Clinicians’ Perspective of the Relational Processes for Family and Individual Development During the Mediation of Religious and Sexual Identity Disclosure

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Clinicians’ Perspective of the Relational Processes for Family and Individual Development During the Mediation of Religious and Sexual Identity Disclosure

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Although the psychological literature regarding gay men from religious families is continually expanding, it is also limited in that few studies focus on the use of therapy in the negotiation of the interrelated systems of religion, sexuality, and family. Utilizing a cultural historical activity theory-based process of analysis, this study focuses on the narratives of 12 clinicians discussing 230 conflicts and how those conflicts are mediated in both productive (e.g., seeking secular support) and unproductive ways (e.g., bringing one’s son to an exorcist) by gay men and their religious families independent of and at the advice of their therapists.

KEYWORDS therapy, clinical practice, gay, religious, conflict, sociocultural

American politics today are at a crossroads in terms of the campaign for sexual minorities’ legal rights. While there have been many recent changes expanding sexual minority rights, such as the 2011 repeal of the military’s “Don’t Ask, Don’t Tell” policy and the Supreme Court’s 2013 ruling that the federal Defense of Marriage Act is unconstitutional, many issues continue to be debated. This sociopolitical context is embedded within a religious one,
as the majority of Americans are raised in families in which religious beliefs are present (Lease & Shulman, 2003), and specific aspects of religiosity have been inversely correlated with sexual minority acceptance (Adamczyk & Pitt, 2009; Fisher, Derison, Polley, & Cadman, 1994) as well as with attitudes toward sexual minority legal rights (Hooghe, Claes, Harell, Quintelier, & Dejaeghere, 2010; Oldmixon & Calfano, 2007).

This relation between religion and sexual minority acceptance was recently highlighted by Texan governor and Republican nominee hopeful, Rick Perry. In his infamous 2012 political advertisement, Perry stated, “I'm not ashamed to admit that I’m a Christian. But you don't need to be in the pew every Sunday to know there’s something wrong in this country when gays can serve openly in the military but our kids can’t openly celebrate Christmas or pray in schools.” Within this narrative, Perry publically supported a cultural narrative suggesting that religion and sexual orientation diversity are incompatible and that alternative assertions encroach on others’ religious freedoms. In this article, we suggest that individual and familial development is situated within such sociocultural narratives and the methods by which they navigate the culturally constructed polarization between religion, sexuality, and family values. For example, extant research suggests that the majority of sexual minority persons from religious backgrounds have reported experiencing a level of conflict between their sexual orientation and religion. For example, Dahl and Galliher (2009) found that 60% of disclosed sexual and gender minority participants (18–24 years) reported some degree of religious conflict, and 40% of all participants reported that they were unable to integrate their sexual and religious identities (Dahl & Galliher, 2009). Similar results were found for an older population as well (18–65 years, $M_{Age} = 35$), with 64% of sexual minority participants indicating that they experienced a conflict between their sexual orientation and religion (Schuck & Liddle, 2001). Within a Jungian and spiritually integrated psychotherapy perspective, self-related conflicts are particularly problematic as the most fundamental human drive is the need to integrate the multiple facets of the self (Jung, 1938). In a similar vein, sociocultural theory suggests that human development is situated within our efforts to construct and make sense of our roles within conflicting and interacting activity systems (i.e., Vygotsky, 1978).

The present study illustrates the significance of applying Vygotsky’s cultural historical activity theory (1978) and the theory of relational complexity (Daiute, 2012) to the study of family and individual therapy regarding the interaction of sexual orientation, religion, and family relations. Within this lens, the therapeutic process is positioned as an activity-based process that occurs and is subject to change in association with the complex demands of dynamic socio-relational contexts. Thus in this article possible solutions to familial conflicts surrounding issues of sexuality and religion are understood to be actively constructed by both the client and therapist to mediate
(modify) the use and purpose of cultural tools (e.g., biblical texts and values) via activities (e.g., therapy, religious institutional engagement, constructing new narratives) in an effort to meaningfully address the demands of changing contexts and sociocultural environments (e.g., more permeable religious environments, gay rights).

Therefore, the focus of this article includes the study of both social–relational dynamics and individual subjectivities and capacities. Given this study’s unique focus on the sociocultural contexts of interpersonal relations, this study specifically focuses on clinicians who worked with gay men as prior research has indicated that the disclosure process may significantly vary across sexual minority groups (Rodriguez & Ouellette, 2000), that men and women often occupy different public roles from each other within the structural location of religious institutions (Glassgold, 2008; Ozorak, 1996), and that biblical prohibitions concerning gay men and lesbians differ as well (Greenberg, 2004).

CONFLICTS WITHIN THE INTERACTING SYSTEMS OF RELIGION, SEXUALITY, AND FAMILY

Religious and familial activity subsystems are often highly interrelated, and, as such, religious orthodoxy is likely to play a significant role in familial responses to a relative’s sexual orientation disclosure and their conflicts (Etengoff, 2013; Mahoney, 2010; Walsh, 2008). For example, a recent narrative study focusing on the post-disclosure familial conflicts of 23 gay men from fundamental Christian and Orthodox Jewish backgrounds found that 74% of participants reported that their familial conflicts were situated within religious contexts (Etengoff, 2013). Moreover, researchers suggest that while religious coping can successfully mediate cultural and familial conflicts (e.g., religiously reframing event, person, or the sacred to improve relations), religion is often used in relationally harmful ways as well (Brelsford & Mahoney, 2009; Etengoff & Daiute, 2014; Pargament, 1999). For example, religious Christians have reported incorporating God into their familial conflicts even at the cost of resolution failure (Butler & Harper, 1994). Brelsford and Mahoney (2009) defined this maladaptive process by which “God/faith is positioned as an ally against [the] other party” as theistic triangulation (Brelsford & Mahoney, 2009, p. 291).

Although research indicates that more religious groups place a higher value on the importance of family than less religious groups (Jensen & Jensen, 1993; Newman & Muzzonigro, 1993; Mahoney, 2010), more religious families also report encountering greater difficulty in accepting their gay relative than less religious families (Conley, 2011; Freedman, 2008; Kubic et al., 2009; Newman & Muzzonigro, 1993; Schnoor, 2003). For example, Newman and Muzzonigro’s (1993) analysis of 27 gay adolescents and emerging adults’
questionnaire data indicate that gay youth from more traditional and religious families felt less accepted during their disclosure process than gay youth from more secular families. Such negative coming-out responses from religious relatives frequently impact the mental health of the sexual minority relative, highlighting the importance of engaging both the systems of family and religion in clinical and community intervention settings (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

A CRITICAL REVIEW OF PRIOR CLINICAL RESEARCH

Despite a growing body of research regarding gay men from religious backgrounds, there is limited knowledge concerning whether the issues explored by researchers are additionally being discussed during therapy and, if so, how these issues are being addressed (e.g., Freedman, 2008; Kubicek, McAvitt, Carpineto, Weiss, Iverson, & Kipke, 2009; Schuck & Liddle, 2001). For example, although Dahl and Galliher (2009) reported that 13% of the 63 sexual and gender minority participants that integrated their sexual and (primarily Christian) religious identities found counselor support to be beneficial, there was no discussion as to how those issues were navigated during the course of therapy.

Furthermore, few studies include clinicians’ perspectives regarding their role in the therapeutic process for gay men and their religious family members, although clinical recommendations are often provided (e.g., Phillips & Ancis, 2008). Those studies that do include clinicians’ perspectives are often quantitatively focused on how clinicians’ religious attitudes and sexual orientations influence the therapeutic process and client relationship (e.g., Balkin, Schlosser, & Levitt, 2009; Green, Murphy, & Blumer, 2010; Stracuzzi, Mohr, & Fuertes, 2011) as opposed to a pragmatic discussion of the conflicts encountered around issues of religious involvement and the methods and strategies that counselors employ when working with sexual minority clients (Bozard & Sanders, 2011). For example, Balkin et al. (2009) found that counselors with more rigid religious attitudes were more likely to exhibit homophobic attitudes. However, the question of exactly how these religious and homophobic attitudes influenced the counseling process was not explored.

In addition, the extant literature that does include clinical perspectives is often limited to case studies (e.g., Glassgold, 2008; Haldeman, 2004; Tan & Yarhouse, 2010), individual therapists’ perspectives (e.g., Mark, 2008; Paul, 2008), discussions of non-empirically tested methods of intervention (e.g., Bozard & Sanders, 2011; McGrady & McDonnell, 2006), and clinical populations of a single faith (e.g., Mark, 2008; Pope, Mobley, & Myers, 2010). Indeed, most studies on religion and psychotherapy in general, as well as in terms of the sexual minority population specifically, focus exclusively on issues of Christian religiosity (Worthington, Kurusu, McCullough, & Sandage, 2010).
1996; Rodriguez, 2010). In addition, much of the extant research focuses on specific, segmented aspects of the difficulties encountered by gay men from religious backgrounds, such as how to reconcile sexual and religious identity, without necessarily including a simultaneous discussion of the multiple actors and systems (e.g., family) that are a part of this negotiation process (e.g., Dahl & Galliher, 2009).

There is currently a noted gap in the clinical literature and limited empirical information available to help counselors pragmatically address religious and sexual development with sexual minority clients (Bozard & Sanders, 2011; Schuck & Liddle, 2001). This gap is particularly problematic as research indicates that sexual minorities’ mental health is enhanced by the ability to integrate spirituality and sexuality (Lease, Horne, & Noffsinger-Frazier, 2005; Wagner, Serafini, Rabkin, Remien, & Williams, 1994). In addition, researchers have reported that the majority of clients in general would like to discuss spiritual and religious issues in counseling (Quackenbos, Privette, & Klentz, 1985; Rose, Westefeld, & Ansley, 2008). Furthermore, it appears as though these needs are not currently being addressed as the extant literature indicates that counselor–client value dissonance is particularly powerful regarding issues of spirituality and sexuality (Zinnbauer & Pargament, 2000). Moreover, recent reports by the American Association for Marriage and Family Therapy clinical members indicate that only 46% received clinical training in graduate school regarding sexual and gender minority client needs (Green, Murphy, Blumer, & Palmanteer, 2009). Clearly, there is a need to expand the current body of clinical literature to include a more applied focus that can assist in narrowing this gap between client and therapist as well as research and practice (Sherry, Whilde, & Quick, 2010).

CULTURAL HISTORICAL ACTIVITY THEORY AND RELATIONAL COMPLEXITY

There is a need to contextualize complex family interactions and relationships within a theoretical paradigm that encapsulates both interpersonal and intercultural dynamics of the coming-out period. Vygotsky’s (1978) cultural historical activity theory offers such a perspective by positing that social interactions within daily life activity systems are formative meaning-making experiences that contribute to human development. In this view, the task of families and individuals engaging conflicting religious and sexual practices is to define and mediate the relation between these activity systems. Within this sociocultural perspective, mediation is understood as “the use of language and other symbol systems to perceive, manage, and develop self-society relations” (Daiute, 2010, p. 48) and is thus studied by focusing the unit of analysis on individuals’ relational uses of sociohistorically constructed and individually adapted physical, symbolic, or abstract cultural
tools (Etengoff & Daiute, 2013). Although this theoretical paradigm has yet to be deliberately applied to the research design and analysis of the population studied in this article, Pargament (1999, p. 176) has developed the complementary paradigm of spiritually integrated therapy, which “assumes that spirituality is often interwoven with the problems clients bring to psychotherapy, the solutions to these problems, and the clients’ larger social and cultural context.”

In addition, the theory of relational complexity (Daiute, 2012) offers an additional dimension of such sociocultural approaches as well as an extension of perspective-taking theory (Davis, 1983). While the theory of perspective-taking asserts that individuals can facilitate improved interpersonal relations by anticipating the behavior and reactions of others (Davis, 1983), the theory of relational complexity suggests that interpersonal and intercultural relations are enhanced when individuals understand the behavioral contexts of the others’ diversity, power, and relational expectations (Daiute, 2012). Within this perspective, adaptive relations are situated within meaningful and flexible interactions as individuals adjust their expressions as related to the others’ socioculturally situated goals and needs (Daiute, 2012). Sociocultural theories of development such as relational complexity are particularly relevant to gay men and their religious families due to the inherently multifaceted interactions among personal and shared relational, familial, religious, and social activity systems.

CURRENT STUDY

The current study aims to explore the following research questions from the clinicians’ perspectives: (a) What types of conflicts are discussed within the therapeutic context by gay men who grew up in religious families, and which conflicts are most frequently referenced by clinicians as emerging during the therapeutic process or being salient foci of the process? (b) What mediational strategies and cultural tools are reported by gay men and their religious families as being used to address those conflicts? (c) What types of alternative mediational strategies and forms of cultural tool use are being suggested by clinicians for gay men and their religious families? (d) How do therapists apply the theory of relational complexity in their advice to gay men and their religious families?

METHOD

Participants

Twelve clinicians from the New York state area participated in the study (\(M_{Age} = 53, SD = 17, 92\% \) White) in 2011 over a course of 3 months. The
only eligibility criteria for participation were that they had worked with gay clients from religious families within the past 5 years, that they were located in the tri-state area, and that they self-identified as a clinician. Of the participants recruited, eight (67%) self-identified as male, three as female (25%), and one as a transsexual man (8%). Nine participants identified as being members of sexual or gender minority communities, one participant identified as being heterosexual and connected to the sexual minority community, and two participants identified as being heterosexual and not connected to the sexual minority community. In response to the question “How would you describe your relationship to the religious community?,” eight participants reported not being currently religious (although three identified as having a Jewish background and one as having a Catholic background), two participants identified as religious Orthodox Jews, and two participants identified as actively involved religious Catholics. Of the participants that currently identified as religious Catholics, one participant is currently a Catholic priest and one participant currently gives sermons at a gay-affirmative church. Although participants identified with a number of relevant affiliations or orientations, it should be noted that the authors did not assume that such affiliations equated with competence or sensitivity to address clinically related issues.

Eight participants attained a Master’s degree in counseling or social work, three attained a PsyD, and one attained a PhD in clinical psychology. Eighty-three percent (10) of participants identified as gay affirmative. The average number of years of participants’ reported clinical experience is 20.6 with a standard deviation of 14.7 years. Eighty-three percent (10) of participants currently work with gay clients from religious backgrounds, and 17% (2) of participants had worked with such clients within the past 3 years. Participants reported that they worked with clients from the following religious backgrounds: Christian (Baptist, Catholic, Jehovah’s Witnesses, Lutheran, Methodist, Mormon, Pentecostal, Protestant) Hindu, Jewish, and Muslim.

Procedure

RECRUITMENT

Participants were recruited via e-mail with the same Institutional Review Board approved recruitment text to complete a semistructured interview focusing on practicing clinicians’ thoughts and experiences regarding the tension between religion and sexual identity that may be experienced at both the family systems and individual level. E-mail addresses were obtained by conducting Internet searches for clinicians in the tri-state area that specialized in gay issues, by contacting community organizations and Listservs, and via the Psychology Today database. In addition, contacted clinicians may have forwarded the call for participation to colleagues with similar areas of
expertise. Forty-eight recruitment e-mails were sent out with a 25% recruitment rate, which is fairly typical for the social sciences. No incentives were offered for participation other than participants’ potential contributions to social science. Recruited participants were then interviewed either in-person at a location of their choosing or via telephone after informed consent had been obtained.

Measures

QUALITATIVE INTERVIEW

The semistructured interview formally comprised 13 questions regarding the salient and significant issues that emerged in the participants’ clinical work with gay men and their religious family systems (see Appendix A: Interview Questions). In addition, follow-up questions focusing on whether religious texts were discussed within the therapeutic context and additional demographic questions concerning age and gender of the participants were included as well. Interviews were audio recorded, transcribed, and de-identified. Clinicians were not asked to share specific details of their clinical practice that are protected by the Health Insurance Portability and Accountability Act (HIPAA). Rather, clinicians were asked to discuss in general terms the most frequently occurring conflicts and most powerful mediational strategies that emerged in the therapy sessions that they conducted. The average interview length was 31 minutes ($SD = 9$ minutes). Nine interviews were conducted in-person, and three were conducted over the telephone.

METHOD OF QUALITATIVE ANALYSIS

In an effort to capture the depth of individual narratives as well as the breadth of possible trends across participants, both descriptive frequency analyses and individual narrative analysis are included. Individual narratives were selected for inclusion in the article if they were able to concisely and comprehensively illustrate participants’ clinical experiences as related to clients’ conflicts, tools, and mediational strategies. The first author developed a coding system that was inductively derived from the narratives and informed by cultural historical activity theory, and the coding system was then reviewed by the second author for content validity. All interviews were coded by the first author and a trained research associate. Two participants’ narratives were used for training purposes, and 10 were then double-coded. All narratives were read through at least once prior to coding to help the researchers gain familiarity with the narrative. Inter-rater reliability for the identification of conflict and strategy scenarios was initially 71%, and the coding manual was referenced and discussed until inter-rater agreement
was reached. Narratives were initially coded for the types of conflicts that clients discussed within the therapeutic context and then coded for the mediational strategies and cultural tool use that was either employed by clinicians, families, gay men, or suggested by clinicians.

Given cultural historical activity theory’s emphasis on the development of individuals within society (Vygotsky, 1978), conflict narratives were identified if the narrative focused on interpersonal, intercultural, or self-development tensions, arguments, or interacting and competing values between these multiple systems. Narratives were explored as mediational strategy narratives if the clinician described how their clients’ developed scripts and cognitive frameworks to navigate poignant and frequently expressed issues (Appendix A: Questions 6 and 7) and how the therapeutic process and strategies were used to navigate the coming-out period (Appendix A: Question 8 and 9). In addition, the complete transcript was read for narratives related to religious coping methods, cognitive reframing, and cultural script adaptation—such narratives were then coded as mediational strategy narratives. Last, narratives were coded as including cultural tools if the clinician discussed scripts, activities, processes, or objects as goal-directed relational activities, helpful or harmful contributors to the coming-out process, or featured within clients’ conflict and resolution narratives as a meaningful or useful player in relational processes. In other words, cultural tools were understood to often be the medium by which mediational strategies were implemented.

Coding for conflicts included the following data points: time of conflict in non-mutually exclusive terms (pre-disclosure, post-disclosure, during disclosure, continuous, unclear from narrative); conflict focus; conflict context (client specific or general clinical impressions); number of conflicts within each conflict focus category; number of conflicts coded for more than one conflict focus category; and the total number of conflicts per narrative. The conflict focus was coded for the following categories, with the possibility of multiple categories for each conflict: (a) self: includes conflicts or states of discomfort that the gay person has with or within themselves. This can be manifested as an uncertainty, desire to change, struggle, conflict regarding their sexual self or their religious self, or fears; (b) God: includes conflicts that a person (gay man or family of) directly has with God as opposed to the religious community or institution. This could be manifested as anger, mistrust, confusion, questioning, and so forth; (c) religion as an institution, community, or figure: includes conflicts discussed within the framework of normative community behavior, acceptance, expectations, alienation, and so forth; (c) family: includes conflicts with the family, either as a unit/system or with individual family members; (d) therapist: includes conflicts between the therapist and client. This can be manifested as the therapist challenging the client. These types of challenges can be both productive (e.g.,
encouraging a client to see that there are different ways of thinking, feeling, behaving) or perhaps maladaptive (e.g., doubting the client’s sexual orientation); (e) friends (not specified as religious); (f) society at large (not specified as religious); and (g) other: includes conflicts that were referenced less than twice across all narratives and included foci that could not be coded in other conflict categories (e.g., conflict with the media, school, gay community).

Coding for mediational strategies and cultural tool use included the following data points: type of mediational strategy used including both adaptive (e.g., religious coping as discussed by Pargament, 2007) and maladaptive strategies (e.g., theistic triangulation as discussed by Brelsford & Mahoney, 2009); recommender and/or initiator of mediational strategy; enactor of mediational strategy; people and systems affected by mediational strategy; and cultural tools used to enact the mediational strategy including both religious and secular tools. The types of mediational strategy categories are listed in Table 1, with the possibility of coding multiple categories for each strategy.

### TABLE 1 Strategies recommended by clinicians and reportedly used by clients

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Examples</th>
<th>Percentage of total strategy types/scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generally Adaptive Strategies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gaining/seeking secular support structures</td>
<td>Therapist recommends parents go to therapy, PFLAG</td>
<td>Gay Men: 14%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 2%</td>
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<tr>
<td></td>
<td></td>
<td>Clinician: 29%</td>
</tr>
<tr>
<td>Positive communication</td>
<td>Verbally expressed acceptance of sexual identity disclosure</td>
<td>Gay Men: 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician: 12.5%</td>
</tr>
<tr>
<td>Explicit efforts to not change sexual orientation</td>
<td>Adult-child expresses independent sexual identity</td>
<td>Gay Men: 3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician: 0%</td>
</tr>
<tr>
<td>Creating relational closeness/reconciliation</td>
<td>Parents telling the child they love them, child disclosing with the aim of creating relational closeness, child addressing negative stereotypes</td>
<td>Gay Men: 6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician: 0%</td>
</tr>
<tr>
<td>Developing insight into self</td>
<td>Going to therapy, reading books about people who navigated similar situations, asking a religious figure for advice about how to understand themselves</td>
<td>Gay Men: 8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 4%</td>
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<tr>
<td></td>
<td></td>
<td>Clinician: 35%</td>
</tr>
</tbody>
</table>

(Continued)
### TABLE 1 (Continued)

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Examples</th>
<th>Percentage of total strategy types/scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing insight into the other</td>
<td>Talking about the other in therapy, asking the person to explain themselves, reading books about the other person’s experiences</td>
<td>Gay Men: 0%  &lt;br&gt; Religious Families: 10%  &lt;br&gt; Clinician: 8%</td>
</tr>
<tr>
<td>Navigating religious texts, values, customs, or rituals and engaging methods of religious coping</td>
<td>Focusing on alternative religious texts or values, picking and choosing certain aspects of the socio-religious norms they would like to retain and those they would like to discard</td>
<td>Gay Men: 24%  &lt;br&gt; Religious Families: 20%  &lt;br&gt; Clinician: 9%</td>
</tr>
<tr>
<td>Finding a mentor or role model</td>
<td>Selecting a gay therapist or a gay-affirmative therapist, attending support groups with the goal of modeling behavior</td>
<td>Gay Men: 5%  &lt;br&gt; Religious Families: 0%  &lt;br&gt; Clinician: 9%</td>
</tr>
<tr>
<td>Educate others</td>
<td>Sharing books, literature, therapy sessions with others with the goal of educating them about your perspective, having a conversation with the specific aim of addressing stereotypes and fears</td>
<td>Gay Men: 1%  &lt;br&gt; Religious Families: 0%  &lt;br&gt; Clinician: 3%</td>
</tr>
</tbody>
</table>

**Generally Maladaptive Strategies**

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Examples</th>
<th>Percentage of total strategy types/scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative communication</td>
<td>Verbally expressed hostility upon disclosure</td>
<td>Gay Men: 1%  &lt;br&gt; Religious Families: 5%  &lt;br&gt; Clinician: 0%</td>
</tr>
<tr>
<td>Changing sexual orientation</td>
<td>Parents pray for child to change sexual orientation, recommend reparative therapy, ask child to change</td>
<td>Gay Men: 4%  &lt;br&gt; Religious Families: 7%  &lt;br&gt; Clinician: 4%</td>
</tr>
<tr>
<td>Creating/increasing relational distance</td>
<td>Parents ignore child, kick child out of home, engage in ritualized mourning, child moves away to different state</td>
<td>Gay Men: 9%  &lt;br&gt; Religious Families: 23%  &lt;br&gt; Clinician: 9%</td>
</tr>
<tr>
<td>Theistic triangulation</td>
<td>God/faith being positioned as an ally against the other party (Brelsford &amp; Mahoney, 2009)</td>
<td>Gay Men: 0%  &lt;br&gt; Religious Families: 7%  &lt;br&gt; Clinician: Less than 1%</td>
</tr>
<tr>
<td>Disclosure avoidance</td>
<td>Refusing to discuss or acknowledge issues of sexual orientation post the disclosure event or avoiding the disclosure event entirely</td>
<td>Gay Men: 13%  &lt;br&gt; Religious Families: 10%  &lt;br&gt; Clinician: 0%</td>
</tr>
<tr>
<td>Engaging in self-harming behaviors</td>
<td>Suicide attempts</td>
<td>Gay Men: 4%  &lt;br&gt; Religious Families: 0%  &lt;br&gt; Clinician: 0%</td>
</tr>
</tbody>
</table>

(Continued)
TABLE 1 (Continued)

<table>
<thead>
<tr>
<th>Type of strategy</th>
<th>Examples</th>
<th>Percentage of total strategy types/scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mourning</td>
<td>Mourning the loss of family and community relationships post-disclosure sometimes leading to clinical levels of depression</td>
<td>Gay Men: Less than 1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician: 0%</td>
</tr>
<tr>
<td>Other</td>
<td>Includes adaptive and maladaptive mediational strategies that were referenced less than twice across all narratives (e.g., resiliency)</td>
<td>Gay Men: 9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Religious Families: 3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinician: 1%</td>
</tr>
</tbody>
</table>

RESULTS

I. Conflicts

TYPES OF CONFLICTS MOST FREQUENTLY REFERENCED BY CLINICIANS

A total of 230 conflicts were discussed by 12 clinicians as emerging during the therapeutic process, with the average number of conflicts referenced within one narrative being 19 ($SD = 10$) and the average number of conflicts coded for more than one focus category being 6 ($SD = 4$). Twenty-eight percent of the conflicts were not discussed within a specific timeframe by the clinicians, 3.5% were discussed as being experienced prior to disclosure, 27% were referenced in terms of the post-disclosure context, 2% were viewed as being continuous and ongoing conflicts, and 2% were referenced as occurring during the time of disclosure itself.

Based on clinicians’ reports, the greatest number of conflicts emerged in relation to the family system, having been discussed on average within 34% ($SD = 11$%) of the conflicts referenced by each clinician. The second most commonly referenced conflict focus is conflicts with the self, emerging on average within 29% ($SD = 7$%) of the conflicts discussed by each clinician. The third most commonly referenced conflict focus is conflicts with religion (as a general institution, values, text, community), emerging on average within 28% ($SD = 7$%) of the conflicts discussed by each clinician. Conflicts with religion were referenced a total of 65 times across all 12 clinicians’ narratives, and 5 out of 12 clinicians’ discussions specifically focused on the “anti-homosexual” messages of the church, religious leaders, and religious texts. The frequency of conflicts within institutionalized religious structures notably contrasts with the frequency of direct conflicts with God, which emerged on average within only 2% ($SD = 3$%) of the conflicts referenced by each clinician.

In addition, conflicts with society at large emerged within 2% ($SD = 4$%) of the conflicts referenced by each clinician, conflicts with clinicians were...
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referenced within 2% ($SD = 4\%$) of the conflicts referenced by each clinician, conflicts with friends were discussed within 1% ($SD = 2\%$) of the conflicts referenced by each clinician, and other conflicts (media, gay society, school) were mentioned within 1.5% ($SD = 3\%$) of the conflicts referenced by each clinician.

**FAMILY SYSTEM CONFLICTS WITHIN INTERRELATED CONTEXTS**

Conflicts with the family emerged a total of 73 times across all 12 clinicians’ narratives. Twelve conflicts (16% of total family conflicts) include the interaction of family and the self alone, without referencing religion. These conflicts focus primarily on the adult-child trying to please their parents; the adult-child’s “anger, fear, and mourning” for the loss of family relationships; fear of disclosure; the adult-child’s experience of family rejection; and the gay client’s efforts to extricate themselves from family relationships. Furthermore, a total of 29 (40%) family conflicts did not explicitly reference conflicts with religion or the self and, instead, largely focused on power dynamics within the family. For example, clinicians spoke of their clients’ fear of general family rejection, parental efforts to “control the gay out of them,” family fears of stereotypes and misinformation, parental fears of losing the adult-child and feeling “controlled” by the adult-child, and the family’s desire to “straighten out” child as expressed to therapists.

Twenty-nine (40%) of clinicians reported family conflicts intersecting with religious values, texts, customs, or community, and only five (7%) of those conflicts referenced specific clients. Conflicts referenced in the context of the intersection of family and religion are that families experienced guilt and community shame for their child’s sexual orientation that they then expressed to their gay relative; families expressed “heavy grief and mourning,” “outrage,” “horror,” and “sadness” due to their child’s sexual orientation in the context of religion; religion became the “focal point of non-acceptance,” and parents viewed their son’s sexual orientation as a “sin”; families “smothered” their child with religion, misquoted religious texts, “co-opted religion,” and told their sons they would burn in hell; families interpreted religion in rigid terms; families brought their gay relative to reparative therapists and exorcists despite their relative’s resistance, gay men had been “inundated” by homophobic messages throughout their childhood by their religious families and were later forced to address those internalized messages.

Of the 29 family conflicts that intersected with religion, 25 (34% of total family conflicts), in addition, explicitly involved conflicts with the self. For example, gay men experienced fear that they were “going wrong in the eyes of parents”; gay men experienced or were afraid of experiencing community and family “withdrawal, isolation, rejection, or abuse.” Conflicts that included
the interaction between the self, family, and religion were largely focused on
the adult-child’s experience of family non-acceptance or fear of family non-
acceptance; working through homophobic messages; heartbreak regarding
familial estrangement and determining the relational responsibility of recon-
ciliation, guilt, and shame; and feeling that their masculinity was out of sync
with family and community expectations.

SELF-CONFLICTS WITHIN INTERRELATED CONTEXTS

Conflicts with the self were described a total of 71 times across all
12 clinicians’ narratives, with 26 (37% of total self-conflicts) of those conflicts
intersecting with religious values, texts, customs, or community (outside of
the context of family and God) and only two of these conflicts referencing
a specific client. Conflicts referenced in the context of the intersection of
the self and religion are the shame experienced within religious environ-
ments; feeling “rejected, inferior, castigated” in light of religious texts and
religion in general; the prevention of self-actualizing behaviors due to the
“emotional baggage” of religious environments; experience of being aban-
donied by one’s religious community; struggle between faith and “identity”;
struggle with perception that “sex is immoral” or how to engage in moral
gay sex; the fear of “what type of men they want to be”; “fear of being
morally wrong and going to hell”; suicide attempts due to depression and
discomfort with being gay and religious; and avoidance and anxiety related
to community disclosure. In addition to the conflicts between the self and
religion, there were three references (4% of total self-conflicts) to conflicts
between the self and God. These conflicts focused on the following issues:
the “fear of losing their connection with, with God”; “them thinking that
God, God couldn’t really accept them for who they were”; and being angry
with God.

II. Mediational Strategies and Cultural Tools Use

GAY MEN’S MEDIATIONAL STRATEGIES AND CULTURAL TOOL USE

Based on clinicians’ reports, a total of 14 mediational strategy types (e.g.,
changing one’s sexual orientation) were discussed as utilized strategies by
gay men 106 times (see Table 1 for further information). These strategy types
were discussed in the context of 83 different strategy scenarios (e.g., believ-
ing that homosexuality is a sin), with 22 of those strategy scenarios being
coded for more than one strategy type. Of the total strategy types discussed
by each clinician regarding gay men within the therapeutic context, the three
most frequently discussed strategies utilized by gay men are the strategies
navigating religious issues and engaging in religious coping (M = 16%, SD =
14%), disclosure avoidance (M = 12%, SD = 12%), and seeking secular support (M = 12%, SD = 10%). Additional adaptive and maladaptive mediational strategies discussed by clinicians as being utilized by gay men are presented in Table 1.

**Gay Men’s Religious Conflict Mediational Strategies and Cultural Tool Use**

The strategy of managing and navigating religious issues was discussed by seven clinicians as having been utilized by gay men in the context of 20 (24%) of the total strategy scenarios discussed, with 35% of these strategy scenarios coded for more than one mediational strategy. The strategy of managing and navigating religious issues was discussed within the context of both religious coping and spiritual struggles (Pargament, 2007). This coding category includes religious coping behaviors as well as spiritual struggles as the act of engaging spiritual struggles within a therapeutic context is understood to be representative of interrelated strategies between secular and religious systems as are religious coping strategies.

For example, clinicians reported that gay men engaged religious coping strategies by becoming involved in gay-affirming religious groups and ministries (e.g., “[The client] chose as an adult to become baptized in the Catholic faith . . . that is gay friendly and he was able to reconcile”), selecting the aspects of religion that are meaningful and ignoring others (e.g., “People who can take from it [religion] what they want and what they need and the other things that are not meshing with who they are they are able to kind of let go of that, or not feel slighted by that, is a real positive you know way of approaching it and incorporating faith into your life”), accepting the sexual and religious self (e.g., “I’ve had other clients who had sort-of made their peace and decided that it was O.K. to be gay and Christian, or gay and spiritual”), discussing cultural tools such as religious texts in therapy (e.g., “Rabbis and priests [as clients] . . . they often refer to their work and for texts, even when it comes to gender and sexuality”), adaptively utilizing religion in relationships (e.g., “Religion is a very kind of stabilizing force in their life, a very meaningful force, and kind of moral center in the way that they function in their relationships”), transferring religious paradigms to the therapeutic context (e.g., “Kind of confessional tone with which he [the client] introduces experiences in his life sort of casting me [the therapist] into the role of the, you know, the person who could offer absolution or judgment”), making decisions regarding the specific sexual restrictions relating to gay sex in Jewish law (e.g., “In terms of anal sex, in terms of mutual masturbation, in terms of oral sex, they [the client] would make different choices . . . Because of religion, yes. Strictly because of religion”). Alternatively, clinicians also reported that their gay clients engaged spiritual struggles by choosing
between actualizing the sexual or religious self (e.g., “They’re sort of forced in some ways to kind of leave some part of themselves out. Whether it’s the religious part or whether it’s the sexual identity”) and navigating the loss of a faith community post-disclosure (e.g., “Coming-out process had meant not only disconnections from their biological family, but it often times meant disconnection from their faith-community”).

All of the above mediational scenarios were coded as utilizing religious tools to accomplish the mediational strategy of managing and navigating religious issues (e.g., focusing on thematic religious values rather than religious laws). In addition, two scenarios were also coded as utilizing relational tools (e.g., improving communication skills by focusing on religious values of love and acceptance), seven scenarios were additionally coded as utilizing therapeutic tools (e.g., discussing text in therapeutic context), and one scenario was additionally coded as using a tool classified as other (self-determination).

GAY MEN’S DISCLOSURE AVOIDANCE STRATEGIES AND CULTURAL TOOL USE
The strategy of disclosure avoidance was discussed by eight clinicians as having been utilized by gay men in the context of 11 (13%) of the total strategy scenarios discussed, with 18% of these strategy scenarios coded for more than one mediational strategy. The strategy of disclosure avoidance was discussed in the following contexts: not wanting anyone to know about their sexual orientation due to the stigma (e.g., “I began before ’73 in which case it was officially a disorder . . . a great deal of shame certainly uh, didn’t want, you know, didn’t want anybody to know”), not feeling comfortable disclosing to family (e.g., “Moving to a different city—I mean—I—a lot of people who moved here to live their life here [New York], and in a way, their more religious family members—kind of—don’t really know about them”), living a heteronormative lifestyle or fear of living a gay lifestyle (e.g., “many of them—Black clients—are on the down-low, which is that they hide out, and get married”), and not feeling comfortable self-identifying as gay or with the gay community (e.g., “Most of the people I [therapist] see with these issues have not ever really identified with the whole gay community thing”). All of the above mediational scenarios were coded as utilizing relational tools to accomplish the mediational strategy of disclosure avoidance (e.g., avoiding discussing issues of sexuality with family members).

GAY MEN’S SECULAR SUPPORT STRATEGY AND CULTURAL TOOL USE
The strategy of seeking secular support was discussed by eight clinicians as having been utilized by gay men in the context of 12 (14%) of the total strategy scenarios discussed, with 42% of these strategy scenarios coded for
more than one mediational strategy. The strategy of seeking secular support was discussed in the following contexts: identifying with and participating in the gay community (e.g., “Some of my patients are really active with the . . . umm, lesbian and gay show in Manhattan. And some of them are doing outreach to different communities”), seeking a gay partner to gain acceptance (e.g., “The gay issue started, so that only, that became sort of a focal point of non acceptance [at community and family level], since that is the ultimate unacceptable thing you could do. So, he met this guy . . . and, and he was very accepting of him in this issue.”), seeking therapy or a support group to come to terms with gay identity (e.g., “Sometimes the presenting problem was coming out, right. They were, they were—umm, sort of in the early stages of coming out; thinking that they were gay or lesbian; knowing that they were gay or lesbian. Having a lot of anxiety about that, or stress about that.”), and discussing gay rights issues and new legislation with others (e.g., “There’s no question that it’s [New York legislation concerning gay marriage] validating. Um and uh, it promotes conversation. There’s no question that, that recognition is, really makes a difference, really counts”).

Three of the above strategy scenarios were coded as utilizing only therapeutic tools to accomplish the mediational strategy of seeking secular support (e.g., engaging in therapy), six scenarios were coded as utilizing only relational tools (e.g., a romantic gay relationship), and two scenarios were coded as utilizing “other” tools such as engaging in the gay community and utilizing political tools (e.g., discussion of gay rights achievements). In addition, one scenario was coded as utilizing both religious and therapeutic tools (e.g., seeking out a therapist with a faith focus).

FAMILY MEMBERS’ MEDIATIONAL STRATEGIES AND CULTURAL TOOL USE

Based on clinicians’ reports, a total of 12 mediational strategy types were discussed within the therapeutic context as utilized strategies by the religious families of gay men 92 times. These strategy types were discussed in the context of 64 different strategy scenarios (e.g., quoting religious texts to adult-child during or post the disclosure event), with 22 of those strategy scenarios being coded for more than one strategy type. Of the total strategy types discussed as being utilized by the religious families of gay men, the three most frequently discussed strategies utilized by religious families are the maladaptive strategy of increasing relational distance ($M = 18\%$, $SD = 19\%$), the adaptive strategy of increasing relational closeness ($M = 15\%$, $SD = 16\%$), and the strategy of adaptively navigating religious issues ($M = 12\%$, $SD = 15\%$). Additional adaptive and maladaptive mediational strategies discussed by clinicians as being utilized by the religious families of gay men are presented in Table 1.
FAMILY SYSTEM’S STRATEGY OF INCREASING RELATION DISTANCE

The strategy of increasing relational distance was discussed by eight clinicians as having been utilized by religious family members in the context of 15 (23%) of the total strategy scenarios discussed, with 40% of these strategy scenarios coded for more than one mediational strategy. The increasing relational distance strategy was discussed in the following contexts: religious families abandoning, disowning, and rejecting the adult-child (e.g., “The most poignant issue has been the experience of feeling rejected by their family... in the context of values, cultural values reinforced by the religious community”), parents’ anger and shame that their son will not live the life they imagined (e.g., “His parents are very angry that he’s not going to fit in to the—uhh—model, that they deemed he should fit into”), and families not allowing their son to bring home a partner or not inviting them to holiday gatherings (e.g., “Feeling left out of family events and socializing and holidays. Umm, people feeling like their partner’s not welcome, when their siblings’ heterosexual partners are welcome”).

All of the above mediational scenarios were coded as utilizing relational tools to accomplish the mediational strategy of increasing relational distance (e.g., asking the gay adult-child to move out), and one scenario was coded as utilizing relational and religious tools (e.g., the adult-child being used as scapegoat for familial problems as their sexuality was viewed as being “out of step with religion.”).

Contrastingly, the strategy of increasing relational closeness was discussed by nine clinicians as having been utilized by religious family members in the context of 13 (20%) of the total strategy scenarios discussed, with 38% of these strategy scenarios coded for more than one mediational strategy. The increasing relational closeness strategy was discussed in the following contexts: parents seeking therapy to improve their relationship with and understand their son (e.g., “I [therapist] worked with those [family members] who were trying to understand. Who were really suffering, because they were torn and who wanted to come to terms with what happened”), parents expressing acceptance of their son’s sexuality and/or maintaining an affiliation or relationship (e.g., “You also have parents who are... I’d say—completely accepting, and are sort-of more wanting to make sure they’re doing the right thing”), and parents navigating religious issues to find a context for accepting their child (e.g., “The parent is integrated to a point that they’re able to say OK, well these are my beliefs, but this is also my child and I’m, I’m going to step outside of what I think the religion is telling me to think about this and have my own loving reaction and accepting reaction”).
Twelve of the above mediational scenarios were coded as utilizing relational tools (e.g., acceptance), two scenarios were additionally coded as incorporating religious tools (e.g., drawing a distinction between religious acceptance of the person and religious non-acceptance of sexual behavior), and one scenario was additionally coded for the use of a therapeutic tool (e.g., parents seeking therapeutic guidance to help improve their communication skills). In addition, one relational closeness strategy scenario was coded as only using a therapeutic tool (e.g., family members seeking therapy to try to understand their child's sexuality).

**Family System's Strategy of Adaptively and Maladaptively Navigating Religious Issues**

In addition, seven clinicians reported that religious family members adaptively and maladaptively engaged religion in the context of 27% of the total mediational strategy scenarios discussed. Sixty-seven percent of these strategy scenarios were coded for more than one mediational strategy. Similarly, both adaptive and maladaptive religious mediational scenarios were coded as utilizing religious tools (e.g., parents adopting a rigid set of religious rules). One scenario was additionally coded as incorporating a therapeutic tool (e.g., parents bringing their gay son to reparative pastoral counseling), five scenarios were additionally coded for the use of a relational tools (e.g., parents drawing distinction between accepting gay behavior and accepting gay son), and two scenarios were additionally coded as utilizing relational and therapeutic tools (e.g., parents consulting with religious leaders and therapists to determine their next pragmatic steps post-disclosure).

Clinicians reported that family members maladaptively engaged theistic triangulation strategies by quoting or distributing religious texts to their gay relative post-disclosure (e.g., “a family member starts quoting these things [religious texts], you know, incorrectly and then it can be of course be very damaging”), by adopting rigid religious rules (e.g., “often people who have grown up with rigidity go into even a more rigid stance. Like, no, you have to conform, because this is what God says, this is what the Bible says”), or trying to change their relative’s sexual orientation on religious grounds (e.g., “Thought he was possessed by the devil . . . that’s certainly not orthodox Catholic teaching . . . but, you find some extreme, extreme people . . . They looked for an exorcist”). Contrastingly, some family members engaged adaptive religious coping mechanisms by focusing on the subtleties of or broadening their belief system concerning homosexuality and religion (e.g., “there’s a distinction between gay actions and gay identity and that it’s alright to be gay in an emotional or biological sense as long as the person chooses not to act on it”). In addition, clinicians reported that family members engaged therapy in an effort to pragmatically develop adaptive
steps to react to their relative’s disclosure and to navigate religious values and religious community (e.g., “What do we do next? Do we want this child to live with us? Do we want him or her to move on with their own lives? Do we absolutely prohibit this? Do we prohibit this in the vicinity of our house or our community and we don’t care if it happens, or we don’t care that much if it happens in California?”).

**Therapists’ Suggestions of Alternative Mediation Strategies and Cultural Tool Use**

A total of 10 mediational strategy types (e.g., finding a mentor or model) were discussed as recommended alternative strategies for gay men and their families by the 12 clinicians during the course of the interview 77 times, with six being the average number of mediational strategy types suggested by each clinician ($SD = 5$). These strategy types were discussed in the context of 48 different strategy scenarios (e.g., parents’ struggling with stereotypes), with 19 of those strategy scenarios being coded for more than one strategy type. Of the total strategy types discussed by each clinician, the three most frequently discussed alternative strategies for gay men and their family members are the strategies of increasing self-awareness ($M = 39\%, SD = 24\%$), seeking secular support systems ($M = 18\%, SD = 17\%$), and increasing positive communication ($M = 11\%, SD = 16\%$). The additional mediational strategies suggested by clinicians during the course of the interview are presented in Table 1.

**Clinicians’ Suggested Strategy of Increasing Self-Awareness**

The strategy of increasing self-awareness was recommended by 11 clinicians in the context of 17 (35%) of the total strategy scenarios discussed, with 47% of these strategy scenarios coded for more than one mediational strategy. The increasing self-awareness strategy was discussed in the following contexts: a general treatment focus (e.g., “What are the psychological issues that created the issue?”; “Understand themselves in a richer and fuller way”), the task of managing and addressing internalized homophobia and negative stereotypes (e.g., “managing the shame”; “deconstruct the narratives that are not helpful to them”), the task of addressing feelings of exclusion (e.g., “They [the client] felt castigated, rejected, inferior. And so, I have to help them get in touch with those emotions”; “How to express feelings about not participating with family, friends, and community”), the goal of understanding and accepting one’s self within the larger context of the intersection of gay culture and religion (e.g., “And for gay men in particular, they have to come to some kind of understanding about what gay-male sex is, as a cultural and as a community phenomenon, as opposed to what they’ve been told”), the task...
of becoming aware that a behavior may be unhealthy or damaging (e.g., “I have to be honest, I would tell the client, you know, I think that behavior is damaging”), and the goal of developing healthy communication skills that can be used during conflict (e.g., “dealing with conflict”; “suspend use of avoidance as a strategy”).

All of the above mediational scenarios were coded as utilizing therapeutic tools to accomplish the mediational strategy of increasing self-awareness (e.g., “I’m a guide to help them find what’s really inside them”). In addition, three scenarios were also coded as utilizing relational tools (e.g., communication skills) and one scenario was additionally coded as utilizing religious tools (e.g., Metropolitan Community Church).

CLINICIANS’ SUGGESTED STRATEGY OF SEEKING SECULAR SUPPORT SYSTEMS

The strategy of seeking secular support systems was recommended by eight clinicians in the context of 14 (29%) of the total strategy scenarios discussed, with 64% of these strategy scenarios coded for more than one mediational strategy. The strategy of seeking secular support was discussed by clinicians in regard to the following contexts: therapists’ efforts to assist clients in the process of self-acceptance by providing empathy and acceptance (e.g., “The therapist is often seen as an alternative parental figure and to accept them um in ways that their parents didn’t is a powerfully healing experience”), therapists’ recommendations that gay men and family members attend Parents, Families, Friends of Lesbians and Gays (PFLAG) and alternative accepting faith communities (e.g., “being able to talk with other parents who might have had similar concerns”; “People are able to connect with other people, other lesbian and gay people that have grown up in conservative back-grounds and, and there’s some healing in telling their stories to each other”), therapists’ suggestion that their gay clients envision their parents attending therapy or a support group (e.g., “Can you imagine your parent ever reading this material or going to meetings like this? Um, could you imagine your parents going into therapy themselves? To adjust to this, you know. Is it fair that you’re the one sitting here with me having this much heartache about it”), and the therapist providing the client with disclosure strategies (e.g., “I’ll advise uh clients to take some friends home before they tell them... And then when they’re coming out... It’s not just a category. It’s not just what they’ve heard... once people know actual individuals... it’s like a house of cards. You know, um, the prejudices just kind of go away”).

Four of the above mediational scenarios were coded as utilizing only therapeutic tools to accomplish the mediational strategy of gaining support (e.g., “Well, you always have to accept the client, I mean no matter what the problem is”), and three scenarios were coded as utilizing only relational tools (e.g., “Don’t bring it up to your family until you are ready; until you
are comfortable. If you bring it up as a tragedy, they’re gonna react as a tragedy”). In addition, five scenarios were coded as utilizing relational and therapeutic tools (e.g., “It’s really the parent’s responsibility to learn how to be a parent to a gay child. I probably most often suggest to the adult child that they put the burden of that responsibility on the parents and explain to them what their expectations are”), and two scenarios were coded as utilizing therapeutic and religious tools (e.g., “[I view myself as] a coach in terms of helping them [the client] find resources for healing, which might be a progressive faith-community where they—you know—can be exposed to a different notion of a God”).

Clinicians’ Suggested Strategy of Increasing Positive Communication

The strategy of increasing positive communication was recommended by five clinicians in the context of six (12.5%) of the total strategy scenarios discussed, with 83% of these strategy scenarios coded for more than one mediational strategy. The strategy of increasing positive communication was discussed by clinicians in relation to the following contexts: explaining the falsehood of stereotypes to family members (e.g., “You don’t have to be lonely if you’re gay or lesbian . . . You can have a wonderful life. And once they [the client] have that kind of confidence, they can explain, they give examples”), communicating relational needs to parents (e.g., “explain to them [the parent] what their [adult child] expectations are in terms of how, how they need to be treated in a way that’s equal and respectful”), communicating with others with similar experiences (e.g., PFLAG), and learning how to communicate during conflicts and express emotional experience (e.g., “So first I [the client] own and recognize that it’s O.K. for me to have my experience and then, how then, do I express that experience to my partner or to others in my contacts and get what I need from them”).

All of the above mediational scenarios were coded as utilizing relational tools to accomplish the mediational strategy of increasing positive communication. In addition, four scenarios were coded as utilizing therapeutic and relational tools (e.g., “My views as an analyst . . . is to help them, if they need coping skills, if they need social skills, dealing with conflict”).

III. The Role of Relational Complexity Within Therapeutic Contexts

In addition, therapists suggested relationally complex strategies that focused on assisting the client in exploring their interpersonal conflicts within the larger interrelated contexts of sociocultural systems such as religion and family values. For example, one therapist suggested that the religious community and leaders
Within the above narrative, it becomes clear that the therapist is strongly recommending a solution strategy that utilizes religious cultural tools (biblical stories and values) to mediate the tensions between the activity systems of religious, familial, and sexual orientation. Instead of banishing religious values and systems to a place of total irrelevance, the therapist is engaging a Living Word method of scriptural interpretation by acknowledging the value that religious individuals place on these cultural tools today. This method of interpretation additionally engages the interaction between family, religion, and sexuality as systems that can be mediated by the use of additional social, political, and environmental dimensions. The therapist’s recommendation is therefore more multifaceted than simply directing religious individuals to become more empathic and recognize the gay experience or perspective; the therapist is very clearly recommending a thoughtful contextualization of the contemporary interpersonal problem within the context of ancient biblical texts and values.

Similarly, another therapist suggested that religious families engage religious coping strategies by modeling God’s unconditional love to transition from viewing their gay children as sinners and their fear of “condoning the gay lifestyle” (for a full review of religious coping strategies, see Pargament, 2007). In the clinician’s words:

One tactic in working with families has been to try and talk about—sort of—accepting your child no matter what, and loving your child no matter what. Unconditional love, right. And—uhh both Judaism and Christianity are sort of rooted—at best—in the notion of a God that’s a God of unconditional love, right. And a God that sort-of says, you know, I embrace all my children. And so, you know, whether it’s not—it’s possible to make a connection with the family around that, right. And that, and that while God may or may not be thrilled with every choice we make in life, that God loves us unconditionally regardless.

Within this suggested strategy, the therapist is acknowledging the multiple value systems (family, religion, sexuality) that are intersecting and is encouraging the families to contextualize their interpersonal conflicts surrounding issues of sexuality within the larger value system of religion. Such suggestions seem to support Pargament’s (1999) theory of spiritually integrated psychotherapy as they indicate that when relational conflicts are situated within complex and interacting developmental systems, the reconciliatory mediational solutions need to be as well.
In addition, relational complexity played a similar role in some of the suggestions that therapists had for their gay clients from religious backgrounds that were struggling with developing a multifaceted version of the self that encompasses both the dimensions of sexuality and religion. For example, as one nonreligious therapist stated:

I do think that there’s a lot of value in faith. I mean I’ve seen that so, so much you know. Particularly after 9/11. Um particularly when someone’s depressed to the point of suicidality. Um and religion is flawed like any, like we all are and but it also has enormous value so I can appreciate more of it and I think people who can take from it what they want and what they need and the other things that are not meshing with who they are they are able to kind of let go of that, or not feel slighted by that is a real positive you know way of approaching it and incorporating faith into your life.

Within this narrative, it becomes clear that gay clients from religious backgrounds may benefit from addressing their personal pain experienced within some religious contexts by carving out a space of faith that meets their specific needs. This approach highlights the complex nature of a “self” that is constantly evolving through interactions, both past and present, within the dynamic activity system of religion. Furthermore, the therapist’s suggestion is one that empowers the client to mediate their relationship with prior religious socialization experiences by focusing on their spiritual and faith needs of the present.

DISCUSSION

The present study is an attempt to explore how gay men and their religious families mediate sexual, religious, and familial systems within the therapeutic context as well as in terms of their independent efforts. Results indicate that clients are frequently addressing the emerging conflicts within the context of interrelated systems (family, self, and religion). This discussion of the interrelationship between religious and family systems has been supported by a number of empirical studies that have reported that more religious groups place a higher value on the importance of family than less religious groups (Jensen & Jensen, 1993; Newman & Muzzonigro, 1993). In addition, it has been suggested that one of the consequences of being both gay and a member of an ethnic or religious minority may be that gay men lose or alter their connection with their community and family (Hidalgo & Christensen, 1976–1977; Coyle & Rafalin, 2000; Schnoor, 2003). However, research also suggests that religious families may be motivated to develop strategies focusing on reconciliation and cohesion (Schnoor, 2003). Therefore, the present
study attempted to address the negotiation of religion, family, and sexuality at both the conflict and solution level by additionally focusing on the various mediational strategies oriented toward relational complexity that clinicians suggested and gay men and their religious families initiated and enacted.

Given the recent debates regarding the sociocultural limitations of sexual identity development models as well as the discussion of such models’ inattention to the likelihood of individualized variability in the coming-out process (see Kaufman & Johnson, 2004 for a full review), this article did not employ sexual identity models as the primary basis of narrative analysis. Yet, despite these concerns, models such as Cass’s Identity Model (1979) can still offer additional insight into the types of self-related conflicts that clients often experience during or following their sexual orientation disclosure. For example, clinicians in this study reported that many of their clients experienced a grieving period somewhat similar to Cass’s (1979) description of the identity comparison stage. Similarly, clinicians’ recommendations that their clients seek secular support and mentors via organizations such as PFLAG echoes Cass’s (1979) discussion of the ways in which the stage of identity tolerance can be achieved. However, the similarities between identity models of development and sociocultural theories of development concludes here as a sociocultural method of analysis revealed that clinicians often viewed their clients’ conflicts as being ongoing, fluid, and related to sociocultural contexts as opposed to being progressively linear and hierarchical. For example, clinicians shared that even if clients had addressed parental concerns regarding their sexual orientation during their youth, clients often had to reconfront or engage new conflicts during their adulthood as they partnered or married. Clinicians’ accounts of this type of sexual developmental fluidity echo similar perspectives put forth by Cohler and Hammack (2007) regarding the socioculturally contextualized developmental processes of gay teenagers, suggesting that this construct may be relevant across the lifespan.

In addition, a cultural historical activity theory–based process of analysis found that clinicians, gay men, and their religious family members are focusing on a variety of mediational strategies in an effort to address the interaction between religion, family, and sexuality. Independent of the therapeutic process, gay men and their religious family members are employing mediational strategies that are likely to lead to both adaptive (e.g., gaining support) and maladaptive outcomes (e.g., creating relational distance). Therapists seem to be addressing the use of potentially negative strategies by suggesting more helpful and healthy alternatives, such as increasing self-awareness, gaining support, and engaging in relationally complex interactions. However, the specific method in which alternative mediational strategies are suggested and how they can pragmatically come to replace more negative strategies has yet to be explored. It is therefore
suggested that future research focusing on this population address the effectiveness of the various therapeutic methods and nuanced strategies that are being employed to help gay clients and their religious families adopt more productive mediational strategies.

LIMITATIONS AND FUTURE DIRECTIONS

A limitation of the current study is that only clinicians’ perspectives of their clients’ experiences were explored due to privacy concerns and the confidentiality of the therapeutic relationship. Although this study did not include client/therapist dyad narratives due to such ethical concerns, a related study focusing on gay men’s and their religious family allies’ parallel post-disclosure experiences has been conducted (Etengoff, 2013; Etengoff & Daiute, 2014). Preliminary results from this study support the efficacy of clinicians’ relationally complex recommendations as family dyads’ reports suggest that positive allied interactions are achieved when both parties focus on understanding the shared human experience and the unique contexts of the others’ standpoint (Etengoff, 2013). However, this study was not referenced in the present article as this article’s focus is on the mediational role of the therapeutic system and the family dyad study included only a small subset of dyads that had attended secular forms of counseling. Future research would therefore benefit from recruiting both clinicians and an independent clinical population of gay men and their family systems.

An additional limitation of this study is the small sample size due to the qualitative in-depth focus of this study and the resultant time required for participation. Unfortunately, a number of potential participants explicitly declined to be interviewed due to the required time commitment. Future studies may benefit from exploring the generalizability of the present study by utilizing the results of this study to create a mixed-methods design consisting of both questionnaire and interview data that would require a more limited time commitment (Creswell & Clark, 2010). Future studies would also benefit from including questions regarding clinicians’ training and knowledge of sexual minority populations and their sexual identity development as well as the training they received to engage the discussion of religion/spirituality in therapy. The need for more preparatory training for clinicians engaging the interface of sexuality and religion would likely be further supported by research exploring how the therapeutic engagement of individual mental health, relational systems, and spiritual functioning correlates with or predicts therapy outcomes.

In addition, it should be noted that clinicians were sampled only from the New York region; therefore, their experiences and their clients’ experiences may not be applicable to gay men and their religious families from other regions of the United States. Furthermore, this study specifically aimed
to understand the unique experience of gay men and their religious families within the therapeutic context and as such caution should be used before applying the results to other sexual and gender minority groups.

CONCLUSIONS

Although there has been a growing body of research related to religion and individual wellbeing, there is limited information regarding how religion impacts family relationships (Mahoney, 2010). This study attempts to address this gap by exploring how the therapeutic process is used as a tool to mediate the negotiation of religious, sexuality, and familial system conflicts as well as how this mediation process is affected by the family system independent of therapeutic suggestions. Narrative analyses suggest that the majority of conflicts discussed within the therapeutic context by gay men and their relatives from religious backgrounds are related to the interaction between family, self, and religion. Given this lens, it becomes clear that relational spiritual frameworks such as those suggested by Mahoney (2010) and Pargament (1999) and the sociocultural theory put forth in this article (Vygotsky, 1978) are relevant and meaningful paradigms for addressing issues of both individual and familial well-being within complex activity system contexts. For example, clinicians reported that gay men and their families struggled more frequently with the institution, community, and practices of religion rather than directly with God, supporting prior research indicating that gay men mediate religious conflicts by differentiating between religion as an institution and spirituality as an emotional state of being (Kubicek, McDavitt, Carpineto, Weiss, Iverson, & Kipke, 2009). Furthermore, it is important to note that a number of conflicts were discussed in terms of interrelated contexts and systems, supporting the need for a developmental systems approach, such as relational complexity (Daiute, 2012), when studying gay men and their religious families.

In addition, it was found that clinicians most frequently emphasized the mediational strategies of increasing self-awareness, seeking secular support, and increasing positive communication. Contrastingly, clinicians reported that religious families most frequently discussed employing (in many cases, independent of therapeutic guidance) the mediational strategies of increasing relational distance, increasing relational closeness, and navigating religious issues. In addition, clinicians reported that gay men most frequently discussed applying (in many cases, independent of therapeutic guidance) the mediational strategies of managing and navigating religious issues, disclosure avoidance, and seeking secular support. These results indicate that both gay men and their religious family members are utilizing mediational strategies that are likely to negatively affect their mental health and familial relationships (e.g., increasing relational distance and disclosure avoidance).
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in addition to employing more helpful strategies (e.g., seeking secular support and increasing relational closeness). Therefore, it may be beneficial for future research to focus on the pragmatics of how clinicians directly address the possible negative outcomes of independently employed mediational strategies and explore healthier alternatives with their clients.

Furthermore, it is particularly important to note that both gay men and their religious families seem to be navigating religious values, texts, and community norms with strategies developed independent of the therapeutic process. It should be noted that some clinicians did discuss this issue in the course of the interview and mentioned that they would feel more comfortable making referrals to clergy and religious leaders for matters of faith rather than directly addressing these issues during therapy. While it may be beneficial for gay men and their religious families to explore alternative faith communities that are gay affirming, there may also be an additive benefit in simultaneously exploring the negotiation of religious and sexual activity systems within the therapeutic context as well. As such, further research is needed to explore how clinicians can best prepare to address questions of faith and sexuality as well as which specific therapeutic methods are leading to the most helpful outcomes for clients addressing these issues.

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**APPENDIX A: INTERVIEW QUESTIONS**

1. How long have you been a practicing clinician? What is your age?
2. What is your highest level academic degree?
3. What is your area of specialization or your focus of interest?
4. Have you worked with clients who are gay men and grew up in a religious family or such religious family units?
5. How recently have you worked with this population?
6. What were the most poignant issues that your gay clients encountered during and post their sexual preference disclosure to their religious family and how did they address those issues?
7. What were the most frequently expressed issues that the religious family members encountered during and post sexual preference disclosure and how did they address those issues?
8. What was the initial reason for beginning the therapeutic process with your gay clients? Did the therapeutic process specifically begin to address issues of sexual orientation?
9. How do you view your role in this therapeutic process?
10. What role do you think community and religious leaders could or should play in addressing this socio-religious issue?
11. How would you describe your relationship to the gay community?
12. How would you describe your relationship to the religious community?
13. What specific questions (themes, contexts, or variables) would you like to see addressed in future research regarding this population? Are there any issues that you would like me to be familiar with that were not included in this interview?