I began working with sexual minority youth during my adolescent medicine fellowship. I worked with outreach organizations and with the LA Free Clinic to serve homeless youth living in Hollywood. Our standard history included questions about sexual behavior and identity. We asked each patient regardless of gender about sex with “males, females, or both.” I continued this aspect of my history taking during a long career at a suburban teenage and young adult medical practice. I learned early on that if I didn’t ask, the patients wouldn’t tell. So I did ask, and the patients did tell. The volume of same-sex behaviors and self-identified gay youth I was seeing initially surprised me. I found that frequently I was the first person a young person came out to, and I always felt privileged to have had that role. I also helped many families to access PFLAG (Parents and Friends of Lesbians and Gays).

After a career in teenage and young adult medicine, a large part of which was dedicated to reproductive health, I decided to retrain in psychiatry. I plan to continue to be an educator, advocate, and practitioner helping gay, lesbian, bisexual, and transgender individuals reach their full potentials.

**Homosexuality Is Not a Disease**

It took years of scientific and political work to be able to confidently assert this idea. Beginning with the psychometric research of Evelyn Hooker in the 1950s (Hooker, 1957), followed by 16 years of concentrated political focus by the gay rights movement, homosexuality was removed as a mental illness from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in two stages between 1973 and 1976 (Rubinstein, 1995). Hooker demonstrated that carefully matched heterosexual and homosexual males were indistinguishable from one another when examined for psychopathology using projective testing. Armed with this scientific fact, the gay rights movement eventually convinced the American Psychiatric Association to end the promulgation of the idea that homosexuals were “sick.”

**Why Discuss This Topic?**

The majority of the chapters in this handbook focus on treatment of the forms of sexual suffering, sexual limitations, or sexual psychopathology that are included in the fifth edition of the DSM (DSM-5; American Psychiatric Association, 2013). This chapter joins the list of others, such as those on infidelity, cancer survivorship, and people who are single again, that discuss background forces that may lead to a diagnosable sexual problem. While homosexuality per se is not a mental disease, it does cause a significant amount of dis-ease in gay, lesbian, and bisexual patients; in their families; in people...
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who are not under psychiatric care; and in mental health professionals (MHPs) who provide care for them. A homosexual issue, poorly managed, can lead to a variety of significant problems. Without sufficient knowledge of relevant topics, both MHPs and patients may approach the subject of homosexual or bisexual orientation with wariness and discomfort. The ultimate goal of this chapter is to decrease the anxiety associated with caring for gay male patients and thereby to make the experience more comfortable and useful for all involved.

I realize that this chapter alone may fail to help every reader to gain the understanding, comfort, and eagerness needed to be of assistance to members of the homosexual community. I hope it will stimulate a greater awareness of what it means to be a gay male in a world that assumes the inherent superiority of all things heterosexual (heterosexism). The current designation for a heterosexual therapist who can work calmly, competently, and helpfully with homosexual men is a “culturally sensitive clinician.” I hope to help you obtain this status.

The Problem of Historical Prejudice

Same-sex behavior and same-sex relationships have always existed. Cultural attitudes, laws, and tolerance have changed dramatically over the centuries, although not necessarily in one particular direction. In ancient Greece young men could engage in same-sex relationships without disapproval. For example, Alexander the Great (born in 356 BC) and Hephaistion were a well-known pair. Each was married and had children while maintaining their relationship. In 130 AD the Roman emperor Hadrian mourned the death of his male lover, Antinous.

In the first half of the 20th century, Gertrude Stein and Alice B. Toklas lived openly as a couple in Paris, entertaining and socializing with the artists and thinkers of the time. However, at the same time, many cultural institutions, ranging from psychiatry to religions to laws in diverse countries, came to describe homosexuality with terms such as mental illness, perversion, sin, crime, and abomination. Men were imprisoned for homosexual behavior at the turn of the 20th century in England. Countries differ dramatically in their attitudes and laws concerning homosexual expression. In some countries today, homosexuality is punishable by torture and death.

Despite the dramatic liberalization of attitudes in the United States among the educated, prejudice and discrimination are still prevalent in this country. Sometimes social forces coalesce to generate psychological abuse, violence, and murder. Homophobia, the fear of homosexuals and prejudice toward them, not infrequently still manifests in job and housing discrimination, adoption and child custody discrimination, avoidance of health care service delivery, end-of-life management of health information, and survivorship asset distribution discrimination.

Eleven years after Massachusetts became the first state to allow gay marriage in 2004, the United States has undergone a major shift in attitude toward marriage equality. In a landmark decision on June 26, 2015, the Supreme Court of the United States ruled that same-sex couples have the constitutional right under Amendment 14 to marry in all 50 states and in all territories. The decision in Obergefell vs. Hodges struck down gay marriage bans in the remaining 14 states where same-sex couples were still prohibited from having the same rights and responsibilities as married opposite-sex couples. As the United States became the 21st country to legalize gay marriage, public opinion surveys indicated that public support for gay marriage was at all-time highs.

Religious organizations have been slow to embrace marriage equality. The exception is the Presbyterian Church (USA), which in 2014 voted to allow same-sex marriages to be performed by Presbyterian ministers when allowed by law.

Definitions

In this section, I begin with an uncommon degree of precision in terminology in order to capture the nuances of orientation. I will be using the word erotic to refer to what occurs within a person’s
subjectivity and the word *sexual* to refer to partner sexual behaviors. Orientation is a mental complexity that combines elements of private subjective erotic experiences and actual sexual behaviors with others. A problem arises, however, because when individuals experience and discuss their own orientation, they use different words than clinicians, epidemiologists, or scientists employ. We will discuss both perspectives.

When erotic and sexual orientation are congruent, there is a simplicity and clarity to the concept of orientation. For example, a college student who has had exclusively homoerotic fantasies since age 13 and is now having sexual experiences with same-sex partners would be called homosexual. The erotic and the behavioral, however, are not always congruent. This is the reason for introducing you to the meanings of the adjectives *erotic* and *sexual*.

**What is erotic orientation?** The phrase refers to the functional organization of the mind based only on fantasies, desires, dream imagery, and attractions for others. A person might be described as homoerotic, heteroerotic, bierotic, of undetermined eroticism, or anerotic based on the partners he or she imagines. Developmentally, erotic orientation usually makes its appearance before sexual behaviors with others. Erotic orientation is often clarified for an individual by self-observation of the imagery that consistently accompanies masturbation. Recurrent erotic imagery often provides sufficient experience for a person to recognize himself or herself as gay or lesbian. When this occurs, the person considers himself or herself to have a gay or lesbian sexual orientation. Obviously, the person does not employ our clinical terminology of the concept of erotic orientation.

**What is sexual orientation?** Sexual orientation is not a choice. As partner sexual behaviors begin to occur, another dimension to orientation appears. A person experiences sexual behavior with another and decides based on the ease of arousal and naturalness of the experience that he or she belongs to one of five categories of orientation: homosexual, bisexual, heterosexual, or, rarely, indeterminate or asexual. When clinicians consider a patient’s orientation, we take into account both the patient’s erotic and partner sexual patterns. Sexual orientation to us, though not necessarily to the individual, includes both erotic and behavioral experiences. In males, sexual orientation is usually, but not always, clarified by late adolescence.

**What is a homosexual?** A homosexual is an individual whose sexual orientation is toward members of his or her own sex as reflected in eroticism and behavior.

**What is sexual identity?** Sexual identity is a collection of self-definitions along three dimensions: gender identity, orientation, and intention. Most individuals have a subtle mosaic of masculine and feminine gender identifications, heteroerotic and homoerotic attractions, and peaceably mutual and paraphilic erotic intentions. This ordinary three-dimensional subjective complexity is generally not readily revealed to others. Many people summarize their identity as gay or straight and leave out references to their gender identities and intentions. MHPs, however, are expected to have a more comprehensive view of the mosaicism of sexual identity components. We are expected to be able to calmly and knowledgeably inquire about and discuss the subjective and behavioral interplay between these three dimensions within heterosexual, homosexual, and bisexual persons.

**What does gay mean?** Self-identification as gay generally means, “I accept my orientation and my identity as a homosexual person.” In most contexts *gay* delineates a male. However, *gay* may refer to women who identify as lesbians. Identifying as being gay usually indicates self-acceptance. *Gay* may also refer to a community of interests, such as the gay rights movement, a gay section of town, or a gay cultural event.

**Can homosexual behavior not reflect a person’s orientation?** Yes, there are diverse situations in which men participate in same-sex sexual activity but do not see their behavior as a reflection of their innate desire, sexual orientation, or sexual identity. This is partially reflected by the research term “men who have sex with men (MSM).” This term was created to acknowledge that in tracking HIV transmission patterns many of the homosexually active subjects did not self-identify as gay. Within some African American communities the phrase *living on the down low* refers to men who identify...
as being heterosexual but who have sex with men. Heterosexual prisoners are known to engage in same-sex behavior while in prison, only to return to heterosexual behaviors when released.

**The Importance to Clinicians of Myths About Homosexuality**

Homosexual men are a heterogeneous population. The gay male population is largely an invisible sexual minority. They come from all economic strata, religions, regions, and ethnicities. They gravitate toward all vocations. Their stories, their capacities, and their incapacities are each unique. They demonstrate all the variations that heterosexuals evidence, including the vital differences in how life is lived by males and females. In our clinical work, we prefer to understand homosexual phenomena by following this sequence. First, we understand their ordinary humanity, then their issues related to their gender, and finally what is unique about them because they are gay. Of course, we have had the benefit of years of thinking about this topic. Some approach the subject of homosexuality quite differently. They mistakenly think of gay men in stereotypical ways: gay men work as hairdressers or florists. They think that homosexual couples divide life tasks, including sexual patterns, into male and female roles. We refer to such ideas as myths. Here are 10 of them.

1. Being gay or lesbian is a choice.
2. Being homosexual is an illness.
3. Being homosexual is a sin.
4. All gay men are effeminate; all lesbian women are masculine (butch).
5. Homosexuals would prefer to be the opposite sex.
6. Homosexuals are out to recruit young people to become homosexual.
7. Homosexuals are pedophiles.
8. Homosexuality is caused by domineering mothers and passive or absent fathers.
9. All bisexuals are really homosexuals who are not yet willing to admit to being homosexuals.
10. All gay men are only concerned with sex and are unable to sustain long-term relationships.

Such concepts are not based on reality. All of these preconceptions interfere with helping gay patients. The more one learns about homosexuality, the less hold these ideas have on one’s mind. The responsibilities of caring for homosexual patients require the clinician, regardless of his or her personal orientation, to be able to listen to the story of the person’s life without the influence of these unexamined concepts. No therapist, even a gay or lesbian one, knows everything about homosexual life possibilities. Please don’t be embarrassed to ask your patient about something you don’t understand. There is no disgrace in asking, but it is dangerous to pretend to understand.

**Therapeutic Concerns**

When one is treating gay male patients it is important to remember that their life concerns are the same as for everyone else. Gay men are concerned about health, school, career, relationships with family and friends, aging, death, marriage and divorce, children, finances, past childhood trauma, long-term care of their parents, and world events. Gay men have the same mental health problems as the general population: anxiety disorders, mood and thought disorders, depression, posttraumatic stress disorder, and substance abuse. The rest of this chapter will focus on unique areas of gay men’s concerns.

**Bullying, Stigmatization, and Discrimination**

Gay male individuals may suffer abuse in the form of bullying, stigmatization, and discrimination starting in childhood in their families, neighborhoods, and schools. This may impact their mental
health and manifest as depression, conduct disorders, school avoidance, attempts to run away, and suicide attempts. The abuse may continue into adulthood and affect career choices, relationships, substance use, and mental and physical health. Violence perpetuated against gay men may lead to injuries and death. Patients may be consciously or unconsciously aware of how the abuse affects them. Some gay men move to more urban areas or states that offer protections. Areas where gay men live, work, and socialize are sometimes called “gay ghettos.” Gay ghettos often benefit from gay gentrification, whereby the gay residents improve the neighborhood.

Coming Out

Understanding the process called coming out is central to being a culturally sensitive clinician. Coming out is a developmental process. We tend to think of it as occurring in stages, but it is more complex than step 1, step 2, step 3, and so on. In a subtle sense, it is a lifelong endeavor. Coming out refers to accepting one’s homosexual orientation and sharing it with others. It is frequently a painful process; many suffer to accomplish it. Coming out essentially ends hiding one’s orientation from others. Initially, individuals may have to break through their own denial and to overcome their own internalized homophobia and self-hatred to achieve its first steps. One first comes out to oneself, then to others. Some go through these steps quickly and completely, some slowly and partially, and yet others at every conceivable point between these extremes. Completely coming out is the sharing of one’s orientation and identity as a gay male with family, friends, co-workers, neighbors, and the community.

When coming out, a person risks ridicule, abuse, and loss of relationships. Parents may reject their son. Siblings may choose to completely avoid their brother and keep them from having contact with their nieces and nephews. Teens may drop out of school when they are bullied there. Employers and landlords may abruptly terminate a job or a housing arrangement on the basis of “not wanting a homosexual person around.” Some states today lack protections against such discrimination. It is reasonable to be wary of these dangers. When fear of these dangers leads to avoidance or a marked delay in revealing one’s orientation and identity, it is commonly said that the person is still “in the closet.”

Clinical Caveats

The choice to come out or not rests with the individual. A MHP should not have an agenda to force the patient to come out more completely or to come out according to a therapist-prescribed timetable or fashion. A prudent approach is to learn about where the person is in the process and to understand the reasons for that position. We call this being supportive. This also applies when treating gay couples who may evidence disparate degrees of being out. This disparity often causes relationship difficulties and is a fruitful topic for discussion.

When dealing with minors, as with any other personal information, the MHP should not disclose the patient’s orientation to school officials, probation officers, and parents. Such outings may cause internal and external psychosocial problems and conflicts. It would likely end the professional relationship because the patient would feel betrayed. We recognize that many MHPs believe that patients are better off if they come out to others, and that might be correct, but the superimposition of the therapist’s agenda on the patient violates the ethical principle of Respect for Patient Autonomy.

The first person that an individual comes out to is often remembered for a lifetime. When that person is the MHP, the MHP should recognize the courage required on the part of the patient to reveal himself, the trust implicit in the occasion, and the honor the patient has bestowed on the MHP.
The Gay Male

The Dawning of Awareness of Homosexuality

Most homosexual adults can recall feeling different as a child. Before they have words to describe it, they are aware that something about them is not like their age mates. This can be purely a subjective experience, but it is often associated with some degree of atypical gender expressions or behaviors. They may be teased or taunted about these differences. By the time they are 10 years old, the average age that erotic attractions appear, they quickly realize from family, schoolmates, and society that being homosexual is not “normal.” They begin to notice innuendos and hear jokes about gays. They note the whispered tones about homosexual relatives, neighbors, and celebrities. They hear hurtful language such as “that’s so gay,” referring to any unwelcome or negative thing. They also witness their peers playing “smear the queer,” a game in which the goal is to attack the identified “queer.” They naturally hide their growing awareness that they may be gay. The situation may manifest clinically as ostracism and rejection, bullying and peer harassment, poor psychosocial fit with family and peers, the sense of being stigmatized or shamed, and low self-esteem. These phenomena are generally more intense for boys than girls. If the individual is also a member of an ethnic, racial, or religious minority, the sense of otherness is even more onerous.

The Origins of Internalized Homophobia

These negative messages during childhood are internalized, applied to the self, and give rise to some degree of worry, self-hatred, and low self-esteem. This is referred to as internalized homophobia. It complicates the process of coming out, making it more difficult to select when, where, and to whom they disclose aspects of themselves.

A study by Wallien and Cohen-Kettenis (2008) of gender-atypical grade school–aged children found that 80% had outgrown their gender dysphoria by age 16 and had developed a homosexual or bisexual orientation. Previous estimates based on the recollections of adult gay men suggested that as many as two-thirds recalled some childhood gender atypicality. In childhood, gender atypicality is stigmatized in boys more than in girls. In adolescence and adulthood, the issues are no longer about gender; they are about being gay. And being gay is treated in the dominant culture with prejudice. It makes adaptive self-protective sense that adolescents who know that they have a homosexual orientation do not completely come out to their families and school mates. When and whether children realize that they are homosexual varies among individuals within each gender. Males tend to be certain of their orientation several years before females become certain.

Some heterosexual youth experiment with homosexual sexual behavior. In large urban centers it is trendy to be bisexual. In the 1940s, Kinsey found that 37% of his adult male sample reported a homosexual sexual experience to orgasm after age 18 (Kinsey, Pomeroy, & Martin, 1948). Most individuals keep their occasional homosexual behavior a carefully guarded secret. Often it is a therapist, after many sessions of psychotherapy, who is first told about same-sex behaviors. Clarifying one’s orientation is a process that takes years for some adolescents. This is one of the reasons that estimates of the prevalence of homosexuality are wide ranging. Not only are accurate, methodologically sound scientific data difficult to obtain, but many people also don’t really know what constitutes being a homosexual person.

Negative Impact on Some Adolescents

Hiding one’s homosexuality impacts the successful completion of adolescent developmental tasks for many teenagers. The gay male adolescent may not learn to socialize and to date, for example. Fear of disclosure and abuse may contribute to poor grades, school avoidance, school dropout, substance abuse, and indiscriminate sexual behavior. Numerous studies have documented higher rates of substance abuse, depression, anxiety, and suicidal ideation among homosexual teens. A disproportionate
number of teen runaways, throwaways (teens whose parents throw them out of the house), and homeless youth are gay.

All teens, including gay teens, are largely socialized to become heterosexual adults. Without identifiable role models, gay teens are at a disadvantage in acquiring the skills necessary to function in the adult world as a homosexual person. Individualization and autonomy are often more difficult to achieve.

In 2010 columnist Dan Savage founded *It Gets Better*, an online compilation of videos by famous and ordinary people to give hope to young people that it is okay to be gay and that life after high school improves for gay teens who may be bullied or abused. To date, more than 50,000 videos of inspiration and hope have been created to curb the number of suicides by gay youth.

**Suicide**

Suicide is currently the second leading cause of death in youth 10–24 years old (Trevor Project, 2014). For every completed suicide by youth it is estimated that 100–200 attempts are made. Gay, lesbian, bisexual, and transgendered (GLBT) youth are four times more likely to attempt suicide than their heterosexual peers. GLBT youth who come from rejecting families are nine times more likely to attempt suicide (Suicide Prevention Resource Center, 2008). It is estimated that as many as 26% of gay youth are forced to leave home because of conflicts over their sexual identity (Remafedi, 1987).

One study found that 28% of GLBT youth were forced to drop out of school because of harassment resulting from their identity (Hershberger & D’Angelli, 1995). The 2013 National School Climate Survey by the Gay, Lesbian, and Straight Education Network showed that 55.5% of gay, lesbian, and bisexual students felt unsafe at school. In the same survey 74.1% of GLBT students reported being verbally harassed, 36.2% had been physically harassed, 16.5% had been physically assaulted, and 49% had experienced electronic harassment in the past year because of their sexual orientation (Kosciw, Greytak, Palmer, & Boesen, 2014). Remafedi et al. (1998) found that 28.1% of gay or bisexual males in grades 7–12 had attempted suicide at least once, compared to only 4.2% of heterosexual males. Similarly, 20.5% of gay or bisexual females had made attempts, compared to 14.5% of heterosexual females.

Factors that increase the risk for GLBT youth to commit suicide include the lack of protective factors available to non–GLBT youth; lack of important family support and safe schools; high rates of depression and substance abuse; coming out at an earlier age; stigma, discrimination, marginalization, and isolation; family rejection; and lack of access to culturally competent care. The GLBT youth who are at highest risk for suicide are homeless, runaways and throwaways, youth in foster care, and youth in the juvenile justice system.

MHPs need to ask gay, lesbian, and bisexual youth about suicide. The Trevor Project runs the only nationwide 24-hour crisis and suicide prevention helpline for GLBT youth (1-866-4-U-TRE-VOR). Their goal is to promote acceptance of GLBT youth and to ensure that there is always a safe place for them to turn. In 2014 the Trevor Helpline received 44,985 calls from youth in crisis. The Gay, Lesbian, and Straight Education Network and gay–straight alliances in high schools are other resources available to homosexual teens. There are a few high schools dedicated to GLBT youth. The Harvey Milk High School in the Hetrick-Martin Institute in New York City provides educational and support opportunities for GLBT youth age 12–21. The Point Foundation provides college scholarships for GLBT youth.

**Violence**

Unfortunately, violence and abuse exist in the lives of many gay individuals. Almost every middle-aged person knows someone who was beaten, shot, or killed because they were gay. Violence for many
homosexuals begins in their families. Often abuse occurs at the workplace and in the neighborhoods where homosexuals live. Those who frequent bars are often targeted by youth from outside the gay neighborhoods because they are easy targets, the victims often don’t report the crime, and the penalties are rarely strong enough to be deterrents to others. Another area of abuse is domestic violence between same-sex partners. This dark aspect of gay and lesbian life has long been hidden and avoided by community members and helping professionals. MHPs need to ask about symptoms of current or remote abuse or violence and look for signs of posttraumatic stress disorder.

**Informing Parents**

When some teens tell their parents that they are gay, the parents may respond, “We have long known about this possibility; we love you, how can we help?” It is a joy to hear of such experiences because most of the situations that we intervene in represent a departure from this. MHPs working with teens who are considering coming out to their parents should make sure that the teens have a safe family environment that will be supportive of them.

When we see tension and conflict in the family after a teen comes out to them, we aspire to help this to be a temporary reaction rather than a prelude to evicting or abusing the teen. When an adolescent comes out to parents, the teen has usually thought about the issue for a long time. The teen may be taken aback by parental reactions. We should be quick to remind the adolescent that the parents are surprised and require a reasonable amount of time to process their feelings about the implications of having a gay child. Parents may try to reassure their child that it is just a phase, which, of course, invalidates the teen’s experience and self-awareness. Parents may have to grieve the loss of their concept of their child’s heterosexuality and the loss of the sequence of courtship of the opposite sex, marriage, and grandchildren. Parents often feel guilt, blame themselves, and worry about the safety of their child. Clinicians can help parents with their self-blame when parents inquire what the therapist knows about the cause of homosexuality. Some highly religious parents worry about the spiritual future of their child in God’s eyes.

While clinicians can be enormously helpful to parents, PFLAG, an organization found in many urban areas, can often provide ongoing assistance to parents as they negotiate this issue. Clinicians often see parents briefly. PFLAG helps them over an extended period of time and puts them into social contact with other parents, many of whom are role models of loving their gay child and integrating their child’s partner into their family’s life. Clinicians and support groups can also be helpful when the coming-out process occurs in adulthood.

**Embracing the Community**

Typically as an individual comes out, there is a shift from a place of isolation to community involvement. The teenager or adult learns the language, style, and codes of the gay community. Those new to the community quickly learn the norms of dating and social interaction. They become aware that there are many people in similar circumstances. They learn the history of the gay rights movement and the pivotal historical and social events such as the Stonewall Riots in 1969, the March on Washington in 1979, the repeal of Proposition 8 in California in 2013, the repeal of section 3 of the Defense of Marriage Act in 2013, the end of Don’t Ask, Don’t Tell in 2011, the Supreme Court of the United States landmark ruling in favor of marriage equality in 2015 and pride celebrations. Many learn about gay authors, celebrities, and politicians. Many also learn about the organizations that advocate for gay and lesbian rights: the National Gay and Lesbian Task Force, the Human Rights Campaign, and the Gay, Lesbian Alliance Against Defamation. They come to know about the books, newspapers and magazines, artworks and galleries, and sports competitions geared toward gay men. Some choose to move from more rural areas to larger cities to increase opportunities to mix with other gay men. The
Internet has increased opportunities to meet other gay men for support, dating, or just sex. The most important lesson learned by embracing the community is that one is no longer alone.

The MHP should keep in mind that embracing the community is an evolutionary process. As gay men become more comfortable with their orientation, it gradually becomes just another part of who they are. As they integrate their sexual orientation into other parts of their lives, they feel more congruent and whole. They may then perceive that the options available to them seem to expand. They may choose to live in a gay ghetto or to live openly in the larger heterosexual community. They may find an affirming or accepting faith community. They may open a business that caters to the gay and lesbian community or choose to support such businesses with their patronage. They may join GLBT professional organizations in their fields or may join GLBT alumni associations. Gay patients may report that their lives seem better-rounded. Such a complete integration may take 5 years or more to achieve. MHPs can support this maturational growth by reassuring their patients that they can build a satisfying future for themselves.

Family of Choice

Since an individual’s family of origin may have negative reactions to their gay family member, gay men may surround themselves with accepting, empowering friends who feel like the family they wish they could have. This family of choice becomes the backbone of support and community for them. Often holidays and typical family celebrations include the family of choice, which may or may not include members of the family of origin.

Living as a Gay Person After a Heterosexual Marriage With Children

Homoerotic men may marry, have children, and come out to themselves and to their spouse and others when they are middle-aged (rarely older these days). They may make the transition to the gay community as a result of a new, psychologically satisfying love relationship. They then bear all of the problems of divorce, including the spouse’s sense of abandonment and betrayal, along with the special problems of coming out to an unhappy spouse, telling the children about their orientation and the sex of their lover, preserving their parental rights as they negotiate for custody arrangements, and coping with the contagion of gossip about the reason for the divorce. The children gay people raise can be from their marriage, from their partner’s marriage, from surrogacy births, from adoption, or from placement from a foster agency. There are many stories to be heard about how well some couples handle the transition to gay life after a marriage, but there are other stories that are quite sad.

Courtship and Relationship Concerns

Therapists will spend much time listening to the dating or relationship concerns of their patients. Finding love, dealing with hurt and breakups, cheating, and being the victim of infidelity are ordinary human concerns, as are the issues of when and if to have sex, who initiates and who says no, where to have sex, and whether to be monogamous. Having marriage equality, patients will present with concerns about whether to get married or not, whether to change their name to that of their spouse, and whether to have children. MHPs will also help patients deal with divorce. Immigration concerns may confront couples when one of the partners is not a citizen. In conjoint therapy, gay couples have ordinary concerns such as the loss of psychological intimacy, disagreements about money, coping with children living with another spouse, illness in the family of origin, and so on.

Heterosexual therapists commonly see patients with homosexual issues. Their challenges are to contain the residues of past stereotypical thinking and remain respectful and supportive of the
patients’ aspirations for greater mental ease. We suspect that MHPs who are gay or lesbian have a higher percentage of patients who belong to a sexual minority than therapists who are presumed to be heterosexual. Gay MHPs may have challenges about maintaining boundaries, running into their patients at gay cultural activities, and making decisions about revealing their orientation and coming-out processes to their patients.

**Generalizations About Gay Men**

Generalizations about members of this community pale in comparison to the uniqueness of every person and each couple. Gay men have to sift through the limited dating pool of other gay individuals to determine who will be friends and who will be lovers. Gay men tend to emphasize physical appearance when meeting each other. Their friendships may evolve from earlier sexual relationships, and these friendships may continue long after they are no longer having sex together. When two gay men become a couple, they may be missing the skill sets of nurturing and compromising, the absence of which makes early relationships difficult. This may lead to poor communication until they acquire these skills. Men have to overcome their tendency to be competitive with one another in order to be supportive of each other.

**Long-Term Relationships**

Gay men form long-term relationships, buy houses, start businesses, have children, raise children, provide care for each other when ill, and help their family of origin, when needed and accepted. Some aspire to get married and have all of the privileges and responsibilities of marriage. Others choose not to get married but maintain long-term relationships.

Homosexual couples share worries about getting older, losing one’s partner, and entering a nursing home that may not support a homosexual life. Hospital visitation, access to health information, ability to make end-of-life decisions, and inheritance are issues facing older gay partners. In the gay community, stories abound about estranged families of a deceased partner swooping in and taking the couple’s possessions.

Many gay couples without their own biologic children seek ways of being parents. In many states adoption and foster care agencies are quietly supportive of gay couples raising children. The American Academy of Pediatrics (2002) has a position paper that confirms that there are no negative effects on children raised by gay and lesbian parents. Surrogacy births are also becoming more prevalent.

**Sexual Concerns**

The good news about homosexual sex is that sex partners have an intuitive knowledge about their partners’ bodies and ways to effectively stimulate them. Sexual tension may arise when one partner may want sexual behaviors such as anal penetration that the other does not want to participate in. There are differences in risk for infectious diseases depending on the role a partner plays. Safer sex negotiations can complicate sexual relations. Some partnered gay men may have open relationships, which may or may not involve their partner. The partners may decide that outside partners are acceptable as long as the sex is not at their home or the liaisons are discreet and do not interfere with the couple’s time together.

It is often surprising to heterosexual therapists how satisfying sex can be within gay pairings. The details of sexual behaviors are a common curiosity of therapists. One can learn by asking, listening, or reading. When deciding to ask about specific sexual behaviors, MHPs should consider whether it serves the therapeutic process or simply satisfies their curiosity. If the latter, it is better not to ask.
HIV

HIV and AIDS have had a huge impact on the gay community. In the early 1980s the gay and lesbian community organized to combat AIDS. Gay men’s health centers and gay and lesbian community centers focused effectively on AIDS prevention and treatment. The community felt abandoned by their government and the medical profession. The community began to raise their own funds. Lesbian women stepped up to the challenge of caring for their dying gay male friends. An entire generation of gay men lost their lives before the improved treatments became available in the late 1990s. This has given rise to survivor guilt in those who are still living. A generation of gay men and lesbians faced serious illness, dying, and death of their cohort of friends at significantly earlier ages than in previous generations.

MHPs need to recognize the anger, guilt, shame, fear, loss, and grief that exist in the gay community related to HIV and AIDS. Gay male patients may present with other concerns and don’t bring up these issues unless asked. Many adult homosexuals have lost partners and close friends to AIDS. Those infected with HIV carry the same crushing stress and anxiety as any patient with a potentially fatal illness. This worry impacts both partners in many small and large ways.

Ironically, the prevention efforts and superior treatments have given rise to prevention burn-out and an increase in risky sexual practices. Barebacking, which is anal sex without protection, is increasing, especially among young gay males. This increase is attributed to improved treatments, giving rise to the notion that AIDS is treatable and now, like diabetes, a chronic medical condition. Some gay men have adopted a fatalistic attitude that it is just a matter of time before they get HIV so they might as well get it over with. Substance abuse, especially of crystal meth, has led to an increase in unsafe sexual practices.

HIV status discordance impacts same-sex relationships. Sometimes an individual will lose interest in sex or develop erectile problems or other sexual dysfunction from fear of acquiring HIV. Sometimes individuals will sero-sort (i.e., seek partners of the same HIV status).

Health Care Disparity in Gay Men

The current emphasis on integrated health care homes whereby mental health and primary care providers collaborate closely in the care of patients (Raney, 2015) makes it necessary for MHPs to understand the barriers faced by gay men in seeking medical care. The health issues that occur disproportionately in gay men include heart disease, some cancers, injury and violence, fitness and body image, eating disorders, substance abuse, and sexual health (Substance Abuse and Mental Health Services Administration, 2012). Sexual health concerns include HIV and AIDS and other sexually transmitted diseases such as syphilis, human papillomavirus, and hepatitis. Substance abuse may include alcohol, drugs, and tobacco. Injury may occur from violence by their partner or from assault and “gay bashing” by strangers. Gay men may seek care initially from their primary care doctor for depression, anxiety, or thoughts of suicide as well as other mental health concerns.

When gay men do seek care it is not uncommon for them not to disclose their sexual orientation. Unless the provider specifically asks about sexual orientation, gay men may not receive targeted surveillance for the health conditions they are at higher risk of developing. Many studies have looked at barriers to medical care for gay men and youth (Burton et al., 2013; Conron et al., 2010; Institute of Medicine, 2011; Levine, 2013; McKirnan et al., 2012). Stigma and discrimination related to their sexual minority status may combine with racial minority status, education level, income level, geographic location, language, immigration status, knowledge, and cultural beliefs (Institute of Medicine, 2011) to prevent gay men from getting appropriate medical care. System barriers include company insurance plans that do not include same-sex partner benefits, lack of provider training about GLBT issues, provider homophobia, and unwelcoming environments. Gay
men also may not receive lifestyle counseling, preventive care, and wellness coaching to maximize their health outcomes.

Studies about the health care of gay men lag behind those for other populations. According to the Institute of Medicine (2011), the most pressing GLBT health research needs are demographic research, social influences research, health care disparities research, and intervention research.

Aging

Many gay men facing the AIDS epidemic in the 1980s and 1990s concluded that they would not have the opportunity to age. As their friends and partners died and their losses mounted, gay men believed it would only be a matter of time before they too succumbed to AIDS. They quit their jobs, sold their businesses and possessions, cashed in their life insurance policies, said their goodbyes, and made their final arrangements. In 1996 this all changed with the availability of protease inhibitors. There quickly followed a 60%–80% decline in rates of AIDS, hospitalization, and death. Gay men began to rethink their future and began preparing for aging.

MHPs will treat older gay men dealing with survivor guilt, grief and loss (including chronic bereavement), loss of their looks and sexual performance in a youth-obsessed culture, financial peril resulting from spent retirement accounts, fear of being alone, and discrimination and stigma in nursing homes and assisted living facilities. Anxiety, depression, and suicidal ideation are present in 24%–39% of GLBT elders (American Psychiatric Association, 2014). Many will be worried about having to “go back in the closet” as they age. Many fear becoming invisible. There is also unequal treatment under the law regarding inheritance, hospital visitation, and partner retirement benefits. Tobacco and alcohol abuse seem to be higher among GLBT elders compared to heterosexuals (Fredriksen-Goldsen et al., 2013).

The health concerns of elderly gay men who have HIV or AIDS include the metabolic, neurologic and neuropsychiatric, and oncologic complications of AIDS. HIV that is undetectable in the blood is present in the cerebral spinal fluid and continues to impact the brain, causing HIV- related dementia. Long-term use of anti-HIV medications may have lasting side effects that are only now being identified.

Aging agencies providing senior care are often ill prepared for the needs of GLBT elders. Gay men often do not have partners or children to help with long-term care. Staff and provider attitudes toward gay men may lead to substandard care. Same-sex partners may not be allowed to room together. Families of choice may not receive the same level of access to elderly gay men as families of origin do for heterosexual men.

It is important for MHPs to make referrals to GLBT community support services. SAGE (Services and Advocacy for GLBT Elders) and the National Resource Center on LGBT Aging are good resources. Local GLBT pride centers may have groups and therapy tailored to these seniors.

Should the Therapist Disclose His or Her Sexual Orientation?

Heterosexual therapists typically do not worry about this topic. A wedding ring, a picture in the office, or an off-hand comment or response may subtly signal to the patient that the therapist is heterosexual. The absence of such clues may lead the patient to wonder about the therapist’s orientation. While many patients will not ask about a therapist’s sexual orientation, an occasional one will. Whether or not you choose to answer the question, I suggest that you first explore the reasons behind the question. If this proves unproductive, you can ask a series of related questions such as, “Why is this important to you now? What do you think the answer is? What led you to think that? What do you anticipate that you will feel and think if I tell you the answer?” In responding in this way you have made use of the patient’s question to explore the patient’s mental processes and his own sexual identity mosaic. We want to handle this question by asking ourselves whether the answer will be useful to the patient.
If you choose to disclose, you have to be prepared to answer additional questions. A gay or lesbian therapist may wish to be a positive gay role model. A heterosexual therapist may wish to be seen as an affirming ally. While the gay male patient may be asking because he is having concerns about his sexual identity mosaic, this is not always the case. If the therapist decides not to answer the question, he or she might consider saying, “I don’t like to answer such questions because I believe that it will cut off your imagination about me, which I always want to be able to explore.” I cannot say that therapists should or should not reveal their orientation; that is a matter for your professional judgment. I recommend not treating the subject casually. Often, when you explore in detail the patient’s reasons for asking the question, the patient no longer thinks the answer is that important.

**Reparative Therapy**

While church-sponsored organizational efforts to cure homosexual males still exist in major denominations, there is no scientific evidence that these efforts to convert a homosexual orientation to a heterosexual orientation work. They remain below community standards of appropriate care by MHPs, not only because they are ineffective, but also because they have a potential to damage patients by increasing their identity conflicts and self-hatred.

That reparative therapy, also known as conversion therapy, has been discredited is evidenced by position papers opposing this approach by the American Medical Association (n.d.), the American Psychological Association (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009), the American Psychiatric Association (2000), the British Psychological Society (2014), the American Psychoanalytic Association (2012), the International Society of Psychiatric-Mental Health Nurses (Hein & Powell, 2008), the American Academy of Pediatrics (1993), the American Academy of Child and Adolescent Psychiatry (Adelson & the American Academy of Child and Adolescent Psychiatry Committee on Quality Issues, 2012), the American Counseling Association (2013), the Association of Gay and Lesbian Psychiatrists (2000), and the National Association of Social Workers (2005; see also Haldeman, 1994).

In June 2013 Exodus International, an ex-gay movement, ceased to operate in the United States. Its president said at its last annual meeting:

> I am sorry for the pain and hurt many of you have experienced. I am sorry that some of you spent years working through the shame and guilt you felt when your attractions didn’t change. I am sorry we promoted sexual orientation change efforts and reparative theories about sexual orientation that stigmatized parents.

(Snow, 2013)

Despite the above, only California, New Jersey, Oregon, and Washington, DC, currently have laws banning the practice for minors. Illinois and Nevada have bills outlawing the practice progressing through their legislatures. In 2015 President Obama and Representative Ted Lieu of California proposed extending the ban nationwide.

**Conclusion**

The idea of human first, gender second, and orientation third is a wonderful way of thinking about the unique issues of sexual minorities. It guides us to not stereotype them, alienate them, or diminish their struggles to create a place in society that honors them, their history, and their aspirations. The most important part of this idea is the humanness of gay men. Like all patients, those who have homosexual orientations have much to teach us.
References


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Selected GLBT Resources

AIDS Education Global Information System (AEGIS): www.aegis.org. The mission of AEGIS is to facilitate access to current patient and clinician information specific to AIDS/HIV. It is the largest virtual AIDS library, consisting of more than 1.3 million articles.

Association of American Medical Colleges. Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD: www.aamc.org/lgbtdsd. The Association of American Medical Colleges offers this free resource to improve competency in medical education about GLBT issues and health disparities.

Fenway Institute National LGBT Health Education Center: www.lgbthealtheducation.org/training/learning-modules. The Fenway Institute offers excellent training modules on GLBT issues.

The Gay and Straight Education Network: www.glsen.org. They strive to assure that each member of every school community is valued and respected regardless of sexual orientation and gender identity/expression. They offer tools to establish gay-straight alliances in schools.

It Gets Better Project: www.itgetsbetter.org. The It Gets Better Project’s mission is to communicate to GLBT youth around the world that it gets better and to create and inspire the changes needed to make it better for them. It was created to inspire hope in teens that life after their teenage years gets better and that suicide is not their only choice when they despair.

The National Resource Center on LGBT Aging: www.lgbtagingcenter.org. Founded in 2010, this is a technical assistance resource center aimed at improving the quality of services and supports offered to older GLBT adults. They offer training, resources, and advocacy.

Parents, Families and Friends of Lesbians and Gays: www.pflag.org. This national organization assists the families and friends of GLBT individuals through support, education, and advocacy.

The Point Foundation: www.pointfoundation.org. This national organization assists the families and friends of GLBT individuals through support, education, and advocacy.

Services and Advocacy for GLBT Elders (SAGE): www.sageusa.org. This organization was founded in 1978 to assist GLBT seniors to age in good health and with financial security. Originally known as Senior Action in a Gay Environment, SAGE partnered with the National Resource Center on LGBT Aging in 2010 to expand their services.

The Trevor Project: www.thetrevorproject.org. The Trevor Helpline (1-866-4-U-Trevor) is the only national 24-hour suicide crisis and prevention helpline for GLBT youth. They also do outreach, education, and advocacy.