

The Impact of Sexual Abuse on Sexual Identity Formation in Gay Men

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ABSTRACT. Emerging data suggests that as children, gay males have an increased risk for physical and sexual abuse. Anecdotal evidence suggests that a significant subset of children abused by clergy identify as gay as adults. However, we know very little about the impact of clergy-perpetrated sexual abuse in childhood on the development and psychosocial functioning of gay men. This article describes the incidence of childhood abuse in the lives of gay men and the probable impact of clergy-perpetrated sexual abuse. In the treatment of gay men sexually abused as children, including those abused by clergy, providers should use a normative frame for gay identity development such as the Homosexual Identity Formation Model. This treatment model, highlighted with case material, is also discussed.

KEYWORDS. Gay identity development, clergy sexual abuse, treatment

The pernicious impact of sexual abuse on child development has been well documented. Herman (1992) stated, "Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality" (p. 96). She emphasized how exposure to early trauma disempowers the child and contributes to a

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disconnection from others, often leading to distrust, shame, guilt, inferiority, confusion, isolation, and despair. Current thinking (Doyle, 2003) regarding clergy-perpetrated sexual abuse (CPSA) suggests its impact is similar to familial incest, which has a particularly devastating impact on identity development (see also Fogler, Shipherd, Clarke, Jensen, & Rowe, 2008). Factors that support this comparison include the following: the families of many victims were closely allied with the life of their church—a spiritual family; the abuse tended to occur over an extended period of time, similar to many cases of incest; adults frequently did not believe reports of abuse when alerted to it, which often also occurs in cases of incest; church leaders tried to silence victims to avoid scandal, also a repeated theme in incest; and many victims did not disclose the abuse until adulthood, again similar to many cases of incest (Doyle, 2003).

This article examines the incidence of childhood physical and sexual abuse in the lives of gay men and extrapolates from these findings to the probable impact of CPSA for this group. It will posit a process of normative gay identity formation and address the impact of abuse on this process. The author will also make detailed recommendations for mental health clinicians treating gay men who have been abused and present two case vignettes. It should be noted that lesbians have a parallel process of identity development that can also be negatively influenced by abuse. However, the issues of lesbian development and abuse are beyond the scope of this article.

ABUSE IN THE LIVES OF GAY MEN

Emerging data suggests that gay males have an increased risk for physical and sexual abuse as children. This includes sexual abuse and other forms of interpersonal violence, which may predispose some gay men to have negative mental and physical health outcomes (Guarnero, 2001; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004; Krahe, Scheinberger-Olwig, & Schutze, 2001; Sandfort, de Graaf, Bijl, & Schnabel, 2001). In a non-clinical sample of 942 homosexual and heterosexual adults, 46% of gay men reported a history of childhood same-sex molestation compared to 7% of their heterosexual counterparts (Tomeo, Templer, Anderson, & Kotler, 2001). In a study utilizing a probability sample of 2,881 urban gay men, 20% reported a history of childhood sexual abuse, primarily by non-family perpetrators (Paul, Catania, Pollack, & Stall, 2001). Niesen and Sandall (1990) conducted a chart review of 201 gay and lesbian chemically addicted inpatients and found that nearly 50% reported a history of

sexual abuse in childhood. Jinich and colleagues (1998) explored the prevalence of childhood sexual abuse among a nonclinical sample of 1,941 gay and bisexual men and found that one-quarter reported a history of childhood sexual abuse.

The development of trauma-related symptoms in gay men may also be influenced by violence and oppression in the form of homophobia (Cassese, 2001; Dillon, 2001). Homophobia can result in a "hate crime" or more subtle forms of oppression and discrimination (Klinger, 1996). In a community sample of 445 young gay and bisexual males, Vives (2002) found that 75% experienced verbal harassment related to sexual orientation and 33% reported physical violence related to sexual orientation. Sexually abused in a cultural context that stigmatizes, devalues, and punishes homosexuality, gay men may thus present for treatment with complex forms of trauma-related disorders (King, 2001).

One reason for the risk of increased trauma among gay men is that as children they tend to display behaviors and attitudes frequently associated with gender atypical behavior. Brooks (2001) contended that gender atypical boys are at increased risk for sexual, physical, and emotional abuse. Violence is often used against these gender atypical boys to punish their "misbehavior" and to teach other boys the "rules" for socially acceptable male behavior. Males who behave in a gender atypical "feminine" manner are at high risk for being stigmatized, ostracized, and abused. Robertson (1997) further postulated that mental health professionals compound the difficulties some of these boys struggle with by diagnosing them with gender identity disorder in childhood. He contended this diagnosis often leads to treatment that is designed to "change" homosexuality in boys, which is of questionable value since 75% of such nontraditional boys are likely to be gay-identified later in life (Swidey, 2005). Additionally, there is an elevated risk of attempted suicide for younger gay men (and lesbians) that may also be attributed to a history of abuse (Fergusson, Horwood, & Beautrais, 1999; Gonsiorek, Sell, & Weinrich, 1995; Herrel et al., 1999; Vives, 2002).

As adults, gay men have an increased risk for anxiety and mood disorders, which are frequently associated with a history of trauma (Dillon, 2001; Edwards, 1996; Herrel et al., 1999; Levinson, 2000; Magel, 2002; Sandfort et al., 2001; Tillotson, 1997). Gay men also have greater than expected rates of chemical and substance abuse when compared to other men, which is also associated with physical and sexual abuse (Gonsiorek et al., 1995; Magel, 2002; Stall & Purcell, 2000).

One of the most disturbing outcomes of abuse in gay men is its relationship to high-risk sexual behavior and, consequently, HIV/AIDS. In a

study of the impact of perceived coercion in sexual abuse for gay and bisexual Latino men, those who reported coercion also reported more alcohol use, more incidents of unprotected anal sex, and more sexual partners (Dolezal, 2002). Gay men, particularly gay men of color, are at high risk for HIV/AIDS and report greater than expected rates of childhood sexual abuse and other forms of trauma (Kalichman et al., 2004). Specifically, men who are abused are more likely to report engaging in high risk sexual behavior, including unprotected anal intercourse, compared to their nonabused counterparts (Jinich et al., 1998; Kalichman et al., 2004). Indeed, regardless of sexual orientation, coercive sexual experiences in childhood may be related to engaging in a wider array of sexual behaviors in adulthood (Stevenson, 2000), including high-risk behaviors for HIV.

Kalichman and colleagues (2004) found that childhood sexual abuse was associated with an increased risk of unprotected anal receptive intercourse, trading sex for money or drugs, self-report of having HIV, and non-sexual violence for a sample of gay and bisexual men. Jinich and colleagues (1998) found that gay and bisexual men who were abused were more likely to engage in unprotected anal sex compared to their nonabused counterparts in the preceding year. Perceptions of being coerced sexually as a child were also associated with a high incidence rate of adult HIV infection. Paul and colleagues (2001) also found that gay and bisexual men with a history of childhood sexual abuse reported higher risk sexual behavior than their nonabused counterparts. This high-risk sexual behavior was mediated by substance abuse, patterns of sexual contacts, and partner violence. The authors of the study suggested a history of childhood sexual abuse among men who have sex with men predisposes those with histories of such abuse to heightened patterns of sexual risk. Gonsiorek and colleagues (1995) posited that the explanation for negative behavioral health outcomes for gay men is that, although homosexuality is not associated with psychopathology, stressors in the lives of gay men, including a history of physical and sexual abuse, may result in a greater incidence of trauma-related symptoms, including high risk sexual behavior.

GAY IDENTITY DEVELOPMENT

As previously noted, the result of childhood sexual abuse frequently leads to distrust, shame, guilt, inferiority, confusion, isolation, and despair. This is particularly challenging for young gay men trying to reconcile an affirmative gay identity in a culture that largely disdains homosexuality

despite increasing evidence that sexual orientation begins in the womb (Swidey, 2005). In the 1970s, investigators began to examine the complex socialization process known as “coming out” in a series of descriptive studies of gay men, which provided an important framework for research on the psychological well-being of gay men (Dank, 1971; Warren, 1974; Weinberg, 1970). These early descriptive studies led to the development of the most widely accepted description of the process of gay identity formation, the Homosexual Identity Formation Model (HIF; Cass, 1979). In the HIF model, Cass proposed that gay men and lesbians change from prehomosexual to homosexual by reconciling conflicts about being gay and moving through six stages of change. HIF is a dynamic process composed of self-identity, objective behavior, and others’ perceptions that moves the individual from one stage of gay identity to the next. The six discrete stages of HIF are: (a) Identity Confusion, (b) Identity Comparison, (c) Identity Tolerance, (d) Identity Acceptance, (e) Identity Pride, and (f) Identity Synthesis. The first three stages concern the question “Who am I?” while the latter three stages concern the question “Where do I belong?”

In Stage 1 (Confusion), the individual experiences an unformed self-perception (or perhaps a presumption of heterosexuality), which includes behaviors, desires, and thoughts that may be labeled as “homosexual” and cause internal conflict. In addition, others’ perceptions/desires for the person to choose heterosexuality increases confusion and discomfort. In Stage 2 (Comparison), the individual has the recognition of being “different”—that one’s thoughts, feelings, and behaviors may be incongruent with societal and even familial expectations or assumptions. Stage 3 (Tolerance) reflects the growing recognition within the individual that he or she may be gay and also includes a great deal of ambivalence about being “different.”

At Stage 4 (Acceptance), an individual enters into the “Where do I belong?” aspect of the HIF process. The individual begins to claim a personal identity as a gay person, which he or she may or may not disclose to others. The Acceptance Stage is a prerequisite for pursuing healthy adult intimate relationships, which developmental theorists characterize as the struggle for intimacy versus isolation (Erikson, 1997). Stage 5 (Pride) is characterized by a rebellion against being “closeted” and an identification (or perhaps overidentification) with all things “gay.” Finally, Stage 6 (Synthesis) is characterized by the integrated, nondefensive identity as a gay person. The individual is comfortable in his or her sexuality and identity.

It is imperative that clinicians working with gay clients understand and appreciate the HIF model and how this relates to the “coming out” experience in order to understand how sexual abuse may distort this developmental

process. In the author's clinical experience, this impact of abuse, which frequently includes the trauma-related emotional states of shame, confusion, isolation, and despair, may retard this process and lead to a self-loathing and a self-defeating identity.

Clinicians treating gay men must also understand the complex impact of gender, sexual orientation, and sexual abuse on self-identity and the ability to have intimate relationships. The majority of gay men (and others) abused as children have been abused by men. Male children who have been abused by men (regardless of sexual orientation) are likely to struggle with the implications of abuse for the "self" as a male. They have to face questions such as, "What kind of man am I going to be?" "Will I become a perpetrator?"

In addition to self-identity, gay men (unlike their male heterosexual counterparts yet similar to heterosexual women) must also be able to establish and maintain healthy sexual and emotional relationships with other men. Gay men who are abused manifest frequent struggles with self-identity and intimacy that may include high risk sexual and drug use behavior. In adulthood, they may be both victim and victimizer in their interpersonal relationships. Wright (2001) refers to a "spiral of risk" where gay men engage in high-risk behavior to "belong" or to avoid abandonment, which has a negative impact on self-esteem and health. Given the high incidence of sexual and emotional violence many gay men have experienced as children, gay male victims of sexual violence may also choose abused partners (King, 2001). As a result, sex, love, and intimacy are difficult to manage in many gay male relationships

TREATMENT

Facilitating Gay Identity Formation

Any provider working with gay men should utilize a normative frame for gay identity development such as the HIF model. Each gay/bisexual client's stage of identity, with particular attention paid to those in early stages of identity formation, should be assessed. As previously noted, the Stages of HIF are a normative process for coming out. Clients who are in earlier stages of HIF are more likely to seek out "nongay" identified providers who they perceive as "less biased." As clients gain clarity about their sexual identity, they are more likely to seek out gay role models, including gay-identified providers. Gay therapists may be particularly

important for newly identified gay or lesbian individuals. Developmentally mature gay clients are more likely to be indifferent to the sexual orientation of their providers once they are assured of therapist competence and comfort with gay individuals.

Clinicians need to educate gay clients about the coming out process and how this process may impact perceived well-being, recognizing that gay men with a history of abuse may have trouble meeting those challenges. Childhood sexual abuse and its associated shame for many gay men may easily translate to a “shameful” existence that includes substance abuse, unsafe sex, mood and anxiety disorders, underemployment, lack of intimacy, and loss of meaning in life. This developmental process is expected to be even more complicated for those gay men who were abused by clergy since the betrayal is of such a basic trust and, as noted earlier, can be akin to incest trauma.

When working with youthful clients, mental health providers need to be aware that many gay adolescents and youth are quite isolated. Many gay youth need positive gay role models who have meaningful work and relationships. Over the past several years, a number of support groups, religious organizations, Web sites, and other multimedia have been created to meet the needs of gay and lesbian individuals. These resources may also prove helpful to mental health professionals working with gay youth.

Treating Mental Health Disorders

Health providers should assess abuse histories, including CPSA, for all clients, including gay males. In addition to questions about physical and sexual abuse, assessments for gay and bisexual individuals should include questions about harassment related to gender atypical behavior in childhood and other forms of gay specific abuse/harassment. These include “gay bashing,” “spiritual” interventions designed to change gay identity, and incidents of being rejected/ridiculed by others (parents/guardians, the military, church groups) as a result of being gay. Abuse and rejection themes, often with onsets at an early age, are central to the lives of many gay men and lesbians struggling with mental disorders and engaging in high-risk sexual and drug use behavior.

Many abused gay men present for treatment in emotional states closely linked to their trauma histories: distrust, shame, guilt, inferiority, confusion, isolation, and despair. Additionally, the results of trauma can be seen in low self-esteem, high rates of anxiety, depression, substance abuse, sexual

risk taking, a lack of intimacy, suicidal behavior, and symptoms associated with post-traumatic stress disorder as well as character pathology including borderline personality disorder. Gay men who are abused by other males, including male clergy, may also be concerned that the abuse "made them gay." Clinicians need to be prepared to explore these concerns keeping in mind that current data does not support a relationship between sexual orientation and sexual abuse (Stevenson, 2000).

When working with gay men, initial assessments need to be modified to evaluate particular risk factors. Gay and bisexual young adults with histories of abuse are at increased risk for suicide and providers should assess this risk and intervene as needed. Gay men who have been sexually abused are also at increased risk for HIV/AIDS and other sexually transmitted diseases. Each gay and bisexual male client should receive a risk assessment for HIV/AIDS and primary and secondary prevention intervention as needed, including awareness of their HIV status and a referral for counseling and testing as needed. Particular attention should be paid to the relationship of abuse, substance use, and HIV risk behavior. A medication consult should be considered as part of the assessment process as the use of antidepressant and anti-anxiety medication is often important adjuncts to the treatment process.

The conditions for recovery in trauma victims, which Herman (1992) and others have described, can be modified and successfully utilized with traumatized gay men, including those abused by clergy. These conditions include: a healing therapeutic relationship, a focus on safety, a process of remembering and mourning the trauma, a reconnection with ordinary life, and a sense of commonality with others who may have been abused. Each of these phases and how they related to working with gay men will be discussed.

The Healing Relationship

The healing relationship facilitates working through a number of developmental challenges abused individuals confront. Erickson (1997) proposed that human beings are destined to struggle with basic trust and distrust, autonomy and shame, initiative and guilt, industry and inferiority, identity and confusion, intimacy and isolation, generativity and stagnation. Individuals traumatized as children frequently struggle more with these developmental challenges. In successful treatment, a client should experience empowerment and autonomy and take initiative, particularly concerning their abuse history. The healthy therapeutic relationship fosters a sense of internal locus of control and industriousness. For the gay client,

it nurtures an affirmative gay identity, promotes intimacy with others, and facilitates existential questioning and meaning.

Safety

A significant challenge in working with traumatized individuals is their tendency to engage in unsafe behavior, including high-risk sexual and drug use behaviors as well as suicidal behaviors. Gay men engage in all of the risky behaviors observed in other survivors. They also engage in behavior that is more prominent among gay and bisexual men, including the use of “designer drugs” and having sexual encounters with anonymous partners. It is very difficult to build and maintain a healing relationship and facilitate developmental change until survivors are able to reduce their risky behavior. Depending on the risk and safety issues involved, clinicians should utilize contracts for safety (particularly for suicidal survivors), promote relaxation training and other self-soothing skills, and rely on motivational interviewing for substance using clients. For the gay client, mental health providers must be particularly aware of the risk of HIV infection associated with risky sexual behavior. HIV prevention interventions, which are both skill based and utilize techniques of motivational interviewing, should be utilized. Additionally, there are a number of cognitive behavioral techniques that may be used to treat sexually compulsive behavior that is a significant problem for some gay men. Finally, it should be remembered that the risk for suicidal behavior may be particularly acute for HIV-infected and traumatized gay men with a history of major opportunistic infections and cognitive impairment (Forstein, 1994).

Remembering and Mourning

The process of remembering and mourning traumatic life experiences can be accomplished only in the context of a healing relationship and relative safety. The choice to confront trauma rests with the survivor. Gay male survivors of childhood sexual abuse, including CPSA, present for treatment with all of the usual positive and negative coping strategies survivors use to manage their traumatic past. There have been a number of empirically based cognitive behavioral interventions developed that have been designed to promote self-care, facilitate reclaiming traumatic memories, and assist survivors with managing the affect associated with these memories. Some interventions include confronting the abuser or utilizing other surrogate experiences that approximate this process of confrontation. These techniques all rely on what Herman (1992) refers to as

the “action of telling a story.” For gay men, this storytelling is characterized by a search for narrative events that would explain their symptoms of trauma (Burnham, 1994).

In addition to remembering and mourning childhood sexual abuse, many gay men must also remember and mourn the loss of their childhood innocence, which was stolen as a result of abuse related to being a gender atypical child. Many others have also been subjected to sexuality-based abuse as adolescents and adults, including gay bashing and being ostracized from peer and family groups. Many of the techniques used to explore childhood sexual abuse can be easily adapted and used to explore the experience of being targeted as a gay youngster.

Reconnecting to the Self and Others: Making Meaning

McCann and Pearlman (1990) identified core needs that trauma survivors struggle with in their interactions with others: to be safe, to trust, to have some control, to feel self-worth, and to be close to others. Gay men with a history of sexual abuse frequently have problems in these areas of self-identity, connection, and commonality. Traumatized gay men who have been able to reconcile their trauma experiences move from “victim” to “survivor” and are able to tolerate painful feelings, counter self-blame, be alone without being lonely, self-soothe when distressed, anticipate the consequences of their actions, set and maintain appropriate boundaries with others, and enter into mutually supportive, give-and-take relationships (Rosenbloom & Williams, 2002). They do not abuse drugs, alcohol, and/or sex. Their life has purpose beyond their own pain and suffering.

Coming out as both gay and abused is often important for many gay survivors. Many gay men seek comfort and meaning in joining civic and fraternal organizations that support the gay community. Reconnecting to the spiritual is also an important component of recovery for many gay men. Unfortunately, the teachings of many religious denominations regarding gay people make reconnecting to their childhood faith difficult for many gay men. The institutional reinforcement of shame for being gay replicates the abuse experience for gay victims of CPSA. Nonetheless, many gay men with a history of CPSA report a spiritual void in their lives. Rather than return to a faith that condemns them, many join other denominations whose teachings affirm their life choices and sexuality.

The ability to form and maintain relationships is central to recovery. It cannot be overestimated how important the development of a network of family, friends, and colleagues are for recovery from abuse. Most gay

men must develop a “constructed” rather than a biological family since most still do not have children. “Friends” often form the core of a constructed family. This is particularly true for gay men and others who may be alienated from their family of origin. Although most families manage their cognitive dissonance about homosexuality and are able to love and support their gay children, others reject them. Most gay men, like others, desire a primary intimate relationship. As has been widely noted elsewhere, intimate relationships are particularly fraught with anxiety and problems for traumatized individuals. Gay men with a trauma history are frequently challenged in developing and maintaining intimate relationships. Therapists must be able to facilitate the frequently bumpy ride many traumatized individuals confront in finding meaning through intimacy.

CASE STUDIES

The following two clinical examples provide an overview of the recommended treatment approaches discussed previously for working with abused gay men at different stages of gay identity development. The first case is of an older gay male who has never resolved a coherent sexual identity and was victimized by other children as a result of gender atypical behavior. The second case concerns a gay male with a clear identity, a history of CPSA, and multiple somatic complaints.

Case 1: Early Stage of HIF Treatment for a Traumatized Gay Men

PS is a 62-year-old married affluent male professional who has maintained a secret life of intermittent anonymous sexual encounters with men for the past 40 years. These anonymous encounters were, until recently, divorced from relationship and attachment (HIF Stage 1: Confusion). Some of his earlier memories included being “in love” with his male babysitter and being taunted as a “sissy boy” by his stepfather. He clearly was a gender atypical child. All of his sexual fantasies, beginning in early adolescence, focused on other boys/men. He also reported a history of coercive childhood sexual abuse by older neighborhood boys beginning at age 9 and ending at age 11.

PS’s presenting problem in therapy was that for the first time in his life, he had become friendly and affectionate with one of his young male sexual partners and was afraid that his wife would discover his infidelity. He

reported that he loved his wife as a “sister” but that he had never had a satisfactory intimate encounter with any female, including his wife. He described his feelings for this young man as “being in love for the first time in my life.” When asked about his sexual orientation, PS winced, became flushed, looked over his shoulder, and whispered, “I might be gay but I try not to think about it.” He reported a self-identity increasingly at odds with his self-perception, his current behavior, and his role as a perception of himself as a “married man.” In short order, PS ended his friendship/romance with this other man, abruptly left therapy, became depressed, was hospitalized, and treated with antidepressant medication. He returned to therapy some months later, overwhelmed with guilt, loneliness, and despair.

Upon his return, the focus of treatment was on the first three “Who am I?” stages of HIF rather than other external life changes PS might make in response to a more coherent identity. There were no easy answers for the dilemma that PS confronted, but relying on a developmental approach was helpful. Assisting this client with the question, “Who am I?” became the central focus of the initial phase of treatment. Much time was spent helping him to manage his anxiety and fear that if he were “truly gay” he would then need to leave his marriage. It can be quite helpful to counsel patients that first they need to know who they are and then they can decide whether to disclose this information to anyone else or make changes in the circumstances of their life. This patient needed to have an honest relationship with himself before he could address other issues. For many, it is also important to explore the meaning of sexual abuse and its relationship to sexual orientation since many gay men question if sexual abuse “made them gay.”

Case 2: Later Stage Treatment for a Sexually Abused Gay Men

WA is a 48-year-old Black male who reported knowing he was gay from early childhood. He had had two long-term relationships with male partners in the past, although he now describes himself as “born again virgin.” He was generally quite open about being gay although he had never disclosed his sexual orientation with his mother. He reported little ambivalence about leading a gay “lifestyle” (HIF Stage Four: Acceptance).

The patient was referred for mental health treatment after being diagnosed with a psychosomatic disorder by his primary care provider. The client had repeatedly sought emergency care for a host of physical complaints for which no acute illness could be identified. This increase in visits

to the ER began after he was diagnosed with HIV disease two years previously. The client's health status was stable, his immune system largely intact, and he had no major opportunistic infections associated with HIV/AIDS. Given WA's relatively healthy immune system, it was highly unlikely he could have any of the infections for which he sought treatment. Indeed, most of WA's free time was spent "researching" HIV disease so that he was aware and could rationally articulate the futility of his ER visits. However, he would become anxious during unstructured times of the day and on weekends and then begin to ruminate about HIV/AIDS, which resulted in panic attacks and subsequent visits to emergency services.

Although the client had practiced safer sex consistently since his late 20s, he reported having had a "cocaine" problem in his early 20s, which led to frequent sexual partners and was likely when he became infected with HIV. He reported being gang raped at least once during a drug-induced state when he attempted to barter sex for drugs.

WA reported that from the ages of 10 to 12, a male clergy member associated with a chorus in which he participated repeatedly molested him. Soon after WA began to be molested, he developed a series of physical ailments (stomach aches, fatigue, nausea, diffuse pain) for which no cause was ever found. As a result, WA was identified as a "sickly child" and frequently kept home from school and choir practice by his mother. He reported that he was also "bullied" by other male children during this period of time and that being ill was a way to avoid this violence. Thus began a long history of somatic complaints whenever WA became anxious or depressed, which persisted to the time of his presentation for treatment. The diagnosis of HIV disease was the first time WA had what he referred to as "a serious disease" and his typical somatic response to stress was less tenable.

The thrust of early treatment for WA was to explore the relationship of childhood CPSA and the development of psychosomatic complaints. Although the link might seem apparent, WA was completely stunned to realize that his symptoms first appeared at almost the exact moment he began to be molested. Although, his symptoms did not magically disappear after this realization, they were significantly reduced after he acknowledged the link between childhood sexual abuse and somatic symptoms. He also benefited by learning stress management techniques to employ when he was feeling anxious or depressed as well as having a prescription for an antianxiety medication, which he could take as needed.

Although the primary focus of therapy was not on gay identity formation, the patient was troubled by not disclosing his sexual orientation and

HIV status to his mother. He was preoccupied with the thought that his mother had a “right to know” about his identity. Although WA described a warm and loving relationship with his mother, the fact that his orientation had never been acknowledged (and more recently his HIV status) had created a distance that he did not desire. At his initiative and with a great deal of therapist support, the client disclosed being gay and having HIV to his mother. She was relieved to finally have him acknowledge his homosexuality, which she had always suspected. Although very concerned about his HIV, she was relieved that he was in such good health. Interestingly, although WA did not disclose his childhood abuse to his mother, he did disclose his irrational fears of illness and engaged in an ongoing dialogue with her about his lifelong struggle with somatic complaints, which he found quite helpful.

WA never had any difficulty describing his abuse or expressing his disdain for his perpetrator, who had long ago “disappeared” from the congregation for unspecified “personal problems.” Rather than confront the abuser, this client felt the need to confront his biological father who was the other man in his life who he felt betrayed him. For the first time, he forged a semblance of a relationship with his father.

Treatment also explored the patient’s identity formation as a Black man. Although he had two intimate relationships with men, he had never dated or had an ongoing intimate relationship with another Black male. Initially, he indicated he had no idea why he preferred White male partners but gradually came to the realization that Black men represented the perpetrator to him since his perpetrator was Black. He also felt that unresolved issues related to his father contributed to his estrangement from Black men. WA described both fearing and desiring men of color. This was evident during his troubled past when he frequently sought out and engaged in high-risk drug and sexual behavior anonymously with Black men. In contrast, he perceived White men as generally safer, although he felt less erotically drawn and less culturally “in sync” with them, which resulted in “boredom” and contributed to his failed relationships. Over a period of time, WA began to seek out other men of color, including a support group of men with HIV. He soon began dating one these men.

CONCLUSION

Substantial evidence suggests gay men are at increased risk for a range of trauma experiences, including childhood sexual abuse, physical assault, and

verbal harassment. In order to assist gay men who are abused, it is important to understand the developmental challenges they experience trying to reconcile an affirmative identity in the context of abuse. Mental health professionals should adopt a normative frame for gay identity development. The HIF Model discussed in this article provides such a framework. Efforts should be made to determine a gay/bisexual client's HIF stage of identity formation and interventions designed accordingly. Prior to beginning treatment, abuse histories should be taken for all gay clients, including questions about CPSA. In addition to questions about physical and sexual abuse, assessments for gay and bisexual individuals should include questions about harassment related to gender atypical behavior in childhood and other forms of gay specific abuse/harassment. Each gay and bisexual male client should also receive a risk assessment for HIV/AIDS and primary and secondary prevention intervention as needed. Upon completion of an initial assessment, trauma treatment protocols (Herman, 1992; Linehan, 1993) can be modified and successfully utilized with traumatized gay men.

There is also a need for clinicians, who are sensitive to the issues of gay identity development, to be engaged in prevention and advocacy designed to reduce the incidence of CPSA and to protect the needs of gender atypical boys. These efforts may include educating the clergy about sexual abuse as well as treating clergy who are at risk for abusing children and may have other mental health disorders. Prevention and advocacy efforts should also extend to working with guidance counselors, school psychologists, teachers, coaches, and others who work with youth and educating them about the needs and vulnerabilities of gender atypical boys.

There are almost no studies that specifically examine the incidence and impact of CPSA for gay men. Research is needed on how clergy abuse, as opposed to other forms of abuse, might impact sexual identity formation and mental, physical, and spiritual health in gay men. Furthermore, interventions should be developed and tested for treating gay men and others with a history of CPSA.

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