Counselling formerly heterosexually partnered gay fathers raised with religion

Eóin Earley, Victoria Clarke and Naomi Moller

Word count: 7,211

Published in the *British Journal of Counselling and Guidance*

Corresponding author:

Dr Victoria Clarke

Department of Health and Social Sciences

University of the West of England, Bristol

Frenchay Campus

Coldharbour Lane

Bristol BS16 1QY

UK

Email: Victoria.Clarke@uwe.ac.uk

Author bios

Eóin Earley is a Counselling Psychologist for the NHS and in private practice.

Victoria Clarke is an Associate Professor in Qualitative and Critical Psychology in the Department of Health and Social Sciences at the University of the West of England, Bristol.

Naomi Moller is a Senior Lecturer in the School of Psychology at The Open University.

This paper has not been published elsewhere and it has not been submitted simultaneously for publication elsewhere.

Disclosure of Interest Statement: *The authors report no conflicts of interest.*

Counselling formerly heterosexually partnered gay fathers raised with religion

Eóin Earley, Victoria Clarke and Naomi Moller

Abstract

Formerly heterosexually partnered gay fathers raised with religion are an under-researched group of LGBTQ parents. This group have potentially complex coming out journeys, which can result in them seeking counselling. This research explores the counselling experiences of such men and offers suggestions for working therapeutically with them. Twelve self-identified gay fathers participated in qualitative interviews. These men all had children in the context of a heterosexual marriage or committed partnership, and a religious upbringing of some kind in the US, Canada, the UK or Ireland. The key finding of the qualitative analysis was that participants wanted therapists to not assume a 'best' outcome for them as either gay or 'straight'. Instead, they wanted therapists to respect and assist them to explore their own individual sense-making around their identities and to reject fixed notions from both ex-gay and (some versions of) gay affirmative therapy of what it means to be a 'well-adjusted' (gay) father.

Key words: 'Coming out'; conversion therapy; ex-gay therapy; gay affirmative therapy; same-sex parenting

Background

Research has consistently shown that many Western mental health professionals are ill-equipped to work with lesbian, gay, bisexual, trans and queer (LGBTQ) clients (e.g. Bayliss, 2009; Byrd & Hays 2012; Moe, Finnerty, Sparkman & Yates, 2015). Historically, practitioners have received little or no specific training for working with LGBTQ clients (Alderson, 2004) and therefore lack knowledge about the specific needs of such clients (Grove, 2009). However, as LGBTQ people are at greater risk of mental health problems than the general population, they are more likely to present for counselling (Davies & Barker,

2015).

One context in which LGBTQ people may seek counselling is when they are ‘coming out’; a common term used to describe both a person’s acknowledgment of a same-sex identity or attraction and the disclosure of this identity or attraction to others (Riley, 2010). Coming out is widely acknowledged as something LGBTQ people must do throughout their lives, because of the operation of a ‘heterosexual assumption’ in a heteronormative social context, rather than being a single, one-off event (Rasmussen, 2004). Although the coming out experience may be a relatively straight-forward part of sexual self-discovery for some (Evans & Barker, 2010), for others it is a difficult and painful experience and they may seek counselling to help them manage this (Clarke, 2007).

One group that may have a particularly complex coming out journey is gay men raised in religion who have fathered children in heterosexual relationships. Having had children in the context of a heterosexual relationship is known to add conflict to identity formation for gay men (see Tasker & Bigner, 2013). Similarly, gay men who have had a religious upbringing have been reported to experience identity conflict when coming out as gay (Lapinski & McKirnan, 2013). Thus, being a father and having a religious background potentially adds further complexity to gay identity formation. Problematically, existing stage models of identity development for formerly heterosexually partnered gay fathers (e.g. Matteson, 1987) tend to imply that these men must be ‘out’ to be psychologically well (Rieger & Savin-Williams, 2012). These models associate being ‘closeted’ with internalised homophobia, the self-internalisation of perceived or experienced external homophobic beliefs (Meyer, 1995), and thus create a ‘one-size fits all’ model of identity development, and implicitly pathologise men who are not out.

It is often assumed that formerly heterosexually partnered gay fathers are a group in decline. In early literature on same-sex parenting, this group of gay fathers was often referred

to as ‘old’ or ‘divorced’ gay fathers, and contrasted with ‘new’ gay fathers, men who chose to parent *after* coming out as gay. Such a distinction problematically implies that gay men who father children *before* coming out are ‘old-fashioned’ and relics of the past, and men who parent *after* coming out represent the new frontier of gay parenthood. Indeed, it has been argued that formerly heterosexually married gay fathers will eventually disappear as a result of changes in social attitudes toward homosexuality and the increasing visibility and acceptance of gay men who chose to parent after coming out as gay (Tornello & Patterson, 2012). However, with discrimination against homosexuality by some religious authorities continuing, homophobic propaganda increasing in some parts of the world (e.g. Russia, see Wilkinson, 2014), and discrimination against ‘closeted’ gay men within gay communities, underpinned by social imperatives for people to be authentic about their ‘true’ identity (Rasmussen, 2004), there may always be a group of men who do not follow the coming out trajectory associated with over-simplified identity development models (e.g. Matteson, 1987).

Counselling gay men: From gay conversion therapy to gay affirmative therapy

The first published report to explore therapeutic interventions for formerly heterosexually partnered gay fathers was authored by US psychologist Dunne in 1987. Dunne set up a time-limited group for 7 gay fathers who were concerned about revealing their gay identity to their children, with the goal of helping them to develop positive strategies to do so through the use of role play (Dunne, 1987). The men rated the group as ‘highly useful’ (p. 213) and a 6-month follow-up found that 2 of the men had voluntarily disclosed to their children and 1 was planning to do so in the near future. Since this study was published, no other research has specifically focused on the therapeutic experiences of gay men who fathered children in heterosexual relationships. However, research with a broader focus on LGBTQ people’s experiences of therapy has shown that this population have historically reported negative experiences of psychological therapy, including feeling unsafe about

coming out in therapy (Riley, 2010), feeling pathologised (Galgut, 2005), and believing that counsellors hold heterosexist beliefs (Hunt & Fish, 2008). Although practitioners from a wide range of modalities have discussed how to work effectively and affirmatively with LGBTQ clients – including person-centred (Davies, 1998), narrative (McLean & Marini, 2008) and feminist (Negy & McKinney, 2006) approaches – discussion of psychotherapy for gay men has often centred on two polarised approaches: gay affirmative therapy (GAT), which seeks to support gay men to embrace their identity, and 'ex-gay' or gay conversion 'therapy' (GCT), which seeks to 'cure' them of their same-sex desires (Beckstead, 2012).

Gay conversion 'therapy'

Men with religious beliefs are said to be most at risk of seeking GCT (Flentje, Heck & Cochran, 2014); described by its proponents as a 'therapeutic approach' (a notion that is obviously disputed) that aims to provide 'gay-to-straight' outcomes for clients (Beckstead, 2012). There is consensus among critics of GCT that it does not work (Spitzer, 2012), professional bodies have made statements condemning the practice (e.g. see Memorandum of Understanding on Conversion Therapy in the UK, 2015), and there is a move towards prohibiting the practice in some Western countries (Clair, 2013). The UK government have revealed plans to ban the practice (*BBC News*, 2018); US states are lobbying to ban the practice (Lawson, 2018); and Canadian provinces are petitioning for prohibition (see https://www.change.org/p/end-gay-conversion-therapy-in-canada-righttobeyoucanada). However, GCT is still practised in many countries (Lawson, 2018), particularly within religion-based therapy programmes (Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015). Although GCT is not promoted by all religious organisations, celibacy or managing same-sex desires (key elements of GCT) are advocated by many (e.g. Mormonism – see Besen, 2012). The experience of GCT has been described as 'brutal and psychologically invasive' (Haldeman, 2002: 124) and creating 'awful, empty hope' (Beckstead & Morrow, 2004: 672).

Gay Affirmative Therapy

GAT was established to provide an alternative to GCT, and poor and unethical practice with LGBTQ populations more generally. It begins with a stance that does not pathologise homosexuality (Hunter & Hickerson, 2003), but rather values LGBTQ identities and affirms them 'to directly ameliorate the effects of heterosexism' (Langdridge, 2007: 30). GAT has been reported to be experienced positively by clients, with descriptions of it being 'affirming of *me*' (emphasis in original) and as demonstrating that the therapist sees one's difficulties as 'human' (Lebolt, 1999: 360-361). GAT proponents claim that is offers a positive framework for respectful psychotherapy that seeks to avoid imposing any expectations on clients about coming out. However, it's wider applicability has been challenged by humanistic and existential psychotherapists (see Langdridge, 2007) because of a perceived agenda of supporting more LGBTQ people to come out (see Davies, 2012). For the purpose of this paper, the pertinent concern is the potential impact of the perception that GAT equates successful therapy with a particular identity outcome for gay men – the client identifying unambiguously gay.

The current state of counselling for LGBTQ people

Overall, the landscape of counselling for LGBTQ people appears to be slowly improving with more reports of 'better' counselling (where same-sex attraction is not viewed as problematic; see King, Semlyen, Killaspy, Nazareth & Osborn, 2007), increased use of affirmative practice (Shelton & Delgado-Romero, 2011) and a greater availability of LGBTQ affirmative training programmes (Davies, 2012). Furthermore, many professional bodies have published guidelines for working with LGBTQ populations (e.g. British Psychological Society [BPS], 2012, the American Psychological Association, 2011, Canadian Psychological Association, 1996, Psychological Society of Ireland, 2015). However, some LGBTQ people

continue to describe early negative experiences of counselling, where the therapist does not work with sexuality effectively or appropriately (Victor & Nel, 2016).

Aims of the current study

This research aims to: 1) explore the counselling experiences of formerly heterosexually partnered gay fathers raised with religion; and 2) offer suggestions for counselling and mental health professionals in their work with this population.

Method

Interpretative phenomenological analysis (IPA) provided the methodological framework and analytic technique for the research (Smith, Flowers & Larkin, 2009). Interviews were relatively unstructured and began with an invitation to the participants to 'tell their story' (about becoming a father, identifying as gay, their heterosexual relationship). Both planned and spontaneous prompt questions were used to encourage further exploration about the participants' experiences of coming out to the mother of their children, and their children, responses of other gay men to their fatherhood, the positive and negative aspects of gay fatherhood, and counselling in the context of coming out and leaving their heterosexual relationship (e.g. 'Did you want to have children?', 'What do you feel (if any) are the positive aspects of gay parenthood?', 'Can you tell me about any forms of support you accessed when coming out/leaving your marriage?). The interviews were conducted by the first author who disclosed his identity as a gay man in the process of adopting a child with his partner in the participant information sheet, with the aim of fostering trust and rapport (Hanson, 2005). The interviews lasted between 49 and 88 minutes (mean 66 minutes) and took place in participants' homes (N=7), or another quiet location (1) or via *Skype* (4). Written informed consent was obtained before the interviews. Interviews were audio recorded and transcribed

verbatim (Braun & Clarke, 2013). The study received ethical approval from the authors' Research Ethics Committee.

Participants and recruitment

The participants self-identified as gay (or in one instance 'gay/bisexual' but nonetheless responded to a call for participants for a study on gay fathers), were either raised in religion in their family home or joined a religious community in adolescence, and had fathered children in a heterosexual relationship. They were recruited via social networking sites for gay fathers (N=6) and snowballing from the first author's personal contacts (N=6). Smith et al. (2009: 51) state "there is no right answer to the question of sample size" in IPA; this is also true of qualitative research more broadly. Several reviews have identified samples of 20 to 30 participants as common in qualitative interview research (e.g. Clarke & Braun, 2019; Mason, 2010). In IPA (interview) research, sample sizes vary considerably, from single person case studies to samples of over 30 participants, but in general, samples tend to be smaller than in qualitative interview research more broadly. The data-set was continually reviewed after each cluster of interviews was conducted in each country, and we determined that for a largely unexplored topic, a sample of 12 participants provided a rich and complex data set. One that would enable both the identification of themes across individual cases and a focus on the unique experiences of each participant; the latter in keeping with the idiographic focus of IPA (Smith et al., 2009).. Sample characteristics are provided in Table 1.

[INSERT TABLE 1 ABOUT HERE]

All participants living in the US and Canada had engaged with at least one form of psychological therapy. Of the 3 UK participants, only one had experienced GCT, with two reports of GAT. Irish participants reported no therapeutic experiences, however, these participants offered suggestions, as did all of the other participants, about what they would like from psychotherapy. Pseudonyms were chosen by participants if anonymity was desired.

Analytic Procedure

IPA aims to explore participants' experiences, and the ways in which they make sense of these (Brocki & Wearden, 2006). This approach is both phenomenological and interpretative in that it views the analytic outcomes as resulting from the researchers' interpretations of the participants' interpretations of their experiences. Analysis was led by the first author in consultation with the second and third authors who acted as 'sounding boards' and 'auditors' (Smith et al., 2009). The authors reviewed and discussed the transcripts throughout data collection and after data collection ceased, sharing their initial impressions of the data. The first author then began the more formal process of analysis by reading and re-reading the first transcript and writing 'initial notes' (Smith et al., 2009). These notes were shared and discussed with, and elaborated on by, the second and third authors, and then the first author organised the notes into emergent themes. These emergent themes were discussed with the second and third authors and then clustered into super-ordinate themes and this process was then repeated for each transcript, the authors meeting regularly throughout this process to discuss and review the developing thematic structure. The authors discussed and produced together a final set of three super-ordinate themes for all participants. This paper reports one of these super-ordinate themes centred on the men's counselling experiences (the other two themes centre on participants' experiences of living with a conflicted identity, and how participants managed and negotiated a gay father identity; see Earley, 2017). This superordinate theme encompasses three themes: Experiences of gay conversion therapy, experiences of gay affirmative therapy and participants' suggestions for counsellors working with gay fathers.

Results and discussion

Experiences of gay conversion therapy

Of the 12 participants, 7 experienced therapy that could be labelled as GCT. Five of these experiences were connected to Christian churches, with 2 experiences within the field of psychiatry. The participants considered the 'therapy' provided by Christian churches as facilitated by therapists and therapeutic leaders, however, participants were uncertain of the qualifications of these 'therapists'.

Restoring heterosexuality and appropriate masculinity

Jason reported that after acknowledging his same-sex attraction to his Mormon Church, a counsellor was assigned to him by the Latter Day Saints (LDS) Social Services, paid for by the Church, with the aim of ending his same-sex attraction. Jason simultaneously attended an LDS facilitated 'ex-gay' group where men were encouraged to share their 'success stories' and 'milestones' about abstaining from same-sex thoughts and behaviours (Wade, Worthington & Vogel, 2007). Jason attended both therapies for 18 months. One-to-one therapy was conducted by a therapist who Jason described as:

> …completely straight. I mean had no clue (laughs) of any of the thoughts or feelings that I was going through, not at all. And he would, like, make me go out and play basketball, y'know, because I needed man-time, healthy man-time. And we would talk about fishing, like in our therapy sessions, because somehow that was supposed to make me straight.

Looking back, Jason thought the therapy ignored his needs and was instead guided by a fixed agenda of 'restoring' his heterosexuality, underpinned by a view of homosexuality as a failure of appropriate masculinity (see Besen, 2012). Jason's story demonstrates his therapist's reluctance to openly explore a gay identity (Israel, Gorcheva, Walther, Sulzner & Cohen, 2008).

Unethical, pathologising and shaming therapeutic practice

After coming out to his Mormon pastor, Bernie too was sent to the LDS Social Services to manage his same-sex attraction. Bernie engaged with the therapist for two sessions but felt negatively judged about his same-sex attraction (Wade et al., 2007). Bernie described the therapy as 'unprofessional… because the looks that I would get from the psychologist, as I was talking to him, just were not conducive to the therapy'. According to Bernie: 'their [LDS therapists'] religion biases their therapy'.

Dan, a Romanian Orthodox Christian living in Canada, sought weekly GCT for a year until the negative impact on his health became too great (see Ford, 2002): 'It made me feel more guilty; it made me feel more inappropriate and I think it triggered my anxiety attacks alone.' Dan thought the therapy had contributed to his diagnosis of Generalised Anxiety Disorder; he continued to take anti-anxiety medication at the time of the interview.

Tom was encouraged by his Charismatic Christian Church to join the non-profit 'ex-gay' organisation *Exodus International* (which was dissolved in 2013), in his home state. Tom described *Exodus International* as an organisation that helped 'gay people to become straight', which for him in effect meant: '… I basically learned how to hide it [my sexuality] better'. GCT endorsed shaming tactics: '…a lot of accountability, like "have you looked at porn? Have you had sex with a guy?" Uhm, we had this whole list of things that they would ask every week.' Tom described the process as helping him to understand his thought processes and triggers, because 'in their minds it was a cause and effect thing'. However, for Tom: 'it never usually took away the desires'.

In the UK, Tim had experience of a similar 'ex-gay' organisation, *Living Waters*, an organisation that was previously operating in the UK, and continues its ex-gay mission in the US. This monthly group was run by a Christian GP who claimed to have experienced a transition from same-sex to heterosexual attraction: '[The group] had a big manual and it was a mixed group, male and female, and we would meet and work through the materials, in

terms of moving from same-sex attraction towards heterosexual relationships'. Tim described feeling 'tormented' within the group, explaining that it offered a 'temporary resolve' that only ultimately served to restore a pattern of self-doubt: 'I had a new resolve to overcome my feelings and to sort of pray them away, so to speak. And then something else would happen and I'd sort of feel myself spiralling again and feeling dreadful.'

Two participants experienced anti-gay psychiatric treatment in 1970s Canada, a period when homosexuality was classified as a 'mental illness' (see Glass, 2018). Paul met a psychiatrist twice weekly for four months to be 'cured' of his homosexuality; the sessions concluded with the psychiatrist determining that Paul was not gay. A few years later, when his same-sex feelings became 'impossible' to control, Paul saw a second psychiatrist for a period of two years: 'at that end of that again the psychiatrist didn't think that I was gay.' Thus, Paul was twice informed of his 'true' sexuality by an 'expert'.

Jared attended a group where: 'the psychiatrists were obviously anti-gay…so it was "we love you because you're human, but we… wouldn't want you to act on your homosexual impulses"'. For him, the impact of this experience was reflected in Jared's ongoing identity struggle over the last 40 years, and the persistent shame he has felt about his same-sex identity: 'I always felt, ashamed was the wrong word, but shame'.

Taken together, participants' experiences of GCT and other types of gay pathologizing therapies were unanimously reported as harmful and ethically problematic as they ignored their needs in favour of suppressing or 'curing' their same-sex desires (Besen, 2012). However, some participants reported that group meetings helped them feel less alone with their conflicted feelings, while also contributing to these feelings of conflict (see also Jaspal & Cinnirella, 2010).

Experiences of gay affirmative therapy

Eight participants (3 from Canada, 3 from the US, and 2 from the UK) had experienced one-to-one counselling that was gay affirmative or otherwise described by the participants as being non-judgemental about homosexuality. Five participants from the US and Canada experienced gay affirmative group therapy (something that was not accessible to British and Irish participants). Participants were asked generally about their experience of gay affirmative therapy, however, when asked specifically about the therapist's therapeutic orientation, they were unsure of their therapist's approach.

Solidarity of gay male/father support groups

Jason attended a coming out ex-Mormon peer support group set up by other gay men who had experienced involuntary excommunication from their Church. This support network aimed to offer unbiased support from ex-members of the LDS community as Jason prepared for his transition out of the family home (see Yarlzouse & Beckstead, 2011). Jason described the group as offering him information and friendship in a supportive environment (note how Jason presents his transition as not from straight to gay but from Mormon to gay, and in so doing conflates Mormonism and heterosexuality):

> you get together and you have like a lesson, like a church lesson. But it's for gay people. Basically you still believe in the church, but you're gay. So we were going to that group together, because it's hard. It's hard to transition from being Mormon to gay.

Similarly, Tom attended a bimonthly coming out support group at his local LGBT centre: 'About seventy per cent of [the members] were married at one point or another. And a lot of them have kids. So, that's really cool because they understand exactly what you're

going through...' This extract demonstrates the significance of feeling understood for such men (see also King et al., 2007).

Scaffolding self-acceptance as a gay father

Three participants (Paul, Dan and Jared) attended a gay father support group that had been running since the 1970s and is one of the first documented gay affirmative peer-led groups for gay fathers. Dan spoke of his growing identity acceptance through the group:

> [In the group] at the beginning I was not sharing much, I was just listening and giving very vague information about myself, but lately I've noted that I'm becoming more open and I'm caring less about what people think of me. How they might label me or how they might judge me. I think I'm growing stronger and stronger.

The group offers a framework that has been developed over the past almost 40 years that seemed to work well for its members. As described by Paul, who was a peer facilitator for the group:

> [Group name] is a peer-led group, we don't have professional leaders but we're all gay fathers, so somebody has to plan every meeting and organise them. They're not just getting together for social purposes… we actively tell people that this is only a discussion group, we talk and that's it… Our mission is to find a way of being tolerable of being gay and being a father. And that probably means leaving the family home. Although, we'll say that probably will happen but you have to figure that out, what works for you… like one former member to this day is still with his wife…that's not going to happen for very many people. But this is one family. And I say anything is possible as long as everybody involved wants it.

The language used by Paul to describe the group's mission statement – 'being tolerable of being gay and a father' – highlights an important finding of this study: that

having two or more identities that the wider social context views as conflicting is something that the men sought to find comfort with. Furthermore, for some men having counselling or attending support groups helped them to achieve this (see also Vincke & Bolton, 1994). Paul's statement that there are multiple possible outcomes for a coming out' journey suggests that professionals should question any model that equates only being 'out' with psychological well-being.

Participants' suggestions for counsellors working with gay fathers

Supporting clients to find their own way of being a gay man and a father

The importance of adopting a gay affirmative therapeutic stance was viewed by all participants as crucial for therapy to be effective. Nonetheless, some participants suggested that the level of positivity expressed to clients about having a gay identity should be tempered (Ed, Dan, Jared). Jared suggested psychotherapy should be '[gay] positive but not…overly positive…I don't think I'm swayed in that [overly positive] way'. Jared appeared to feel that a therapist being *too* encouraging of a gay identity made him uneasy because he viewed being gay as not a lifestyle choice, but rather something innate that he had worked hard to accept (Vincke & Bolton, 1994). This further emphasises that therapists should not demonstrate a clear interest in the client being 'out', but rather encourage the quest for self-exploration and understanding (see Johnson, 2012).

The importance of signalling a gay affirmative (but non-directive) stance

While Jared wanted a therapist to be not 'too' affirmative, Paul and Ed made the opposite point, recounting experiences of a 'neutral' therapeutic approach – one that was silent on issues such as sexuality – which they found unhelpful and frustrating. Paul noted seeking meaning in the smallest of gestures because the therapist did not state their stance on sexuality: 'You, as the client, go through everything to a raised eyebrow or a nod.' This

suggests that it is important for therapists to signal in some way that they are gay-affirmative (see McGeorge & Stone Carlson, 2011).

Ed suggested that being a 'good' (affirmative) therapist might sometimes mean pushing somewhat in relation to sexuality:

> There is a dichotomy where the therapist's role is to support the client. But…support isn't always enough, doesn't move you on. There are therapists I've been to who…don't get involved at all. And it's just very interesting… there's no communication…I think the theory is a good therapist would lead you towards exploring your own things that you think are too dangerous to touch… they've just gotta push you into the difficult things, if they can identify what the difficult things are coming, and to make you delve into them and to work out…

Ed suggests that the role of therapist should be to support exploration of the parts of the self that the client has worked hard at leaving unexplored, and perhaps to help them integrate these hidden parts into their identity. Given both the empirically-supported relationship between psychological wellness and living openly as a gay man (e.g. Rieger & Savin-Williams, 2012) and the assumption in most GAT models that being out is the desired end-point of therapy (e.g. Davies, 2012), it is interesting that all participants argued for the importance of a non-directive therapeutic agenda.

Exploring the implications of a heteronormative culture with clients

Ed's comment about 'things that are too dangerous to touch' hints at the anxiety men can experience as they begin to realise their same-sex attraction, an attraction that in some cases seemed to make them feel like less of 'a man'. To manage the complexity of beliefs such as this therapeutically, Richie suggested therapists should recognise the effect of a heteronormative culture for gay men: 'always observe that the person comes out and is gay

and is loving a man. That doesn't mean he is less. Society can do that to people' (see Harris, 2015). Bernie similarly suggested the importance of normalising same-sex attraction:

> [You don't] need to be fixed…that there was nothing wrong with being attracted to the same sex…if you're counselling a gay person, even if they aren't ready to 'come out', helping them to come to an understanding that there's nothing wrong with who they are is important.

The participants' comments suggest that feeling 'less' as a gay man – something that has been imposed on gay men by the heteronormative world they live in – is likely to be a common concern for this group of gay fathers (Ganzevoort, van der Laan & Olsman, 2011).

Signposting to resources

Participants stressed the value of therapists adopting a non-judgemental stance (see Winslade, 2013). For example, Dan believed the greatest benefit to him was: 'the fact that I have somebody to talk to very openly without hiding anything… it's okay to say everything we feel, there is no judgement, there is no bad judge'. The importance of therapists signposting towards information and resources was also highlighted. For example, Jason said: 'I would have welcomed any information at the time, just because I didn't know. I didn't know anything. I didn't know anything…' Like many participants, Jason's religious context prevented him from accessing information about homosexuality, which made coming out particularly frightening.

This paper aimed to explore participants'experiences of therapy, specifically how positive and negative therapeutic experiences shaped their self-identity journeys, to better inform therapists in their work with this group of men. In the therapeutic space participants' fatherhood status and prior heterosexual relationships were not a major focus because participants were typically not in a place of struggle with these identities (e.g. many

participants had already decided to end their heterosexual relationship). However, for certain participants both identities could be a nexus for identity struggle outside the therapy room, in relation to feared and received negative reactions from gay and heterosexual communities (see Earley et al., 2019).

Implications for practice

Participants' discussion of their experiences with therapy hold a number of clear implications for practitioners. First that, therapists are encouraged develop their understanding of the experiences of formerly heterosexually partnered gay fathers with a religious background, while recognising that these men are likely to have complex and varied personal histories (see Barnes & Meyer, 2012). A second core implication from this study is that an LGBTQ affirmative approach is an essential underpinning of therapeutic work with such men, moreover that it is critical that therapists make their adoption of this stance clear to clients (being 'neutral' is not enough).

Third, the findings also suggest that a key part of therapy for this group is exploring the impact of a heteronormative culture on gay men and normalising homosexuality. This will of course require practitioners to have some critical awareness of the concept of heteronormativity and the ways in which normative heterosexuality is tethered to traditional gender roles (e.g. see Hudak & Giammattei, 2010). The findings suggest that for some clients (particularly those who have been isolated from mainstream society) it will also be important to offer information and signpost to relevant resources. While such signposting may not be necessary for all clients, and should not be offered without discussion, it is important that therapists have an awareness of where to direct clients who are in need of further LGBT resources (e.g. online forums – see Harris, 2015). A fourth suggestion is that in working therapeutically with this population, the role of the therapist may be to support and guide the client to places that are difficult, in particular around sexuality (see McDougall, 1995);

however, this must be carried out in an appropriate way (see below). Last, the results of this study suggest that the psychological formulation of a client should be driven by their individual story and wishes, rather than formulation being driven by any pre-existing GAT or 'one size fits all' identity development model (e.g. Miller, 1979). Therapy models should not be drawn on in a rigid way (e.g. the assumption that being 'out' is best, see Rieger & Savin-Williams, 2012). Feeling comfortable with one's identity (whatever that means for the individual client) should be the goal of therapy, consistent with more recent approaches to GAT (see Johnson, 2012). This means being non-judgemental in general and also specifically when clients (for example) elect not live as 'out' gay men. Concurrently, therapists should be aware of the problem of pathologising same-sex sexuality and should feel confident in teaching clients in search of GCT about evidence highlighting the negative impacts and ineffectiveness of such 'therapy' (e.g. Besen, 2012).

The suggestions provided here are aimed at improving therapeutic interventions for a specific group of gay fathers and are intended to supplement the LGBTQ therapeutic guidelines published by professional bodies (e.g. BPS, 2012). In making these suggestions for practice, it is recognised that as 10 of the 12 participants identified as White North American or European, and 11 of the 12 participants identified as Christian, this study offers a far greater account of the experience of 'coming out' for White Christian men from the Western Northern Hemisphere than for other religious, ethnic/racial and cultural groups.

Conclusion

As long as religious communities that are hostile to homosexuality exist, particularly those that are isolated from the mainstream socio-cultural context, a population of formerly heterosexually partnered gay fathers raised with religion is likely to exist and to continue to seek therapy. This group may face particularly complex coming out journeys and they may be more likely than other gay men to have had damaging experiences of GCT. It is hoped

therefore that these findings improve the quality of the therapy offered to them; in particular, the findings highlight the importance of providing therapy without a pre-determined outcome, and offering the men the space to explore their identity without negative judgement and with acceptance of individual identity pathways.

References

Alderson, K.G. (2004). A different kind of outing: Training counsellors to work with sexual minority clients. *Canadian Journal of Counselling*, *38*(3), 193-210.

American Psychological Association (2011). *Guidelines for psychological practice with lesbian, gay, and bisexual clients*. Available from: http://www.apa.org/pubs/journals/features/amp-a0024659.pdf

Barnes, D.M., & Meyer, I.H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry*, *82*(4), 505-515.

Bayliss, S.E. (2009). I*mproving lesbian, gay and bisexual healthcare: A systematic review of qualitative literature from the UK*. Available from: http://diversityhealthcare.imedpub.com/improving-lesbian-gay-and-bisexual-healthcare-a-systematic-review-of--qualitative-literature-from-the-uk.pdf

BBC News (2018). Available from: https://www.bbc.co.uk/news/uk-44686374

Beckstead, A.L. (2012). Can we change sexual orientation? *Archives of Sexual Behavior*, *41*(1), 121-134.

Beckstead, A.L., & Morrow, S.L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counselling Psychologist*, *32*(5), 651-690.

Besen, W. (2012). *Anything but straight: Unmasking the scandals and lies behind the 'ex-gay' myth*. New York: Routledge.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

British Psychological Society (2012). *Guidelines and literature review for psychologists working therapeutically with sexual and gender minority clients*. Available from: http://www.bps.org.uk/sites/default/files/images/rep_92.pdf

Brocki, J.M., & Wearden, A.J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*(1), 87-108.

Byrd, R. J., & Hays, D. (2012). School counselor competency and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. *Journal of School Counseling, 10*(3), https://eric.ed.gov/?id=EJ978859.

Canadian Psychological Association (1996). *Policy and position statement: Equality for lesbians, gay men, their relationships and their families*. Available from: http://www.cpa.ca/aboutcpa/policystatements#families

Clair, N. (2013). Chapter 835: Gay conversion therapy ban: Protecting children or infringing rights. *McGeorge Law Review, 44*, 541.

Clarke, C.M. (2007). Facilitating gay men's 'coming out': An existential phenomenological exploration. In E. Peel, V. Clarke & J. Drescher (Eds.), *British lesbian, gay and bisexual psychologies*. New York: The Haworth Medical Press.

Clarke, V. & Braun, V. (2019). Feminist qualitative methods and methodologies in psychology: A review and reflection. *Psychology of Women and Equalities Section Review*,

2(1), 13-28.

Davies, D. (1998). The six necessary and sufficient conditions applied to working with lesbian, gay and bisexual clients. *The Person-Centered Journal*, *5*(2), 111-20.

Davies, D. (2012). Sexual orientation. In A.M. Horne & M.S. Kiselica (Eds.), *The Sage handbook of counselling and psychotherapy* (pp. 44-48). London: Sage.

Davies, D., & Barker, M.J. (2015). Gender and sexuality diversity (GSD): Respecting difference. *The Psychotherapist*, 60, 16-17.

Dehlin, J.P., Galliher, R.V., Bradshaw, W.S., Hyde, D.C., & Crowell, K.A. (2015). Sexual orientation change efforts among current or former LDS church members. *Journal of Counseling Psychology*, *6*(20), 95-105.

Dunne, E.J. (1987). Helping gay fathers 'come out' to their children. *Journal of Homosexuality*, *14*(1-2), 213-222.

Earley, E. (2017). "People don't understand who you are": An exploration of how formerly heterosexually partnered gay fathers raised with religion make sense of their identities. DCounsPsych, University of the West of England. Available from: http://eprints.uwe.ac.uk/30577/12/Eo%CC%81in%20Earley%2C%20full%20thesis%20with%20viva%20ammendments.pdf

Earley, E., Clarke, V & Moller, N. (2019). *How do formerly heterosexually partnered gay fathers manage and negotiate identity*. Manuscript in preparation.

Evans, M., & Barker, M. (2010). How do you see me? 'Coming out' in counselling. *British Journal of Guidance & Counselling*, *38*(4), 375-391.

Flentje, A., Heck, N.C., & Cochran, B.N. (2014). Experiences of ex-ex-gay individuals in sexual reorientation therapy: Reasons for seeking treatment, perceived helpfulness and

harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*, *61*(9), 1242-1268.

Ford, J.G. (2002). Healing homosexuals: A psychologist's journey through the ex-gay movement and the pseudo-science of reparative therapy. *Journal of Gay & Lesbian Psychotherapy*, *5*(3-4), 69-86.

Galgut, C. (2005). Lesbians and therapists - the need for explicitness. *Counselling and Psychotherapy Journal*, *16*(04), 8-11.

Glass, G.F. (2018). Doctor anonymous: Creating contexts for homosexuality as mental illness. *Journal of Medical Humanities*, *39*(1), 101-109.

Ganzevoort, R. R., van der Laan, M., & Olsman, E. (2011). Growing up gay and religious: Conflict, dialogue, and religious identity strategies. *Mental Health, Religion & Culture*, *14*(3), 209-222.

Grove, J. (2009). How competent are trainee and newly qualified counsellors to work with lesbian, gay and bisexual clients and what do they perceive as their most effective learning experiences? *Counselling and Psychotherapy Research*, *9*(2), 78-85.

Haldeman, D.C. (2002). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. *Journal of Gay & Lesbian Psychotherapy*, *5*(3-4), 117-130.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research*, *5*(2), 96-104.

Harris, A.J.L. (2015). *To disclose or not to disclose? The LGBT therapist's question.* Unpublished doctoral thesis, University of Lincoln.

Hudak, J. & Giammattei, S.W. (2010). Doing family: Decentering heteronormativity in 'marriage' and 'family' therapy. In J. Ariel, P. Hernández-Wolfe & S. Sterns (Eds.),

Expanding our social justice practices: Advances in theory and training. Washington, DC: American Family Therapy Academy, Inc.

Hunt, R., & Fish, J. (2008). *Prescription for change: Lesbian and bisexual women's health check.* Stonewall. Available from: https://www.dora.dmu.ac.uk/bitstream/handle/2086/4747/prescription_for_change.pdf?sequence=1

Hunter, S., & Hickerson, J. C. (2003). *Affirmative practice: Understanding and working with lesbian, gay, bisexual, and transgender persons.* Washington, DC: NASW Press.

Israel, T., Gorcheva, R., Walther, W.A., Sulzner, J.M., & Cohen, J. (2008). Therapists' helpful and unhelpful situations with LGBT clients: An exploratory study. *Professional Psychology: Research and Practice*, *39*(3), 361.

Jaspal, R., & Cinnirella, M. (2010). Coping with potentially incompatible identities: Accounts of religious, ethnic, and sexual identities from British Pakistani men who identify as Muslim and gay. *British Journal of Social Psychology*, *49*(4), 849-870.

Johnson, S.D. (2012). Gay affirmative psychotherapy with lesbian, gay, and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry*, *82*(4), 516-522.

King, M., Semlyen, J., Killaspy, H., Nazareth, I., & Osborn, D. (2007). A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people. *British Association for Counselling and Psychotherapy*. Available from: https://www.researchgate.net/profile/Helen_Killaspy/publication/228696900_A_Systematic_Review_of_Research_on_Counselling_and_Psychotherapy_for_Lesbian_Gay_Bisexual_and_Transgender_People/links/00b4951a4aa98b5531000000.pdf

Langdridge, D. (2007). Gay affirmative therapy: A theoretical framework and defence. *Journal of Gay & Lesbian Psychotherapy*, *11*(1-2), 27-43.

Lapinski, J., & McKirnan, D. (2013). Forgive me father for I have sinned: The role of a Christian upbringing on lesbian, gay, and bisexual identity development. *Journal of Homosexuality*, *60*(6), 853-872.

Lawson, K. (2018). Gay conversion therapy is still legal in 41 states. Available from: https://broadly.vice.com/en_us/article/kznvvv/gay-conversation-therapy-is-still-legal-in-41-states

Lebolt, J. (1999). Gay affirmative psychotherapy: A phenomenological study. *Clinical Social Work Journal*, *27*(4), 355-370.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research*, *11*(3).

Matteson, D.R. (1987). The heterosexually married gay and lesbian parent. In F.W. Bozett (Ed.), *Gay and lesbian parents* (pp. 138-161). New York: Praeger.

McDougall, J. (1995). *The many faces of Eros: A psychoanalytic exploration of human* sexuality. New York: WW Norton & Co.

McGeorge, C., & Stone Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy*, *37(1)*, 14-26.

McLean, R., & Marini, I. (2008). Working with gay men from a narrative counseling perspective: A case study. *Journal of LGBT Issues in Counseling*, *2*(3), 243-257.

Memorandum of Understanding on Conversion Therapy in the UK (2015). Available from: https://www.psychotherapy.org.uk/wp-content/uploads/2016/09/Memorandum-of-understanding-on-conversion-therapy.pdf

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of health and social behavior*, 38-56.

Miller, B. (1979). Gay fathers and their children. *Family Coordinator, 28*(4), 544-552.

Moe, J.L., Finnerty, P., Sparkman, N. & Yates, C. (2015). Initial assessment and screening with LGBTQ clients: A critical perspective. *Journal of LGBT Issues in Counseling, 9*(1), 36-56.

Psychological Society of Ireland (2015). *Guidelines for good practice with lesbian, gay and bisexual clients*. Available from: http://www.psychologicalsociety.ie/page/file_dwn/207/PSI%20Guidelines%20for%20Good%20Practice%20with%20LGB%20Clients%20(final).pdf

Negy, C., & McKinney, C. (2006). Application of feminist therapy: Promoting resiliency among lesbian and gay families. *Journal of Feminist Family Therapy, 18*(1-2), 67-83.

Rasmussen, M.L. (2004). The problem of 'coming out'. *Theory into Practice, 43*(2), 144-150.

Rieger, G., & Savin-Williams, R.C. (2012). Gender nonconformity, sexual orientation, and psychological well-being. *Archives of Sexual Behavior, 41*(3), 611-621.

Riley, B.H. (2010). GLB adolescent's 'coming out'. *Journal of Child and Adolescent Psychiatric Nursing, 23*(1), 3-10.

Shelton, K., & Delgado-Romero, E.A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*(2), 210-221.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory,* m*ethod and research.* London: Sage.

Spitzer, R.L. (2012). Spitzer reassesses his 2003 study of reparative therapy of homosexuality. *Archives of Sexual Behavior, 41*(4), 757-757.

Tasker, F., & Bigner, J.J. (Eds.), (2013). *Gay and lesbian parenting: New directions*. New York: Routledge.

Tornello, S.L., & Patterson, C.J. (2012). Gay fathers in mixed-orientation relationships: Experiences of those who stay in their marriages and of those who leave. *Journal of GLBT Family Studies, 8*(1), 85-98.

Vincke, J., & Bolton, R. (1994). Social support, depression, and self-acceptance among gay men. *Human Relations, 47,* 1049-1062

Victor, C.J., & Nel, J.A. (2016). Lesbian, gay, and bisexual clients' experience with counselling and psychotherapy in South Africa: Implications for affirmative practice. *South African Journal of Psychology, 46*(3), 351-363.

Wade, N.G., Worthington Jr, E.L., & Vogel, D.L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17*(1), 91-105.

Wilkinson, C. (2014). Putting 'traditional values' into practice: The rise and contestation of anti-homopropaganda laws in Russia. *Journal of Human Rights*, *13*(3), 363-379.

Winslade, J.M. (2013). From being non-judgemental to deconstructing normalising judgement. *British Journal of Guidance & Counselling, 41*(5), 518-529.

Yarlzouse, M.A., & Beckstead, A.L. (2011). Using group therapy to navigate and resolve sexual orientation and religious conflicts. *Counseling and Values, 56(1/2),* 96-120.

Table 1: Characteristics of participant sample

Age	Range: 25-68 years; mean: 42 years	
Nationality	US	4
	Canadian	3
	British	3
	Irish	2
Religious background (self-described)	Ex-Mormon	3
	Ex-Southern Baptist	1
	Ex-Evangelical	1
	Charistmatic non-practising	1
	Ex-Catholic	2
	Catholic	1
	Christian Orthodox	1
	Methodist	1
	Masorti Judaism	1
Race/ethnicity	White	11
	Hispanic	1
Number of children	1-4 (including 1 participant with 2 adopted children)	
Living context at time of interview	Left marital/family home	10
	Living in marital/family home	2
Heterosexual relationship status at time of interview	Divorced	7
	Separated	2
	Married	3

Same-sex relationship status at time of interview	In a same sex relationship	9 (including 1 participant living in the marital/family home)
	Not in a same-sex relationship	3 (including 1 participant 'exploring options')