INTENTIONAL HEARTS

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ADVANCED INFORMED CONSENT

THIS IS A CONSENT FORM FOR PARTICIPATION IN THE SEXUAL IDENTITY APPROACH. PLEASE READ AND SIGN THIS FORM, WHICH IS AVAILABLE TO YOU SINCE YOU ARE REQUESTING PROFESSIONAL SERVICES WITH RESPECT TO SAME-SEX ATTRACTION AND/OR BEHAVIOR.

Please note at the outset that homosexuality is no longer viewed by the major mental health organizations, such as the American Psychological Association or American Psychiatric Association, as a mental illness, disease, or pathology. The services you are requesting are being considered because you are requesting assistance in sorting out questions or concerns you have about your sexual identity.

Informed consent is an important part of our work together. In part growing out of a consumer-model of service delivery, informed consent has emerged as a critical part of establishing our goals together.

Advanced Informed Consent:

1. Hypotheses as to what is causing your problems (including causes of same-sex attraction);
2. Professional services available, including success rates and definitions and methodologies used to report "success";
3. Alternatives to professional services, including reported success rates and the relative lack of empirical support for claims of success;
4. Possible benefits and risks of pursuing services at this time;
5. Possible outcomes with or without services (and alternative explanations for possible outcomes).

Cause of Difficulties
It is important to begin with a discussion of the current view of homosexuality by mental health organizations. Homosexuality had at one time been viewed as a mental illness by mental health organizations, but it has since been removed from the official resource of the American Psychiatric Association. You should not have to find out from another source that mental health organizations do not view homosexuality as a disease or pathology.

It is usually in this early discussion that some mention of psychology's lack of knowledge is important. The mental health community is divided on what sexual orientation actually *is*. Some view sexual orientation as a social construct, similar to what it means to be a Democrat or Republican. Others view sexual orientation as a stable and universal reality, one that can be found across cultures and throughout history. Although a clinician may have his or her own opinion on this matter, it is most accurate to say that good people disagree on this point.

Another important topic has to do with what causes experiences of same-sex attraction. Obviously, since scientists are in disagreement about what sexual orientation is, there are bound to be disagreements about what causes some people to have same-sex verses opposite-sex attractions (or both, in the case of those who identify as bisexual). Some of the earliest psychological theories for homosexuality were based in psychoanalytic theory, specifically an understanding of how parent-child relationships can shape gender identity (Bieber et al., 1962; Nicolosi, 1991; van den Aardweg, 1986). You may have heard of these theories, and you may be interested to hear more recent discussion from Moberly (1983) and others about how homosexuality may signal a relational deficit due to failure to attach to the parent of the same sex. In this theory, failure to meet normal developmental needs with the parent of the same sex can lead to a "defensive detachment" and "ambivalence" about relationships (Moberly, 1983, p. 6).

Whenever possible, it helps to discuss the research that supports (or fails to support) a given theory. In the case of implicating parent-child relationships, it is accurate to point out that some research does appear to support this theory, although other studies paint a different parent-child dynamic, and still other studies appear to contradict the theory (e.g., Bieber et al., 1962; cf., Bell & Weinberg, 1978; Saghir & Robins, 1973).

Other theories for the origins of same-sex attraction are not tied to a psychological theory of development *per se*, but seem intuitively appealing and clinically relevant. For example, some argue that early sexual debut and childhood sexual trauma can lead to a homosexual adjustment. Research cited to support these theories include studies reporting higher incidence rates of childhood sexual abuse among homosexuals as compared to their heterosexual peers (Doll, et al., 1992; Laumann, Gagnon, Michael, & Michaels, 1994; Peters & Cantrell, 1991).

You should also be aware that there has been a recent effort to study to what extent biological factors contribute to experiences of same-sex attraction or later homosexual orientation. The most prominent of these studies include indirect research on genetic and prenatal hormonal factors, such as the comparisons of neuronanatomical structures in the brains of homosexual and heterosexual males (e.g., LeVay, 1991) and the impact of abnormal hormonal levels on animal fetuses (e.g., Ellis & Ames, 1987). More recently, researchers have attempted direct research on genetic factors by attempting to isolate regions of specific chromosomes that may be involved in homosexuality for a subpopulation of males (e.g., Hamer, Hu, Magnuson, Hu, & Pattatucci, 1993; Hu, et al., 1995). The research in this area has been criticized, though perhaps not as widely as theories implicating parent-child relationships. The most accurate presentation would most likely acknowledge that the studies completed to date do not support any one theory for the origins

of same-sex attraction and homosexual orientation, and that most experts in the field readily acknowledge that there is probably no one "cause" of homosexuality; rather many factors may converge to provide a "push" in the direction of homosexuality (Jones & Yarhouse, 2000).

The discussion thus far has been more of a review of the existing research in the area of homosexuality. The next important topic is to sort out what it is about experiences of same-sex attraction that is difficult for you. Put differently, why are you seeking services? What is it about your experiences that bring you to seek help?

Possible motivations for seeking services include:

- Personal beliefs or values about homosexuality
- Fear of HIV/AIDS or other STDs
- Teaching of a religion regarding the morality of same-sex behavior
- Desire to be married or to have children
- Friends or family members have told you to get help or gave you an ultimatum
- Feeling unhappy or experiencing lack of social support
- Confusion regarding your sexual identity or sorting out whether to identify as "gay" in a mostly heterosexual society
- Concerns about discrimination

Professional Services Available
After discussing the various motivations for you seeking services, it is usually helpful to inform you of the kinds of services that are available.

Concerning change of orientation, most approaches are related to depth psychology and include individual psychoanalytic therapy (Bieber et al., 1962), reparative therapy based on dynamic theory (Nicolosi, 1991; 1993), and group therapy approaches based on psychoanalytic (Hadden, 1958) and dynamic (Nicolosi, 1991) theories. Other approaches to change of sexual orientation have included behavioral sex therapy (Masters & Johnson, 1979), aversion therapy (McConaghy, 1993), and group interventions from a social learning prospective (Birk, 1974; 1980) and other perspectives (Beukenkamp, 1960; Mintz, 1966). The average success rates across individual and group approaches tends to range between 30-40%, but the studies themselves were often poorly designed from a methodological standpoint. This is an important part of informed consent. The success rates are not as meaningful as they would be had there been control groups and consensus as to what constituted success. However, the studies are important as they suggest that people may in fact benefit from services for same-sex thoughts, behavior, and (in some self-reports and professional reports) sexual orientation. The fact that these studies failed to utilize more stringent methodologies does not disprove success. But it is important to realize that there are no well-designed outcome studies that address sexual identity concerns – whether reorientation, gay affirmative, or sexual identity approaches, including this one.

More recent survey research seems to confirm the potential benefit of professional and paraprofessional or religion-based ministries. For example, two large-scale surveys (MacIntosh, 1994; Nicolosi, Byrd, & Potts, 2000) have been published recently that challenge the claim that people cannot change their sexual orientation. Although neither study was trying to say anything about the "typical" gay or lesbian person, the results were that clinicians reported working with clients who changed and clients reported experiencing change.

While a variety of interventions exist, the definitions of success have varied significantly across studies. It was mentioned earlier that success has been defined to include increased heterosexual behavior, decreased homosexual behavior, marriage, and so on. The more well-designed studies of typically behavioral interventions have demonstrated the effectiveness of these approaches in helping people to manage or change thoughts and behaviors (e.g., McConaghy, 1969; 1970; 1976).

Alternatives to Professional Treatment
Perhaps the removal of homosexuality as a psychopathology from the DSM has led to a rise in the number of paraprofessional, religion-based ministries for homosexuality (Yarhouse, Burkett, & Kreeft, 2002). Many of these ministry groups publicly hold out the hope of change of sexual orientation, while some are more concerned with sexual brokenness in homosexual and heterosexual persons; still other groups work explicitly with people to attain and maintain chastity in relationships.

Although fewer studies have been conducted on religious ministries, research by Schaeffer and his colleagues (1999; 2000) has made it clear that many people report success in their attempts to change orientation and behavior. Recent research on persons in Christian ministry programs found that some persons reported more heterosexuality than they reported experiencing in adolescence, and that religious motivation was an important element in efforts to change. These results have also been supported by a longitudinal study by Jones and Yarhouse (2007) on the attempt to change through involvement in religious ministries over approximately 4 years.

The largest umbrella organization of change ministries used to be Exodus-International, which had over 100 ministries in the U.S. and throughout the world until its recent closure. Homosexuals Anonymous (HA) is another large organization with approximately 50 chapters in the U.S. Each particular group will send a different message about what can be expected through efforts of change. Some promote change of sexual orientation, while others emphasize changed behavior and self-identification. Other religion-based support groups, such as Courage, emphasize chastity and behavior change (Harvey, 1987).

Benefits and Risks of Services
Another important part of informed consent is to inform you of the potential benefits and risks of services. The risks of intervening to expand alternatives include the financial and emotional investment. Professional services cost a lot out of pocket, and third-party payers generally will not reimburse for these services. The financial investment can pale by comparison to the emotional investment, especially depending upon your expectations. If your goal is a complete shift in sexual orientation from predominantly homosexual to predominantly heterosexual, you may make a different emotional investment than those who work toward chaste relationships with members of the same sex. If you view failure to change orientation as a personal moral failure or as signaling a lack of faith, you may have a qualitatively different experience than someone who is informed of the potential limitation of existing intervention strategies and is open to exploring how religious beliefs and values might be integrated with a commitment to chastity but not same-sex identity. In any case, the risk of failure and what that means to you is an important part of informed consent.

Although it is unclear if attempts to intervene around same-sex identity and behavior contribute to experiences of depression, anxiety, or decreased self-esteem, there is some research that supports this view (e.g., Shidlo & Schroeder, 1999), though these are not representative samples and cannot be generalized to all persons seeking change. On the other hand, it would not be surprising to find that the emotional investment one might expect from interventions in this area would increase the risk of negative emotional experiences at some points throughout seeking assistance.

The potential benefits to seeking services include reduced frequency and intensity of same-sex thoughts, reduced frequency of same-sex behavior, celibacy and chastity in relationships, increased social support, and so on. Self-reported change of sexual orientation is also possible, though that is not the focus or emphasis of the *Sexual Identity* approach.

Possible Outcomes With or Without Services
Possible outcomes from seeking services were mentioned above. Some clients may experience changes in thoughts and behaviors, and some may experience self-reported change of orientation. Based on the motivations and definitions of success, some clients may not experience a sufficient degree of change to justify ongoing services.

Outcomes without services are difficult to predict. Some clients may choose to live a chaste and celibate life, although they may have been thinking of changing their sexual orientation. Other clients may limit same-sex relationships and enter an exclusive, monogamous relationship having struggled with compulsive sexual behavior. Research on lifetime partners of homosexual and heterosexual persons suggests, however, a different experience (e.g., Laumann et al., 1994, published findings that homosexual males on average reported 42.8 lifetime sexual partners as compared to 16.5 lifetime sexual partners among heterosexual males, 9.4 lifetime sexual partners among lesbians, and 4.6 lifetime sexual partners among heterosexual females).

You may benefit from knowing that people disagree about the meaning of this research. Some argue that gay males, for example, do not as often make promises to be physically monogamous; others argue that lack of recognition of same-sex unions makes stability in relationships more difficult. These may be difficult findings to discuss, and the lack of consensus as to the meaning of the research may be particularly frustrating, but this is part of what makes advanced informed consent more detailed than informed consent to a variety of other presenting concerns.

During informed consent you may choose to change your coaching goals. This can be a slight change, if you originally wanted to change orientation, but are now more interested in focusing on chastity and fidelity in existing relationships. You may want to identify the patterns of disconnection that make you susceptible to acting out sexual behavior or fantasy. You may make a radical change in your goals. Rather than work toward change of orientation, you may choose instead to work toward integrating your experiences of same-sex attraction into a gay, lesbian, or bisexual identity. To make this decision, you will want to be aware of the experiences of those who go on to identify with their experiences of same-sex attraction. It is important to stress that there is no one “gay experience” that a clinician can point to as typical of a person who makes such integration. Research does suggest higher rates of depressive symptoms, alcohol and drug use, suicidal ideation, and common sexual practices that increase the risk of physical harm and disease, and there may be benefit of participating in professional help of some kind, even if the preference is not for this approach. Also, there are competing theories as to why gay and lesbian persons may report the higher elevations noted above. Some experts in the field argue that integrating one’s impulses into a gay, lesbian, or bisexual identity and publicly identifying as such (“coming out”) actually lowers one’s scores on measure of anxiety and depression as compared to those who remain confused or distressed by their experiences of same-sex attraction (e.g., Schmitt, Patrick, & Kurdek, 1987). Being “out” may not guarantee lower levels of anxiety or depression, however, especially if a person experiences discrimination or prejudice (McKirman & Peterson, 1988; Mosbacher, 1993).

Coaching for Sexual Integrity Approach: The specific approach provided here is a *Sexual Identity* approach to coaching. The goal of this approach is to assist clients so that they can experience greater congruence, which we see as being able to live and identify themselves in ways that are consistent with their beliefs and values. This approach is not designed to integrate same-sex attractions into a gay identity as such, though this is a decision you may make over time. Nor is this approach designed to change sexual orientation as such, though you may make decisions that contribute to decreased behavior and attraction that may signal a change in your sense of your sexual orientation. The goals of this approach include but are not limited to: (1) recognizing the distinction among experiences of attraction, a homosexual orientation, and a gay identity, so that you are able to use more descriptive language; (2) increase your knowledge of the possible variety of influences on your current experiences of attraction and behavior; (3) make choices about attraction and behavior in keeping with your beliefs and values; and (4) recognize and give weight to the different aspect of your sexual identity in a manner that facilitates congruence.

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What is most important during informed consent is to help you make a truly informed decision about the kinds of goals you might have and the kinds of services that are available. If in this approach you are not making much headway, it is important (just as in other types of programs) to revisit goals and the program itself as to whether it is the best fit for your present needs.

Consent to Sexual Identity Approach: I have read this document, have had an opportunity to discuss its content with Michael Todd Wilson, agree to its terms, and have received a copy. This authorization constitutes informed consent for the *Sexual Identity* approach. A photocopy or facsimile of this form and signature(s) shall be considered as valid as the original.

Client Signature **Date**

Printed Name of Above Individual