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“Unraveling Shame”: Therapy Experiences of Religious

Sexual Minority College Students

Audrey Parker

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Master of Science

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ABSTRACT

Unraveling Shame: Therapy Experiences of Religious Sexual Minority College Students

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Sexual minority adolescents and adults experience higher rates of psychological risk factors and mental health disorders than their straight peers. As theorized by the minority stress model, this increased distress may be related to both external stressors (including discrimination and violence) and internal stressors (concealment, expectation of rejection, and internalized homonegativity). For some sexual minority individuals who also hold religious beliefs, conflict between their sexual orientation and religious beliefs may act as another stressor. Sexual minority adolescents and adults present to therapy at higher rates than their straight counterparts, and clients seeking help with religious and sexual conflict make up some portion of this distressed group. We qualitatively explored the therapy experiences of religious sexual minority college students using CQR methodology. Specifically, we investigated the role therapy plays in helping clients navigate conflict between their sexual orientation and religious belief. Fourteen participants completed 60-90 minute interviews that included questions about their therapy experiences. Themes emerged representing both helpful and unhelpful aspects of group and individual therapy. Helpful group themes included "learning from others," "connecting with others," and "a supportive environment;" and unhelpful themes included "not connecting with others," and "discomfort with group content." Helpful individual therapy themes included "processing and exploration" and "a supportive environment;" and unhelpful themes included "problems with the therapist" and "problems with the therapy process." Connections to Yalom's "curative factors" and common factor theory are discussed, as well as special considerations when working with a religious sexual minority population.

Keywords: sexually minoritized, LGBTQ+, CQR, psychotherapy

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Unraveling Shame: Therapy Experiences of Religious Sexual Minority College Students

Over the past several decades, studies have repeatedly shown sexual minority (SM) adolescents and adults to have higher rates of mental health concerns than their straight peers. These elevated concerns include psychological risk factors such as hopelessness, low self-esteem, and emotion dysregulation (Haztenbuehler et al., 2008), as well as diagnosed disorders such as major depressive disorder, obsessive compulsive disorder, and substance use disorder (Chakraborty et al., 2011; McAleavey et al., 2011; Pachankis, 2018). As an example, a 2003 survey of American adults found that 38% of gay or bisexual men reported experiencing a mental health disorder, compared with 14% of straight men (Cochran et al., 2003). Lesbian-bisexual women had much higher rates of generalized anxiety disorder (GAD), with 15% endorsing GAD compared to 4% of straight women. Comorbidity was also significantly higher, with lesbian, gay, and bisexual (LGB) men and women four times as likely to report having been diagnosed with two or more disorders than straight men and women. More recently, using a large, college-age treatment sample, Lefevor et al. (2018) found sexual minority students scored significantly higher on a distress index that incorporates depression, GAD, eating concerns, and more, than their straight peers, with effect sizes ranging from small to medium.

Researchers have hypothesized a variety of both external and internal contributors to the increased psychological difficulties of SM individuals. Meyer’s (2003) minority stress model places these possible contributors in a framework of distal (external) and proximal (internal) stressors. Distal (external) contributors include discrimination, harassment, and violence and have been well-documented as part of the experience of many sexual minority individuals. For example, a 2012 meta-analysis found that 55% of lesbian, gay, and bisexual individuals reported experiencing verbal harassment and 41% reported discrimination (Katz-Wise & Hyde, 2012). A

study in 2005 looking at LGB adults and their heterosexual siblings found that LGB participants reported significantly more childhood psychological, physical, and sexual abuse, as well as more partner victimization and more sexual assault in adulthood than their sibling who presumably grew up in the same social and socioeconomic environment (Balsam et al., 2005).

Internal (proximal) stressors include intrapsychic processes such as internalized heterosexism/homonegativity, identity concealment, and expectations of rejection. Research has consistently found these processes to be associated with markers or risk factors of poor mental health, including depression, substance abuse, and suicidality (Hatzenbuehler et al., 2008; Huynh et al., 2022; Pachankis et al., 2008; Shidlo, 1994). Further work on the minority stress model has theorized that internal stressors work as mediators between external, objective stressors and negative mental health: when a sexual minority individual experiences discrimination and harassment, they are more likely to become hypervigilant for rejection and develop anxiety and depression or maladaptive coping such as substance abuse or disordered eating. Similarly, some sexual minorities internalize the discriminatory messages and harassment they hear and internalize negative beliefs about same-sex attraction that conflict with their own romantic and sexual feelings. This conflict can lead to shame and guilt – risk factors for depression and suicidality (Hatzenbuehler et al., 2008; Feinstein et al., 2012).

For a subset of sexual minority adults who identify as religious, conflict between religious beliefs and sexual orientation serves as a possible contributor to poor mental health. This conflict likely operates through the external and internal pathways described above. Participation in a conservative religion that condemns same-sex romantic and sexual behavior can create internal discord for the sexual minority observant who believes in and practices their religion but experiences feelings of attraction toward people of the same sex (Kashubeck-West et

al., 2017). Research has indeed found that many sexual minority individuals feel conflict between their religious beliefs and sexual orientation (Kashubeck-West et al., 2017; Lefevor et al., 2019; Schuck & Liddle, 2001) and like other stressors, this conflict has been associated with risk factors for pathology as well as diagnosed mental disorders (Kashubeck-West et al., 2017; Suprina et al., 2019).

Likely due to their higher rates of mental health concerns, sexual minority individuals have been found to participate in psychotherapy at higher rates than straight individuals (McAleavey et al., 2011). Although sexual minority adolescents and adults may present to psychotherapy for any of several possible causes or contributors, conflict between religion and sexuality may be a particularly salient and distressing concern for those who hold religious beliefs (Schuck & Liddle, 2001). That sexual minority clients with religious beliefs seek help for this conflict in therapy is concerning given psychology's complicated history with queer identities and religious belief. The field formally pathologized queer identities for centuries, beginning in the 1800s with the categorization of homosexuality as "moral degeneracy" or "stunted sexual development" caused by decadent living, poor relationships with the opposite sex parent, and avoidant anxiety (Bieschke et al., 2007; Drescher, 2012; Johnson, 2012; Minton, 1986; Moon, 2022), and continuing into the 1900s with its classification as a "sexual deviation" subtype of "sociopathic personality disorder" in the first Diagnostic and Statistical Manual (Mendelson, 2003). Though growing research and activism led to the gradual removal of homosexuality as a disorder beginning in 1973, the legacy of pathology remains in the form of the persisting (although unsanctioned by the APA) practice of conversion therapy by some clinicians (Drescher, 2015; Higbee et al., 2022).

Psychology also has a history of disregarding or discounting religious beliefs. Religion and spirituality were largely ignored in the literature for the first half of the 20th century, and religious belief was dismissed as pathology, a sign of an immature mind, a form of behavioral control, and as disordered thinking (Bartoli & Gillem, 2008). Due in part to growing emphasis on humanism and multicultural competency in the 1990s, researchers and theoreticians began discussing religion as a relevant piece of human experience and respecting belief as a legitimate form of diversity (Bartoli, 2007; Yarhouse & Burkett, 2002). However, clinician training in religion and spirituality continues to lag that of other multicultural domains, and some clinicians continue to see belief as falling solely under the purview of ecclesiastical leaders (Vieten & Lukoff, 2022; Young et al., 2002). Because of this historical antipathy toward both religion and sexual minority orientations, it is worth investigating psychotherapy's current approach to clients with these multicultural factors.

Several articles have discussed and provided recommendations regarding psychotherapy for religious sexual minority (RSM) clients. Regarding individual therapy, authors of this research emphasize the importance of addressing grief and loss that is commonly associated with navigating these conflicting identities (Kashubeck-West et al., 2017; Moon, 2022) and of providing an environment where clients can work through their ambivalence (Moon 2022; Morrow 2011; Bartoli & Gillem, 2008). Lefevor et al. (2022), among others, advise therapists to ally with the client rather than with a particular ideology or outcome and to be careful to evaluate and monitor their own biases. This is particularly relevant in this setting where clinicians may have strong opinions about or complicated histories with issues of religion and/or LGB individuals.

Articles by Yarhouse and Beckstead (2011) and Lefevor and Williams (2021) have addressed group therapy practices with RSM individuals. In the first, Yarhouse and Beckstead use their own experience as leaders of therapy groups to describe the importance of emphasizing possible options for approaching feelings of conflict and of providing “permission to learn about and evaluate such possibilities.” They also discuss helping clients develop problem solving and assertiveness skills as they make decisions about coming out, current relationships, and their involvement with religion and LGB communities. Lefevor and Williams use the article to propose a framework for interpersonally-based, process-oriented group therapy for LGBTQ clients. They focus on the sexual and gender minority population more broadly but do explain that process groups may be useful to religious LGBTQ clients facing existential factors including crises of faith and concerns about being denied a place in heaven.

In addition to these theoretical articles, a recent empirical study qualitatively explored therapy experiences of LGBQ-identifying young adults from religious families (Heiden-Rootes et al., 2021). Participants described positive aspects of therapy that included feeling “free” in relation to the therapist. They were able to talk and struggle freely and openly with these conflicting parts of their identity in the therapy setting. In particular, they cited therapists’ ability to stay emotionally nonreactive, or in other words to “not make a big deal” about what they were saying. This facilitated productive and meaningful exploration. They also appreciated when the therapist took a “nonexpert” position but rather showed interest and curiosity, respecting the client’s autonomy. Participants appreciated the opportunity to talk about their sexuality in reference to their religion - using religious language and discussing scripture. In contrast, participants described negative experiences in therapy where they felt rejection from their therapist, in the form of both overt rejection and disguised intolerance.

Beyond the study done by Heiden-Rootes and colleagues, there has been little empirical research considering the conflict between religious belief and sexual identity in the context of therapy. Beckstead and Morrow (2004) qualitatively investigated the experiences of Mormon clients who had undergone conversion therapy. Although an important topic, the focus on only conversion therapy does not provide insight into other aspects of therapy clinicians may be using and whether those are helpful or unhelpful. More recently, Rosik et al. (2022) surveyed a relatively large group of sexual minoritized individuals, asking them to rate a variety of methods for addressing sexual orientation distress (i.e., restraining sexual desires, self-development, and aversive conditioning). These results provide valuable information on the use and helpfulness of these methods; however, they did not gather information about these methods taking place inside or outside of therapy, and therefore do not add information on psychotherapy's role in navigating this conflict.

The objective of the present study is to build upon previous discussion, recommendations, and empirical findings by adding additional empirical insight into the aspects of therapy that are helpful and unhelpful for RSM clients. We will focus particularly on the role that therapy plays in helping RSM clients navigate the conflict between their religious beliefs and sexual identities. Additionally, we will add to the current research by contributing information on the role of group therapy in helping RSM young adults navigate sexual and religious conflict.

Method

Participants

After receiving approval from the university Institutional Review Board, we carefully followed recommended procedures regarding confidentiality of participant information.

Participants were recruited from a pool of students enrolled in a religious university who had participated in therapy groups specifically designed to address conflict between religious beliefs and sexual orientation. These students had previously agreed to be contacted for research purposes during their intake process for services at the Counseling and Psychological Services center of the university. Potential participants were emailed a Qualtrics survey with a consent form, basic demographic questions, and a measure of sexual orientation. We selected participants who identified as any orientation except *exclusively heterosexual* or *asexual*. Asexual students were excluded because asexuality has been found to interact differently with religious identity (Rothblum et al., 2019). Participants agreed to participate in a 60-90 minute interview regarding their therapy experiences. As participants had been recruited from therapy groups, they all discussed group therapy experiences. We didn't select participants based on use of individual therapy, but all participants reported on their experiences in individual therapy.

After completing the above process, our final sample included 14 current or recent (attended within last six months) students from a religious university in the western United States. Of these students, eight identified as male, three as female, and three as non-binary. All 14 participants reported being current or former members of The Church of Jesus Christ of Latter-day Saints (TCJCLDS). Nine of the participants identified their current religion as LDS, two as agnostic, one as secular, one as questioning, and one as spiritual/not religious. Thirteen participants reported their race/ethnicity as Caucasian and one as Hispanic. All participants were over 18, and their average age was 22.

Interview

Participants were interviewed via Zoom for 1-1.5 hours. Interviews were conducted by five licensed, PhD-level clinicians employed at the university (one woman, four men; all White;

ages 39-66; with 9-25 years of clinical experience; all identify as straight). The interview protocol consisted of 12 questions and was conducted in a semi-structured format (Burkard et al., 2012; see Appendix). Following the interview, participants received a debriefing email with resources for any resulting distress and a link to a $25 Amazon gift card.

Analysis

The research team used consensual qualitative research (CQR; Hill 2012) methodology, to investigate the therapy experiences of participants. This methodology has been used in over 600 published studies and represents a peer-reviewed, established methodology for analyzing qualitative data. CQR involves conducting semi-structured, in-depth interviews with a small sample (10-15) to allow for more in-depth, exploratory interviews. This process yields rich information that provides a foundation for future research. The interviews are analyzed by teams of multiple researchers, who meet to discuss and reach consensus on participants' meaning and identify common themes across interviews. Working toward consensus serves to minimize researcher bias when working with qualitative data.

In this study, seven coders (six undergraduate, one post-graduate; five identify as cisgender women, one as a cisgender man, one as genderqueer; ages 22-48; one Native American/Indigenous, one Asian, five White; one identifies as asexual, one as lesbian/demisexual, one as lesbian, one as gay, and three as straight) were organized into two coding teams. Coding was reviewed by two auditors (psychologists with 13 and 17 years of experience; one cisgender woman, one cisgender man; ages 42 and 43; both White; both identify as straight). As per CQR methodology, coding teams met prior to reviewing data to discuss their biases and assumptions regarding therapy, religion, and sexual identity.

Note on Results

The structured interview questions covered several topics related to the experience of religious sexual minority students and resulted in extensive results. The large volume of results would be difficult to meaningfully discuss in a single article, and so instead, we decided to report the findings in four separate articles, each covering a different topic. In making this decision, we consulted research colleagues and used Fine and Kurdek's (1994) criteria for publishing multiple articles from a single data set. Our data and potential articles fit these criteria in that (1) they are too extensive to be written up in one integrative article, and (2) each article addresses a distinct topic or aspect of the research. This article is the second of these and discusses the role of therapy for religious sexual minority clients who are navigating the conflict between their religious beliefs and sexual orientation. Other articles address RSM students' sexual identity development and understanding, RSM students' interactions with university policy and culture, and conflict between religious and sexual identities.

Results

Through consensual qualitative analysis, we identified four broad categories among the interviewees' responses: *Helpful Aspects of Group Therapy, Unhelpful Aspects of Group Therapy, Helpful Aspects of Individual Therapy,* and *Unhelpful Aspects of Individual Therapy.* Within each category, we found three to five themes. These are listed in Table 1, along with the number of interviews that mention each theme. Category and theme frequencies are represented by the following labels: General (13-14 participants mentioned); Typical (8-12 participants mentioned); Variant (2-7 participants mentioned).

Helpful Aspects of Group Therapy

Nearly all participants (Typical) described ways that group therapy was helpful. Common themes included learning from others (Typical), connecting with others (Typical), working through thoughts and emotions (Variant), therapy providing a supportive environment (Variant), and experiencing increased authenticity (Variant).

Learning From Others

Many participants talked about learning from others in group therapy and how this helped them navigate the conflict between their sexual and religious identities. Within this broader theme, students talked about hearing other perspectives, learning new information or new ways of thinking, and seeing different options for navigating their distress and confusion.

Several students benefitted from hearing other students' perspectives. For one student, hearing from other religious, queer students was a new experience: "I thought it was a good experience to be able to meet with other LGBT members of the church and kind of hear from their perspective, because I really hadn't known many individuals." Another student similarly said "I'll go talk to each of these groups or different people and hear all these different perspectives. Talking about my worries and frustrations helps, but I also hear what everybody else has to say. And sometimes that's really helpful."

The group also spurred participants to change their perspective and incorporate new ways of thinking. One participant explained this saying, "I found myself being opened up to new ways of thought that I never would have if I had not been in those groups. A lot of that new learning came from the students themselves." Another participant echoed this experience saying group therapy involved "having someone there to prompt you to shift into different mindsets to look at things in new ways, prompting you to attempt new approaches to reconciling issues." For this

student, learning new perspectives opened up new options for navigating his conflict. A third student described “discovering different interpretations of the gospel” that allowed her to approach her reconciliation process differently.

Along these lines, many participants in group therapy came to see several different paths for navigating the conflict. For example, one participant said “Group has been good to have those conversations and to see where people’s beliefs are similar to me and are different from my own.” Another participant put it this way: “The LGBT group therapy at BYU, as I was exposed to more experience others have had, really opened up my eyes to [the idea that] there are other ways to live this life.” For another participant, discussions in group made a significant difference in the way he felt about his own choices and those of other religious sexual minority adults:

> Another person in group was talking about how he was a convert [to TCJCLDS], but he was also gay and how the community he found through the church was hugely beneficial to him. That gave me a new perspective because my experience with the church community was so ostracizing and so negative. So I was able to remove myself from the story and see, Oh, this is why people would choose this instead of this, and they’re all okay choices, because we’re all different people. So yeah, it was hugely helpful in helping me come to terms with where I was at, but also where other people were at.

Connecting With Others

Connecting with other religious queer students in therapy groups helped several participants feel less alone. They appreciated being able to talk with other students who had a firsthand understanding of the unique difficulties associated with being both religious and queer.

Multiple participants described realizing, some for the first time, that they were not alone in struggling with the conflict between religion and sexuality. For example, one participant says

"I really appreciate the faith and sexuality groups. Just knowing there are other people here in my same situation. I used to think I was the only gay person at [university]." Discovering that there were other queer students at [university] helped a participant who had felt he didn't belong:

> I'm really glad [university] has a place where LGBTQ members of the church can meet other people in their same boat. You realize you are not alone, that there are people who care about you and know what you're going through. You're not a freak who doesn't belong there at all. You're in good company.

Another participant highlighted the value of this connection, saying "I think it's been really useful in just realizing that I wasn't alone on campus. It was a big part of connecting with more queer religious people."

Relatedly, other queer religious students could understand the particulars of each other's experiences in ways other friends and roommates could not. One student explains this saying,

> Having this group of people that are all queer and have gone through many of the same things as me is really helpful. I can talk about problems that I have, and they'll say, "I know that's frustrating because I've had those same questions" or "I've been in that same place before." They understand me on a level that so many other people can't actually understand.

Another participant expressed a similar experience, appreciating that he could talk with other religious queer students who are struggling with the conflict between their religious beliefs and sexual orientation:

> It was helpful because I was able to meet other individuals who are in a similar boat as me, trying to reconcile our faith and sexuality. And we have these difficulties of being in the church, but we also have these things we're grateful for with the church and trying to

> figure out how we belong and do we belong? And it doesn't make everything easier all the time but it certainly was really helpful for me.

Working Through Thoughts and Emotions

Several participants noted that therapy helped them work through their thoughts and emotions regarding their conflicting identities. For one participant, this took the form of fellow group members helping him understand he had some freedom to make choices:

> I feel so much happier and so much more comfortable in my skin and stuff . . .being able to talk to a therapist or the people in support group and say, I'm uncomfortable here and I don't know what I should do about that. I guess I'm just stuck. And then being told, No, you're not stuck, you don't have to be stuck. That's not something that would have occurred to me had I not been in therapy.

Another participant delayed addressing both his sexual and religious identities. He explains that he was able to finally investigate his sexuality because of group therapy, saying,

> Before [therapy] it was just, I don't really know what this means, but there's time for it later . . .I would have been 18 [when I started group] where I really confronted those feelings and was like, you know what, I think I align myself with this group. This is a part of me.

He was also able to investigate his religious identity in this setting:

> . . . [talking] about our doubts and what we struggle with was huge . . .to talk about how we felt in response to a lot of how we were raised, and the belief systems that we had, and how it continues to affect us and whatnot.

Finally, therapy helped another participant resolve some of their continuing concerns, "It's been really nice in just kind of tying up some loose ends of, you know, figuring out who I am, how I feel about things."

A Supportive Environment

Therapy groups designated for religious sexual minority students at the university provided a valuable space where participants felt comfortable expressing themselves. Participants described "a very safe environment" where they could talk about "whatever needs to be talked about," with "group facilitators who are very kind and nonjudgmental." One participant elaborated on the experience saying,

> I felt comfortable in that space because. . .we had all agreed to keep it amongst ourselves. And so it felt like there was going to be no negative consequences. So I felt comfortable sharing whatever came to mind, and that opened up these floodgates of, Oh, I can actually share this out loud.

Another participant was grateful for the chance to talk to people other than family and friends too tied to the participant's experience, saying they appreciated "being able to talk about things that need to be talked about . . . and having that completely without fear of judgment, or any other emotional investment beyond that." For another participant, therapy provided a supportive setting to explore stating her identity. She appreciated

> . . . having a space where you can try out saying things like, I'm bisexual. And maybe that's scary, but it's a room full of strangers and there's confidentiality and you can kind of experiment. So that's been really great for me.

Participant Being Authentic

Being authentic in group therapy was a meaningful and helpful experience for some participants. For one participant, being able to be themselves while at the university was particularly powerful:

> It's really nice that there's a space made for us at [university]. It's the only space, unfortunately. . . But it feels really great to be like, I'm at [university], in a [university] setting, speaking my honest truth. That is so cathartic.

Another participant had worried that his positive views of religion and [university] would not be accepted in the group, so he appreciated being able to be himself. He explains that many group members had expressed frustration with [university] and the church,

> . . . and there I was, Hi, I like [university], I like the church. And I was afraid that I was going to get all this backlash. But as [Therapist 2] promised me, I received compassion and support in my journey where I was. And now I confidently walk into my RFS groups every semester. And so those were very helpful and very healing.

Unhelpful Aspects of Group Therapy

Only three participants (Variant) discussed aspects of group therapy that were not helpful. Although these themes were uncommon, they represent an important minority opinion and are valuable to our understanding of sexual minority students who struggle to feel heard and understood in university-sponsored group therapy settings. Themes in this category include not connecting with others (Variant), experiencing distress from different perspectives (Variant), and therapy not providing a supportive environment (Variant).

Not Connecting with Others

Although many participants felt that group therapy was a place to connect with others, this was not the case for two participants. One participant explained his experience saying, “And since those people aren’t my friends, I don’t feel like I can meet with them on the same perspective, or like, level of thought, or background or whatever.” Another participant was disappointed he did not meet like-minded people in therapy, saying “I thought it would be more helpful, you know, like – Oh, I’m meeting people who think like me, but no, that wasn’t . . . it didn’t really have any effect.” This participant also described feeling annoyed by other members whose experiences he could not relate too.

Discomfort with Group Content

A few participants felt discomfort with the content that was discussed in their groups. In discussing whether their sexual identity felt positive or negative, one participant responded that therapy highlighted the negatives saying, “And it being therapy means that we’re not going to talk about many positives.” Other participants described feeling very drained from their group participation. One said “I reached this point where I just said, this is not healthy. Because every day I would come home, and I just felt awful. I never felt good after leaving one of those groups.” Another said, “every time I went, I would leave feeling worse.” For another, hearing the pain of other students who had been rejected by their parents was sometimes too much:

> And there were several weeks where it was really, really emotionally draining and I would just leave completely exhausted because it just is so sad to hear about, like, my mom doesn’t love me anymore because I’m gay.

This participant also described how discussions in the group contributed to his internal conflict between his identities. He had decided to stay committed to his religious teachings, but it was

confusing to hear other students talk through their conflict navigation that resulted in their prioritizing their sexual identity:

> And so, it makes me so happy that they're doing what they feel is right, and that's great, but it's also a little bit hard to watch these people and worry as they all talk about things that I have conflict with, and they say "Oh, well, I was like that, but I just don't worry about that anymore." He said that these discussions make him think "Oh, is that the only way for this to go? Like, is the only way for this to go that I leave the church? Or give up on my faith?

Not a Supportive Environment

Although many students found group therapy at [university] to be a haven, a few participants found it "hostile" and "toxic," particularly to their conservative or religious opinions. One participant explained it this way: "It's not necessarily that they explicitly said that my desire to be active and get into a mixed orientation marriage was wrong . . .but it was very much, almost like unacceptable for me to express that kind of a belief." He goes on to say, "I felt very boxed and closed in, because I couldn't express my true opinions." When he did express himself, he

> . . . got a lot of backlash. They were just like, no, that's wrong . . . And that was kind of difficult, because I was like, I get that maybe it needs to be qualified a little bit, but this is how I feel. And this is what I believe. And so, I can't just abandon that.

Another participant had a similar experience and related his thoughts at the time: "I'm like, here you are bashing everything I believe in constantly, and I can't say one tiny thing about like, hey actually I do believe this, without someone freaking out and running off."

This disconnection, negativity, and lack of support prevented these students from benefitting from a group therapy setting at their religious university – one of the few school-sponsored places they could have discussed their experiences with other students facing similar conflict.

Helpful Aspects of Individual Therapy

Almost all participants (Typical) said that therapy was helpful as they navigated the conflict between their sexual and religious identities. We found themes in their responses relating to the helpfulness of processing and exploration (Typical), of having a supportive environment (Variant), and of their therapist encouraging social connections (Variant).

Processing and Exploration

Most participants said that therapy facilitated their processing of the complicated issues accompanying their sexual and religious identities. Having a place to explore their thoughts and feelings made a difference in their wellbeing. One student described feeling suicidal after attending a class about eternal families. A friend encouraged them to try therapy, which they did and found it "really helpful because I just had all this grief and emotional constipation, I guess, that I was able to talk through with somebody." Another participant put it this way: ". . .honestly, I feel like just being able to talk about what I was going through is what helped me get to where I am now where I feel so much happier and so much more comfortable in my skin."

Many participants also reported that through processing their thoughts and feelings in therapy, they gained greater self-understanding. One participant explained that therapy helps by "guiding you through putting your thoughts together a little more. Like actually being able to draw conclusions from a bunch of experiences that maybe you weren't sure were related." A couple of participants referred to the role of exposure in overcoming anxiety, with one student

saying they learned about “accepting yourself and exposing yourself to some of the things that cause anxiety with the goal of helping me not be as anxious in the future.” Another student discussed his trouble with thoughts and concerns that would get stuck in his head. He said that before he felt like he had to “completely get rid of that and not even think about it,” but with therapy, he learned to talk about it and “figure out how to put it in a good place so that it’s not so overwhelming in [my] mind.”

The ability to process thoughts and feelings with a therapist was especially necessary for students who were not out to everyone in their lives or who did not feel comfortable talking about their sexual identity with family or friends. For example, one participant said “Individual therapy is a good thing, good just to. . .talk about my individual thoughts, where it’s awkward to talk to other people. Especially if I’m not out to them, then it means that it’s impossible for me to talk to them.” Another said therapy was helpful “just having the consistency and somewhere to be like “blegh,” you know, because there’s a lot going on and in this environment, you can’t really expose it.”

Therapy also played an important role for some students in helping them navigate their religious beliefs; beliefs that had become complicated in light of their sexual identity. One participant explained this saying,

> I would be able to have existential conversations and reconcile where I was on that journey and what I feel about God, and what God feels about me, if there is one, and learn to reclaim a sense of love and purpose, even if it wasn’t necessarily rooted in a religion.

Another participant similarly described working through their internal conflict in therapy:

> Because growing up with the LDS faith and this, you're constantly going to be battling yourself all the time. Because your own, actual desires are going to go against what everyone's told you, and so it's kind of like this constant butting heads inside. And if it's happening inside you, you can't really be a very good authoritative opinion on which side is right, because they're both you. And so having someone who's trained to take them apart and be like – Okay, this is how you're feeling about this, and this is how you're feeling about this . . . you have to find out which one of those is really what you actually want and it's hard to do that on your own.

A third, female student related how their therapist helped them explore beliefs about dating someone of the same sex:

> I remember talking to my therapist about how I had wanted to date a girl, just so I could clarify things and maybe figure out if I was bisexual or just gay. And my therapist said, well why haven't you? And I said, well, going on a date would be a sin. And they said, well is it a sin? And I said, I don't know. And I think that was just one of those parts where it was like, oh, this is okay for me to kind of explore so I can at least figure out what this is.

A Supportive Environment

Several participants described the supportive environment their therapist created, which made them feel comfortable to explore their thoughts, feelings, and options. One participant related their experience of seeing the acronym "LGBT" written on the whiteboard in the therapist's office: "And that was one of my first times seeing any trace . . . of gay people existing at [university], and I was like, whoa!" They go on to say:

> . . . to hear same sex attraction or hear reconciling faith and sexuality, you're like, is this a safe space for me? Is this going to be like conversion therapy, or is this going to be like, undermining or gaslighting, or anything like that scary stuff. But when I hear LGBT, I feel like I'm in a place of respect and safety.

Another participant appreciated the "open and positive" setting his therapist created:

> He never said, 'this is the only way that you can be happy', or 'do this or that'. He just said, 'Explore your options, explore your possibilities. And in the end, God is going to be appreciative of your efforts in trying to figure out what the right thing is to do, even if you don't know in the moment.' And that was a really positive experience.

The therapist's "open perspective" was important to another participant, who also valued their therapist's understanding of their religious identity: "She's very validating of my feelings but also, she understands my religious background, and so that's really helpful." Similarly, another participant appreciated that their therapist did not seem to be pushing an agenda:

> They weren't trying to get me to stay in the church or leave the church or anything. They were just asking questions and wanting to see where I was at, and what I thought about things. And it became a very safe sort of refuge to just be able to be like, hey, today I feel this, last week I felt this . . .

These participants found it meaningful and helpful that their therapists provided an atmosphere that recognized their religious and sexual identities.

A few students said the supportive environment helpfully allowed them to be authentic and honest with themselves. For one participant, this authenticity moved him toward accepting himself:

> Once I got talking to him, that was definitely helpful, just kind of being able to be more honest with myself. And it's hard for me to remember specifically how much of that was accepting myself, but I think it definitely played a role.

Another participant talked about how he struggled at first to be authentic, saying "I had a huge sense of pride about how good I was at putting up walls." But when he asked another therapist to confront him and "call me out on my crap," that was "the beginning of dismantling the walls" and he was able to start being honest and authentic, which led to progress. Similarly, a third participant also took time to be authentic in therapy:

> I remember my first few sessions, I felt like I was trying to fake progress to make my therapist feel good, instead of saying, no, I don't feel better... And eventually, I realized that was bullshit and decided to cut that out and be more authentic. And that's when things became so much more doable for me.

This participant's authenticity was also catalyst for progress in individual therapy.

Therapist Encouraged Social Connection

A few participants talked about how their therapist encouraged them to make connections with other people. One participant remembered his therapist telling him to "have someone that knows that I'm gay that I could talk to. Like, don't come out entirely, but have close friends that know." Another participant's therapist urged him to "join the support group, because he said, it's probably nice to be able to talk to other people on a weekly basis who are at similar points that you are." Connecting with a therapy group, at the encouragement of his therapist, helped another student navigate his conflicting identities: "we opened up the idea of that therapy group – that's what really helped to take off the chains, metaphorically, and really give myself the room to think about those things."

Unhelpful Aspects of Individual Therapy

Almost half of the participants (Typical) described how individual therapy was unhelpful at times. These more negative therapy experiences centered around problems with the therapist (Variant), participants' unreadiness for change (Variant), and problems with the therapy process (Variant).

Problems With the Therapist

Several students related difficulties they experienced with therapists in individual therapy. The most common of these was trouble connecting with the therapist. One student described their first attempt at therapy saying that "it was with some lady that was pretty new, and I just didn't vibe with her and really get anywhere and so I kind of just stopped." Another talked about the "difficult transition" of starting with a new therapist because "he doesn't necessarily connect with me on the same level that the last guy did." Similarly, a third explained how it can be hard finding a therapist you connect with: ". . . with individual therapy, it's just, it's just hit and miss about whether you and your therapist are really going to get into the flow of things, really going to bounce off of each other in the most effective way possible. And I've yet to really find an individual therapist that I click with."

A few participants reported negative experiences with therapists that went beyond trouble connecting. One interviewee described a therapist he had early on as almost a conversion therapist: "Sometimes it's easier for me to say he's a conversion therapist. He's not really a conversion therapist but he's on the verge of it." This therapist encouraged the gay, male participant to date women. The participant still feels unsure about how to think of this therapist, saying, "Sometimes I look back and I think I made the wrong decision [leaving the therapist], and I should have just kept with his way of thinking about things. And sometimes I'm glad I

didn't, and I'm always wrestling with that." However, when asked about feeling tension between his religious and sexual identities, this participant said "When I was talking to [this first therapist], that was when it was the worst. . . I was really trying to belittle [my gay identity], and beat myself up, that aspect of my brain up in order to keep the spiritual identity."

Another participant described having a "humanistic therapist" who he felt went too far in discounting the participant's religious beliefs:

> And so, he's very much just of the mindset of, it doesn't matter what the Church says, Just do what you, you do you and no matter what happens, you are right, you are validated. And sometimes it goes a little bit too far to the point where it almost feels like we're throwing out morality saying like, oh, because everything, you know, has such unconditional positive regard, it almost feels like we're taking away right and wrong.

A third participant noticed he became defensive because he distrusted his therapist's intentions: "I was getting all defensive because. . . I thought he was trying to turn me gay."

Problems With the Therapy Process

For some participants, the difficulty was less with the therapist than with the format and process of therapy. One student described his inexperience with therapy: "It was hard to do therapy for the first time because I had no idea what I was doing. I didn't have the language. I didn't have the understanding of what I was supposed to do and be working towards." Another participant says he "didn't go in with the right attitude."

Participant Not Ready to Change

A few participants encountered difficulty in individual therapy because they were unprepared to make changes in their lives. One student mentioned that his struggle with therapy "might have been partly my attitude going in" and another talked about how his therapist "got so

little out of me" because he "gave her so little, and I was even proud of myself saying how I even fooled a therapist." He goes on to say, "I remember putting up a lot of walls and closing a lot of doors in a sense that I wouldn't talk about those things," referring to talking about his sexual identity. A third participant attributed the difficulty of his early therapy to his own reluctance to engage: "I used to walk out emotionally drained, and I would call it emotional chemotherapy. And at the same time, I recognized that a lot of that pain came from my own resistance to the therapy session."

Discussion and Limitations

The objective of this study was to explore the therapy experiences of religious sexual minority college students. We were particularly interested in the role of therapy in students' exploration and navigation of the conflict between their religious beliefs and their sexual orientation. In response to interview questions, participants described ways that group and individual therapy did or did not help them work through their feelings of conflict. For both group and individual therapy, many of the themes we found in participant responses represented principles of therapy that have been found to be helpful (or not) across many populations. In other words, good and bad therapy experiences for RSMs appear to be very similar to good and bad therapy generally. Here we describe these themes and their related principles, as well as present a few considerations when applying these general therapy principles in working with RSM clients.

Group Therapy

Participants described helpful elements of group therapy that included learning from and connecting with others, working through thoughts and emotions, having a supportive environment, and being able to be authentic. Unhelpful aspects included not connecting with

others, not a supportive environment, and discomfort with group content. These themes relate to the therapeutic factors laid out by Yalom and Leszcz (2020) in their work on group psychotherapy, including group cohesiveness, universality, imitative behavior, and insight.

Group Cohesiveness

Group cohesiveness is an analogue to the client-therapist relationship in individual therapy and includes not only each group member's relationship to the therapist, but also to other members and to the group as a whole (Yalom & Leszcz, 2020). Like alliance, cohesiveness is significantly positively associated with outcome. Yalom and Leszcz (2020) explain that members of a cohesive group "feel warmth and comfort in the group and a sense of belonging; they value the group and feel they are valued, accepted, and supported by other members" (p. 76). Such group qualities create the setting for other therapeutic factors to bring about change. We see this in our findings when participants described experiencing a supportive environment, saying "I felt comfortable in that space . . .sharing whatever came to mind" and describing "a very safe environment" with "group facilitators who are very kind and nonjudgmental." This comfort and acceptance led to increased openness and exploration, as participants felt free to "talk about whatever needs to be talked about." For one participant, for example, the comfort "opened up the floodgates" of being able to openly express and work through his conflicting feelings.

The cohesiveness-related value of acceptance, in particular, played a prominent role for good and bad for participants. A few participants worried that their religious beliefs may not be accepted in the group, that they "would get all this backlash." For one participant, this fear was disconfirmed as he participated in a group that demonstrated acceptance: "I received compassion and support in my journey where I was." Because of this support, he found the group "very helpful and very healing." Other participants had the opposite experience. They experienced their

groups as lacking support and acceptance, at least for their beliefs and opinions, saying that "it was unacceptable for me to express that kind of a belief" and "I couldn't express my true opinions." Yalom & Leszcz (2020) explain that "cohesive groups have norms . . . that encourage open expression of disagreement or conflict alongside support" (p. 97). These students did not feel able to express disagreement. It seems it was this missing cohesiveness these participants found unhelpful.

Cohesiveness may be somewhat more challenging in groups focused on the navigation of religious and sexual orientation conflict. Participants who fully hold to the teachings of their religion may see other group members as "sinful" or "bad influences," whereas participants who have chosen to separate from their religion may feel "triggered" or distressed by other members' desires to "stay faithful." We see an example of this in the response of the participant who said, "I'm like, here you are bashing everything I believe in constantly, and I can't say one tiny thing about, hey, actually I do believe this, without someone freaking out and running off." This student describes feeling that his beliefs are being "bashed," and his description of other students possibly "freaking out and running off" when they hear his beliefs demonstrates the other students' distress at hearing positivity about religion. Yalom and Leszcz (2020) emphasize the role of the group leader "to endorse critical and analytic thought by the group members" saying "it is always wise to respect the perspective of the dissonant voice" (p. 101). Special attention to the challenge to cohesion created by the religion-sexuality conflict may assist therapists in structuring and running groups in a way that is helpful to all participants, regardless of where they are in their navigation.

Universality

Yalom and Leszcz (2020) describe universality as the “disconfirmation of a client’s feelings of uniqueness” (p. 15). It is the feeling that other people are going through the same problems - that the client is not alone in their suffering or unacceptable to the rest of society. This is particularly important for people who have felt they have to hide their problems, or parts of who they are, as some RSM individuals likely do. Indeed, Yalom and Leszcz (2020) go on to explain that “when secrecy has been an especially important and isolating factor for someone, a specialized group composed of individuals with similar experience can offset stigma and shame” (p. 17). Many of our participants echoed this, saying it was helpful “just knowing there are other people here in my same situation” and that the members of their group “understand me on a level that so many other people can’t actually understand.” One participant detailed the group member’s common problem, saying “we have these difficulties of being in the church, but we also have these things we’re grateful for with the church, and trying to figure out how we belong, and do we belong?” We can see the decrease in shame one student felt as they realized that they are “not a freak who doesn’t belong there at all.”

Conversely, when a group member does not experience universality in their group, they find therapy less helpful. A few of our participants portrayed this as they described feeling that “those people aren’t my friends” and they could not “meet with them on the same perspective.” One participant thought therapy “would be more helpful” because he would be meeting people “who think like me,” but did not end up feeling that in his group. Group members may have similar difficulties but be approaching these problems differently. This seemed to be the case with these participants who struggled in groups – they were navigating their conflicting sexual orientation and religious beliefs but approaching the conflict differently than other group

members. This led both to them not experiencing cohesiveness-related acceptance (as described above) and not experiencing universality – that commonality of perspective. The lack of these therapeutic factors was unhelpful for the participants.

When therapy groups are focused on the navigation of the conflict between sexual orientation and religious belief, there may be members who are more closely identified with their sexual orientation than their religious beliefs and vice versa. This may increase the difficulty of participants experiencing and benefitting from universality. A possible solution might be that a therapist abstracts out a level and helps participants see the commonality of the uncertainty and pain of their struggle, or of the loss involved with certain choices. Yalom and Leszcz (2020) describe this saying that group leaders “must also look at transcultural – that is universal – responses to human situations and tragedies” (p. 18). Helping group members see their common struggle, even with members making different choices, may facilitate increased universality and therefore benefit to members.

Imitative Behaviors and Insight

Yalom and Leszcz (2020) explain that “group members learn not only from the therapist but also from watching one another tackle problems” (p. 29). They call this phenomenon “imitative behaviors” and describe it as an underestimated therapeutic factor. This imitative behavior is a type of learning that can lead the participant to gain insight into their own thoughts, feelings, beliefs, and choices. Insight is another of Yalom and Leszcz’s (2020) curative factors and “occurs when one discovers something important about oneself – about one’s behavior, one’s motivational system, or one’s unconscious” (p. 66). We found evidence for this imitative learning and associated insight in our theme of “learning from others.” Our students described how hearing other perspectives “opened their eyes” and showed them “new ways of thought”

and “different mindsets.” This new knowledge helped them become aware of and consider different ways (“attempt new approaches”) to navigate the conflict between their sexual orientation and beliefs. As these students watched their peers “tackle” the problem of their conflicting sexual orientation and religious beliefs, they learned from each other’s efforts and experiences. As an example, one participant heard another group member describe going through a “grieving period with the church” as this person “[recognized] that this idea for the future was no longer a thing.” Hearing this language used by this group member helped our participant put words to their own experience, gaining insight and understanding into what they were feeling.

Experiencing insight through social learning process may be particularly useful for RSM young adults. As Lefevor and Williams (2021) point out, unlike racial and ethnic minorities who usually grow up in families consisting of members with those same identities, sexual minority individuals often grow up as the only non-straight member of their family. They do not have the same opportunities to learn from the modeled behavior of those around them. Further, if the individual is part of a non-affirming religious community, they may be less likely to be “out” or know other “out” individuals. This set of circumstances heightens the value of seeing and learning from the various modeled behaviors and approaches of group members dealing with similar difficulties.

Unfortunately, some participants were unable to benefit from this aspect of group therapy. One participant said they “never felt good after leaving one of those groups” and another said they “would leave completely exhausted because it is just so sad to hear” the difficult situations of other group members. For another participant, the distress resulted from hearing about life choices that were different than their own. Hearing other group members describe their process of letting go of their religious beliefs made him worry “is the only way for

this to go that I leave the church?" It is interesting to consider why the social learning experiences had this negative effect on some participants. Theorists have also described the issue of homogeneity and heterogeneity within the group, variably recommending a mix depending on presenting problems, diagnosis, symptom severity, etc. (Lefevor and Williams, 2021; Yalom & Leszcz, 2020; Yarhouse & Beckstead, 2011). It could be that groups for RSM clients should consider increased homogeneity of participants' current approach to the conflict between their sexuality and religiosity. Perhaps insight is more readily experienced when group members learn from others they perceive as familiar and relatable. On the other hand, it would seem that learning to sit with and tolerate others' differing choices would be an important skill for clients who are dealing with such a complex conflict. Insights gained from exposure to discomfort and pain may be deeper and more abstract, applying to processes throughout the person's life rather than only conflict-specific topics.

Summary of Group Therapy

Taken together, our interviewees expressed helpful and unhelpful aspects of group therapy that are represented in Yalom and Leszcz's (2020) "curative factors" - therapeutic elements that serve as mechanisms of helpfulness and change. Participants experienced cohesiveness, universality, and imitative behaviors as helpful, and the lack of these unhelpful. Specific challenges to these therapeutic factors may result from the subject matter these groups address – particularly that as clients navigate conflicting religious beliefs and sexual identities, their choices may lead to conflict and difficulty between group members themselves. Group leaders can mitigate these difficulties by attending to the cohesiveness of the group, engendering universality by emphasizing common human emotions "tragedies" as opposed to specific

choices, and by helping participants process and manage their distress at others' negative experiences or different life choices.

Individual Therapy

Participants described helpful aspects of individual therapy that included processing and exploring, a supportive environment, and their therapist connecting them with social resources. Unhelpful elements included the participant having problems with the therapist and the therapy process, and not being ready to change. In these themes we see principles that have been discussed in broader psychotherapy research. There is a rich body of literature discussing so-called common factors of psychotherapeutic healing that are found across therapy modalities. Here we discuss how elements of three of these models – Bailey and Ogles' (2023) common factors therapy, Lambert and Ogles's (2004) common factors, and Wampold and Imel's (2015) contextual model – relate to themes found in our data.

Initial Bond and Real Relationship, Support Factors, and Therapeutic Alliance

Wampold and Imel (2015) claim that before other therapeutic factors can operate, "the therapist and client must form an initial bond" (p. 53) built on "sufficient engagement and a level of trust" (p. 55). The client and therapist can then build on this bond to create a "real relationship" that involves connection, genuineness, and empathy. Bailey and Ogles (2023) term this the "therapeutic relationship," which they define as a "discernable bond and an attitude of working together on tasks to move toward agreed-upon goals that help the client remoralize," fostered by an empathetic therapist (p. 45). Lambert and Ogles (2004) similarly include trust, positive relationship, therapeutic alliance, and therapist empathy in his "support factors" - one of three sets of factors (the others are learning and action factors) that work sequentially to create change in the client (pp. 171-173). Each of the models emphasize the essential quality of

therapeutic relationship. Bailey and Ogles (2023) explain that "a good therapy relationship is the foundation upon which change intervention strategies are built" (p. 38), and Lambert and Ogles (2004) describe the support factors as providing for "a cooperative working endeavor in which the patient's increased sense of trust, security, and safety . . . lead to changes in conceptualizing his or her problems and ultimately in acting differently" (p. 173). Budge and Wampold (2015) explain that with a bond and relationship, the client will have "the assurance of a continuing relationship with a therapist who is trained and expected to be empathetic" (p. 222). The relationship also provides "doses of connectedness" (p. 223) throughout therapy that contribute to overall wellbeing (Budge & Wampold, 2015).

We see these aspects of the therapeutic relationship at work in the theme of "a supportive environment" when participants describe therapists who are "validating of my feelings" and "open and positive," and who create "a place of respect and safety" and "a very safe sort of refuge" in the therapy room. The participants' own genuineness with the therapist stood out particularly as a helpful aspect of therapy. One participant describes being "more honest with myself." Another says that when he was "more authentic," "that's when things became so much more doable for me." This genuineness is likely especially important for students who may not have been "out" to many people. On the other hand, experiencing problems with the therapist was the most frequently reported unhelpful aspect of therapy. The problems they describe demonstrate a lack of a trusting, engaged bond or a genuine, connected real relationship. For example, participants explain experiences with new therapists, saying "I just didn't vibe with her," "he didn't necessarily connect with me," and "I've yet to really find a therapist that I click with." Our participants' responses support the importance of the initial bond and real relationship, as they comment on that relationship being helpful or unhelpful.

For an RSM client, the therapist may need to make a specific effort to demonstrate respect for and understanding of the client's religious beliefs and sexual identity as they work to create the bond and real relationship. We see this in the participant relieved at seeing the "LGBT" acronym because she had feared "conversion therapy," as well as in the participant who appreciated that his therapist "understands my religious background." Interestingly, in addition to incorporating general interpersonal dynamics, the initial bond may show the impact of our discipline's history regarding sexual orientation and religious belief. Clients may be more hesitant to trust therapists given their knowledge of conversion therapy, or their perception of therapists telling clients to leave their religion. These were concerns our participants voiced in describing their first visits with a new therapist.

Another aspect of therapeutic relationship described by Bailey and Ogles (2023), drawing upon the work of Bordin (1979), involves the creation of tasks and goals, which are therapeutic activities and objectives agreed upon by the therapist and client (p. 46). Participants who described problems with the therapy process were speaking to a lack of these tasks and goals. For example, one explained that "I had no idea what I was doing . . . I didn't have the understanding of what I was supposed to do and be working towards." This client was not clear on the tasks of therapy ("what I was supposed to do") or the goals (" . . . and be working towards"). Another participant's description of the unhelpfulness of a "humanistic" therapist who had the mindset of "you do you and no matter what happens, you are right, you are validated" also might represent this misalignment of tasks and goals. Here the participant does not seem to have agreed with the therapist's tasks and goals of therapy. His goal was not to have all his action validated. Because he and the therapist did not agree on what they would do and why, he found this therapy unhelpful. It is possible that this lack of clear tasks and goals relates to the

nature of the distress – it may be hard to identify a goal with a client navigating a seemingly intractable conflict. The therapist may assume that the client has a goal of choosing one identity or set of beliefs and abandoning the other and may believe they know which goal the client should work toward.

Creation of Expectations, Motivation

A second pathway of the contextual and common factor models is the "creation of expectations" or "motivation." Bailey and Ogles (2023) discuss the difficulty of change and the usefulness of therapy in addressing that difficulty: "Therapy can be a vehicle for exploring not only the whats and hows of change, but also the whys, the reasons that feel compelling enough to help clients move toward change" (p. 85). Wampold and Imel (2015) explain that this exploration is facilitated by the client's acceptance of the explanation for the disorder, as well as the therapeutic actions that are consistent with the explanation" (p. 59). In other words, they need to "buy in" to the therapist's plan. Within our theme of "participant not ready to change," participant responses seemed to indicate both a lack of this buy-in as well as an identification of compelling reasons for change. They describe "put[ing] up "a lot of walls" as well as putting up "resistance to the therapy session." One participant said he believes therapy was unhelpful in part because of his "attitude going in." These participants do not seem to believe that the therapist's approach, the method of the therapy, would work for them. Using words like "resistance" and "walls" portrays an unwillingness to engage, which may be due to an absence of hope and expectation that therapy will work.

Specific Ingredients, Learning and Action, Insight and Corrective Experiences

Wampold and Imel's (2015) third pathway involves "specific ingredients." These "specific ingredients" are healthy behaviors clients do both in and out of therapy that lead to

better functioning. As examples of this healthy behaving, clients might “substitute adaptive attributions for maladaptive ones, address emotional issues with significant others, act assertively, develop friendships, express repressed emotions, and so forth” (Budge & Wampold, 2015). Lambert and Ogles’s (2004) learning and action factors include many similar therapeutic activities, such as cognitive learning, affective experiencing, and taking risks, as well as insight, corrective emotional experiences, and encouragement of facing fears (p. 173). Bailey and Ogles (2023) name insight and corrective experiencing as change processes, and these categories incorporate many of the specific ingredients and learning and action factors of the other models (p. 32). In each of these models, these factor or activity groupings represent an abstracted level of change processes and interventions that span many types of therapy. Where the therapeutic bond included an agreement on tasks, this is the level of therapeutic tasks themselves.

For many participants, these specific ingredients or factors were at work in the theme of “processing and exploring” and were helpful parts of therapy in navigating their conflict. Primary among these were gaining insight and awareness in therapy. For example, participants learned to “be aware of [my] thoughts and feelings,” "draw conclusions from a bunch of experiences,” and recognize their “black and white thinking.” Participants also described corrective experiences of being open to thinking about their sexuality rather than just “completely getting rid of ” an unwanted thought, and of feeling a sense of love and purpose “not necessarily rooted in a religion.” Other helpful therapeutic actions similarly reflected change process elements of the common factor and contextual models, such as “talking about my thoughts,” “exposing [my]self to some of the things that cause anxiety with the goal of helping me not be as anxious in the future,” and figuring out how to put “stuck” and unwanted thoughts and concerns “in a good place so that it’s not so overwhelming in my mind.” Another theme, that

the therapist encouraged social connection, also serves as an example of a healthy behavior described by Budge and Wampold (2015): building social connection and resources (p. 218). One therapist encouraged a participant to "have someone that knows I'm gay that I could talk to" and another participant's therapist urged him to "join a support group." These social behaviors may be particularly relevant for RSM students at a religious university who may lack necessary connection and resources due to concerns about their sexual identity.

Summary of Individual Therapy

Participants reported helpful and unhelpful aspects of individual therapy that represented common factors of therapeutic effectiveness theorized by Lambert and Ogles (2004), Wampold and Imel (2015), and Bailey and Ogles (2023), among others. Many students experienced a strong and meaningful bonds and relationships with their therapist, while others described the unhelpfulness of therapy with a weak or absent bond and relationship or a lack of agreement on tasks and goals. Participants also benefitted from specific ingredients or learning and action factors (including Bailey and Ogles' insight and corrective experiencing), which are the aspects of therapy that increase certain healthy behaviors. Specifically, for these RSM students, therapists can deliberately validate their sexual identity and religious beliefs as a way of strengthening the bond and relationship – particularly when these clients may be skeptical of the therapist's approach toward these identities. Therapists can also work to clearly identify and agree on goals with clients who are struggling with a conflict that may not lend itself to a clear, hoped for outcome.

Conclusion and Limitations

We set out to further the understanding of effective therapy for religious sexual minority clients. Our findings indicate that well-established therapeutic factors are helpful for this

population. In addition to these general “curative” and “common” factors, we found that additional steps such as paying careful attention to issues of universality and cohesiveness in groups of individuals differently navigating conflicting identities, and specifically validating clients’ sexual identity and religious beliefs when those have historically been oppressed or devalued in psychotherapy, may be important in providing effective therapy for RSM clients.

Our findings contribute useful information to the knowledge base of therapy for religious sexual minorities; however, our results should be interpreted within the limitations of the study. These limitations include a small sample composed of predominately white students who are all members of TCJCLDS, various forms of selection bias, as well as interviews conducted by psychologists who were all white and all members of TCJCLDS.

Our sample was deliberately small, as per CQR methodology, to allow for greater interview depth. Even with that in mind, however, the sample was composed of students from only one religion, and all but one are white. Therefore, our results do not represent the experience of religious sexual minorities from other religions. This is important, as the specific beliefs and practices of different religions likely interact differently with a minority sexual identity. For example, there may be different prohibitions on or beliefs about afterlife consequences for same-sex relationships or sexual behavior. Additionally, sexual minorities from different racial or ethnic backgrounds, or of different ages or abilities, may experience their sexual and religious identities differently. For example, racial minorities may access necessary community or resources through their religious affiliation, thereby giving their religious identity heavier practical weight than it holds for a member of the majority racial group.

Additionally, our sample suffers from both selection and self-selection bias. We recruited participants from a therapy group focused on religious and sexual conflict. Though this was our

intention, as we wanted to study the role of therapy in dealing with this conflict, that each participant experiences conflict may give the mistaken impression that all religious sexual minorities feel conflict between their religious beliefs and sexual orientation. Also, the participants who responded to our request for interviews may not represent the broader group dealing with the conflict. Our participants may have had especially positive or negative experiences that led them to feel more compelled to share their experience than students with a more neutral experience.

Finally, our interviewers all identified as white, straight members of TCJCLDS. Though the interviewers did not disclose their sexual identity, they did identify as being associated with the university, and participants may have assumed they were heterosexual and felt less comfortable sharing their experiences with someone who did not share a minority sexual orientation. It is also possible that interviewers who are not sexual minorities may have chosen different follow up questions and emphasized different aspects of participants responses during the interview than a sexual minority interviewer would have. Also noteworthy is that no interviewer shared participant sexual identity, but all interviewers identified with participants' religious belief system. By holding the religious beliefs but not the sexual orientation, interviewers may have inadvertently placed more weight on religious experience and not gathered complete information regarding both sides of the conflict experienced by the participants.

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Table 1

Sexual/Religious Conflict in Therapy: Results

Category	Theme	Frequency
Group therapy helpful (n=12)	Learning from others	T (10)
	Connecting with others	T (9)
	Working through thoughts and emotions	V (7)
	A supportive environment	V (4)
	Participant being authentic	V (3)
Group therapy unhelpful (n=7)	Not connecting with others	V (2)
	Discomfort with group content	V (2)
	Not a supportive environment	V (2)
Individual therapy helpful (n=12)	Processing and exploration	T (11)
	A supportive environment	T (9)
	Therapist encouraged social connection	V (3)
Individual therapy unhelpful (n=6)	Problems with the therapist	V (5)
	Problems with the therapy process	V (3)
	Participant not ready to change	V (3)

Appendix A

Semi-Structured Interview Questions

1. Tell me about yourself.
2. How would you describe your spirituality and/or religious practice at this time in your life?
3. How would you describe your sexual orientation?
    a. Do you prefer to identify as LGBQ or SSA (Same-sex attracted)? Or do you not have a preference?
    b. If you have a preference, what is your reasoning behind choosing one label over the other?
4. When did you first start to recognize that you may be a sexual minority?
    a. Can you tell me what the coming out process looked like for you?
    b. How were you accepted by your family, peers, church, school, etc.?
    c. c. Any experiences you can share here?
    d. Is your sexual identity a positive, negative, or neutral aspect of your life?
5. Tell me about your choice to come to [university]?
6. How did you first understand your sexual orientation in the context of religious beliefs?
    a. Has that understanding changed over time? If yes, how?
    b. Any experiences you can share here?
7. Have you ever seen or felt any tension between your religious identity and sexual identity?
    a. How have you dealt with that tension?
    b. What has helped to ease the tension or made the tension worse?
8. Do you feel like there has been any conflict in reconciling your religious beliefs with your sexual identity?
    a. Tell me about this process (process of reconciling your sexual identity with your religious identity. Or if no conflict, how they think about it.)
    b. If yes, what is helping you in reconciling your identities or keeping you from reconciling your identities?
9. What role has therapy played in working toward reconciliation?
    a. Can you speak to the effectiveness of individual therapy and/or group therapy in helping you in the reconciliation process?
    b. What aspects of therapy are the most beneficial to you in helping you in this process?
    c. Any experiences that you can share here?
10. Future ideas about reconciliation-- if you were to guess, how would you resolve this conflict (if there is a conflict)?
11. What would help you move towards resolution of a conflict/reconciliation?
    a. What can family, peers, church, school, etc. do or change to help you in this process?
12. Is there anything else you would like to add that you think is relevant?