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By Dennis C. McGrath

So...how are you feeling today?

It should be obvious to all by now, that the new millennium, far from having heralded in a new age of peace, love, and understanding, is really about more. Everything is bigger, faster: more stress, bigger problems, and faster communications of new trouble every day.

GLBTI people, like all minorities, bear an even bigger burden when the world goes loopy. "Outsider" behavior becomes implicitly un-American in some quarters, scapegoating ratchets up yet another notch, and our willingness to assert ourselves against the dominant heterocentrist hegemony (that is, to stand up for ourselves against the great crowd of straight people who don't get it, and don't care that they don't get it) takes yet another beating.

And so, when the going gets tough, even the tough sometimes shut off the phone, pull the covers over their heads, and peruse ancient issues of "Advocate Men" or "On Our Backs" by flashlight, with a Haagen-Dazs half-gallon on the nightstand and a liter-and-a-half of Absolut in the freezer.

Which, for one weekend, is totally okay. As a lifestyle, though, it lacks. But between AIDS, Matthew Shepard, the presidential election debacle, the stock market crash, the ongoing recession/depression, September 11, anthrax, Afghanistan, Iraq, SARS, and the thousand-and-one individual trials and tribulations we all experience, it's all too clear: people are hurting, and when people are hurting, sometimes they take it out on themselves or others.

That was the missing ingredient in the recent "bug chasing" media frenzy: the idea that GLBTI people, like everyone else, sometimes behave in unhealthy, self-destructive ways should not have come as any great shock to anyone. Queers are human, too (maybe that was the part that was too hard for Rolling Stone to fathom). But though "bug chasers," men who are alleged to deliberately seek infection with HIV, represent a tiny, tiny percentage of the whole of gaydom, nothing is too insignificant to blow into a major news story if it reinforces society's view that gays are "not quite right" in the head.

It's an opinion shared by some in our community, even about themselves: they think gay people are just, well, f\*\*\*ed up. But are GLBTI people inherently more likely to resort to unhealthy, or "maladaptive" (as opposed to healthy, or "adaptive") coping skills? Are we somehow "sicker" than our straight counterparts? Out in Jersey asked a variety of mental health professionals serving the GLBTI community some questions about what they thought of our community's resilience in spite of internalized homophobia and an indifferent,

often hostile society, and here's what they offered in response.

OIJ: Are GLBTI people inherently more likely to need mental health assistance than heterosexual people? If so, why?

"In my experience, most people seek treatment today for depression, anxiety, relationship issues, family issues, addictions and similar problems that arise out of stresses in the environment...stresses that are heightened for the GLBTI individual due to living in a heterosexist society," replied Annmarie Agosta, a Licensed Clinical Social Worker (LCSW) who practices in Somerset, N.J. "The GLBTI individual is NOT inherently more likely to be biologically predisposed towards mental illness than a heterosexual. If the tables were turned and 90% of our population was gay, chances are that the 10% of straight people trying to live their lives in a gay world would be highly represented among those seeking mental health treatment."

Somerville-based LCSW Russell Healy expanded upon the idea. "The question here is whether GLBTI persons have more diagnosable mental illnesses than non-GLBTI persons. Until recently, that answer was no," Healy noted. "However, new research by Susan Cochran, Ph.D., at UCLA has found higher rates of depression, generalized anxiety disorder, and substance use/dependence in lesbian and gay-identified youth. Also, there appears to be higher rates of recurrent depression among gay men. And, among people ages 15-54 with same-sex partners, higher rates of anxiety, mood and substance use disorders were found."

"Do these findings give ammunition to those who want to argue that GLBTI persons are by nature mentally ill?" Healy asked. "Cochran says no. She says her findings do not reflect 'levels of morbidity consistent with models that say homosexuality is inherently pathological.' Furthermore, there appears to be more new data to suggest that social stigma (homophobia) may explain these new findings."

Healy notes that Cochran and her team found that GLBTI people perceived more discrimination than heterosexual control groups. This perceived discrimination was not necessarily GLBTI related; but a sense (to which most GLBTI persons are keenly attuned, Healy noted) of general disrespect when dealing with the non-GLBTI world. These findings are an important step towards quantifying the relationship between discrimination and levels of stress that can produce emotional and behavioral problems, he said.

"But there is good news, as well," in the current research, Healy said. "(As a group), lesbians experience mental health in equally strong measure as do their heterosexual sisters, and, higher levels of self esteem than heterosexual women." And lesbian and gay youth, once thought to be at substantially more risk for suicide than heterosexual youth, are now found to be only marginally

more at risk.

OIJ: Are gay people more likely to seek mental health assistance than their heterosexual counterparts? If so, why?

"I have observed that the key factors in whether or not someone seeks treatment is the intensity of emotional pain in their lives, and their beliefs about what seeking professional mental health services means to them," Agosta said. "Emotional pain is a fact of life that no one escapes...gay or straight. However, the social stigma that some people associate with seeing a therapist seems to be much less prevalent in the GLBTI community. Why? Perhaps we know, as members of a community that has been stigmatized and marginalized and discriminated against for much of history, that such blind stigmatization carries no merit and can be very damaging."

Healy concurred, "The same research upholds previous findings that persons with same-sex partners are more likely to use mental health services. All this really suggests is that GLBTI persons are on a quest for health, and are brave enough to seek assistance when needed."

OIJ: In your experience, do men seek treatment for different issues than women? Do gay men develop different coping strategies than gay women for internalized and external homophobia?

"Anecdotally, I would say yes," Healy said. "Men tend to need help establishing relationships, while women have been socialized since childhood to develop bonds with others. In terms of coping, maladaptive coping in gay men looks like maladaptive coping in men overall: substance abuse, sexual compulsivity, temper problems, high risk behavior/sensation seeking and other attempts to feel numb or escape (acting "out"). Lesbian maladaptive coping tends to be in the form of losing one's self in a relationship with another, (such as) co-dependency or staying in destructive relationships in spite of ongoing harm.

"Overall, women and lesbians tend to cope poorly by "acting in"...by engaging in self harm or ignoring their own needs," Healy said.

"From what I have seen, many more men seek treatment around addiction issues than do women," Agosta said. "Men have been socialized in this culture that their inherent value as men is based on individualism, and to express feelings, other than anger, is to leave oneself open to being perceived as 'weak.' Since gay men were socialized in much the same way that straight men were, a man may be more likely to turn to drugs, alcohol, sex, or other addictive behaviors as an outlet for painful and confusing emotions. Women, on the other hand, who have been socialized to value themselves in terms of relationships and are not under the pressure that men are to display their strength through

stoicism, find it less threatening to share their pain and let others see their vulnerability. Therefore, it appears that it may be easier for a woman to reach out to others for help with her emotional pain than it is for a man."

"The flip side of this is that women tend to place a great deal more importance on relationships and other people's needs than they do on their own," Agosta said. "As a result, more women tend to seek treatment for self esteem and relationship issues than do men."

Agosta continued, "I have also observed in my work with gay men and lesbians that these groups differ in their experience of sexual abuse or trauma. Many lesbians present a history of sexual trauma (incest, rape, molestation) as a reason for seeking treatment. Many gay men have also had similar experiences. However, men are much less likely to report that these experiences had a traumatic effect. There could be many reasons behind this discrepancy."

"For one thing, different people have different definitions of "abuse". What may be sexual play for one person could be traumatizing to another, and it is no secret in this community that the sexual appetites of gay men differ greatly from the sexual appetites of lesbians. For this reason, I always ask my clients if something that sounds like it could be sexual abuse was traumatizing for them. If it was traumatizing, and the client felt victimized, then issues of sexual trauma need to be worked on. However, if a client reports that the incident did not have a traumatizing effect on him/her, I do not treat it as sexual trauma," Agosta said.

"Of course, there are cases where a client will minimize or repress feelings related to traumatic experiences. If this is the case, there usually will be clues to be found in the person's functioning. If these clues are present (e.g., explicit nightmares, flashbacks, feeling rage or fear when having sex) and the client has a questionable history of sexual abuse, then the incidents should definitely be looked at in therapy to determine whether or not the client is a sexual abuse survivor," Agosta concluded.

In the end, said Healy, it's not that the real-life problems gay men and women face are so different, but that men and women develop different styles of coping—or "maladaptive" behaviors when their efforts to cope fall short of what's needed. "I'm not sure that the presenting problems differ for individuals, just the maladaptive coping styles. In couples' therapy, gay men tend to struggle with intimacy, commitment, trust and cooperation. Lesbians tend to struggle with independence, 'separateness' and resolving conflicts."

In short, "lesbians tend to 'merge' and lose separateness, while men have trouble sustaining intimacy for long periods of time," he said.

OIJ: As gay people, we try to be non-judgmental about others' behaviors, but where is the line between "lifestyle choice" and "self-destructive behavior?"

"The line is the same line that is used when assessing addictions or compulsions," said Healy. "In short, everything in moderation is okay. When one's 'lifestyle choice' begins to interfere with the rights of others, or with one's social or employment life or personal finances, or threatens interpersonal relationships, then it's time for help."

OIJ: Are young gay people experiencing less, more or about the same amount of traumatic homophobia as their elders? Are they coming into therapy at a rate and with complaints similar to their heterosexual peers, or do you feel their lives are still disproportionately difficult compared to the majority of adolescents and young adults?

"I don't think the level of social homophobia in the U.S. has changed. It just looks different than it did 30 years ago," Healy replied.

Agosta's view is more optimistic, "I see a tremendous difference in the experiences that gay teens have today. Gay teens today are more widely accepted than at any other time in American history. Many of the high schools have gay-straight alliances; gay teens see themselves represented in mainstream television shows, movies, music, and media. There are many GLBTI organizations that have reached out to our queer youth...that young lesbians proudly proclaim themselves "Dyke Grrrls", and young gay men affectionately call each other 'fag,' points to the fact that our younger generation has taken back the language that was used to taunt and wound many of our adult members. The queer youth of today definitely have an easier time in society than any of our previous generations did," she said.

But are their lives still more difficult than their heterosexual peers? Agosta answers with an emphatic "YES!"

"The fear of being disowned; of being discriminated against in a society that still categorizes classroom discussion of gay and lesbian families as a sexual topic; worries of how one's teammates would react to having a 'fag' share the same locker room; having to base one's career decisions, in part, on which industries and companies are the most gay friendly; determining spring break vacation plans not only on finances and fun, but how safe is it for me to hold my boy/girlfriend's hand walking down the street in a different state or country; wondering if, indeed, my small N.J. town could become the next Laramie; hearing N.J. senators compare gay and lesbian marriages to people wanting to marry their dogs...The sad fact is: Yes, the lives of GLBTI youth are still more difficult than those of their heterosexual peers," she said.

"However, if we as a community continue to reach out to our youth to mentor and support them through their coming of age, and model our commitment to social justice and change, their challenges will become the triumphs of future generations of healthy, well adjusted, happy GLBTI adults," Agosta concluded.

OIJ: If you could post three "Get Help Now" symptoms or behaviors, what would they be? Are they different for men? For women?

Pat Brennan, a Lawrenceville LCSW, said, "The three 'get help now' symptoms I would identify are: thoughts of suicide (or passive wish for death), or of harming others; symptoms of depression or anxiety which impair functioning; and engaging in dangerous or self destructive behavior. These are not gender-variable."

Agosta offered this list:

- 1) Ongoing depression, lasting two or more months.
- 2) Self-destructive behaviors or thoughts (including addictions).
- 3) Overwhelming, persistent negative thoughts or fears.

Healy also emphasized that these danger signs are the same for men and women, and added a fourth to consider.

- 1) A person has experienced a tremendous loss or crisis, and is experiencing difficulties showing "adjusted behavior." For example, a victim of a gay-bashing, or of September 11th, becomes unable to meet obligations, has problems caring for him or herself, or experiences a subjective sense that they can't handle the emotions they are feeling. A significant other may also raise the question of these post-traumatic stress responses, such as poor coping.
- 2) A person has been living with tremendous stress of whatever variety, including depression, and is contemplating self-harm, or wants to harm someone else.
- 3). A person has lost control of behavior that was once pleasurable, and is facing severe consequences as a result of this loss of control.
- 4). A psychiatric symptom (anxiety, obsessions/compulsions, thought problems/disordered thinking and/or psychosis) has become unmanageable.

OIJ: What should a gay person look for in a therapist? Must that therapist be gay? Are different modalities more effective for certain issues?

Dr. Judith Glassgold, Psy.D., of Highland Park, recommends that GLBTI consumers of psychological services spend some time reading the American Psychological Association's Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients, which can be found at the association's website: [www.apa.org/pi/lgbc/guidelines.html](http://www.apa.org/pi/lgbc/guidelines.html).

In Healy's view, there's no substitute for experience with queer clients, regardless of the therapist's own identity. "First, always see a licensed professional," he advises. "Only licensure can protect the consumer from harm. Secondly, the therapist does not have to be gay...but mileage matters. In

addition to having a lot of experience treating GLBTI clients, a non-gay therapist should be able to demonstrate competencies specific to working with GLBTI persons. The APA practice guidelines are relevant to all licensed mental health professionals. Also, the National Association of Social Workers regularly updates its ethical standards with respect to working with GLBTI clients.

"Secondly, different modalities have been found by research to be more effective when applied to certain problems. Essentially, a good therapist is well-versed in insight-oriented approaches, as well as, cognitive/behavioral approaches and knows which approach to use (and when)," Healy explained. "Generally, behavioral problems and depression and anxiety disorders respond well to cognitive/behavioral approaches, with use of insight-oriented therapy once the behavioral difficulty or anxiety or mood-related problem is under control. Interpersonal or 'personality' problems respond well to insight-oriented approaches with some cognitive/behavioral techniques."

Brennan emphasized empathy, "A gay person, or any person, should look for a therapist who provides a safe and caring atmosphere and has the ability to convey empathic concern and trustworthiness, and who has experience and expertise in dealing with the problem being presented. A therapist need not be gay to be helpful, but each person should decide whether this is important to him or her."

"A therapist has theoretical underpinnings driving their approach; some may use a combination of approaches," Brennan continued. "Research does indicate that for certain symptoms specific approaches may be more helpful than others. For example, anxiety disorders seem to respond to cognitive/behavioral approaches; a severe depression may need biological (medication) intervention initially so that psychotherapy can be beneficial."

Agosta also doesn't insist that gay people see gay therapists. "I, personally, do not believe that a therapist has to be gay to be effective. However, there is a very important distinction between gay tolerant and gay affirming. A clinician who is gay tolerant subscribes to the belief that 'gay is OK.' Such a clinician does not impart the message that there is anything wrong with the client for being gay, and that being gay should not affect the client's treatment."

A gay affirming therapist projects to the client that, not only is being gay OK, but it is one of the treasured manifestations of identity that the client possesses which make him/her valuable, unique, and cherished," Agosta continued. "Being gay is not something to be tolerated to an affirming therapist, but something to be celebrated, as the whole human being is celebrated. A gay affirming therapist will also be knowledgeable about GLBTI culture and issues. S/he is also very aware that being gay does, indeed, influence one's treatment, since gay and lesbian family and relationship dynamics are different in many ways than traditional heterosexual dynamics."

OIJ: How does the client know when therapy is working? How does he or she know when it isn't?

"That's probably the most important question of all," Healy said. "Here are some guidelines: The client should feel that s/he and the therapist are working towards the same goal. A good question for the first visit: how will we know we are done? That sets the goal. The client should feel a greater sense of confidence, or experience a belief that they will be able to succeed as therapy proceeds. Also, the client should experience a greater tolerance for strong emotions, along with the ability to think clearly in spite of intense feelings. A general goal for all therapy is serenity, or the ability to act instead of react."

Healy added, "Therapy can only assist the individual, and can't guarantee that others will behave according to a client's desires. That's why getting a boyfriend is not an actual goal, but developing the capacity to be in a relationship and improving interpersonal skills is a valid goal. If the client feels or thinks therapy isn't working it should be addressed with the therapist immediately. A good therapist is flexible, and is capable of resolving problems in the service of good therapy."

"On the one hand, persons seeking therapy should acknowledge that meaningful therapy is not brief and may require a commitment of several years. On the other hand, good therapy does not last forever or continue for a long time without any signs of change."

What if things seem to be going off the rails? Healy notes, "Good therapy is not about the relationship between therapist and client, but on improving the quality of the client's life and relationships and change. Sometimes dynamics occur between clients and their therapists that can usefully illustrate interpersonal dynamics in the client's life. That's an appropriate use of a therapeutic alliance. Each mental health profession (clinical social work, psychology, psychiatry, nursing and counseling) is regulated by a State board with published statutes and regulations. Consumers should contact the appropriate board or professional organization and request copies of relevant standards. Finally, clients should not leave therapy without addressing perceived problems with a therapist; a powerful opportunity for learning could be missed. Actual malpractice is another matter, is obvious when it occurs, and does not require consultation with the offending practitioner."

"A client can have a sense that therapy is working if they have established a meaningful and effective working relationship with the therapist, and if they notice an improvement in the frequency and intensity of the symptoms which brought them to treatment," Brennan said. "Conversely, if these are not present, the client may want to discuss this. Other concerns that the therapy may not be helpful (or, in fact harmful) would be; the therapist blames or criticizes the client, talks about his/her own problems, or attempts to establish a personal

relationship outside of the office.

“A good therapist will, at regular intervals, ask for the client’s assessment of how s/he feels the therapy is progressing,” Agosta noted. “Ideally, the client should begin the therapeutic relationship with some ideas or goals that s/he wants to work on, and keep track of the ones that have been met, are no longer important or valid, or need to be changed. If, at any of these assessment periods, the client feels that s/he has met these goals and wishes to terminate treatment, this should be brought up in session. Perhaps the client may have new goals s/he wishes to add, or life situations have changed and brought new challenges to deal with.”

“In any case, a client should have measurable objectives for treatment that s/he can judge his/her progress by,” concluded Agosta.