

Views expressed by workshop presenters in the two below workshops are entirely their own and do not necessarily reflect those of NACSW. Being selected to present a workshop at this convention in no way implies NACSW's endorsement or certification of a presenters' qualifications, ability, or proficiency to practice social work.

This document is comprised of material from two separate convention workshops reflecting alternative perspectives on the topic working with LGBT clients.

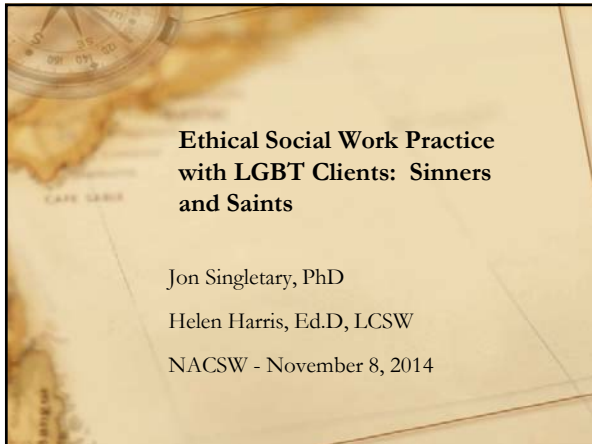
Workshop #1:



ETHICAL SOCIAL WORK PRACTICE WITH LGBT CLIENTS

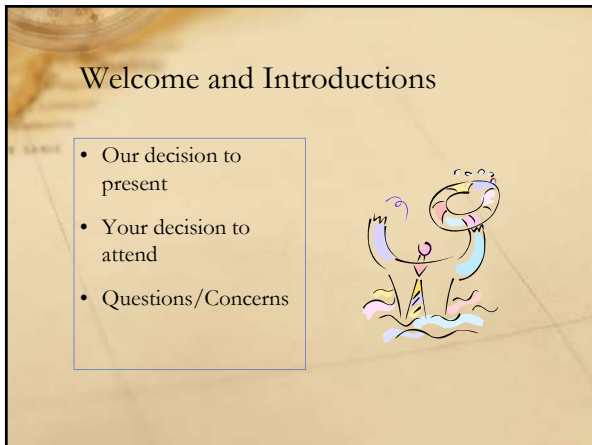
By: Helen Harris & Jon Singletary

**Presented at:
NACSW Convention 2014
November, 2014
Annapolis, Maryland**



**Ethical Social Work Practice
with LGBT Clients: Sinners
and Saints**

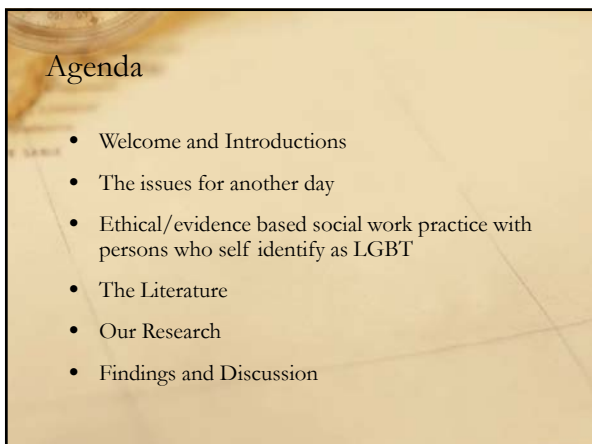
Jon Singletary, PhD
Helen Harris, Ed.D, LCSW
NACSW - November 8, 2014



Welcome and Introductions

- Our decision to present
- Your decision to attend
- Questions/Concerns





Agenda

- Welcome and Introductions
- The issues for another day
- Ethical/evidence based social work practice with persons who self identify as LGBT
- The Literature
- Our Research
- Findings and Discussion

What this is... and what this is not...

- **This is a workshop on professional social work values, practice, and research**
 - Evidence-Based
 - Culturally Responsive
 - DSM 5
 - Social Justice
- **This is a workshop that seeks to be Christ-centered, but is not primarily a theological discussion**
 - Integrating faith and practice
 - Clients' faith
 - Social workers' faith
 - Organizational context

Group Rules/Agreements

- Treat everyone with respect.
- Raise Hands: No speaking over anyone.
- Use "I" messages for your thoughts/feelings.
- Use "Noted" to acknowledge someone else's thoughts/feelings.
- Incivility will end the session.
- Prayer will keep it going!

The Ethical Integration of Social Work Practice

- The Client
- The Social Worker
- The Organizational Context
 - The Church as Context

Code of Ethics

- Client's Interests First (1.01)
- Self Determination (1.02)
- Competence (1.04)
- Equal Access (1.05)
- Evaluation and Research (5.02)

• (Dressel & Bolen, 2014;
<http://www.socialworkers.org/pubs/code/code.asp>).

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.) <http://www.socialworkers.org/pubs/code/code.asp>

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

- <http://www.socialworkers.org/pubs/code/code.asp>

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

<http://www.socialworkers.org/pubs/code/code.asp>

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

<http://www.socialworkers.org/pubs/code/code.asp>

5.02 Evaluation and Research

- (c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

<http://www.socialworkers.org/pubs/code/code.asp>

Self Determination

- Definition:
- Social Work Value:
- Biblical Value:
- Challenges:
 - When clients feel pressure to change
 - When clients do not have access to change therapy because of bans

Saints and Sinners, One and All

- Out of the closet...
 - It's true. I am a judger
- Throwing stones

Definition: Affirmative Practice

- Affirmative Practice is the conscious effort of the social worker to create an environment that fosters comfort, safety, and openness for the client to share and seek help.

– (Dressel & Bolen, 2014)

Some of the special issues:

- Similar rates of depression, anxiety, suicidal ideation, physical abuse, rape sexual attack, domestic violence and childhood incest
- Stigma; Lack of social support
- Lack of medical coverage; spousal benefits
- Internalized homophobia
- Major developmental theories assume heterosexual development (Falco, 1991)

Special Issues:

- Lesbian mothers; custody
- Lesbians of color; multiple layers of cultural heritage, identification, acceptance
- Sexuality and sexual dysfunction; therapist competence
- Alcohol and drug use; higher than general pop
- Youth and Aging: life stage issues (Falco, 1991)

Special Issues: End-of-Life and Bereavement

- End-of-life: (Cartwright, Hughes, Lienart, 2012)
 - Historical disadvantage of lack of support
 - Advanced care planning and medical decisions
 - Health risk factors
 - Lesbians: breast and endometrial cancers
 - Gay men: Hodgkins disease and cancer
 - Transgender: diabetes, heart disease, liver disease
- Bereavement: (Fenge, 2013)
 - Risk for isolation and disenfranchised grief
 - Lack of cultural competence of helpers

Social Work Practice Process

- Engagement: Client presenting problem
- Assessment
- Planning/Contract for Work
- Work/Intervention
- Evaluation of Practice/Work/EOP/Work...
- Termination
- Follow-Up

Engagement

- Starts with self awareness and identifying our own stereotypical thinking and prejudices.
- Affirmative Practice Reminder
 - Affirmative Practice is the conscious effort of the social worker to create an environment that fosters comfort, safety, and openness for the client to share and seek help.
 - (Dressel & Bolen, 2014)

Assessment: The presenting problem...

- Care/Case Management
 - Resource Development
 - Care Planning
 - End of Life
 - Loss and Grief
- Therapy
 - Anxiety
 - Depression
 - Substance Use
 - Trauma
 - Complicated Mourning Falco, 1991

When the client has physical illness:

- Most Common Physical Health reasons for social work
 - Impact/Adjustment to diagnosis/prognosis
 - Health Care Coverage
 - Skilled
 - Unskilled
 - Health Care Planning
 - Immediate/Continuum
 - Caregiving
 - Immediate/Continuum

Care and Case Management: Best Practice

- Task Centered Model

- Problem Solving Model

When the client has mental illness:
Therapy

- Anxiety and Depression
 - CBT, REBT, TFCBT
 - Behavioral Therapy/the Exposure Therapies
 - EMDR
 - Role of Medication
- Substance Use
 - Motivational interviewing
 - AA/group model
 - ACT
 - EMDR

Therapy Continued

- Trauma
 - EMDR
 - For Family Relationships: SFT
 - Trauma Focused CBT
- Complicated Mourning
 - Guided Mourning
 - Re-grief

The question you haven't asked yet

- What about sexual orientation as the presenting problem?
 - Conversion/Reparative Therapies
 - Scripturally Based Cognitive Behavioral Therapy
 - Celibacy
 - Renouncing the church and sometimes the faith
 - Living in the faith / finding a church

Social Work and Macro Practice

- What does it mean when the system needs to change?
 - Advocacy
 - Education
 - Modeling
 - Referral for Resources

Some resources we found helpful:

- Rob and Linda Robertson
- http://www.huffingtonpost.com/linda-robertson/just-because-he-breathes-learning-to-truly-love-our-gay-son_b_3478971.html
- http://www.huffingtonpost.com/linda-robertson/a-letter-to-the-just-because-he-breathes-haters_b_5971808.html?utm_hp_ref=religion&ir=Religion
- <http://justbecausehebreathes.com/>
- Pastor Danny Cortez
 - <http://www.youtube.com/watch?v=WqYvkVqVLFo>

Evaluation of Practice and Research

- Contract for work with clear measurable goals and objectives
- Baseline data measuring the scope of the problem
- Regular measures evaluating progress
- Change in treatment when indicated
- Post treatment measurement with results

What about Conversion therapy?

- <https://www.youtube.com/watch?v=rWYAwknMlH4&feature=youtu.be> (confronting and withdrawing fellowship from your Christian adult child who comes out)
- <http://www.nclrights.org/bornperfect/> (born perfect group committed to the end of conversion therapy)
- “To date there is no conclusive evidence that reparative therapy is beneficial to patients” (Hein & Mathews, 2010, p. 31 in Dessel & Bolen, 2014, p. 242).
- NASW policy statement: *“No data demonstrate that reparative or conversion therapies are effective, and in fact they may be harmful (Davison, 1991; Haldeman, 1994).”*

Our Research

- Qualitative (phenomenological) Study
- Question: What is the Lived Experience of Persons Who Identity as Christian and Identify as LGBT? What is their experience with physical and mental health treatment?
- Six interviews to date: telephone and in person interviews; transcribed; confidentiality protected;
- Preliminary analysis with primary and secondary coding in ATLAS.ti

For more details on Preliminary Themes in our data, please contact the presenters. These findings are not included as they are being prepared for publication.

Summary: Physical Health Best Practices

- Advanced Case Management
 - Task Centered
 - Problem solving
- Resource Development
- Budget Planning
- Caregiving Planning
- Least Restrictive Setting

Summary: Mental Health Best Practices

- Identification of the Mental Health Diagnosis
- See previous slide for best practices for anxiety, depression, substance use, etc.
- Sexual orientation is not a mental health diagnosis
- Social work opportunity for identity congruence, affirmative practice, and macro interventions

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Workshop #2:



SEXUAL ORIENTATION CHANGE EFFORTS (SOCE)

By: James E. Phelan & Christopher Doyle

**Presented at:
NACSW Convention 2014
November, 2014
Annapolis, Maryland**

Proceedings of NACSW's 64th Annual Convention

Title of Presentation: Sexual orientation change efforts (SOCE):
Faith-based Challenges in the Midst of Cultural and Legal
Shifts – Harboring the Storm

Presenters: James E. Phelan, LCSW, Psy.D and Christopher Doyle MA, LCPC

Presentation Track(s): Direct Practice: Individuals, Couples, Families and
Children; Human Development, Diversity,
and Behavior in the Environment

Audience: Social Workers and related professionals; Leaders;
Policymakers and Administrators

Content Level: Intermediate

Abstract:

Sexual orientation change efforts (SOCE) are controversial, not often well operationalized, and affect faith-based social workers, related professionals, clients, and potential clients as new laws and climate changes limit practice, faith convictions, autonomy and self-determination. This workshop examines the controversies and clinical issues that surround SOCE and ethical integration of spirituality, faith, and practice. Christian social workers and other professionals need to learn about SOCE and how new cultural shifts and laws are emerging to limit this practice and how it may affect ethical issues and religious freedoms. This workshop contributes to the growth of attendees and related professionals in overall ethical integration of spirituality, faith, and practice during difficult and controversial challenges (“harboring the storm”).

Introduction:

Undoubtedly, there has been a gradual shift towards acceptance of homosexuality in many circles. After *homosexuality* was no longer viewed as a mental disorder, *per se* many clinicians halted the practice of SOCE, some

continued, while others diverted to the practice of gay affirmative models. Same-sex marriage is now legal in 29 states and the District of Columbia, the Defense of Marriage Act (DOMA) has been ruled as unconstitutional, and gays and lesbians now serve openly in the military. However, professionals should be aware of the history and the current practice of SOCE from faith-based and secular perspectives and how this affects practice and ethical considerations.

In addition, it is important to understand the current legal and cultural context involved. Currently, two states, California and New Jersey, have banned the practice of SOCE for clients under 18, while similar legislation in 14 others has been rejected in 2014 (Virginia, Maryland, Washington, Minnesota, Illinois, Hawaii, Rhode Island, Vermont, Ohio, Pennsylvania, New York, Massachusetts, Florida, and find last one). Despite these losses, anti-SOCE advocates will continue to introduce legislation in many states in 2015 and beyond, despite client, or parent autonomy and self-determination to seek treatment to overcome or express their same-sex attractions in ways that do not violate their Christian faith.

This workshop aims to help attendees learn about the ethical and spiritual implications around laws surrounding SOCE and how these may impact Christian social workers and related professionals. At times, there is incongruence between a Christian professional's civic allegiance to local laws and his or her spiritual allegiance to following biblical teachings and faith-based convictions. How these are untangled can be a challenge.

It is important to have discussions about what self-determination means to faith-based practice and how the issues of secular impeding factors affect practice,

faith convictions, and human rights.

Social workers are challenged to examine their own faith stance and practice implications. Illustrations of personal challenges are included using practical examples and legal examples of integrating faith and practice. Faith-based social workers should exercise ways to discuss scenarios such as: “how would you handle...”; “how does this affect your faith...”; “what are the legal and ethical issues to consider...”; and “what are the client’s self-determination factors identified...”.

Learning Objectives:

1. Articulate the history and current practices of SOCE from faith-based and secular perspectives.
2. Identify laws and proposed legislation that limit, set out to limit, or ban SOCE.
3. Describe the ethical and spiritual implications around laws surrounding SOCE and how these may impact Christian social workers, and other professionals.
4. What are the conflicting messages related the homosexuality and SOCE.
5. Describe what self-determination means to faith-based practice and how the issues of secular impeding factors affect practice, faith convictions, and human rights.
6. Process how to deal with incongruences (harboring the storm) between a Christian professional’s civic allegiance to local laws and his or her spiritual allegiance to following biblical teachings and faith-based convictions.

7. Through case illustration learn to discuss the varies aspects related to SOCE and how these may impact Christian social workers.

History and current practices of SOCE from faith-based and secular perspectives.

Incongruence between history and current practices of SOCE from faith-based and secular perspectives now exist. When *homosexuality* was no longer viewed as a mental disorder, *per se* many clinicians halted the practice of sexual orientation change efforts (SOCE), while others diverted to the practice of gay affirmative models. However, some still practiced SOCE with reporting successes (Phelan, 2014). Despite the decline of the practice and shifts in modalities a strong resistance to SOCE has emerged.

Currently, two states (CA and NJ) have banned the practice of SOCE for clients under 18, and while similar legislation in 14 states was rejected in 2014, anti-SOCE advocates will continue to introduce these bills in many states in 2015 and beyond, especially considering recent judicial rulings in the 3rd and 9th Federal circuit courts that have upheld such bans, and the Supreme Court's decline to hear *Pickup v. Brown*, which challenged the California SOCE ban law for minors (Staver, 2014). Additionally, protesters and academic papers accuse SOCE as not providing reliable evidence of effectiveness or safety (APA, 2009; Beckstead, 2003). *Welch et al. v. Brown* challenged California's 9th Circuit Court of Appeals arguing that the laws against SOCE restricted freedom of speech in the name of professional regulation.

Christian social workers must be aware of the legal storms they might

encounter in relationship to their faith convictions and social climates. For example in 2009, Eastern Michigan University (EMU) student Julea Ward was assigned a client seeking help with a homosexual relationship. Believing that taking on such a case would violate her Christian convictions, Ward asked the clinic to reassign the client to another counselor — a move she believed was keeping with the school’s counseling code of ethics. She explained that she was a Christian and that she could not endorse homosexual behavior. Following a formal review hearing, EMU sent Ward a letter dismissing her from the school’s graduate program.

Ward was forced to enter many legal battles as a result. After a long battle, the 6th Circuit Court found that: “A university cannot compel a student to alter or violate her belief systems... as the price for obtaining a degree.... Tolerance is a two-way street.” As a result the Julea Ward freedom of Conscience Act was enacted, which stated that:

A public degree or certificate granting college, university, junior college, or community college of this state shall not discipline or discriminate against a student in a counseling, social work, or psychology program because the student refuses to counsel or serve a client as to goals, outcomes, or behaviors that conflict with a sincerely held religious belief of the student, if the student refers the client to a counselor who will provide the counseling or services (HB-5040, Sec. 3).

Conflicting messages

Conflicting messages make it a challenge to harbor the storm. Several exist

as it relates to this topic:

In an appraisal of some SOCE studies an American Psychological Association (APA) task force concluded that, “[studies] provide no clear indication of the prevalence of harmful outcomes among people who have undergone [SOCE]” (APA, 2009, p. 42). However, they admitted the population who sought SOCE is largely unknown; they utilized inconsistent standards; and the evidence they chose to use was no better than the evidence they use to discredit SOCE (Jones, et al. 2010; Phelan et al., 2012). In all fairness, the APA task force report did state that, “...we cannot conclude how likely it is that harm will occur from SOCE” (APA, 2009, p. 42).

While the APA sees debates over legal, social and political issues derived from religious teachings as expressions of prejudice they view debates over conflicting research data as unbiased intellectual freedom (Byrd & Cummings, 2010; Cummings, O’Donohue & Cummings, 2008).

While a large voice in the popular media and in many other circles (e.g. APA) promote total acceptance of homosexuality (including transgender and bisexuality) and the banning of SOCE, this is not necessarily a universal notion. A global survey which assessed attitudes on homosexuality in 39 countries found widespread rejection of homosexuality particularly in Russia as well as in parts of Asia, Africa and predominantly Muslim nations. Given that American is generally diametrically opposed to many of the views of those countries, the same survey also found that one-third of Americans do not think homosexuality is acceptable (Reilly, 2013). The author concluded that, “Russia’s anti-gay laws [are] in line with public’s views on homosexuality” (p. 1).

A 2012 Pew Research Center survey found that roughly half of Americans (51%) said that a gay or lesbian person's sexual orientation could not be changed, while 36% said it could be changed. But in 2003, opinion on this question was divided, with 42% saying one's sexual orientation could be changed and an equal share (42%) saying it could not (Lipka, 2013).

Another conflicting message took place when Professor Robert Spitzer, MD from Columbia University, who in 2003 published a study claiming that "highly motivated" and highly religious gay and lesbian people could in deed change their sexual orientation then years later wrote a letter to Kenneth Zucker, editor of the *Archives of Sexual Behavior*, in which he expressed his regret for publishing the original study (Carey, 2012). The apology came after a gay man said he didn't like the findings. Spitzer was then criticized by former study participants and counselors who stated that they were surprised by the apology stating that such an apology could not erase the facts (Armelli, et al., 2012).

Recently, a study published in the *Journal of Counseling Psychology*, examined sexual orientation change efforts by over 1,600 current or former Mormons (Dehlin et al., 2014). Some beneficial results were noted, but the primary finding was that sexual orientation is highly resistant to change attempts, and the efforts were either ineffective or damaging. However, this is not the case in other reports that did not indicate harm and found success in various degrees (Phelan, 2014). Longitudinal study of attempted religiously mediated sexual orientation change efforts show that change is indeed possible for some and not harmful (Jones & Yarhouse, 2011). Further, in review of Dehlin et al. (2014), Rosik (2014) stated

that,

...the authors... have not chosen...a scientifically accurate and measured approach but rather offered what appear to be advocacy-emboldened recommendations that support the further professional marginalization and legal prohibition of professional SOCE. This only serves to fuel the polarization around SOCE that constitutes an ongoing disservice to individuals with unwanted same-sex attractions who seek professional psychological care (p. 1, last para.).

Problems exist as to how sexual orientation and change are actually operationalized. There are many domains to consider such as attractions (sexual, romantic), behavior, self-labeling, identity, beliefs, thoughts, identity, emotional attraction, fantasy, and relationships/lifestyle (Phelan, 2013).

Opponents of SOCE have the idea that conversion therapy is about reinforcing that the client believe and act a certain way (Beckstead, 2104). However, this is contrary to practical guidelines that proponents of SOCE have published for professionals who want to help people with unwanted same sex attractions. Here they state, "Professionals support the principle that individuals are capable of making their own choices in response to same-sex attractions and promote autonomy and self-determination..." (Rosik, et al., 2010, p. 19).

Discussion:

1. What are your thoughts about these conflicting messages?
2. What are some suggestions to add clarity to the conflict in messages?

Case Illustrations and Discussion Questions

Case 1:

In 2014, a Christian social worker in the state of New Jersey began meeting with a 15 year-old client who reported a history of sexual abuse from a male adult, beginning when he was seven years old to the age of ten. Two years after the abuse when the client entered puberty he began experiencing unwanted homosexual feelings, accompanied by Post Traumatic Stress Disorder (PTSD) and severe anxiety. In reviewing the relevant scientific literature, the social worker discovered some correlation between an increased rate of childhood sexual abuse among homosexual clients compared to heterosexuals (Tomeo, 2003). After discussing treatment options, the social worker decided to assist the young man in pursuing his self-described goal of healing from sexual abuse and reducing unwanted SSA. The social worker, who is trained in Eye Movement Desensitization Reprocessing (EMDR), begins treating the young man weekly for his sexual abuse while supporting his goal of not engaging in homosexual sexual activity. In one year's time, the young man made significant progress in treatment, and was enthusiastic about continuing to work with the social worker.

Discussion:

Due to a recent law passed in New Jersey prohibiting SOCE therapy for minors, the social worker learns that he could in fact lose his license if he continued to assist his client's goal of reducing unwanted SSA. Consider the following dilemmas the social worker is now faced with:

- 1) If he stops the effective treatment, he is violating his ethical duty to not

- abandon a client in the course of therapy, which could have a profound negative affect on the client's well-being and future life goals, thus violating the "do no harm" ethical standard.
- 2) If he refers the client to an unlicensed pastoral counselor, he runs the risk of putting the young man in a setting that is potentially inadequate to provide effective treatment for his unwanted SSA, especially considering that pastoral and/or Biblical counselors are not always highly trained in mental health and able to offer evidence-based best practices in therapy, such as EMDR and other advanced therapeutic techniques to heal trauma, nor are they always informed and educated on the complexities of human sexuality from a scientific perspective.
 - 3) If the social worker continues to treat the client with EMDR, yet refuses to support the client's goal of reducing unwanted SSA, he may be in effect providing de facto gay-affirmative therapy (which violates his personal Christian values) by withholding guidance and coaching to the client that could potentially assist him in achieving his goals of treatment, thus potentially causing the client harm, which presents yet another ethical dilemma for the social worker.
 - 4) If he refers the client to an out-of-state provider that can legally treat him using distance therapy, he could compromise the client's progress since some of the techniques used in session could be difficult to employ over phone or web-based counseling. Additionally, the client may not be able to get insurance reimbursement for his sessions with the

out-of-state therapist due to his insurance policy restrictions, thus making the treatment unaffordable and therefore creating financial burden on the client.

- 5) Because of the social worker's strong Biblical conviction to assist the client in a time of need, if he decides to officially terminate formal therapy with the client and begin seeing the client informally to avoid the state prohibitions against SOCE therapy for minors. However, the therapist then puts himself at risk for personal liability should something go wrong in future treatment, as well as potentially putting the client in a dangerous situation where there is no accountability for either therapist or client.

Questions:

1. How do you resolve these conflicts?
2. What do you do when your religious conviction and a particular stance within your profession are diametrically opposed.

Cases 2 and 3:

On September 29, 2012, Governor Jerry Brown of the State of California in the United States signed a law which had been passed both Houses of the California Legislature (California SB 1172). In its original form, it proposed to prevent or significantly limit "mental health provider(s)" from engaging "in sexual orientation change efforts (SOCE)" with adults, as well as children (persons under 18 years old). The form of the bill signed into law limited the provision of services only to "a patient under 18 years of age." For the purpose of this law, "sexual orientation

change efforts” were defined as any “efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.”

SB 1172 depended heavily on the 2009 Report of the American Psychological Association (APA) Task Force on Appropriate Therapeutic Responses to Sexual Orientation. As its primary rationale, the law cites the 2009 Report of The American Psychological Association convened a Task Force on Appropriate Therapeutic Responses to Sexual Orientation as concluding: “that sexual orientation change efforts can pose critical health risks to lesbian, gay, and bisexual people.” However in fact, no objective evidence that any harm even occurred.

Prior participants of SOCE who are now opposed to the goals of SOCE may look back upon their experience as harmful or ineffective. Laws and proposed legislation set out to limit, or ban SOCE. At the same time, some clients who may wish to pursue SOCE may be actively discouraged by gay-identified or gay-affirming therapists due to internal bias, ignorance, or lack of training. Below are two scenarios that may ensue, each with ethical dilemmas followed by discussion and questions:

Case 2:

Parents of a seventeen year-old client set up an appointment to meet with a Christian social worker that is known in his work with clients who are conflicted with homosexual feelings and seek sexual orientation change. The state in which the therapy takes place is very conservative, where homophobia often abounds, and

there is a great pressure on homosexually oriented individuals to change their “sinful lifestyle”. During the first meeting with the parents and seventeen year-old client, who is conflicted about his homosexual feelings, it becomes apparent to the social worker that the parents are much more enthusiastic that their child pursue SOCE than the son. While the son is not altogether opposed, he has reservations in committing to a lengthy therapeutic process which may require more time and effort than he is willing to put forth, nor is he convinced that his sexual feelings can or should be changed, although he is open to meeting with the social worker to discuss treatment options and talk about his sexuality.

During the course of therapy, the social worker discovers that the client’s parents persist in pressuring their son to commit to a process of change, and as their son is a senior in high school, they tell him they will not support him financially in college unless he commits to changing. While the son is still ambivalent or in the process of deciding which course of treatment to pursue, he feels pressure to commit to what his parents desire or face retribution. Because of the parent’s enthusiasm and financial support of their son’s weekly therapy sessions, the social worker aligns with the parent’s agenda and tries to influence, and in some cases, manipulate the minor into committing to a process of change. He uses several scare tactics, such as telling the client that his behavior is sinful and could potentially result in damnation if he doesn’t change, as well as cites the latest scientific research of HIV infection rates among men who have sex with men as a means to convince the client to not embrace a gay identity. After five years of treatment, the client finishes college and terminates with the social worker, not having changed

his sexual orientation, and further, becomes angry at the social worker and his parents for having been manipulated. The relationship between son and parents and the social worker deteriorates even further, and he ends up telling his story to a gay activist group, who then use his experience as an example of abuse in order to further their agenda to ban SOCE therapy in the state.

Case 3:

In the beginning of treatment, a social worker tells the parents of a 17-year old college freshman young man who is conflicted by his same-sex attraction that he intends to help their son work out conflicts between faith and sexuality, and that he intends to use his Christian theology as a foundation for treatment. The parents naively agree without asking the social worker about the details of the social worker's Biblical worldview. The son is conflicted about whether homosexuality is condoned in scripture, and is therefore vulnerable to the social worker's influence. The social worker then proceeds to influence the young man with pro-gay theological and Biblical revisionist views as a means of persuading the client to embrace a gay identity. The vulnerable young man listens to the social worker and is convinced that his feelings are compatible with his faith and begins dating several upper class gay men in college.

In the course of his studies, the client begins to experience depression after several relationships with men fail after only a couple of months each. The client expresses interest in pursuing SOCE interventions, citing that "gay relationships are not working for me" and is interested in exploring heterosexuality. Rather than refer the client to a qualified therapist who would support his goals of change, the

therapist instead cites several biased research articles and anti-SOCE books by prominent gay therapists to persuade the young man not to seek change.

Disillusioned by gay relationships, and discouraged by his therapist to seek an alternative, the client plunges deeper into depression with accompanying suicidal thoughts. To kill the pain, he begins to binge drink, and while his inhibitions are low, engages in unprotected sex with another man at a fraternity party. Two months later, the client learns he contracted HIV.

Discussion/Questions:

1. Each social worker violated ethics in the course of treatment with their client. Can you list some of the ethics that were violated, and what the social workers could have done differently while still keeping their allegiance to their faith and spiritual values?
2. How can faith-based providers deal with incongruences (harboring the storm) between a Christian professional's civic allegiance to local laws and his or her spiritual allegiance to following biblical teachings and faith-based convictions?
3. What happens when you feel a client should have self-determination, individual liberty, and the right to respond to one's own moral conscience; the hallmarks and fundamentals of our modern democratic society? Is self-determination as a primary value in all of our policies? How can we remain focused on the right of persons to deal with unwanted sexual attractions as well as the right of therapists to offer psychological care to those who wish to deal with these attractions by diminishing or eliminating

them rather than just identifying with and acting upon them. At the same time, how can we acknowledge and respect the right of individuals to claim a gay identity and pursue therapy to help them live more peacefully with their family and faith communities? People have various personal, interpersonal, health, religious, and other reasons for wanting to pursue change in their unwanted same-sex attractions and behaviors. They have every right to have their values respected. Yet, the psychological and counseling profession at large is sending messages that SOCE should be banned while providers are under attack by various political movements (e.g. Ferguson et al. v. JONAH¹). What are your thoughts?

4. Should Christians who operate a counseling an agency be protected for their religious freedom such as in the case in Hobby Lobby whereas the majority of Supreme Court justices ruled that forcing Christians business owners to provide contraceptives to employees was a violation religious freedom (Liptak, 2013)? In the case of SOCE, would the same rights apply whereas regulations against the practice of SOCE violate religious freedoms?

Conclusion

We have learned that sexual orientation change efforts (SOCE) are controversial and affect faith-based social workers, related professionals, clients, and potential clients as new laws and climate changes limit practice,

¹ *Michael Ferguson, et al., v. JONAH, et al.*, a lawsuit where four former clients of a counseling group called JONAH (Jews Offering New Alternatives for Healing) are suing in New Jersey for alleged deceptive practices. The former clients argue they paid thousands of dollars for therapies that did not rid them of same-sex attractions, and that they then had to pay for mainstream therapy to repair the damage done by the conversion therapy. JONAH is a Jewish agency and argues that their practices were consistent with stated objectives and Torah's teachings.

faith convictions, autonomy and self-determination.

Despite the decline of the practice and shifts in modalities a strong resistance to SOCE has emerged. Currently, two states have banned the practice of SOCE for clients under 18, and while similar legislation in 14 states was rejected in 2014, anti-SOCE advocates continue to introduce these bills putting limitations on those who may seek such services and those who may provide them. At any rate, many conflicting messages exist.

Faith-based social workers who may be compelled to provide SOCE are vulnerable to criticism and even possible legal and/or organizational recourse. However, this may present incongruence between his or her civic allegiance to these local regulations and organizational adherences and his or her spiritual allegiance to following biblical teachings and faith-based convictions. How to harbor this storm can be a challenge.

Finally, the presentation of case illustrations provides the opportunity to think through possible ethical dilemmas, inter-subjectivities, and the sharing of thoughts and ideas.

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