Homosexual Men: A journey from Shame to Authenticity

by Ivan Kennedy

Abstract

"Homosexuality is wrong": This message is ubiquitous throughout society (e.g., family, peer-groups, media, institutions), and internalised in many gay men (Downs, 2005). Reported evidence highlights LGBT people's vulnerability in society with particular emphasis on homosexual men whose internalised shame underlies much of their distress and despair. Whilst illuminating this issue, this article explores Downs' (2005) 3-stage-model of male homosexual development: Overwhelmed by shame; compensating for shame; and discovering authenticity. Because it is important to explore clients' experiences, beliefs, and/or attitudes of homosexuality and our own as therapists, this article combines Downs' model with aspects of Gay Affirmative Therapy (see Davies & Neal, 1996) which necessitates counsellors exploring their own feelings, motivations, and behaviours of homosexuality from personal and professional capacities—and how these capacities are linked. This piece considers this issue from national, international, and psychological contexts.

Irish and International Contexts (Background of Perspectives on Homosexuality across Cultures)

Perspectives on homosexuality have changed over time and across cultures. In recent years many societies adopted more affirmative views of homosexuality than they had in preceding years. A cursory glance at popular culture can highlight changing attitudes towards homosexuality; seemingly, it has become more acceptable, common, and/or discussed. Similar movement occurred with legislation changes in many countries which, to varying degrees, legally protect homosexual people. However, despite progressive changes, undercurrents of societal homophobia remain.

By 1974 the American Psychiatric Association declassified homosexuality as a mental illness due, partly, to protests against labelling homosexuality as an illness and various "radical" research of homosexual development (Cain, 1991). Research swung from viewing homosexuality as a sign of psychological maladjustment to focussing on how society's rejection of homosexuality leads to many societal and individual problems, e.g., abuse, isolation, low self-worth, and self-harm. Subsequently, many health-care professionals' treatment methods and awareness changed accordingly; essentially, psychological problems were seen to be caused more by society's imposed covert existence than sexual preferences (Cain, 1991).

By the 1980s homosexuality was legal in many current European Union countries which promoted equality for Lesbian, Gay, Bisexual, and Transgender (LGBT) people (Waaldijk, 2009). However, despite

advancement, no European country ensures full legal equality for LGBT people (ILGA Europe, 2013). The ILGA Europe (2013) study includes 6 categorical issues (46 sub-categories)—e.g., equality, family, verbal/physical bias—affecting LGBT people across Europe. When compared with other European countries, the UK performed best, ensuring 77% compliance; Ireland performed below average, ensuring 36% compliance, suggesting that across Irish culture there may be many pervasive homophobic attitudes and beliefs that view homosexuality as an abnormal variation of sexuality.

Regardless of whether such attitudes and beliefs are transparent or opaque to oneself or to others, they affect clients and therapists because virtually everyone receives society's anti-gay messages; it is presumptuous, states Iasenza (1989), to think that therapists are immune to such influences. Consequently, therapeutic neutrality is impossible (Isay, 1989) especially if therapists are unaware of their own sexual biases (Iasenza, 1989).

Davies (1996a) highlights the importance of therapists being trained to work ethically with LGB[T] people and states that training/retraining is essential to be aware of (i) the varying theories of homosexual identity and components thereof, (ii) the varying cultures and subcultures and how to develop identities within them, and (iii) their own homophobia and heterosexism.

Until 1992 the World Health Organisation using the International Classification of Diseases (commonly used in Ireland) still classified homosexuality as a mental disorder (Davies & Neal, 1996). According to Davies (1996a), this "heterosexist bias" contributed much therapeutic prejudice towards clients in numerous counselling disciplines and is intrinsic to several traditional counselling and personality development theories.

The underlying societal message is that heterosexuality is the norm: Therefore, forming an "atypical" sexual identity is extra challenging

Regarding Ireland, homosexuality was decriminalised in 1993 (Waaldijk, 2009) after much legal battling ending in the European Courts of Human Rights in 1988—the High Courts of Ireland refused to decriminalise on grounds of public health, religion, and institute of marriage (Norris v. Ireland Judgement, 1988). However, many similar arguments influence Irish society still. Despite the Equal Status Act, 2000 and the Employment Equality Act, 1998, discrimination of homosexuals legally occurs in areas of (i) health (e.g., blood donations), (ii) employment (e.g., religious, medical, and educational institutes), and (iii) marriage (e.g., adoption and social support) (see Marriage Equality, 2013).

Although the majority of the public support same-sex marriage (Marriage Equality, 2013), Catholic organisations, in contrast, do not. For example, the Iona Institute (2013) says care provided to children is superior in heterosexual marriages than same-sex marriages. However most evidence contradicts this view (Allen & Burrell, 1997); evidence provided by the National Association of Social Workers, the American Psychological Association, the American Psychiatric Association, and the American Psychoanalytic Association state that no research comparing heterosexual with homosexual parenting styles found detrimental effects upon children (Cahill & Tobias, 2007).

Although, the Iona Institute often cites Regnerus (2012) as evidence showing hazards of homosexual parenting, several researchers have claimed that this research is methodologically flawed (e.g., Perrin, Cohen, & Caren, 2013). Therefore, as evidence predominantly reports no detrimental effects of homosexual parenting styles, perhaps fundamental Catholic ideology influences beliefs that homosexual parenting is harmful, e.g., homosexuality is a "strong tendency ordered toward an intrinsic moral evil...the inclination itself must be seen as an objective disorder" (Ratzinger & Bovone, 1986). Most mainstream religions express similar sentiments except the Society of Friends (Quakers), who accept homosexuality as normal self-expression; not doing so condemns the search and/or formation of homosexual identity (Lynch, 1996, p. 200).

Seemingly, society provides disparate messages: Homosexuality is not a mental illness and is an objective disorder; homosexuality is legal but less legal than heterosexuality. In general, the underlying societal message is that heterosexuality is the norm: Therefore, forming an "atypical" sexual identity is extra challenging (Cass, 1984).

Importantly, therapists must explore their own values, beliefs, and attitudes, and their origins from personal and professional positions. We must question if our principles and viewpoints prevent us from respecting clients, compassionately exploring their identity, lifestyle, and culture, and/or fully accepting or supporting clients who are gay, i.e., working ethically.

The Psychological Context (Understanding the Individual's Experience)

To understand how these perspectives impact on one's life and therefore our work, it is important to first outline some theoretical processes of homosexual identity formation.

Theories. Several theoretical models outline processes of homosexual disclosure and identity formation. For example, "coming out"

is not a single event but a process of tentatively and continually assessing the environment and its people's reactions (Cain, 1991). Coleman (1982) states that it incorporates five developmental stages: Pre-coming out; coming out; exploration; first relationship; and identity integration. Similarly, Cass (1984) proposes six stages of homosexual identity formation—confusion, comparison, tolerance, acceptance, pride, and synthesis. Both theories suggest that homosexuals, typically experience various behaviours relating to sexuality: Uncertainty and turmoil; denial, avoidance, and comparison with other homosexuals; tolerance; acceptance; anger with society's prejudice; and self-integration/identity formation.

Akin to Erikson's (1963) stages of identity, each stage of developmental crisis must be resolved before subsequent stages are resolved (Cass, 1984). Conversely to Erikson's model, many homosexual identity formation models (e.g., Cass, 1984; Coleman, 1982; Downs, 2005; Elizur & Ziv, 2001) de-emphasise the importance of family support (potential environmental stressors) and emphasise the importance of social support to achieve identity formation. Particularly, minority culture association can provide a sense of belonging, validation, well-being, and self-acceptance and ease familial and societal alienation (Elizur & Ziv, 2001). Specifically, within a supportive group of gay people, nurturing and respectful friendships can be formed which promote the belief that one's homosexuality is normal, can be fulfilling, honourable, and self-affirming, and can counteract society's homophobia.

Naturally, just as some heterosexuals fail to form their true identity, some homosexuals fail in overcoming the crises of the coming out and homosexual identity formation processes (Downs, 2005). Indeed, because of (perceived) threats of rejection and/or physical harm from family, peers, and society, some homosexuals reject disclosing or accepting their true sexual identity (Cain, 1991). Such environmental stressors can manifest in various forms of self-destructive behaviour stemming from internalised shame and homophobia (Isay, 1998; Higgins, 2002).

Evidence of self-destructive behaviours. Much research, investigating homosexuals' risk/self-destructive behaviour, concludes that homosexuals are more psychologically vulnerable than heterosexuals because of society's negativity towards homosexuality, not for being gay specifically (see Elizur & Ziv, 2001). When compared with heterosexual peers, homosexuals are more likely to:

(i) abuse substances more frequently/intensely to numb the ridicule and suppress the anxiety and depression for being gay, and to partake in excessive substance abuse common in gay pub/nightclub scenes (see Bontempo & D'Augelli 2002; Hughes & Eliason 2002);

(ii) engage in risky sexualised behaviours, e.g., multiple and/or anonymous partners, unprotected sex (McNamee, 2006);

(iii) be linked to homelessness, self-harm, prostitution (Jordan, 2000), and

(iv) attempt suicide in their teens (Savin-Williams & Ream, 2003).

Regarding adults, many heterosexual married men engage in homosexuality covertly (Brownfain, 1985). Such secrecy, and entering/remaining in heterosexual marriages is often due to self-esteem injury; essentially, one has internalised society's homophobia (Higgins, 2002; Isay, 1998). All gay men, states Isay (1989), internalises frequently experienced social hostility and these injuries make "social compliance important and acceptance of sexual orientation impossible" which manifests in various self-harming behaviours (Isay, 1998, p. 424). Indicatively, clients presenting with self-harm, risk-behaviours or marital/relationship issues might have sexuality issues. This suggests therapists need to view exploration of sexuality and emotional and physical wellbeing as similarly important, to be comfortable with exploring sexuality, and to have addressed their own values regarding sexuality.

Therapists must become aware of their own feelings, motivations, and behaviours of homosexuality from personal and professional positions

Downs' Three Stages: Shame; Compensation; Authenticity

Overwhelmed by Shame. Society's constant heterosexism and homophobia creates an immense sense of internalised shame in the typical homosexual man (Downs, 2005). This stage mostly includes the "in the closet" period whereby one hides, denies, avoids, or rejects his sexuality.

Numerous homosexual men concurrently recognise their difference (same-sex attraction) in youth (majority pre-puberty) and experience society's homophobia (e.g., Savin-Williams & Ream, 2003). Research of gay high-school students show that (i) 97% report regularly hearing homophobic remarks from peers which are generally ignored by teachers (MSSGLY, 1993) and (ii) 69% experience harassment: Verbal, 61%; sexual, 46.5%; physical, 27.6% (GLSEN, 1999). Although similar research in an Irish context is scarce, similar patterns emerge: Homophobic bullying was experienced by 15.6% of Irish secondary-school students

(students' reports; Minton, Dahl, O'Moore, & Tuck, 2008), excluded from most schools' anti-bullying policies, often ignored, and less manageable than non-homophobic bullying (O'Higgins-Norman, 2009).

Regarding the family, the bilateral socialisation process between child and parent enables the child to form his/her identity through perceiving and rejecting or accepting parental values (Knafo & Schwartz, 2004). For many who "come out", mismatches in parent/child values leads to various negative reactions—e.g., (i) estrangement and rejection, (ii) physical/verbal abuse (Savin-Williams & Ream, 2003), and (iii) increased suicide ideation (D'Augelli, Hershberger, & Pilkington, 1998)—to which one may foreclose on identity formation and remain stuck in that stage of the process or revert to heterosexuality (Coleman, 1982).

The aforementioned research suggests a salient anti-gay bias and threat that is rarely corrected and is caused by peers and authority figures. Consequently, many people (i) hide their sexuality to avoid similar negative reactions whilst completing the identity formation process (Cass, 1984), and (ii) internalise societal and familial values and deny their own needs due to internalised shame and/or homophobia (Downs, 2005; Higgins, 2002). Indeed, throughout life, gay men need to hide their sexuality, adopt heterosexual mannerisms and behaviours, and disregard the importance of their sexual fantasies: This damages their true identity as the external heterosexism is internalised (Davies & Neal, 1996). Therapists must resist colluding with anything that may reinforce the clients' internalised homophobia or shame and instead, offer unconditional positive regard and a safe, respectful space to explore and accept their sexual identity.

This stage of development, states Downs (2005), concludes with a crisis of identity—foreclose or, ideally, acknowledge and disclose one's homosexuality.

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Compensating for Shame. Years of frequent, prevalent societal invalidation produces an obstinate sense of shame on gay men's psyche (Downs, 2005). According to this model, despite coming out and (partly) accepting his gayness, he fails to silence the shame and futilely compensates in many forms—from excelling in vocation, material wealth, sexual prowess, aesthetics, etc., to being the most "out and proud", most flamboyant, exuberant, zealous gay man possible. Such shame-compensation is extremely evident in the gay community with body image and contributes to increased incidences of body dissatisfaction, disordered eating behaviours, and gruelling exercise and diet regimes (for more see Duncan (2007); Siever's (1994) sexual objectification theory; Williamson & Hartley's (1998) internalised homophobia theory). Essentially, perceived invalidation begets attempts to attain tangible, aesthetic, or persona "perfection" to overcome psychological "imperfection" and hinders true personal growth as authentic validation is denied.

This stage of development concludes with crisis of meaning—foreclose (behaviour is repeated/enhanced) or, ideally, achieve authenticity. Therapists must challenge the shame of homosexual thoughts, behaviours, and feelings and explore the reasons for any compensating behaviour and its impact. Effectively, therapists must try to help eliminate the internalised message from society (he is gay ergo he is bad) and encourage him to talk openly and warmly of same-sex attractions in the hope of eradicating his internalised homophobia (Davies, 1996a).

Discovering Authenticity. True identity and sexual expression grows through resolving feelings of uncertainty, turmoil, hesitancy, fear of rejection [or punishment] (Elizur & Ziv, 2001) and shame (Downs, 2005). In this stage, behavioural repertoires built on avoiding and compensating for shame are redundant. Instead, ambiguity grows as shame-fuelled behaviours are slowly replaced with new behavioural repertoires whereby more trusting, authentic relationships are formed (Downs, 2005). The client/therapist relationship could model trusting and authentic relationships. As the therapist explores, respects, and accepts the client for who he is, the therapist provides a template for wholesome relationships whilst he begins to see himself with less shame and guilt and more compassion and acceptance.

Of the various factors of achieving authenticity, i.e., healing past relationships traumas (abandonment, abuse, ambivalence, betrayal, etc.), passions, and loves, the main factor Downs (2005) highlights is integrity. Specifically, honestly synthesising one's components; resolving past hurt and blending private and public selves (cf Cass's (1984) and Coleman's (1982) models).

However, families (and social networks) can hurt and heal; therefore, controlling information (and potential repercussions of coming out) and synthesising public and private selves is essential for identity formation (Elizur & Ziv, 2001). Whether coming out or controlling the information one reveals, integration of one's sexuality is crucial to identity formation (Davies, 1996b). As this developmental stage can be tumultuous, fragile, and incredibly painful (Elizur & Ziv, 2001), therapists must support clients in their journey

by exploring various aspects of their lives, e.g., locality, family, and ethnicity. In particular, to protect the client whilst promoting his identity formation explore whether or not his (i) locality is safe, has support groups, clubs, and/or others who are visibly "out", and has safe and nurturing places/ groups to explore his sexuality, (ii) family is supportive of his decisions and prepare for possible reactions, and (iii) minority/majority group might object to homosexuality and how this might manifest. Clients from minority groups might experience prejudice on two fronts: Sexuality and race. (Other considerations include gender, age, individual variations; see Davies (1996b) for more).

The Counsellor Context

In recent years, high risk-levels (destructive behaviours outlined above) have stimulated concern of those caring for LGBT community members suffering society's heterosexism/homophobia (McNamee, 2006). Indeed many gay men realise their "difference" before they realise their sexuality (average age 12-14 Years Old; see Carolan & Redman 2003; Warner et al 2004) which enhances their confusion over the harassment and their self-identity and attitudes towards it (Morrison & L'Hereaux 2001).

To support clients most effectively, therapists must explore and/or challenge their own attitudes towards homosexuality or indeed their own homophobia and to acquire more relevant information of a (sub) culture like we might do any other. Davies (1996a) states that to work effectively with LGB[T] clients, therapists need to re-evaluate their attitudes, values, beliefs, and awareness of LGB[T] issues, identities, and cultures, and to integrate this awareness into therapy.

Furthermore, therapists must become aware of their own feelings, motivations, and behaviours of homosexuality from personal and professional positions (Davies, 1996). So, let's consider these questions:

(i) Would you promote your clients' homosexual feelings?

(ii) Would you bring your clients' experienced heterosexism into consciousness to work with?

(iii) Would you challenge negative homosexual stereotypes that may have become part of your clients' identity?

(iv) Would you try to desensitise your clients' feelings of shame and guilt around homosexuality?

(v) Would you encourage your client to establish support networks in gay communities?

(vi) Are you comfortable/aware of any homosexual feelings you may have?

(For more see Davies (1996a) and Clark (1987).)

Exploring these points helps to honour our feelings about homosexuality and our clients' homosexual identity, the oppression that they experienced, their growing self-awareness, and how best to support them in their crisis (Davies, 1996a).

Conclusion

Evidence shows that gay men are disproportionately vulnerable when compared to their heterosexual peers. Through society's palpable and continual negative messages that homosexuality is wrong, gay men internalise and compensate for shame of their sexuality. Such is evident in how they try to off-set shame through destructive behaviours, e.g., substance misuse, suicide, and body dissatisfaction. The evidence highlights the need for counsellors to be aware of schemas of homosexuality and of specific issues affecting LGBT people who may be experiencing distress or despair because of society's prejudices and discrimination and their own internalised shame. Only through integration and self-acceptance can identity achievement occur—when one's public and private selves become more congruent, trusting, and nurturing, longer lasting relationships are formed, and shame dissipates.

As therapists we must explore our values, beliefs, and attitudes towards sexuality, and be willing to explore, respect, and accept our clients' sexuality thereby modelling a truly warm, safe, authentic relationship. Such will enhance our clients' acceptance of their sexuality and rejection of their sense of shame because of their sexuality. Furthermore, it will honour them for who they are. We must be aware of the typical and unique perils facing our homosexual clients; how sexuality based prejudice and abuse from family, friends, community or society in general can manifest in various self-destructive behaviours.

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Ivan Kennedy

Ivan Kennedy is a counsellor in training at the Institute of Integrative Counselling and Psychotherapy, Dublin. Ivan counsels clients in Carlow and he is the current Director of the Carlow/Kilkenny branch of Samaritans. He holds a BSc in Psychology and a PhD in Education and Psycholinguistics from Bangor University, Wales. He has worked as a lecturer in Child Development and in research skills, as an ABA Tutor for children with autism, and as a Care Worker in residential care with adolescents with emotional and behavioural difficulties.

Any thoughts or reflections on the subject of this article are welcomed and can be sent to kennedy.ivan@gmail.com