

REFLECTIONS OF A GAY MALE PSYCHOTHERAPIST

DOUGLAS C. HALDEMAN

University of Washington

Issues of diversity and multiculturalism are typically framed and conceptualized in terms of client characteristics. This is reflected in the literature on competent and ethical treatment of lesbian, gay, bisexual, and transgender (LGBT) individuals. However, when it comes to personal characteristics of the therapists involved, little has been written, save the obvious proscriptions against personal bias and misinformation in conducting psychotherapy. This article represents the personal reflections and feelings of a European American gay male psychologist with 30 years' experience working with the LGBT community. Intersections of sexual orientation and gender identity with race/ethnicity, age, health factors, and socioeconomic status are explored as the effects of therapist characteristics on the therapeutic process are considered. Observations about client differences, as well as therapist differences, are made in such a way that the reader might extrapolate to his or her own practice.

Keywords: gay, male, psychologist

Typically, discussions of diversity and multicultural competence center on the matrix of client variables. We attend to any number of sometimes overlapping characteristics—gender, age, race/ethnicity, sexual orientation, ability status, gender

identity—in order to optimize our effectiveness in serving clients. Additionally, when practitioners talk about themselves, it is generally regarding their theoretical approaches, or what might constitute best practice. Rarely do practitioners lift the veil that separates their personal experience and their feelings from public view. Nevertheless, such personal experience—particularly from practitioners belonging to diverse groups—may have a bearing on the therapeutic relationship, and even on the prospects for a positive outcome in treatment.

The purpose of this article is to reveal a bit about myself as a gay male psychologist. I will share something of my journey as a member of a socially marginalized group, as well as commenting on the effect that my diversity status—as well as my privilege as a White male—have on my clinical work. In so doing, perhaps you will think about ways in which your own differences—and similarities—have an effect on your professional life. In reflecting openly on issues that I do not normally share, you may find that more questions are raised than answers offered. Furthermore, many of these questions about all aspects of diversity—how sexual orientation interacts with generational, racial/ethnic, socioeconomic status (SES), and gender differences—require careful thought as to how, or even if, to raise them in therapy. With that in mind, I welcome you to my office.

My Diversity Status

Being gay has brought experience with oppression, to be sure, but also much joy. I have, at various times, felt the sting of hatred and prejudice, as well as the comfort and power that derive from the privileged aspects of my identity (male, European American, able-bodied, married, financially stable). But the gay element is what makes me different as a man, and as a psychologist; permit me to briefly contextualize it in my personal history, in the service of better understanding its relationship to my psychotherapy practice.

At age 25, I'd landed my dream job. After reconsidering my original plan to be an actor, I

Douglas C. Haldeman, Department of Psychology, University of Washington.

Correspondence regarding this article should be addressed to Douglas C. Haldeman, PhD, 101 Stewart St., Suite 1111, Seattle, WA 98101-1060. E-mail: doughaldeman@aol.com

got a Master's degree in Education and subsequently a position as a full-time Drama teacher at a high school in a beautiful beach town in California. Teaching an elective subject in the performing arts, my students were generally engaged and motivated. Many of them later mentioned to me that, paradoxically, my drama class where they were taught to take on different character roles, was the one place where they felt safe to be themselves. I loved my job and 4 years after I started I was voted "Teacher of the Year."

My personal life, however, was complicating things. I was dealing with coming out as a young gay man in the 1970s, and thought I could conceal this from my high school work environment by living a double life in which I went to San Francisco on the weekends to socialize. I met and became acquainted with legendary activist Harvey Milk, and joined his Saturday marches from the Castro district to City Hall. I worked on the successful campaign to defeat Proposition 6 in California that would have prohibited gay people or their friends from teaching in the public schools. At the same time, keeping my "weekend life" quiet in a small town proved difficult. Facing escalating harassment and threats at school, I moved from the beach to a cabin in the woods with no house numbers, alongside an enclave of drug dealers. They were actually ideal neighbors because they left me alone. But at school, I lived in constant fear of the next threat, the next nameless face in the crowd who would call out "Faggot!" as I passed from the office to my classroom. The stress was unbearable and I resigned.

As someone who enjoyed and valued the interpersonal contact with my students, moving on to psychology was a natural fit. My job requirements were having a safe place in which to work, and the ability to give something back to a lesbian, gay, bisexual, and transgender (LGBT) community in need of support to counteract stigma and bias. Psychology has more than succeeded for me on both counts. I have been a psychotherapist serving the LGBT communities and an educator of psychology students on LGBT issues. Stimulated by my clinical background with patients who have been harmed in some form of so-called "reparative therapy" to change their homosexuality, I have written and lectured extensively on the ethical and competent treatment of LGBT individuals in psychotherapy. The American Psychological Association (APA) has provided me with numerous opportunities to par-

ticipate in the development of science-based policies and practice guidelines to inform the profession and the public about LGBT issues. Moreover, I have found professional psychology to be not only a safe but a very welcoming place to work. I've often remarked that some of my closest friends are professional colleagues I may not see often, but yet with whom I maintain very close relationships.

Issues for Clients Relative to My Diversity Status

Many gay patients seek out gay treatment providers. Although the reasons for this have not been established in the professional literature, it is likely that some gay people feel a greater level of comfort with a gay therapist than even a sympathetic heterosexual, due to the perception of greater understanding owing to shared life experiences. The implications for psychotherapy include a greater sensitivity to mental health issues related to *minority stress* (Meyer, 1995; DiPlacido, 1998), which is the concept that LGBT individuals are vulnerable to a number of negative mental health consequences from living in a society that stigmatizes them, as well as issues of relationship configuration and sexual expression. The potential psychological damage for LGBT individuals due to internalized social stigma has been well documented (Herek, Gillis, & Cogan, 2009). Mays and Cochran (2001) point out that antigay discriminatory behavior can put the individual at greater risk for health-related problems, including substance abuse. As a result, I have always had a high proportion of gay men in my caseload. I have also worked extensively with heterosexual men, but should offer a disclaimer: since this is a commentary on my personal experience as a therapist, the reader should be informed that I have worked to a much lesser extent with lesbians and bisexual men and women. This proportionality will be reflected in the cases to follow.

Public opinion data show that attitudes about LGBT individuals have changed dramatically over the past 30 years. LGBT individuals enjoy a far more tolerant social climate, one in which discrimination based on sexual orientation is generally opposed and some form of domestic partnership or same-sex union is supported (Herek, 2009). Still, recent data clearly indicate that there are mental health risks for LGBT individuals

living in jurisdictions in which their civil rights are voted up or down by the general populace (Rostosky, Riggie, Horne, & Miller, 2009). Despite a noted growing trend toward generational differences in stigma associated with LGBT status in which younger people see stigmatization on the basis of sexual orientation and gender identity as less of an issue (Savin-Williams, 2010), sexual stigma in all its forms (Herek et al., 2009) is a primary factor in generating mental and emotional distress for LGBT individuals. Therefore, it is my practice to pay particular attention to the potential mental health consequences of minority stress in all of its external and internal manifestations, which include depression, anxiety, intimacy concerns, and a generalized sense of alienation from the mainstream culture.

This is not to say that it is my habit to attribute all gay patients' presenting concerns to the psychological sequelae of sociotraumatic life events. Indeed, not all gay individuals suffer equally in our culture, nor do we react in a uniform response pattern. Some gay individuals seem able to survive cruel families of origin and hostile social environments relatively intact due to their resilience and innate coping skills. Nonetheless, one thing in common I have with my gay patients is that we have all come of age in a culture that makes us feel badly about who we are; most of us have at one time or another felt the sting of antigay hostility, and we have all experienced and to some degree internalized the stigmatizing effects of a heterocentric culture. Inquiry about the individual's history relative to abuse, rejection, discrimination, and social and familial marginalization is always of interest to determine what role, if any, this history plays in the individual's current life concerns, as well as his overall psychological adjustment.

Eric, a 34 year-old gay male, came to treatment with complaints of loneliness and social isolation. He was employed as a software engineer, was in good physical health and condition, and financially stable. An examination of his background revealed that he and his siblings moved frequently as children, bouncing back and forth between two alcoholic parents in a high-conflict relationship. Eric had been raised in a fundamentalist Christian tradition, and maintained a strong faith in adulthood. He attributed much of his social anxiety to the lack of stability in his youth. Eric has never been in a primary relationship. He

has dated since coming out 10 years previously in a furtive sexual relationship with a coworker, but never for longer than a month or two. Eric's preferred method of meeting men has been on-line.

It became clear over time that Eric also experienced a great deal of social marginalization among peers in adolescence over the perception that he was gay. He reports that other boys at school frequently beat him up and called him a "homo" before he even realized what the term meant. Home was no safe haven, especially during the time when an abusive boyfriend of his mother's would beat him with a belt for "acting like a girl."

Eric had obviously internalized a great deal of shame over his sexual orientation, in addition to a generalized fear of other men. He had dichotomized sexual and social interaction (sex is for strangers, emotional attachment is for friends) and these patterns had to be examined in treatment. For Eric, what ultimately helped him turn the corner was participation in face-to-face social groups with other gay men who shared common interests (a running group, a gay men's group at a progressive church). The experience of being in community with other gay men was crucial in helping Eric internalize positive feelings about himself as a gay man, and neutralizing his history of shame and abuse. This validates theories of gay identity development in which the community plays a significant role in the individual's personal evolution (Fassinger & Arseneau, 2007).

Eric's story parallels my own early life as the only child of a single mother. Having been bullied and socially marginalized for not being a "real boy" (unathletic, "sissified"), it was easy for me to identify with his feelings of shame and heterophobia, an unconscious or conscious generalized aversion to straight men. So easy, in fact, that I made the conscious effort not to overidentify, or to superimpose my own history on his. It made sense to encourage Eric that the gay community may provide a place in which gay identity and social relationships can flourish. What felt less clear was how to facilitate his transition to a community of faith, given my own very mixed feelings about organized religion.

Some years ago, I developed a specialty in working with gay men who had been harmed in some effort, therapeutic or otherwise, to change their sexual orientation. Almost all of these men

had done so in the service of strongly held religious beliefs with which their homosexual orientation was incompatible. In most cases, they also faced loss of membership in their families and communities of faith. As a generically spiritual but areligious individual myself, it was initially difficult to understand how someone could submit themselves to the torturous methods of sexual orientation change that were still conducted when I started practice in the early 1980s. When I learned of the physical pain and degradation to which some of my patients had subjected themselves at the hands of their religious institutions, I was outraged. Given my own upbringing as a Christian Scientist, I struggled to understand what factors could bring someone to submit to genital electric shock to eradicate their desire simply to love other men. Nonetheless, I came to accept that for some people, religious identification and expression are aspects of identity that are as salient as sexual orientation (Haldeman, 2004), and require a treatment approach that helps the client from her or his perspective (Beckstead & Morrow, 2004). Personally, I would not agree with the decision to therapeutically (or otherwise) subvert sexual orientation, and invent a treatment strategy aimed at celibacy or some dishonest adaptation of sexual expression, in the service of religious affiliation. Nor would I be party to such a treatment plan. Psychologists do not impose social science on religious or scriptural tenets, but neither do we accept religious dogma as a relevant factor in planning or conducting psychotherapy (APA, 2008). The decision, however, to seek out such an intervention is not mine to make for a client.

It has been my privilege and challenge to work with a number of cases involving what I call *sexual orientation reconciliation and integration* following a period of abstinence or attempted heteroeroticism in the service of hyperreligiosity. I treat the shame and guilt following failed attempts at sexual orientation change, and its attendant depression and intimacy avoidance. I also engage the client on a deep level to determine what led him to attempt (often, multiple times) to change his sexual orientation, and/or to engage usually uninformed women in fraudulent relationships. Typically, maintenance of membership in good standing in some conservative religious families and communities requires heterosexuality or celibacy. When such individuals come out, in many cases, there is distancing or outright

exile from family and former conservative religious social networks, but no concept of how to replace them with gay friends, or familiarity with a gay community that seems difficult to navigate. In some cases there is sexual dysfunction following attempts at so-called “reparative therapy.” All of the above require intrapsychic healing, of course, but also “gay social skills training” to help the person understand the norms and customs of the gay community.

For many of these cases, it is also important to consider a replacement religious/spiritual life—one that is gay-friendly. In seeking change, it is far easier to adapt to a different religion than to alter one’s sexual orientation. In most urban areas, there are reconciling congregations that serve as a welcoming substitute for refugees from more antigay religious traditions who still seek a community of faith. For those who wish to preserve adherence to conservative religious tenets in a gay-friendly environment, there are gay groups for Evangelical Protestants, Conservative Jews, and Mormons. The Internet affords the “ex-ex-gay” conservative religious individual opportunities for informal networking with individuals around the world who share their beliefs and similar life experiences. I believe in the therapist’s responsibility to remain neutral in the execution of these choices, knowing that integrating a gay identity is an evolutionary process. In time, many of these individuals turn away from organized religious or spiritual practice altogether—but always absent any influence from me. It is a challenge to create a therapeutic space in which a person with homoerotic feelings may choose to return to his homophobic religious tradition than to come out as gay.

When identity is embedded in a variety of factors, however—as in the link between religious affiliation and race and ethnicity—the clinical picture is far less clear. The concept of *intersectionality* (Cole, 2009) has been identified as key to understanding the interrelationship between different aspects of identity and life experience. As a White male, I have found myself treading much more carefully with clients of color who experience conflicts between sexual orientation and religious affiliation than I do with white clients. With some clients of color, if I challenge their internalized religiously mediated proscriptions against homosexuality, I fear being perceived as disrespectful of their cultural experience, and I say so. I truly strive to work without

agenda in the resolution of these issues, and I support the individual's autonomy in decision-making around the relationship between sexual orientation and all life choices. This is entirely consistent with APA's most recent report on Appropriate Therapeutic Responses to Sexual Orientation (2009). This report is recommended reading for anyone working with clients conflicted about sexual orientation, as it contains the most comprehensive review of the literature in this area ever published. Although the report has been characterized as supporting patient autonomy, which is correct, it also finds no basis for suggesting that sexual orientation can be changed, or even that changes in sexual behavior can be sustained.

Gay male patients (such as Eric, above) may experience a range of issues with which I have some familiarity myself, such as *heterophobia*. I came to understand in my own life, some years ago, that I was often uncomfortable around straight men, and thus coined the term "heterophobia." I have written extensively about this phenomenon elsewhere (Haldeman, 2006), but suffice it to say that it deserves more study than currently exists. The heterophobic gay male is constricted in his social and vocational interactions with straight men, but there is also reason to believe that heterophobia may contaminate relationships with other gay men, both of a fraternal and romantic nature. I have described a case (Haldeman, 2006) in which a gay man's generalized fear of other men adversely affected his ability to develop a primary relationship with another man. Parenthetically, I have personally made great strides in confronting my own heterophobia—partly by developing close friendships with straight male friends and family members, and partly by reclaiming my art of the "straight man's terrain"—be it in the boardroom or the locker room. This has helped me identify and process the same phenomenon with my clients.

Other clients of mine are different from myself by virtue of their heterosexual orientation. I have always liked working with straight men, which may in part be attributable to my own "Queer Eye for the Straight Guy" syndrome. This TV program featured a team of gay men who gave advice to heterosexual men on issues of relationships, attire, grooming, cooking, and home décor. In short, for once, "they" needed "us"; so too, in psychotherapy, a gay male therapist can for once

feel powerful in his being needed by the man who has heterosexual privilege. I will confess that I have appreciated that from time to time. However, since the age of the Internet (when all it takes is a visit to Google for a prospective patient to learn that I am gay and work on gay issues in psychology), I tend to see fewer straight men than I once did. I would attribute this to many straight men's reluctance to see an openly gay therapist, although culturally and generationally this reticence may be changing. Some straight men have actually sought me out because I am gay (see the case of Marty, later in this article) and may expect that I will be less likely to reinforce traditional gender expectations and their attendant pressures. At the same time, given the popularity of theorists like Pleck (1995) and Levant and Pollock (1995), whose paradigms of working with men involve the freeing of men from the psychosocial behavioral and attitudinal constraints imposed by traditional male gender role requirements, there are many progressive heterosexual male therapists. In other words, we gay men no longer have the market cornered on free emotional expression. The men's movement in psychology has been particularly clear about drawing the relationship between antigay prejudice (or *homophobia*) on the part of straight men and constrained or impaired relationships with female partners and other straight male friends (Scher, 2001).

Nonetheless, even the most progressive, "metrosexual" straight man is not immune to the cultural effects of heterosexual male privilege, and given the opportunity, it is my responsibility as a therapist to point this out. Hegemonic masculinity, and the rights and privileges assigned thereto, is still the dominant paradigm for both straight and gay men in contemporary American culture. The risks for interpersonal relationships associated with this can be considerable; I have found that both gay and straight men in my practice can benefit from an alternative, feminist perspective in their social and familial relationships.

In summary, I would say that my diversity status is the foundation on which I investigate the meaning of the life experiences of all the people with whom I work. Most LGBT people bear wounds of some kind, and these may be relevant to the problems they seek to address in psychotherapy. At the same time, heterosexual men, regardless of their privileged status, are not im-

mune to gender role pressures that can lead to negative psychosocial consequences of a different nature. In either case, my own experience of what it means to be a member of a diverse group is probably the single most important factor in the way I conceptualize and structure treatment.

Issues for Clients Relative to My Diversity Status

I'd now like to turn to a consideration of the central issues raised for my clients given my being gay. It is not always possible, of course, to know how, or if, my identification as a gay man affects those with whom I work. Some would not acknowledge their ambivalence, if they had any, and for some it is simply not relevant in a society that is increasingly (and prematurely) being identified as "postgay." I am not always sure of its relevance, so I am reluctant to introduce the topic into the client's therapeutic agenda without some evidence that it may matter. Recently, a gay male patient in treatment for sexual compulsivity—the sort of patient who would historically have wanted to be reassured that I was indeed gay—said, "I just realized I have no idea if you have a partner, or even if you are gay." I asked, "Do you want to know?" Response: "No. What difference would it make?" Nevertheless, there have been some interesting, and unanticipated, cases in which my gayness was of particular relevance for some patients.

I would like to mention that so far in this article I have only discussed my work with men. For as long as I have been in practice, a small but constant percentage (10–15% at any given time) of my caseload has been composed of women. Why would a woman seek out a gay male therapist? Perhaps for some of the same reasons that many gay men and straight women engage in friendship: the intimate bond of friendship can run deep without the complications associated with sexual attraction or interaction. Again, in the pre-Internet years of my practice, I saw many women but cannot recall a time when the fact of my being gay ever emerged as an issue in treatment. Now, some women seek me out because I am gay. The case that follows is typical of such women:

Anne is a 38 year-old entrepreneur involved in an acrimonious divorce from a man she describes as a "narcissist." In the initial stage of treatment,

she is fomenting with anger at him, as well as anger at herself for putting up with his self-centeredness and controlling habits.

The couple has two young boys, ages 5 and 2. At one point, Anne voices her concern that her anger not contaminate her sons' view of their father, or that her negative feelings about her husband be generalized to all men.

Anne remarks one day that she is glad to be seeing a gay therapist, opining: "I'm not sure I could do this work with a straight man." In response to inquiry, she states that her relationship with me makes a "bridge" to the world of men in general. Expressing her anger to me in a direct and unfiltered manner enables her to set it aside and see it in the context of a particular relationship and understand herself and her "partner selection" process better. She is also able to vent her frustrations in therapy, leaving her interactions with her children free of any residual bitterness toward her husband.

I find working with women to be, in some ways, more relaxing than with men. For me, there is no sexual tension (as there might be with a gay male patient), or concern about the privilege differential and resultant power dynamic (as there might be with a straight man). The same is even more true for my lesbian patients, with whom there is no sexual tension in either direction. Consider the following case:

Maria is a 42-year-old woman who has been married to a man for 20 years. The couple has two preteen children; both Maria and her husband come from a Baltic culture and are devout Roman Catholics. Maria has just ended a 7-year relationship with a woman, and has decided to come out as a lesbian; however, she does not intend to leave her children or disrupt her family situation until the children are out of the house. She seeks support in "holding" her lesbianism while remaining in her heterosexual marriage.

Maria's case raises issues of sexual orientation as well as religion, gender, cultural expectations, and socioeconomic status (she must plan for a way to support herself when she ultimately leaves her marriage). I wonder if she can relate to me as a male who does not have children, is unfamiliar with her culture, has financial independence, and does not subscribe to her religious beliefs. I also wonder, what do I do with these questions? Absent her raising them, do I? After consultation, I ask her, "Do you ever wonder if I can fully relate to your experience, given our differences?" She

responds by saying that her main concern had not been any of our differences, but rather our one similarity, being gay. Early on, I had reassured Maria that I had no agenda in terms of what she should do. When it was clear to her that I was not going to recommend she “come out” fully and leave her husband, she felt much more comfortable.

I work with some gay men who have sought me out expressly because we belong to the same group, and they expect that I will understand certain aspects of their lives and identity. This tends to be particularly true when issues of sexuality or relationship structure are at issue. There can be a certain amount of reticence among gay men to discuss their sexual lives with straight providers, or to acknowledge patterns of sexual relating that are different than what one would normally expect in a primary heterosexual relationship. Such is the situation in the following case:

Greg, 43, and John, 32, have been together for 7 years. They have experimented with an open relationship and found the dynamics of jealousy and control too difficult to deal with. However, they are struggling in their sexual connection with each other, and are trying—with limited success—to include third parties in their sexual lives from time to time. Even here, though, there is disagreement: Greg sees the periodic inclusion of third people simply for sex. John objects to what he considers “sexual objectification” of other men and would like to seek out someone who might be interested in playing a secondary role in their relationship. Greg finds this threatening.

In the meantime, the conflict and tension the two are experiencing have led to a mutual sexual withdrawal. They seek help in resolving the conflict about their relationship structure, as well as reconnecting in the face of their sexual distance.

Although some form of open relationship is less common among gay men now than it was before the advent of the health crisis, many gay couples still maintain—or engage in periods—of some form of open relationship. Greg and John correctly believed that I would have some experience in working with couples struggling with this issue. I also clarified that I would be able to help them with their sexual concerns. I do not take a position on what kinds of relationships are right for gay couples; with Greg and John, however, I did recommend that they get their own

“house in order,” so to speak, before involving others in their relationship in any significant way. This strategy required a focus on erotic reconnection between the two of them prior to the resolution of the relationship structure issue. Predictably, the successful sexual reconnection between the two of them resulted in a diminished interest on both of their parts in including others in their sexual experience. Successful sexual reconnection is not always possible, however, especially when only one of the couple is in treatment.

As previously mentioned, I can never know the number of heterosexual men who do not come to see me because, for one reason or another, they do not want to see a gay therapist. Perhaps the idea of therapy itself is stigmatizing enough without having a gay therapist, or perhaps they mistakenly believe that I work solely with gay men. In any case, here is the somewhat unusual situation of a heterosexual man coming to see me because I am gay.

Marty is a 28-year-old heterosexual man employed as a manager at a local coffee retailer, although he is not certain what he ultimately wants to do with his life. He has had several girlfriends, but no serious commitments with any of them. Recently cited for driving under the influence, he is questioning the role alcohol plays in his life. Typically, he likes to go out with his friends to clubs on the weekends.

Marty is the youngest of five siblings, and he reports that his “best friend” was his oldest brother, who was gay. At the first session, Marty states that his brother recently passed away and that he misses him terribly—especially at this critical time in his life. He says that he has come to see me because he knows that I am gay and am hopeful that I can in some way step into the void left by his brother’s death.

Gently, I reminded Marty that no one, gay or straight, can replace his brother, but that we could certainly work through the grief he was experiencing and examine the role it played in his life. Through the course of our work, Marty came to understand that he associated the support he received from his brother with a gay mentor figure. In addition to grief work, there was a significant element of existential work Marty needed to do. As the result of work Marty did in treatment, he was able to identify and pursue a stable career path, as well as following a lifelong dream of moving to Southern California. Could he have done this work with a heterosexual therapist? It is

quite likely. However, the recognition of my gayness probably created an easier—albeit more painful—start to the process. For me, the personal grief of many friends and clients lost over the years is reactivated by a case such as Marty's. It is painful, but familiar, and dealt with outside of Marty's treatment, as is my countertransferential paternal reaction to this young man. As I age, in fact, the young men I see—for whom sexual orientation is indeed less salient than for men in my “baby boomer” cohort—I frequently feel a paternal combination of affection and desire to motivate.

Addressing Diversity Status in the Context of Treatment

At the beginning, I mentioned response to oppression as a common factor in diverse orientation with respect to professional psychology. Where does this lead? In several parallel directions: first, enhanced sensitivity with respect to the ways in which patients may have experienced pain over socially traumatic events, and made life decisions based on those experiences. Second, enhanced sensitivity with regard to the patients themselves: how do we avoid replicating their pain in psychotherapy? And what to do once you have identified the precursors of depression/anxiety secondary to minority status? Consider the case of Larry:

Larry, a 28-year-old African American gay man, comes to treatment with a variety of issues: lack of professional fulfillment, sense of isolation with no primary relationship, and alienation from his family of origin. He is a self-described “underachiever” who has been rejected by his family and feels out of place in a gay community he perceives as being dominated by White men. Even among other gay black men, he feels ill at ease because of his skin tone (too light), and his lack of religious affiliation.

Larry's case brings up the important question of how we view dual—or multiple—minority status. Furthermore, a true connection needs to be established: it was not enough, with Larry, to simply say, “I hear your pain.” On the one hand, I wanted Larry to know that I was familiar with the literature on multiple minority status in the gay community; to validate his perceptions about the covert and sometimes overt racism of White gay men (even though I am one myself); and to let him know that I would understand the poten-

tial effect of all these factors on his mental health. In part, I do this to establish credibility; in part, to assuage my own anxiety (can an African American client truly find me credible?); and in part, apologetically (there are no out gay African American psychologists in our community). Would Larry wonder what an apparently well-off White man could understand about growing up in poverty in the South, only to come out to a gay community rife with racist behavior? This creates an emotional dilemma that I do not want to affect the therapeutic process.

Fortunately, Larry was interested in discussing the dynamic of multiple differences between us. He was well schooled in the concepts of privilege, and we had many “difficult dialogues,” and in the process we developed a productive working relationship. I asked him if he wished he could have an African American therapist, and he responded that race was but one dimension of a relationship that he found to be productive. I was reassured by this response, but still we continue processing his experiences of racism and classism both in and out of the therapy office. Larry recounted numerous sociotraumatic experiences in these respects, and also needed to have encouragement to move forward. Larry had just two classes to complete for his Bachelors' degree. Furthermore, he was exploring a new relationship and needed bolstering regarding his self-esteem. I have found the techniques of *motivational interviewing* (Miller & Rollnick, 2002) to be useful in helping patients access their own inner resources relative to self-actualization.

Brad is 38, a physician who is going through a divorce. The couple has two young children, and he describes the separation as amicable. Brad identifies as a “true bisexual” who has become involved in a romantic relationship with another man, who identifies as gay and would like Brad to live with him. Brad struggles with the notion of commitment, however, given his ongoing attraction to women as well as the heterosexual privilege he stands to sacrifice should he be perceived as “gay.”

When Brad introduced himself as a “true bisexual,” I asked him what that meant. He responded by saying that he thought some people, including professionals, saw bisexuality as a transitional state on the way to coming out as gay, and he wanted to assure me that he was genuinely attracted to both men and women (although perhaps more to men). I asked if he wondered what

I thought, and he acknowledged that he did. I replied that I did indeed endorse bisexual identity as true and enduring, and explained that I would be willing to help him explore how to better understand and live his romantic life as a bisexual man. Once, long ago, I was somewhat “biphobic”; I had resented the fact that they could “flip a switch” and immediately access heterosexual privilege just by being with a member of the opposite gender. Those days are an unpleasant memory. Now I see the therapeutic challenges of working through issues of relationship stability and community connection (given that bisexual people are still viewed with suspicion in some quarters of the gay community) as significant.

Whether we are gay or straight, we grow up in a heterocentric society. It is therefore essential to be willing to confront and monitor without shame one’s own homophobia or lack of understanding about LGBT issues in general. How questions are framed; what is viewed as normative; ability to empathize with the typical life experiences of LGBT individuals; and an ability to recognize that sexual orientation is but one element in a diversity matrix where class, race, age, and ability status all intersect—these are all emblematic of what constitutes technical and ethical competence in work with LGBT patients.

Being gay is not, for me, an afterthought or an ancillary characteristic. My gayness is central to the way I live in all areas of my life: from my profession to my social relationships to my marriage, being gay infuses my interpersonal interactions, my thoughts, my dreams, my feelings. It is the single aspect of identity that serves as the cornerstone for interpersonal interactions—and what, for a psychologist, is more studied, more conscious, than the psychotherapy relationship?

References

- American Psychological Association. (2008). Resolution on religious, religion-related and/or religion-derived prejudice. *American Psychologist*, *63*, 431–434.
- American Psychological Association. (2009). *Report on Task Force of Appropriate Therapeutic Responses to Sexual Orientation*. Washington D. C.: American Psychological Association.
- BECKSTEAD, A. L., & MORROW, S. (2004). Mormon clients’ experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist*, *32*, 651–690.
- COCHRAN, S., SULLIVAN, J., & MAYS, V. (2003). Prevalence of mental disorders, psychological distress, and mental services use among lesbian, gay and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, *71*, 53–61.
- COLE, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*, 170–180.
- DIPLACIDO, J. (1998). Minority stress among lesbians, gay men and bisexuals: A consequence of heterosexism, homophobia, and stigmatization. In G. M. Herek (Ed.), *Stigma and Sexual Orientation* (pp. 138–159). Thousand Oaks, CA: Sage Press.
- FASSINGER, R., & ARSENEAU, J. (2007). “I’d rather get wet than be under that umbrella: Differentiating the experiences of lesbian, gay, bisexual and transgender people. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients*. Washington D. C.: APA Books.
- HALDEMAN, D. (2004). When sexual and religious orientation collide: Considerations in working with conflicted same-sex attracted male clients. *The Counseling Psychologist*, *32*, 691–715.
- HALDEMAN, D. (2006). Queer eye on the straight guy: A case of gay male hetero-phobia. In M. Englar-Carlson & M. Stevens (Eds.), *In the room with men* (pp. 301–317). Washington, D. C.: APA Books.
- HEREK, G. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In D. Hope (Ed.): *Contemporary perspectives on lesbian, gay and bisexual identities: The 54th Nebraska Symposium on Motivation* (pp. 65–111). New York: Springer.
- HEREK, G., GILLIS, R., & COGAN, J. (2009). Internalized stigma among sexual minority adults: Insights from a social psychological perspective. *Journal of Counseling Psychology*, *56*, 32–43.
- LEVANT, R., & POLLACK, W. (Eds.). (1995). *A new psychology of men*. New York: Basic Books.
- MAYS, V. M., & COCHRAN, S. D. (2001). Mental health correlates of perceived discrimination among lesbian, gay and bisexual adults in the United States. *American Journal of Public Health*, *91*, 1869–1876.
- MEYER, I. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, *3*, 38–56.
- MILLER, W., & ROLLNICK, S. (Eds.). (2002). *Motivational interviewing: Preparing people for change* New York: Guilford Press.
- PLECK, J. (1995). The gender role strain paradigm: An update. In R. Levant & W. Pollock (Eds.). *A new psychology of men* (pp. 11–32). New York: Basic Books.
- ROSTOSKY, S., RIGGLE, E., HORNE, S., & MILLER, A. (2009). Marriage amendments and psychological distress in lesbian, gay, and bisexual (LGB) adults. *Journal of Counseling Psychology*, *56*, 56–66.
- SAVIN-WILLIAMS, R. (2010). The new post-gay, lesbian and bisexual teenager. *The California Psychologist*, *43*, 1, 10–13.
- SCHER, M. (2001). Male therapist, male client: Reflections on critical dynamics. In G. Good & G. Brooks (Eds.). *The new handbook of counseling and psychotherapy with men* (pp.719–733), New York: Jossey-Bass.