# The Case of Abel:

# Religion as Boon and Bane for a Catholic Gay Man

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Abstract

Conservative religious institutions and leaders that condemn homosexual sexual orientation and acts as unnatural and sinful pose significant challenges for gay persons whose faith is a core part of their identity. The condemnation presents a serious barrier to the acceptance and integration of their sexuality, a primary task of psychosexual development. As a result, they can manifest depression, anxiety, suicidal ideation and even attempts. The ecclesiastical censure also imposes an untenable dilemma for homosexuals in that they feel pressed to reject their sexual identity or renounce their spiritual identity and heritage. Psychotherapists who treat gay persons caught in this quandary can find themselves facing a similar problem: how to help their homosexual client accommodate their proscribed sexuality with their spiritual beliefs, commitments, and obligations. The case presented here recounts the treatment over many years of a gay man suffering from such a conflict and his eventual accommodation of both his homosexuality and his faith. Recommendations are offered for constructive treatment with those torn between two conflicting core identities.

Keywords: gay, homosexuality, spirituality, religion, psychotherapy

## Growing up gay as trauma

Growing up gay is itself a form of trauma to which organized religion may contribute and/or mitigate, depending on its acceptance or rejection of same-sex attraction and expression. For gay men growing up in conservative religious environments that condemn same-sex attraction the process of identity formation may involve a particularly traumatic process of integrating sexual identity with religious identity. Under such conditions, self-acceptance and healthy psychosexual development become all the more difficult (Cerbone, 2012; Pietkiewicz & Kolodziejczyk-Skrzypek, 2016; Shilo, Yossef, & Savaya, 2016). Thus, the spiritual component of gay identity may be repressed and damaged by early and ongoing religious rejection serving as a form of sexual abuse and abandonment. As with other interpersonal trauma, ensuing skirmishes between religious and sexual identities may result in profound states of depression, anxiety, suicidal ideation, guilt, shame, internalized homophobia, religious alienation, and even weakened faith (Rodriguez, 2010; Shilo et al., 2016).

Rodriguez (2010) frames the challenge facing religiously identified gays and lesbians as a series of poignant questions. "Why'" he asks, "do gays and lesbians put themselves through such ordeals and try so hard to stay connected with a religion that rejects them? A strong Christian religious faith, and a strong desire to be 'out' as a gay man or lesbian, leads many individuals to try to find some way of dealing with both identities. How do they do it? How do some gays and lesbians not only live with two identities that are perceived by so many…as being completely incompatible, but thrive while fully embracing and combining them both" (p. 7)?

The significant relationship that exists between religious trauma and gay psychosexual development throughout the lifespan (Burdette, Hill, & Myers, 2015; Cerbone, 1990) makes it especially compelling for psychologists to explore these conflicts in the lives of their patients

regardless of age, the number of years after coming out, or the number of years after which some level of religious reconciliation is reported.

**Religion: boon and bane**

Like the Roman god Janus who has two faces that squint in opposite directions, religion possesses two countenances. The first is a benevolent offering of compassion and community to its adherents; the second engenders severe abjuring of those who do not conform to its prescriptions for worthiness. The former comforts, heals and lifts the spirit through times of trouble and travails, especially in facing the inevitability of death. Importantly, it provides grounding in the face of the ambiguities and vicissitudes of life. Often, the latter creates divisions and is experienced as threatening the wayward with stigma, condemnation, and expulsion. Moreover, for believers the threat derives from the godhead itself whose absolute power cannot be challenged. Both faces have particular importance for persons who are same-sex attracted and conservatively religious (Worthington, 2004).

There is evidence to support that religion has both positive and negative effects on individuals (APA, 2007). Religion is an important positive influence in the lives of the vast majority of people (APA, 2007; Delaney, Miller, & Bisono, 2007; Knapp, Lemoncelli, & VandeCreek, 2010), and has been found to be associated with good mental health (APA, 2007; Knapp et al., 2010; Rosario, Yali, Hunter, & Gwadz, 2006; Rosenfeld, 2010). For some clients, religion is an important part of identity (Milstein, Manierre, & Yali, 2010). Religion may also facilitate positive adaptation to trauma and adversity like HIV/AIDS (Golub et al., 2010). On the other hand, religion is frequently referenced as a justification for discrimination and prejudice (APA, 2007; Sherry, Adelman, Whilde, & Quick, 2010). Religion and anti-gay prejudice are frequently linked in defining homosexuality as unnatural (Gillis, 1998). Some religious

practitioners go so far as to support and offer conversion therapies for those whose sexuality conflicts with their religious beliefs (Morrow & Beckstead, 2004; Throckmorton, 2002) notwithstanding data indicating that such therapies are ineffective for their intended purposes and are often harmful (Beckstead et al., 2004).

Yet, despite the professional consensus of its importance, two-thirds of surveyed clinical psychologists reported that they did not feel competent to treat clients facing religious conflicts (Shafranske & Malony, 1990). Similarly, Saunders, Miller, and Bright (2010) reported that psychologists are reluctant to address the spiritual and religious beliefs of their patients but recommend that psychologists engage in "spiritually conscious care with all patients" (p. 355). Rosenfeld (2010) indicated that exploration of a client's religious involvement and values can strengthen the therapeutic alliance. And as Haldeman (2004) noted, for some same-sex oriented persons, religious identity is primary while sexual identity is secondary. Given professional reluctance and in spite of potential helpfulness, working with clients compelled to choose between their faith and sexual orientation can pose weighty challenges for a psychologist.

The case below summarizes the treatment of a gay man who found the solace and strength in his Catholic faith to survive childhood physical and sexual abuse while enduring the condemnation that the same church leveled at him for his homosexuality. He has given his consent for his story to be told in this manner.

## Abel

Abel is a 52-year-old Caucasian, HIV-positive, and Catholic gay male who sought therapy for depression approximately twenty years ago. A very successful corporate attorney, Abel was articulate and psychologically astute. He is the fifth of six children with three older sisters, one older brother and one younger brother. He reports that his younger brother is

mentally disabled and continues to live with his mother in a retirement home where she moved a couple of years after Abel's father died of cancer. His older brother is described by Abel as having severe behavioral dysfunction and now resides in an assisted care facility.

While never expressing a desire to be anything other than gay, Abel's depression was related to ambivalence about the moral value of his sexuality. He was out to his family about his sexuality, though discussions about it were few and awkward, except for those with two older sisters. He has not disclosed his HIV+ status to any of his family members.

He reported having a few brief and ultimately disappointing relationships. Early in his therapy, Abel reported a pattern of frequenting heavy cruise bars on Saturday nights, drinking heavily, and engaging in casual sexual encounters. Sundays, he would be filled with guilt and shame. He believed that homosexuality was inimical to the official position of his Church. Frequently, he sought advice from his confessor, a priest who was compassionate, never chastised him or demeaned his homosexuality, and encouraged him to seek therapy to help resolve his ambivalence.

Abel's ambivalence often extended to the gay subculture where he experienced pressures to conform that mirrored the pressures he felt from his church. Though his friends and social acquaintances were almost exclusively gay, he played softball in a gay sports league, read books in a gay book club, and sought healthcare from gay providers, he was often highly critical of gay people, particularly those he felt used their stigmatized status to entitle themselves. While supportive of legal protections from discrimination and for same-sex marriage, he would disparage the political principles or legal strategies that gay groups employed when in his mind they created prejudicial prerogatives.

Abel did not see his HIV+ status as a major focus for therapy and seldom mentioned it in sessions. He has been positive for more than twenty years, manages his infection effectively with medications, and experiences no ill effects from the infection or the medications. Nonetheless, like many positive gay men, he preferred to date others who were positive. He believes he knew how and by whom he was infected. He bears no ill will toward that person but holds himself responsible and carries shame about it. This shame was further evident in his unwillingness to talk in detail about his sexual history outside of acknowledging a history of drunken sexual encounters that caused him alarm and embarrassment.

Coming out to his family was met with mixed results. First, he told his oldest sister who appeared anxious and strongly encouraged him not to tell his parents. This delayed his coming out to other family members. His two other sisters were accepting. One has a gay son for whom she has occasionally sought Abel's advice. His mother neither accepted nor rejected his homosexuality but has remained reluctant to discuss it further with him. His father disapproved of his homosexuality as immoral and told him that he was destined to lead a lonely life. At the same time, his father opined that maybe Abel's homosexuality would be his avenue to finding God.

It took Abel more than two years of psychotherapy before he trusted the therapeutic relationship enough to disclose childhood sexual abuse by his older brother. He had already revealed being physically abused on several occasions. Reporting the abuse as a preteen to his parents roused his father's anger toward him, rather than protection. Instead of stopping the abuse, his father blamed Abel for provoking his brother at a time when his brother was described as showing early signs of mental illness. In response to Abel's report of abuse, his mother expressed fear of her husband's explosive anger: "You know how he can get." Hearing Abel's

retelling of is father's WWII experiences as part of the invading forces on Okinawa raised questions about whether his father himself may have had PTSD.

Feeling alone and isolated, Abel avoided his brother by sleeping on an unheated porch even in winter. A growing awareness of his homosexuality intensified the loneliness and isolation he felt. For a long while, he contemplated suicide. Only the threat of hell from his Church and the legacy he would leave his family kept him from making an attempt. The abuse stopped, as it so often does in child abuse, when Abel was strong enough to threaten his brother with physical force.

Initial Axis I diagnoses were major depression, with associated symptoms of anxiety, and alcohol abuse. Later, PTSD was added as a major focus of therapy.

**Course of therapy and countertransference**

Given the purpose of this article to address the relationship of religion and faith to sexuality and identity, the following review of Abel's therapy will focus less on major clinical concerns such as his substance abuse, family and romantic relationships, and his sexual abuse during childhood and young adolescence. At the same time, it should also be noted that gay men report sexual abuse as children in greater numbers than heterosexual men (Tomeo, Templer, Anderson, & Kotler, 2001). They also report histories of substance abuse more frequently (Berke, Maples-Keller, & Richards, 2016).

From the first months of therapy it was apparent that Abel's faith was a major support, sustaining him through years of reported abuse. Attending Mass regularly, even daily during Lent, and praying to God and saints provided him with a strong sense of identity, meaning, and what seemed his only positive connection with his deeply religious and observant family. At the same time, the threat of eternal damnation plagued him, causing intense emotional conflict and at

times even despair. How to help him retain the benefits of his faith while resolving the dilemmas it presented became the first challenge of psychotherapy.

As a psychologist, it was important to recognize and support the strength and resilience Abel derived from his faith without denying the brittle defense system he had developed to manage conflicting pressures. This meant encouraging and exploring the strong moral and ethical integrity his faith fostered, the resilience he developed to survive unspeakable pain and abuse, and the hope it provided for the salvation he craved while always attending to the task of integrating his sexual identity and behavior. When he raised questions that appeared less psychological and more spiritual in character, he was advised and was receptive to being encouraged to consult with his spiritual director.

It was equally evident that building trust between Abel and the psychologist would be essential to achieving productive outcomes. Abel found bases for trust in the psychologist, first, in the referral from his trusted primary care physician, second, in information garnered from the internet, and third, from questions to his psychologist that revealed similar personal histories. Both he and his psychologist had attended the same Midwest university, though many years apart, and had entered and left Catholic seminaries because of their homosexuality. Though never mentioned as an important criterion, their male gender was another unspoken source of bonding. Many gay men prefer seeing other gay male psychologists, particularly if sexual behavior is a likely focus. Abel also valued his psychologist's history of activism in promoting affirmative care for LGBT patients and clients. The psychologist's professional and social visibility in the LGBT community provided knowledge that might otherwise be unavailable, e.g., his being partnered. Having a psychologist who understood the meaning of being Catholic and gay provided on important basis for an early and positive transference. Thus, the relationship was

formed in part through Abel's identifying with the psychologist as a healthy and accepting moral authority.

With the positive transference came the obligation to examine countertransference. For this, the psychologist had a longstanding relationship with two psychology colleagues who provided weekly case consultation and peer supervision. Given the professional and personal knowledge and trust that comes with longtime supervision, these relationships provided the ongoing support and corrections necessary. In particular, the psychologist developed trust and assurance that shared histories would not confound the therapy. Supervision helped to differentiate projective identifications from client-focused intuitions that in turn informed interventional strategy. Grounding the therapy in evidence from psychological research on LGBT issues, the relationship between stigma and substance abuse, gay male sexual behavior, and attachment styles further helped to manage risks associated with counterproductive countertransference.

## Discussion

Gonsiorek (2004) has noted that "for clients who are both same-sex attracted and conservatively religious, effective therapy cannot focus on one of those aspects but must work to integrate both if it is to be effective and beneficial" (p. 752). Haldeman (2004) has suggested, "The ultimate task of the therapist…is the integration of disparate aspects of identity" (p. 693). For a gay man like Abel, it was important for the therapy to acknowledge and support the emotional and psychological support that his religion provided. Because it was a core operating and organizing principle for his life, it was critical to respect the centrality of his faith to his identity. Yet neither could it be denied that his religious beliefs and experiences imposed a significant barrier to what Knapp et al. (2010) discussed as an integration of sexuality and

identity. Considerable costs were evidenced in his reports of alcohol-induced sexual encounters leading to considerable shame and religious conflict the morning after.

With the trust that years of working together built, Abel grew into greater levels of comfort exploring the complexity of his relationships with family and friends, alcohol, professional identity, sexuality, and indeed faith. Psychotherapy fostered first an awareness of his dependence on the judgments from within his church for his sense of self-worth. Carefully avoiding discrediting that respect for authority, therapy explored the psychological vulnerabilities associated with relying on the judgments of others in other areas of his life, including his employment and social circles.

Therapy further explored the psychological importance of internalizing his locus of self-esteem. As Abel grew to appreciate this, he made decisions first about the direction of his career that became based more on self-interest than corporate interest. Over time, his adherence to the Church as an institution tempered, again with the support of his spiritual director. In its stead, Abel placed more trust in his direct relationship with his God and with Christ as a way to mediate his sexual and spiritual dilemma.

The pastoral emphasis of Pope Francis who encouraged compassion toward gay men provided implicit support for Abel's self-acceptance. A transition from a doctrinal to a pastoral stance permitted Abel to adhere more comfortably to his faith while simultaneously affirming his identity as a gay man. The internal peace this afforded allowed for the pursuit of more appropriate relationships, a secondary presenting problem that mitigated as his self-esteem and acceptance grew.

In time, he sought help for his alcohol abuse at a clinic that offered gay-affirming behavioral health services to LGBT patients. Curtailing his drinking had the salubrious effect of

removing a major gateway to the sexual encounters that shamed and frightened him. Likewise, seeking treatment aligned him more closely with the tenets of his faith regarding alcohol abuse and sexual behavior.

The most significant psychological shift in his thinking was the gradual modulation of his self-criticism, shame, and guilt. Like the stock market, his progress advanced in fits towards increasingly greater self-acceptance. For example, he looked more to the biblical teachings of Christ that emphasized love for others and contained no condemnation of homosexuality.

Today, Abel is much less depressed, still wonders if the abuse he endured was as bad as his younger sisters remind him it was, is still a very observant Catholic, and has a stable and rewarding relationship with a same-sex partner. The ambivalence and conflicts that drew him into therapy have mitigated to the point that they no longer are a primary focus of therapy. To the contrary, Abel takes a measure of pride both in his faith and in his homosexuality.

**Conclusions and recommendations**

The case of Abel demonstrates the importance of addressing the intersection of spiritual and sexual identities in psychotherapy in a manner that acknowledges and supports the meaning of each identity for each client as an individual. The contributions of religion to the client's identity can be significant, as they were for the man in this case. Most significantly, Abel's faith helped him survive the repeated trauma of physical and sexual abuse from a family member.

At the same time, it is critical to note and attend to the contradictory contributions to the self-criticism and self-rejection, as well as depression and anxiety that his church's anti-homosexual teachings engendered. Ignoring one for other would have been counterproductive and potentially recreate the conflict that drew him into therapy. It may even be the case, as it has been for Abel, that the issues encountered around sexual orientation provided a catalyst for a

deeper and ultimately rewarding examination of his religious affiliation and his sexual behavior (Sherry et al., 2010).

Understanding the gay experience of discrimination is an important cultural competence that will enhance psychotherapy beyond an intellectual understanding of minority stress. It can also diminish the likelihood of making stereotypical assumptions (Berke et al., 2016), such as that gay men are necessarily/typically anti-religious. Understanding this experience also promotes trust between the psychologist and client that in turn allows for the exploration of more vulnerable concerns like sexual behavior. In this regard, it is wise for psychologists to understand their own attitudes toward both same-sex identity (APA, 2007) and the religious values and commitments of their clients (Plante, 2016). Peer consultation and supervision can be supportive to the psychologist as well as monitor for possible prejudicial reactions to the client. Consultation is particularly advisable with religious clients, whom are significantly more likely than psychologists to be religious (Delaney et al., 2007).

The primary task for the psychologist in such cases is to help the religious client find a balance between the boon and the bane as they relate to faith and sexual identity integration, a critical psychosexual developmental task, though without abandoning or rejecting the client's religious identity. So doing might be experienced as taking one side in the client's dilemma, would likely be rejected by the client, and may be psychologically harmful in many respects. In this way, the psychologist is more likely to avoid becoming another judging moral figure of the gay male client's sexuality or religiosity, either overtly or through more subtle and covert acting out in the therapeutic relationship.

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