THE INVISIBLE MEN:

VALIDATION, BELONGING, AND IDENTITY DEVELOPMENT IN GAY MALES

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Abstract

There is relatively little research and literature on the psychosocial development of gay males. This qualitative study explores the developmental experiences of gay males, as expressed by adult gay male patients, ages 20 to 29, in psychotherapy. Three composite cases were created, drawing upon data from real psychotherapy cases from clinical training experiences, published clinical examples, and fictional details to protect patients' confidentiality. Each of these cases is presented as one key aspect or category of gay male development: validation, belonging, and identity development. Particular attention is paid to these formative developmental experiences. Case material is analyzed qualitatively, through the method of experiential phenomenology, or phenomenology of practice, as explicated by Richards and Morse (2007), van Manen (2007), and van den Berg (1972). The lived experiences of the three cases are addressed phenomenologically. The following themes emerged: (a) dissociation, (b) hypervigilance, (c) anxiety, (d) microaggression, (e) shame, (f) true self/false self, (g) avoidance of self, and (h) invisibility. Implications for psychotherapy with gay male patients are explored and limitations of the study discussed.

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Chapter I

Introduction

Purpose of the Study

"If we want to understand man's existence, we must listen to the language of objects. If we are describing a subject, we must elaborate on the scene in which a subject describes himself." (van den Berg, 1987)

The goal of this study is to explore the experience of validation, belonging, and identity development in gay males, as expressed by adult gay male patients, ages 20 to 29, in psychotherapy. Three composite cases are presented and examined, using clinically real phenomena, with elements from additional cases, published clinical examples, and fictional details. While the emotional experiences of real patients are preserved, no real individual is represented by any composite case. Particular attention is paid to the formative developmental experiences of gay males as revisited in psychotherapy. In so doing, the intended purpose is to gain insight and understanding about the experiences of gay male patients in order to ideally improve psychotherapy services for this population. The treatment modality of all composite cases presented is brief psychodynamic therapy (BPT), based on the models of Davanloo (1980), Fosha (2000), Levenson (2010), and Mann (1973).

Three Composite Cases

In addition to drawing upon elements from fictional and published accounts, clinically real phenomena were derived from real cases of gay male patients, ages 20 to 29, in short-term dynamic psychotherapy treatment in outpatient settings. Data for all composite cases were drawn from cases of gay males within this age group. Therefore, inclusion criteria are gender (male), sexual orientation (gay), and age (20 to 29). A brief overview of the three composite cases follows.

"Greg." This composite case is a gay male patient, age 20, whose areas for attention in psychotherapy included separating himself from negative self-evaluation learned during his adolescent years. This patient attended a competitive, private, all-boys high school, where he perceived his environment to be a dangerous place. He learned to cut off from essential parts of himself, namely his feelings toward male peers and his developmental needs for connection, camaraderie, and commiseration. He experienced a loss of true self, as he habitually identified with repression as intrinsic to his personality.

"Peter." This composite case is a gay male patient, age 29, who came to therapy in distress over a lack of any intimate relationships in his life. At the start of therapy, he had not dated or had sex in ten years, since losing his virginity. As a child, he experienced his household as chaotic and unsafe, with an alcoholic father who was repeatedly unfaithful to his mother and a mother who tolerated this behavior without assertiveness or confrontation. In his professional life, this patient felt he was

never good enough and was constantly anxious over gaining the acceptance of his supervisors. In his personal life, he felt that he was never physically attracted to males his own age who seemed kind and well-mannered. Instead, he was attracted to older men whom he perceived as controlling.

"Andrew." This composite case is a gay male patient, age 26, who was raised in a conservative, religious household. He learned to place the needs of others ahead of his own and to assume responsibility for the problems of others. While taking on the problems of others and adopting a "martyr" identity, his unconscious anger and resentment grew. He came to therapy in a state of depression, turning inward his overwhelming anger toward his family, church, friends, and teachers. To him, this anger felt more manageable and controllable when directed toward himself because it avoided conflictual feelings toward loved ones and because it was consonant with his experience as a victim and martyr who deserved struggle and was responsible for pain.

Chapter II

Review of the Literature

The following literature review focuses on the findings of studies examining the developmental experiences of gay males and psychotherapeutic needs that result.

Blum and Pfetzing (1997) draw a connection between growing up gay and childhood trauma. Gay children are like victims of childhood sexual abuse in that there is no one to corroborate their story or even share their story. Dissociation can result in both cases, where the child cannot cope with the unarticulated trauma (Howell, 2005). The "coming out" process is analogous in importance to a victim of sexual abuse having the opportunity to tell his story. Psychotherapy allows the victim of trauma to have what he has not had: someone to bear witness to his story and respond in a safe, emotionally supportive way (Neimeyer, 2001).

Nader (2007) and Osterman and de Jong (2007) counter the dominant societal heterosexist perspective and, in so doing, contribute to broadening our understanding of the patients that we treat. However, our work as therapists with the LGBT population has only begun. In a field that officially de-pathologized homosexuality merely a generation ago, sexual orientation in our patients merits abundant discussion and exploration (Anhalt & Morris, 1999).

When Corbett (2003) states that the use of the word "faggot" commonly signifies "loser," he explains that the lack/loss felt by the name-caller is projecting onto the target. In this way, the victim becomes for the victimizer the representation

of lack. In a society that prizes masculinity, male homosexual orientation is a failure to meet traditional masculine standards (Thompson, 1995).

As a result, gay males become targets of projected loss, antitheses of cherished ideals (Cass, 1979). Potentially dangerous outcomes for such victims result from what Moss (2003) identifies as "internalization of the dominant culture's attitude" (p. 198) and the "shame and self-loathing" (p. 197) that stem from this internalization.

Gay males are outsiders of the dominant heterosexual culture (Bond, 2007). Like victims of abuse, gay children can be shamed into believing the abuse is their fault. Believing that they do not have support or protection, gay children adapt by keeping their shame to themselves (Neimeyer, 2001). The lesson learned is that, while other children are permitted to express and assert their feelings, gay children are not allowed.

Accordingly, these formative years are marked by the hyperarousal of self-protection (van der Kolk, 2003). This is an experience of constant vigilance, scanning for signs of danger, assessing each encounter for safety, questioning and testing each person for trust. Particular caution is taken with other males, and this is compounded because males are both threatening and attractive, a potential source of both victimization and love (Bond, 2007). This vigilance merits attention and working through in the therapeutic relationship (Dalenberg, 2000). If a gay male patient has adaptively learned the defense of hypervigilance, he will constantly gauge whether he can be honest in psychotherapy and whether his therapist can be trusted (Nader, 2007).

What further contributes to these issues of vigilance, gender, shame, victimization, and sexual attraction is the connection between sexual enjoyment and guilt (Howell, 2005). Without an adequate sense of safety and support, gay males can feel isolated, blamed, and punished. In this way, they can be made to feel shame and responsibility for being different (Troiden, 1993). Helplessness results in feeling that there is nothing they can do – that they have to allow themselves to feel victimized and remain silent (Howell, 2005).

Alone with a secret through adolescence, gay males may have no one to explain their same-sex orientation. Their objects of attraction are the same people to whom they cannot indicate their feelings, for fear of exposing their secret (Savin-Williams, 1994). Such exposure would bring the threat of rejection, ridicule, and violence (Canarelli, 1999). Being forced to remain silent means tolerating the majority's wishes and perspective. At the same time, gay male adolescence brings feelings of sexual attraction that conflict with feelings of resentment, anger, hatred, distancing, and self-protecting vigilance (D'Augelli, 1998). In learning to feel guilty and responsible for these conflicting feelings, gay males may take the blame for feeling attracted to their perceived oppressors. In carrying this burden, gay males learn that their worth is less than those around them, less than those who victimize them. They also learn that their power is less than those of their heterosexual peers (Howell, 2005).

Herek (2009) calls this burden "internalization of stigma" (p.7), which he defines as "the process whereby individuals adopt a social value, belief, or prescription for their own conduct, and experience it as part of them" (p. 7).

Internalized stigma is the personal acceptance of denigrating values (American Psychological Association, 2012; Malyon, 1982).

According to the literature, some gay males are particularly sensitive to rejection by others and are more vulnerable to fear of negative self-evaluation, social anxiety and lower self esteem than heterosexual males (Pachankis & Goldfried, 2006; Pachankis, Goldfried & Ramrattan, 2008). Gay males who are less open about their sexual orientation and who are less comfortable with being gay are more likely to experience anxiety in social situations (Pachankis & Goldfried, 2006).

Stress stemming from sexual orientation is multidimensional (e.g., Meyer, 1995; Rosario, Schrimshaw, Hunter, & Gwadz, 2002). One aspect of this stress is external in nature and involves the experience of violence, verbal abuse, rejection, and other stressful life events perpetrated by other individuals against persons who are, or are perceived to be, gay (D'Augelli, 1998; DiPlacido, 1998; Herek, 2007).

Other aspects of this stress are chronic and internal in nature, involving internalization of society's stigmatization of homosexuality (Glassgold, 2009). Many gay males share society's negative attitudes regarding homosexuality to some extent because they were raised with a general expectation by family and society that they would be heterosexual and because they were raised to evaluate homosexuality negatively (Glassgold, 2009). These negative attitudes toward homosexuality, also known as internalized homophobia, create internal conflict (Malyon, 1982; Meyer, 1995).

Race-related stress can also manifest in this way, and the concepts of microaggression and invisibility are relevant here (Franklin & Boyd-Franklin, 2000).

Dominant societal attitudes can leave members of minority groups experiencing lack of recognition and understanding due to limiting stereotypes (Franklin, 1999; Franklin & Boyd-Franklin, 2000; Franklin, Boyd-Franklin, & Kelly, 2006). This experience is one of invisibility, of not being seen or understood accurately. Recipients of microaggression "feel invisible in its rejection and disrespect of their personhood" (Franklin & Boyd-Franklin, 2000). Sue (2010) includes sexual orientation in his discussion of these concepts, including how microaggression and heterosexism pervade daily living for those who are not heterosexual. This microaggression impacts one's experience of the classroom, the workplace, and the mental health practitioner's office (Sue, 2010).

The gay male's discomfort with others' knowing his sexual identity is attributed to his fears of discrimination and rejection that may result when others actually learn his sexual identity (Vincke, De Rycke, & Bolton, 1999). The chronic aspects of this stress are particularly prevalent among gay males who are just becoming aware of their sexual orientation and identity (Meyer, 1995).

Pachankis (2007) presents an explanation of the potential psychological consequences of concealed stigma and the threat of discovery, such as hypervigilance, preoccupation, and emotional distress. All of these factors can lead to negative views of the self and lack of self-efficacy (Rotheram-Borus, Hunter, & Rosario, 1994). Further hiding can have interpersonal impacts, such as isolation and lack of intimacy, and an impact on the self, such as inauthenticity and a sense of dishonesty that prevent engaging in protective factors like community and group identity (Malyon, 1982; Pachankis, 2007).

When gay males have more negative attitudes toward their sexual orientation, they are less likely to disclose their sexual orientation to others (Rosario, Hunter, Maguen, Gwadz, & Smith, 2001). Challenges in psychotherapy with gay male patients include working toward patients' realization that expression of feelings can have positive outcomes and that the lack of safety once experienced will not recur in the therapeutic relationship (Resick and Schnicke, 1996). Additionally, in addressing patients' self-worth and self-expression, we emphasize the value of feelings and desires (Chan, Chan, and Ng, 2006).

Despite progress, the literature has historically pathologized non-heterosexual orientation (Anhalt & Morris, 1999). Psychotherapists are taught to ask different questions of gay people and gay patients, asking why they are gay, but are less likely to consider and ask why someone is heterosexual. Because heterosexuality is seen as normative, psychotherapists often don't explore those questions with those patients (Hershberger, 1995).

If trauma occurs when the ego is overwhelmed by anxiety, then cumulative trauma is a continual state of this anxiety over time (van der Kolk, 2003). There is more information than can be processed, happening more quickly than a person is able to file it away. This trauma becomes unmetabolized experience, like a computer file that your computer won't read, stored in a format than cannot be translated (Resick & Schnicke, 1996). It is stored in the brain as unreadable. It is persistent and unexplained, repetitive and unrelenting, like slow torture (Howell, 2005).

Holmes (2011) explains it this way: Imagine being in an alien land, where everyone else does not need or want to eat food, but rather they use and value food in

a different way. Meanwhile, you need to take in food and are uncertain how to assimilate to the norm when you have this need. This is what development is for gay people: conflict between an internal experience and an external world that has no evidence of that experience. Gay people are told that they are not alright and that there's no evidence that their needs are legitimate. In this manner, there are two options available: 1) maintain both ideas simultaneously, namely psychosis, or 2) separate the two ideas, namely splitting. The consequences of this double bind are important and inform the work of psychotherapy (Holmes, 2011).

What can result is abject dissociation, where one side of the conflict is not aware of the other side (Safren & Heimberg, 1999). A person can ignore internal experience or pursue the craving to the exclusion of anything else. This drive to feed the craving results in operating in a sexual way that is dissociated (Safren & Heimberg, 1999).

The experience of gay development can mean growing up knowing that one's earliest sexual experiences are going to be compartmentalized (Halpin & Allen, 2004). An essential aspect of psychotherapy for gay patients can be to make meaning, to give structure to the psyche.

Human sexuality is an emergent phenomenon, which as Freud (1905/1962) conceptualized it, begins at birth. We talk of "coming out" as starting in puberty, but for gay males there is a conflict from birth that has not been metabolized. There is lack of appropriate mirroring (Halpin & Allen, 2004). As the mother's behavior is based on a gendered experience, there is an unconscious disconnect between mother and child. Coming out, then, is not a discrete passage, but actually a process that

begins much earlier. It does not begin with coming out of the closet. It begins with going into the closet. Gay people are not born in the closet (Holmes, 2011).

This is an aspect of gay development that is generally neglected. Going into the closet can be conceptualized as a series of traumas, as a child senses repeatedly that he is not allowed to be (Pachankis & Goldfried, 2006). He is introduced to the stigma of being gay very early in his life, and he scrambles moment to moment for self-preservation and avoidance of stigma (Pachankis, 2007). He considers himself lucky to maintain physical safety, but his safety comes with a great cost.

Forbidden to be and to grow through experience, he experiences delayed adolescence, which cannot truly begin without movement toward self-awareness (D'Augelli, 1998). Relational development is delayed, as relational behavior is restricted. Clinically, this may manifest in a gay male patient who has been taught to be rigidly constrained from self-expression (Malyon, 1982). This patient is successful in his career, and in this avenue is an accomplished adult. However, he is frustrated because he cannot form or hold a relationship. He is an adult, but he has not yet experienced adolescent intimacy (Malyon, 1982).

Parental anxiety and uncertainty about their own stability, both financial and emotional, is translated to their sons about what they need to be for their parents (Warner, 2009). Even boys who are not gay who reveal interests that may appear stereotypically less masculine, like music or academics instead of sports, are vulnerable to degradation by their peers and discouragement by their parents (Goldfried & Goldfried, 2001). In such cases, bullies are often given a free pass with an attitude of "boys will be boys." The message sent is that not only is it permissible

to bully, but it is preferable to be the bully than the bullied (Pascoe, 2007). Warner

(2007) writes:

> The message to the most vulnerable, to the victims of today's
> poisonous boy culture, is being heard loud and clear: to be something
> other than the narrowest … sort of guy's guy is to be unworthy of even
> being alive. (http://www.nytimes.com)

With the September 2010 suicide of Rutgers University undergraduate student

Tyler Clementi, along with four other male teenagers within the same month,

increased attention has been given to the issues of bullying and hate crimes,

particularly based on sexual orientation (GLSEN, 2010). These five boys, all taunted

for being gay, committed suicide after escalating incidents of being overwhelmed by

public shame. It is the intent of this study to address the salient factors in the lives of

gay male adolescents, in the hope that improved understanding will result in

improved care.

The Research Questions

This research study was designed as an exploration of gay male development, as revisited and experienced in individual psychotherapy. The study intends to explore five major questions about gay male psychotherapy patients:

1) What emotional needs were experienced as met vs. unmet in gay males during the early years of their lives (childhood through 20s)?

2) To what extent did gay males feel validated (including self-esteem, self-expression, assertiveness, and wholeness) vs. inferior during these early years?

3) To what extent did gay males feel belongingness (including safety, agency, and empowerment) vs. isolation during these early years?

4) In what ways did gay males develop identity (including expectations of self and others, vision for future life, initiative, and goal setting) during these years?

5) What implications does this have for psychotherapists in providing effective psychotherapy for gay male patients?

Chapter III

Methodology

Richards and Morse (2007) explain various approaches to qualitative research, including phenomenological, ethnographic, and grounded theory. Analytic strategies common to these approaches are as follows: collecting data, recording reflections and insights, sorting through the data for emergent themes, extracting patterns for subsequent analysis, elaborating on generalizations from the data, and addressing these generalizations within a theoretical framework (Miles & Huberman, 1994).

The study was conducted over the course of 15 months, from October 2010 to January 2012, where clinically real phenomena of composite cases were examined. The data from real psychotherapy cases from clinical training experiences were combined with elements from published clinical examples and fictional details to create three composite cases. Each of these cases is presented as one key aspect or category of gay male development: validation, belonging, and identity development. Neither the cases nor the categories are intended to entirely represent one actual individual, nor do they represent all gay males. Instead, these composite cases are presented as clinical examples aimed to gain understanding of the lived experience of some gay adolescents.

In order to ensure confidentiality, all data that contained identifying information was kept by the principal investigator in a secure location for the duration of the project. Interview notes and any audio tapes were kept in a personal locked filing cabinet, to which only the principal investigator had access. Any verbatim

quotations from sessions that might breach the confidentiality of the subject have been excluded or changed.

Given the nature of the data collected in this study, the method of phenomenology was chosen. Phenomenology attempts to describe phenomena of the human experience. Among the many phenomenological movements and traditions are transcendental, existential, hermeneutical, linguistical, ethical, and phenomenology of practice (van Manen, 2011). Phenomenology of practice is used here to designate the employment of phenomenological methods in applied or professional contexts like clinical psychology. Early practitioners of phenomenology of practice are the psychiatrist van den Berg and clinical psychologist Linschoten (van Manen, 2011).

Phenomenology of practice is also called experiential phenomenology, lifeworld phenomenology, or applied phenomenology (van Manen, 2007). Often differentiated from "philosophical phenomenology," this "practical phenomenology" is the method utilized herein. Also intertwined are elements of hermeneutical phenomenology in the interpretation and understanding of language.

Phenomenological methods engage "radical reflection." The reflective method is focused on lived experience, and both stages of phenomenological methodology, the *reductio* and the *vocatio*, are involved (van Manen, 1990). *Reductio*, or the reduction, is the "bracketing" of our day-to-day assumptions, perspectives, and attitudes. This is achieved through writing via the *vocatio*. The goal in this linguistic approach is to create resonant representations of meaning.

Vocatio, or the vocative as in "voice," expresses this concern with language (van Manen, 1990).

The aim of experiential phenomenology is to achieve a "direct and primitive contact with the world" (Merleau-Ponty, 1962). This is to engage experience, rather than conceptualization, resulting in experiencing lived meaning. In other words, the method of experiential phenomenology is meant to bring the aspects of meaning of a particular phenomenon into nearness (Merleau-Ponty, 1962).

Phenomenological methods involve two types of inquiry activities: empirical and reflective methods (Burch, 1989). The main purpose of the empirical method is to explore examples and varieties of lived experiences, especially in the form of lived experience accounts. The purpose of the reflective method is to achieve phenomenological understanding that becomes both information about meaning and experience of meaning (Baydala, Hampton, Kinunwa, Kinunwa, & Kinunwa, 2006). This method requires a certain kind of attentiveness, not only thoughtful but holistic. The intent of phenomenological writing is to produce textual "portrayals" that resonate and make intelligible the kinds of meanings that are recognizable in our lives (van Manen, 1989). Listening with a phenomenological ear means being available and present – physically, intellectually, and emotionally – to the other person. This is not simply theoretical application (van Manen, 1989).

Thematic analysis of a phenomenon, or a lived experience, is a creative process (van Manen, 1989). Analyzing themes is the process of uncovering meaning in human experience. Inquiry in phenomenological analysis is through writing. In

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the case of applied psychology, our focus in on the application of phenomenology to clinical practice (van Manen, 1989).

Phenomenological research studies the phenomena of human living. The process of writing recreates an emotional and intellectual experience of a phenomenon. Van Manen (1990) explains that phenomenological research as an intensive writing activity helps the researcher explore the unique phenomena of lived experience. It is a method of understanding the person (van den Berg, 1980). Openness to hearing personal stories, and openness to the possibility they will conflict with one's own personal meanings, broadens understanding in an ongoing process of emerging meaning (Ricoeur, 1981).

Interpretation of the data depends on becoming immersed in the lived experiences (van Manen, 1989). The researcher interprets qualitative data by searching for patterns and relationships (Patton, 1987). The validity of information comes from its trustworthy representation of an actual life situation, rather than because it is generalizable across persons and contexts. In this way, information is valid as it is constructed through phenomenological interaction (Baydala et al., 2006). Phenomenological research engages depth and thoroughness in process and reevaluates the traditional scientific insistence on reliability, falsifiability, and objectivity (Burch, 1991).

Chapter IV

"Greg"

Validation

"No one ever said anything to me."

Greg was a 20 year-old, Chinese-American, undergraduate male, whose areas for attention in psychotherapy included separating himself from negative self-evaluation learned during his adolescent years. This patient attended a competitive, private, all-boys high school, where he perceived his environment to be a dangerous place. He learned to cut off from essential parts of himself, namely his feelings toward male peers and his developmental need for connection, camaraderie, and commiseration. He experienced a loss of true self, as he habitually identified with repression as intrinsic to his personality. He came to therapy midway through his college experience, feeling overwhelmed, indecisive, and afraid.

"It's lonely," Greg stated in the present tense when telling me about his past experience of his childhood and teenage years. Greg recalled watching television at age 7, viewing a talk show where gay males were being interviewed. His sister said, "We have to make sure this doesn't happen to you." This communication was complex. It showed a child's (Greg's sister's) innocent understanding of being gay to be something scary and to be avoided. Greg assured me, and himself, that the comment came from a place of concern and protection of an older sibling. Her fears were communicated to and then shared by Greg. He understood that he couldn't communicate to her or anyone his knowledge that he was like those adults, even at 7

years old. He already had the sense that he was different from the norm, but also that he was like those men being interviewed. For Greg, unlike his sister, the realistic goal was not to prevent himself from being that way, since he already was. The goal was hiding it from that point on. At age 7, he already saw his life as burdened by a secret forever. At age 7, he already felt closed off to possibility. At age 7, he already felt alone.

This early experience was an introduction, though surely not the first, of a development marked by microaggression. The complexity of the communication is something that would become part of Greg's daily life. While his sister communicated her fearful warning explicitly, his parents' message was unspoken and implicit. They valued academic achievement and wanted Greg to distinguish himself among his peers in this way. He was not, however, to stand out in other ways, and he was discouraged from self-expression or individualism. He held onto his secret with an urgent sense that it must be hidden from his parents, as much or more than anyone. As a college student, he remained especially fearful about coming out to them.

As an adolescent, Greg sought acceptance and commiseration from his peers, someone with whom to share his secret and who could support and accept him, even someone to return his physical attraction and give him the validation of reciprocal attraction. Greg's integrity and sense of wholeness was threatened by both girls and boys. Girls who found him attractive were threatening in that he could not return their feelings and therefore was doomed to disappoint them. The only response that would perhaps not hurt their feelings would be to reveal his secret to them. On the other hand, telling his secret risked his well-being, both physical and emotional. To

show too much interest in his male peers would be to give himself away. To stand out too much risked unwanted attention from both genders, attention against which he felt defenseless.

His dilemma remained in his college years: How could he let someone know he was interested in them romantically without risking rejection? In Greg's case, this rejection was not just the universal risk adolescents face when seeking a mate, the risk that the object of our affection will not reciprocate. For Greg, there was also the experience of rejection of self, of his very personhood and dignity. The risk was that a recipient of his attention would be heterosexual, would find his attention offensive to his own dignity, would respond abusively.

Greg's self expression became dangerous. The world became a dangerous place from which to hide, a place to be feared, a place to focus on surviving, not thriving. Greg's major survival skills during high school ranged from blending to hiding. Through these years of stifling himself in order to go unnoticed, he lost access to his sense of power, assertiveness, agency, and competence. Not only did he learn to be constantly anxious and hypervigilant in an unsafe world, but also he could not tell friend from foe and therefore had to hide from them all. Making a true friend would involve being his true self, which he was not only afraid to do but also he was losing sight of how to do it.

Greg became so good at hiding that he lost himself. He became so good at pleasing others that he no longer knew how to please himself. He felt he didn't know who he was or what he wanted. Ironically, he realized that in trying to blend, in trying to be more like his peers and more accepted by them, he simply presented

himself as dull and dispassionate, and he still did not gain acceptance. He merely

avoided outright rejection.

Through middle school and high school, Greg's fear and social anxiety grew,

and after experiencing panic symptoms for several years in the classroom setting, he

recalled finally having a "full-blown panic attack" during his junior year of high

school:

> I was called on to read, which I always hated. I always worried that
> people would know I was gay if they heard my voice, so I always
> wished I could just not speak at all. Right away, when I was called on,
> I could feel my heart race, and I wanted to somehow get out of
> reading. I started to read and couldn't breathe. I kept coughing every
> other word, which I thought maybe helped catch my breath. I couldn't
> tell if everyone was quiet because they were weirded out or they just
> didn't care. I thought it would never end. My teacher excused me to
> go get a drink and pull myself together. No one ever said anything to
> me.

Despite his attending an all-boys high school, which Greg ironically stated

was like "no man's land" for him, he learned to seek out girls as friends who would

embrace him and not judge him. Although he likewise did not come out to his female

friends, largely for fear that word would spread to his male peers, he felt less inclined

to put on an act for the girls or to hold back from expressing himself genuinely. His

preference for the arts over sports was acceptable in this crowd, as was his giddy

enthusiasm. For the most part, Greg found that girls appreciated these qualities,

rather than saw them as evidence of being abnormal.

He found some safety – and some hiding – in the company of his female

peers. During pre-adolescence, he felt comfortable and competent with girls, sharing

some interests and priorities. He was the first of his peers to go on a date with a girl,

not feeling nervous or intimidated due to more identification and less sexual attraction

than his heterosexual male peers felt toward girls. He experienced his friendships with girls as comfortable and safe, and for a time, even dating was not threatening.

However, as adolescence progressed, Greg's lack of sexual attraction to girls became more noticeable to him and others, as gender differences became more prominent and dating became more common. Unlike his heterosexual male peers, Greg was not interested in kissing girls, much less being sexually active with them, and this not only made him different from his male peers, but also from the girls he was dating. Greg did not want to kiss them, while they wanted him to do so. Repeatedly, this became an impasse in dating relationships for him, and his "last ditch effort," as he called it, in dating females ended during his sophomore year of high school when his girlfriend broke up with him because, she said, "It seems like we're just friends."

Greg's understanding of what this meant had evolved to that point, from initial nervousness about kissing, to uncertainty about whether he was "doing it right," to discomfort in what felt like an obligation, to keen awareness that he had no sexual interest in girls, to ultimately acknowledging that he could no longer put himself or his girlfriends through this impossible struggle. He had hoped that he would be able to date successfully and to be or learn to be heterosexual. When his final dating relationship ended during high school, he described that "if it couldn't work with her, who I liked more than anyone, then it was never going to work."

Where did that leave him, with still two more years left of high school? Greg's sense of comfort and belonging with his male peers had steadily decreased from elementary school to middle school to high school. The safety of elementary

school and the latency stage gave way to the uncertainty of middle school and the genital stage. Greg transitioned from one classroom where all school activities included boys and girls together to multiple classrooms, single-sex locker rooms, and a major shift in gender roles and expectations. Greg wondered who he was supposed to be and could he succeed as this person?

By seventh grade, Greg found himself increasingly drawn to and afraid of his male peers. Reminiscent of *Schopenhauer's Porcupines* (Luepnitz, 2003), Greg wanted to be close, to belong, to be accepted and affirmed, but he did not know how. He feared that in showing too much of himself, he would be rejected. Instead, he tried to hide his feelings in order to avoid rejection, but this did not conversely gain him acceptance. In attempting to blend, he made himself nearly invisible.

What he longed for, he could not have. Still, much of his longing remained repressed. Greg was attempting to hide what was conscious: the knowledge that he was gay. However, he could not consciously hide what remained unconscious: the longing for closeness, intimacy, and reciprocity with male peers. At the age of 20, he began to realize through the course of therapy that this longing permeated much more than an occasional interaction with a crush. His day-to-day interactions with male peers, which were many at his all-boys high school, were driven by his desire for mirroring and validation, but also his desire to have intimacy.

Greg's experiences of dating girls and his experiences interacting with his male peers captures what Bromberg (1998) calls "self organization." As Greg navigated an adolescence of cumulative trauma (van der Kolk, 2003), he experienced

a dissociative "knowing and not knowing" (Petrucelli, 2010) of what his feelings meant.

Greg shared that he had been frequently asked the question, "When did you first know you were gay?" His response varied from "I guess I always knew" to "I knew with certainty in high school when I stopped dating girls" to "I knew more and more as time passed." Greg knew and he didn't know. Or he knew but didn't want to know. He held onto hope for normalcy, that his secret would go away.

Greg's existence was marked by the hyperarousal of self-protection (van der Kolk, 2003). He had known what it was to live in constant vigilance, scanning for signs of danger, assessing each encounter for safety, questioning and testing each person for trust. He was especially cautious with men, given that his experience proved men to be most threatening (Bond, 2007). This vigilance was present in the room in Greg's trust issues with me (Dalenberg, 2000). As he had adaptively learned, Greg was constantly gauging whether he could be honest with me and whether I could be trusted (Nader, 2007).

For Greg, keeping a shameful secret in isolation was akin to trauma, like sexual abuse. In both cases, the shame was experienced as the victim's fault. The secret could not be voiced without the risk of dangerous consequences: ridicule, compounded social isolation, punishment, blame, physical injury, and death.

As a gay male, Greg was victimized and abused mostly by straight males. No one was more dangerous or threatening to him throughout the course of his life. Even as a 20 year-old college student, Greg still engaged in the day-to-day, hour-by-hour assessment of each man that he met, cautiously determining whether he was friend or

foe. Like any victim, he had the burden of adjusting and accommodating, depending on the level of acceptance or rejection coming from the other party. He sensitively determined how much of himself could be safely tolerated. He was expected to compromise himself because the dominant male perspective would not (Bond, 2007).

 This case-by-case vigilance was further complicated in that his enemies and his friends were physically identical. His victimizers were men, and the objects of his sexual attraction were also men. His vigilance about safety and acceptance coincided with searching for love, as he sought gay men in a vast pool of mostly straight men.

What further compounded these issues of vigilance, gender, shame, abuse, and sexual attraction was the connection between sexual enjoyment and guilt. Like a victim of sexual abuse, Greg was blamed and punished. He was made to feel shame and responsibility for his secret. He learned that there was nothing he could do – that he had to remain silent (Howell, 2005). Alone in his secret through adolescence, he had no one to explain his same-sex orientation. The objects of his attraction were the very people to whom he could not indicate his feelings, for fear of exposing his secret. This would mean rejection, ridicule, and violence. He was forced to remain silent and to tolerate the majority's wishes and perspective. At the same time, Greg's body was experiencing natural feelings of sexual attraction that painfully conflicted with his feelings of resentment, anger, hatred, distancing, and self-protecting vigilance. As Greg learned to feel guilty and responsible for his conflicting feelings, he took the blame for feeling attracted to his oppressor. In carrying this burden, he learned that his worth was less than those around him, less than those who victimized him. He also learned that his power was much less than theirs (Howell, 2005).

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Being forced into a position of keeping shameful secrets and hiding feelings without receiving validation or support for them, Greg learned that his feelings were not worthwhile or purposeful. In fact, his feelings betrayed him and resulted in punishment and abuse. He hid his feelings in order to protect himself, and being honest about them only led to disappointment.

During high school, had Greg been able to have one friend, or even boyfriend, with whom he could express his feelings openly and have them reflected, accepted, and validated, his burden would have been eased. His burden of secrecy, restraint, and hypervigilance would have been lightened through sharing the experience with another, without the result of rejection. Therein was our work in psychotherapy.

Greg's ability to tolerate both rapid affective involvement and rapid affective disengagement was critical to our work (Mann, 1973). Our therapeutic foci were threefold: fostering a strong attachment in the therapeutic relationship, validating his lived experience, and processing the cumulative trauma of his development. In order for Greg to move forward in his ability to make life decisions, he would have to know himself, particularly his lost self that he so effectively repressed over many years.

Considering Greg's experience of his family, teachers, and peers, my goal as his therapist was to create a new, corrective relationship with him. Thus far, the dominant communication regarding his sexual orientation was fear. In contrast, my way of being in the room communicated ease and comfort with myself and with Greg. This communication was complex and was intended to achieve not only a bond of attachment that he had lacked but also to model for him an adult gay male who did not experience himself with shame. It is uncertain whether or not Greg

consciously knew my sexual orientation, but it is likely that his experience of me was once again in the "knowing and not knowing" territory where his own self-awareness once lived.

In creating this new relationship and introducing a new perspective, I strove to shift Greg's focus. I reacted to his disclosure of his being gay as unremarkable because I recognized the importance of the newness of this response. In this way, I communicated not only that being gay was not shameful, but also that I was both comfortable and experienced interacting with gay people. I emphasized that the shame was not in being gay but in the unfairness of how Greg had to live as a result. The choice was not his – whether or not to be gay. The choice was theirs – how they treated him as a gay male.

Indeed, I did not take a "neutral" stance. In caring about Greg, in hearing his pain, and in wanting to help, I was not a blank screen or a sounding board. It was essential for me to take a stand, as with any victim of trauma. There was no ambiguity in my reaction to the injustices Greg faced. He had not experienced anyone, especially another male, who powerfully and unequivocally stood by him and supported his experience. In experiencing me this way, Greg could then recognize and seek out validating relationships in his own life, while also gaining empowerment in a new view of himself.

Greg had learned that self-expression was dangerous, yet I was asking him to express himself to me every week. Through a trauma-focused lens, we looked at Greg's experiences of fear, safety, control, and agency. We created a safe environment where emotional expression did not have dangerous consequences.

To create this new experience, we considered Greg's past experiences: what had he lacked and what did he already have that should not be replicated? Above all, Greg's lived experience had not been validated. Chief among my techniques was the simple art of reflection and mirroring, with constant, consistent repetition: "I see you," "I notice," "I observe." In many cases, this was to bring to his attention aspects of himself that had been repressed. He had been so good at hiding for so many years, in part because, as he remarked, "No one ever said anything to me." In a desperate game of hide-and-seek, Greg was hiding, and no one was trying to find him. In our work together, I aimed to communicate to Greg my sincere desire to find him.

Chapter V

"Peter"

Belonging

"I'm on the outside looking in."

Peter was a 29 year-old white, non-practicing Jewish, male, graduate student in the social sciences. He was self-referred and reported depression and "negative thinking." Peter presented as a stereotypical "stoner" and "loner" and, at the start of psychotherapy, smoked marijuana every evening and drank approximately three to five beers, three nights a week. He also frequently paid for online video chatting with male models, often while engaging in drinking and smoking. His presentation was groggy. He would wake up immediately before our 11:00 AM appointment time and generally appeared to be still waking up as our sessions began. He showed a guarded exterior, a persona that is too "cool" to show a wide range of emotion or to volunteer descriptive details. He sat in a slumped fashion and spoke in a low, lazy voice. His presentation, posture, and tone displayed an expectation that the therapist was responsible for driving the session and determining the route, while the patient would join as a passenger who had free reign to apply the brakes and veto the travel itinerary.

Peter's life was marked by social isolation and withdrawal. During his adolescent years, he never had close friends or a sense of belonging to any group. He spent much of his afterschool time alone in his room. His parents typically gave him his space, without much inquiry or acknowledgment that he was lonely and unhappy.

His mother would alternate between "nagging" him with a barrage of questions about his wellbeing and leaving him alone entirely. His father, whom Peter described as a "workaholic alcoholic" was only home in the late evenings, when he would drink alcohol and smoke marijuana nightly.

Peter oscillated between framing these childhood experiences as positive and negative, and he readily scapegoated his school peers, while refusing to assign any responsibility to his parents. He lamented that he was lonely and isolated, but prided himself in the independence his parents allowed him. He also framed his outsider status as an indication he was smarter and more worldly-wise than his peers.

Peter gave the impression by the end of the first session that he would reliably attend weekly 50-minute sessions for an entire year, and in fact, he did. He specifically requested a male therapist and also gave the impression upon meeting me that my relatively young age was also his preference.

Peter was in distress over a lack of any intimate relationships in his life. At the start of therapy, he had not dated or had sex in ten years, since losing his virginity at age 19 as a college freshman. As a child, he experienced his household as chaotic and unsafe, with an alcoholic father who was repeatedly unfaithful to his mother and a mother who tolerated this behavior without assertiveness or confrontation. In his professional life, Peter felt he was never good enough and was constantly anxious over gaining the acceptance of his supervisors. In his personal life, he felt that he was never physically attracted to males his own age who seemed kind and well-mannered. Instead, he was attracted to older men whom he perceived as controlling.

A graduate student, spending much of his time alone at the library and at home, Peter shielded himself from contact with his invalidating home environment as well as any replication of this environment. The library and his apartment were relatively safe environments with minimal risk of the dangers of social rejection, ridicule, vulnerability, or scrutiny. Within these confines, Peter's social life and sexual outlet primarily consisted of his regular habit of visiting a for-pay website, where he would chat with online, on-camera models. Off camera himself, Peter remained safe and anonymous, protected from the rejection he feared, and further protected in the knowledge that he was paying for a service and would therefore be accommodated, not neglected. These were his only sexual relationships, safe and comforting.

Early in the course of therapy, Peter recalled the following memory from his freshman year of high school:

> I was on the schoolbus for a fieldtrip, sitting in the back corner by myself. And I remember this extraverted sophomore. He sorta glowed with a spotlight wherever he went. I saw him laughing and telling stories and getting a lot of attention. Then I saw him turn to another kid, and I heard him say, "Why is this dude staring at me?" I turned to look out the window and wished I could disappear.

In that moment, Peter wished he could go unnoticed. He was unaware of how others perceived him, unaware that he was neither blending nor disappearing. He let out a sigh of resignation and said, "I'm on the outside looking in."

Peter's developmental conflict could be characterized as belongingness vs. isolation: desire to belong versus fear of not belonging. This differs in part from Erikson's (1968) Young Adult stage of Intimacy versus Isolation in that it permeated his experience throughout his life and is characterized by a core fear of rejection. He

feared being rejected in countless ways: physical violence, public humiliation, neglect, and exclusion among them.

Prior to this treatment, Peter had seen another therapist the year before. Although he felt that this therapist was competent, he felt bullied, misunderstood, and neglected by him in his reaction to Peter's online habit. When Peter entrusted the therapist with his shame about what he had been doing – shameful to Peter for many reasons including the considerable amount of money he was spending – the therapist responded with the certainty of a model of therapy that he, and many of us, had been taught: "We are not going to focus on the behavior itself but rather the purpose the behavior serves for you." This intervention is not necessarily unsound, as it seemingly prioritizes the patient's emotional needs, overwhelming feelings, and dissociative coping mechanisms.

The mistake of this therapist's intervention was not in the formulation, which is reasonable, but in the inflexible certainty with which it was approached. The therapist established a rigid boundary, drawing a line that the patient was instructed not to cross. This inadvertently reinforced the patient's longstanding sense of isolation, shame, invalidation, and helplessness. What was replicated for Peter was the message that his feelings and what he wanted to express were not important. Peter had learned over time to put the agenda of others ahead of his own, and now in therapy, he was repeating this experience of rejection when attempting to trust and engage. Among the problems here was that Peter was overwhelmed by his feelings and was unable to confront them directly, as the therapist aimed to do. Instead, Peter was asking the therapist for a more palatable approach: for the therapist to stay with

Peter in addressing his experience of the behavior first so that he could better understand it.

Additionally, there was the reality that in the course of that therapy, Peter's unwanted behavior did not change, and in the year that followed, it increased. Peter reported a decrease in distress over the behavior, as he learned from his therapist's modeling that his distress over spending large sums of money, creating credit card debt of several thousand dollars with no income, and spending all of his free time at home online by himself were all secondary. The primary focus, he learned from this therapy, was his underlying emotion that this behavior served to escape. And escape he continued to do.

Silberschatz (2005) asserts that each patient has an unconscious plan that is "highly individualized and case-specific" (p. 9). From the start of his prior therapy and his therapy with me, Peter clearly had an unconscious plan: a sense of what he needed and what would be effective for him. Given a variety of circumstances at the start of his treatment, I was compelled to value and respect this plan. Perhaps the most immediate and powerful factor was Peter's prior experience in therapy, where he felt his plan, which was partly unconscious and partly conscious, had not been respected. Peter had already felt bullied into an inflexible treatment that suited his therapist's conscious plan, and we were now in a situation where I very nearly enacted the same bullying.

The information I was given from Peter's fifteen-minute phone intake (done by another clinician) identified Peter's nightly marijuana habit as a major concern. My supervisors suggested that I immediately focus on referring Peter to an on-

campus drug and alcohol counselor, as his drug use appeared to be most pressing and would interfere with the therapy process.

During our first session, Peter explained that he wanted to work on his negative thinking and depression, and that he did not want to discuss decreasing his marijuana use, which he found to be more helpful than harmful. Likewise, by our second session, when I gently directed him toward the topic of his parents and their role in his adolescent loneliness, his response was unexpected and intimidating. Rather than using any words to explain that he preferred to focus on other topics, he very strongly and coldly shook his head. In one fell swoop, without uttering a word, he communicated that I was off-track in my interpretation and that he would not acknowledge any negative feelings toward his parents. My mental checklist from supervision was now exhausted, and my hands were tied. I was at a crossroads, where I could push further like his prior therapist had, or I could choose to honor his unconscious, or perhaps somewhat conscious, plan.

The treatment of this case exemplifies what Stark (1994) and Luepnitz (2002) call "a yes and a no" (p. 2 and p. 78, respectively). Stark (1994) states, "There is always a tension between [the patient's] investment in changing and his reluctance to let go of his old ways of doing things" (p. 3). Luepnitz (2002) echoes this: "everyone who seeks therapy brings a desire for and a resistance to therapy" (p. 78).

Despite his tough exterior and discomfort with displaying his emotions in session, I felt certain from the start that Peter was invested in the process. "It helps me," he informed me at the end of our first session, as if to say that he was already accustomed to the process from his prior experience. This was also his first of many

indications that I played little role in helping him. His frequent message was that it was his coming to therapy and the process of therapy that were helpful, not anything I did.

Wolf's (1988) discussion of transference, particularly devaluation and idealization, are pertinent here and are reiterated in Stark's (1994) explanation of positive and negative transference. What surfaced for many months as Peter's devaluing my ability ("I am doing much better, but I don't want you to think it's anything you're doing") and my vocabulary ("Funny that you used the word 'imaginal' instead of just saying 'imaginary'"; "Neat? Did you just say 'neat'?") became more accurately characterized as fear of idealizing me, fear of becoming close with me, fear of showing me his feelings, fear of being rejected by me. Analyzing this transference was crucial to our process. Peter distanced himself from me and from others in many ways, including devaluing others in order to justify his loneliness and depression: "They don't get it (or me), so they are happy and stupid. I get it, which is why I am depressed and they are not."

Stark (1994) suggests that, although I may have wished that Peter could openly and freely feel his feelings without resistance, he needed to hold onto his defenses in order to cope. Peter preferred to believe his depression and loneliness reflected his own superiority and the shortcomings of his peers. Peter was comfortable with unloading the entirety of the blame on them. In contrast, as Stark (1994) reminds us, "it would simply hurt too much were he to confront the intolerably painful reality" (p. 6) that his parents also played a significant role by neglecting his emotional needs. For Peter, it was easier to frame this in a positive light, that his

parents' neglect was actually their way of giving him freedom and independence. Stark (1994) provides insight into Peter's need to hold onto these beliefs about his parents, that Peter invested "in being self-sufficient because his parents were not people he could rely on" (p. 6).

Peter's transference was powerfully and vividly reminiscent of Ainsworth's (1978) Strange Situation. Peter enacted with me an anxious-resistant attachment style, where he sought for me to neither nag nor ignore him. He wanted me to care and remain invested without pushing him. There was a constant push/pull, yes/no, "this is helping me but you are not," "leave me alone but don't go away." His ambivalence was such that he wanted me to remain close but did not want me to *do* anything.

Davies and Frawley (1994) shed light on this aspect of treatment in their discussion of "the unseeing, uninvolved parent and the unseen, neglected child" (p. 168). Peter identified with his neglectful parents, especially his father who was depressed and smoked marijuana nightly, and therefore cast me in the role of his disowned, neglected self. Peter was at times what Davies and Frawley (1994) call "profoundly withholding" (p. 169), while also neglecting and devaluing his own feelings. Although Peter's parents loved him, cared for him, and did their best – as Peter often reminded me – they gave him the message that attending to his feelings was unimportant.

Peter experienced me as the "unseeing, uninvolved parent" (p. 170) when he let me know that my interpretation was inaccurate, that I didn't understand him (Davies and Frawley, 1994). Having experienced this neglect from his parents, Peter

then repeated this pattern with his peers in his life, and then with me in therapy. Not only was he identifying as neglected child, but he was also identified with neglectful parents, who communicated to him that he had to gratify their needs in order to keep them interested and around. Peter's younger, heterosexual brother was able to correct Peter's failures by being born and fulfilling his parents' expectations. Peter's brother was able to do what he could not, and for Peter, this meant that his brother was more loveable and deserving of attention.

More prevalent, however, was Peter's experience of me not as the neglectful mother but the nagging mother. His own mother, who oscillated between the two roles, tended to bombard him with questions about her worries and concerns. His ambivalence was characterized by statements like, "I want her to leave me alone, but at least I know she cares and is trying." He preferred nagging to neglect, although he challenged me to avoid both. He frequently sat in silence, as we waited together. As the silence became increasingly uncomfortable for him, he generally requested that I direct some specific questions to him. My first preference was to avoid complying with these requests, in favor of exploring his discomfort and feelings in the silence. However, on occasion, I complied and asked him some more directive questions. Although he tended to be initially appeased, inevitably he became dissatisfied with my line of questioning, giving me one-word answers or complaining, "We always talk about that," etc. Nag me, but don't nag me. Leave me alone, but don't leave me alone.

Luepnitz (2002) and Davies and Frawley (1994) emphasize the importance of recognizing and making explicit the transference-countertransference paradigm.

Countertransferentially, I often felt, as Davies and Frawley (1994) suggest, "deflated" (p. 174). Peter's fears of neglect and hopelessness about relationships led him to restrict me in what he would and would not accept from me. As a result, I was left feeling equally ambivalent: I wanted to help, but I felt inept when my tools were taken away. Wolf (1988) offers comfort to such a devalued therapist as I:

> It is not the content of the information conveyed to the patient, nor the substance of the interpretations and interventions made, not the correctness of the therapist's conjectures, nor even the therapist's compliance with demands to 'mirror' the patient or be his or her ideal that is pivotal: It is decisive for the progress of the therapeutic endeavor that the patient experience an ambience in which he or she feels respected, accepted, and at least a little understood. (p. 100)

Indeed, Wolf's (1988) emphasis on "optimal responsiveness," "therapeutic ambience," and "corrective emotional experience" (pp. 132-134) proved invaluable in working with Peter's devaluing transference. Despite Peter's correct perception that my interpretations were not perfect and I was not clairvoyant, our experience over the year provided Peter with the start of a corrective emotional experience. Although Wolf (1998) notes that this does not necessitate role-playing by the therapist, I would consider that role-playing may indeed be exactly what we do in working through a corrective emotional experience. Like an actor, whose job it is to get at the truth, rather than to embody falseness, I deliberately and instinctively chose aspects of my tone and persona based on the particular needs of this patient.

Peter's particular needs became explicit through a thorough progression of transference tests (Silberschatz, 2005). At his own pace, Peter discerned his therapist: whether I could help him, whether I could be trusted, whether I cared, and whether I would respond to him as others have. Seemingly, Peter had a long checklist with the

following: mother, father, brother, classmates, friends, and teachers. He carefully

tested me to see how I was like these people and how I was different. Silberschatz

(2005) explains that the sometimes precarious art of passing transference tests can

involve a series of levels, where consistent boundaries can be very useful and

occasional slip-ups reparable.

Peter repeatedly tested me to see if I would nag or neglect him like his mother

(even while directly asking me to nag and neglect him), fluctuate in my emotions like

his father, assert unfeeling authority like his professors, judge him like his classmates,

or mock his feelings like his friends. Of course, the overlap between one relationship

and another is more complicated, and in proceeding with caution, I discovered some

key areas of overlap and areas that are critical to avoid. Although I would like to

think of myself as young and relatable to an undergraduate patient, Peter gave me a

reality check early on: "I like that you are not one of my friends and that you can

offer me a different perspective." I realized that, to Peter, I was neither young nor

cool, and that was a good thing. He wanted to share with me the experience of not

belonging and, in so doing, experience a new kind of belonging.

This brings us back to Silberschatz's (2005) notion of the patient's

unconscious, and sometimes conscious, plan. What I didn't initially realize is that

boundaries were so important to Peter not only because he didn't trust the judgment

of his peers but also because he identified their behavior with his father. Peter's

father saw Peter as a peer with whom he would sometimes smoke marijuana while

Peter was an adolescent. Peter's parents treated his brother in age-appropriate ways

but told Peter that he was mature beyond his years and, therefore, capable of

independence. Both parents relied on Peter to ease their own anxieties, and Peter's

father turned to Peter for a buddy with whom to smoke marijuana and commiserate.

But Peter did not want this kind of belonging. Peter's plan, from the beginning, was

to avoid having another pot-smoking father.

Accordingly, Peter's resistance had everything to do with differentiating me

from his other relationships, and thus, disconfirming pathogenic beliefs (Silberschatz,

2005). By ensuring that I was neither of his parents, he was relieved of his obligation

to take care of me, the way he had taken care of them. He was able to trust me and

express himself more freely because he felt that I would not betray this trust by

excessively worrying about him, as his mother would, or trying to be his buddy, as his

father would.

In this way, we see elements of Ogden's (1994) analytic third. The

"dialectical nature" and "dynamic tension" (p. 463) of the therapeutic process are

such that there is not only patient and therapist but also an intrapsychic, largely

unconscious "co-creation" (p. 489). Similarly, we see what Greenberg (1986)

explores in the "optimal tension" (p. 142) of the analyst's neutrality: "the analyst

inevitably participates somewhere within a historical continuum of the patient's

relationships with others" (p. 140). The therapeutic challenge with Peter was to strike

that balance for optimal progress. As Greenberg states, "If the analyst cannot be

experienced as a new object, analysis never gets under way; if he cannot be

experienced as an old one, it never ends" (p. 143).

In assessing this work with Peter, I recognize some of my initial shortcomings

in approaching this case, and I refer to McWilliams (2004), particularly her chapter

on "Preparing the Client" (pp. 73-98). In the earliest sessions, I did not sufficiently secure an alliance with Peter or adequately explain the therapeutic process. Although there were many reasons for this at the time, I would have preferred to more clearly address expectations of the process. Additionally, as I grappled with trying out new skills and approaches derived from new classes and supervisors, I rushed into technique before offering appropriate rationale. In the early stages of therapy, when I asked Peter about his feelings about the process or how he responded to me, he perceived this as being a therapist's insecurity because I had not taken my time with a clear explanation of the process. I took some of this for granted, but in retrospect, I could not be sure what Peter had or had not learned in prior experiences and would have been wise to err on the side of repetition. In this manner, a stronger start may have made it easier for Peter to express his feelings in the room, knowing that we were prepared and had a clear purpose in mind.

On a final note, evoking Buechler's (2004) chapter on "Inspiring Hope" (pp. 31-48), I feel compelled to highlight for the reader Peter's state at the end of our work together. I decided to honor his requests that I not push the topics of his parents and his marijuana use, but I planted a seed early on by mentioning the importance of these issues. About three months into treatment, Peter began casually introducing the topic of his family in session, often with the explanation, "I know *you* think it's important, so…." These became my windows of opportunity to gently guide him to explore his feelings about his family relationships on his own terms. Likewise, about five months into treatment, Peter began volunteering information about his ever-decreasing use of marijuana. Although I had avoided "nagging" him about this, I

frequently helped him articulate his feelings about smoking marijuana, as well as the benefits and costs of this behavior. Peter made his own decision to limit this habit, and he went from nightly smoking to about once every other week. Without my nagging him about these areas, he found his way at his own pace. Furthermore, while our dynamically-oriented treatment did not directly address scheduling, behavioral activation, or thought logging, as cognitive-behavioral therapy would, Peter grew to engage in a far more active schedule. He went from a self-proclaimed "loner" who played video games and smoked marijuana alone in his room, who had difficulty socializing, who believed he did not deserve a boyfriend – to a much more social person, who recognized that he feels better when he is with people, who was planning a cross-country road trip with friends, who began a mutually attentive and respectful relationship with a 30-year-old boyfriend. All of these areas were not directed activities of treatment designed to create good feelings, but rather, feeling better happened first and then came the behavior. Thus, both patient and therapist have been inspired with hope.

Chapter VI

"Andrew"

Identity Development

"I feel like one of the victims myself."

Andrew, a 26-year-old, single, white, male graduate student, came to therapy in a state of overwhelming depression. He lived in constant uncertainty about his future, his place in the world, his worth. He said he felt like a "square peg in a round hole," that he had been told all his life who he was supposed to be, but he felt unable to be that person. Above all, he was unable to be heterosexual, which according to his family and religion was his biggest failure.

At the start of psychotherapy, Andrew reported that he was feeling depressed, frustrated, and overwhelmed with school. He stated that he had "bad thoughts" about wanting to be dead. Andrew reported anxiety and depression related to job seeking. He reported low self-esteem and increased anxiety about performance on job interviews and sexual performance. He described both areas as extremely daunting tasks, where he felt the need to "oversell" and overexert in order to achieve any success.

Andrew was raised in a conservative, religious household with his parents and two older brothers. He learned to place the needs of others ahead of his own and to assume responsibility for the problems of others. While taking on the problems of others and adopting a "martyr" identity, his unconscious anger and resentment grew. He came to therapy in a state of depression, turning inward his overwhelming anger

toward his family, church, friends, and teachers. To him, this anger felt more manageable and controllable when directed toward himself because it avoided conflictual feelings toward loved ones and because it was consonant with his experience as a victim and martyr who deserved struggle and was responsible for pain.

Andrew expressed in our first session his passive ideation of being dead. He said these thoughts were isolated to when he was in class but later said he also felt this way when he was home alone. He presented as very comfortable in the room and related to me in a jovial, casual way, as though he were relating to a peer at a bar. When addressing difficult emotions, his affect remained casual and cheerful, as he moved on briskly to another subject. Despite his seemingly calm, comfortable presentation, he acknowledged feeling much calmer and better by the end of both of the first two sessions, saying he was very nervous at the start of each.

Growing up, Andrew was a stellar student and skilled musician, surpassing his older brothers in both arenas. He felt favored in his family at a young age, but as he grew older he became increasingly aware that he was gay. His older brothers, though not outstanding students or musicians like Andrew, were better at sports and in social situations. In his memory, this did not become a problem until he was in middle school, when boys and girls began to date and engage physically. It was at this time that the pressure of expectation, which Andrew had always felt, began to weigh far more heavily on his shoulders. He wondered how he could continue to live up to the expectations of his family and church unless he was able to date girls.

As a result, he did just that. He proceeded to follow the example of his peers by dating girls, and he did so throughout middle school and high school, recalling that this experience felt like a painful charade and a lie to the girls he dated. He was put in an impossible situation: admit his true feelings and brand himself a sinner, or hide his feelings and be a liar. Andrew had always succeeded in doing what he was told and being a good boy that it felt especially unfair that, despite his efforts and pure desire to be good, he would fall short no matter what. After making every effort to avoid such a situation, Andrew would be judged as bad no matter what he did.

Andrew experienced his parents as being more comfortable when he was depressed. He stated they didn't like him to "rock the boat" and that depression looked a lot like good behavior. The message he received was that his empowerment threatened them. They preferred a boy to a man, and they preferred to remain in charge as Andrew grew into adulthood.

Andrew's disempowerment affected him across many areas of his life, including body image. A skinny child who was validated for being "naturally thin," Andrew began to lift weights during puberty. He recalls his mother's reaction to his appearance after a few months as complimentary but uncomfortable for him in its diffuse boundaries. His father had shared with Andrew at around that age that Andrew's father and mother no longer had sexual intercourse, despite his father's wanting to continue to do so. As Andrew made efforts to grow into a man, it was met with confusing messages from both parents. Among them was the message to remain a skinny child in order to avoid threatening his parents.

Andrew learned that to live his life honestly and to receive equal treatment would be flaunting his lifestyle. He learned that if he was going to be gay, he should do it quietly and invisibly because other people don't want to hear it or see it (Neimeyer, 2001). The rule was to keep quiet while pretending to be someone else.

Andrew's ego was overwhelmed by ongoing anxiety in wanting to live up to the expectations of his family. He felt trapped in this impossible role and wanted to be free to be his own person, but focusing on pleasing his parents was also his way of avoiding the anger and shame of facing himself.

Andrew dichotomized what he wanted to do versus what he should do, who he was versus who he should be. He felt pressure to live up to expectation, saying that his parents "inflated" him to be something he was not, having career strengths and capabilities he did not have. He believed he would never live up to expectation, but he continued to try to reach his parents' standards.

Andrew's feelings of inadequacy began in early childhood. As the youngest of three brothers, Andrew felt he could never keep up. Just as he was still striving at age 26 to live up to his idealized brothers, he was always chasing their accomplishments as a child. His fear of falling short paralyzed him from taking chances and taking action.

His childhood was full of examples of this fear of falling short. He did not learn to find adaptive solutions in these instances, but rather he felt he needed to either succeed perfectly or not even make an attempt. He frequently gave up on childhood sports after the slightest error. He quit little league after the first practice where he didn't know how to throw the ball and also got hit by the ball. Attempting

one sport after another, he felt, "I am supposed to want to do this. What is wrong with me that I don't want to do this?"

Andrew lacked nurturance from his parents, who allowed him to quit in all of these instances without inquiring about his feelings or his experiences. He frequently felt shame in not knowing how to do things, and he didn't have anyone teaching him. He was given neither the emotional validation that his feelings were natural nor the problem-solving skills to ease anxiety through fostering competence and internal locus of control.

As a child, Andrew did not express his needs due to his shame of his inadequacy. Andrew feared being judged and being seen as inadequate. He acknowledged that he learned to "put up walls" to defend against "what I am really thinking." He learned to be highly effective in hiding his feelings of anxiety, protecting others from the burden of his anxiety and protecting himself from acknowledging it. This defense left the burden of his anxiety entirely on his shoulders, without the ability to seek help from those in his life. The feelings that for years he so successfully avoided volunteering returned to the surface involuntarily through suicidal ideation.

During the course of psychotherapy, Andrew had stopped attending church, which he had attended every Sunday throughout his life. He tearfully explained his feelings:

> I had such a hard time with the sex abuse scandal in the church. It's weird, I feel like one of the victims myself. It's so wrong. To be so mistreated. And what did any of those kids do to deserve it? And then to have to keep it secret, all by yourself.

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Andrew identified with the victims, who were forced to comply with their abusers' wishes and forced to keep secrets. The betrayal of trust by religious authority, hypocrisy of double standards, and isolation of secrecy and shame were intrinsic to his childhood and adolescence as a gay male. It was as if he had been a victim of traumatic abuse because, in a way, he had (Dalenberg, 2000).

Andrew had not learned to tolerate anxiety, as evidenced by his splitting. He viewed events and people, including himself, as either all good or all bad. Most of the time, other people were all good, and Andrew was all bad. He considered his brothers to be perfect, while he could never be as good. His classmates were "true academics," while he was not. His parents were successful and hardworking, while he was not.

Splitting was also evident in his problem-solving behaviors throughout his life. "Either I will be a perfect athlete on my first try, or I will quit." "Either I will write a perfect paper very easily, or I won't do the assignment at all." "Either I will earn a Master's degree and succeed in that field, or I will drop out of school and work in a coffee shop."

Andrew utilized these defenses throughout his childhood, while his parents approached his feelings with their laissez faire approach. They allowed him to quit countless activities without adequate consideration of his feelings and experience, and Andrew learned that when he defended against his feelings, people would leave him alone.

Andrew adopted the role that his family taught him: the "life of the party" to cope with emotions. He learned that being strong means an outward presentation of

composure, which Andrew mastered. The family's interaction was centered on food and alcohol, which was both in keeping with their Italian-Irish culture and a means of cutting off from unwanted feelings. Drinking alcohol together allowed them to distance from pain and create a sense of joy and togetherness.

Accordingly, Andrew learned to cut off from his unwanted feelings, namely his anger toward his parents and brothers for neglecting his emotional needs. Instead of acknowledging and experiencing this anger, Andrew directed his anger inward. His ideation of self-harm and his constant negative self-appraisal were means of self-punishment and a way to direct his overwhelming anger. He could not tolerate any anger toward his family members, who were not there for him as coaches or teachers when it came to sports or school. Andrew's affable sociability defended against his underlying hostility.

As he was in the final stages of graduate school, Andrew was in the process of searching for a job. He reported that as time passed, his anxiety about finding a suitable job increased, as did his feeling of hopelessness about his future career. As his fellow classmates were finding jobs, Andrew felt that they were judging him and wondering what was wrong with him.

Andrew's boyfriend suggested that they cohabitate and admitted that he was thinking entirely about alleviating the cost of rent by sharing the cost with Andrew. This suggestion came only after Andrew secured employment as an office temp. Before this, Andrew's boyfriend had been possessive of his apartment and would not give Andrew his own key, despite the fact that this would have spared Andrew a long daily commute to and from his graduate school, which was located near Andrew's

boyfriend's apartment. Andrew's boyfriend frequently talked about his job that he loved, and Andrew felt comparatively inadequate and unable to contribute financially.

With his parents and his boyfriend, Andrew said that they asserted their thoughts and feelings to him without being receptive to his thoughts and feelings in return. He stated that in order to avoid conflict, he hid his thoughts, feelings, and desires. Where his career was concerned, this meant hiding his career goals from his parents, who disapproved.

Andrew expressed intense anxiety about sexual intercourse with his boyfriend and reported chronic problems with sexual performance. He felt inadequate in his competence and ability to please his boyfriend, and he also felt that his boyfriend was not concerned with pleasing Andrew in return.

Andrew reported feelings of guilt and remorse over a past psychotherapy experience, indicating that he grew too attached and dependent on his male therapist, and that he felt disappointed in the therapist's response to his behavior. He also repeatedly assured me that he would be very reliable with payment and indicated that this had been a problem in his previous experience.

Andrew recalled as a child seeing his father succeed in his professional life, while his mother remained frustrated and unfulfilled professionally. Andrew observed the effect this had on his parents and decided that he would much rather be like his father, despite his father's cold, distant, and narcissistic personality, than his mother, who brought home her frustration and often used Andrew as a scapegoat for these feelings.

Andrew learned that he was to blame for his mother's feelings and that he was expected to match his father's professional standards. He learned that he was responsible for his parents' emotional and physical well-being and that he was expected to achieve success while simultaneously remaining closely tied and loyal to his parents, putting their needs and desires ahead of his own.

Andrew's parents paid little attention to his likes and dislikes, and when he expressed interest in careers that involved writing and creativity, his parents repeatedly expressed disapproval and said that he was not allowed to pursue those careers. His parents prized financial stability and status above job satisfaction.

Andrew's parents instilled in him the belief that their unhappiness was his fault and his responsibility. He learned to put their well-being before his own. Throughout his life, he pursued academic and professional achievements as a means to making his parents happy. Despite his many achievements, his parents' unhappiness was not alleviated, as they dismissed and discounted all that he achieved. Andrew adopted his parents' behavior and expectations. No matter what he achieved, he refused to acknowledge his achievements, as he continually set the bar higher and higher. When he did accomplish something, he dismissed it as a fluke, and when he failed to meet a goal, he considered that evidence of his worthlessness.

Anticipating the completion of graduate school activated these beliefs in that Andrew was faced with what he considered the ultimate test of his worth and his ability to make his parents happy: finding a job. Because of his father's high standards which Andrew adopted, he turned down suitable jobs because they weren't

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good enough. He discounted these job offers and focused instead on the "perfect" job that he was unable to secure.

Psychotherapy with Andrew involved attacking defenses in session in order to break defensive patterns of agreeability, negative self-appraisal and blame, and feelings of helplessness. At the core of Andrew's feelings were inferiority and shame, and underneath those may have been anger at his family's lack of attunement. These feelings shaped his interpersonal patterns in his compulsion to live up to an idealized standard.

Among Andrew's underlying beliefs was that he was worthless and inadequate: "I am worthless," "Work defines my worth," "I am responsible for my parents' happiness." He sought constant proof of worth from external sources: his parents, his boyfriend, potential employers, etc. He identified job success as the ultimate proof of worth, but even more important to him was his parents' recognition of his worth. Even in his job search, he was especially concerned with the effect that securing a job would have on his parents. He believed that securing the "perfect job" would be a cure-all that would gain his parents' approval and love, his boyfriend's respect and sexual attraction, his peers' admiration, and his confidence and self-esteem. Because he felt inadequate, he viewed all daily events through that lens. Any negative event was further proof of his inadequacy, and any positive event was a fluke or a case of fooling someone by hiding his inadequacy.

Through the course of psychotherapy, Andrew made tremendous strides in self-acceptance and self-esteem. He gained agency, assertiveness, and ability to tolerate and accept his feelings and imperfections. He moved away from the need to

be like other people or please other people, toward self-realization and positive self-regard. His relationships with his family improved, along with his outlook on school and career. Andrew's helplessness and despair subsided, while his sense of hope and engagement grew. Andrew stated that the therapeutic relationship was a meaningful factor in these changes: having someone to shoulder the burden of despair, to truly listen and validate his feelings and worth, to remember and take time to think about the details of his case from week to week, to clarify interpersonal themes and patterns, and to unconditionally accept and like him for who he was.

Chapter VII

Results

In the phenomenological analysis of the three developmental categories represented by the three composite cases, validation (Greg), belonging (Peter), and identity development (Andrew), essential themes emerge across subjects. Invalidating experiences (Greg) and lonely isolation (Peter) become part of a person's development and identity (Andrew). While each case characterizes one category, the three cases and categories powerfully interrelate. The phenomenological analysis and synthesis of these categories results in emergent themes that can be considered with multi-directionality in mind. Lack of belonging is experienced as invalidating, resulting in an identity of an independent loner. Invalidation or rejection speaks to the development of self-esteem, both frustrating and amplifying one's yearning to belong. Sublimation of self-needs and adoption of selfless identity yield validation through external achievement based in pleasing others. Thus, one's sense of belonging is defined entirely by what others gain and what others think. One seeks validation based on anticipating reactions, accommodating demands, and avoiding reciprocity. In infinite ways, Greg, Peter, and Andrew represent a dynamic interaction of emergent themes of gay male development.

Dissociation

Many of these themes can be viewed through the lens of trauma. Stemming from the unmet developmental needs surrounding belonging, validation, and identity

development are the accumulative symptoms of traumatic experience. Across cases is the theme of dissociation through the numbing effects of substance abuse and the voyeurism of pornography, online video chatting, and television. These learned behaviors became habits that served the crucial purpose of tolerating overwhelming feelings. When constant attempts, both conscious and unconscious, to connect, experience, and express proved repeatedly unsuccessful, unfulfilled needs were met, at least in part, with compromised solutions. Internal feelings conflicted with external realities, and the instinctive urge for intimacy clashed with the instinctive urge for safety. To choose one meant losing the other.

Compromises and solutions were found. Dissociation allowed for temporary alleviation of overwhelming sadness, frustration, anxiety, and anger, none of which were experienced as being allowed, much less purposeful. Greg, Peter, and Andrew found themselves constantly in a double bind, forbidden to express their feelings but unable to hold them in. Loneliness, isolation, and shame resulted in learned helplessness, as every choice was fraught with danger and fear. They found ways to dissociate from these seemingly impossible emotions, and in states of dissociation were able to experience their feelings honestly, while anonymous, safe, passive, and hidden. Online models were sources of acceptance, able to give attention and validation unavailable among peers. Television characters became safe friends who were approving, assertive, and free, again providing a vicarious experience that was otherwise lacking.

Hypervigilance

Learning to approach every interaction with fear and caution, subjects became hypersensitive to and perceptive of danger, another behavior that initially proved adaptive and valuable to survival. Throughout the course of development, they engaged in day-to-day, minute-by-minute evaluation of every situation and every person: friend or foe? Safe or dangerous? Accordingly, they censored and questioned every behavior of their own, wondering which move to make and whether expressing themselves would reap treacherous consequences. Not only did this apply to the unending, self-disclosing process of coming out, often occurring without choice or agency, but also to the everyday process of encountering strangers, revealing oneself, and expressing opinions, likes and dislikes, joys, and woes.

Anxiety

Across cases, anxiety was prevalent, and symptoms of panic and fear were major characteristics of subjects' developmental experiences. Unmet needs of commiseration, camaraderie, and connection, which are fundamental to the prevention or alleviation of overwhelming anxiety, resulted in an experience of aloneness and despair. Accompanying this presentation of anxiety was the helplessness of depression, and at the root of these feelings could be repressed rage. Subjects learned that anger was not permitted, while their anger grew with their sense of injustice and inequity.

Microaggression

Insidious in these experiences was the relentless microaggression in their lives. Their lived experience was of language that equated their intrinsic sexual orientation with weakness, worthlessness, stupidity, incompetence, and deviance. Their experience was in a heterosexist, heteronormative culture where the best thing to be is a straight male and conversely the worst thing to be is a male who lacks straightness. Idealized images on television and popular culture paralleled more immediate idealization of peers who fit a certain mold, one that was placed on a pedestal. To be the star of the movie, the standout of the team, the leader of the school, the CEO of the company, the President of the country – they were instructed to be straight. Locally and globally, the priorities most strongly and loudly communicated were winning the battle, scoring the victory, making the conquest, getting the girl. Happy endings were made of such things. Greg, Peter, and Andrew were either denigrated in or excluded from the script.

Shame

Without sufficient support or opportunity for self-expression, subjects directed their feelings inward. Their secret – being gay – was something they didn't choose and they didn't want, but the blame and the burden, nonetheless, were theirs to carry. Unable to understand or process why they should be treated as such, they internalized the feeling, if not the conscious belief, that they were inferior.

True Self/False Self

When their needs and lived experiences were repeatedly negated over time and the perspectives of others given greater credence, subjects participated in a pattern of interaction that was experienced as loss of true self. Their false self was rewarded and reinforced, and subjects both consciously and unconsciously chose to play their part. The true self, integrated and whole, moved toward dormancy, while the false self became familiar and parasitic to the identity. Subjects experienced this as a pivotal loss, as cutting off parts of themselves seemed necessary and inevitable. Once lost, these aspects of true self felt irretrievable.

Identifying over time with a Winnicottian (1955) false self or Jungian (1971) persona, subjects felt unable to identify or access their true selves and their concordant desires. Their desires proved ineffectual, and their agency was discouraged. Assertiveness became increasingly challenging, initially because it was not validated. Eventually, subjects' problems asserting their emotions and needs were compounded as they became less able to identify their needs. True self gave way to false self, feelings were inconsequential, and responsiveness diminished. Uncertain about who they were and what they wanted, subjects did not know how to choose. The result was the indecisiveness of anxiety and depression, rooted in a life vision ranging from uncertain to bleak.

Avoidance of self

Subjects opted to wait it out. Hiding, getting through, numbing, and ignoring were their goals, not knowing that these temporary goals would become longstanding

habits. Delaying their own happiness and satisfaction for the duration of their teenage years, they came to psychotherapy in their twenties reeling from the aftereffects. They believed that the passages of life, among them the process of coming out, would bring clarity and peace. Instead, they found a void that came from inexperience. They came to therapy in need of a new experience – of themselves, of others, of relating to the world.

Invisibility

Subjects learned to go unnoticed. Others couldn't see them, and they lost sight of themselves. They lacked mirroring, they lacked reflection, and they lacked acknowledgment of who they were and what they were experiencing. Invisibility became the ultimate solution. Invisibility was the way to repress the developmental needs of validation and belonging. Invisibility was the identity they became.

Discussion

Historically, we have lacked adequate and accurate understanding of validation, belonging, and identity development in the gay male population. Because of their unique status in society, gay males are limited in their role models, outward expression of identity, and integral community. Greg, Peter, and Andrew found themselves lost in the lifeworld of not being allowed (Husserl, 1970). Just as they were often not allowed to feel their feelings, not allowed to voice their thoughts, not allowed to live their lives, they were also not allowed to protest this status.

The life experiences of Greg, Peter, and Andrew are as much about what they haven't had as they are about what they have. Their experiences are about who they're not as much as who they are. They are not straight men. They have been victimized by men, rejected by heterosexuals, and seemingly betrayed by their feelings. They failed to meet the standards of masculinity that were so prized in their environments.

What can be derived for psychotherapeutic recommendations? For Greg, in his lived experience of invalidation, tools of psychotherapy would include mirroring, attunement, and validation. For Andrew, who represents fixation in identity development, major therapeutic goals could be corrective emotional experience and reinforcement of becoming and integrating himself. For Peter, representative of an unmet developmental need for belonging, an empathic psychotherapeutic relationship should emphasize acceptance, joining, and unconditional positive regard.

Peter's prior experience in psychotherapy provided an opportunity for us both to consider a rupture and to repair it. His therapist framed his habitual, dissociative behavior as having underlying meaning and purpose, and the therapist was correct. However, the therapist then set a boundary that their process would not include addressing or discussing the behavior itself but only the emotions involved. Why did the therapist set this limit? Consciously, the therapist was sticking to his theoretical model of intervention, where Peter's behavior was simply a manifestation of underlying feelings that were fundamental to the treatment at hand and worth targeting. While this makes sense, I caution therapists in working with gay male patients (or any patients) to beware of their own blind spots and prohibitions about what constitutes therapy and what does not.

The word "behavior" does not have to be taboo in the course of psychodynamic psychotherapy. In fact, in accommodating Peter's request to discuss the particular behavior rather than or in addition to his unconscious feelings behind it, a therapist could gain access to present-day feelings as they relate to the behavior and the patterns of his past. Indeed, this would constitute a phenomenological approach.

Where sexual behavior is concerned, particularly with gay patients, we therapists must be mindful of our own level of comfort. If we are uncomfortable with discussing homosexual sex, or sex in general, convincing ourselves that a patient is getting off track by processing his sexual feelings may be a way of justifying avoidance of topics that make us uncomfortable.

Accordingly, we do not pass a patient's transference tests (Silberschatz, 2005) when we show them that we are uncomfortable with an area that is meaningful and

important to them. In rigidly sticking to our protocol of what we consider proper psychodynamic psychotherapy in our handling behavioral patterns, we lose an opportunity for attunement with the patient. Perhaps more important to the patient in this instance than the topic for discussion is the need for this attunement, to know that we will stay with them, that they are safe to discuss their secrets, explore their feelings, and release their burdens. With gay male patients in particular, who have been told that their feelings and instincts are wrong, our openness to their therapeutic needs is critical. In the context of a safe therapeutic environment that allows for such freedom of expression, often the expression will abound as though released from a floodgate. So great and so overdue is the need to be heard and allowed.

Greg, Peter, and Andrew do not want to be told that they are limited in their capacity to relate. Although this may be a defense and part of their self-concept that makes them feel good, as Nader (2007) attests, it is also a shared and empowering reaction to the reality that they are more than the limiting categories in which they have been placed. They are not gay or male in only the limited ways they have been told they can be.

In my psychotherapeutic work with the subjects of this study, I strove to build the "rapport and acceptance" (p. 182) that Nader (2007) describes. Although my sexual orientation was never explicitly disclosed, my work was informed, while mindfully not limited, by my own lived experience. What the subjects and I share is outsider status in society (Nader, 2007). Mutual rejection occurred between the subjects and society: society rejecting them because they failed to meet its standards of what a male should be, and the subjects because they rejected the subjugated and

stereotyped role that they were assigned as gay men. The standards of their families and their upbringing deemed them outsiders and rejected them, just as they subsequently rejected aspects of their upbringing and disidentified with them.

Limitations of the Study

While this study aimed to phenomenologically capture experiences of gay male patients and their development, it did not specifically examine the development of other groups of people by comparison. Therefore, the findings of the study are not to be understood as entirely unique to gay males, although they are likely to be especially salient for this population.

Likewise, as with any study of a specific population, the case presentations and results are not intended to represent all members of the population, nor do they capture the entirety of three people and their lives. The intention is to focus on particular aspects of the experiences of three gay male patients as they relate to unmet developmental needs and their relevance for effective psychotherapy.

A notable challenge in such a study is creating composite cases in order to protect the confidentiality of the patients discussed. From the perspective of experiential phenomenology, it is a delicate balance to determine which details can be changed without significantly impacting the completeness and essence of the presentation. When in doubt, preference was always given to removing patient details, in order to prioritize confidentiality.

An alternative or future study could consist of interviewing gay males and analyzing discrete variables quantitatively, or interviewing both gay and straight

males and examining variables through comparison and contrast with regard to developmental experience.

Conclusion

This study was an exploration of the components of the lived experience of gay male development, as experienced and processed in the context of psychotherapy. Approaching this material with a phenomenological eye, not to mention heart, soul, and intellect, afforded me a uniquely powerful empathic experience. These men whom I have been honored to know are case studies in strength, resilience, hope, and possibility. This study has been many things. Among them, it has been a profound exercise in the purposeful task of empathically drawing upon shared human experience and identity.

By infusing what I have learned in my clinical coursework and casework, I sought to address the intersection of sexual orientation and adolescent development. In so doing, I have begun an area of future exploration in my work. I have shared with the patients addressed in this study an experience that greatly enriched my empathy for them and allowed me to expand prior consideration of their experiences.

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