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### Recommended Citation

Dentato, Michael P. PhD, MSW; Argüello, Tyler M.; and Wilson, Courtney. Practice with the Gay Male Community. *Social Work Practice with the LGBTQ Community*, , : 286-314, 2017. Retrieved from Loyola eCommons, Social Work: School of Social Work Faculty Publications and Other Works,

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## CHAPTER 14

# PRACTICE WITH THE GAY MALE COMMUNITY

*Michael P. Dentato, Tyler M. Argüello, and Courtney Wilson*

## INTRODUCTION

Understanding the complex needs of the unique and widely diverse gay male community underscores the importance of practitioners to robustly examine the wide array of sociocultural, lifespan, health and mental health factors. While gay men are a subpopulation of the broader lesbian, gay, bisexual, transgender, and queer (LGBTQ) community, practitioners should realize that they have unique needs associated with their sexual orientation, gender, gender identity, and gender expression sometimes similar to their LGBTQ counterparts but often separate from factors that impact LGBTQ individuals. In the same fashion, while gay men may encounter similar life challenges as their nongay counterparts separate from some associations with gender and sex, there are clearly unique issues related to their sexual orientation and other intersecting factors (e.g., race and ethnicity, socioeconomic status, religion/spirituality, rural/urban setting, HIV status, etc.). This chapter starts with an examination of the relevant literature associated with cisgender gay men—defined largely as gay men who were born male, ascribe to a male gender and a gay sexual orientation, are not on the transgender spectrum, and do not identify as bisexual or heterosexual. The opening background section explores the relevant literature on this community while tying in relevant historical and sociological events from the twentieth and twenty-first centuries that have influenced their lives and culture, followed by an examination of lifespan considerations from early school age through older adulthood and death and dying; the impact of dating, marriage, and relationships; culture and subculture factors; various health and mental health needs; and best practice approaches for practitioners in the field of health and mental health and across the related disciplines of social work, mental health counseling, psychology, and other related fields. The chapter focuses on the experiences of cisgender gay men from a Western perspective and by no means is meant to imply that the experiences of gay men across the globe is identical or even similar. While some experiences may be shared (e.g., oppression, violence, coming out, etc.), the severity and significance of challenges for

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gay men across the world may differ from positive affirmation, complete inclusion, and civil equality within their community to the quite negative and opposite extremes of criminalization, imprisonment, or death solely due to the perception or self-identification as a gay man. Last, the term “gay men” is used throughout this chapter as the term “homosexual” has an often diagnostic, negative, or derogatory connotation, history, and meaning for many gay men. The term “homosexual” is only used when appropriate and due to referenced sources or context.

## SOCIOHISTORICAL BACKGROUND

It may be helpful to begin with a discussion centering upon the impact of homophobia and heterosexism upon the lived experiences of gay men. This history chronicles unethical practices, oppression, and mistreatment, sometimes emanating directly from the medical and mental health professions. Progress over the years will also be examined due to activism and other efforts by the lesbian, gay, bisexual, transgender and queer community movement for equality.

### HOMOPHOBIA AND HETEROSEXISM

Many gay men experience direct and indirect forms of homophobia while living within a heterosexist society (Pachankis & Goldfried, 2004). Such experiences begin early on and continue for much of their lives. Whether at home with their family of origin or within school settings, the workplace, or the larger community, such experiences can increase the likelihood for vulnerability, trauma, and health/mental health risks as well as heighten internalized homophobia (Miller, 2013). “Homophobia” is defined as the conscious or unconscious yet pervasive fear of homosexuals and can result in verbal and physical aggression against gay men to overt violence or psychological battering (Sears & Williams, 1997). Homophobia can be implicit or explicit, affecting gay men’s attitudes about themselves and others, which may ultimately result in the fear of self-disclosure of their sexual orientation or impact their ability to seek relationships and intimacy. Institutionalized forms of homophobia may arise within the workplace or businesses that openly or subtly discriminate against gay men through written and unwritten policies (Giuffre, Dellinger, & Williams, 2008). Internalized homophobia is the process by which gay men may adopt and accept negative feelings and attitudes about themselves or homosexuality, which may manifest itself in many ways including challenges associated with mental health, relationships and intimacy, sexual risk behavior, addiction, suicide ideation, or low self-esteem, among other areas of concern (Herek, Gillis & Cogan, 2009; Meyer, 2003; Williamson, 2000). The terms “heterosexism,” “heterocentrism,” and “heteronormativity” refer to assumptions and processes that are integrated within mainstream society that imply that people and lifestyles are naturally heterosexual and the normal standard by which members of the LGBTQ community should be understood and evaluated (Herek, 2000; Pachankis & Goldfried, 2004; Shernoff, 2006). Various forms of homophobia, internalized homophobia, and heterosexism can have a huge impact on the health and mental health of gay men. Practitioners must understand and fully explore the history, depth, and relevance of such issues when working with gay men across practice settings.

## HISTORY OF OPPRESSION

Gay men have been subject to a long history of oppression that includes institutional, societal, religious, and other forms of stigma imposed by individuals and groups. Several sociohistorical examples follow to underscore the long-term impact of oppression, stigma, and violence on gay men and gay male culture as well as to illustrate how such events have directly affected various age cohorts of gay men across time. While the context of understanding oppression on gay men is important, it should be noted that the gay male community has exhibited an exorbitant amount of collective resilience as a group as well as resilience evidenced through individual experiences. The importance of understanding individual and collective resilience as well as an ability to adapt and cope with oppression, stigma, stress, and minority status are examined later in this chapter.

## THE HOLOCAUST

The Nazi occupation of Europe and subsequent extinction of 7 million members of the Jewish community during World War II was a dark time in our world's history that included the arrest, punishment, and death of members of the gay community as well (Grau & Shoppmann, 2013). Individuals identified as homosexual were persecuted as part of the Nazi moral crusade to racially and culturally purify Germany. This persecution ranged from the dismantling of the homosexual press and the closing of bars, clubs, and organizations to the internment of thousands of gay individuals within concentration camps (Grau & Shoppmann, 2013; Vetri, 1998). Gay men, in particular, were subject to harassment, arrest, incarceration, and even castration (Grau & Shoppmann, 2013). Identified by pink triangle badges placed on their prisoner uniforms, gay men were singled out as being sexual deviants (Grau & Shoppmann, 2013; Plant, 2011). The pink triangle (see Appendix A) has since been reclaimed both as a token of remembrance for those gay individuals lost during the Holocaust as well as a symbol of empowerment for the LGBTQ community (Jensen, 2002).

## UNETHICAL TREATMENT APPROACHES

During the 1950s and earlier, several behavioral therapies were utilized in conjunction with harmful medical approaches to “cure” or “alter” one’s sexual orientation or attraction to the same sex through use of psychopharmacology, electroshock therapy, lobotomies, or medical castration (Berrill & Herek, 1990; Murphy, 1992). The harmful impact of such archaic, violent, and trauma-inducing treatment approaches for gay men clearly resulted in multiple short- and long-term health and mental health challenges. Similarly, modern-day approaches known as conversion or reparative “therapies” have been widely rejected by most professional organizations (Jenkins & Johnston, 2004) across disciplines (e.g., American Psychiatric Association [APA], American Psychological Association, American Counseling Association, American Academy of Pediatrics, American Medical Association, National Association of Social Workers (NASW), Council on Social Work Education, and others). Conversion and reparative approaches are presently against the law in several states including California, Oregon, New Jersey, Illinois, and Washington, D.C. (Shumer, 2014). Further discussion of the negative impact of reparative/conversion “therapies” is provided in this chapter under the section on effective approaches and interventions.

## THE STONEWALL REVOLUTION

Discourse centered on the role of such events as the Stonewall revolution in New York City during June of 1969 cannot be overlooked, especially with regard to the impact on gay men and the movement for LGBTQ equality. Many scholars reference the events at Stonewall as the rise of the modern LGBTQ liberation movement promoting tolerance, equality, and resistance to continued oppression to create larger national attention through protest led by LGBTQ individuals (Hall, 2010). The interesting factor about discussing Stonewall is that it lends to differences in understanding the lives of gay men and the impact of living before, during, or after the creation of this civil rights movement lasting through the modern day. While the three days of protest in New York City was predominately led by members of the transgender community along with gay men and lesbians, the long-term impact it has had on progress for LGBTQ civil rights led to the national landmark status of the Stonewall Inn bar to insure its protection and honor (Armstrong & Crage, 2006). The events at Stonewall also led to the broadened visibility of many national LGBTQ organizations including those active throughout the 1950s and 1960s such as the Mattachine Society, Daughters of Bilitis, and Gay Liberation Foundation, while certainly giving cause to modern-day organizations including the Human Rights Campaign, LAMDA Legal, GLAAD, GLSEN, and many others that can be found in Appendix C of this text.

## HARVEY MILK

After the events at the Stonewall Inn during the summer of 1969, the movement for LGBTQ equality spread across the United States. Harvey Milk was an openly gay man and activist who relocated from New York City to San Francisco in 1972 and was soon elected to the San Francisco board of supervisors in 1977. Milk not only supported and promoted gay liberation but also emphasized the importance of individual rights and the need for a gay rights city ordinance and helped lead the counterattack to the Briggs Initiative, which failed by voter referendum to remove gay teachers from California's public school system (Hall, 2010). Milk and his ally Mayor George Mascone were assassinated by Dan White, a disgruntled former San Francisco city supervisor in November of 1978. White was acquitted of murder and sentenced for manslaughter due to his attorney's claims that White had eaten too much junk food and could not be held accountable for his crimes, which came to be known as the "Twinkie defense" (Shilts, 1982). The city of San Francisco held a candlelight vigil that soon erupted into civil unrest known as the White Night Riots between upset citizens and the police (Shilts, 1982). Milk's legacy continues on in many ways with the Harvey Milk Foundation run by his family and a school named in his honor for LGBTQ youth in New York City.

## DIAGNOSTIC CRITERIA CHANGES

Over the years, the APA has published the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) that assists practitioners across disciplines with understanding a multitude of criteria by which to measure an individual's mental health needs and create a diagnosis to assist with their

care. The DSM is widely utilized by the psychiatry, psychology, and social work professions, among others—while it also has recently garnered attention for its notable limitations and flaws by the National Institutes of Mental Health (Carey, 2014). One of the biggest hurdles for the LGBTQ community stems from inclusion of homosexuality in the DSM as a mental disorder. In fact, until the third edition of the DSM was published in 1973, homosexuality was listed as a mental disorder. However with the release of the third edition, a new diagnosis titled “ego-dystonic homosexuality” was created and remained until all references to homosexuality were removed by 1987 (Morin & Rothblum, 1991). Thus the historical impact of the DSM’s inclusion of diagnostic criteria labeling homosexuality as a “mental disorder” combined with other forms of societal oppression and stigma stemming from antigay legislation, employment discrimination, family stressors, and other challenges have had a profoundly negative impact on gay men (Atkins, 2003; Weststrate & McLean, 2010; Williams & Freeman, 2007). Additionally, continued challenges related to the DSM remain for members of the transgender community as “gender identity disorder” was changed to “gender dysphoria” with the publishing of the fifth edition of the DSM in 2013 (Duschinsky & Mottier, 2015).

## HIV/AIDS AND ACT UP

The impact that the earliest years of the HIV/AIDS epidemic through the 1980s and early 1990s had on gay men cannot be overstated as the disease continues to devastate this minority population of men, especially those within diverse racial/ethnic backgrounds, younger gay men, and those over the age of 50 (Hall, Byers, Ling, & Espinoza, 2007). The first report of five gay men being diagnosed with pneumocystis carinii pneumonia in 1981 from the *Morbidity and Mortality Weekly Report* caused great uncertainty with regard to understanding the origins and transmission of what would ultimately become HIV/AIDS (Sepkowitz, 2001). The early 1980s were a time of great fear, stigma, moral panic, and government inaction while thousands of gay men and others (e.g., hemophiliacs, Haitians, heterosexuals) with HIV/AIDS were dying (Labra, 2015; Weeks, 1989). Potential treatments were withheld due to drug pharmaceutical bureaucracy and financial barriers to treatment and care (Isbell, 1993). This inaction led to the development of community based HIV/AIDS organizations (e.g., Gay Men’s Health Crisis in 1981) as well as activist groups including ACT UP in 1987 and Queer Nation in 1990, which organized public protests to raise awareness for those living with and impacted by the epidemic (Haldi, 1999; Lune, 2007). Many gay men, members of the LBTQ community, and their allies became active leaders and members within these organizations. Protest events and marches at the Centers for Disease Control and Prevention, Wall Street, the White House, and throughout major metropolitan areas such as New York City and San Francisco can be ultimately credited with drug pharmaceuticals lowering prices for early treatments such as AZT and the movement for more rapid release of treatments such as antiretroviral therapies (ART) in the mid-1990s (Smith & Siplon, 2006). While ART treatments remain the main approach to treatment and care for those living with HIV, smaller doses taken daily are being used to prevent HIV transmission known as pre-exposure prophylaxis (PrEP; Brooks et al., 2012). Ultimately, the long-term impact of HIV/AIDS among gay men cuts across age cohorts from those that lost many of their best friends, lovers, and partners in the early

years, to those that found much hope with new treatments in the mid-1990s, to the newer generations living with HIV long term and asymptomatic and lowering potential for transmission with PrEP. The majority of gay men living today have never truly known a world without HIV/AIDS, which has likely had some impact on shaping their identity, relationships, sex, sexuality, health, and mental health.

## DON'T ASK, DON'T TELL, THE DEFENSE OF MARRIAGE ACT, AND MARRIAGE EQUALITY

Two significant challenges for gay men pertained to an inability openly serve as an out gay man in the military and the ability to legally marry rather than commit via domestic partnerships and civil unions. The 1994 Clinton era policy of “Don’t Ask, Don’t Tell” was meant to protect gay men from coming out or being outed in the military. However, the policy was flawed and often caused a negative or more hostile impact (Knauer, 2009), later to be overturned by the Obama administration in 2011. In the same regard, the Defense of Marriage Act was passed in 1996, which defined marriage as the union of one man and one woman, allowing states to refuse to recognize same-sex marriages granted under the law of other states. While several states provided some form of domestic partnership or civil union (e.g., Vermont, Illinois, and Connecticut) as early as 2000, it was not until the Commonwealth of Massachusetts became the first state to legally sanction same-sex marriage in 2004 that other states would soon follow by enacting either similar legislation for marriage or some form of domestic partnership or civil union (Pierceson, 2014). In 2011, the Obama administration refused to uphold or defend the 1996 Defense of Marriage Act (Elze, 2006; Landau, 2012), and it was ultimately struck down by the US Supreme Court in the 2013 case of *U.S. v. Windsor* (Pierceson, 2014). On June 26, 2015, the US Supreme Court ruled in favor of marriage equality across the 50 states, also ruling in favor of all states recognizing one another’s marriage laws (Mills, 2015).

## LIFESPAN CONSIDERATIONS

Examining the role of neuroscience upon lifespan development of gay men, as well as looking at specific stages (e.g., childhood, adulthood), may assist with understanding implications for health, wellness, mental health and practice with this diverse community. Understanding elements of intersectionality is often helpful related to sexual orientation, racial/ethnic background, culture and subculture, and sexual risk behavior, among other key areas of concern.

## NEUROSCIENCE

The history of scientific inquiry regarding sexuality, including the study of neuroscience and possible biological differences among gay men, has long been fraught with the oppression and subjugation of those who identify as gay. Beginning in the late 1800s and lasting through much of

the twentieth century, many individuals belonging to the medical establishment defined unacceptable sexual behaviors, such as homosexuality, as pathological brain disorders (Wolpe, 2004). Using science as justification, doctors and scientists performed castration and lobotomies and used hormonal therapies to “cure” homosexuality (Byne & Lasco, 1999; Wolpe, 2004). Science both reflects and influences culture, and it is important for practitioners to take this into consideration when attempting to find empirical support explaining homosexuality and sexual behavior (Wolpe, 2004). The medical ethicist Paul Wolpe (2002, 2004) suggests that using categories such as “heterosexual” and “homosexual” when researching differences in sexuality is not particularly helpful due to the fact this binary classification system discounts the fluidity of sexual orientation. Scientists have yet to come to a conclusion regarding biological determinants in the development of human sexuality, and the understanding of the human brain is still in its infancy (Byne & Lasco, 1999; Rahman & Wilson 2003). Research focusing on differences between heterosexual and homosexual men has pointed to fraternal birth order, differences and abnormalities in different sections of the brain, and genetic differences in the X chromosome (Rahman & Wilson, 2003). While brain science has been advancing at lightening speeds, it is imperative for scientists and mental health practitioners to reflect on the political, social, and cultural implications created with new research to inform clinical practice.

## CHILDHOOD AND ADOLESCENCE

Exploring how gay men experienced childhood and the beginning stages of their sexual orientation may be significant to assist with development of treatment and understanding early experiences of stigma and oppression (Miller, 2013). Norms associated with adolescence, such as dating, mating, social groupings, and status, are framed from a heteronormative perspective and can raise feelings of isolationism and stigmatization for gay men (Miller, 2013). Many gay men have expressed that, as youth, they felt different from their peers and were treated differently by family, peers, and outsiders (D’Augelli, Grossman, & Starks, 2006). A study of 191 gay and bisexual men emphasized the role of childhood experience in the development of their adulthood relationships (Landolt, Bartholomew, Saffrey, Oram, & Perlman, 2004). This study found a significant relationship between childhood rejection and attachment anxiety in adulthood—whereas rejection from parents, siblings, and peers in childhood directly related to higher levels of attachment avoidance in both romantic and platonic relationships (Landolt et al., 2004). All of this research points to the fact that childhood and adolescence is such a pivotal developmental time in a gay man’s life: impacted by positive and negative experiences affecting self-image and self-esteem with lasting consequences.

## COMING OUT

Once a gay man begins the process of resolving the internal conflict of his sexual orientation being different from that of heterosexuality, the self-disclosure process can begin a process on a path toward full acceptance and integration including among family and friends (Carrioin & Lock, 1997). The disclosure process is a common and important step of the sexual identity development



and integration process that occurs over time for most gay men across the lifespan (Grafsky, 2014). The initial coming out process may occur at different times and ages depending on age cohort factors and perceptions of support and safety. Additionally, the process of coming out takes place across time whether in social settings, the workplace, school, a doctor's office, a retirement home, or an assisted living facility. The impact of coming out on family and caregivers should also be considered. Assisting parents and caregivers with their gay son's coming out may be necessary as they may respond and adjust in both supportive and/or negative ways while also have a coming out process themselves (Phillips & Ancis, 2008). A more comprehensive discussion related to understanding the impact of disclosure processes and coming out stages for members of the LGBTQ community may be found in chapter 5 of this text.

## BULLYING

Understanding how gay men have experienced bullying in childhood and how these experiences may have influenced their development, self-image, and self-esteem or increased their risk for challenges associated with health (e.g., obesity, smoking, drugs) and mental health (e.g., suicidality, depression) is important. Unfortunately, bullying, which is sometimes referred to as sexual orientation victimization within research literature, is a common childhood occurrence for gay men: research studies have shown that close to 80% of gay men experienced some sort of sexual orientation victimization in childhood. Bullying can arise in differing forms including physical abuse, name-calling, teasing and threats, social exclusion, and rumor spreading (Meneses & Grimm, 2012). The effects of bullying can look different for gay youth than their straight counterparts, due to a lack of support from parents or school personnel (Meneses & Grimm, 2012). The majority of gay males who experience school-based bullying often do not report it to teachers, school administration, or parents (Meneses & Grimm, 2012). Ultimately, the impact of childhood bullying cannot be ignored, as risk for mental health disorders, including suicide and suicide ideation, are high (Meneses & Grimm, 2012).

## ADULTHOOD

The role of stigma and discrimination based on sexual orientation and other factors (e.g., HIV, partner, socioeconomic status) may affect gay men throughout adulthood. Living within a heteronormative culture in which expectations for adults include marriage and children, gay men have been historically barred from experiencing such milestones throughout life (Herdt, Beeler, & Rawls, 1997). In their study of lesbian and gay adult males and their development, Herdt et al. emphasized the difficult task faced in overcoming stigma based on sexuality. Further research has shown continued marginalization and oppression based on sexual orientation and the toll this has on individuals who identify as gay. In his research, Weeks (1998) coined the term "sexual citizenship," a phrase used to describe the phenomenon of citizenship being shaped by society's normative and socially accepted sexual behavior, whereby those who do not fit within this construct (e.g., gay men who are not in heteronormative marriages producing children) are consistently devalued and undermined throughout their adulthood. However, changes such as the US Supreme Court

ruling on marriage equality, have the ability to completely change the scope of how gay men and their families are perceived and treated. It will be equally important to follow how this ruling at the federal level impacts the lives of adult gay men over time.

Ageism is an important factor to consider when attempting to further understand the life experiences of adult gay males, and the process of aging and the complexities that surround it are another topic of interest in the research literature. Herdt et al. (1997) found that many gay men have a significant loss of self-esteem as they age. This loss of self-esteem can be attributed to many factors. Some research has shown that the value of youth and beauty is prized higher in gay culture than in dominating cultures (Dorfman et al., 1995). In the same regard, while previous studies found large differences in societal acceptance of gay males, with those age 50 and older least likely to have accepting attitudes (Kaiser Family Foundation, 2001), evolving perceptions have been much more favorable (Lewis et al. 2015). Ultimately it may be important for practitioners to explore the impact of societal stigma and prejudice experiences among older gay men.

Gay men often create families of “choice,” which are communities and individuals that often replace families of origin due to alienation and rejection. Historically, in many states gay couples were unable to legally marry or adopt children, which led them to build relationships outside of the traditional family system. One study of Chicago area of 160 lesbians and gay men found that up to two-thirds of the sample reported having a family of choice (Beeler, Rawls, Herdt, & Cohler, 1999). Another study found over half of the 145 gay men interviewed considered close friends to be “as close” or “closer” to them than family members, as well as believing personal friendships to be of great importance (de Vries & Johnson, 2002). Such families of choice, and the strong bonds that form within them, have been found to be protective against isolationism and depression (Beeler et al., 1999).

## DEATH AND DYING

While the rates of HIV transmission have been steadily declining throughout the past 20 years for specific subsets of the gay community, the impact of HIV/AIDS on the lives of gay men is still a very relevant topic. In their study of 746 gay men over a seven-year period, Martin and Dean (1993) examined the impact of HIV/AIDS bereavement, finding a large loss of cohort support with diminished mental health effects of such losses over time. This fact is especially relevant in the older gay male community as they are more likely to have lost family support due to their sexual orientation combined with losing friends, lovers, and partners to HIV/AIDS, likely having long-term consequences for their supportive networks (Martin & Dean, 1993). Others have studied grief and bereavement within the gay community focusing attention on the effect disenfranchisement has on grief and loss and the lack of legitimacy this loss is given by the dominant culture (Doka, 1989). Brown, Alley, Sarosy, Quarto, and Cook (2001) underscored the fear and reality of aging and dying without strong levels of social supports, as older gay men are increasingly shut out from mainstream gay culture and left without strong support systems.

In measures to combat the isolation that many older gay men face, different community groups across the United States were formed. These included SAGE (Services & Advocacy for GLBT Elders) in New York City and GLOE (Gay and Lesbian Outreach to Elders, now New Leaf Outreach to Elders) in San Francisco, among many others. With the focus on community building

within the aging gay community, these organizations have had a positive effect on the well-being of older gay men within the LGBT population (Morrow, 2001). In response to HIV/AIDS stigmatization and disenfranchisement, such projects as the AIDS Memorial Quilt were organized. This project, ongoing since 1987, stitches together quilts with the names of individuals lost due to HIV/AIDS. The project was created to be a community-building endeavor, giving those impacted by HIV/AIDS a public forum to show expressions of grief and loss (Corless, 1995).

Although the Supreme Court ruling in the matter of *Obergefell v. Hodges* may change the legal status of many gay men who have been in long-term partnerships and wish to be legally married, attention still needs to be paid to the legalities of end-of-life decisions. Previously, many gay men in long-term partnerships were faced with the lack of decision-making authority automatically granted to married heterosexual couples, further adding to experiences of oppression and disenfranchisement.

## RACIAL AND ETHNIC CONSIDERATIONS

Greene (1994) explored the impact of minorities that have additional minority status (e.g., sexual, ethnic, gender, disability) and the multiple levels of oppression and discrimination that accompany such identities. Racial/ethnically diverse gay men must manage the dominant culture's racism, sexism, and heterosexism as well as that of their own ethnic group. However, such ties to their ethnic minority group may provide practical and emotional support and significance. Ongoing challenges related to often explicit homophobia within these groups may cause racial and ethnic diverse gay men to remain closeted and more vulnerable for certain risk factors (i.e., substance use, suicide ideation). Additionally, ethnic minority gay men have been disproportionately affected by HIV/AIDS. Although rates of new transmissions has been declining for White gay males, HIV has continued to greatly impact gay African American males and gay Latino males. While African Americans represent only 12% of the overall population, they accounted for 44% of new HIV/AIDS cases in 2013 (Centers for Disease Control and Prevention [CDC], 2013). Similarly, the HIV transmission rate in the gay Latino community is more than three times that of Whites (CDC, 2013). Correlates of poverty and the overall lack of HIV testing, prevention, and treatment resources has been given the most attention in the ongoing study of these unbalanced statistics related to transmission. There also has been strong momentum for advocacy, continued outreach, education, and prevention measures and programming such as *Dentengamos Juntos el HIV* (Let's stop HIV together), Act Against AIDS Leadership Initiative, and the Care and Prevention in the United States Demonstration Project. All of these health advocacy, prevention, and educational programs focus specifically on ethnic minority communities (CDC, 2013).

## RELIGION AND SPIRITUALITY

There is a fine balance between understanding the historical oppression of gay men by religious groups and institutions when compared to the supportive role that religion and spirituality has upon this diverse community. Many religious institutions have a history of stigmatizing and excluding gay men from their congregations, barring gay religious leaders, and prohibiting

religious ceremonies such as weddings. In a study of 66 lesbian, gay, and bisexual individuals, nearly two-thirds reported experiencing conflict through their involvement with religious institutions, resulting in ongoing negative effects including difficulty in coming out and an increase in internalized shame and depression, among other factors (Schuck & Liddle, 2000). Such marginalization and oppression can negatively impact gay identity formation along with having lasting psychological consequences (Schuck & Liddle, 2000). While many gay men view religious institutions as oppressors, it is also true that many often turn to spirituality (Tan, 2005) as an alternative to organized religion. Additionally, Tan (2005) found that individuals who express higher levels of spirituality had higher self-esteem, more self-acceptance, and better overall well-being. It is important to note that a good number of religious institutions have become “open and affirming” by openly welcoming LGBTQ congregants as well as providing the potential for leadership roles. For example, in early July of 2015, the Episcopal Church affirmed and invited same-sex couples to be married at their institutions. Exploring ways that religion and spirituality can be effectively integrated into social services and counseling experiences for gay men remains an important aspect for social workers to consider when providing care or building a therapeutic alliance.

## RURAL AND URBAN LIVES

Throughout the twentieth and twenty-first centuries, gay men have been moving en masse to urban areas such as San Francisco, New York City, and Chicago. In these densely populated urban areas, gay men have created vibrant communities providing a wide range of support systems (Lindhorst, 1998). However, there are still many gay men living in rural areas out of choice or an inability to afford the expensive costs of moving to large cities (Lindhorst, 1998). Gay men living in rural areas experience a different lifestyle than those living in large cities and also have differing needs. Rural areas are traditionally more politically conservative and have inhabitants who hold moral values created in a fundamentalist religious context (Lindhorst, 1998; Mancoske & Lindhorst, 1994). Although public attitudes have improved for the LGBTQ community over the past 30 years, studies consistently show communities in rural areas continue to have homophobic attitudes (Lindhorst, 1998). This can lead to gay men in rural areas experiencing more isolation, higher levels of explicit homophobia, and smaller networks of support than their urban counterparts (Bacharach, 1987; Lindhorst, 1998). Some research has shown gay men in rural areas experience higher rates of depression and suicide compared to those living in more populated areas (Bacharach, 1987; Paulson, 1991). Typically fewer health and mental health resources exist in these areas, limiting access to necessary support (Lindhorst, 1998; Mancoske & Lindhorst, 1994). Luckily technology has enabled many rural gay men to join online communities, thus expanding support networks previously unavailable to them (Kirkey & Forsyth, 2001).

## MIGRATION AND IMMIGRATION

The lives and experiences of gay men who are also migrants or undocumented immigrants is a topic that has only recently been receiving the attention it deserves. The intersection of sexual orientation and undocumented status often poses unique and difficult challenges for many

LGBTQ individuals. They often face multiple layers of oppression due to racism, homophobia, and xenophobia. Additionally, undocumented immigrants are the victims of crime, including kidnapping, rape, trauma, and verbal and physical abuse, all with an underlying fear of immigration police and being discovered as undocumented (Bianchi et al., 2007). The historical context of understanding the intersection between sexual orientation and immigration is also an important consideration when working with gay men. Specific statutes regarding naturalization and immigration laws barred members of the LGBTQ community from become legal citizens (Carro, 1989). Additionally, many undocumented immigrants come to the United States with the hope of receiving quality care for HIV/AIDS and related illnesses. However, lack of access to proper health care is a reality that many of these gay immigrants and migrants face (Manalansan, 2006). Bianchi et al. (2007) found that the reasons for immigration among gay men are extremely varied and nuanced to each individual. Some individuals come to escape conservative, homophobic countries and to achieve greater sexual freedom, while others leave their home countries due to widespread poverty, political instability, and limited educational opportunities (Bianchi et al., 2007). Understanding the social and political context of immigration choices is imperative when working with this community of individuals.

## DATING AND RELATIONSHIPS

To fully understand patterns of dating for gay men, practitioners should not assume such patterns align or follow those of their nongay counterparts. In the same regard, gay men are typically raised in heteronormative environments, witnessing their opposite-sex parents' relationships (through both positive and negative aspects) while living in environments that focus on male and female dating, mating, and relating patterns affirmed through institutions such as schools, churches, and the mass media (Potârca, Mills, & Neberich, 2015). Some progress has been made since the 1990s with more visible symbols of same-sex dating and mating through literature, movies, television, and advertising (Campbell, 2015). There remains limited research and empirical literature with regard to understanding the long-term impact of marriage and divorce or patterns that may be developing among gay couples. Negative implications associated with marriage among gay couples along with assumptions stemming from those opposed to marriage equality have yet to arise as well (Langbein & Yost, 2015).

## MONOGAMY, NONMONOGAMY, AND POLYAMORY

Gay male couples may have spoken or unspoken agreements with regard to the status of their relationship, intimacy, and needs for sexual relations. Such agreements may range from monogamy to nonmonogamy or polyamory. There are also clear differences related to fidelity factors as some gay couples may openly agree to the terms of their sexual relationship while others may not or may find ways to secretly engage in sexual relations, causing infidelity. Sanchez, Bocklandt, and Vilain (2009) compared single ( $n = 129$ ) to partnered ( $n = 114$ ) gay men and found differences regarding concerns over traditional masculine roles and interest in casual sex. Researchers found that single men were more restrictive in affectionate behavior with other men and more interested

in casual sex than partnered men. Oppositely, partnered men were more interested in success and power and were more competitive than single men.

One main difference between gay couples and opposite-sex couples is that many, but clearly not all, within the larger gay community have an easier acceptance of casual or anonymous sex, nonmonogamy, and sexual nonexclusivity, which is a clear departure from typical heteronormative views and values (Shernoff, 2006). Some of these views may have arisen due to the decades of oppression and repression of male sexuality causing gay men to socialize, date, and engage in sex in public settings while rejecting sexual patterns they may have witnessed from their parents or nongay counterparts over time as discussed in the previous paragraph (Sanchez et al., 2009). Furthermore, some of these factors and sexual inclinations may simply be due to gender (Shernoff, 2006). Mitchell, Harvey, Champeau, and Seal (2012) examined the impact of various sexual agreements made between gay male couples ( $N = 144$ ), finding that couples demonstrated a lower risk of unprotected anal intercourse with their secondary partner when in a strictly monogamous relationship with a primary partner and a commitment to their sexual agreement. In addition, there were other factors that impacted such agreements (e.g., HIV/AIDS complacency and treatment optimism, substance use, failure to practice safe sex, etc.) as well as various relationship factors (e.g., HIV status of each partner and testing, faulted sexual agreements, perceived monogamy) that impact overall sexual risk behavior among gay male couples. Sexual agreements may include conversations surrounding trust, honesty, and negotiated safety (e.g., use of condoms); serosorting (e.g., sorting partners by HIV status); seropositioning (e.g., lessening risk by selecting HIV-negative partners for insertive and not receptive anal sex); seroconcordant status (e.g., selecting partners with the same HIV status; Mitchell et al., 2012).

## CULTURE AND SUBCULTURE

Historically and currently, gay men have had a unique relationship with and within public and private spaces. As no concrete demographic exists to determine or predict one's sexuality, gay men have had to harness various forms of mediated communication in order to associate socially and sexually. Incidentally, some have claimed that gay men (and more broadly LGBTQ people) hold an innate sixth sense or "gaydar" (Shelp, 2002) to locate another gay person. Yet, more important, gay men have existed and continue to exist within social climates that range from accepting and tolerant to blatantly hostile and oppressive. Depending on the location, it may be illegal to self-identify as gay or engage in same-sex behaviors (see [www.ilga.org](http://www.ilga.org)). From that perspective, gay men are not simply a subpopulation; instead, they can better be conceptualized as a "counterpublic" (Warner, 2002) or networks of individuals and groups that continually interact with and are defined, to various extents, by normative structures and oppressive forces. Because of this, when considering the ways in which gay men participate in the public sphere, mediated communication is central. This can take the form of finding unique spaces and places (e.g., bathhouses) to socialize or find sexual partners, engaging in social and sexual behaviors (e.g., joining the leather, drag, or bondage, discipline, and sadomasochism [BDSM] communities), or actively choosing and expressing identities atypical of those expected by larger LGBTQ culture or society in general.

Few documented histories are available that illustrate the cultures that have allowed for homo-socializing over time (Boyd, 2005; Chauncey, 1995). Still, LGBTQ neighborhoods have been established around the United States and beyond, including the Castro District in San Francisco, West Hollywood in Los Angeles, Chelsea in New York City, and Boystown in Chicago. These locations allow for social and material capital to exist, social identities to find expression, and sexual encounters to occur. Especially with stricter social and legal policing, gay men have relied on a variety of strategies to connect with other gay men for socializing and sexualizing (Frankis & Flowers, 2005, 2007, 2009). Importantly, cruising among gay men has existed as a social behavior to search for sexual encounters. Public sex venues (PSV), such as bars, parks, and bathhouses, have been sanctioned and contested places where gay men can congregate, including engaging in sexual encounters. In the early days of the HIV epidemic, many cities ushered in the closing of PSVs for fear of contagion and in hope of controlling the epidemic (Woods & Binson, 2003). Parallel to PSVs, gay men have engaged in cruising in public sex environments (PSEs), which are places not originally built for sexual activity; instead, PSEs can include parks, truck stops, gyms, or public bathrooms, among other spaces. These places have historically been met with high levels of policing (see Humpheys, 1970). As of late, both PSVs and PSEs have received increased attention from public health and allied professionals in order to better understand the correlation of these locations with the continued HIV epidemic and other sexually transmitted infections (STIs; Frankis & Flowers, 2007).

In more recent times, another place that has been a prominent scene of association for gay men is online and through social media. Even before the rise of the Internet, gay men, and more generally men who have sex with men (MSM) have been early adopters of technology for social and sexual purposes. Gay men and MSM have utilized multimedia channels and, progressively, internet spaces for seeking out sexual health information, cruising for and finding sex partners, social networking, dating, having cybersex, and consuming pornography (Groves, Breslow, Newcomb, Rosenberger, & Bauermeister, 2014). Prior to the 1990s, mediated communication among gay men centered on media such as telephone chat lines, magazines, and VHS videos. Moving into the 1990s brought about the rise of the Internet, which included online chatrooms for cruising, the development of new language for online connections (e.g., M4M), and the proliferation of sexual networking websites like Manhunt.net and Adam4Adam.com. In the early 2000s, broadband and wi-fi technologies allowed for increased interconnectivity, bringing about increases in not only sexual connections but also relationships between gay men. These connections were found to correlate Internet usage and HIV/STIs (Liau, Millet, & Marks, 2006). Public health researchers, therefore, worked to gain methodological traction for conducting research online, as well as begin rolling out more Internet-based interventions targeting gay men and high-risk behavior. Even more recently, new media has been attributed to the decline of built gay spaces and historically entrenched “gayborhoods.” Parallel to this, with the advent of smartphones and tablets, even greater personalization and connectivity has developed (Groves et al., 2014). Applications for social and sexual networking have taken hold, such as Facebook, Grindr, and Scruff. Accordingly, a research focus has increased especially regarding the high-risk sexual behaviors of young MSM. Gay men now have greater choice of media spaces for connecting, especially in relation to social identities, sexual fetishes, and other behaviors. For example, apps such as Scruff allow for greater networking of bears, cubs, and otters, or those affiliated with a subculture of gay men focused on

more masculine archetypes and hairier, rugged men. In the same regard, those who may be more attracted to leather, BDSM, or other fetishisms may be able to locate others with similar interests via an app when compared to the more historical venue of a bar or club.

## HEALTH AND MENTAL HEALTH

A paucity of empirical population-based information exists on the health and mental health of gay men (Institute of Medicine [IOM], 2011), as data regarding sexual orientation, gender identity, and expression are not routinely and consistently collected on state and federal surveillance research projects. This concerning disparity leaves an inaccurate picture with regard to the health of gay men (and LGBTQ persons at large) and is a priority for the outcomes of “Healthy People 2020” (US Department of Health and Human Services, 2013). Blosnich, Farmer, Lee, Silenzio, and Bowen (2014) were able to aggregate population-based data of adults in the United States ( $N = 93,414$ ) from a behavioral risk factor survey across 10 states, finding that adult gay men, as compared to heterosexual peers, were nearly twice as likely to smoke, had higher odds of mental distress and life dissatisfaction, and more commonly had activity limitations due to physical, mental, and emotional problems. Alternatively, gay men utilized health-care services at a similar rate as heterosexual men and were less likely to be overweight or obese, were more likely to be vaccinated for the flu, and were more likely to undergo HIV testing than heterosexual peers. Bisexual men were 60% less likely to have ever had an HIV test (Blosnich et al. 2014).

### HIV/AIDS, STIs, AND SEXUAL RISK

Whereas gay, bisexual, and other MSM are estimated to comprise 2% of the US population, they continue to be disproportionately affected by HIV (CDC, 2015). In 2010, gay and bisexual men accounted for 63% of all new HIV infections and 78% among men overall (CDC, 2015). White MSM accounted for the largest number of newly infected (38%), followed by African American MSM (36%) and Latino MSM (22%) (CDC, 2015). In 2011, 57% (or 500,022) of all people living with HIV in the United States were gay and bisexual men (CDC, 2015). In 2013, gay and bisexual men comprised 81% of new diagnoses among men (13 years and older) and 65% of all new diagnoses overall. Disproportionately, young people and African Americans (of any age) are the populations with increasing rates of new infections and diagnoses, with the latter being the most affected population in the recent years. Moreover, MSM of color account for almost three-quarters of those diagnosed with AIDS and typically have worse HIV-related health outcomes. As of 2011, of the gay and bisexual men diagnosed, 80.6% were linked to care, 57.5% were retained in care, 52.9% were prescribed antiretroviral therapies, and 44.6% had achieved viral suppression (CDC, 2015). With these medical advances, it is estimated that people living with HIV nowadays will have typical lifespans in the United States and Canada (Samji et al., 2013).

This raises a number of challenges, however, for prevention. As of 2008, it has been estimated that close to one in three gay and bisexual men do not know they are HIV positive, and, as of 2011, one in five gay and bisexual men who tested had HIV, with the prevalence increasing with age.



The main direct risk factor for transmitting HIV within this population is anal sex. Contributing to risk for acquiring HIV are a number of biopsychosocial factors, including increased numbers of sexual partners, having a committed partner, group sex environments (Groves, Rendina, Ventuneac, & Parsons, 2013), as well as homophobia, stigma, and discrimination. Adding to this calculus is perception of risk, especially for younger people, and substance use, including methamphetamines, alcohol, and injection drug use. With the increased numbers of partners, gay men are at increased risk for all other STIs, including gonorrhea, chlamydia, HPV, hepatitis, and syphilis. In 2013, MSM accounted for 75% of all new syphilis cases (CDC, 2015).

In the face of this context, attention has been paid to the ways in which gay men have negotiated risk and relationships including serosorting and other seroadaptive behaviors with prospective and regular partners (Rönn, White, Huges, & Ward, 2014). Parallel to this, gay men have factored into their sexual behavior with partners increasing attention to HIV status, viral loads, CD4 counts, and adherence to treatment. Very recently, antiretroviral drugs were approved for use by high-risk populations as another prevention method, known as pre-exposure prophylaxis (PrEP). PrEP is recommended in concert with testing, condom use, and other risk-reducing behaviors.

The politics of “barebacking,” also known as condomless or unprotected anal intercourse, has garnered much attention from public health authorities among gay men experiencing “prevention fatigue” or complacency, thus being critical of the gay community’s obligation to be altruistic sexual citizens (Davis, 2008). Such criticism eclipses the responsibilities of public health authorities and questions of effectiveness of health promotion efforts (Perry-Argüello, 2008).

## SUBSTANCE USE, BODY IMAGE, AND MENTAL HEALTH

As a subpopulation of sexual minorities, gay men are more likely to use alcohol and other drugs, have higher rates of substance abuse, are less likely to abstain from use, and continue heavy drinking into later life (CDC, 2015; Ostrow & Stall, 2008). These behaviors not only have immediate consequences; they are correlated with an increased risk for heart disease (Ostrow & Stall, 2008; World Heart Federation, 2012). In concert with an increased risk for HPV, gay men have an increased risk for colon, testicular, and prostate cancers (Asencio, Blank, & Descartes, 2009; Heslin, Gore, King, & Fox, 2008; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Additionally, more attention is being paid to the issues of the interplay among identity, eating, body, and sexuality for gay men. Siconolfi, Halkitis, Allomong, and Burton (2009) found in a cross-sectional sample of 219 urban gay men that body dissatisfaction was positively correlated with age and external motivations for working out (e.g., social comparisons, sexual prowess), while eating disorder scores were positively correlated with more frequent and longer exercise routines as well as anxiety, depression, ambivalence, and self-esteem related to sexual orientation. These findings dovetail existing knowledge of the link between internalized homophobia and problematic body image (Kimmel & Mahalik, 2005; Reilly & Rudd, 2006) and support a deeper analysis of the biopsychosocial consequences of the “buff agenda” that has predominated much of the mainstream Western gay culture (Halikitis et al., 2004).

In terms of mental health, an analysis of data from a national study of alcohol and related conditions ( $N = 34,653$ ) found that sexual minorities are 1.5 to 2 times more likely to experience mood and anxiety disorders in their lifetime (Bostwick, Boyd, Hughes, & McCabe, 2010) compared to heterosexual counterparts. This is echoed and further confirmed by meta-analyses for LGB people more generally, which estimate depression, anxiety, and substance misuse are 1.5 times more common (King et al., 2008). Gay men, specifically, were more than twice as likely to have a mood or anxiety disorder in their lifetime and the past year when compared with heterosexual men. Relatedly, gay men have an increased risk for suicide ideation and attempt. Gay men (and lesbians) are estimated to be 2.47 times more likely to have attempted suicide—and gay and bisexual men specifically have a lifetime fourfold increased risk for suicide overall (King et al., 2008). A number of factors co-exist with and contribute to these rates, such as age, affiliation with gay culture(s), levels of stress, and level of outness (SAMHSA, 2012). Hatzenbuehler, McLaughlin, Keyes, and Hasin (2010) found that institutional policies, like anti-gay amendments in various US states had an impact on increased rates of mood, anxiety, and substance use disorders.

## STIGMA, DISCRIMINATION, ABUSE, AND VIOLENCE

Gay men commonly experience discrimination in everyday life, which is often thought to have an impact on their mental health and overall quality of life. Bostwick, Boyd, Hughes, and West (2014) continued analysis of their work (see Bostwick et al., 2010) and found that gay men were more likely than bisexual or heterosexual men to report any discrimination in the past year, especially in health-care settings and public places (e.g., sidewalks, stores, restaurants), and being verbally assaulted—including physical threats. When racial/ethnic discrimination was added into this analysis, negative reactions to the experiences of discrimination increased as did the negative overall effect on mental health. This study illustrates the ways in which the multiple identities of individuals intersect and relate to outcomes associated with health, mental health, and other psychosocial factors.

In a study of 936 gay men, Brennan, Hellerstedt, Ross, and Welles (2007) found that one in seven participants may have been victims of childhood sexual abuse. Young sexual minorities on average experience 3.8 times more sexual abuse, 1.2 times more parental physical abuse, and 1.7 times more assaults at school (Friedman et al., 2011). Further, depression and substance abuse have been strongly correlated with experiences of interpersonal violence (e.g., physical, verbal, and sexual including unprotected anal intercourse). One study ( $N = 817$ ) found 32% ( $n = 265$ ) of gay men reported abuse in present or past relationships, while 54% of those same participants ( $n = 144$ ) reported more than one type of abuse within their relationships (Houston & McKirnan, 2007).

The central role of stigma often acts as a primary motivator for health and mental health disparities among gay men, as well as other minority populations (Hatzenbuehler, Phelan, & Link, 2013). Stigma includes discrimination but speaks to a broader system of co-occurring and intersecting lived experiences of labeling, stereotyping, separations, and loss of status within settings in which power is exercised. The short- and long-term impact of stigma on housing, educational

outcomes, employment, health care, and beyond are often misunderstood or understudied among sexual minorities. Psychosocial factors can mediate the relationship between stigma and health disparities and include various resources, social relationships, an ability to manage stress, and psychological and behavioral responses (e.g., coping and resilience). The first national probability-based sample of LGB adults ( $N = 662$ ) found gay men at the greatest risk for person or property crimes based on antigay stigma, with almost 40% of the participants reporting such victimization (Herek, 2009). More generally, among LGB adults, 1 in 10 noted experiences of stigma in housing and employment, with 1 in 5 reporting crimes against person or property (Herek, 2009). Moreover, gay men are at increased risk for developing internalized homophobia, which is associated with such health issues including depression and anxiety, eating disorders, relationship problems, sexual compulsivity, substance use, and the synergizing of negative health consequences (Dew & Chaney, 2005; Frost & Meyer, 2009; Herrick et al., 2013; Lehavot & Simoni, 2011; Meyer & Dean, 1995; Wiseman & Moradi, 2010). It is important to note that higher levels of self-esteem, positive affect, and resiliency among gay men often assists with the resolution of internalized homophobia as well as other negative health and mental health consequences (Herrick, Gillis, & Cogan 2009) previously discussed.

## EFFECTIVE AND BEST PRACTICE APPROACHES

Mental health practitioners across disciplines should be knowledgeable of the issues facing sexual minority populations, mindful of their own personal attitudes and histories, and judicious in selecting and implementing affirming therapeutic interventions (Kissinger, Lee, Twitty, & Kisner, 2009). While many allied professions have called for great attention to the needs and clinical issues of gay men (see APA, 2012; IOM, 2011; US Department of Health and Human Services, 2013), translations of evidenced-based interventions have yet to be widely tested and disseminated. Given the aforementioned health and mental health disparities, it is understandable that many applied interventions arise from cognitive-behavior theories, as well as dominant approaches to behavior change through health promotion activities. And, as clinical research is being conducted to adapt these widely adopted interventions (see Alessi, 2014; Pachankis, 2014), the attention to process and approach are equally important. Many clinical interventions can be adapted to work with gay men (Alessi, 2014; Crisp, 2006; Meyer, 2003) and, to that end, the macro-level forces that shape feelings, attitudes, and behaviors cannot be underestimated (Glassgold, 2007; Russel & Bohan, 2006). Thus the role of the competent, affirming, and highly self-aware practitioner becomes even more critical so as to not replicate or reinforce homophobic behaviors and ideologies (Davison, 2001).

Before going any further regarding approaches and techniques, it is important to understand that the NASW (2015), the National Committee on LGBT Issues, and the Council on Social Work Education (2016) released statements that definitively denounce and reject any use of sexual orientation change efforts, such as reparative or conversion approaches. Conversion therapy has already been rejected by a number of other organizations, including the APA, American Academy

of Pediatrics, American Medical Association, American Psychological Association and American Counseling Association. The states of California, Illinois, New Jersey, New York and Oregon, as well as the District of Columbia, have also banned licensed professionals from practicing conversion therapy with minors. The NASW reaffirms that such efforts are empirically unfounded and compromise the health and mental health of gay men and all LGBTQ persons. Moreover, they are in direct opposition to the NASW Code of Ethics (2008) as well as other professional ethical standards and guidelines.

## THEORETICAL, AFFIRMATIVE, AND RESPONSIVE MODELS OF CARE

One longstanding approach to working with gay men, as well as persons who are lesbian or bisexual, is LGB affirmative psychotherapy (Davies, 1996). This is less a set of discrete intervention tasks as it is an interdisciplinary conceptual framework that brings together attitudes, knowledge, and skills in service of empowering gay men. The clinician approaches the client keeping in mind four central principles: (a) sexual orientation is positively regarded and supported, (b) prejudices within the clinician and in the relationship are avoided, (c) stigma is recognized and repaired, and (d) attention and sensitivity are paid to gay development, issues of lifestyle, and cultural practices (Davies, 1996; King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). This perspective is then operationalized through three interlocking and complimentary processes, which include the person-in-environment perspective, cultural competency, and the strengths perspective. An ecological-based perspective allows for an understanding to emerge of the networks, resources, and relationships that the gay male client is embedded within and has been navigating. Cultural competency requires attention to knowledge, attitudes, beliefs, and skills that can be developed and deployed in order to more fully appreciate the standpoint and development of the client as well as foster increased affirmation through an engaged process of learning and growth. As Crisp (2006) astutely argues, practicing affirmatively is not synonymous with practicing without discrimination. From a gay affirmative standpoint, the clinician and client are both committed and engaged, and the clinician is not divorced from operative homonegative discourse and other oppressive forces at work in the local context. In the third aspect, a strengths perspective underscores attention to self-determination, well-being, and the health of the gay male client (versus pathologizing and other demoralizing tactics) and consciousness raising of one's own identities and social locations.

In more practical terms, a gay affirmative approach would directly espouse a number of tenets. During assessment and other phases of intervention, heterosexuality should not be assumed, no matter the legal arrangement of the client (e.g., married, domestically partnered, single). The social oppression of homophobia is just that: a societal problem, not an issue for the client to tolerate. Sexuality and sexual orientation are to be valued, accepted, and perceived as positive outcomes of an empowerment-based helping process, that is, lived experiences of becoming. Quite importantly, then, internalized homophobia must be confronted and reduced in order to increase well-being. This relates to the client as much as the clinician tending to their own homophobia and other heteronormative biases. Much of that reflection can be facilitated by increasing one's

knowledge of various theories of identity development, sexuality, and stories of coming out, disclosing, and coming to terms with one's identities. And, as clients come into their own identities, it is imperative to not focus on pathologizing origins of sexuality and forcing normative ideas of coming out; rather, it is important to support the client's level of outness and experiences of disclosure (Alessi, 2008; Hunter, Shannon, Knox, & Martin 1998).

On an empirical level, minority stress theory (MST) has been developed as a model for conceptualizing the lived experiences of being a minority in society, especially gay men (Meyer, 2003). It is also an increasingly validated model to understand and explain the pathway between the continual social stress of being in a marginalized social position (i.e., living with chronic prejudices and discrimination) and the consequent health and mental health effects. The MST model is particularly apt for gay men as it draws together interdisciplinary perspectives on stress and coping, appreciating the multiple contextual factors that facilitate or work against well-being (Bostwick et al., 2014). Pachankis (2014) conducted the first participatory-based study with clinicians ( $n = 21$ ) and consumers ( $n = 20$ ) alike to adapt MST into an intervention program specifically for gay men. Project ESTEEM combined cognitive-behavior techniques with the conceptual framework of MST. When tested further, it will be the first adapted intervention showing the efficacy of MST in reducing mood and anxiety disorders for gay men. Similarly, Alessi (2014) has shown promising operationalization of MST in individual clinical work. Based on MST, Alessi developed a two-phase minority stress assessment process to be used with sexual-minority adults. The first part assesses prejudice events in the client's life, the nature of the client's experiences with internalized homophobia, and the extent of sexual orientation concealment. The second phase examines the client's coping strategies and emotion regulation, social and interpersonal repertoire, and nature of cognitive processing. See chapter 12 for more information about MST and its use with gay men.

Given the continued disproportionate burden that gay men bear in the HIV epidemic, the incorporation of sexuality and health behavior change strategies into existing interventions is necessary when working with this population (Spector & Pinto, 2011; also see Stampely, 2008). Unlike the work yet to be done to scale up MST and other gay-affirmative approaches, many versions of evidenced-based interventions exist that incorporate translations of behavior change theories, like the health belief model or social learning theory (Glanz, Rimer, & Viswanath, 2008), with cognitive-behavior approaches to individual and group work. These interventions all share the common goal of preventing HIV transmission, while simultaneously targeting other biopsychosocial outcomes like increased adherence, quality of life improvement, or social connections. The CDC regularly updates and disseminates these "high impact prevention" interventions via its website (<https://effectiveinterventions.cdc.gov>).

Third-wave cognitive-behavior therapies, or contextual psychotherapies, have been proving to be effective clinically for a number of issues, including depression, posttraumatic stress disorder, and anxieties (Boone, 2014; Dimeff & Koerner, 2007; Thompson, Luoma, & LeJeune, 2013). As an extension of more traditionally understood cognitive-behavior therapy, they incorporate and emphasize more mindfulness and acceptance in an effort to increase more effective behavioral repertoires. One in particular, acceptance and commitment therapy (ACT), continues to be supported empirically through various clinical trials (Harris, 2006; Masuda, 2014), and clinical researchers have been adapting it to more specific issues and populations (e.g., gay men). The

premise of ACT is that humans experience pain and change and in turn often understandably struggle, leading to high levels of cognitive fusion and experiential avoidance. ACT aims to foster psychological flexibility to promote a more satisfying and worthwhile life. This is achieved through simultaneous processes of acceptance, mindfulness, and behavior change. Given this focus, ACT is an apt approach to target stigma, internalized homophobia, and related internalizing tendencies that commonly exist for gay men (Masuda, 2014).

Additionally, narrative therapy is an increasingly sought-after intervention utilized in working with LGBTQ populations. It has foundations in family systems work (Madigan, 2010) and builds off this approach to incorporate postmodern sensibilities around identities and critical theory commitments of tending to structural forces in the lived experiences of marginalized persons. For gay men this becomes an important method of intervention as it allows for a closer analysis of operative cultural values and worldviews and how power and privilege work in those prominent narratives both individually and collectively. To that end, narrative therapy offers a framework for understanding how the stories we hold onto impact our well-being (Behan, 1999; McLean & Marini, 2008; Tilsen & Nylund, 2010).

## CLINICAL SUPERVISION

Parallel to clinical interventions and affirmative approaches, the role of clinical supervision cannot be underestimated. The entrenched prejudices and biases that exist around sexuality make an attention to self-reflexivity a continual practice that must be explored (Davison, 2001). In working with gay men, it is common that questions may arise from the client about the clinician's own sexuality. Some clients will seek out a clinician specifically because they are (or are perceived as) LGBTQ. Whereas this may be an important element for the client, it does not have to be a barrier to effective treatment. Alessi (2014) and King et al. (2007) direct attention to the value of a clinician's knowledge, attitude, and skills when working with gay men. So one does not have to be gay in order to conduct effective treatment, nor does one's sexuality guarantee success. Instead, clinicians should be willing and prepared to process such inquiries about their sexuality and should consider disclosing their own sexuality rather than immediately dismissing, avoiding, or resisting such lines of questions (Knox & Hill, 2003).

Further, it is common that cultural-based countertransference can emerge for clinicians (Spector & Pinto, 2011; Stampley, 2008) and take the form of denying client's strengths, distancing oneself and conversations from sexuality and HIV, relying on assumptions about sexuality and cultural practices too often, marshaling hetero- and homonormative assumptions about relationships and sexual practices, and avoiding topics like assessing properly for HIV-related considerations. In part or in sum, these may be effective "warning signs" that biases and prejudices are operating within the helping relationship. Prejudices held by the clinician have the ability to interfere with the efficacy of counseling, inflame countertransference and transference, lead to ineffective treatment choices, and result in treatment errors (Berkman & Zinberg, 1997; Davies, 1996; Van Den Bergh & Crisp, 2004).

# ONGOING TRAINING AND EDUCATION

In keeping with an affirmative approach, social workers can engage in a number of strategies to reduce clinical errors, increase self-reflexivity, and increase well-being when working with gay men. Culturally humble practice requires continued education and training. One place to start with this is in the clinician's own local context; this is to say, social workers should be aware of the community resources, networks, organizations, and other assets that support their gay male clients and the larger LGBTQ community (Alessi, 2014; Saari, 2001). Next, social workers should locate and revisit peer-reviewed literature about the most current understandings of gay identity and psychosocial development. Parallel, grey literature (e.g., policy papers) and other cultural resources (e.g., movies, social media, non-/fiction books) are necessary tools to expand any clinician's sensitivity and acceptance of gay men—as well as work through their own process of coming to terms with sexuality, personally and professionally.

Another source of continuing education and training for social workers is the health profession itself. The clinical attention to and research projects regarding gay men and the LGBTQ community at-large have resulted in numerous allied health professions updating best practice recommendations as well as guidelines for practical training and curriculum standards (see, for example, APA, 2012; Lim, 2013; NASW, 2015; IOM, 2011). Many of these recommendations provide guidance to fostering more inclusive climates within professional programs as well as within larger university and health-care systems. Examples of such standards are (a) comprehensive nondiscrimination policies, (b) ubiquitous use of inclusive language (e.g., “partner” and/or “spouse”) and human resource policies (e.g., full health care and related domestic benefits), (c) increased data collection regarding sexuality and gender identity and expression (d) increased availability of LGBTQ content in courses, (e) opportunities for practical training with LGBTQ populations, and (f) clearly identifiable and easily accessible administrative and clinical supervision mechanisms for LGBTQ students and/or those working with LGBTQ clients to field concerns and experiences with discrimination that may arise within training programs, the university, or agency settings.

## CONCLUSION

Gay men have been a visible element of the movement for LGBTQ equality for decades alongside other members of the community. Challenged by living in an often oppressive society facing a multiplicity of challenges stemming from oppression to HIV/AIDS and fighting for equal rights under law related to marriage or to serve in the armed forces, the level of resilience found among this sexual minority group is truly astounding. Practitioners working with gay men should be keenly aware of the unique challenges that they have faced specific to their race/ethnicity, age cohort, socioeconomic status, and other areas of intersectionality discussed in this chapter. Providing an affirming and supportive experience and abiding by the tenets and ethics of our professions remains essential to best meet the needs of all gay men. Working collectively in a strong

therapeutic alliance is essential, as is the creation of safe spaces within therapeutic settings such that gay men will not feel vulnerable but rather empowered to work through their health and mental health needs.

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