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Stigma and Family Relationships of Middle-Aged Gay Men in Recovery

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Abstract

The primary objective of this study was to explore how middle-aged gay men in recovery cope with stigma and family relationships. For gay men, perceptions of acceptance of their sexual orientation and degree of social connectedness can play a role in their recovery from alcohol and substance use disorders. Yet gay men may have a more difficult time accessing certain family-level health resources because their families of origin may stigmatize, reject or silence them on account of their sexual orientation. Semi-structured interviews were used to explore how participants in recovery constructed and coped with their experiences of stigma, family relationships, and alcohol and substance use. Participants (30 gay men aged 50–64) completed a questionnaire and interview. We used constructivist Grounded Theory method and Minority Stress Theory as a theoretical

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framework to interpret the data. We identified the following themes: Internalization of Stigma, Changes in Coping Strategies, and Ongoing Stigma. Future research should explore how to incorporate familial support into gay men's recovery, address ongoing internalized stigma, and develop a social response to stigma, rather than leaving it to individuals to confront on their own.

Keywords

Gay Men; Recovery; Stigma; Minority Stress; Aging; Family Support

Introduction

Gay men often enter treatment with more severe substance abuse and mental health problems than heterosexual people (Butler Center for Research, 2013; Green & Feinstein, 2012). The characteristics of families of origin and social networks predict substance use disorders (Canino, Vega, Sribney, Warner, & Alegria, 2008), as well as important long-term outcomes for those in recovery from such disorders (Alvarez, 2009). Recovery is defined as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship," and sobriety is defined as "abstinence from alcohol and all other nonprescribed drugs" (Betty Ford Consensus Panel, 2009, p. 495, 494). Familial support has been consistently shown to predict positive outcomes for those in recovery (Laudet, Savage, & Mahmood, 2002). As men age, familial relationships and influence play a role in their decision to stop using alcohol or substances (Henges, 2008), and family dynamics, especially in early recovery, can either increase or decrease the possibility of relapse (Captain, 1989). For gay men, perceptions of acceptance of their sexual orientation and degree of social connectedness also play a role in their recovery (Milliger & Young, 1990). Yet gay men may have a more difficult time accessing certain family-level health resources because their families of origin may stigmatize, reject or silence them on account of their sexual orientation (Diaz, 1998; Frost & Meyer, 2009). Stigma is defined as "an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p.11). People perceived to have this "negative attribute… are understood to be negatively valued in society" (Stuber, Meyer, & Link, 2008, p.353). A family's stigmatization of gay sexual orientation makes it difficult for them to provide the type of emotional support needed by gay men in recovery.

Gay men's challenge with stigma extends beyond familial relationships. Stigma and discrimination characterize the social, legal, and political context in which gay men make choices and start their recovery from alcohol or other substance use disorders. Some gay men experience stigma, discrimination, and violence (Institute of Medicine [IOM], 2011), and hence experience more social stress than their heterosexual counterparts (Conron, Mimiaga, & Landers, 2010; Frost, Lehavot, & Meyer, 2015; Mays & Cochran, 2001; Meyer, 2003). Sexual stigma leads to stress, which can have long lasting psychological consequences (IOM, 2011; Feinstein, Goldfried, & Davila, 2012; Herek & Garnets, 2007). This may explain in part why studies show that gay men experience higher rates of psychiatric morbidity and poor or fair self-rated health than their heterosexual counterparts

(McLaughlin, Hatzenbuehler, Xuan, & Conron, 2012; Meyer, Dietrich, & Schwartz, 2008; Wallace, Cochran, Durazo, & Ford, 2011). A recent study demonstrated that gay youth raised in highly stigmatizing environments had a blunted cortisol response to stress, leading researchers to conclude that social exclusion may exert biological effects akin to traumatic life experiences (Hatzenbuehler & McLaughlin, 2014). Even anticipation of negative treatment, i.e., vigilance, chronically activates a person's psychological stress responses, which in turn leads to negative health outcomes (IOM, 2002; Meyer, 2003; Meyer et al., 2008).

We know that some gay men report abusing alcohol and other substances to cope with sexual stigma and family rejection, especially in their youth and as young adults (Author, 2014; Kertzner, 2001; Kus, 1991; McAdams-Mahmoud et al., 2014; Ryan, Huebner, Diaz, & Sanchez, 2009). We know less about how gay men experience stigma and family relationships in *middle age*, especially after they enter recovery. Middle age is typically associated with an increased awareness of mortality, greater cognitive complexity in the assessment of relationships to the social world, and a gradual disengagement and decreasing identification with the world of the young (Kertzner, 2001). Yet the literature on coping among gay men tends to focus on younger men (McDavitt et al., 2008) or include participants whose average age is below middle age (Christman, 2012). Middle- aged gay men's developmental trajectory differs from that of younger cohorts in terms of when they first recognized their same-sex attraction and then self-identified as gay (Floyd & Bakeman, 2006). In the United States, their historical context also differs from that of younger cohorts: these men were adolescents and young adults in the 1960s and 1970s and would have witnessed the birth of the gay rights movement, followed by the AIDS epidemic of the 1980s as well as the peak of AIDS-related deaths between 1987 and 1996 (Rosenfeld, Bartlam, & Smith, 2012). All these factors shaped middle-aged gay men's experiences of stigma, family relationships, alcohol and substance use, and how they think about recovery today.

To understand how middle-aged gay men in recovery experience and cope with stigma, we interviewed a multiethnic cohort of gay men and looked at the changes in their coping skills as they transitioned from young adulthood to middle age and from alcohol misuse to recovery. We look at the range of experiences that middle-aged gay men in recovery have of their stigmatized identities and how their ability to cope with stigma changed. If we understand the impact and internalization of stigma, then we can provide culturally relevant support for middle-aged gay men in recovery who confront ongoing stigma.

Method

Overview

The University's Institutional Review Board approved this qualitative study. We used semi-structured interviews to explore how study participants interpreted their experiences of being stigmatized by their families of origin and communities, how they coped with these experiences before recovery, and how they cope with them now. Semi-structured interviews are effective in revealing the emotional and symbolic meanings of a person's experiences, such as experiences of shame, often missed by structured questionnaires (Creswell, 2013).

The semi-structured interview approach allows each participant the freedom to describe his experiences, in his own words, and enables the interviewer to probe and further clarify participants' responses.

Theoretical Framework: Minority Stress Theory

Minority stress theory is an ideal theoretical framework for interpreting the impact of stress in the lives of the gay men in our study. *Minority stress* refers to the excess stress experienced by individuals from stigmatized social categories because of their social (i.e., minority) position (Meyer, 2003). Meyer asserts that minority populations, particularly those with stigmatized identities, experience stressors that are (a) unique—in addition to the usual stressors experienced by everyone, (b) chronic—related to relatively stable social and cultural structures, and (c) socially based—stemming from social or institutional processes beyond the individual, individual events, or non-social characteristics of the person or group (Meyer, 2003). Gay identity is a stigmatized identity: gay men experience excess stress on account of their social position as sexual minorities and this stress is unique to them, chronic, and social in nature.

For gay individuals who do experience stigma, minority stress typically unfolds in the following manner: 1) there is a stressful event or condition of a chronic nature such as religious condemnation, family rejection, or concealment of sexual orientation; 2) those affected by this stress start to expect these events and therefore become more vigilant; 3) over time, some of the negative attitudes become internalized (Meyer, 2003).

Participants

We recruited middle-aged gay men using a variety of methods such as posting flyers at 12-step centers, contacting agencies throughout Los Angeles County that serve gay men, and chain sampling ($N = 30$). We planned to recruit men in the following racial/ethnic categories: African American ($n = 10$), Latino ($n = 10$), and White ($n = 10$). We partnered with a community-based organization that operates three alcohol and substance abuse centers in Los Angeles County that includes programming targeting gay, lesbian, bisexual, and transgender populations. Participants who completed the study were asked to refer their friends. Participants had to meet the following inclusion criteria: 1) self-identify as African American/Black, Latino, or White men; 2) self-identify as gay; 3) aged 50–64; 4) self-report a history of alcohol abuse or dependence; 5) report being sober for at least the last 30 days; and 6) have contact with family and friends at least once per month.

The persons conducting the interviews had experience working with the population and conducting interviews with them. Interviewers obtained informed consent from the participants the day of the interview. Participants were given the opportunity to ask questions about the consent form and the process before they were enrolled in the study. Most of the interviews were conducted in a private office at a local university in Los Angeles. Other interviews were conducted at the offices of our community partner in a private room. Participants gave assent and written consent for audio recording the interviews, which were all conducted in English. The interviewers provided participants an opportunity to ask questions about the study and the consent process before they signed any forms. Each

participant received $50 for his participation in the study and an additional $20 for each friend he referred. The referral incentive was limited to a maximum of two friends who had to complete the study.

Data Collection

From April to September 2013, the research team conducted semi-structured, hour-long, individual interviews with each participant. Two interviewers collected the narrative data for the study. One was a community partner who received interview training from the research team and who also brought to the study his own experience as a counselor. The second interviewer was a member of the research staff, with expertise in conducting qualitative interviews.

The study team worked collaboratively to develop the data collection protocol that informed the development of the qualitative interview guide as well as the demographic questionnaire that assessed age, birth country, relationship status, and birth order. The interview guide included a set of 12 questions that covered the following topical areas: 1) Their families reaction(s) to their sexual identity disclosure (e.g., How did your parents react when they found out that you are gay?); 2) their perceptions about whether their sexual orientation influenced the family support they received (e.g., How has your being gay affected how your siblings support you?); and 3) their perception of whether the level of family support or comfort with their sexual identity changed as they aged (e.g., Has your family support changed with time? and How well would you say you they now accept your sexual identity?). To assess the appropriateness and applicability of our interview protocol, we used the strategy of *member checking*—sharing iterations of the interview guide with key informants and our community partners for feedback and guidance—to guide this process (Charmaz, 2006; Krefting, 1991).

Data Analysis

We used SAS Version 9.2 software to calculate demographic characteristics. Interviews were transcribed and entered into *Atlas.ti* (Muhr, 1991), a qualitative data analysis program for the management of large amounts of narrative data. All participants' identities were anonymized by assigning them a pseudonym. With regard to the interview data analysis strategy, the research team implemented a process similar to the collaborative one it used to develop the interview protocol. Prior to beginning the coding process, we discussed our approach to coding the transcribed narrative data. First and fourth authors discussed codes and resolved differences through consensus. With this process and agreement in place, the codebook was developed and then the first author coded all the transcripts. Using the constructivist grounded theory method as advanced by Charmaz (2006), interviews were coded and interpreted through the constant comparison method (a repetitive or cyclical process that leads to further and further refinement of emerging theory). This particular grounded theory methodology was chosen—as a means of examining, comparing, and contrasting qualitative data across participants, situations, and settings—rather than assuming there is a single truth to be discovered; this approach ultimately enables the researcher to develop theory, theoretical questions, and hypotheses (Charmaz, 2006). Further, we wanted to emphasize how each of the study participants constructs and interprets his experiences. This inductive

approach helps us to understand what the participants' experiences with people and social structures mean to them *as middle-aged gay men in recovery*, as opposed to what these experiences would mean to people who are neither stigmatized nor in recovery (Puddephat, 2006). All authors reviewed the final themes. The team proactively addressed the trustworthiness and credibility of our process and results by checking the preliminary findings and our interpretations with some of the participants. Our community partner-researcher, L. F., was instrumental in ensuring that the themes we developed reflected the data, given his extensive experience working with gay men in recovery.

Results

Participant Characteristics

Our sample included 30 gay men in recovery, aged 50–64. Each one completed an individual interview and a demographic questionnaire. To get a sense of their family relations, we collected data on the number of siblings they have, whether they had ever married a woman, and whether they have children. Because of their age, we also collected information on their health, such as HIV status, mental health, and polypharmacy. Table 1 shows that on average, respondents have been sober for 10.7 years, with range of 0 to 32 years. Two participants had been sober for less than one year, while 10 participants had been sober for 11 or more years. Sixteen reported being HIV-positive and the majority had been diagnosed over 15 years ago, with the exception of one Latino man who was diagnosed within the last five years; there were three Latino, three White, and no African-American men who had been diagnosed over 20 years ago. Most of the men had been HIV-positive longer than they have been sober. Seven men reported being in a long term relationship with a man, six of the men had been married to a woman, and six had children. Almost all of the White participants (n=9) but only a few of the African-American participants (n=3) reported ever having been diagnosed with a mental health disorder.

Thematic Analysis

All the participants reported using alcohol to cope with feelings of shame, guilt, or emotional pain because they felt uncomfortable with their sexual orientation and because they either expected to be or were actually rejected by their family, friends, and religious institutions. The majority of the participants also reported that being in recovery helped them to come to terms with their sexual identity and helped them to develop new coping mechanisms for dealing with ongoing rejection or stigma. Yet some participants reported that they continued to feel uncomfortable being gay and that their families continued to stigmatize them. Most African-American men and some Latinos reported experiences of racial stigma as an extra burden.

We consider how these themes tell a story of experiences of stigma, how the participants coped and continue to cope with this stigma, and how given the social nature of stigma they continue to experience some of the same stressors that led them to use alcohol and other substances to cope in the first place. We analyzed and interpreted, using Minority Stress Theory, the various dimensions and sources of stress associated with sexual orientation stigma that middle-aged gay men in recovery reported. We identified the following themes:

(1) internalization of stigma; (2) changes in coping strategies; and (3) ongoing experiences of stigma. In our analysis, we conceptualized stigma as a subset of stress, i.e., the list of all stressful experiences would include the list of all stigmatizing experiences.

Theme 1: Internalization of Stigma—Participants reported experiences of stigma and *how* they internalized the stigma; they reported feeling shame and guilt because of the moral condemnation they experienced. Junior, a 51 year old Latino, remembers being told that "being gay is wrong," and that being gay meant that he was "possessed" and "going to hell." Amino, a 59 years old Latino Vietnam veteran, reported similar experiences: "[I felt] shame and guilt [for] being gay because of the Roman Catholic Church where I grew up." He also reported more than one stigmatized identity: "I just had this guilt… and shame because of the way I was brought up, and the prejudices of being, you know, my being Latino and being gay in Pasadena, California at that time." Like Junior, Kobe, a 58 year-old African-American male, reported feeling overwhelmed with stigma because of his sexual orientation and his racial identity. He said, "[Homosexuality] was always taught against [in the church], so I figured one, being prejudice against for my color and then another for my sexual orientation was a bit much, you know what I'm saying?"

For others, moral condemnation came from family members. Frank, a 51-year-old White male, was jogging with his father when he was a sophomore in high school and during their run he said to his father, "I think I'm a homosexual." He said that his father cried, and then told him that "God is punishing you for this"—in reference to a difficult situation Frank recently encountered— and that "you're gonna have to struggle through this because it'll go away." Cass, 52 years old, reported a subtle yet common form of moral condemnation:

> I was basically told by my mother that it was ok to be gay, just don't act on it. I said, 'Of course I'm gonna act on it. I came out to you!' That basically… ended our relationship…. I was told that I couldn't come into town unless I was invited and escorted.

Participants reported internalizing the negative messages they heard about gay men by their own family members. These messages had a negative influence on how they chose to interact with their family, and often led to respondents avoiding their adult family members. The experiences of Anderson, a 53 year-old White male, demonstrate what it means to internalize negative messages:

> I abandoned the family for a long time because I just didn't wanna – well, first it started off I didn't wanna molest my brothers because that's what I was told – that's what gay men do. They recruit and they molest. So I left the family so I wouldn't do that to my brothers.

These participants' experiences of moral condemnation are representative of other participants' stories of stigma and fit the pattern of minority stress. Moral condemnation was (1) unique, i.e., they were singled-out on account of their sexual orientation; (2) socially-based, i.e., coming from their families and religious institutions, and (3) chronic, i.e., ongoing in their lives. Over time they internalized some of the negative messages from the dominant culture (e.g., established heterosexual norms, social customs, religous values), which led them to feel shame and guilt, and even to believe that gay men sexually abuse

children. The men in this study began to conceal their identity from their families of origin and from their communities at large to avoid experiences of stigma in the form of moral condemnation.

Theme 2: Changes in Coping Strategies

2.a Using alcohol to cope: Many of these men turned to alcohol and other substances early in life to cope with their negative feelings and sexual orientation. Amino talked about using alcohol to manage his feeling about his sexual identity: “Well, it didn’t make me feel better, but it was like, I just didn’t have to look at it or deal with it. It just kind of hid all the pain and all the feelings [of guilt and shame].” Tyler, a 57-year-old African-American, also used alcohol to cope with feelings of loneliness and abandonment:

> You know, I’m gay. I’m different or whatever. Those negative messages that you heard from the church and the community and all of that from time to time comes up and you have this battle [inside you] and alcohol feeds into that battle…. Sometimes you have to keep drinking and drinking to try to drown out the negativity and as a result you actually [end up] highlight[ing] the negativity because now, not only are you gay, but you’re a drug addict [too]. You’re an alcoholic… which alienates you from people even more.

Tyler makes a clear connection between the negative social messages and his use of alcohol to “battle” the messages that he internalized, which are “inside you.” Yet his using alcohol and drugs created new stigmatized identities: drug addict and alcoholic, which further alienated him from people. Tyler’s story, like that of the other participants, brings to the foreground how these men used alcohol and drugs to avoid their own sexual thoughts and desires, as well as to cope with the resulting emotional pain.

2.b Recovery and coping: Today, most participants tell a different story about how they regard their sexual identity and how they handle their family, friends, and strangers’ negative reactions and attitudes directed at them because they are gay. Many attribute this change to their being in recovery. Frank reported that sobriety helped him to become comfortable with his sexuality and to handle his family’s rejection differently than before.

> My sobriety has helped me to deal with my sexuality, and I think now I have a great comfort level with my sexuality. The other stuff is gone: that guilt, that shame, that embarrassment is gone… I used to feel ashamed… like I’ve brought shame on the family. Now I feel sorry for [my brothers]. When they feel [or express negative attitudes toward gays] I think, ‘Wow, how sad that you feel that way.’

He went on to share how he went to church a few years ago with his father but did not take communion because “I don’t want to take communion from those people [who supported Proposition 8 to ban gay marriage in California].” His father told him that he was worried that Frank was going to hell. Frank told his father, “You know, I know how that feels. I used to worry about me too, but I don’t anymore.” Nevertheless, his father continued to reiterate that he was worried about Frank’s spiritual wellbeing. Frank finally said to his father, “You know I feel terrible, it’s gotta be really painful for you, but better you than me. I know how horrible that is, I’m sorry that you still think that I’m gonna go to hell, but I don’t [think

so].” Frank concludes his story by saying, “My sobriety, and I think working my steps, has allowed me to leave all that behind.”

Likewise, Joe, a 55-year old African-American male, talked about how sobriety enabled him to deal with the homophobia he encounters. His sobriety has to do with his “trust and faith in my higher power… the more of it I have, the easier it is for me to deal with the rough spots that come in the future…” He gives an example of being at the gym and hearing homophobic remarks. “Some guy is talking about, ‘These faggots, this that’ and blah blah blah, all of that homophobic stuff.” He reports how his emotional reactions have changed. “I don’t have to run out of the gym and never come back again. I can feel uncomfortable. My blood pressure can go up… but I don’t have to react in any kind of extreme way.” He now has more muted reactions compared to how he used to react or would have reacted in the past. He connects how he now handles experiences of homophobia to his recovery. “My recovery isn’t… just about not drinking alcohol. That’s only a small part of it. My recovery has to do with all the other things that made me not want to be here anymore. Drinking was just part of it.” He explains: “Part of being in recovery means being ok with who I am. It starts there.”

Frank and Joe’s stories mirror that of other participants about how recovery has affected the way in which they respond to homophobia and stigma. They now experience less stress when they encounter stigmatizing attitudes from their families or from strangers. They attribute their being sober as the source of this new ability to handle situations that before would drive them to abuse alcohol and drugs.

Theme 3: Ongoing Stigma—Many of the men in our study learned to cope with ongoing stigma in recovery. However, there were some participants for whom self-stigma and stigma from family members continued to pose a challenge.

3.a Lack of self-acceptance: Although the men in this study reported using alcohol and substances to cope with feelings of shame and guilt over their sexual orientation when they were younger, some of the participants reported still feeling shame and guilt over their sexual orientation even though they are older and sober. This sheds light on just how effectively messages can be internalized. The following quotes suggest that aging does not always mitigate feelings of stigma.

When Mike, a 55 year old African-American was asked, “At what point did you feel you had that self acceptance,” he replied, “Sometimes I still have problems with my gayness,” and as far his friends’ knowing whether he’s gay, he said, “The gay ones do [know that I’m gay]” but that he doesn’t tell his “heterosexual friends about my sexuality” because “It’s not like I’m trying to jump into bed with them. That’s the only reason why they would need to know.”

Anderson still worried about being stereotyped. He believed that being gay limited his life, and so he had to struggle against that.

> I don’t fit into the Hollywood stereotype. My self-hatred and self-loathing is always somewhere close to the surface, but I don’t want this to be a wasted life, so I’m

> hoping I can do something to help the gay community [by participating in this interview].

When Junior was asked when did he finally accept his being gay, he felt that he could not answer the question, and in the middle of his response he got upset with himself because he still had not accepted himself. His reply reflects his ongoing struggle.

> Junior: When [did I accept myself]? Wow. When? I don't know. I really couldn't answer that because I'm in some acceptance, more than I ever have been in my entire life, but I don't' think I'm in like full acceptance, you know? And I hope I get there right now because that's where— when I said that, it got me pissed off. You know, why wouldn't I be [in full acceptance]? You know what I mean? But I mean, you know why, it's because people wouldn't [accept me]… I think I'll get there…. Like, we're just people, human beings. Like what is anybody going to do? I'm—well, you know what I mean? Interviewer: Still stuck there? Junior: Yeah.

Amino describes himself as a "proud [U.S.] veteran of the Vietnam War" and reported, "I was ashamed of [being gay]. I didn't want to be gay." These feelings have only recently subsided. When asked when he started to accept himself, he replied:

> But it really wasn't until… President Obama was elected, and because of his wife, our first Lady, Michelle Obama and Dr. Jill Biden, all of the things that they have done for our community for Vietnam veterans. That really—that was like a major turning point in my life. So that hasn't been very long ago.

The experiences that these men report, feeling "self-hatred and self-loathing" and not experiencing "full acceptance" from themselves, underscore their discomfort with their sexual orientation after many years. Amino's experiences demonstrate the social nature of stigma, and more importantly, how the solution to stigma is also social. He only recently started feeling better about being gay, and these positive feelings were precipitated by President Obama's election and attitudes toward gays in the military. As a Vietnam veteran, this made a world of a difference to Amino.

3.b Ongoing family rejection: The participants' continuing lack of self-acceptance may also be attributed in part to experiences of ongoing rejection from their families of origin. Frank shared how his teenaged niece was asking him about his relationship with his partner; his niece has known his partner since she was 4 years old. He approached his sister-in-law and told her how perhaps it was now time to inform his niece that he is gay. He went on to share: "My sister-in-law just looked at me straight and [said], 'I hope they never find out because once they do they'll hate you because they know the difference between what's right and wrong.'" Frank did not anticipate this reaction and it affected him profoundly. He shared: "And [her reaction] just sort of sent me on this spiral. Yeah, and I started using [drugs] again within a couple of months."

Jorge provides the context for the value that these men place on their families. He reveals that even as a middle-aged man he continues to look to his family for support and acceptance. He corroborates Frank's story of how families can influence decisions to use drugs or alcohol. "I think our relationships with our family, they're very important… A lot

of time when we feel isolated or we feel shunned, that contributes to our alcoholism and the drug abuse." Jorge explains the impact of isolation and being ostracized:

> It's horrible to not feel part of— for somebody to make you feel not a part of [because of their beliefs or their own stigma]. I don't agree with that, you know what I mean? Because everybody wants to feel wanted, everybody wants to feel loved, especially if it's your own family, you know what I mean?

Whether families choose never to talk about the participants' sexual identity or to continue to condemn them on moral grounds, these families in effect continue to perpetuate the stressors that led these participants to drink in the first place. Although the men are now middle aged and not teenagers or young adults, they still report wanting "to feel loved" by their own family, and how "horrible [it is] to not feel part of" or to be rejected on account of their families' moral beliefs.

Discussion

Similar to other studies on sexual minorities and alcohol and substance abuse, our results show the detrimental effect of family rejection and stigma on the emotional wellbeing and mental health of gay men (Dillon, De La Rosa, Sastre, & Ibañez, 2013; Mulia, Ye, Zemore, & Greenfield, 2008; Ryan et al., 2009). The participants all reported misusing alcohol and substances to cope with feelings of shame and guilt as a result of the sexual orientation stigma they experienced. Although experiences of stigma did not always decrease over time, strategies for coping with stigma did change with age and during recovery. However, neither age nor recovery always ameliorated middle-aged gay men's self-stigma, nor did families always become more accepting over time. For some, family rejection led to relapse. This should come as no surprise because family-related stressors are associated with a higher likelihood of relapse, a lower likelihood of abstinence, and more post-treatment substance use problems (Venner et al., 2006). Recovery, at least for some men, provided an environment in which they were able to confront their feelings of shame and guilt over their sexual identity and achieve a level of self-acceptance.

Coping with Stigma through Recovery

Participation in AA, for example, helped some of the participants to develop new ways of coping with their experiences of stigma: as young adults they abused alcohol and drugs, but now as middle-aged adults in recovery they rely on their higher power when they encounter stigmatizing situations or feel sorry for people who disapprove of them for being gay. This resonates with studies that have shown that participation in AA often results in the acquisition of new coping skills (Humphreys, Mankowski, Moos, & Finney, 1999) and an increase in self-efficacy (Connors, Tonigan, Miller, & Group, 2001; Groh, Jason, & Keys, 2008; Owen et al., 2003). We must note, however, that one of the ways in which AA helps gay men in particular is by enabling them to become more comfortable with, and accepting of, their sexual orientation. This is in line with the study by Harawa et al. (2008) in which men reported that admitting their same-sex sexual activity and coming to terms with their homosexuality or bisexuality was necessary for recovery. AA can function as the necessary alternative structure and set of values necessary for enhancing a group's identity (Crocker &

Major, 1989; Laudet, Magura, Vogel, & Knight, 2000), especially for those who are just coming out or finding new ways to cope with their sexual identity and all the stigma attached to it (Morris, Waldo, & Rothblum, 2001). We suggest that for the participants in our study, the opportunity to establish a new social support system through AA provided some relief from the chronic stigma and related stress unique to them as gay men.

Stigma and Health Consequences

Internalized stigma has negative health implications for individuals and the public. At the individual level, internalized stigma has been linked to depressive symptoms, low self-esteem, and even unemployment and income loss, as well as to increased stress and the chronic activation of psychological stress responses as a result of anticipating negative treatment (IOM, 2011; Hatzenbuehler & McLaughlin, 2014; Stuber et al., 2008). If these men were to relapse, then their use of alcohol, for example, would lead to worse health outcomes than if they were young adults. Age-specific risks associated with alcohol use include an increase in blood alcohol level for a given dose of alcohol because of physiological changes associated with age and increased brain sensitivity to alcohol (Moore et al., 2011). As middle-aged men, they would be more likely to begin developing health conditions such as diabetes mellitus and heart disease and other comorbid conditions and symptoms that may be adversely affected by concomitant alcohol use, and to take medications that may interact negatively with, whose efficacy may be diminished by, alcohol (Weathermon & Crabb, 1999). If they have an HIV infection—as did 16 of the men in our study— their health outcomes would be worse because alcohol use is associated with medication nonadherence, especially on the day of, and after, heavy drinking (Justice, Sullivan, Fiellin, & Veterans Aging Cohort Study Project, 2010), as well as with drug interactions and hepatotoxicity (Schneider, Chersich, Neuman, & Parry, 2012). At the public level, alcohol use by people with HIV is also associated with sexual risk-taking and a higher probability of transmitting a drug-resistant strain of the virus (Kozal et al., 2004; Ross et al., 2007; Schneider et al., 2012).

Connecting Middle-aged Gay Men with their Families

The importance of family support, especially for middle-aged gay men in recovery, warrants further attention than it has received to date. An examination of the participants' reactions to their families' moral condemnation reveals the strength of their attachment to their families, as well as their reliance on receiving emotional support from them. While this may not be surprising for gay youth or young adults, it does serve as a stark reminder of the ongoing importance of family acceptance across the lifespan: the men's looking to their families for acceptance and support does not end when they enter middle age. As our participant stated, "…everybody wants to feel loved, especially if it's your own family…." We ought to find ways to incorporate family members into gay men's recovery process and in intervention programs because recovery is influenced by interactions with others within a social context (Venner et al., 2006), and families tend to be uniquely positioned to provide a context for sustained recovery, especially spouses and mothers (Groh, Jason, Davis, Olson, & Ferrari, 2007; Room, 1989; Room, Greenfield, & Weisner, 1991). Families are encouraged to play a role in the recovery of loved one (National Council on Alcoholism and Drug Dependence,

Inc., n.d.), yet to our knowledge, there are limited resources about how families can be incorporated into the recovery process of gay men (Pride Institute, n.d.).

Moreover, including family members in middle-aged gay men's recovery efforts requires that we expand the traditional conception of family. Gay men who experienced family rejection usually turned to friends and life partners to construct a family network of choice (Muraco, LeBlanc, & Russell, 2008; Nardi, 1999). One study showed that chosen family connections were especially important to older gay men without partners (Hostetler, 2004). Nevertheless, some gay men do maintain ties with biological family members, such as former wives, children (both biological and adopted), siblings, and extended family members (Cruz, 2003).

Limitations

One of the limitations of this study is an overrepresentation cohort of men with at least 11 years of recovery, so the results may not capture or accurately represent the perspectives of those with less time in recovery. Focusing on those in recovery could paint a different picture (perhaps more positive) of the experiences of gay men than if men who are not in recovery were included. Also, the snowball or chain sampling strategy probably yielded less independent information than other approaches might have produced. In addition, we only included only men who maintain contact with their families at least once per month, which may bias the sample in favor of those who already experience some degree of acceptance from their families. However, this enabled us to focus on the impact of these family ties both in the participants' past as well as present, thus shedding light on the complexity of these relationships even when families appear to be accepting. Finally, although we recognize that experiences of stigma were informed by the participants' racial and ethnic identities, which we did not explore these differences. We expect to do so in a future article.

Conclusion

There is no single approach for understanding the social and emotional support needs of middle-aged gay men in recovery as they head into older age, especially when we consider the cumulative and interactive effects of stigma, racism, ageism, and heterosexism on their overall health. Nevertheless, our study leads us to conclude that the social nature of stigma, e.g., from families, from religious institutions, underscores the need to supplement individually-based intervention efforts with group-level approaches. If stigma and all its negative health consequences is a social problem, then a social or collective approach may also prove to be beneficial: explicit statements of support from political and religious leaders, coupled with families modeling how they embrace their gay family member(s), can help to promote stigma-free social environments. We suggest that new interventions must not only address stigma (internalized and familial), but also focus on coping strategies used by this population, emphasize their resiliencies, as well as find ways to include supportive family members in gay men's recovery efforts. We know that recovery impacts the friendship networks of people in recovery, but it does not affect their family network (Groh et al., 2008). It is here where we as researchers need to focus our attention. We recommend that future research explore the types of familial support that may prove crucial for middle-

aged gay men's recovery process within an appropriate cultural context, while bearing in mind the ways in which families might perpetuate stigma and stress.

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Table 1

Socio-demographic and health-related characteristics (n =30)

Characteristics	Total *N* = 30	African-American *n* = 10	Latino *n* = 10	White *n* = 10
Age				
Mean (Range)	54.7 (50–64)	54.7 (50–58)	55.4 (50–64)	54.1 (51–59)
Years of sobriety (n=30)				
Mean (Range)	10.7 years (0–32)	6.8 (1–14)	13.4 (0–31)	11.9 (0–32)
< 1 year	2	0	1	1
1 – 5 years	11	4	3	4
6 – 10 years	6	4	1	1
11 – 20 years	5	2	1	2
> 20 years	6	0	4	2
In long term relationship with a man	7	4	1	2
Previously married to a woman	6	1	2	3
Have children	6	2	2	2
Closer to brother(s)	5	1	3	1
Closer to sister(s)	17	6	5	6
Neither	3	1	0	2
Both	5	2	2	1
Number of siblings				
Brothers				
0	8	3	3	2
1	9	3	2	4
2	5	1	4	0
3	3	2	0	1
4	2	0	0	2
5+	3	1	1	1
Sisters				
0	4	2	0	2
1	10	5	2	3
2	7	2	3	2
3	4	0	2	2
4	3	0	2	1
5+	2	1	1	0
HIV-positive (n=16)		n=5	n=6	n=5
Mean	20 years	18	19	22
< 5 years	1	0	1	0
15–20 years	9	5	2	2
> 20 years	6	**0**	3	3
Diagnosed with mental health disorder, e.g., depression, anxiety	17	3	5	**9**
Polypharmacy (5+ meds)	3	0	1	2