CASE STUDY

Treatment of Homophobia in a Gay Male Adolescent

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This paper presents an extended discussion of the treatment of an adolescent male for internalized homophobia. It discusses a case that illustrates the problems and stages that gay adolescents go through as they move through different phases of adolescence.

BACKGROUND

For adolescents who are gay or lesbian, significant problems can develop secondary to internalized homophobia—the self-hatred that occurs as a result of being a socially stigmatized person. In one recent study of this group (ages 15–21), it was found that as a result of their sexual orientation 80% had experienced verbal insults, 44% had been threatened with violence, 33% had objects thrown at them, 31% reported being chased or followed, and 17% reported being physically assaulted.[1] Numerous studies have identified an increased suicide-attempt rate among gay and lesbian youth.[2] Other studies find increased high school dropout rates, substance abuse, and family discord in families with gay youth and adolescents.[3]

In order to assist gay and lesbian youth with homophobia, therapists employ both individual and group approaches.[4] Key elements of psychodynamic treatments include efforts to neutralize internalized homophobia through education, interpretation of anxieties about passivity, dependency, and masculinity and femininity, and supportive and homosexual identity-affirming techniques.[5] Group approaches for teens and young adults aim to diminish isolation, create supportive communities, and serve as psychoeducational forums.[6,7] Other treatments focus on the societal origins of homo-

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phobia and have attempted to provide prevention and intervention for gay and lesbian youth in high schools or community centers.[8]

The following case illustrates the impact of homophobia on the development of a gay teenager as he moves through early, middle, and late adolescence.

CASE

J.,a 14-year-old student between his freshman and sophomore year of high school, was referred to me by a child psychiatrist who had seen J. and his family for an evaluation after J. had abruptly returned home from boarding school. In his referring call, the psychiatrist said that J. wished to have support for developmental issues associated with being a gay teenager. The psychiatrist felt he did not have the skills to provide optimal treatment. J.'s mother called to make the initial appointment for J. She described her son as very bright and strong willed. She was supportive of him in trying to get help from me.

J. had entered his freshman year at a prominent preparatory school, leaving his family for the first time the preceding fall. He did fairly well at first, but became increasing despondent as the fall semester progressed. He began to call home almost daily and sometimes more than once a day, begging to come back home. He offered no explanation for this request to return except that he missed his family. He returned and enrolled in a local school. According to his mother, J. became moody, withdrawn, extremely hostile and alternatively very needy after his return. Although she was concerned, it was not until he told his family that he was gay that they understood the cause of his behavior. However, his disclosure resulted in J. wishing to run away or commit suicide. He reported feelings of isolation and anger, and considered his family a "barrier" for him to develop other social or emotional supports. He reported sleep problems and feelings of sadness, but no problems with appetite or concentration.

J. was the oldest of three children in an intact family. He had two sisters who were younger than he. J.'s mother was a librarian and his father a business manager. There were no financial problems in the family. J. was described as a child with a difficult temperament who could also be demanding and willful. He had been a physically uncoordinated child from his earliest years.

His parents, especially his mother, doted on him and clearly had difficulty limiting him. His father was distant from the entire family, but especially so from J.

Evaluation and Early Phase

The early phase (ages 12–14) of adolescence is dominated by concerns with the dramatic physical changes associated with puberty. Issues related to sexual identity and self-esteem are associated with this phase. Limited capacity for reflection and self-observation make treatment challenging at times for any teen in this age group In the case of the therapist working with a homophobic gay male in this period, the principal problems are (1) building a treatment alliance with the patient and establishing safe boundaries around the therapeutic work; (2) premature "coming out" and working with stereotypes of gay male behaviors as homophobic expression; (3) avoidance of leaving from the family, creating heightened emotional tensions and inhibiting social developments.

Treatment Alliance and Boundaries

Building rapport with a gay teenager can be even more difficult than with some heterosexual teens. In this case, several important things should be considered. The first is that J. was referred to me to assist him with the issue of being gay. There are pros and cons to this as a starting point. For a person secure in his/her identity, who is looking for a place to discuss issues with the sense that there will acceptance and understanding, such a starting point is almost always helpful. For a gay teenager, it may be more problematic. Internalized homophobia can be projected onto the therapist and add to resistance as well as inhibit trust. Conversely, for some teenagers, there is increased security in the idea of an accepting therapist and a chance to explore in a more positive way conflicts that underlie homophobia.

One of the most important initial actions by a therapist working with a gay teen is to establish safe boundaries for the work. Gay teens, like many teens, are exquisitely sensitive to how much adults, especially parents, know about them. In my work with J., I made sure both he and his family were aware of the confidential nature of J.'s communications with me. I also, however, told J. the limits of confidentiality and included in that list any sexual behaviors with men significantly older than he was when he told me their names and any sexual behaviors that constituted high risk for HIV infection. This allowed J. to tell me if he needed help with a situation with abuse or was concerned about disease, but to control that information when he felt more comfortable.

As rapport with J. developed, he began to share a little more about his internal fantasy world. It was difficult for him to describe to anyone his sexual wishes. Sexual material was highly guarded and what he revealed

was limited to oral sexual impulses. He was more able to discuss his ideas about gay men and his generally negative appraisal of them as "sexual, effeminate, and as preying on younger men."

Disclosure of sexual feelings and impulses is difficult for many teenagers. It is, perhaps, a more important element in the work with gay teens, partly because, in many instances, there are so few alternative settings for gay teens to explore these feelings and impulses. J. had a particularly difficult time doing this. Part of the reason was his own psychological make up. He used intellectual defenses to manage much of his anxiety, but this was accentuated by his homophobia, so that even though he had much information to the contrary, he continued to hold stereotypical ideas about homosexual men.

J.'s wishes to be close to a male were only thinly disguised in his homophobic attributions. His own anxiety about being close to someone and the resultant vulnerability were translated into being afraid others were out to prey on him. In J.'s case, these feelings were complicated by the abandonment and rejection he felt he had experienced from his father. His wish for closeness to his father was transformed defensively into a sarcastic rejection and constant demeaning of his father. Attempts on my part to interpret this at this stage were rebuffed.

Premature "Coming Out"

Another issue that commonly arises is the wish for gay peers. This is a normal element in the middle phase of adolescence but, when embarked on prematurely, such seeking can misfire. In our early meetings, J. reported interest in attending a gay teen support group at a local gay community center. He was however deeply ambivalent about it and reported this in terms of "real versus surreal" relationships. When he did attend, he was profoundly disappointed and reported that he felt he had little in common with the other gay teens there. In carefully worded, but no uncertain terms, he found that these gay teens were not attractive enough, masculine enough, were from a different socioeconomic background, and were not as educated as he.

In this case, J.'s homophobia was still so severe that he was unable to use the gay support group. His own homophobia made it injurious to identify with the range of gay persons in the group. In particular, he was uncomfortable with what he perceived of as femininity among most of the boys in the group. Intellectually, he rejected the idea of gay equalling being feminine, but he was also intolerant of those gay males who were effeminate. This was "not me" as he put it. For J., the group represented a hope for acceptance,

normality, and possibly an opportunity for meeting a boyfriend. His internalized homophobia distorted the group into being one that was composed of misfits, unattractive gay persons, and effeminate males. This resulted in his developing feelings of hopelessness, worthlessness, passive suicidal ideation, increased confusion, and worsening anxiety. He also had worsening problems with sleep, appetite, and concentration.

J.'s hopes for being rescued by the gay teens support group were dashed and he deteriorated clinically. This illustrates the importance of timing referral to such a group as well as the need to be aware that simply referring someone to such a group is not a cure for the psychological adjustment that some gay teens have with internalized homophobia. Interpretations of his disappointment and wish for a "boyfriend" solution to his problems briefly helped to control his anxiety and keep his mood from further deterioration.

J.'s response to his disappointment with the gay group pushed him to explore other options. He wore his "gay rings" to school on several occasions and when people asked him he told them he was gay. J. began to wear other gay insignia to school. Although he discussed this in terms of "coming out," it was clear that he was only doing this "symbolically;" in fact, this was self-destructive because it undermined his wish to be accepted by "normal" boys at his school in contrast to the "abnormal" ones he had seen at the gay group. The result of J.'s coming out was further peer rejection and further isolation. On a conscious level, J. was seeking peer validation, unconsciously he was seeking punishment and an experience of externalized homophobia that would serve as a way to relieve, through projection, his own internal discomfort with his homosexuality. This symbolic form of coming out is not uncommon in gay teens. It fits with a developing sense of political and social awareness common to adolescence. The unfortunate side of this is that it can also serve these other more self-destructive purposes.

Family Issues

Simultaneous with these individual sessions, family therapy was conducted. The role of family therapy, especially in the early stage of adolescence cannot be overstated. Such therapy can assist a teen to extricate himself from the tangle of familial dynamics when impediments of whatever sort develop. In the case of gay teens, this modality would usually be indicated, but it is often not possible because parents are unaccepting and unwilling to participate in such therapy. J. was lucky because both his parents wanted to do whatever they could to help him. And although they may have had other wishes at times, they viewed therapy for J. as something

to help him with the problems of being a gay teenager rather than a way to try to make him change his sexual orientation.

The family psychodynamic issues in J.'s case are associated with early phase of adolescent processes that are complicated by being homophobic and gay. His attempt to separate from his family, a usual part of early adolescent development, with his move to boarding school failed, at least in part, because his anxiety about being accepted by peers and by himself as a gay person diminished his abilities to accomplish this separation. After returning home, his negative self-evaluation and his continued inability to locate support outside the family, led to increased depressed feelings and increasing hostile and volatile reactions to his family.

Early family treatment focused on J.'s belief that his family rejected and devalued him—actually feelings he projected onto them. As tensions developed around his lack of peer support, further deterioration of his behavior followed. He struck his mother and sister on two occasions and police were called. Attempts were made throughout these sessions to involve J.'s father in the process, but only after these assaults did he become actively involved.

The key dynamic factors that had to be addressed in family therapy were his enmeshment with his mother and poor identification with his father. With J. and others of his age group, practical interventions, including assignments of time spent together, and changing of parental disciplinary and role relationships, help balance the emotional involvement of parents. I actively supported J.'s father in his parental role and thus, because J. valued me by this point, helped J. to consider the possibility that he could accept his father without so much fear of rejection.

In the early phase of work with a homophobic adolescent gay male, the therapist must first accept that the therapy will likely be complex. Work with establishing confidentiality, initiating safe discussions about desires in the context of a gay teen's social world, support for efforts to come out that fail, assistance with family dynamics and social limitations, and noninjurious interpretations about a gay teen's own homophobia are the basic components of therapeutic work in this period.

Middle Phase

The middle phase of adolescence (ages 14–16) is dominated by increasing use of peers and growing abstracting abilities that are used to define self and other from parents. This is the core period of identity formation. Difficulties arise in this phase when there are internal or external factors that inhibit this separation from family or preclude such exploration. In the

middle phase, there is a shift in emphasis in therapy for homophobic gay males away from family issues to those more concerned with the deprivation of social opportunities for peer and romantic relationships. Principal problems the therapist may face during this phase are problems associated with (1) early sexual experimentation; (2) inadequate gay and heterosexual friendships; (3) increased depression. J.'s course in the middle phase reflects problems with these issues.

Early Sexual Experimentation

As J.'s strategy to "come out" at high school failed, he decided to become involved in activities in a nearby city. Although he was not yet old enough to drive, he was aware of many of these activities through his computer connection. J. began to visit the city on Saturdays. He described these days with continued ambivalence. He liked to do political work and occasionally another gay teen would interest him, but his primary contact was a man in his late twenties who, J. felt, had a sexual interest in him. He described this as being something he was not interested in but, at the same time, it was clear that he did not actively discourage and in some ways encouraged this man's interest.

J. began to stay later into the evening and described petting episodes with this man. These were J.'s first sexual experiences and he described them in negative terms—he felt dissociated and distant from himself. When these culminated in J.'s experiencing an orgasm and afterward feeling empty, unhappy, and dissociated, he decided to end these encounters and stopped his trips to the city.

Interpretation of these activities as avoiding real relationships and escaping from the confines of his school helped J. to make the transition to the middle phase. In addition, after the resolution of some of the family struggles, he began to try to make his virtual world of sex and political activity a real one. Again this was premature because he was still quite homophobic. The result was increased anxiety and ultimately led to allowing himself to be taken advantage of sexually. Since he was not ready to do this when it happened, he retreated from reality to a dissociated state. With interpretation of these events, J. was able to decide to desist from this type of exploration for the time being.

J. was in hurry to "experience" being gay and this meant touching another male. This points out a special difficulty in working with gay teens. They must, for the most part, live in an "as if" world. The ability to test their attractiveness and their social and intimacy skills with peers is severely curtailed because of limited social outlets for gay teens. This means that the

therapist must help the gay teen to explore this "as if" world until they are older and able to find appropriate peers. I, like many therapists, try to help gay teens and others who are struggling in this period by suggesting reading materials, movies, and so forth. Although some can use it, many are so uncomfortable with their homosexuality that they cannot tolerate reading or seeing movies with homosexual themes until there is some resolution of the most vexing elements of their self-hatred. Timing of the distribution of such materials should be carefully considered.

J. once again turned back to his school to seek peer support. In the late spring of his sophomore year, he began to develop a crush on D., an older male student. He began to be interested in D. because this boy spoke to him and made a point of being friendly to him. J. found D. attractive, but was also quite anxious about him. Over the next year, D. continued to dominate J.'s sexual fantasy life although they never met alone at any time and never exchanged more than a few words. Within the high school however their relationship was a subject of gossip and J. was teased while D., who was athletic and popular, simply brushed it off.

J.'s fantasy about D., although problematic in some respects, represented the first time J. was able to speak of caring about another boy in an emotional way. Fantasies for gay males, as for all teens, are an important way to manage feelings and wishes that cannot be lived. Problems with fantasies arise when they are the only way one can live or when the division between fantasy and reality is blurred. In J.'s case, neither of these took place and his use of fantasy was constructive in the sense that he began to imagine and accept that he could love another male. This signaled some decrease in internalized homophobia. As a therapist, I encouraged the elaboration of this fantasy and helped J. to explore what it was he hoped for in a relationship. In this sense, his homosexuality became more real and personal and less stereotyped and emblematic.

Peer Relations

During this period, J. found himself for the first time associated almost exclusively with girls at school. J. had mixed feelings about this because he felt he was being "relegated to girl status" that for him was injurious. At the same time, though, these girls supported him at school, helping him make better progress in peer relations overall. He sorely resented having come out at school because he suspected that had he not, he would have been able to "pass" for straight and thereby have greater access and probably more likely contact with males whom he found attractive. As it was, they were too embarrassed or anxious to be friends with him.

At this juncture, J. began summer vacation. During part of that summer he was in a three-week summer program for gifted students in another part of the country. J. conducted an experiment for himself during those three weeks and rather than announcing his sexual orientation to everyone, he chose a few people to trust. He reported that overall he felt more comfortable and so did everyone else there. He also said that those males he did confide in were more accepting. This episode helped J. realize that his previous attempts at coming out were self-destructive.

Depression

When J. began his junior year he was upbeat, but anxious about returning to a setting where everyone knew he was gay. He was also excited because he now had a car and the independence associated with it. This quickly faded with the realities of school. D. had graduated and so he felt bereft of any hope of a romance at his school. He became increasingly despondent and began to miss therapy sessions. After a month, he came to therapy with definite symptoms of a depression, including sleep, appetite, concentration, and other difficulties. He was started on sertraline to which he had a clear positive response, but not a sufficient one. At this junction he also developed a number of somatic symptoms, began to skip school and his grades also began to fall.

J.'s depression during his junior year was pronounced. The ongoing stress of high school and his sense that it would never end was a major component of this. A therapist can only provide so much support for a gay teenager and the realities of his needs for peer relationships and his needs for opportunities to practice dating and other mating and pairing behaviors are realities.

During J.'s depression, he agreed to begin twice-a-week therapy once again. He came regularly and showed increasingly good use of the time. However, during this time he also met a gay young man who was a freshman in a nearby college. He carried on a brief affair with this man. Although J. remained somewhat dissociated from their sexual experiences, J. felt that this young man's interest in him confirmed that he was attractive and that he could hope to attract someone that he would also find attractive.

By the spring of his junior year, he had emerged from his depression and was again socializing more at school. At this point, some of the girls at his school began to try to set him up with dates with gay guys at other schools. In this way, they "double dated" for a time. J. liked meeting these other gay

high school students but he did not feel particularly interested in getting to know any of them more intimately.

After an initial crisis at the beginning of the middle phase of adolescence, J. had been able to return to therapy and use it well. He also moved his need for peer relations to the closest available age group, a few college freshmen who were about a year and a half older than he. His relationships were friendships and sexual experiences rather than really intimate relationships. For J., this represented a close approximation of the male sexual behavior of his heterosexual male fellow students. Sex first, intimacy later. My acceptance of some of this behavior, but interpretation of its limits, helped J. to identify his wish to develop more intimate relationship. This signaled J.'s movement to the final phase of adolescence.

The therapist working with a homophobic gay male in the middle phase can assist the patient through the following: (1) help the gay teen to explore sexual wishes and fantasies by using the "as if" world and through films, books, and magazines since real relationships are difficult to find; (2) assist with depression and anxiety; (3) expand the use of interpretation of homophobia in order to exploit the teen's increasing capacities for introspection; and (4) support the appropriate exploration of same-sex romantic and sexual interactions.

Late Phase

The late phase is dominated with setting patterns and plans for work and career as well as establishing patterns of deeper interpersonal relationships, especially physical and emotional intimacy. Difficulties arise in this phase when, making this transition, these impediments including factors, such as immaturity, anxiety about leaving the home environment or family structure, and problems with longer-standing emotional or physical problems inhibit this separation and connection with others outside the family. In the late phase, the homophobic gay teenager faces increased challenges in relationship to coming out and self-acceptance. Sometimes these are expressed by regressing to earlier behaviors or by withdrawal and depression. A therapist working with homophobia in the late-phase gay adolescent should expect the following problems: (1) continuing social isolation; (2) need for, and pressure to, establish more intimate relationships; (3) termination issues associated with transition to college. J.'s case illustrates how these issues arise and can be approached therapeutically.

Continuing Social Isolation

Another summer came and this time J. was scheduled to go on a school trip to Europe. This time he had no opportunity to "go in" as he had

already "come out" at school. Nonetheless, because he was more self-accepting and because some of his girl friends and a few males he had gotten to know also accompanied him, he had a good trip. Upon his return he reported a dream that he was "abandoned" by his family. This signalled the beginning of the last phase of adolescence. It was J. who was in the process of leaving his family, but his dream suggested there were still significant anxieties about how his family felt about him. This ambivalence characterized his fall semester.

J. had a tumultuous fall quarter with continuing struggles with social isolation, but family issues were less involved in his struggles. Instead, these struggles were evidenced by more social avoidance, increased feelings of shame, and intermittent depression. He began missing therapy sessions once again and some minor self-destructive behavior occurred, including drinking a bottle of wine and getting a ticket for a traffic violation, that resulted in his not being allowed to use his car for a period of several weeks. J. experienced this restriction as somewhat of a relief as it freed him from the anxiety of having as much freedom as the car allowed.

The Need for Greater Intimacy

J. described his hopelessness and despair in relation to being gay and struggled with the injury to his self-concept that this entailed. J. talked about wanting a relationship and stopped using his virtual computer friends; yet, he showed no interest in several young men his age, who, though attractive to him, did not hold any promise for a more intimate friendship. In therapy, we explored his ambivalence about leaving home and the associated anxiety of having the real opportunity for forming intimate relationships. J.'s ability to use these interpretations steadily strengthened and his hope for his future increased.

In the spring of his senior year, J.'s mood brightened. He became more active in school activities, theater, debating, and chorus. He also made a trip to visit colleges with his father that went extremely well and the two of them had a good time together. Their relationship was much improved. J. sought out a college that was accepting of gay students and wrote about these issues in his essays for admission. He was accepted into his first choice of colleges. J. needed therapy a good deal less and was performing well in all areas of his life. He still did not have an intimate relationship, but was beginning to better understand what it was he was looking for.

Termination

Termination with J. began in the summer before he started college. It was partially initiated by a long trip I took in the spring of his senior year.

Because J. had a characteristic fear of being rejected and tried to avoid feelings of loss, he often tried to anticipate the situation and take control. After my trip he made several appointments in succession but failed to show up for them. Finally, he kept an appointment during which I told him the approximate number of sessions he had left before leaving for college. He was astonished at the idea that he would not see me and immediately said that he could see me on his vacations, from college. He struggled to keep planned appointments but offered repeated excuses for not keeping them. When these behaviors were interpreted to him as a possible attempt to avoid working on our termination, he concurred, and discussed how difficult it would be to "not have me to talk to." His attendance at sessions improved.

One of the more difficult areas for J. was the ongoing identification with being gay for the rest of his life. He was troubled by patterns of failed gay relationships, purely sexual relationships, and had difficulty separating his stereotyped assumptions from his own coming-out process that had entailed certain aspects of this. Helping J. understand that some parts of being a gay person required experience of these kinds, but that being gay was not limited to them will continue to be a task for J. as he grows. This longer-term perspective is a characteristic feature of work with adolescents in the late phase. It can be a risky time if a great deal of internalized homophobia remains because such a long-range view can lead to hopelessness. Many gay suicides occur in this transition.

In the late phase, J. was beginning to locate his peer group outside high school, and he interviewed as an openly gay student and chose a college where he knew that there was a substantial gay community. Although this will not guarantee him success, the probabilities are greater that he will find a compatible group of peers as he continues to work out some of the unresolved peer relationship and intimacy issues that were of necessity foreclosed, though identified in therapy, during his high school years.

In the late phase of adolescence, homophobic gay males can be helped by a therapist who is able to do the following: (1) interpret the needs and wishes for intimacy and the ambivalence about them in the homophobic teen; (2) confront regressive behaviors with supportive but clear identification of the issues underlying them; (3) continue to assist the gay teen to mollify the real difficulties of being gay by providing information about the complexity of being a gay person in contradistinction to stereotypes; (4) appreciate the increased capacity for and risk of self-destructive behaviors and provide necessary supports; (5) interpret projected homophobia in

other relationships; and (6) educate and help the homophobic gay teen to see the challenges for development in the college years.

SUMMARY

Gay teenagers experience normal adolescent developmental processes, but need assistance negotiating the effect of homophobia on their development. Homophobia in the early phase may increase reliance upon the family. This can make it difficult to extricate oneself from family sufficiently to develop peer relationships. Supportive individual and interpretative family work can help modify these problems. Problems in the middle phase are associated with societal homophobia in the institutions where adolescents develop. High school social dynamics support homophobia and make opportunities to develop a peer network difficult. Therapeutic interventions that support a gay teen's efforts through fantasy and symbolic action are key to success in to this period. Referral to gay teen support groups are more likely to be successful during this phase. During the late phase of adolescence, homophobia complicates the quest for an acceptable social role and the need for more intimate relationships as plans for work and pairing become the focus. The therapist helps the gay teen overcome stereotypes and see themselves as individuals and as a members of a group called "gay." This makes it possible to integrate personal aspects of the self with gay-group identity.

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