Cognitive and Environmental Interventions for Gay Males: Addressing Stigma and Its Consequences

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ABSTRACT

In order to maximize the effectiveness of their interactions with gay males, social workers must assess and address the impacts of stigmatization on their clients' mental health. Furthermore, they need to find ways to reduce stigmatization in their clients' environments. Using three case studies, the author will demonstrate how to help gay men overcome their gender-related reluctance to discuss the emotional impacts of stigmatization, and how to use cognitive therapy to diminish these impacts. The author will also illustrate environmental interventions designed to reduce anti-gay harassment in family and school settings.

Despite a growing body of literature describing the treatment of gay men (e.g., Appleby & Anastas, 1998; Greenan & Tunnell, 2003; Van Wormer, Wells, & Boes, 2000) surveys have shown that many clinicians, including gay and lesbian therapists, fail to acknowledge or assess for internalized homophobia in their clients (Edwards, 1996; Murphy, Rawlings, & Howe, 2002; Nystrom, 1997). Clinicians need accessible information regarding specifically how to identify the impacts of anti-gay oppression on gay clients and how to modify and apply existing models of treatment to reduce these effects. Using the case studies of three outpatient mental health clients, this paper adds to the knowledge in this area by demonstrating how cognitive therapy can help gay male clients acknowledge and reduce the painful consequences of living as members of a stigmatized group, and how social workers can combine individual and environmental interventions to reduce stigmatization and its impacts.

Stigma

Stigma is a personal quality or condition that is considered deviant and diminishes the bearer's worth and status (Dovidio, Major, & Crocker, 2000; Goffman, 1963; Link & Phelan, 2001). Emphasizing the structural causes of stigmatization, Link and Phelan (2001) assert that those in power label people who have certain distinguishing characteristics, such as mental illness or homosexuality, as deviant, and use this label to justify harassment and denial of civil rights.

Luchetta (1999) describes how stigmatized people are perceived to be at fault for their condition. For example, people who are obese are thought to lack discipline in their eating, and those with diseases such as AIDS or cancer are believed to have poor health habits or immoral lifestyles that resulted in their illnesses. Non-stigmatized people use these attributions to justify the oppressive

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treatment of the stigmatized and to defend psychologically against fears that they themselves are vulnerable to the stigmatizing affliction (Luchetta, 1999).

Gay men are clearly stigmatized, as evidenced by the fact that they are often verbally and physically harassed, and for the most part, denied civil rights and legal protection from discrimination because they are perceived to be choosing a deviant, abhorrent lifestyle. Also, some data suggest that those who stigmatize gays may be defending against fears of their own same-sex attractions (Adams, Wright, & Lohr, 1996).

Goffman (1963) describes how painful it can be to learn of a particular stigma and then later to find oneself bearing it. By the time a man realizes he is gay, he has been long influenced by societal forces that stigmatize gay people. He has grown up in a culture that labels gays as being sick and perverted, and therefore unworthy of love, respect, and civil rights (Meyer & Dean, 1998). Thus, as he attempts to reconcile his sexual orientation with his status as a stigmatized person, he could develop a devalued self image that bodes poorly for his mental health and ability to maintain long-term intimate relationships (Coffman & Green, 2000; Greenan & Tunnell, 2003; Meyer, 2003; Meyer & Dean, 1998).

The violence and discrimination that gay men face as a consequence of stigmatization can further jeopardize their mental health. Among samples of gay males, perceived stigma and reported incidents of discrimination and violence have been found to be associated with mental health problems, including suicidality (D'Augelli, Pilkington, & Hershberger, 2002; Huebner, 2002; Meyer, 2003; Vives, 2002). Thus, it is crucial that social workers assisting gay men assess and address the psychological consequences of stigma.

Sam

At intake, Sam was a 40-year-old graphic artist complaining of depression, low self-esteem, and suicidal ideation. He reported feeling depressed for most of his adult life and thought himself a failure because he was socially isolated and had no friends or boyfriend. Sam believed he was unattractive and therefore unlovable, and he avoided social situations such as gay bars because he feared rejection. He could not pinpoint the causes of his depression, although he did say he was "not normal—not like everyone else."

Brandon

Brandon, a 22-year-old college student employed part-time in a convenience store, sought relief from anxiety and depression and wanted help accepting his homosexuality, which he had long kept secret. At intake, he revealed that he had impulsively come out to his parents recently, hoping that this revelation would provide relief from his painful depression. Their feelings of surprise and disappointment were overshadowed by their alarm over his agitated mental state, and they urged him to get counseling. To make matters worse, his male coworkers and supervisor teased each other in his presence using anti-gay epithets (i.e., "Hey faggot; get in the back and clean out that stockroom."). Brandon hated how his friends and roommates used the phrase, "That's so gay," to refer to childish or foolish behavior. These experiences left Brandon hurt, angry, and afraid to come out. His turbulent feelings were aggravated by his loneliness and his growing desire for a romantic relationship with a man.

Diego

Diego was the 14-year-old son of divorced, immigrant parents from Mexico. His mother, Marta, brought him to therapy following a brief psychiatric hospitalization due to a suicide attempt. Marta and Diego's father, Juan, divorced when Diego was 10 years old. Following the divorce, Diego visited his father on the weekends. One weekend, Juan caught Diego viewing gay pornography on his computer. Upon the discovery, Juan became enraged and punched Diego in the stomach, yelling that he was not going to have a *maricon* (Spanish anti-gay epithet) in the family. This incident led to Diego's suicide attempt and hospitalization.

Compounding his family difficulties, Diego experienced harassment at school. Peers would shout insults such as "faggot" and "queer" and kick or trip him as he passed them in the halls. At intake, Diego said he found this so frightening and humiliating that he was refusing to attend school.

The Family as a Stigmatizing Environment

Goffman (1963) identified that stigma spreads to those people affiliated with a stigmatized person. Upon discovering that their child is gay, parents may experience the effects of stigma. Historically, the field of psychiatry relied upon research findings flawed by investigator and sampling biases to classify homosexuality as a disease caused by dysfunctional parenting (e.g., Bieber, et al., 1962; Thompson, Schwarz, McCandless, & Edwards, 1973). Despite subsequent findings that contradict this myth (e.g., Siegelman, 1974, 1981), many parents still believe they are to blame for their child's homosexuality or worry that others will blame them for it. Research findings show that such concerns may contribute to the hostility and guilt parents experience when they discover that their child is gay (Herdt & Koff, 2000; Savin-Williams, 2001). As a result of adverse parental reactions, many gays and lesbians do not receive the potentially buffering support of family. Parental disappointment or hostility for those who experience it (like Diego), or the fear of it (for those who are not out) can reinforce the stigma of being gay in a profound and deeply personal way, and may play a role in a client's presenting problem.

Treatment

Special Consideration: Shame and Engagement

During childhood, many boys who grow up to be gay, particularly those seen as effeminate, experience anti-gay verbal and physical abuse from peers and family even before they identify themselves as being gay (D'Augelli, Pilkington, & Hershberger, 2002). This early victimization during formative, vulnerable developmental periods could create a lasting sense of shame that would inhibit a gay man's ability to discuss the impacts of stigma in therapy (Greenan & Tunnell, 2003; Pollack, 1999). In general, men are socialized to be stoical about personal problems in order to avoid appearing incompetent or weak (Cochran & Rabinowitz, 2003; Mahalik, Good, & Englar-Carlson, 2003). Hiding, denying, or repressing stigmatizing events to avoid looking weak or vulnerable might be a gender-based method of stigma management for many gay males. Furthermore, members of stigmatized groups do not believe their therapists want to hear about their oppression because typically, their feelings about such experiences have been ignored or minimized by those who are not stigmatized (Teyber & McClure, 2000). Thus, a gay client's shame and gender-related unwillingness to discuss these feelings, along with his belief that the clinician is uninterested, could impede therapeutic efforts to help him recognize and describe thoughts and feelings related to stigmatization.

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To counteract client shame and gender-based reluctance to discuss it, social workers must create strong therapeutic relationships in which their gay male clients perceive they are interested in all of their feelings, including those resulting from gay-related oppression. Therapists must demonstrate willingness to discuss the effects of societal stigma on their gay clients' lives, either by validating their feelings if they report them, or if they do not, directly inquiring about these effects. It is also advisable to explain how stigmatization can lead to internalized homophobia whereby the stigmatized come to believe negative societal messages. When clients report incidents of discrimination or harassment in a highly distressed manner or use anti-gay statements to refer to themselves or others, therapists can assess it is likely that they have been emotionally affected by stigmatization. However, as previously stated, hesitance to recognize and discuss these feelings can be strong. Persistently inviting clients to discuss these issues can counteract their tendency to discount or repress their feelings and can encourage them to identify and reflect upon the effects of stigmatization.

Cognitive Therapy

Once they have engaged their clients, practitioners can then use cognitive therapy to help them diminish their stigma-related feelings of depression and anxiety. According to cognitive therapy theory, emotional distress is not caused by events and situations themselves, but by how such situations are perceived (Beck, 1976; Beck, 1995; McKay, Davis, & Fanning, 1997). In response to stressful circumstances, some adopt *cognitive distortions,* or overgeneralized, pessimistic, or perfectionist thoughts such as "my life is over, nothing will be right again," or "I made this mistake because I am such a loser—I can never do anything right." Such thoughts cause depression and anxiety.

This model has a strong educative component whereby the cognitive therapist teaches clients to identify, label, evaluate, and correct their distorted thoughts and beliefs (Beck, 1995), replacing them with others that are less self-punitive and more realistic, such as "This is a difficult situation, but I can get through it," or "I am not a loser because I made a mistake—I'm only human, and I do things right plenty of times." Clients experience emotional relief once they adopt these more rational beliefs.

Changing such dysfunctional thinking is known as *cognitive restructuring* and cognitive therapists employ a variety of techniques to achieve this aim. One method is Socratic questioning, whereby therapists ask questions designed to foster independent, rational problem solving in clients (Overholser 1993). Another is the use of the dysfunctional thought record (DTR) in which clients record their stressful situations, their depressive or anxious responses to the situation, and the irrational thoughts that fuel these feelings (Beck, 1995; McKay et al., 1997). They are then taught to "argue back" in response to the irrational thoughts and record those that are more logical and realistic. Clients learn and practice cognitive restructuring during sessions and homework assignments. Research has repeatedly demonstrated that cognitive therapy is effective for depression and anxiety as well as a variety of other disorders (Beck, 1995; Caballo, 1998; Clark & Fairburn, 1997: Persons, Davidson, & Tompkins, 2001).

Externalization and Cognitive Therapy

For some, the tendency toward negative thinking is related to *core beliefs* or distorted global ideas clients maintain about themselves that they are inadequate or unlovable (Beck, 1995). When society stigmatizes a group, its members are likely to adopt society's distorted impressions of their group, believing they deserve the harassment and discrimination they receive (Hanna, 2002; Meyer, 2003). It is understandable how gay youths come to believe homosexuality is sick and shameful, considering how few messages they hear to the contrary.

However, Crocker & Quinn (2000) argue that self-esteem is related to how people perceive the causes of stigma. Research findings show that some African Americans and women escape psychological injury and experience equal or even higher levels of self esteem than their non-stigmatized counterparts when they attribute negative messages exclusively to others' prejudices, thus externalizing the causes of stigma (Crocker & Quinn, 2000; Major, Barr, Zubek, & Babey, 1999). Cognitive therapy can help gay men identify inaccurate negative thoughts about themselves stemming from core beliefs that reflect internalized homophobia. Once therapists identify such thoughts, they can help clients place the blame for these ideas on a stigmatizing society, and as a result, help clients diminish their emotional suffering.

Sam

During Sam's initial sessions, the therapist empathized with his hopelessness, despair, and frustration over not knowing the cause of these feelings. In this way, the practitioner established a relationship with Sam where he felt free to express all of his feelings, including potential anger and shame related to stigmatization. In response to questions about his upbringing, Sam reported that he had been raised by a physically abusive father. This man was "a perfectionist bastard," who would force him to stand with his hands on his head for hours when Sam did not complete chores to his father's unrealistically high standards.

On several occasions, the therapist suggested that even though Sam had survived these experiences, they had left emotional wounds from which he still suffered. In this way, the therapist communicated a belief in Sam's resilience along with an interest in hearing the adverse emotional impacts of the abuse. The clinician was also setting the stage for Sam to externalize some of the causes of his distress and therefore become less self-critical. As a result, during the third session, Sam began to identify how his father's high standards and abusiveness led him to become very self-punitive

Although Sam initially denied that negative experiences as a gay man had contributed to his depression, as therapy progressed, he realized that stigmatization had played a role. During the seventh session, Sam tearfully discussed having come out to his parents at age 16. In response, Sam's stepfather drew a gun to his chest and threatened to kill him. After talking his way out of the situation, Sam left home and became homeless, supporting himself with odd jobs and occasional prostitution. Following several months of homelessness, Sam joined a fundamentalist Christian church to try to stabilize his life.

Once church members recognized his intelligence, they sponsored Sam's attendance at a small Christian college in the Southeast. However, at this school he endured daily verbal and physical harassment from other students. He was particularly embarrassed that they had surmised he was gay, even though he had not disclosed this information to anyone at school. Rather than recognizing his anger at his father or his fellow students, Sam developed core beliefs that he was defective and unlovable. He believed that mistakes he made at work were proof of his incompetence. Certain that rejection was inevitable, Sam avoided opportunities to meet people and form relationships. This explained why, at age 40, he had neither a partner nor friends.

The therapist taught Sam how his father's violence and the harassment he had received in college had shaped his self-concept. He showed Sam how he had internalized the harshly abusive messages he had received, as evidenced by his thinking that he was crazy, sick, incompetent, and unlovable. The clinician also taught Sam how this thinking had generated his feelings of depression. The therapist asked Sam to record his thoughts in a dysfunctional thought record (DTR) whenever he was depressed and to bring it to sessions. His DTR contained statements such as: "My father was right, I am a stupid fairy who cannot do anything right;" "I am depressed because I am crazy—there is something wrong with me;" and "I will never meet friends or a partner and will always be alone."

Through the DTR and the therapist's Socratic questioning (e.g., "Is it really true that you *never* do anything right, *ever*?"), Sam learned that he was overgeneralizing his occasional mistakes at work, as well as his feelings of depression, as evidence that he was inadequate and unlovable. Sam replaced his harsh self-criticism with reasonable, realistic thoughts such as, "I made a mistake, I am only human…I have done many things well; this doesn't mean I'm a screw up," and "I am depressed and lonely now, but I deserve credit because I am working to change these things."

In addition, as Sam came to terms with the impacts of his father's abuse and his college peers' harassment on his self-concept, the therapist helped him find ways to argue back with his anti-gay self-statements: "Just because I am gay does not mean I deserve abuse or disrespect. That's a lie I learned from ignorant, bigoted people." Similarly, Sam began to understand that if he approached a man in a gay bar and was rejected, this did not mean he was ugly or unlovable.

During the course of therapy, which lasted one year, Sam continued to replace his dysfunctional thinking, and his depression lifted. At termination, he was attending a local gay social organization and had made several friends. Follow-up six months after termination revealed that Sam continued to feel much better. He was elected to be an officer of the gay organization he had joined and he had begun to date a fellow member.

Brandon

Beginning with the first session, the therapist used supportive empathic reflection to create a safe space for Brandon to explore his anxiety. Brandon was initially unsure why he was anxious and like many male clients, he had trouble articulating his painful feelings. Therefore, at the end of the initial session, the therapist assigned him the homework task of recording what he was thinking each time he experienced these feelings.

Brandon's struggle with anti-gay stigma was evident in the recordings he brought to the second session. When he found himself feeling anxious, in addition to thinking, "Oh no, I am anxious again," he was also thinking about his homosexuality. For example, after spending time with his roommates he would worry: "If they find out I am gay, they will think I am sick and perverted and won't want to hang out with me anymore." He also despaired that an enduring, loving relationship was beyond his reach because he believed gay men were too sexually promiscuous to commit to a long-term relationship.

Using Socratic questioning, the therapist asked Brandon what evidence he had that being gay was sick. Brandon's answers reflected prejudicial stereotypes (e.g., gay men are promiscuous, are all effeminate, etc.). He then asked Brandon whether he thought the therapist, an openly gay man, was sick. Brandon replied that he knew he was not and admitted that this contradicted his ideas. By gently pushing Brandon to explore this contradiction, the clinician helped him recognize and discuss his ambivalence and confusion—he was ashamed of being gay, yet he had sought an openly gay therapist to help him change his views so he could become a well-adjusted gay man. This soft confrontation and subsequent discussion helped Brandon feel safe enough to discuss his painful ambivalence about his homosexuality.

With the therapist's help, Brandon realized that his difficulties were a function not only of societal stigma but also the result of having been raised by parents who wielded harsh criticism to motivate their children. Brandon was assisted in understanding how this "double threat" made him prone to severe self-criticism, which left him feeling incompetent and anxious. Brandon was taught to expand his recordings of anxiety into a DTR in which he would "argue back" with his self-critical misperceptions by recording more realistic thoughts. For example, through this exercise Brandon realized that he had little proof that his roommate would reject him once he came out. In fact, his roommate had several openly gay friends. He also learned that his negative predictions about finding a partner were based on untested assumptions adopted from a homophobic society. Through these exercises and discussions, the therapist helped Brandon change his thinking about his potential for happiness as a gay man.

As Brandon began to feel better about his sexual orientation, he wanted to come out to his friends. However, his fear of rejection re-emerged. He was self-critical of his fear, writing in his dysfunctional thought record and complaining to the clinician: "I shouldn't be afraid. Why am I not proud to be gay? What's wrong with me?" The therapist initially empathized with Brandon's fear and normalized his anxiety, emphasizing the role of societal homophobia and heterosexism in his feelings. However, further exploration uncovered Brandon's persistent belief that everyone would reject him because he was gay. The therapist used Socratic questions to help Brandon modify his dysfunctional thinking (e.g., "What proof do you have that complete rejection is inevitable?")

With the clinician's help, Brandon recognized that, while some rejection and discrimination was possible, he was engaging in what Beck (1995) would call *catastrophizing*, predicting the future as bleak without considering other likely, less severe outcomes. The therapist challenged Brandon's "all-or-nothing" thinking and helped him realize that it was unlikely that all of his friends would reject him, and that if some did, new opportunities to meet gay and tolerant straight friends could compensate for these losses.

Over the next 10 weeks of therapy, Brandon came out to his friends, and for the most part, they were accepting. As he grew more comfortable with his sexual orientation, Brandon became angrier about the heterosexism he experienced daily at work, and in a moment of bravado (and without the therapist's prompting), he came out to his supervisor. The supervisor responded with shock, and apologized for his previous homophobic remarks. Brandon felt empowered and elated as a result of this act and its outcome. Unfortunately, one of his male friends distanced from him, refusing to return Brandon's numerous telephone calls and e-mail messages. Rather than viewing it as evidence that he was sick or unlikable, Brandon attributed this rejection to this man's homophobia, which was a sign of therapeutic progress.

Diego

During his initial, individual sessions, Diego's embarrassment prevented him from discussing his feelings about being gay. To help Diego feel less alone in his shame and to model that it is possible to discuss and survive hardships related to stigmatization, the practitioner disclosed that he himself had been beaten up and called names by

peers in high school. Intrigued, Diego wanted to know how he had coped. In response, the clinician carefully explained that he grew up in a different era than Diego (the 1970s). Although he understood Diego's desire for a foolproof recipe to deal with anti-gay harassment, he could not give one. Instead, the therapist promised he would help Diego find *his own* ways to cope. Through this sharing, role modeling, and problem solving the clinician engaged Diego in a therapeutic relationship in which he could discuss this embarrassing topic.

Diego also felt lonely and isolated, and prior to intake, the only information he had about gay men was material he had downloaded from pornographic websites. Because he was proficient in accessing the Web, the therapist referred Diego to educational sites, such as Planet Out (www.planetout.com) and the Gay, Lesbian & Straight Education Network (GLSEN) (www.glsen.com), which offered information to gay and lesbian youth and sponsored online discussions. The therapist cautioned Diego about the dangers of in-person meetings with people he encountered on the Internet and warned him never to meet an online acquaintance without his mother's consent and supervision. He also urged Marta to monitor her son's activities on the Web.

During individual sessions, the clinician taught Diego how to develop a DTR. Among his many self-punitive thoughts were "I am a freak," and "I will never be happy [because I am gay]." Through individual sessions as well as online contacts, Diego learned that his thoughts were incorrect; there were many gay youths who were happy and "normal," which for Diego meant that they looked and acted like typical teenagers. Verbal and physical persecution was not evidence of something wrong with him, but instead was a result of the ignorance and homophobia of his father, his fellow students, and society at-large.

As he became more comfortable with his sexual orientation, Diego developed ways to respond to the peer harassment. With the therapist's help, he decided that when he was in class he would ignore the harassment to avoid getting disciplined for disruptive behavior. However, he planned to defend himself verbally, and physically if necessary, during recess and after school. If the harassment became unbearable, he would approach a teacher, the school social worker, or the principal for help. With this plan in place, Diego agreed to return to school.

Intervening in the Stigmatizing Environment

Stigma is a social problem that leads not only to psychological distress but also to discrimination, violence against stigmatized groups, and policy decisions that have broad, deleterious impacts on the stigmatized. By focusing exclusively on the psychological consequences of stigma without attending to the structural causes, clinicians risk violating their ethical responsibilities to improve their clients' social environments through client and system advocacy. When working with youth, therapists should always consider family assessments and interventions. In school settings, social workers should persistently act as advocates for this vulnerable group by appealing to school administrators for services such as support groups, as well as tolerance and anti-violence education for the student body (Kosciw, 2001). Social workers can also contact national organizations such as the Gay, Lesbian & Straight Education Network (www.glsen.org, 212-727-0315) and Parents and Friends of Lesbians and Gays (P-Flag) (www.pflag.org, 202-467-8180) for information and technical support for macro interventions as well as local referrals for their clients.

Practitioners should also create gay-positive environments at their agencies by developing and advocating for policies that prohibit discrimination against lesbian, gay, bisexual and transgendered (LGBT) clients and employees. To this aim, clinical social workers should consider the variety of organizational interventions possible, ranging from collaboratively engaging and persuading people in positions of power (Brager & Holloway, 1992) to more adversarial actions like public protest and engaging the media (Netting, Kettner, & McMurtry, 2004). Sam did not report being harassed or feeling discriminated against at the time he was in therapy. However, by actively promoting equal rights legislation, social workers could effect changes, making the abuse he experienced in the past less likely and also eradicating the potential discrimination he faces daily.

Intervening in Diego's Family

Because some of Diego's difficulties stemmed from his family, the therapist held conjoint sessions with Diego and each of his parents. During the first session with Diego and his mother, Marta reported that she loved and accepted him and would do whatever she could to assist him. The therapist praised Marta for her acceptance and helped her find ways she could support him, like taking him to meetings of a local gay youth organization, and periodically checking in with him to ask if he wanted to discuss problems related to his sexual orientation.

In separate sessions, the therapist met with Diego and his father Juan. During these initial sessions, Juan apologized for his initial physically abusive reaction, but he also stated that he did not understand why his son was gay. Diego still feared his father and balked at the idea of talking to him about his homosexuality. So after two unsuccessful conjoint sessions, the therapist met with Juan alone to help him process his feelings about having a gay son. Juan explained how in Mexican culture, male homosexuality is particularly shameful. Juan expressed concern that he had done something wrong to "make" his son gay and that if his family or friends knew about Diego, they would label him a poor father and a weak man.

The therapist taught Juan that the idea that he had made his son gay was a reflection of societal homophobia and, although no one knows the causes of homosexuality, there is no evidence that parents cause it. The clinician also empathized with Juan's struggle to integrate his son's sexuality with his cultural values as well as his fear of censure from his family and friends. The therapist referred Juan to a local chapter of a national parent support group (P-Flag) for information and support. By talking with other parents, including Latino parents, Juan gained more information, learned how to decide who to come out to and also how to educate friends and family who were homophobic or blaming. During the course of therapy, Diego never felt comfortable enough to talk to his father about his homosexuality. Hopefully, by demonstrating his growing acceptance, Juan will eventually convince Diego that he can discuss this topic in a supportive manner.

Although Diego was lucky to have an accepting mother, Marta's Anglo boyfriend Ralph, who spent a lot of time with the family, was clearly homophobic. As treatment progressed, Diego described how Ralph would call his mother belittling names if she made a mistake like overcooking dinner, and in response Diego would verbally defend her. In turn, Ralph would make anti-gay remarks and gestures, such as bending his wrists and walking in a mincing fashion. Hoping to help Marta resolve her difficulties with Ralph without Diego's assistance, and also to get Ralph to understand the impacts of his harassment on Diego, the therapist asked Marta to invite Ralph to a family session. However, Ralph declined. The therapist warned that Ralph's maltreatment of Diego could have grave impacts on her son's mental health. At the therapist's urging, Marta agreed to see Ralph only outside of her home. After a few weeks, she decided this difficult relationship was not worth the trouble and terminated it.

Intervening in the School Environment

Too often, clinical social workers incorrectly assume they lack the power or authority to intervene with larger systems that affect their clients, and therefore they do not pursue administrative change. This is unfortunate because, even though clinical social workers are limited in their ability to intervene at macro levels, there are situations where they can initiate policy, program, or procedural modifications that will benefit their clients, even if such changes are small in scope.

Both Marta and the clinician met with the principal of Diego's school and politely but firmly demanded that he take a proactive role in stopping Diego's harassment. The principal agreed to the plan that Diego would contact the school social worker, a teacher, or the principal when he was being harassed, and the perpetrators would be punished. During these contacts, Marta and the therapist learned that the school social worker was quietly running a support group for LGBT youth. In an effort to avoid community censure, this group was not widely advertised. Upon learning of it, the therapist contacted the school social worker to refer Diego, who immediately began to attend.

During the referral process, the school social worker discussed with the therapist how she was learning of the harassment kids like Diego faced every day. The school social worker, the therapist, and Marta realized that something needed to be done to reduce the heterosexism and homophobia in the school environment. Working together, the three developed a macro intervention and presented it to the principal. Each year, the school sponsored an ongoing program for the students entitled "Celebrate Diversity," which consisted of guest speakers and education workshops that taught ethnic and racial tolerance. Marta, the therapist, and the school social worker requested that the school add workshops on LGBT issues. At first, the principal declined their request. However, strongly worded letters from the therapist and Marta, in addition to ongoing advocacy on the part of the school social worker and the students in her LGBT group, eventually persuaded the principal to include LGBT content in the program. To ensure that anti-gay harassment and homophobia were covered, the therapist, Marta, and volunteers from the local P-Flag chapter assisted with the program's planning and presentation.

Cognitive restructuring, family therapy, the diversity workshop, and support from online gay and lesbian peers diminished Diego's embarrassment and misperceptions about being gay. As he grew stronger, he came out to some of his friends. Diego also began to verbally—and, when necessary, physically—defend himself against the abuse he experienced at school. To his surprise, some of his friends who now knew he was gay would come to his aid by telling his tormenters to back off. These actions, in addition to the tolerance education offered by the school, seemed to reduce his harassment, which made him more comfortable attending school.

Brandon

Eight weeks into therapy, Brandon reported that a classmate was harassing him, calling him "fag" and "fudgepacker" when he walked into class. As a result, Brandon relapsed, feeling so anxious and humiliated that he stopped attending this class. The therapist was also a university employee, and remembering how harassment in college had affected his client Sam, he offered to act as an advocate for Brandon and appeal to the administration on his behalf. However, Brandon begged the clinician not to do this, and asked him instead to let him find his own way to handle the tormenter.

The therapist normalized Brandon's feelings of fear and anger and coached him to reprise the cognitive techniques he had learned (i.e., the DTR). As a result, he recognized that this harassment was not a reflection on him but yet another indication of oppression related to societal

stigma. This realization freed Brandon to find a better way to handle this fellow student. When he returned to class, he created a minor spectacle by approaching the harasser, calling him a bigot and telling him to "fuck off." This action startled the tormentor, who never again bothered Brandon. At the end of therapy, which lasted 12 weeks, Brandon was less anxious and had a better sense of how societal prejudice had affected his feelings about himself.

Although the clinician wanted to report Brandon's harassment to the university's administration, it was important to respect Brandon's confidentiality and self-determination, as mandated by the Code of Ethics (Code of Ethics of the National Association of Social Workers [NASW], 1999). Brandon's experiences, along with those of some of the therapist's other gay and lesbian clients, suggested that the university had a problem with homophobia. The therapist negotiated with Brandon to allow him to contact the university's Office of Diversity Affairs and, without giving any of Brandon's identifying information, report that hostile and homophobic remarks by one student had distressed another sufficiently for him to stop attending classes. He urged these officials to use this information to plan for future education and intervention programs to address anti-gay harassment, and he volunteered to help with these efforts. As a result, the Office of Diversity Affairs invited the therapist to join a task force that is currently planning LGBT tolerance workshops for the campus.

Summary and Conclusions

It is important to recognize that it is possible for gay clients to present with issues that are unrelated to stigma (Davies, 1996; Gray, 2000). Davies (1996) asserts that if a client seeks help for a relationship, for example, feelings about stigma should not necessarily be a focus. However, there is a danger in oversimplifying the tangled and at times obscure relationship between presenting problems and gay-related stigma. Sam's presenting problem did not initially seem related to stigmatization. Only after establishing a trusting relationship and undertaking an extensive assessment did the therapist realize that his history of anti-gay harassment had led to punitive self-talk that was a factor in his depression. Therefore, it is recommended that therapists assess the role of stigma in their gay clients' presenting problems, no matter what complaints they articulate.

The harassment boys face for showing signs of homosexuality or femininity, along with the gender-related reluctance to discuss feelings of shame from these experiences, makes therapy for gay men coping with stigma uniquely challenging. However, cognitive therapy in the context of a strong therapeutic relationship along with environmental interventions could also assist lesbians, bisexuals, transgender individuals, and others who are members of oppressed and stigmatized groups. Furthermore, for individuals who are members of multiple stigmatized groups, (i.e., LGBT persons of color) adverse effects can be additive (Diaz, Ayala, Bein, Henne, & Marin, 2001; Walters, 1998) and these techniques could help clients cope with multiple and overlapping oppressions.

For example, an African American lesbian youth could experience racism, homophobia, and sexism in the general society, racism in the lesbian community, and homophobia and sexism in segments of the African American community. It is reasonable to assume that she is at high risk for internalizing messages that she is inadequate and unworthy of love. For such clients, the clinician is advised to explore all potential sources of stigma and their impacts on their clients' beliefs about themselves. It would also be important to assess and address sources of racism, sexism, and homophobia in a client's family, school, and community.

This paper adds to the existing literature on the treatment of gay men by describing how to combine cognitive therapy in the context of a strong therapeutic relationship with environmental interventions specifically to address the impacts and sources of stigma. Even though cognitive therapy was effective with the clients described in this paper, some clients may have been so deeply traumatized by violent or severe experiences of oppression that they need an extensive period to explore their intense feelings before they are ready to examine the thoughts behind them.

Whatever individual approach is used, the worker needs to build strong therapeutic relationships with stigmatized clients and also attend to the environmental sources of stigma. The empirical investigation of coping methods among nonclinical samples of stigmatized people could provide further information about successful coping strategies. Like the respondents in the Crocker and Quinn study (2000), gay men and members of other oppressed groups may have found unique ways to avoid internalizing stigmatization. Such information could surely benefit oppressed clients struggling with stigmatization and the social workers who seek to assist them.

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