes Christian clients in particular as having problem narratives that usually involve a shame script and/or a gay script. Some

examples of these problem stories associated with a shame script and their suggested counternarratives include (p. 119):

- "My same-sex attractions are willful disobedience." [Counter-narrative: "My same-sex sexuality is not a result of willful disobedience; I found myself experiencing same-sex attraction when I was a teen. I have decisions to make about how I live my life and what my sexuality means to me, but to say it was a choice is simply not true."]
- "My same-sex sexuality is the result of bad parenting." [Counter-narrative: "I don't know why I experience same-sex attractions, but I don't think there was anything my parents did or didn't do that caused it".]
- "My same-sex sexuality is the result of sexual trauma." [Counter-narrative: "I'm sure sexual abuse complicated my sexuality, but I don't know that it caused me to experience same-sex attraction."]
- "To be gay is a sexual addiction." [Counternarrative: "To be gay is to experience same-sex attractions as an orientation—it is not an addiction."]
- "To be gay is an abomination." [Counternarrative: To be gay is not an abomination, but my same-sex sexuality raises questions for me about how I ought to live my life."].

From my perspective, these counternarratives are about reframing understandings and developing self-compassion through a more or less Christian values framework.

Developing such counternarratives helps SIT clients to reach the end goal of therapy, i.e., congruence. In SIT, "congruence is achieved when a person is able to adopt an identity outcome and live it out in ways that are keeping with their beliefs and values" (p. 12). Congruence can be achieved in two primary ways: (1) moving behavior and identity into alignment with previously held beliefs and values, or (2) realigning beliefs and values so that they become congruent with behavior and identity. The former is usually associated with maintaining traditional religious identity and sexual behavior, while the latter is typically a pathway to gay identity, though there can be hybrids, such as a sexually celibate Christian who identifies as gay.

Yarhouse anticipates and addresses criticism directed at this conception of congruence from some traditional Christian perspectives.

> Congruence can take many forms. This is one reason why some religious affiliated individuals have criticized SIT; this therapy model doesn't hold out one identity outcome as the prescribed outcome for all clients. The clinician is asked to "get out of the way" of how the client resolves the conflict between religious and sexual identities, so that the decisions that clients make in developing counternarratives and achieving congruence are truly their own. . . . Our goal as clinicians who practice SIT is to value both clients' faith and their same-sex sexuality. What we are trying to do is join clients on a journey as the work to determine how these aspects of their lives best fit together. (p. 137)

The book continues with helpful chapters focusing on working with mixed-orientation couples and with parents subsequent to their teenager coming out as "gay." Four appendices conclude the work, including three case studies so the reader can get a sense of what SIT looks like in practice. Of

particular interest is the appendix that is a reprint of the original SIT framework that was published in 2006 by Yarhouse and Warren Throckmorton. While *Sexual Identity & Faith* adheres fairly closely to this original framework, there are some differences in emphasis that seem noteworthy, which I will explore shortly.

Observations

In many respects, this is a book with which any clinician working with clients who experience conflicts between their faith and sexuality should be familiar. Yarhouse demonstrates appropriate sensitivity to and clinical acumen for the many landmines that can be present in working with this client population. On a strictly practical level, I appreciated the numerous worksheets and suggested clinician language he provides for conducting SIT, much of which can aptly be utilized regardless of whether the therapist strictly adheres to the SIT framework. His work is a service to clinicians looking for a model that may place their therapy under less professional and legal scrutiny than past and present change-oriented therapies. That said, I can imagine some therapists sensing there is more to this field than SIT allows and not feeling fully satisfied with the book generally and the SIT model specifically.

Clinicians looking for any consideration with SIT of potential psychodynamic, developmental, attachment, and childhood trauma influences on same-sex attractions and behaviors will be disappointed. Yarhouse notes early on that he has seen many failed SOCE cases who were taught their SSA is the product of sexual abuse or unmet emotional needs in relationship to their parents: "I didn't think much of these theories for the etiology of same-sex sexuality" (p. xi). Of course this is a problem if clients were coercively "taught" by their therapists any etiological model, but there are clients who gravitate to a particular view because they feel it matches their experience. I hope SIT would not try to reeducate these clients away from their perspectives, although no etiological belief guarantees change.

Yarhouse's reluctance to entertain any etiological role for developmental and/or trauma experiences may relate to a number of factors. As a cognitive-, behavioral-, and narrative-oriented clinician, potential psychodynamic and attachment issues are an unlikely focus of therapeutic interest or exploration. On pages 46–47, Yarhouse lists the kinds of goals that could guide SIT focus, and nowhere is mentioned the assessment and treatment of trauma. Nor is the clinical exploration of traumatic experience or adverse childhood events ever mentioned in the case study material offered. Perhaps such exploration is assumed as a parallel therapeutic focus outside of the SIT domain, but the failure to mention it throughout the book raises concerns. It would also seem plausible that clients who want to explore the degree to which their trauma history may have influenced the development of their same-sex attractions and/or have experienced fluidity in these attractions would be less likely to consult with a CBT-oriented clinician. Individuals who did not benefit from change efforts or who do not report or do not recognize trauma histories may be more likely to self-select for SIT. This may be why he tells clients, "Most people who come to see me have been down that [change approach] road and have not found it to deliver on the promises that were made" (p. 45). This does not mean Yarhouse's observations, derived from the small subset of sexual minority clients with whom he works, cannot be spot on for a number of individuals who have found therapeutic change efforts wanting. However, it is possible he may be overgeneralizing from his clinical experiences to the population of traditionally religious sexual minorities with

conflicts about their SSA who present for therapy, some of whom may report changes in their experience of SSA have been important in their pursuit of personal congruence. Finally, it is hard to imagine that professional status considerations are not also an understandable factor in Yarhouse's reluctance to address or take a clear position on some of the more controversial issues associated with working with this population, such as the influence of childhood trauma on sexual orientation or the possibility of some degree of therapy-assisted fluidity and change for some clients. Surely taking a wrong step on such radioactive issues would jeopardize his position as perhaps the foremost bridge builder between traditional Christian communities and the secular psychological world of the APA and beyond.

Perhaps Yarhouse's limited exposure to a variety of client experiences with change efforts is reflected in his characterization of SOCE, which generally mimics the APA's sentiments. In this caricature, change-allowing therapies attempt to "make gay people straight" and "manipulate orientation" (p. 7). They also have as their goal "a fixed outcome in which clients shift toward a heterosexual orientation" (p. 52). By contrast, SIT is "implicitly integrative" as a model that "does not explicitly align with a value system" (p. xiii) and does not allow therapists' "biases to direct clients toward one path over another" (p. 50). This strikes me as a false dichotomy for at least a couple of reasons.

First, these depictions of SOCE, which no doubt have applied to historical uses of coercive and aversive techniques in religious and professional psychological circles alike, simply have not been a part of change-allowing therapies for decades. Yarhouse does not seem familiar with client experiences of fluidity and change that are not attempts at direct manipulation but rather *emerge* as byproducts of therapeutic work addressing trauma or emotional-relational development. Therapists must be exceedingly careful not to give false hopes of change, but should they not also exercise caution in foreclosing any possibility of sexual attraction fluidity?

Second, positioning SIT as being values neutral seems to me to be a somewhat shallow philosophical stance to take. If stating that SIT does not have a value system is meant to convey the need for therapist sensitivity to the values of clients and to work as much as possible within their value frameworks, then this is good advice. However, strictly speaking, to not have alignment with a values system is, in fact, to adopt very clear value framework from which to do clinical work. If this values-neutral stance of SIT is as thorough going as it is made out to be, then there can never be value conflicts between the client and therapist so stark that it places limits on the therapeutic work or necessitates referral to a clinician with more aligned values. This may be why the book has no guidance for therapists who conceivably could experience such conflicts regarding how best to avoid such situations and/or to orchestrate a referral.

Yarhouse's inclusion as an appendix of his 2006 description of SIT is of particular interest as it provides some contrast to the rest of the book, appearing more balanced in its treatment of SOCE in a therapy context. For example, he acknowledges, ". . . for some clients, exploration of how fluid their sexuality could be is of prime therapeutic interest" (p. 191), and elsewhere even notes some clients report change experiences:

> To varying degrees, some clients may come to believe change has occurred in their sexuality while some will believe little or no change has occurred. These perceived changes can be examined, but we do not view

> such change as a determinant for the success or failure of SIT. (p. 183)

Unlike the book, here Yarhouse and Throckmorton acknowledge in a non-dismissive tone some clients do wish to explore SSA fluidity and report experiencing change. They also affirm the appropriateness of examining this in therapy, with appropriate warnings that change should never be promised or made the only measure of helpful therapy. He later cites a 2002 quote from Douglas Haldeman, which states, "Psychology's role is to inform the profession and the public, not legislate against individuals' rights to self-determination" (p. 186). The full quote makes clear this self-determination includes change-oriented goals. Of course, in a more than ironic twist, Haldeman in 2018 testified in support of California legislation that would have declared any speech construed as promoting change within a fiduciary relationship (including therapists and pastoral counselors) as consumer fraud, encouraging legal action against such providers.

The 2006 SIT paper also makes explicit the inclusion of change-oriented goals in treatment options: "Professional interventions available include an active focus on same-sex identity, efforts to modify erotic orientation, and/or a more integrative approach" (p. 195). Referrals due to value conflicts are likewise allowed, though the risks of doing so are recognized:

> Moreover, if a therapist's value position or professional identity (e.g., gay affirming, conservative Christian) is in conflict with the client's preferred direction, the referral to a more suitable mental health professional may be indicated. (p. 197)

Perhaps most astounding of all, Yarhouse and Throckmorton encourage clinicians to be familiar with a wide range of information and resources to assist clients in informed consent and decision-making, including works by past Alliance leaders Joseph Nicolosi, Sr. and A. Dean Bryd. These are the only references to such authors in the entire book.

These contrasts between the 2006 paper and this 2019 book seem likely to reflect the continued movement in the culture and in organized psychology away from any consideration of change-allowing therapies in favor of outright hostility toward them. This plausibly has placed ever tighter constraints on what Yarhouse might say about change-allowing therapies. Yarhouse is undoubtedly aware that although his immediate audience may be the Christian community, his broader audience includes LGBT+ activists within the APA who would not stomach too much deviation from affirmative models of therapy. For those who wish to maintain credibility within contemporary organized psychology, giving any credence to therapy-assisted SSA fluidity and change or etiological models that do not universally prioritize biological factors and dismiss developmental influences such as trauma is likely a career endangering move and thus professionally untenable.

I will close with one further observation and prediction: the exponential growth in gender dysphoria (particularly among girls) may well test the elasticity of the SIT framework's values neutrality. Yarhouse has already published a book on gender dysphoria, but to my knowledge he has not weighed in on the applicability of SIT for transgender concerns. What does SIT do with clients (including especially minors) who decide personal congruence for them means hormonal treatments and surgical removal of healthy body parts that could result in sterility and potentially serious medical risks? Will

this be a bridge too far, even for SIT, to remain aligned with such clients' goals, leading to a heightened risk of losing credibility within the culture of secular psychology? Or will the SIT framework simply incorporate conflicts between religious values and transgender feelings into its existing template for therapeutic service, likely raising further apprehensions about SIT within the conservative Christian communities Yarhouse intends to reach? I'm not sure it will be possible for SIT to achieve a mutually satisfying resolution to these imminent tensions, but I wish Yarhouse the wisdom of Solomon in navigating them.

This critique of *Sexual Identity & Faith* has admittedly focused on areas of the book that raised some apprehensions for me. However, this should not obscure the fact that there is much good clinicians can glean from Yarhouse's SIT framework, even if it is not adopted in wholesale fashion by the reader. SIT attempts, often successfully, to straddle the fence between the traditional faith-based community and secular psychological associations. This is a worthy endeavor, though it may be reaching its limits as most secular mental health organizations move increasingly toward a sexual world completely unrestrained by Christian values and moral sensibilities beyond that of mutual consent. At least for the time being, however, Yarhouse's book continues to offer a lot of valuable insights and guidance for therapists who encounter in their work clients experiencing conflicts between their faith and their sexuality.