

Religious Experience, Gender, and Sexual Orientation<sup>1</sup>

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**Abstract.** Increasing attention being paid to therapy with Lesbian, Gay, and Bisexual (LGB) individuals generally has not addressed the importance of religious and spiritual issues for these clients. This paper develops an in-depth theoretical basis for understanding the complex religious experience of LGB clients along with developing initial formulations on a welcoming or affirming approach to therapy. The first part of the paper examines the religious challenges which many LGB people struggle including the common religious views of homosexuality. Next, we provide an overview of faith development and LGB identity development with considerations for how these interact. Lastly, we discuss implications for therapy, training, and future research.

A growing body of literature has explored gay and lesbian issues in therapy (Omoto & Kurtzman, 2006; Perez, DeBord, & Bieschke, 2000) along with religious and spiritual issues in therapy (Cox, Ervin-Cox, & Hoffman, 2005; Richards & Bergin, 2005; Shafranske, 1996); however, contributions addressing religious and spiritual issues with lesbian, gay, and bisexual (LGB) clients is limited (Davidson, 2000; Hoffman, 2004). When religiosity and spirituality are mentioned, they are normally discussed in passing without dealing with the important, complex religious issues. Despite this, it remains evident that LGB clients have religious and spiritual issues when presenting in therapy. Considering how controversial this topic remains in contemporary culture, it is understandable that many clinicians are afraid to touch this topic; however, this makes it no less important.

In this paper, we focus primarily on LGB<sup>2</sup> individuals coming from a theistic background (Judaism, Christianity, and Islam) who wish to maintain their religious

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beliefs and affiliation. We will explore how LGB identity development and faith development affects religious experience. Additionally, we will discuss implications for therapy, clinical training, and research.

### The Problem

LGB clients generally have three options when dealing with religious and spiritual issues. First, they may choose the route of reparative or conversion therapy, in which the therapy is focused on attempting to help clients change their sexual orientation.<sup>3</sup> While this practice has received strong criticism and discouragement from organizations such as the American Psychological Association, many therapists continue to practice and advocate this approach. Further, the majority of therapists practicing this approach specifically integrate a religious perspective into their practice. A second option is to use therapy to help people live a celibate life. These two options are generally most appealing to clients who are religious and who believe identifying with a homosexual orientation is sinful or otherwise wrong. A third option is to abandon their religious beliefs and work through the issues related to the anticipated loss of meaning and support in their lives.

We propose a fourth option that needs further exploration; we refer to this option as an affirming or welcoming model. Many clients who do not believe that their homosexuality is sinful or wrong wish to maintain their religious beliefs. Various challenges come with this decision. While some churches such as the United Church of Christ (UCC), the Unitarian Church, Unity, and the Metropolitan Community Church (MCC) are intentionally inclusive, the majority of churches, synagogues, and mosques retain strong prohibitions against homosexuality. A primary challenge to developing an affirmative therapy model to address religious and spiritual issues with LGB clients is the lack of theory, research, and training for therapists in this area (Davidson, 2000; Hoffman, 2004). Our purpose in this paper is to begin to address this deficiency.

### *Ethical Consideration*

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<sup>2</sup> It was with considerable discussion that we decided to focus on LGB, as opposed to GLBT issues. We feel being transgendered brings some significant additional challenges that go beyond the focus of this paper. Because of this, we decided for focus on LGB issues in this paper.

<sup>3</sup> We will use "conversion therapy" and "reparative therapy" interchangeably in this paper.

Ethics is the greatest challenge to working with religious and spiritual issues with LGB clients. This is particularly difficult due to the controversial nature of this issue. Because so many LGB individuals have been hurt by religious individuals, the sensitivity around this issue often leads to distortions and misunderstandings. For this reason, we suggest that it is beneficial to discuss these ethical issues before addressing the four religious and spiritual options in depth.

Within religious and spiritual approaches to psychotherapy, one of the most challenging ethical issue is avoiding imposing beliefs or values upon clients (Hoffman, Grimes, & Mitchell, 2004; Richards & Bergin, 2005). Oftentimes, various assumptions, especially assumed agreement on religious issues, leads to an unintentional imposition of the therapists' beliefs upon clients (Hoffman, Grimes, & Mitchell, 2004). In order to avoid this mistake, it is important for therapists to listen closely to what clients are saying, to explore clients' religious beliefs openly, and to try to create an environment where it is safe for clients to disagree with their therapists. Additionally, becoming familiar with the various ways of being religious, including the various ways of being Christian, Jewish, or Muslim, can help therapists recognize the nuances of differences in belief systems.

Many LGB clients come to therapy with strong beliefs about whether homosexuality is a sin. Other individuals, particularly those in the early stages of the LGB identity development process, are still working through their integration of sexual identity and religious identity. Therapists working with clients who are undecided about these religious beliefs can help them explore different alternatives in the context of their identity development along with potential consequences of those alternatives. However, they should allow clients to make their own decisions about their beliefs. If a client chooses to leave religion, the therapist can help the client explore the consequences of this choice, but should also try to create an environment where the client can make her or his own decision, even if the therapist disagrees. Similarly, if a client decides to live a celibate life because of her or his religious beliefs, the therapist should honor this choice.

Therapists, particularly therapists with strong beliefs about homosexuality, need to maintain awareness of countertransference issues. For example, the

assumption that a client wants to change their sexual orientation or religion can bring ethical complications. As another example, many therapists assume that a client is heterosexual, particularly if the client has made her or his religious beliefs known. Subtleties in the therapist's response, along with not hearing the hidden messages, can lead to the client not revealing their sexual identity or identity confusion.

The two extreme positions remaining are more difficult from an ethical perspective. Some religious therapists who strongly believe that engaging in homosexual behavior, thoughts, and/or impulses is sinful may have a difficult time maintaining an appropriate ethical stance when working with LGB clients. In these situations, we advise that the therapist not work with clients or individuals who are conflicted regarding their sexual orientation. An appropriate referral is the better ethical choice.

The other extreme, conversion therapy, brings additional difficult ethical questions. *We, the authors of this paper, do not advocate or support the practice of sexual orientation conversion therapy or so-called reparative therapy.* Furthermore, we have a number of ethical concerns about the practice of these approaches to therapy. In reviewing the study by Shidlo and Schroeder, Spilka, Hood, Hunsberger, and Gorsuch (2003) reported:

Eighty-seven percent of the respondents regarded their therapy as a failure; only 13% felt that it was successful *to some degree*. Approximately half of the "successes" experienced lapses or participated in alternative practices that implied continuing adjustment difficulties. There was also evidence that such therapy could eventuate in considerable psychological harm. (p. 194; emphasis added)

While, as Haldeman (1994) pointed out, additional research on the dangers of reparative therapy is still needed, it appears apparent that risks are far greater than benefits. While some good critiques of this research exist (e.g. Yarhouse, 2006), we maintain that there is sufficient empirical and clinical support for the concerns about reparative therapy.

This creates a difficult ethical challenge when a client presents desiring conversion therapy. Because few therapists are trained in conversion therapy, it is

easy to forgo this option as a treatment alternative. However, a referral to a therapist who has been trained in conversion therapy may be an option; however, given the poor success rates of conversion therapy, along with the research suggesting the potential harm, we recommend that therapists strongly consider the potential dangers in this type of referral. Additionally, if the client is considering seeking a referral for a therapist who practices conversion therapy elsewhere, it may be best for the therapist to help the client become aware of potential dangers in a manner that is sensitive to the client's beliefs and values.

### *Conversion Therapy and Reparative Therapy*

Given the ethical concerns, we do not see conversion therapy as a viable option, especially without significant research suggesting potential benefits. All of the primary mental health organizations, ranging from social work to psychiatry, have issued strong warnings about reparative therapy based on the lack of empirical support of success and the potential for harm (Spitzer, 2006). While Spitzer correctly pointed out that many other acceptable forms of therapy also have not received empirical support, including many affirmative therapies, these do not carry the same potential for harm.

Spitzer's (2006) study of 200 participants (143 male; 57 female) who claimed to have successfully change their sexual orientation is the most significant research supporting potential success and benefits of reparative therapy to date. While this study does provide some evidence supporting reparative therapy, the results are not as impressive as they seem. Carlson (2006) pointed out various methodological and ethical concerns in this study. Of particular concern are the lack of an informed consent and the interviewer's knowledge of the identity of the research participant. This is likely to introduce demand characteristics and other biases into the research. It is likely that clients, particularly without an informed consent, may be hesitant to share openly with the researcher. Additionally, this study did not take into consideration the potential for harm with reparative therapy.

Shidlo and Schroeder (2002) conducted a research study that provided strong support for the potential of harm resulting from reparative therapy. However, Yarhouse (2006) argued that this study contained the same methodological problems

as the Spitzer study stating, "The methodological limitations in the Shidlo and Schroeder study are, in some important ways, quite similar to those limitations found in the Spitzer study. To reject one study on methodological grounds means rejecting the other" (p. 218). We disagree and find Yarhouse's statement somewhat surprising. For one, the Shidlo and Schroeder study included an informed consent. This alone suggests a strong methodological superiority to the Spitzer study. Second, there is a significant difference between the potential harm of therapy and potential success. Third, the Spitzer study recruited individuals who claimed to have successfully changed their orientation, while Shidlo and Schroeder used participants who participated in reparative therapy, regardless of successful or unsuccessful outcome. Given that the individuals in the Spitzer's study claimed successful outcomes, they are likely to be more invested in a particular view of reparative therapy. Fourth, the Shidlo and Schroeder article demonstrated greater balance and openness to both perspectives than the Spitzer study.

Shidlo and Schroeder (2002), in their conclusion, acknowledged that a small number of clients reported that reparative therapy was successful and resulted in mental health benefits. Despite their evident personal reservations, Shidlo and Schroeder suggested that reparative therapy should not be ruled out as an option for clients desiring to pursue this approach. However, they suggested that several important considerations be addressed with the client before pursuing this option. First, "If a clinician pursues conversion therapy, a detailed informed consent is essential" (p. 258). This informed consent should clearly indicate the potential harm and that several prominent governing bodies discourage attempting to change sexual orientation. In addition, "The clinician should educate the client on the various definitions of change that exist in conversion therapy" (p. 258). Throckmorton (2002) added that "neither gay-affirming nor ex-gay interventions should be assumed to be the preferred approach recommend to clients presenting with concerns over sexual identity" (p. 246).

We suggest the following additional ethical concerns that should be addressed before pursuing reparative therapies. First, therapists should consider with clients their reason for wanting to change their sexual orientation, particularly in the context

of their sexual identity development and faith development. These issues may be best explored by a therapist who is not invested in the client choosing a particular therapeutic approach. If the reasons for desiring change are external (e.g. pressure from friends, family or religious groups), these pressures should be explored prior to initiating a referral for reparative therapy. Second, therapists practicing this approach to therapy should be closely monitored and in consultation or supervision with an impartial professional who is able to evaluate potential harm to the client. While this seems like an extreme measure, considering the potential for harm associated with this type of experimental therapy, we believe that it is warranted. Third, any therapist practicing reparative therapy should be familiar with the harmful approaches and techniques discussed by Shidlo and Schroeder (2002). This familiarity can help prevent the therapist from utilizing inappropriate techniques. Lastly, therapists making referrals should be familiar with the approach taken by the reparative therapist and should only refer to therapists taking appropriate precautions to protect the client's psychological well-being.

Our assent to a standard that does not completely rule out reparative therapy does not come without reservations. As noted above, *we do not support or advocate reparative therapy and have great concern about its practice*. However, at the same time, we respect the right of clients to make choices consistent with their values if they have engaged in appropriate consideration of developmental and identity issues, social pressures, and the potential for harm. Additionally, clients desiring reparative therapy are likely to seek alternative sources to attempt to change their orientation if this therapy option is not available. If reparative therapy is not available, it is likely that these individuals may seek approaches to changing their orientation outside of psychotherapy that carry much greater risk of harm. If an individual attempts to change his or her orientation, we believe it is preferable to do this in a responsible therapeutic context where a treatment team can closely monitor the potential for harm.

### *The Celibacy Option*

Through the decades of Western philosophy and psychological theory, a coherent, cohesive self has been thought to be an important component of adaptive

human functioning. To the extent that the self is underdeveloped or fragmented, vulnerability to various emotional and psychic disturbances arise (Wolf, 1988). Two domains of existence that potentially contribute to a sense of self are the religious and sexual identities. For those people who experience same-sex attraction, this stands to pose a conflict that has profound implications for the self. Many perceive, or are coerced by others to confront the tensions between their sexual identity and their religious identity (Wilcox, 2002). As a result, many repress their sexual or religious identity. This is significant because a considerable body of research supports a positive relationship between religiosity and well-being (Ervin-Cox, Hoffman, & Grimes, 2005; Steger & Frazier, 2005). As Yarhouse (2004) noted, humans are physical beings who have a fundamental need for connectedness to others, and “this is grounded in part in our sexuality” (p. 10). Repressing either the sexual identity or the religious identity has implications for emotional well-being whether from the aspect of fragmenting and denying part of their identity, diminishing or eliminating an important contribution to well-being made by religion, or constricting the capacity to meet the existential need for belonging and connectedness (Yalom, 1980). In this section, we will discuss alternatives to compartmentalizing or denying parts of their identity.

First, we consider a model of sexual identity formation. Yarhouse (2001) discussed a model of sexual identity development that begins with confusion or crisis, which may lead to premature identity foreclosure with a heterosexual identification. Potentially overlapping with or following confusion or crisis, identity attribution may occur, which involves making sense from experiences of same-sex attraction. Attribution may be followed by foreclosure of identity as same-sex oriented or an expansion of identity involving exploration. Identity reappraisal occurs when the individual assesses the effects of either their identification or their exploration of alternatives. The final stage (and a desirable achievement), identity synthesis, is characterized by either greater identification with the sexual self or exploring personal development more broadly using values as a frame of reference. Yarhouse and colleagues offered another characteristic of identity synthesis, the relinquishment of an “us versus them” perspective (Yarhouse, Tan, & Pawlowski,

2005). The authors noted that sexual identity itself is thought to be informed by sex, gender identity, sex role, sexual orientation, and the person's value system vis-à-vis sexuality.

Yarhouse and Tan (2004) wrote that a Judeo-Christian worldview includes, for many, a theology and set of official teachings that view homosexuality as sinful. Delineating theological and anthropological beliefs, Yarhouse explained that the physicality and relational nature of human beings are honored, but that humans are able to "transcend" their physical selves in obedience to the will of God (Jones & Yarhouse, 2000). Indeed, Jones and Yarhouse noted that the Catholic Church holds same-sex sexual *behavior* to be sinful, not the experience of same-sex attraction. In its narrowest interpretation, this suggests that Christians who experience same-sex attraction and who accept religious teachings that proscribe non-heterosexual sex must choose between the sexual and the religious identity. This view holds that the sexual self is defined only in terms of sexual attraction and behavior. Recalling the multiple strands from which a sexual identity is woven, as listed by Yarhouse (2005), the sexual self is defined by more than these two threads. According to Christian theological anthropology as elucidated by Yarhouse, living in obedience to God's will is the crucible in which the true self is formed. Following this reasoning, relinquishing sexual behavior might result in investing sexual identity in the other strands that create the whole: gender, sex role, gender identity, and sexual ethics. Arguably, it may be possible in this context to maintain both religious and sexual identity as well as to achieve identity synthesis by embracing celibacy.

Yarhouse and Tan (2005) acknowledged the importance of faith as a source of coping for both LGB-identified people and non-LGB-identified people. The results of their study, which are supported by other research, indicated that many of those interviewed who reported an LGB-identification deployed a variety of methods to include both religious and sexual selves in their self-structure rather than relinquish their religious selves. Wilcox (2002) reported that some LGB-identified respondents believed God's plan encompassed same-sex orientation. Others defined their identity more broadly: Rather than *either* sexual self or religious self, they identified with their sexual *and* religious selves as religious, sexual beings who chose to live

celibately (Yarhouse & Tan, 2005). Yarhouse (2004) reported that some respondents invested their identities in other aspects of their existence, recognizing that personhood is a multi-faceted construction of attitudes, emotions, beliefs, and behaviors including those in sexual and religious contexts. In this formulation, same-sex attraction became a facet rather than the core of what it meant to them to be a person.

In terms of psychotherapy, the research conducted by Yarhouse and his colleagues offer the following clinical directions:

1. The existential angst accompanying same-sex attraction may emerge as anger toward God, the church, and others who share in religion. These feelings should be explored (Yarhouse, Tan, & Pawlowski, 2005).
2. Be prepared that, for some, the secrecy and isolation so long a part of their experience may result in waiting longer for self-revelation (Yarhouse & Tan, 2005).
3. Clinicians should develop a network of referrals and community resources to draw upon as needed (Yarhouse, Tan, & Pawlowski, 2005).
4. Informed consent must include all available treatment options, the related research, possible outcomes and consequences, and the variety of choices available, including reorganization of the emphasis given to various components of identity and developmental pathways of individual and sexual identities, and taking a broader perspective for meaning, evaluation, and attribution (Yarhouse, Tan, & Pawlowski, 2005).
5. Clinicians should explore religious, ethical, interpersonal, and intrapersonal belief systems and their influence; clinicians should further be wary of the use of theological disputation and avoid using terms like "orientation" or "identity" because these terms may imply the imposition of a label (Yarhouse, Tan, & Pawlowski, 2005).
6. Care should be taken to respect the right of self-determination of clients, even if that therapy choice is one at variance with the opinion or values of the clinician; otherwise referral is necessary (Yarhouse, 2004).

7. Meaning-making about sexual orientation placed in broader context of meaning may be helpful (Yarhouse, 2004).

### *Leaving Religion*

Many LGB individuals see leaving religion as their only option. For them, religion has become too closely associated with pain, rejection, and judgment. Some will find alternatives in other sources of meaning or alternative spirituality; however, for many, the loss of meaning is something they choose to live with. It is simply easier than the pain.

Religious faith has been reported as producing high levels of personal happiness, life satisfaction, and fewer negative psychosocial consequences of trauma (Ellison, 1991). Schuck (2001) reported that two-thirds of the sample experienced conflict between religion and sexual identification. The conflict resulted from denominational teachings, scriptural passages, and congregational prejudice. Emotions described were shame, depression, and suicidal ideation. Participants resolved this conflict by developing a spiritual belief rather than religious involvement, thus reinterpreting religious teachings, changing affiliations, and remaining religious but not attending services, or abandoning religion all together.

Yarhouse (2005) wrote about the co-development of sexual identity and spiritual identity. Due to the competing claims about identity and behavior, conflict develops. Due to the conflict, there often develops negative emotion toward God or negative attributions toward God that may affect belief in God.

Developing a religious identity allows a person to develop a sense of identity and worth in relation to God and his or her place in the universe. Some develop a positive sense of being connected to God's love for them. Others do not feel they have a divine worth or even potential to have a positive relationship with God. This is consistent with research by Lease, Horn, and Noffsinger-Frazier (2005) in which they reported a positive relationship between spirituality, religion, and mental health. In the religious climate, however, sexual orientation and religious identity are often incompatible. LGB individuals participate in organized religion to a lesser degree than do their heterosexual counterparts.

Lease, Horn, and Noffsinger-Frazer (2005) suggested that internalized homonegativity or internalized homophobia mixed with faith messages about family, sexual expression, after life, and divine worth are often in conflict for LGB individuals. Religion and spirituality are among the most important factors for developing a person's experience, beliefs, values, behavior, and overall sense of well being (Rose, Westefeld, & Ansley, 2001). Tix and Fraiser (1998) added further evidence that religious coping is an effective coping strategy for a variety of stressful circumstances.

Institutional heterosexism is defined as societal level ideologies and patterns of institutionalized oppression of non-heterosexual people (Maradi, van den Berg, & Epting, 2006). A majority of religious organizations maintain a stance that homosexuality is morally wrong. Many homosexuals reject their religious faith in order to accept their sexual orientation, while others do not express their homosexuality. A tremendous struggle occurs for LGB individuals attempting to integrate their religious beliefs and sexual identity.

Spirituality is a personal belief system, whereas religion is associated with institutional beliefs and attitudes (Buchanan, Dzelme, Harris, & Hecker, 2001). Spirituality is compared to intrinsic religious orientation, while religiosity is generally associated with extrinsic religiosity. During the developmental process, a person begins to acknowledge their homosexuality, which is labeled as the "coming out" process. This process is often complicated by feelings of self-hate, guilt, depression, fear, or rejection from family, friends, and society (Buchanan, et al. 2001, p. 437). Wagner, Serafni, Rabkin, Remien, and Williams (1994) suggested that religious involvement may be associated with greater internalized homophobia or negative societal attitudes toward homosexuality. Oftentimes, LGB individuals hear the message that they are not welcome nor can they have membership or fully participate in religious privileges. Wagner et al. (1994) stated that rejecting a part of the self, be it either the spiritual or sexual identity, may have negative effects on a LGB individual's mental health. Barret and Barzan (1996) discussed that after rejection from traditional religious organizations, LGB individuals freed from external authority

are available to reflect on and integrate their own life experiences, thereby creating their own personal spirituality.

In summary, it is often difficult for LGB individuals to reconcile religious and sexual identities. Oftentimes, the easier choice is to leave religion, since they are not able to leave their sexual orientation. This is particularly true when experience with organized religion is characterized by homophobia, stigmatization, and non-affirming messages. This produces the question: how does developing a personal spirituality influence a LGB individual's God image?

### *Affirming and Welcoming Approaches to Therapy*

A few attempts at a welcoming psychotherapy or pastoral care have been attempted (Davidson, 2000; Graham, 1997; Hansen, 2001; Hoffman, 2004; Struzzo, 1989; Unterberger, 2001). Many of these have come from pastoral care perspectives instead of psychotherapy. The voices of psychology and psychotherapy have been disturbingly quiet on this issue. A primary purpose of this paper is to end this silence.

Within psychology, various integration attempts have been made to combine elements of religion and psychotherapy to work more effectively with religious clients. Within this movement, it is often emphasized that what is needed is a scholarly level of both fields (Leung & Hoffman, 2005; Pulleyking, 2005). In the next section, we address important definitional issues regarding sexual orientation. Following this, we attempt to build a solid theoretical basis for an approach to working with LGB clients' religious experience in psychotherapy from an affirmation perspective.

### Definitions Related to Homosexuality

The cause of homosexuality is not known; however, the American Psychological Association (APA) holds that homosexuality is not a choice, rather "it emerges from most people" without prior sexual experience in early adolescence (APA, 2003). In 1994, APA stated "homosexuality is neither a mental illness nor a moral depravity. It is a way a portion of the population expresses human love and sexuality" (Johnson, 2003). Further, the American Psychiatric Association removed homosexuality from the Diagnostic Statistical Manual (DSM) in 1973 (Pillard, 2003). In 1975, a public

statement was made proclaiming that homosexuality was no longer considered a mental disorder (Bailey & Pillard, 1991).

The Kinsey Scale of Sexuality rated all individuals on a spectrum of sexuality, ranging from 100% heterosexual to 100% homosexual and those in between (Pillard, 2003). In 1994, APA stated that "homosexuality is neither a mental illness nor a moral depravity. It is a way a portion of the population expresses human love and sexuality" (Johnson, 2003). Much is unknown about the cause of sexuality in general, as well as the cause of homosexuality in particular. There is a great deal of common understanding that lay people do not know or understand the cause; however, the existence of the phenomena is not denied. There continues to be debate about whether homosexuality is a choice or develops prior to a child's ability to choose. Researchers have developed several theories about homosexuality and, as is often the case, the answer is probably within the combination of many of the research results.

Attempts to answer the nature versus nurture question associated with the development of homosexuality were initiated in the 1950s. Hooker (1957), on a grant from the National Institute of Mental Health, concluded that there was a zero correlation between social determinism and sexuality. In 1991, Simon LaVay studied the hypothalamus of the human brain, concluding that homosexuality and heterosexuality differ in the central neuronal mechanisms that control sexual behavior. He continued to suggest that sexuality is determined during prenatal cerebral development and that there is a structural differentiation between the brains of gay men and heterosexual men.

Pillard (2003) conducted twin studies and found 52% of monozygotic (MZ) twins were self-identified as lesbians or gay, compared to only 22% of the dizygotic (DZ) twins, and only 5% of adopted brothers. Again, this suggests a strong indication of something other than simple social determinism as a cause for homosexuality. Hamer, Hu, Magnuson, Hu, and Pattatucci (1993) found remarkable concordance for five genetic markers on a section of the X chromosome called Xq38. This provided additional support for the development of "cause" for homosexuality, as opposed to it being a choice. Taylor's (2003) research supports Hamer, et al's research, further linking homosexuality to the X chromosome.

Many lay people, along with a number of religious leaders, adhere to a sociobehaviorist position that dates back to ancient Greece (Johnson, 2003). Most early psychoanalytic theories, consistent with the sociobehaviorist position, stress the role of parental and family dynamics in the development of LGB sexual identity. Halperin and Foucault place stock in Freud's theory of "failure to resolve Oedipal issues." However, there has not been any significant scientific evidence produced to support the sociobehaviorist or psychoanalytic positions.

As the theory and research on homosexuality increased, the language has also evolved becoming more able to describe different nuances of experience. *Sexual identity* refers to the self-concept an individual organizes around her or his sexual predisposition. Additionally, sexual identity describes how a person thinks and feels about sexual attractions and how the person communicates his or her sexual identity to others, i.e. gay, lesbian, bisexual, heterosexual, or straight. Identity and orientation do not always coincide (Cass, 1994). There is a set of implicit developmental criteria that gradually emerge by which "true sexual minorities" might be distinguished from others without same-sex orientations (Diamond, 2003).

*Sexual orientation* is an expression of the person's sexual attraction to the opposite sex, same sex, or both sexes. It appears to involve a developmental process with self-awareness of the person's sexual orientation early in childhood.

*Homosexuality* is the sexual desire or behavior directed toward persons of one's own sex, or sexual attraction to members of the person's own sex. Last, *gender identity* is more stable and refers to one's identification as female, male, or transgender.

### Religious and Spiritual Experience

Religious experience can be understood broadly as the various cognitive, behavioral, and affective aspects of religiosity. In stating experience, we assume that, at least in part, this experience goes beyond intentionality or is not merely the product of the individual's intentions. Oftentimes, the distinction between the cognitive and affective realms of religious experience is not made in the psychological literature, confusing the various levels of experience. In this next section, we will distinguish between the God concept and the God image as two aspects of religious experience.

*The God Concept.* The God concept refers to an individual's cognitive understanding of God (Lawrence, 1997). Using religious terminology, this refers to a person's theological understanding or beliefs about God. According to Hoffman (2005), a variety of factors influence the development of the God concept. Most of these are educational in nature, such as what parents, teachers, and other influential people teach about God.

*The God Image.* The God image refers to an individual's emotional, affective, or relational experience of God (Lawrence, 1997; Rizzuto, 1979). The idea of the God image is best understood as a complex, multidimensional construct that is not always internally consistent. In the psychological literature, the idea of the God image originated in Freud's writings on religion (1913/1950; 1927/1961). According to Freud, the idea of God developed from people's child-like desires for a father figure. It should be noted that, for Freud, these desires were always for the male father figure, not the mother. While Freud used this argument to suggest that religion was an illusion, Rizzuto (1979) took a different approach in which these early experiences and primordial desires were seen as distorting the experience of God, but said nothing to the reality of God.

Rizzuto's (1979) book, *The Birth of the Living God*, was based on her psychoanalytic research of several individual's experience of God. Her method employed using projective drawings of God and interviews to elucidate the way people experienced God at a more base level. She found that, for most people, their experience of God was similar to their childhood experience of their parents. The combined theories of Freud and Rizzuto suggest that religious experience is the result of projective and transference processes in which previous object relations and wishes are projected upon God.

Several studies provide support that an individual's experience of God is largely dependent upon their experience of parents or childhood attachments, often referred to as the correspondence model (Brokaw & Edwards, 1994; Hoffman, Jones, Williams, & Dillard, 2004; Tisdale, et al., 1997). However, several other studies have supported a compensation hypothesis, which states that God serves as an ideal attachment figure (Kirkpatrick 1997, 1998, 2004; Kirkpatrick & Shaver, 1990). This latter view is

consistent with Freud's (1913/1950; 1927/1961) wish fulfillment theory, suggesting that God is an idealized figure created by an individual's imagination to provide security. As an alternative, several researchers have proposed that both theories may be correct (Dickie, Eshleman, Merasco, Shepard, Vander Wilt, & Johnson, 1997; Eshleman, Dickie, Merasco, Shepard, & Johnson, 1999; Hall, Halcrow, Hill, Delaney, & Teal, 2005; Hall & Porter, 2004; Granqvist & Hagekull, 1999). Several approaches to reconciling these views have been proposed.

Some research suggests that the point of development may be key to understanding the discrepancies. Dickie et al. (1997) and Eshelman et al. (1999) found an interaction between children's ages and perceptions of their parent's nurturance, power, and closeness. Younger children are more likely to fit the correspondence model, while older children display greater variance depending upon aspects of their relationship with their parents. Similarly, Granqvist and Hagekull (1999) found that the correspondence model was a better fit for explaining early childhood experience of God, while attachment could predict the greater variance found in older individuals. For individuals with an insecure attachment, the compensation model was a better predictor of adult religiosity, sudden conversion experiences, and intense religious experience.

Hall and Porter (2004) presented a third option, which proposes that both models may be accurate at different levels of processing. This theory does not contradict the developmental theories; however, it does explain aspects of the variations. In general, the more remote, presymbolic, and preverbal religious experience may be more consistent with the correspondence model, while more symbolic, verbal conceptions show greater variance. For individuals with predominantly negative early parental experiences, they may be more likely to fit the compensation model at this more conscious level of processing.

Several research studies discovered gender differences in images of God (Foster & Babcock, 2001; Krejci, 1989; Nelson, Cheek, & Au, 1985; Roberts, 1989). Additionally, Hoffman, Hoffman, et al. (2005) found cultural diversity to be predictive of differences in the God image. These findings suggest various cultural and socialization factors are important in understanding religious experience.

*The God Image, the God Concept, and Religious Experience.* There are many conceptual and empirical challenges for research and theory on the God image and the God concept. In particular, in the review of the research above, it can easily be noted that there are many inconsistencies in the use of language. Many of these language variations are significant in that they are pointing to different aspects of the broader category of religious experience. While this could be used to question the conceptual distinction between concepts such as the God image and God concepts, we maintain that they reflect different gradations and nuances which are significant, but difficult to measure empirically.

The God concept refers to an aspect of religious experience that is more conscious, verbal, and cognitive. Because of this, it is easier to measure than the God image, which is conceived as more unconscious and, oftentimes, more presymbolic and preverbal. Most current measures of the God image have many construct validity problems (Hoffman, Grimes, & Acoba, 2005). Despite recent promising research innovations (see Gibson, 2006), much of the research to date comprise significant methodological limitations.

A number of researchers and theorists seem to ignore the theoretical differences between the God image, the God concept, images of God, and other psychological constructs. This has led to some concerns about whether these are distinct constructs. While early research has supported the distinction between these constructs (Hoffman, Jones, et al., 2004; Lawrence, 1997), the various theoretical and clinical distinctions may be equally as important (Hoffman, 2005; Moriarty, 2006; Sorenson, 2005). We believe that a thorough overview of the current literature provides strong evidence that these concepts are interrelated, yet distinct psychological constructs.

The relationship and distinction between these concepts may also have important clinical utility. It has been proposed that the God concept is more conscious, thus accessible, while the God image is more unconscious, or inaccessible. When asked about their experience of God, individuals are likely to respond with an answer consistent with their God image, not their God concept (Hoffman, 2005). From a clinical perspective, the God concept can serve as a defense mechanism against the

God image. For example, if a person's God image is that of experiencing God as distant, rejecting, and unloving, that individual is likely to be aware that this is not a socially or religiously acceptable description of God. Furthermore, experiencing God in this manner may be quite painful. When asked about their experience of God, people are more likely to give the socially acceptable answer, which is their God concept. Additionally, these individuals may work very hard to convince themselves that their God image is their true experience of God, thus further repressing their painful God image.

Research suggests that while the God concept and God image are distinguishable constructs, they are still related or influence each other (Hoffman, Jones, et al. 2004). In other words, beliefs or cognitions about God do influence how God is experienced affectively or relationally; however, these beliefs do not fully explain this experience. Furthermore, while early theory suggested that the God image is determined by early childhood relationships, more contemporary research and theory suggests that a variety of relational experience over the lifespan continues to influence the God image (Hoffman, 2005; Hoffman, Hoffman, et al., 2005; Sorenson, 2005; Tisdale, et al., 1997). Two additional influences demonstrated in the literature are particularly important. First, the research of Tisdale et al. (1997) suggests that therapy may change a client's God image. In some individuals, prior to therapy, their God image was closely related to their experience of their parents. However, after therapy, it was not as dependent upon early parental experiences, and more closely related to the experience of the therapist. A second line of inquiry suggests that various aspects of identity, such as gender and culture, influence the God image (Foster & Babcock, 2001; Krejci, 1998; Hoffman, 2004; Hoffman, Hoffman, et al., 2005; Nelson, Cheek, & Au, 1995).

#### Challenges of Being Religious and Lesbian, Gay, or Bisexual

Research reviewed in the previous section provides evidence for gender and cultural differences in the experience of God. We propose that these influences could likely be extended to LGB individuals. Hoffman (2004) developed an initial formulation on how the unique experiences of LGB individuals may contribute to their God image. According to Hoffman, two factors remain primary for many individuals

choosing to embrace religion and their homosexuality. The first is paradoxical messages about God and themselves as good and bad. Second, LGB individuals are encouraged to repress and deny essential, natural impulses. In this section, we will begin with these two challenges before moving into additional challenges with being religious and LGB.

### *Paradoxical Messages and Repression*

*Paradoxical Messages.* Many LGB individuals have painful, complex experiences with religion, particularly as they begin to discover their sexual identity. Hoffman (2004) stated,

[Religious experience] in itself is very troubling for many [LGB individuals]. They experience rejection and judgment from many in the church in the midst of being told about God's love and God's grace. This paradoxical message provides an important experiential basis for the God Image, which becomes more powerful than the early experiences with parents. Perhaps more than any other example, the experience of [LGB individuals] reveal the oversimplification of prior theories which have not taken into account the later [life] experiences. (p. 12)

The paradoxical message necessitates a primary cognitive dissonance for many LGB individuals choosing to embrace religion.

A consistent message that many LGB individuals hear is, "God is love, but God doesn't love you." While this message is evident in cultural discourse, the more powerful message is often experiential in nature. LGB individuals are often told they must change their sexual identity as LGB in order to be accepted by the church or by God. They hear consistent messages of judgment and hate from people and organizations proclaiming love. They witness other people being accepted despite engaging in a variety of hurtful and sinful behaviors, while they are rejected because of identifying as being LGB. It is hard to imagine that such experiences would not create deep, emotional wounds for people trying to reconcile their natural sexual desires with being religious.

A common paradoxical statement that LGB individuals hear is, "Love the sinner, hate the sin." This statement is often viewed as being compassionate and

understanding by religious heterosexual individuals, while it is viewed and experienced as judging or rejecting by LGB individuals. The message "I love you despite of..." is much different than, "I love you as..." While most LGB individuals are quite aware of this discrepancy, many heterosexual religious individuals are not, especially at an experiential level. Heterosexuals must be willing to move beyond their comfort zones in order to understand how many LGB individuals experience this statement. Sadly, many in the heterosexual community are more interested in defending this position as compassionate than engaging in the compassionate behavior of understanding the experience of the LGB individual who hears it. In the end, this position is more effective as a defense mechanism for heterosexual individuals in maintaining a self-concept of being compassionate toward LGB individuals than as an actual expression of compassion.

*Repression and Sexuality.* The sexual revolution did not free everyone to enjoy healthy sexual expression. Most religious individuals were able to benefit from aspects of the sexual revolution. Sex, if in the context of marriage, became seen as a healthy expression of love. However, this freedom was not extended to religious LGB individuals. First of all, because they are not allowed to marry in many states, LGB individuals are not able to create the context necessary to condone sexual intimacy. Second, many religious groups view homosexuality as sinful. Third, for some religious individuals, they believe sex is only for procreation. Recreational sex is deemed sinful.

Three theological positions are common among religious groups pertaining to homosexuality and sin (Hoffman, 2004). First, many will state that homosexual behavior is sinful. In this perspective, the sexual impulses, desires, and orientation may still be viewed as acceptable as long as they are not acted upon. Second, some religious groups view homosexual behavior, desire, and impulses as sinful, but not the homosexual orientation. For these people, if the LGB individual can "contain their lustful desires," then being homosexual is not as problematic. A third position states that being homosexual, even if the desires, impulses, and behaviors are contained, is sinful in itself. While the prevalence of this third perspective appears to be decreasing, it is still evident in the hate crimes and hateful statements made by many

religious extremists. This was the case when several prominent religious figures made statements implying that the 9/11 bombings, Katrina's devastation in New Orleans, and the bombings in the London subway were God's vengeance for tolerance of homosexuality. Such statements of hate are reprehensible in any religious context. Additionally, clinical experience brings stories of LGB individuals who were traumatized by dangerous exorcisms intended to remove demons believed to cause homosexuality.

All three of these positions encourage some type of repression that is not required of heterosexual individuals. Even the positions advocated by Yarhouse and colleagues, as discussed previously, require the repression of aspects of an individual's natural sexual identity. While appreciating attempts to integrate sexual identity, and acknowledging that this may be a preferable solution for some religious LGB individuals. We believe that a gay or lesbian individual opting out of relationships and into a celibate sexual identity because of external sources stating that homosexuality is wrong or deviant is not the same as a heterosexual individual who freely chooses to opt into a celibate lifestyle for religious reasons. The heterosexual individual still is given the *choice of* celibacy, while for the homosexual individual celibacy is given as the *only* acceptable religious option. While the heterosexual individual is given the option of finding healthy, sexual expression of natural desires, this is denied to the LGB individual (Hoffman, 2004).

Becker (1973) maintained that the repression of what is natural does not work. This is a common tenet within much of the psychoanalytic literature. Necessitating repression as the only appropriate religious option for LGB individuals is bound to have consequences for psychological health and possibly physical health. The repressed sexual impulses may find unhealthy alternative expressions, lead to somatic issues, or contribute to a variety of emotional consequences.

#### Faith and Identity Development

A number of developmental models have implications for religious experience in LGB individuals, including faith development (Fowler, 1981) and LGB identity development (Cass, 1979; Reynolds & Hanjorgiris, 2000). While many other developmental issues are also relevant, we will focus on these two in this section.

### *Fowler's Faith Development*

Fowler (1981) presented one of the most comprehensive and well-researched perspectives on faith development. Most individuals mature to Fowler's third stage, synthetic-conventional faith, through normal cognitive and emotional development, so we will begin our review with this stage. The development of abstract thought is central in the transition from stage 2 to stage 3; however, many individuals retain a rather concrete understanding of religion. Synthetic-conventional faith is characterized by conformity or uncritically aligning with a particular faith group. The opinion of others, particularly religious or spiritual heroes, is important. Power or authority sources also play an important role in guiding their belief system. It remains important to retain agreement with authoritative religious sources. The transition out of stage 3 is often marked by clashes between authority and/or authoritative sources.

Stage 4 is called Individuative-Reflective faith (Fowler, 1981). This stage appears regression-like in many ways. It can be described as a spiritual desert, full of questioning of previous religious assumptions. Another way of conceptualizing this stage is as a transitory stage in which individuals deconstruct and reconsider previously held beliefs. For people who move beyond this stage, their beliefs become their own instead of merely being internalized from external authoritative sources. However, if people remain in this stage too long, it is easy to become cynical about faith or lose faith all together. Additionally, many may regress to the a more simple and secure faith, or stage 3 faith, to avoid the insecurity of stage 4. These individuals often take a more rigid approach to stage 3 in order to protect themselves against the anxiety experienced during their journey into stage 4 beliefs.

Fowler's (1981) stages 5 and 6 represent a more differentiated, personal faith. These stages also reflect a growing openness and respect for differences. The ambiguities that were threatening in previous stages are no longer as scary. These individuals are increasingly able to consider and explore different belief systems without them threatening their own. Additionally, faith may not be as rooted in absolute knowledge, as there is a greater respect for paradox and the unknowns of life.

### *Gay and Lesbian Identity Development*

Reynolds and Hanjordiris (2000) compared various approaches to LGB identity development and elucidated several important themes. As with any developmental process, any linear step-wise description necessitates some oversimplification. There is no exception in LGB identity models; however, several factors add to the complexities. In particular, the personal and social lines complicate the developmental process. In comparison to racial identity development, LGB identity is disclosed at the individual's discretion. Because of this, personal acceptance and social acceptance have more variation in the degree of separation. For example, a person may disclose her or his sexual orientation early after personal acceptance, or he or she may wait many years before telling anyone. The point of disclosure, especially in its more public forms, begins a second developmental process in dealing with how people react to their being a LGB.

Significant differences exist between the stages of LGB identity development based largely upon the unique experience of each of these groups (Reynolds & Hanjordiris, 2000). However, several similar themes can also be addressed. Many of these models center on personal identity development. However, this process is complicated by various social elements. As LGB individuals disclose their sexual orientation, they generally have to deal with some tensions and renegotiations of relationships. Typically, most individuals experience loss of relationships and stigmatization through this process. This may cause some to become less open in disclosing, to question their sexual orientation, or to try to change it. Religious beliefs and the beliefs of their religious community may also complicate the process of identity development.

*Identity formation* is the process by which a person acquires the identity of a being homosexual as a relevant aspect of self. *Identity foreclosure* can occur during any time during the developmental process (Cass, 1979). The process of identity formation builds a connection between behavior and the establishment of personal meaning. This interaction contributes to homosexual identity formation and the recognition of the significance of psychology and social factors. When the environment is interpreted as congruent or incongruent, change and stability in

human behavior occurs within an individual. Growth results when a person attempts to resolve the inconsistency between perception of self and others.

The individual experiences doubt and attends to any input on homosexuality and assigns personal meaning to that input. He or she becomes aware that homosexuality has relevance to him or her and their behavior. The individual becomes incongruent within the self as well as the perception of others. The more the individual is able to define his or her behavior as homosexual the more incongruence is elevated.

Males and females have different approaches to coping with the developmental process because of the difference in sex role socialization. Men and women have different past and present social attitudes and experiences as the impact of age have significant influence on his or her mode of coping with homosexual identity formation (Cass, 1979).

Cass (1979) proposed a six stage model of homosexual identity formation. She anticipated that people gradually establish their sexual identity as a homosexual as they do or do not progress through the six stages. During the first stage, the individual adopts one of three strategies (Cass, 1979). The first is to search for more information through reading, therapy, and seeking as much information as possible regarding homosexuality. Often the individual has increased distress during this strategy. Second, the individual inhibits all behaviors related to same-sex orientation, restricts any information on homosexuality, and denies that the information has any relevance. Often he or she will adopt strong anti-homosexual stance and will increase his or her involvement with the opposite sex. This strategy has the risk of beginning of what may become a negative or self-hating identity. This can also become a period of moratorium. Third, this strategy can refine the meaning of his or her behavior and sexual identity foreclosure may occur. He or she uses his or her bias to define homosexuality according to narrow stereotypes that exclude the person from LGB identity.

If the individual does not foreclose during the sexual identity development, he or she will continue to move into Stage 2. This stage involves accepting the possibility of being homosexual. The primary task of this stage is to cope with the social

alienation that is created by the development of the sense of not belonging. The beginning of acceptance of being homosexual, even though intense anguish of being different and feeling alienated from his or her family, friends, and/or religion, is extreme. Some do not experience the intense anguish because his or her social environment is open, accepting, and affirming of all types of diversity.

The coping strategy of passing develops during this stage (Cass, 1979). *Passing* allows time for the individual to absorb and manage the developing homosexual identity. Threatening situations, controlling personal information, deliberately cultivating a heterosexual image, and adapting a stance that conveys detachment from homosexual situations are ways that passing is developed. Passing has the potential to contribute to identity formation.

Stage 3 is the stage of identity tolerance (Cass, 1979). During this stage, if identity foreclosure has not occurred, he or she will have increased feelings of not belonging as the individual begins to the possibility that they are *probably homosexual*. Two primary groups exist. The first one emerges when an individual sees both her or his behavior and self as desirable. The second is when the individual perceives his or her behavior as desirable but the self as undesirable. How this stage is resolved will depend on the positive or negative social experiences. Unrewarding contacts result in greater self-hatred with marked negative identity. When contact with the LGB individuals and the inhibition of homosexual behavior occurs, foreclosure often results.

As an individual increases contact within the homosexual community, their experience is validated and the "self" is normalized, LGB identity becomes more acceptable (Cass, 1979). Inner tension is felt, but it is greatly reduced. During this stage the individual may choose to disclose his or her homosexuality to significant others. The individual begins to feel as if he or she *fits in* both the homosexual and heterosexual institutions. As the individual moves through stage 3, he or she will often dichotomize the world into homosexual and heterosexual. He or she will find the gay subculture more satisfying and finds more support and a stronger sense of "belonging" in the homosexual subculture.

The final and fifth stage is that of identity syntheses. During this stage, there is greater congruency, along with the ability to establish support in both the homosexual and heterosexual environments. He or she will find similarities between himself or herself and heterosexuals as well as other homosexuals. The key aspect of this stage is that his or her sexual identity becomes merely one aspect of the self and not the defining aspect of the *self*.

Same sex orientations that develop at an early age are more stable and less likely to be relinquished (Diamond, 2003). Individuals with early onset of same sex attractions or behavior recall atypical gender ideation or behavior and are triggered more by ideological factors, social reference groups, and social political messages.

There appears to be a great deal of interest in the fluidity of sexual identity often described as *the sexual continuum*. It is important to distinguish between sexual orientation and sexual identity. There are many young people who may develop a same sex orientation during high school and college, but then return to the more stable sexual identity of a heterosexual. However, those young people who not only label their behavior as gay or lesbian, but who also develop a homosexual identity, will move through the developmental process either foreclosing during the process or accepting their homosexual identity (Diamond, 2003). It is important to understand that when an individual moves into the fifth stage of development, he or she will synthesize their sexual identity. At the point of synthesizing a LGB sexual identity, it becomes one of the organizing constructs upon which a person has built his or her self concept.

### *Integrating Developmental Perspectives*

The interaction between faith development and LGB identity development may help explain LGB religious experience. As with many developmental models, conflict along with resolution is at the heart of the transition from one stage to the next. In Fowler's (1981) faith development, the transition from stage 3 to stage 4 is often instigated by conflict between authoritative sources. For LGB individuals, this may be a conflict between growing acceptance of their own sexual identity and religious beliefs. Attempts to resolve this conflict often leads initial attempts to deconstruct religious beliefs deemed unquestionable in stage 3.

In stage 4, which we described as a spiritual desert, successful resolution requires working through the conflicts between authority sources. This typically involves changes in the way people believe as well as what they believe. For example, an individual in stage 3 has difficulty accepting paradoxes of faith while these are embraced in stage 5. Stated differently, stage 5 is more accepting of limitations of knowledge and understanding along with being more open to differences and diversity.

Individuals who stay in the spiritual desert for too long may be in danger of becoming cynical or losing faith. This is a common experience of many LGB individuals. In part, this may be due to being pushed into stage 4 before they are spiritually ready. Therapists and spiritual guides who are aware of this potential conflict may be an important resource to help clients navigate a premature stage 4. For others who are prepared for stage 4, particularly if they have a healthy LGB identity, their sexual identity may accelerate spiritual growth. Regardless, if therapists and other resources are able to help LGB individuals navigate the challenges of faith development, it may facilitate developing a spirituality that is able to support them through the stigmatization, prejudice, and homophobia they experience in the rest of their lives.

Religion may also affect an individual's LGB identity development. For an individual solidly in stage 3 who believes that homosexuality is a sin, this may delay their development with their LGB identity. Additionally, this may cause them to keep their sexual identity secret, further isolating them from potentially helpful resources. Religion, for many LGB individuals, may result in foreclosure or delay and complicate their sexual identity, leading to isolation, loneliness, and depression. Additionally, it is likely that individuals in stage 3 who strongly react against their developing sexual identity are the ones most likely to seek out reparative therapy. Therapists working with these clients should be aware of the developmental issues that may influence clients' decisions to seek reparative therapy. If clients are able to explore the integration of their religious and spiritual identities, this may change their developmental trajectories. It is possible that as individuals continue along these developmental lines, the urgency to seek reparative therapy may subside.

## Implication for Therapy and Research

### *Therapy Implications*

Although there is movement toward gay affirmative therapy, LGB clients continue to be a hidden minority that is ignored, discriminated against, and oppressed with the field of mental health (Fassinger, 1991). Therapists who are to work with LGB individuals need to understand externalized-internalized homophobia and heterosexism among individuals and the role that religion often plays in this process. We recommend that doctoral programs in psychology continue development and implementation of curriculum for gay affirmative therapy, including approaches that deal with religious and spiritual issues (Kilgore, Baca, Sideman, & Bohanske, 2005).

Even when clients do not view homosexuality as pathological, mental health professionals need to consider the distress that anti-homosexual bias can cause LGB individuals. Therapists are often inadequately informed or trained to handle the issues unique to LGB individuals. It is important to consider the issues that religious LGB individuals may bring to therapy. Religious LGB individuals seek conversion therapy at higher rates than do nonreligious individuals. The psychological impact that anti-LGB religious doctrine can have on LGB persons can be particularly devastating and offers a discussion of the ethical concerns that therapists ought to consider when working with LGB clients.

Division 44 of American Psychological Association (APA) adopted Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients in 2000 that containing 16 guidelines (APA, 2000). Guideline 3 and guideline 4 are especially relevant for this paper. Guideline 3 states that psychologists should strive to understand the ways in which social stigmatization (i.e., prejudice, discrimination, and violence) poses risks to the mental health and well-being of LGB clients. Guideline 4 states that psychologists should strive to understand how inaccurate or prejudicial views of homosexuality or bisexuality may affect the client's presentation in treatment and the therapeutic process.

Careful attention to the many ways that religious strain may be explored and eventually resolved may help psychologists provide services that are more relevant to individuals experiencing sexual identity and religious identity conflict. Because

traditional training programs do not address therapeutic approaches to working with LGB individuals and often do not address religious and spiritual issues in therapy. Even fewer programs address the religious and spiritual needs of LGB clients who may be experiencing religious and sexual identity development conflict. We suggest that this should be an essential part of all clinical training programs.

We believe the content of this paper provides some important initial formulations on the unique religious experience of LGB individuals. While it is an initial formulation, we suggest that it is an important contribution to the literature. Awareness of these issues, and the potential identity conflicts discussed, may assist therapists in providing more sensitive therapy around religious and spiritual issues with LGB clients.

### *Research Implications*

The research on religiosity, religious experience, and sexual identity, particularly as it pertains to psychological health, is sparse. While theoretical applications based upon solid clinical experience is an important beginning, it is imperative to have a research perspective as part of the dialogue. Research will help to refine and develop the theoretical perspectives initiated in this paper.

*Research Challenges.* Any research on such a hotly debated and controversial issue is bound to have challenges. Even the most solid research is sure to receive severe attacks from those who disagree with the findings. Additionally, it becomes difficult to separate agendas and ideology from research results. Few potential research topics are more controversial than homosexuality and religion in contemporary the United States culture.

Social and ideological pressures are likely to bias both research participants who become aware of the themes of the research as well as the researcher himself or herself. Additionally, a number of construct challenges exist in religious research, especially regarding religious experience. Regarding sexual identity, there is a lack of some necessary measures to begin examining the unique religious experience of LGB individuals. Despite this, we believe clear research agendas are needed.

*The GLBT Religious Research Group.*<sup>4</sup> The GLBT Religious Research group was formed to begin researching the religious experience of gay, lesbian, bisexual, and transgendered individuals. This section will provide an overview of current research projects. Currently, two projects are in development. It is our hope that the current research agenda will inspire additional research from other research groups and individuals.

An initial research project is aimed at designing an instrument that can be used to examine the impact of common religious statements about homosexuality and homosexual individuals. Three categories of items were developed. The first group of items reflects a positive view of homosexuality (e.g., "God loves homosexuals just as much as heterosexuals."). A second category describes negative conceptions of homosexuality (e.g., "God wants homosexuals to be straight."). A final category involves ambiguous statements that are likely to be viewed as understanding and compassionate by some individuals and negative or harmful by others (e.g., "Love the sinner, hate the sin."). In the next stage of development, we will conduct several focus groups to refine the items before implementing the pilot study that will determine which items to include in the final scale.

A second research project will utilize this scale, along with measures of the God image, to investigate the impact of these statements on religious experience and psychological health. A primary goal of this research project is to better understand the affect of religion, both positively and negatively, on the psychological health of GLBT individuals. As additional knowledge about the unique religious experience of GLBT individuals is gained, this can be used to develop better treatment approaches along with educating therapists, counselors, and religious leaders.

### Conclusion

We have provided some initial theory development pertaining to the unique religious experience of LGB individuals, as well as addressing the need for education, training, and future research. Therapists working with LGB clients who are not aware of normal developmental processes of faith and sexual identity development may be inclined to prematurely facilitate clients considering potentially dangerous therapy

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<sup>4</sup> More information available at [www.glbtreligiousresearch.com](http://www.glbtreligiousresearch.com).

options, such as reparative therapy. Additionally, through misunderstanding the client's needs, the therapist may inadvertently create instances of empathetic failures. It is imperative that therapists receive appropriate training to assist clients in developing religious and sexual identity integration and health.

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