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José A. Hernández
The Political Birth of
Gay Affirmative
Social Services

ABSTRACT

This thesis reports on the preliminary oral history findings collected for a larger national study directed by David S. Byers and Stephen Vider. The findings reported here focus on the experiences of clinicians and social service providers in Los Angeles, California. Another student, Dexter Rose, conducted similar field research in Seattle, Washington. Both projects were under the supervision of the principal investigators. This investigative oral history study examines the perspective of clinicians and social services workers who provided affirmative services to gay and lesbian communities in the years 1960-1987. These years are of great importance because they mark the beginning of political gay and lesbian movements, LGBT riots and organizing, the removal of homosexuality from the DSM, and the discovery and devastation of AIDS. This study documents the experiences of the founders and leaders of the gay and lesbian social services and seeks to understand their motivation to organize their communities.

The following question guided this study, “What motivated social services providers and mental health professionals to provide affirmative therapy and services to LGBT during the 1960-1987?” I conducted semi-structured interviews with 10 gay and lesbian leaders from Los Angeles. Qualitative research allows for naturally occurring patterns and themes, which were interpreted through theoretical lenses. Analysis of the data made salient these themes: social services needs; Latinos, social services, and the AIDS crisis; and mental health as a response to oppression sickness.

In the end, gay affirmative services in Los Angeles are the result of political activism and following the example of other social movements, such as Stonewall and the Black Panthers. Gay affirmative mental health is the result of grassroots activism and “bottom up” development and not the result of the psychological establishment’s changing their views about LGBT people.

The Political Birth of Gay Affirmative Social Services

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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Northampton, Massachusetts 01063

2016

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This thesis is a part of a larger research project. I completed this thesis based on the data I collected as a research assistant supervised by social work professor David S. Byers and historian Stephen Vider. Additionally, this thesis could have not taken place without the participants and agencies that provided their resources and experiences to support the development of this project. Thank you. This project would not have been completed without the supervision of professor extraordinaire, David Byers. Thank you for your patience, guidance, and understanding of my anxieties and thorough hate for writing. Thanks to Stephen Vider for his incomparable dedication and knowledge of research methods, and to Dexter Rose for your warm, kind and funny messages and conversations when I needed humor to vent.

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS..... ii

TABLE OF CONTENTS..... iii

LIST OF TABLESiv

CHAPTER

I. INTRODUCTION 1

II. LITERATURE REVIEW 3

III. METHODOLOGY 22

IV. FINDINGS..... 30

V. DISCUSSION AND CONCLUSIONS..... 52

REFEENCES 56

APPENDICES

Appendix A: Recruitment Flyer..... 60

Appendix B: Demographic Interview Protocol 61

Appendix C: Guiding Questions..... 63

Appendix D: Consent Form..... 64

LIST OF TABLES

Table 1. Los Angeles Participants	24
Table 2. Sociodemographic Characteristics	25

CHAPTER I

Introduction

Nowadays there are many mental health and social services programs that provide an array of psychological, emotional and self-affirming supportive services to lesbian, gay, bisexual, and transgender (LGBT) communities. However, there is little written about how these affirmative services emerged, what created the shift in mental health and social services models for LGBT people, and who were the leaders to serve as catalysts for these changes. This thesis reports on preliminary oral history findings collected for a larger national study directed by David S. Byers and Stephen Vider, and used here with their permission for the purposes of my MSW thesis. The findings reported here are based on data I collected as a research assistant for this project, focusing on experiences of clinicians and social service providers in Los Angeles, California, during this period. This thesis was also written in collaboration with another MSW student and research assistant on this project, Dexter Rose, who conducted similar field research in Seattle, Washington, both projects under the supervision of the principal investigators. The larger study—and each city specific thesis—examines the driving forces behind the creation and emergence of affirmative mental health and social services models, the social and political context within which they arise, and a few of the people who spearheaded these changes within specific urban contexts. The guiding question for study is, “What motivated mental health and social service providers to provide affirmative supportive services to LGBT people from 1960-1987?” Because there is little information in today’s literature that provides the perspective of early clinicians and social service providers, this study provides an opportunity for their voices to be heard from this critical period for LGBT people.

Understanding how affirmative services emerged matters because through the early 1970s, “homosexuality” was classified as a disease or as the result of arrested development. The consequences of being labeled “homosexual” included jail time, being institutionalized against one’s will, police harassment, family rejection, and experiences of stigma during medical care. This study aims to understand how, given this social and political context, community-based clinicians and social service workers for this population developed affirmative services. Achieving this aim requires speaking with those who lived through these times and yet managed to resist the mental health establishment, reject social norms, and develop new models of mental health and social services. For this reason we chose a qualitative approach and conducted semi-structured interviews with mental health and social service providers. The focus for this thesis is Los Angeles during the timeframe of the project.

This project will also look at how local and broader political social movements of the 1960s influenced clinicians and social service workers during this period. Specifically, in Los Angeles the Black Panthers influenced how some of the founders of the first organizations for LGBT people conceptualized mental health and social services. These organizations included the Gay Community Services Center and the Women’s Center. This study will show how mental health cannot be divorced from its social and political context. This study gives clinicians and social service workers historical context for their practice, as well as remind them of the importance of a person’s identities, such as their race and gender, which continues to be a challenge for some clinicians and social service workers today. It can help clinicians and social service workers think about how to draw connections between their practice, their clients, and the current social and political environment within which their clients make choices.

CHAPTER II

Literature Review

Historical Background

Several historians have documented the history of mental health professions, including psychiatrists, social workers, and psychologists, attempting to change the sexual orientation of their LGBT clients (Berger, 1977, Doyle 2009, Gallagher, 1975, Gonsiorek, 1991). Bayer (1987), Terry (1999), and Doyle (2009) show that during and after World War II, homosexuality was treated as a psychological aberration, and by the 1950s, psychiatrists considered it a personality disorder that resulted from “arrested psychosexual development” and required “immediate attention” (Bayer, 1987, Doyle, 2009, p. 768). Berger (1977) and Gallagher (1975) found that the clinical approach to homosexuality assumed that it was a psychological problem that interfered with normal functioning. Other psychoanalytic approaches saw homosexuality as sign that a person found the “normal heterosexual outlet... too threatening,” and so homosexuality was conceptualized as a “flight from heterosexual relations,” and hence a symptom of underlying pathology that needed to be cured (Morgan, 1993, p. 135). Doyle (2009) found that at the LaFargue Clinic in Harlem, New York, (operating between 1946 to 1958) clinicians believed that homosexuality was a medical condition and that only they could define it. For example, clinicians had labeled two of Black men (who as children had been raped by older men) as homosexual, even though the clients themselves did not identify as such, because they interpreted the men’s victimization as a “history” of “homosexual experience” and as an “indication of homosexual tendencies” (Doyle, 2009, p. 770). Clinicians set themselves as experts over matters of sexual identity without taking any client’s experiences into account.

At the same time, Batza (2011) notes that there were social movements in the West Coast that started to reject what they considered oppressive social norms and struggled to change society. She argues that the larger political landscape started changing, especially in Los Angeles: its long history of political oppression, deplorable housing conditions, police brutality, and insufficient social services for African American people culminated in the Watts Uprising. The uprising started August 11, 1965, lasted for six days until August 17, 1965, and covered a 50 square mile area (Civil Rights Digital Library [CRDL]). The uprising was sparked by a White policemen pulling over a young African-American motorist on suspicion of drunk driving. The crowd that gathered believed the police were being abusive and a fight broke out and the uprising ensued (CRDL). Over 14,000 California National Guard were mobilized to South Los Angeles (CRDL). This incident left 34 dead and led to almost 4,000 arrests and \$40 million in damaged property. Batza (2011) argues that the riots mark the beginning of the political shift in Los Angeles.

The Watts Uprising paved the path for the founding of the Los Angeles chapter of the Black Panthers Party in 1965. The founder of the Black Panthers in Los Angeles, Alprentice “Bunchy” Carter, explicitly attributed the growth of the Black Panther party to the Watts Uprising (Batza, 2011). Although their main focus was the cultural survival of African American communities, they additionally focused on personal protection, education, health, and job training programs in the late 1960s, before the more often discussed 1969 Stonewall Riots in New York City (Batza, 2011). The Black Panther’s Free Breakfast for Children program deserves special mention because it became the model and impetus behind all federally funded breakfast programs in existence today in the United States (Heynen, 2009).

According to Batza (2011), the idea of survival helped the Black Panthers to organize and mobilize their communities. Black Panther leader, Huey P. Newton, describes the threats to the survival of the Black community, such as “racist police agencies through the country [that] intensify the terror, brutality, murder, and repression of Black people,” as well as “the savage lynching of thousands of Black men and women,” and recognizing that the United States’ policy toward people of color has always been one of “repression, genocide, terror, and the big stick” (p. 70). As a result, Newton concludes that

A people who have suffered so much for so long at the hands of a racist society must draw the line somewhere. We believe that the Black communities of America must rise up as one man to halt the progression of a trend that leads inevitably to their total destruction (p. 119).

The Black Panthers as an organization was one way to respond to the threats that the Black community faced. This supports Batza’s (2011) point that the Watts Uprising had political consequences that reverberated through many communities of color in Los Angeles because the Black Panthers in Los Angeles started after the Watts Uprising. Moreover, this rhetoric, influenced subsequent social movements as well (Batza 2011).

In the years following the Watts Uprising, other ethnic minority groups throughout California began mobilizing and employing the Black Panther’s survival politics specifically to their own communities (Batza, 2011). For instance, the American Indian movement organized to fight the oppression and destruction of their tribes and culture and to demand tribal independence. They aimed to reclaim their lands, such as the land that the Alcatraz prison had been built on, in 1969 (Batza, 2011). The Chicano movement, United Farm Workers, and the Brown Berets, Batza explains, organized around issues important to their communities, such as

immigration, safety, worker's rights, and accessibility to social services. The Chicano movement and the Brown Berets also organized around the concept of survival and associated threats to personal safety with extinction (Batza, 2011). What all these groups had in common was the belief that their problems were socially based: "white, heterosexual male dominated society and state were literally killing off their communities" (Batza, 2011, p. 107).

Batza (2011) points out that during this period another political group was particularly important: feminists. Feminists embedded their protests around reproductive rights within the context of survival with "white women pointing to the health risks of illegal abortion practices and women of color equating forced and uninformed sterilization with racial genocide" (Batza, 2011, p. 108). They also focused on institutional patriarchy and the health repercussions that resulted from their political oppression, which they acknowledged were compounded by race and class (Batza, 2011). They also brought attention to the small number of women doctors and the ways in which the medical school curriculum and medical research maintained or contributed to their oppression (Batza, 2011). Instead, they called for methods of care in which women were encouraged to participate in their own healthcare (Batza, 2011).

Faderman and Timmons (2006) point out that the Watts Uprising inspired a new kind of radicalism, embodied especially by the Black Panthers. What is less documented and understood is how the political analysis of the Black Panthers influenced the gay liberation movement, gay and lesbian identity, and activism in 1970s Los Angeles. There were different aspects of these analyses. For example, the gay liberation movement borrowed the theoretical analyses of the Black Panthers in Los Angeles and started framing health as an "indicator of oppression," and were primarily influenced by ideas of "survival" (Batza, 2011, p. 111). Health outcomes were seen as a direct result of social injustice, such as lack of access to healthcare, lack of safety, all of

which threatened the survival and livelihood of these communities. Their approach to mental health also changed when they introduced concepts of survival and oppression (Gallogly, 2014, Kenney, 2001). It was at this time in 1970 that the first gay and lesbian organization in the country, the Gay Community Services Center (GCSC), opened its doors on Wilshire Blvd. near McArthur Park in Los Angeles. As the first services organization for gay and lesbian people, the GCSC set the foundation and started the conversation around the services gay and lesbian people need. Their influence in terms of services and activism on future organizations cannot be overstated, so I will look at this organization in more depth below.

Gallagher (1975) points out, the Gay Community Services Center inherited the philosophy of the Gay Liberation Front, which argued that gay people had been the victims of severe prejudice, that the inevitable response was rage—which until now had been repressed or misdirected—and this rage could now be channeled to “combat the oppressor” and establish a “unified gay community” (p. 14). Like other social movements, gay liberation rhetoric framed their struggle using the concepts of oppression and “oppression sickness” (Batza, 2011, p. 109).

The concept of “oppression sickness” for the gay and lesbian community encompassed most of the challenges faced by the gay community, such as job loss, violence, homelessness, and the “self-destructive behaviors that stemmed from societal homophobia” (Batza, 2011, p. 109). She adds that in the early stages of the movement, the organization of gay and lesbian groups centered on their physical and mental health needs. They classified the lack of mental health services specific to the gay and lesbian community as a form of oppression, just as the Black Panthers had argued on behalf of the Black and African American community. By focusing on their needs as a gay and lesbian community, these groups developed and sharpened their political criticisms of the homophobia in society (Batza, 2011). Moreover, by claiming that

the lack of services was a form of oppression, gay and lesbian people made health disparities a central focus of their political identity, even before the start of the AIDS epidemic (Batza, 2011).

Gay Liberation

Faderman and Timmons (2006) have shown the important place of Los Angeles in the early gay rights movement, which was home to the Mattachine Society, one of the first “homophile” groups in the country. The word “homophile” was used to “deflect the criminal and mental illness connotations of ‘homosexual’” (Faderman and Timmons, 2006, p. 111). In the 1950s, the Mattachine Society was among the first homophile organizations in the country to look at gay and lesbian people outside of a clinical framework (Faderman and Timmons, 2006, p. 124). Nevertheless, most people continued to keep their identities secret to avoid social and legal repercussions, and the Mattachine Society “operated under the realistic conviction that extreme discretion was necessary” (Faderman and Timmons, 2006, p. 112). These convictions, however, would later be challenged by the events of Stonewall.

According to Altman (1971), after the Stonewall Riots, gay liberation changed the discourse from one in which gay people attempt to present themselves as “decent, as patriotic, as clean-living as anyone else” to one in which American society itself needed to change to accommodate them (p.128). Gallogly (2014) confirms that gay liberation no longer tried to find ways to fit into society, but instead called for changing society altogether, because “personal and psychological liberation was the first step towards revolution” (p.7). Kenney (2001) draws a similar distinction between the goals of early activists and the Los Angeles Gay Liberation Front (GLF). Early activists aimed to educate closeted gay and lesbian people about their existence and history, whereas the GLF focused on protests against oppression and unfair treatment. For example, the GLF organized around a number of social issues for gay and lesbian people,

including homophobia in healthcare, psychiatry and the media. The men in the GLF formed a coalition with the Black Panthers, even though this alienated lesbian women from participating more fully in the GLF, because of the Black Panthers' "quintessentially macho" attitudes meant they gave "more significance for male GLFers than any issue raised by... GLF lesbian sisters" (Faderman and Timmons, 2006, 182). Eventually, the women grew frustrated with this arrangement and left the organization to "find [their] own identity and [their] own causes as gay women" (Batza, 2011, p. 136).

The GLF had chapters in Los Angeles, San Francisco, New York, Boston, and Chicago, and "focused on street protests" and "targeted actions against the police" (Kenney, 2001, p. 81). Kenney (2001) notes that Los Angeles differentiated itself from other cities because its GLF chapter provided the "organizational and tactical base" for social services aimed at gay and lesbian people, epitomized by the founding of the Gay Community Services Center in mid-1971 (Kenney, 2001, p. 80-81). The GLF in Los Angeles was the first gay organization to list itself in the phonebook in an effort to reach "gay youth arriving at the bus station in downtown" and provide them a resource (Kenney, 2001, p. 82). The GLF in the other cities started to offer social services to the gay and lesbian community only much later after Los Angeles (Kenney, 2001, p. 81).

While early activists focused on individual outreach, the GLF set out to change mainstream mentality and approaches rather than replicating the practices of current institutions (Kenney, 2001). Gallagher (1975) argues that the gay liberation movement in L.A. also led to the rejection of traditional psychotherapy, which usually tried to "cure" homosexuality, and to the development of non-professional approaches, such as peer counseling and hotlines, that identified the "emotional stress suffered by many gays" as a normal response to oppression and

repressed rage (p.2). Berger (1977) concurs that this new approach to mental health saw homosexuals as a legitimate minority group that “seeks redress from grievances inflicted by society” that otherwise claims to value equality (p. 280). This new approach emphasized that the emotional stress experienced by gays and lesbians was a natural response to the oppression they faced in society and that Gay Liberation did not reject therapy for gay people but instead focused on helping gay and lesbian people accept themselves (Batza, 2011, Gallagher, 1975). As a result, the aim of therapy for gay and lesbian people is to help them adjust to their “minority status in society” and to address their oppression by society (Berger, 2014, Gallagher, 1975). Gallogly (2014) claims that Gay Liberation provided the framework for thinking about the mental health of gay and lesbian people because fighting back stereotypes was now increasingly seen as part of mental health and as the first step toward freedom and rejecting shame.

LGBT Social Services Organizations

Gay Community Services Center. Kenney (2001), Faderman and Timmons (2006), Batza (2011), and Gallogly (2014) argue that the Gay Community Services Center (GCSC) was particularly important as a site for social services in the city. Founded in 1970 by GLF activists including Don Kilhefner, the GCSC was among the first organizations to offer supportive mental health services that were not trying to cure them (Gallogly, 2014, Lee, 2013). The GCSC offered gay people an alternative therapy model in which people could explore their sexuality freely and as a source of pride. It provided safe spaces for meetings such as rap groups (casual conversations in a group setting where anything related to being gay was discussed); growth groups (focused on questions such as, “How gay do I feel? How much a part of my life is it? How comfortable am I with it?”); peer counseling (helped people manage their problems by talking about them with other gay people, people who knew “where [they’re] coming from” (p.

17)); and consciousness-raising (redefining one's identity in contrast to self-conception inherited by the dominant culture, how one is oppressed and oppresses others). Gallogly (2014) argues that these changes in services aimed to provide role models of people who had come to terms with their sexual orientation for those who were still struggling with theirs. The gay-identified therapists providing services at these organizations were seen as role models by the clients and were seen as being able to “provide security for [clients] who need[ed] to see gay counselors” (Rochlin, 1982, p. 27).

According to Gallogly (2014), the founding of the Gay Community Services Center—referred to as “The Center” and known today as the Los Angeles LGBT Center—marks the turning point in mental health services for gay and lesbian people). Like Gallogly, Gallagher (1975) portrays the GCSC as changing the course of mental health services for gay and lesbian people by offering alternatives to mainstream therapy because it allowed clients to understand “the gay experience” for both the client and practitioner, and this included discussion of awareness of oppression and anger. Although GCSC considered itself the “first human service agency in history to deliver human services specifically designed for the gay community,” there were precedents in Los Angeles of providing services to the gay community, such as the Metropolitan Community Church (founded in 1968 for gay people who did not feel welcome in traditional churches) (Gallogly, 2014, p. 15). Metropolitan Community Church provided some social services such as crisis and alcohol counseling, as well as employment services, and there were alternative health clinics founded in the 1960s that catered to “women, hippies, gay people, and other who felt alienated by traditional health services” (Gallogly, 2014, p. 15). By this point, the Metropolitan Community Church was “emerging as the largest single membership institution

in the national gay community” with 36 churches throughout the country (Clendinen & Nagourney, 2013, p. 179).

These new accepting and loving environments allowed gay people to ostensibly “be themselves” and to evolve as whole human beings, physically, emotionally, and psychologically. Gallogly (2014) and Gallagher (1975) emphasize the Gay Community Services Center created a new model of therapy that provided spaces for gay and lesbian people to talk about their experience and intimacies. They argue that gay people were “taking control of their own lives” and rejecting the pathologizing of their sexuality (Gallagher, 1975; Gallogly, 2014). Lee (2013) agrees that this marks a shift in what it means to provide mental health services to gay and lesbian people. He describes a contextual shift in the psychosocial approach and claims that clinicians and social service workers started to see the challenges of being gay within the context of the larger society. These included experiences of violence, discrimination, social isolation, substance use, sexual health, as well as romantic and familial relationships. Additionally, Lee (2013) identifies social adjustments, chemical health, sexual health, and family support as additional needs to be explored.

Venereal Disease Clinic. The GCSC also ran a sexual health clinic. Gallogly (2014) claims that the venereal disease clinic also followed the model of the self-development programs. She argues that traditional clinic health programs would require patients to disclose their sexual orientation to a sometimes hostile heterosexual doctor, whereas GCSC offered a gay alternative without the stigmatization and alienating services of a heterosexual medical practice. Although the clinic worked on diagnosing and testing for venereal diseases, it also served as an education program because it provided gay people with gay specific educational materials and later introduced community outreach (p. 24). Outreach was a strategy also employed by the

consciousness-raising groups. Furthermore, Batza (2011) suggests that the VD clinic was designed to meet the needs of the gay and lesbian community, foster community, and challenge the “ignorant mainstream medical establishment” (p. 147). Batza also sees the self-affirmative posters hung on the clinic’s walls, such as “Don’t Give Him Anything But Love,” in addition to a sign written by the clinic’s medical director, Dr. Ben Teller, “This clinic runs on love and money, please give some of both,” as forms of community building (p. 148). By fiscal year 1976-1977 the venereal disease testing program saw 12,143 patients (p. 149).

The Los Angeles Women’s Center. The Los Angeles Women’s Center opened in 1969 and placed radical feminism at the core of its organization (Batza, 2011). Lesbianism became a “political solution” to the oppression women faced in society and in heterosexual relationships (Batza, 2011, p. 137). In 1971, Lesbian Feminists (formerly known Gay Women’s Liberation Group) joined the Women’s Center because they found it to be more aligned with their own leftist political views, especially because it celebrated lesbianism (Batza, 2011). The Women’s Center hosted 40-50 lesbians for weekly consciousness-raising rap groups (Batza, 2011). Although this was a good space, some lesbian women left in search of a place they could call “their own” (Batza, 2011, p.137).

Gay Women’s Services Center. In 1970, lesbian activist Del Whan, known for her activism in the GLF and with the Women’s Services Center, opened the nation’s first health service center specific to lesbian’s needs, the Gay Women’s Services Center. This center was in the Echo Park neighborhood of Los Angeles. The affordable housing of Echo Park also allowed many organizations such as the Gay Women’s Center to flourish. Whan and the Gay Women’s Center’s members followed in the steps of ongoing social movements to focus and customize services to meet the needs of lesbians (Batza, 2011, Retter 1999). For instance, Batza describes,

lesbians were faced with physical violence, emotional ostracism, and shame. The Gay Women's Center also focused on incarceration in both prison and mental institutions. According to Batza, it fought against the imprisonment of women because of their sexuality. These women would raise money to bail women out of jail and out of psychiatric institutions, and organized to protect lesbian inmates from sexual and physical harassment (Batza, 2011, Retter, 1999). In addition, the Gay Women's Center functioned as a shelter. Some members reported that, "it was better to sleep on the floor than to sleep out in the park or to be walking the streets" (Batza, 2011, p. 139). Batza notes that the GWSC provided a safe space for lesbian dances, rap groups, dinners and self defense classes— basically the same services that the Gay Community Services Center offered. The GWSC believed that by working to improve the physical, mental and social health for women in the lesbian communities of Echo Park and Los Angeles, they were also developing the tools to fight oppression.

Mental Health Models

Gallogly (2014) claims that in the new mental health model, the practitioner is not expected to be the expert, but rather "somebody who shares where [the client] is coming from" in terms of their experiences (Gallogly, 2014, p.17). She further explains, using GCSC as an example, the relationship between the clinician and patient went beyond the session. GCSC extended their relationship beyond a therapeutic one through the variety of self-development activities offered. In this new model, Gallogly argues, there is an emotional investment from both the counselor and the participant that was intended to lead to the growth of both individuals. Unlike professional models at the time, counselors often also shared their own experiences of being gay or of rejection and modeled a new way of being gay, a way in which engrained

feelings of disgust or shame had been overcome (Gallogly, 2014, p. 19); the GCSC provided a space for gay and lesbian people to affirm their identity and to heal from their wounds (Kenney, 2001). The ideal counseling relationship would extend outside the session and into other activities provided by GCSC, thereby creating more opportunities to create friendships and build a sense of community. Having counselors of the same gender and same sexual orientation was GCSC's way of creating a "gay alternative setting" (Gallogly, 2014, p.21). This model was based on a humanistic conceptualization for understanding therapy and the role of the counselor, one in which the counselor's experience, as a full human being was part of the therapeutic relationship. This approach was in keeping with GCSC's model of community and service, that is, of providing services for survival and services for community building.

Like Gallogly (2014), Kenney (2001) also points to community building as an essential component of the gay and lesbian movement. This feature was the result of their having been prevented from partaking in social discourses, community, and social services institutions. She argues that fostering one's identity and continuously providing community support had been an important part of the gay liberation fronts for they provided a sense of security and visibility that could not be achieved simply from demonstrations by activists and "disconnected actions" by diverse and loosely connected grassroots groups. Citing an interview with Morris Knight, one of the co-funders of the Gay Community Services Center, Kenney (2001) shows how GCSC self-consciously set out to challenge social norms through the development of affirmative social services for gay and lesbian people. GCSC also, as previously mentioned, opted to challenge the mental health industry by creating self-affirming, self-loving consciousness raising groups. Knight asserts that GCSC was not only the first social services agency but the headquarters of "great advocacy," an organized response, to the social hostility of mainstream organizations to

the needs of gays and lesbians (p. 83). For both Knight and Kilhefner, Kenney explains, protesting in the streets would not by itself lead to social services for the community. In order to achieve these changes a different type of organizing and organization was needed. Kenney explains that both Knight and Kilhefner wanted to create a space where gay and lesbian people could “come to affirm their gay and lesbian identities” in order to mitigate the impact of social wounds as a result of prejudice experienced in society (p. 88). Batza (2011) explains that making health a political issue helped the community establish this institution (GCSC) to provide for their own healthcare. By using “oppression sickness” (e.g., job loss, violence, depression, homelessness, substance use, medical malpractice), as a political tool, the Gay Community Services Center succeeded in getting Los Angeles County to subsidize its building. This also allowed the GCSC to qualify for free medications, and its venereal disease testing program quickly became one of the most effective at identifying “a higher percentage of new venereal disease cases than nearly every other clinic” in the city of Los Angeles (Batza, 2011, p. 149).

Furthermore, Gallogly (2014) argues that GCSC’s self-development and self-affirmation programs, such rap groups, helped to combat traditional psychological approaches to homosexuality that “brought enormous misery and suffering on gay people due to the prejudices of the practitioners” and that these services helped pave the way to joy and liberation from an unjust society (p.15). Resisting traditional psychological approaches was a key feature of mental health for LBT people (Jay & Young, 1977, Morgan, 1993). In the new model, GCSC’s staff, as well as the clients, shared their experiences in the sessions. By doing so, GCSC’s staff demonstrated and modeled positive and self-loving ways of being gay and that “engrained feelings of sickness or disgust [for being gay]” could and had been overcome (Gallogly, 2014, p. 19). The versatility of the self-development model allowed a cycle of growth where participants,

over time, became leaders. Further, Gallogly (2014) explains that this model of social services was revolutionary because it sought to empower gay people to “craft their own solutions to the problems created by an oppressive straight society” (p. 33).

Challenges to Community Building: Inclusion, Exclusion, and Tension between Movements

GCSC, race, and class. Gallogly (2014) notes that despite GCSC’s efforts to be inclusive, by 1973 GCSC served primarily men (62%) over women (38%), and whites constituted 70% of the clients. Black, Mexican/Latino/a, and Asian people made up 10%, 9%, and 3% respectively (Gallogly, 2014, p.28). Moreover, in terms of programming, racial and class identities were not discussed in the rap groups and were rarely mentioned in the new self-development guidelines. For example, a survey of program participants between 1971 and 1972 “did not list or discuss race or class” although it did consider gender and age; the counseling training programs included a session called, “Our prejudices (Racism, Ageism, Sexism, Classism, Education level, Beauty),” but this was the seventh topic considered after cruising and loneliness; and racism and classism were “listed at the end of a list of topics discussed in consciousness raising sessions” (Gallogly, 2014, p. 29). Gallogly (2014) believes this means that programs offered by GCSC demonstrated a “deprioritization of [race and class] identity categories.”

Batza (2011, p. 111) corroborates this view, namely, that many “white gay men framed health... focusing primarily on gay identity and sexuality with much less concern for gender and race.” In the end, this would impact the type of programming available, the issues they would cover, and how welcome transgender and People of Color felt within GCSC. According to Lee (2013), although the early movement attempted to recognize people who were marginalized for

other reasons besides being gay (such as race or gender expression), they nevertheless felt the need to establish their own groups. In the early and mid-1970s, different groups tried to create spaces to fit other facets of their identities, such as Latin Americans (“Unidos Plans” 1971), transgender people (“One Brick,” 1971; “Transsexual Help,” 1971), and deaf or hard of hearing (Emery, 1976; “Gay is Good,” 1976) (Lee, 2013, p. 168). These did not last for very long (Lee, 2013).

This dissatisfaction with gay and lesbian social services agencies that continued to marginalize People of Color was brought into sharp relief in the early 1980s at the start of the AIDS pandemic. In response, Jose Ramirez and Roland Palencia founded Gays and Lesbians Latinos Unidos (GLLU) in the summer of 1981 (Faderman, 2015). By this time, People of Color realized that “there was a lack of services going to minority communities,” even though AIDS Project Los Angeles (APLA) had at this point received large federal grants and was now “the main service provider to the gay community” (Esquivel, 1991, p. 91). This was seen as the beginning of the “professionalization of services to the LGBT communities and [people of color] were being completely excluded” because “gay men of color were getting sick and dying and were not being serviced by APLA” (Esquivel, 1991, p. 91). GLLU picketed APLA and issued a press statement publicly criticizing the agency (Esquivel, 1991, p. 91). The first successful (and ongoing) services center for gay, lesbian, bisexual, and transgender Latinos, Bienestar Human Services, Inc., would not be founded until 1989 and evolved from GLLU’s AIDS Committee. It is worth noting that GLLU supported the United Farm Workers’ boycott of Lucky grocery stores, and in return they “won the support of César Chávez for a California bill prohibiting job discrimination against gays” (Alanis & Cornish, 2008, p. 273). This shows how for gay and lesbian Latinos, their ethnicity mattered just as much as their sexual orientation.

GCSC and gender. The GCSC began making its political and social marks on Los Angeles' gay and lesbian communities. The lesbian community did not see eye-to-eye with the gay men of the GCSC because they felt that both GCSC and GWSC had different ideals. According to Batza, the male founders of the GCSC were firm on uniting the centers to make the GCSC the center of the growing lesbian and gay community (p. 160). Batza notes that this would have given the GCSC a political and logistical advantage over other centers, such as saving on overhead expenses by housing both gay and lesbian services under one roof. Politically, uniting both GCSC and GWSC could have increased their political weight. The GCSC was a product of the GLF, which lesbian activists viewed as a collection of white sexist males insensitive to women's issues.

Batza (2011) explains that the GCSC's efforts to become the headquarters of gay and lesbian services often led them to belittle lesbian services organizations (p. 162). Don Kilhefner and Morris Knight, of the GCSC, used many tactics to meet their goal of uniting both centers, which only increased tensions between the GCSC and the GWSC. According to Batza, Knight made many attempts to convince the women to join them by visiting their center, yet the women were reluctant to join (p. 162). After Knight and Kilhefner saw that their attempts were futile, the GCSC took on more aggressive means to get the GWSC members to come to the GCSC. According to Batza, the GCSC started scheduling their women's rap groups on the same day and time as the GWSC's meetings (p. 163). Immediately, the GWSC experienced a drop in numbers. As result of the decreasing numbers, the founders of the GWSC saw the merging with the GCSC as inescapable. After six long months, the founders of the GWSC decided to close its doors. In an interview, the founders shared, "They [Kilhefner and Knight] eventually wore us down...we were basically following the women who had left us," (p. 163). Batza suggests that the women of

GWSC did not feel alienated or ostracized by the men of the GCSC as did the founders of the GWSC.

Gay Liberation Front and gender. Yet the challenges faced by the GCSC reflected the challenges faced by ongoing social movements. Batza (2011) notes that although both the GLF and the Feminist Lesbian movement incorporated health into their survival politics by the early 1970's, gender difference started to cause turmoil and division (p. 135). Initially, the GLF had five female members who were frequently excluded from decision-making in impromptu meetings held at Kilhefner's all-male housing cooperative. Batza suggests that these exclusions, the lack of acknowledgement of how GLF's decisions affected women's issues, and the GLF's decision to form a partnership with the Black Panthers, all caused a bigger gap between male and female GLF's members. According to Batza, women from the GLF—upset with marginalization and apparent second-class affiliation—left the GLF by 1970 to find “our own identity and own causes as gay women” (p.136).

As a result, agencies were developed specifically for lesbians to find political and social support. One activist asserted, “... there was no lack of places. There were lots and lots of organizations. They all had political arms and they had social arms.” These included the largest chapter of The National Organization for Women, whose president's lesbianism was no secret (p. 136). Still, there were rifts among the women's groups as well. Although it was a political environment, many of the GLF women found NOW's political middle-class agenda too far out from their own political aims.

Summary

The literature review shows how the development of new mental health models for gay and lesbian people were rooted in social activism and learning from other social movements.

Gay affirmative models cannot be separated from the political activism that gave rise to it.

Nevertheless, there is little in the literature about services specifically for African American or Latino/a people at this time, nor is there much information about programming for transgender people.

CHAPTER III

Methodology

This thesis reports on preliminary oral history data collected for a larger national study directed by David S. Byers and Stephen Vider, and used here with their permission for the purposes of my thesis. The findings reported here are based on data I collected as a research assistant for this project, focusing on experiences of clinicians and social service providers in Los Angeles, California, during the period of 1960-1987. This thesis was also written in collaboration with another MSW student and research assistant on this project, Dexter Rose, who conducted similar field research in Seattle, Washington, and also under the supervision of the principal investigators. The larger study—and each city specific thesis—examines the driving forces behind the creation and emergence of affirmative mental health and social services models, the social and political context within which they arise, and a few of the people who spearheaded these changes within specific urban contexts.

The Oral History Association defines oral history methodology as “gathering, preserving and interpreting the voices and memories of people, communities, and participants in past events. Oral history is both the oldest type of historical inquiry, predating the written word, and one of the most modern” (OHA, 2015). Oral history’s strength is giving voice to the past and providing a context for the present. It can offers a voice to politically and often marginalized populations by looking beyond known written documentation, documentation often written by those with means and privilege. Oral history provides background information and personal anecdotes that are seldom documented in research. Some of the limitations of this this approach include that key figures may no longer be alive or may be too cognitively impaired to participate, thereby leaving out their version of events.

A qualitative methodology was best suited for this type of oral history research project because the experiences of some of the first gay affirmative clinicians and social service workers have not been explicitly articulated elsewhere in the social work, psychology, psychiatry, or historical literatures. An oral history approach allowed us to focus on the voices and insights of the clinicians and social service workers during this period, to integrate their experiences within broader historical contexts. Conducting surveys would not have provided the level of data needed. A survey assumes we know the domains over which we should ask questions and what the response categories should be. The type of information we would have gotten would have been how many people answered the questions in one way rather than another. The strength of interviewing was that it allowed participants to explain in detail their experiences in their own words and gave the interviewer the freedom to probe the participant and follow the conversation wherever it might lead.

Participants

The inclusion criterion for this oral history research project was to have provided any form of affirmative counseling, psychotherapy, or social services to LGBT people from 1960 to 1987. Individuals who provided services outside the study's time frame were excluded. The inclusion criterion included not only licensed professionals, but also paraprofessionals, lay counselors, and volunteers. The idea behind this extension was to learn about alternative means of affirmative support in marginalized communities, specifically in communities of color during this period, though the preliminary research at this phase has not identified that any alternative resources were available. The geographical selection criteria for this specific project were to interview candidates at various locations nationally. The larger study examines the early development of affirmative models and services at a national urban level, including Boston, New

York, Seattle, and Los Angeles. This thesis reports on interviews conducted in Los Angeles (see Table 1).

Table 1.

Los Angeles Participants

<u>Name</u>	<u>Gender</u>	<u>Sexual Orientation</u>	<u>Race/ethnicity</u>	<u>Affiliations</u>
Roland Palencia	Male	Gay	Latino	GCSC ^a /GLLU ^b
Don Kilhefner	Male	Gay	Caucasian	GCSC
Nancy Valverde	Female	Lesbian	Latina	GLLU
Alexie Romanoff	Male	Gay	Caucasian	GCSC
Dan Fast	Male	Gay	Caucasian	GLASS ^c /GCSC
Rita Gonzalez	Female	Lesbian	Latina	GLLU
Del Whan	Female	Lesbian	Caucasian	GWSC ^d /GCSC
Jon Platania	Male	Gay	Caucasian	GCSC
Rev. Troy Perry	Male	Gay	Caucasian	MCC ^e

^a Gay Community Services Center, ^b Gay and Lesbian Latinos Unidos, ^c Gay and Lesbian Adolescent Social Services, ^d Gay Women Services Center, ^e Metropolitan Community Church

Demographic data

The table below shows additional demographic data collected from participants: gender, race/ethnicity, educational level, spirituality/religious affiliations, vocation and training. As a research assistant for this study, I interviewed nine participants for this portion of the research in Los Angeles, California: six men and three women (see Table 2). One of the participants was interviewed twice at his request.

Table 2.

Sociodemographic Characteristics

<u>Characteristics</u>	<u>Total (n=9)</u>
<i>Provided affirmative therapy as...</i>	
Social worker	1
Psychologist	
Psychiatrist	2
Psychoanalyst	
Clergy	1
Volunteer/ Lay counselor	4
Other	1
<i>Training</i>	
Formal training	6
On the job	3
<i>Gender</i>	
Male	6
Female	3
<i>Sexual orientation</i>	
Gay	6
Lesbian	3
<i>Race/ethnicity</i>	
Black/African American	0
Hispanic/Latino	3
White	6
<i>Religious affiliation</i>	
Spiritual	2
Organized religion	3
None	4
<i>Setting of practice</i>	
Private practice	1
Agency	6
Hospital	
Other	2

Recruitment

We used a purposive and theoretical sampling method. In purposive sampling, the researchers decide the purpose of the informants for the project and then go and find such

informants; there is no sampling design that determines how many of each type of informants the study needs (Bernard, 2002, p. 189). In theoretical sampling, researchers sample “incidents, slices of life, time periods, or people on the basis of their potential manifestation or representation of important theoretical constructs” (Patton, 1990, p. 238). In our case, we were especially interested in the life experiences of a special population during a particular time period, i.e., those who provided affirmative services to gay and lesbian people between 1960 and 1987. We knew ahead of time what type of informants we needed. We also used key informants, who are people that possess lots of knowledge about their culture and are willing to share that knowledge (Bernard, 2002, p. 196).

We posted flyers at agencies that provide services to LGBT populations (see Appendix A). We also used a snowball sampling technique by asking participants who were interested in participating in the study for leads or referrals to other service providers they may know.

A limitation of snowball sampling is that it can lead to a racial, gender, and class homogenous group of participants (Bernard, 2002). We made a concerted effort to recruit from agencies that serve diverse LGBT populations. However, we were not able to recruit enough participants who were women or people of color to learn about experiences already deeply under-represented in the literature on this topic. Though this type of research design does not lead to generalizable results, descriptive information gathered will contribute to the body of literature and expanded our understanding of the clinician and social service workers’ rationale behind providing support to LGBT communities. Barriers to recruitment we faced included study participants that were cognitively challenged, and that people we would have liked to interview had already died of HIV-related complications. In other cases, we attempted to locate key informants based on referrals or direct outreach, but some were unresponsive and others we

could not locate. In Los Angeles, one African-American man and two African-American women were unavailable for interviews.

Materials

The principle investigators for this study developed a demographic questionnaire (see Appendix B) to collect information on the participants' age, race, gender, and sexuality, level of education, training and any religious affiliations. They also developed guiding questions (see Appendix C) that served as a conversation starter and guided the interviewer through gathering the essential information. The interviews were audio recorded, transcribed, and then coded.

Procedures

Once a participant was identified, an initial phone assessment followed to assure subjects met the inclusion criterion. Once that was confirmed an interview was scheduled. These interviews could be done at the participant's home, place of business, or public place. The interviews were also arranged according to personal available time. On the day of the interview, participants first signed a consent form (see Appendix D). They had an opportunity to ask questions before starting the interview. After they signed the consent form, they completed the demographic questionnaire. Then the interview started. We asked questions such as: When did you first become interested in working with LGBT populations? Why was this important to you? How did you decide to provide affirmative services to these populations? We ended the interviews by asking them if there was anything that we should have asked, or if there was anything else they would want to tell us. At the end of the interview, participants were asked to refer (if applicable) people they know that provided support services to LGBT communities during the previously mentioned time period. Once the interviews were conducted the audio recordings were transcribed and analyzed.

Analysis

While participants are usually named in oral histories to allow others to check the research, social work research also privileges the privacy of the research participants. We balanced these competing ethical concerns by giving participants the choice for their identifiable information to be anonymized or fully disclosed. (DeBlasio, Ganzert, Mould, Paschen, & Sacks, 2009; Shopes, 2007). If they wished their identifiable information kept private, we would then develop codes to keep such information private. Interviews were then analyzed for themes and meanings. Once themes were identified we shared the themes with each other. The team decided by consensus when the process of analysis was completed.

Interviewer Reflexivity

I found myself reflecting on my own intersectionality when processing data, coding and conducting the interviews. My race, gender, sexual orientation, social, ethnic and economic statuses, and my past and present flashed before my eyes. I could identify with Palencia's immigrant status, culture shock and some of his social and sexual identities. As an immigrant myself, I recalled leaving Mexico only to find myself homeless, not speaking English and struggling to fit in as both an ethnic and a sexual minority. Like Palencia, a Latino role model also influenced my professional path. Like most, if not all of the interviewees, I too became involved with LGBT issues soon after acknowledging my sexual identity. Like them, I too wanted to contribute to society and provide the aid I wish I had had while struggling with my own demons.

In retrospect, my cultural background also made it a little difficult to conduct some interviews because the interviewees were "elders." It was a bit hard to culturally question their motives, ask for clarification, or even challenge or question their motives. I did notice, however,

the interviewees of color seemed more relaxed and less concerned with formalities. I attributed this our similar histories in the broader spectrum of race and sexual identities.

In terms of race, it was difficult to conduct two of the interviews with white, older men who engaged in culturally derogatory remarks about Mexicans, and sexually objectified men of color in general and me in particular. The transcripts of these two interviews do not convey this sexual objectification because much of it was communicated through non-verbal physical gestures.

Also, it was hard to not feel ashamed of some of the actions described as “entertainment” by some of the interviewees, especially when they derided today’s LGBT pride marches. I was there on those floats prancing around feeling proud of myself during these apolitical pride parades.

CHAPTER IV

Findings

Participants (see Table 1)

The following leaders of the LGBT community in Los Angeles agreed to be interviewed.

Don Kilhefner is psychologist, activist and one of the founders of the Gay Community Service Center and the Radical Faeries. He was raised in an Amish-Mennonite community, and then studied at Howard University where he joined the anti-Vietnam War movement and the Student Nonviolent Coordinating Committee. Kilhefner joined the Peace Corps and travel to Ethiopia soon after college. He also joined the Peace and Freedom Party. Kilhefner used his learned activism and became a lead figure in the gay and lesbian movement in Los Angeles. He lead the Gay Liberation Front that later evolved into the L.A. Gay Community Services Center. Kilhefner became its first executive director.

Roland Palencia, community activist and organizer, is a native of Guatemala and immigrated to the States after paramilitary forces assassinated his father, a small business owner and a revolutionary who fought for democratic change in Guatemala. He came to Los Angeles and attended UCLA and earned a B.A. in history. Palencia has spearheaded various NGO's that advanced equality and social justice for the LGBT and immigrant communities. Palencia is a co-founder of pioneering community-based organization, Gay and Lesbian Latinos Unidos (GLLU), the first major Latino LGBT advocacy group in the country, which later led to the establishment of Bienestar Human Services, Inc., which currently serves the Latino community with 11 locations in Los Angeles.

Del Whan is an activist, social worker, member of the Gay Liberation Front and founder of Gay Women's Service Center. Whan has been a minority rights activist since the 1960s. She joined the Gay Liberation Front in 1969 and then the Los Angeles Women's Center. However, her passion to promote and fight for gay women's issues led her to found the Gay Women's Services Center.

Dan Fast is a psychiatrist and activist. In his early career as a psychiatrist, Fast worked with LGBT youth in residential facilities throughout LA. He mobilized around LGBT issues at his *alma mater*, Cornell University, and later at Arizona College of Medicine. He finally moved to Los Angeles and became actively involved with The Gay and Lesbian Center. During his early career, Fast provided psychotherapy and pharmacology management to runaway youth, transgender youth, and youth with substance use problems.

Alexei Romanoff was born in the Ukraine. He came to the United States during World War II. Romanoff became involved in the gay rights movement by organizing demonstrations against police brutality after witnessing the Black Cat Tavern raid in 1967. He co-founded the Santa Monica Bay Coalition for Human Rights in the 1970s in response to the Anita Bryant/Briggs push for discrimination. In the 1983, Romanoff co-founded Avatar Club Los Angeles, and has served as President of Avatar and in many other capacities. As HIV impacted the community, Romanoff fought for funding for research and demonstrated for the rights of AIDS victims. At the age of 78, Romanoff continues to participate fully in the LGBT communities.

Nancy Valverde is a Chicana lesbian activist. Valverde recalls living in men's clothing and the battles she faced because of her sexual identity. She was incarcerated many times,

harassed and beaten by police. Valverde was a group co-facilitator for Gay and Lesbian Latinos Unidos. At 83 years of age, Valverde still gets involved in social issues affecting her community.

Reverend Troy Perry is a community activist and founded the Metropolitan Community Church in 1968. Rev. Perry first got involved with the LGBT community after realizing that the gay and lesbian community lacked supportive services from the church. Perry's activism has taken many turns, including positions on a number of boards of gay, lesbian, bisexual, and transgender organizations. He held a seat on the Los Angeles County Commission on Human Relations in 1973. Ever since he began his activism, Rev. Troy Perry has received numerous awards and has been invited to represent the LGBT communities on issues civil rights, hate crimes, HIV and AIDS at the White House by Jimmy Carter and Bill Clinton.

Rita Gonzalez is a lesbian activist and media producer. Gonzalez has been involved in the founding of many organizations including the largest Latino services organization in the U.S., Bienestar Human Services, Inc. Rita first became involved with gay and lesbian issues when she joined Gay and Lesbian Latinos Unidos. When the AIDS crisis started, Rita mobilized to educate and bring awareness of the disease to communities of color.

Jon Platania is a social worker turned psychologist, activist and one of the three founding members of the Gay Liberation Front. Platania was a key member in the founding of the Gay Community Services Center, where he trained facilitators to lead the Consciousness Raising groups. Platania was also responsible for the founding of the Liberation Houses in Los Angeles, which provided lodging, food and a stable and supportive environment for gay and lesbian people. Platania continues his activism through his private practice in Berkeley, CA.

Themes

We analyzed the interviews and identified common themes. Although there were lots of experiences in common, the following theme were most salient: (1) the lack of social services, (2) Latino/a people, services, and the AIDS Crisis, and (3) Gay Mental Health as Response to Oppression Sickness. Below we elaborate on each theme.

Theme 1: “[Gay Social Services] just didn’t exist.”

Mental Health Needs. The first providers of formal social services for lesbian and gay people (and later people who would identify as transgender) described both the lack of mental health services for the queer community and the oppressive and stigmatizing nature of the services queer people did manage to access. Many of the early services provided by gay and lesbian leaders can be seen as the direct result of their own negative experiences seeking services as gay and lesbian people. John Platania, shared that prior to the organizing of social and mental health services for gay and lesbian people, some clinicians and social service workers tried to “help” gay men, but at that time they did not have the capacity to do so. These mental health specialists were still steeped in the prevailing “professional assessment” of gay and lesbian people. Even though they did not condemn these men for being gay, gay men were still labeled as “sick.” They were told that they were “not a sinner [or] a degenerate” but instead they were “very sick [people]” (Platania, Interview, p. 13). And the reason they were sick, according to these clinicians, was because they “suffer from arrested psychological development.” The most “helpful” advice they received was usually being told that, “‘You can live with this but you really need to control this because it’s against the law...’ and ‘If you practice a little self-discipline... lots of guys get married’” (Platania, Interview, p. 13).

At one point, Platania sought couples therapy for his partner and himself from a closeted gay social worker at UC Berkeley, someone he considered a friend. He recalls asking, “Would you be willing to talk with us,” only to be told, “You know, Jon, no, not really. There isn’t—marriage counseling is a different kind of thing and I just wouldn’t be comfortable with [providing counseling to a gay couple]” (Platania, Interview, p. 6). Platania not only recalls how there were no social services available for gay men prior to the gay and lesbian movement. He also said, “There was nothing. There was no gay student service...that was just in a different universe [in the 1960s]. There was no Gay Community Services Center. There was no gay psychotherapy or—none of it, none of it. It just didn’t exist” (Platania, Interview, p.7). He is keenly aware of how the lack of mental health services specifically for sexual minorities not only affected him, but also his relationship with this partner. He shared that, “there wasn’t anybody to help us. I think if there had been, our relationship would have survived, but it didn’t. I think it was the weight of oppression that—that made that relationship impossible” (Platania, Interview, p. 7). It is not surprising, then, that as one of the co-founders of the GCSC, he went on to train facilitators to lead consciousness-raising groups that would address mental health needs specific to gay and lesbian people. He would eventually complete a PhD in psychology. Today he is in private practice and continues to address issues of internalized oppression.

Most of the participants talked about how they were made to feel that they were sick because of their sexual orientation. Rev. Perry represents the experience of many participants when he shared his experience reading about homosexuality: “I picked up... the book, saw the word ‘homosexual,’ and it said you were sick, you were sinful, you know, you knew—you were a criminal” (Perry, Interview p. 1). Kilhefner also remembers being labeled “sick” and “illegal” (Kilhefner, Interview 1, p. 6).

Another mental health challenge at the time was alcohol and substance use, which was associated with coming out. After people realized and accepted their sexual identity, they lacked places to act out their new gay and lesbian identities. The only places available were underground, dark hidden places, bars and clubs where gay and lesbian men would meet and alcohol was readily available. Del Whan recalls that “the only institutions we had at the time were the bars. And our youth couldn’t even get in there legally, and if they did, what did the bars have to offer, other than alcohol and maybe some understanding?” (Whan, Interview, p. 5). Palencia reinforces this view when he tells us that a lot of his peer came out of the closet at bars and clubs, including himself. He said, “I came out of Studio 1, but I really, really, came out at Circus [first gay Latino disco in Los Angeles]. You know, I mean, that was like my second home” (Palencia, Interview, p. 13). Yet although bars and clubs provided the space for gays and lesbians to come out of the closet, they also presented their own set of perils. Palencia said that besides a safe space for coming out, there was not much else they could find in these clubs. Without denying the value of these bars and clubs, Palencia goes on to point to the problems associated with these venues. “So, and what was there [in the bars and clubs]? There’s alcohol running like water, right? So that associated your coming out with your liberation with alcohol and drugs, and all that was available” (Palencia, Interview, p. 13).

According to the participants, the rise in alcohol and substance use by gay and lesbian people created new needs: gay and lesbian specific alcohol and substance abuse prevention programs. Palencia said there were “very high rates of alcohol and drug use... there were very high rates, and that was a big big big big issue” (Palencia, Interview p. 12). And a big contributor to this problem, according to him, was that “many of the places that were most hospitable to LGBT people at that time were bars.” The bars met people’s “emotional need to be

connected to something or to someone, to be wanted, to be acknowledged, to be validated.” Fast supports these claims by adding “I think that’s always been one of the major problems is substance abuse or substance-fueled sexual encounters, particularly for gay men” (Fast, Interview, p. 5). The Gay Women’s Services Center was in some way a response to the problem of alcohol and substance use in the community. Del Whan said

Most of the people just needed a place to socialize that wasn’t in the bars. And that was my purpose in starting it, really, was to have a—basically a sober place, and maybe even to have some AA meetings get going there (Del Whan, Interview, p. 5).

The Gay Women’s Services Center was in part the result of Del Whan’s own experiences with alcohol abuse and the lack of lesbian-specific services available.

Housing. Furthermore, gay and lesbian needed other basic services such as housing and job placement. According to Palencia, gay and lesbian youth started coming to Los Angeles seeking services. Many of these youth, like those today, were either running away from home or had been kicked out of their homes on account of their sexual orientation. Of these youth, Palencia explains, they were primarily “coming into Hollywood” and were between “16 to 25 [years old], for the most part” (Palencia, Interview p. 3). The young age and the location in Los Angeles where these youth arrived made them what we would call today “high risk youth.” As a result, this influx of youth created an additional need to be addressed, particularly housing. Housing was especially pressing for this population because, as Fast noted, LGBT youth that came to Hollywood had usually been thrown out of their homes, and “if they [didn’t] find a place to live within three days, [they would] probably [go] on drugs or prostitution or both” (Fast, Interview, p. 9). So, Platania brainstormed ways to address this increasing need by creating and opening a shelter for this group of youth. Platania called these Liberation Houses. Platania

explains that after opening his first Liberation House, “That place was overwhelmed within two months, and so we opened another one, and then we opened another one. We had three [within a year]” (Platania, Interview, p.8). He said that within a day of opening a home, they would become a “slop-house for kids who didn’t have any place to stay and we found ourselves bringing clothes and brining food...” Although more resourceful groups such as the GLF were addressing housing issues, smaller groups, such as the Women’s Center had to resort to using their personal space as shelter for homeless women. Del Whan recalls that “from time to time we would have a young woman, troubled young woman, sleeping in the back behind the partition, actually crashing there... to that extent we would provide housing for one” (Whan, Interview, p. 5). Not only did these new arrivals increase the demand for housing, but they also contributed to the increase of homeless LGBT youth in Los Angeles. Kilhefner explained that the GLF began to tackle this issue by finding a house with low rent, one that had three, four, or five bedrooms. “We would take it over, and we would find housing for gay men who were homeless” (Kilhefner, Interview 1, p. 8). These homes were not limited to gay men, but lesbian women were also given shelter. He recalls that, “lesbians lived in some of the houses as well, where they had a bed to sleep in that night, they had a break and they had a dinner that was provided to them” (Kilhefner, Interview 1, p. 8). These homes provided more than just shelter for LGBT people, but they also provided meals and a sense of community where they could fit in.

Theme 2: Latinos, Services, and the AIDS Crisis

Although supportive services for the greater population began to sprout, they did not meet the needs of Los Angeles’ diverse population; Latino and African-American communities

were left unnoticed. Just like the revolutionaries of the GLF front, it was at this point people of color began to meet to raise awareness of their needs, how to address these needs, and also to address the lack of community within the larger GLF movement.

The GLF had set the foundation to address the needs and develop services for gay and lesbian people. Although these services were important to all communities, Gonzales' experience speaks to the lack of attention to specific needs of people of color who were gay and lesbian. The GLF leadership was entirely "white dominated," and that was the only perspective taken into account when services were developed. Although important, these services didn't address the needs of gay and lesbian ethnic minorities. Yet, because ethnic minorities had nowhere else to go, they sought services here because they could meet other sexual minorities like themselves. Palencia makes this point when he talks about his experience with the Gay and Lesbian Center (formerly known as the Gay Community Services Center). He went to the Center for the first time after coming across a flyer for a support group.

I went to the support group that José Ramírez was leading, and I got hooked, and I said, "This totally connects with all parts of me. These people are radical, they accept my gayness, they accept my ethnicity and my language." So it resonated for me (Palencia, Interview p. 6).

Yet even then, Palencia was keenly aware of the racial dynamics of the group. He said, "So that was a place I was comfortable, even though the place was really white dominated..." (Palencia, Interview, p. 6). Palencia's experiences also reflect that of immigrant Latino/a people, which often differ from those of U.S.-born Latino/a people. Palencia shared:

So I never felt this whole issue of race, [which] never really resonated with me until I came to the U.S., and it was very clear that the [racial] pyramid here was set up a little bit differently. I was not anywhere at the top of that pyramid (Palencia, Interview p. 5).

Here Palencia is referring to the fact that back in his home country, he was not a “minority” but instead he was seen as a member of the majority group. He quickly understood how his status changed in the racial hierarchy once he came to the U.S. He recalls

We crossed the border without any documents, so we’re undocumented, but then it was called “docu-queer,” but we didn’t have the language at that time. So I was undocumented, an immigrant, did not speak English, and it was very clear to me that I was not anywhere close to the top of that pyramid. So when we came here, I had pretty much, we had been demoted, not only in class...(Palencia, Interview p. 5).

Palencia’s experiences show how his different identities intersect— immigrant, monolingual Spanish speaker— and change within the legal context: when he arrived in the United States he was now also “undocumented.” And at the same time, he show how he integrated these identities by using “docu-queer” to signal his sexual, immigrant, ethnic identity and legal status all at once.

If white privilege prevented the leadership of the GLF from recognizing the needs of Latino/a people, it would have made it that much harder for them to grasp the nuances of racial and class differences between immigrant and U.S.-born Latino/a people. Palencia’s experience is emblematic of this difference in the Latino/a community between those who are U.S.-born and those who are recent immigrants.

Palencia elaborates on how the LGBT Latino/a community seemed small at the time, which in the end provided the space for Latino/a LGBT leadership to emerge. “The other thing

is that there wasn't, even though there was a large [gay] Latino community— obviously not as large as it is now— it was relatively very small [compared to whites]" (Palencia, Interview, 7). He was especially struck by the fact that there were no older Latino leaders for young men like himself to look up to. He said

Like I could never, I never never met anyone older than us at that time. I'm talking about me in my mid-twenties, but I didn't meet 40-year-old men or 50-year-old men who had been out who had been leaders in the community, who were trailblazers. You know what I'm saying? I never met anyone like that. None of us ever met anyone like that (Palencia, Interview p. 7).

Still, the lack of leadership left room for people like him to step up and become leaders, not only for the Latino/a community, but leaders that would reach out and engage other communities as well. "So we were really the trailblazers, the, kind of like, the first battalion of the LGBT Latino movement, and so even though we knew that there was this ethnic social whatever whatever, we also wanted to create alliances" (Palencia, Interview p. 7).

The AIDS crisis, which continues to disproportionately impact communities of color today, brought into sharp relief the lack of services for people of color. Palencia recalls that in the early days, "[AIDS] decimated and so disempowered those communities [of color] that I don't think we ever really recuperated from that. You know, like the strongest arm of the People of Color movement was the African American community, and they were devastated" (Palencia, Interview, p.10). Like Palencia, Gonzalez also recounts what it was like living through the early days of the AIDS crisis and how her organization, GLLU, responded.

We knew about it, but we didn't know exactly what it was yet. It didn't really have a name. Everybody was calling it different things and it means that a lot of people were

dying. And it was scary. Then when they started calling it AIDS [and] we started an AIDS committee and the focus would be AIDS (Gonzalez, Interview 2).

Gonzalez experience mirrors those of her contemporaries, namely, not knowing enough about “AIDS” and experiencing fear. Yet GLLU was sufficiently organized and responded.

Gonzalez goes on to recount how in the early years of the crisis people of color felt excluded from AIDS Project Los Angeles [APLA], the first AIDS service organizations founded in 1983 in response to AIDS.

Like I said, [white people] were pretty much just concerned about their own community. Remember, we were still outsiders, Latinos. And not just Latinos. The Asians were outsiders. African American— outsiders. It was just their little group of people that they were taking care of (Gonzalez, Interview, p. 3).

As Gonzalez notes, people of color felt like “outsiders” when they needed to access resources, even in the midst of the AIDS crisis. They did not feel that their communities were being taken into consideration by agencies with the resources to respond to the pandemic.

The feelings of exclusion were so strong that the people of color who were on APLA’s board left the organization. Gonzalez recalls that, “In fact, several of the people of color that were on the APLA board actually left... because they were fed up with what was going on and [because] they weren’t doing anything for [people of color]” (Gonzalez, Interview, p. 4). She goes on to report that other leaders of color were also involved with APLA but later left the agency, such as “Jewel Thais-Williams [from the African American community]. Some of those people were involved with APLA but they left because they felt they weren’t meeting the needs of people of color” (Gonzalez, Interview, p. 4). Thais-Williams would go on to be a co-founder and a board member of the following organizations: Unity Fellowship Church, The

Minority AIDS Project, Rue's House, Ladies Concerned, and Imani Unidos. In Los Angeles she is especially known for having started the first gay Black disco club in 1973, Jewel's Catch-One, because Blacks were often denied entrance to the white gay clubs in West Hollywood.

Gonzalez elaborates on the needs specific to the Latino community. For example, there were no services targeting Spanish-speaking people of color. There were no educational materials for the Spanish-speaking communities. Gonzales shares that, as a gay collective, they had to be creative to provide information to marginalized communities. She reiterated that all educational materials were in only in English, so her community decided that they just had to "[write] it themselves." And after writing the materials, they would find ways to disseminate them to community members. She said

They wrote it themselves.... made photocopies. They would go to the bars and different things [to distribute]. But we were pretty much on our own. There was APLA, but APLA was not doing anything for us (Gonzalez, Interview, p. 3).

Gonzalez explains how Latino leaders responded to the epidemic, especially for monolingual Spanish speakers, despite not having the infrastructure and resources available in organizations like APLA.

The lack of leadership and supportive services for people of color, especially Latino/a people, ultimately led to the creation of Gay and Lesbian Latinos Unidos (GLLU). Rita Gonzalez describes GLLU, "And it was co-gender, and I just loved everybody. Everybody was so warm. They were just really great people. They really treat you like you're part of the family. So, I got involved with them" (Gonzalez, Interview, p. 2). She goes on to make a reference to Roland Palencia. "I believe one of the people who founded was Roland Palencia and Oscar de La O" (Gonzalez, Interview, p. 1). (Oscar de la O would later found Bienestar Human Services, Inc. in

1989, which today is the largest Latino AIDS service organization in the country.) GLLU advocated on behalf of Latinos, who were being overlooked not only by social service providers, but also by the media and government. Gonzalez said, "...when the media or the senate did something [about AIDS], they'd [GLLU] call them on it and said, 'Hey, if you're gonna do something, you've got to make sure it's in Spanish too. We're here too. Hello.'" (Gonzalez, Interview, p. 5). GLLU had an AIDS committee, started in 1985, in charge of distributing information and getting people tested. "Whatever information that we knew we tried to disperse it and make sure that it was bilingual. Because a lot of people who were Latinos did not speak English."

Further, Gonzalez corroborates Palencia's claim of wanting to "create alliances," and reports on one specific event.

So [GLLU] had an AIDS education committee... [In 1986], the Reverend Carl Bean [founder of Minority AIDS Project] came to our board meeting and wanted to start an organization for People of Color. He felt no one was addressing the African-American community or the Latino community. And so him and a group wanted to do something (Gonzalez, Interview, p. 4).

In the end, the alliance forged led to the creation of an AIDS service provider specifically for People of Color, Minority AIDS Project. Gonzalez recounts, "The Reverend Carl Bean came and said he wanted to start an organization, but he did not have his 501 yet, so could GLLU be the umbrella organization? And we said yes. So that's how Minority AIDS Project started" (Gonzalez, Interview, p. 5).

Although ethnic minorities did not receive the same level of services from the Center, they did benefit from the discourse at this time, such as oppression sickness and consciousness

raising, in the same way that early White LGBT leaders benefitted from the discourse of the Black Panthers.

Theme 3: Gay mental health as response to oppression sickness

Oppression sickness

Another theme in the interviews was oppression and “oppression sickness” and how this social construct paralyzed, marginalized, and scared gay and lesbian communities at that time into hiding. Experiences of oppression were shaped by social, legal norms, and religious bigotry, and being ostracized. Kilhefner sums up oppression sickness like this

Fundamental was “oppression sickness” (Kilhefner, Interview 1, p.11). We believed that many of the problems that gay

people were facing had nothing to do with anything where they were intrinsically deranged. It was the oppression that they suffered, from birth until death, the continual oppression was making gay people sick.

Kilhefner emphasized that gay and lesbian people were not to be blamed for their oppression, but society was responsible for marginalizing, ostracizing and labeling gay and lesbian people as “sick.” The problems encountered by gay and lesbian people were socially created and not of their own making, and it was a problem that would follow them “until death.”

Del Whan speaks to the consequences of oppression sickness: “We’d all gone through the oppression sickness of being in the closet and wondering what was wrong with us” (Whan, Interview, p. 2). She said that recognizing oppression sickness helped her to reframe her worldview: “I realized that I wasn’t sick, that society had made me sick, thinking negatively about myself” (Whan, Interview, p. 1). They borrowed this language of oppression sickness from

the Black Panthers. Kilhener notes that he read many of the same texts that the Black Panthers read, such as *The Wretched of the Earth* by Frantz Fanon. According to Kilhefner, oppression sickness not only devastated (and continues) the LGBT community's self-esteem, but it subsequently impaired their psyche by because people internalized society's negative views of them.

Although the GLF movement recognized that sexual orientation was not an illness, they realized that bringing this information to the masses was going to be one of the hardest hurdles they had to face. The GLF had to find ways to fight such oppression while educating and empowering the gay and lesbian communities who at that time were scared of being found out due to societal repercussions. Kilhefner explains, "you know, oppression sickness takes its toll. And for many gay people at that time, they [were] still living lives of secrecy... they were afraid of police raids" (Kilhefner, Interview 2, p. 1).

Affirmative Therapy

The participants in this study were among the first to challenge the mental health establishment's view of gays and lesbians and to pioneer new ways for this community to view itself and new ways to provide mental health services. The origins of "affirmative therapy" for LGBT communities evolved from a combination of different conceptual frameworks and looking to the experiences of other oppressed people, especially African Americans; it is also the result of grassroots activism. The foundation of mental health services specifically for LGBT people was the concept of oppression sickness, as discussed above. Understanding the social nature of homophobia and oppression was the key to developing a positive outlook of what it meant to be LGBT and how to confront social, legal, and religious bigotry. Kilhefner summarizes the new approach in this way: "And the way that... we heal gay people is by making them aware of

oppression sickness, and making them aware that part of their healing involves fighting back” (Kilhefner, Interview 1, p. 11). Using the concept of oppression sickness enabled LGBT leaders to shift the blame for the negative feelings and low self-esteem of LGBT people from the individual to society at large. Gays and lesbians were not the problem: society was the problem.

But early leaders had to “internalize” the concept of oppression sickness and make this shift their own worldview before they could help anyone else. And they understood this. Nancy Valverde elaborates on this point when she says that in order to grow, they had to think differently: “Don’t put your life in jeopardy, but put your foot down, and just— you respect yourself, other people will respect you, you know?” (Valverde, Interview, p. 17). Kilhefner describes his own healing process in this way:

The most useful thing in my own healing, as a gay man, was those demonstrations and fighting back. Getting angry, being able to—as Frantz Fanon taught—letting that anger out and directing it towards the oppressor, not towards oneself or towards other gay people... it has a healing effect, certainly on this gay person (Kilhefner, Interview 1, p. 11).

For Kilhefner, “demonstrations,” “fighting back” and targeting his anger “towards the oppressor” and not toward himself, was a way to heal from oppression sickness. And this was the process he wanted to share with gay and lesbian people.

After the first leaders “freed themselves” from psychosocial frameworks that perpetuated their oppression, they realized they had no clear path or guidance for developing a new model that fit the experiences of LGBT people. The one thing they did know and were sure of was that they needed to reject psychological establishment if they were to flourish. Del Whan recalls, “We’ve had years and years and years of oppression heaped on our heads by this profession and

you need to stop it” (Whan, Interview, p.14). Don Kilhefner recalled that “We called it the mental health industry. We felt that one of the primary oppressors of gay people was the mental health industry” (Kilhefner, Interview 1, p. 7). The mental health professionals at that time were seen as “oppressors” because they perpetuated negative and stigmatizing views of gay men and lesbian women. But rejecting one model did not help these leaders find a new one.

Early providers wrestled with how to provide services to this community, especially because there were few models for them to follow. Roland Palencia reported that

The whole frame of mind at that time was how do we provide social services to gay and lesbians, to LGBT people, who need the psychotherapy, they need a job, they need somehow to be more integrated in society kind of thing (Palencia, Interview p. 2).

Hence, they started to adapt models they thought might be useful. One such model was Alcoholics Anonymous, a recovery program based on 12 steps to quitting alcohol use. Whan elaborates on this point: “I wanted to combine the good aspects of AA, the loving, supportive twelve-step program, with the activism and the philosophy of Gay Liberation. And that’s what we tried to do [at the Gay Women Services Center I founded]” (Whan, Interview, p. 5). What attracted her about the AA model was that people could pick a topic and everyone would talk about that topic, and they would “limit the cross-talk and don’t talk about each other, but listen to each other and be grateful.” At the heart of what attracted her to the AA model was “this whole thing of one person helping another person, and that’s kind of how it got started.”

The other aspect of AA that deeply influenced Whan was that “you were loved” when you were part of AA, regardless of the mistakes you made (Whan, Interview, p. 4). She did not experience love in the gay liberation movement. As she describes it, she “found activism” in the movement and people saying, “Let’s just move forward,” yet “it didn’t matter if someone knew

your last name or not, you were suddenly swept up in something [political]” (Whan, Interview, p. 4). She did not think this was enough, especially for younger people who really needed services.

So I didn't think that anybody—a troubled youth, say, coming off the streets into gay liberation, would be able to find their place very well, because it was very political... I might have thought along the same lines of Don Kilhefner and John Platania, how were thinking in terms of a service center, only I beat them to it. I rented a place at the spur of the moment, and I was very impulsive and I just put some money down on a storefront one time in Echo Park and it became the Gay Women's Service Center (Whan, Interview, p. 4).

Although Whan embraced her activism, she was keenly aware that activism alone would be insufficient for younger gay and lesbian people. Besides activism, she also wanted people to experience love and to be known by name. This motivated her starting the center.

They also sought to borrow from models used by social movements from African American communities. This was most explicitly done by Kilhefner, one of the founders of the Gay Community Services Center. He shared that

I came back and got a Master's Degree at Howard University, 'cause I wanted to be taught Black history by Black people, further changing my consciousness, because—ah—at Howard, I came in contact with some of the leading intellectuals of Black culture in this country, and I was given an education that I wouldn't have gotten anywhere else about how this country operates (Kilhefner, Interview 2, p. 15).

This contributed to his own healing, as evidenced by his referencing of Frantz Fanon earlier. He goes on to say that the “Gay Liberation identified with those organizations [Black Panthers] in

society that were changing society. We were not a status quo organization, we were a militant organization.” He shared that they wanted to model community members helping their own community, like the Black Panthers Party. The idea of “fighting back” oppression, being “militant,” and holding society accountable for the ills of a community are hallmarks of Black liberation and anticolonial movements of the times. And he was not alone in identifying with African Americans and adopting and adapting their philosophy or practice. Del Whan talked about she tried to join the Black Students’ Union when she was in college because she “was looking for a place to fit in and this was before there was anything gay. So I identified with the oppression of Black people” (Whan, Interview, p. 8).

As mentioned earlier, prior to the organizing, collaborations, protests and marching of the GLF an individual psychological shift took place within. Prior to being able to create safe spaces for others, the leaders had to heal themselves first. They understood that their oppression was learned. They had to understand and internalize what societal norms had done to their psyches, such as believing that they are sick or criminals, and then be able to externalize those oppressions onto the oppressors. Through these methods of accepting themselves, rejecting society’s norms and fighting back, leaders elevated their consciousness. They introduced and inculcated these methods onto those who sought similar goals and self-acceptance by creating affirmative groups called consciousness-raising groups.

Kilhefner explains what consciousness-raising as a social service looked like in the early days of the Center. Groups usually consisted of eight to 10 people and a trained facilitator for people to “talk about their lives as gay and lesbian people. How were they oppressed, what were their own stories about traumatic experiences that they’d had, as a gay person?” (Kilhefner, Interview 1, p. 11). It is through these groups men and women found peace within themselves;

they found there were not alone and that they were not ill, but that society made them feel like the problem. But increasing awareness was their first part. Consciousness-raising also involved seeking a solution, and the solution was to fight back.

This idea of heightened consciousness was used to recruit mental health specialists to the Center. Kilhefner explains:

With almost everything we did, we didn't look for social workers or psychologists or psychotherapists. We were looking for gay people who had a certain kind of consciousness, and that consciousness was around the oppression of gay people and how to change that. Most psychotherapist social workers were too conservative (Kilhefner, Interview 1, p. 12).

And because they found the mental health professionals too conservative, they rejected the establishment's approach to working with LGBT people. The idea of being conscious of oppression sickness served to screen mental health workers in the early days of the GCSC, especially when gay and social workers, psychologists, and psychiatrists wanted to get involved. Kilhefner explains that

... it was not as psychiatrists, psychologists, social workers [that we sought]. It was as a gay brother or lesbian sister—gay brother or lesbian sister they were helping us. It was not their credentials that we were interested in, it was their level of consciousness. And that's really important to get that because—it was the difference—it was the change in consciousness that we were after (Kilhefner, Interview 1, p. 13).

The GCSC was not interested in a person's professional credentials, but wanted to make sure that they understood the gay experience in terms of oppression and understood that the solution entailed some level of "fighting back" and "letting that anger out." By screening mental health

workers for their level of consciousness, the Center wanted workers who would support the clients and help them to see that “we were not sick, timid, afraid people. It was that we were fighting back.” More importantly, by using consciousness as the foundation for LGBT mental health these early pioneers were rejecting the models that the mental establishment recommended. They wanted their mental health workers to understand that, to that “they were wrong. Their models were wrong. Their models were oppressing people, not just gay people, other people as well.” And consciousness mattered, and having a group of mental health providers committed to the idea of consciousness mattered because in the end, “We wanted to create new models, gay friendly models, gay affirming models, gay conscious models of mental health work.” New, gay-affirming models would not be possible without a new consciousness.

This may explain why the early days peer counseling provided a model for the provision of mental health services because it was a “gay brother or lesbian sister [that was] helping us.” Kilhefner recalls, “When we opened up the Center... we had a counseling program, but was called peer counseling program” and “we trained those peer-counseling, through consciousness-raising” (Kilhefner, Interview 1, p. 11). Fundamentally, the peer counseling program was “based on oppression sickness and liberation modalities” (Kilhefner, Interview 1, p. 12). Gay affirming models of mental health evolved from this, as Kilhefner explains: “in 1976, it was the beginning of social workers coming in, psychologists coming in, MFTs coming in, and slowly the peer-counseling program evolved into a trained psychotherapist working with ordinary people” (Kilhefner, Interview 1, p. 18). Gay affirmative models essentially entail consciousness raising, shifting the blame of the problems of LGBT people from the individuals to society, and the idea brothers and sisters working together, sharing their experiences, to bring about personal change and social change by fighting back.

CHAPTER V

Discussion and Conclusions

The purpose of this ongoing oral history project is to explore the how clinicians and social service providers began to develop affirmative models for gay and lesbian people in the years 1960-1987. Furthermore, this project also aimed to record their experiences as they created these affirmative services. This portion of the study's findings provides insight into a psychotherapy and social service world there is little written about.

Our findings help us to understand the social, political, and individual psychological factors that influenced the early leaders to stand their ground and fight for social justice. They also shed light into the models they drew upon to create groundbreaking, gay specific programming and mental health services. Coupled with historical events, such as the Watts Uprising, the formation of the Black Panthers, Black Cat Tavern riot, and Stonewall, it is no surprise that political activism was at the heart of all LGBT consciousness. Although people speculate how this may have influenced gay liberation, we know from our interviews that one of the founders of the Center explicitly looked to the Black Panthers and Black Nationalist models to conceptualize the oppression faced by LGBT people.

Black Panthers focused on community survival, social services, and health, which is exactly what the GLF modeled as well. The GLF mobilized like the Black Panthers. This also became the foundation for "affirmative" therapy for LGBT people. And the key concept was oppression sickness. Participants experienced what they called "oppression sickness" either by assaults on their self-esteem or the inability to get services, such as couple's therapy, as Jon Platania shared. Palencia and Del Whan also noted, alcohol and substance use was prevalent in those days and continues to be a problem for LGBT communities even to this day (Centers for

Disease Control and Prevention, 2013). Batza (2011) talks about how oppression sickness was used as an advocacy and political tool that helped them get the city to subsidize the Center's building and services. The concept of oppression sickness remains fundamental and its importance cannot be overstated.

Political consciousness became the foundation of LGBT mental health in part because they were reacting either to the lack of gay-specific services or the hostile views held by those who did provide services to these communities. Our participants confirmed the findings in the current literature that the only services available to LGBT people at the time all deemed them "sinful," "sick," or "illegal." Mental health models all claimed that gay and lesbian people suffered from arrested psychological development. There were no resources for LGBT people and current institutions only perpetuated stigma and discrimination against them. In this setting people wanted to find or develop models that promoted unity among community members, models that would not push gay people into hiding or to live in fear. Leaders wanted to create services that would affirm and embrace their sexual identities.

Kilhefner's interview spoke most directly to this point and confirms what Gallagher (1975) and Gallogly (2014) claimed, namely, that new models of mental health now called for gay people to "[take] control of their own lives." We saw this with Palencia, Del Whan, Platania, the idea of taking control of their own lives, and this started with self-acceptance and a change in consciousness. Our findings suggest that to this day, a change in consciousness remains the cornerstone for any affirmative mental health for LGBT people.

The new models of LGBT mental health also reconceptualized the role of the mental health provider. As Gallogly (2014) notes, the mental health practitioner was not seen as the expert. This view was most explicit in how mental health providers were selected. Leaders used

the idea social/political consciousness as a litmus test for new mental health workers to work at the center. Peer support models confirm how mental health approaches for LGBT at this time started shifting toward both what Gallogly claims was an emotional investment from both the counselor and the participant and a holistic approach of the client to eradicate “engrained feeling of sickness or disgust” by sharing and supporting one another. In this process, participants would eventually become leaders and thus strengthen the LGBT community. This innovation continues to this day, as gay therapists in particular can be seen as role models for gay clients, or as people who can be “idealized” or someone with whom the client could “identify” with (Lebolt, 1999, Rochlin, 1982). The participants in one study “experienced the therapist's self-disclosure of [gay] sexual orientation as beneficial, even... when it occurred before or without exploration of the client's transference fantasies” (Lebolt, 1999, p. 365).

Finally, our findings show how the LGBT communities were fractured by gender, race, and ethnicity from the very start. This can be explained in part by what Batza (2011) notes, namely, that white gay men framed health within the larger political context focusing exclusively on gay identity. The Gay Community Services Center also did the same thing with the programs it offered. As a result, considerations of race/ethnicity and gender were often overlooked or overshadowed by “gay” identity. And at this time gay identity was implicitly assumed to be white, corroborating Palencia and Gonzalez’s experiences of “white dominance” in LGBT social and political spaces. This was especially stark at the start of the AIDS crisis. Gonzalez’ narrates how the LGBT community fractured along racial/ethnic lines, and how Latinos were left out of the early wave of AIDS services, prompting them to start their own. These challenges seem to continue to this day in terms of the allocation of funds, provision of services, and taking into account the perspectives of people of color.

This is not to say that LGBT people of color did not benefit from “gay” politics or programming. Just like the GLF benefitted from the Black Panthers’ political rhetoric, LGBT people of color gained from “gay” politics. For example, consciousness raising around sexual orientation provided other ways for some people of color to conceptualize their oppression. They noticed that their needs were not being meet, so they created services to meet the needs of their community.

The participants interviewed gave us first-hand insight into how affirmative therapy for LGBT people started, their process for creating new mental health models, and the frameworks they borrowed from other oppressed groups. These mental health approaches veered away from standardized methods of psychoanalysis by viewing person-in-environment, which is taking the person’s environment into account, such as gender, race, class, and sexual identity. Yet at the heart of these approaches was an implicit social justice perspective because the solution to any oppression is social justice. At that time, ideas of social justice did not form part of traditional psychoanalytic approaches. These models continue to be used today, such as peer counseling. It also gives us a glimpse into what they thought an affirmative model should have, such as love, acceptance, to help one another, and always to challenge the status quo of society and the mental health establishment.

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Appendix A

Recruitment Flyer

ORAL HISTORY PROJECT

LGBT Affirmative Psychotherapy and Social Services, 1960-1987

We are conducting interviews with individuals who provided any form of affirmative counseling, psychotherapy, or social services to LGBT people between 1960 and 1987. This includes social workers, psychiatrists, psychologists, clergy, and peer/lay counselors.

If you would like to share your stories, please contact co-researchers David Byers, MSW, LICSW, PhD Candidate, and Stephen Vider, PhD, at LGBTcounseling.oralhistory@gmail.com to schedule an interview. Interviews may be conducted in person, over the phone, or by Skype.

In L.A. contact Jose Hernandez at [REDACTED] or at jhernandez@smith.edu



Appendix B

Demographic Interview Protocol

This questionnaire is to be completed independently by participants. This information is useful in order to provide an overall description of participants in this study. You may choose not to answer any questions by leaving them blank.

1. In what capacity did you provide LGBT affirmative psychotherapy or social services between 1960-1987?

(check as many as apply)

- Social worker
- Psychologist
- Psychiatrist
- Psychoanalyst
- Clergy
- Professional counselor
- Lay counselor/ volunteer affiliated with an organization
- Other _____

2. Where did you train in your field (if relevant) _____

3. What is your gender? _____

4. What is your sexual orientation? _____

5. What is your ethnic/ racial background? (Please check all that apply)

- Native American, American Indian, Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Hispanic or Latino, A person of Cuban, Mexican, Puerto Rican, Central or South American descent

- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

6. What is your religious affiliation, if any? _____

7. In what setting(s) did you practice during this period?

- Private practice
- Agency
- Hospital
- Other _____

8. In which cities /towns / states did you practice during this period?

Appendix C

Guiding Questions

- 1) Where and when did you first get started as a psychotherapist? When did you start working with LGBT people in particular? What led you to that work?
- 2) How would you describe the people you saw? What were their reasons for seeking psychotherapy or social services?
- 3) How would you describe your training? What models of psychotherapy or social services did you draw on?
- 4) Were you aware of other people or organizations conducting LGBT affirmative psychotherapy and social services?
- 5) What did you understand as the most pressing needs of LGBT people at the time?
- 6) What other organizations were you involved in, locally or nationally?
- 7) Were you involved in other forms of social services or social activism?
- 8) How would you have described your own social background or social identity at the time?
- 9) Are there any clients or experiences from that time that stick out in your memory?
- 10) How aware were you about larger debates about the classification of homosexuality or gender variance as forms of mental illness?

Appendix D

Consent Form



**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....
Title of Study:

LGBT Affirmative Psychotherapy and Social Services, 1960-1987, Oral History Project

Investigator(s):

David S. Byers, MSW, LICSW, Ph.D. Candidate, Smith College School for Social Work, ~~617-253-1111~~

Stephen Vider, Ph.D., [REDACTED]

.....
Introduction

- You are being asked to be in an oral history research study to explore the history of LGBT affirmative psychotherapy, counseling, and social services.
- You were selected as a possible participant because you have identified yourself as having provided LGBT affirmative psychotherapy, counseling, or social service work, between the years 1960 and 1987.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn from clinicians and social service workers about their experiences providing LGBT affirmative services to clients between 1960-1987.
- This study is being conducted in affiliation with Smith College School for Social Work, where David S. Byers, MSW, LICSW, is a Ph.D. candidate and lecturer and research advisor in the MSW program. Research assistants may use data collection experience and findings toward partial completion of their MSW thesis requirement.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things:

1. Participate in one 60-90-minute individual interview held at a location convenient to you, or by phone or Skype. After reviewing the consent forms with the researcher or research assistant, but before beginning the interview, you will be asked to complete a brief questionnaire to collect demographic information. You may skip any questions you do not feel comfortable answering. The interview will focus on your experiences providing psychotherapy, counseling, or social service work to LGBT clients any time between 1960-1987. With your permission, the interview will be audio recorded so that it can later be transcribed and analyzed. The demographics form and interview transcript will be assigned a number code. If you indicate below that you prefer your participation to remain confidential and anonymous, your name and any identifying information will not be included with the transcript. You have the option to not have the interview recorded, in which case your thoughts and ideas can still be very valuable to the study in a more general way.

Risks/Discomforts of Being in this Study [*choose one of the following*]

- There are no anticipated risks associated with participation in this study. With the current study, we are not aiming to learn about stories that cause distress or embarrassment to recount. You will be welcome to stop discussing a painful memory or experience at any time during the study.

Benefits of Being in the Study

- The benefits to participants include the opportunity to reflect on their own experiences developing affirmative approaches to working with LGBT clients. The experience may help individual participants to better understand their own perspectives and actions, and to develop an understanding of their efforts within the historical context.
- There are also potential benefits for the fields of social work, psychology, psychiatry, counseling, pastoral care, and related fields. Very little is known presently about efforts by clinicians and social service workers to develop affirmative services and approaches for LGBT clients. Your memories and stories are vital for understanding the role of clinical practice and social services for addressing needs of marginalized and oppressed people.

Confidentiality

- You have the option to participate either confidentially or using your name. If you would like your participation to be kept confidential, only the researcher, David Byers, MSW, LICSW, co-researcher, and research assistant working with you directly will know your name. A questionnaire for demographic information and transcripts of interviews will be assigned a code number for purposes of sorting responses. Your name will not be included on the demographic questionnaire or any interview transcripts if you decide to participate confidentially. *In addition, if you choose*

confidentiality, the records of this study will be kept strictly confidential. If you agree that the researcher can audio record interviews, recordings will be kept as audio files on a password protected computer or a USB Flash Drive, and stored in a secure and locked location. The audio files will be accessible to the researcher, co-researcher, research assistants, and an outside transcriber, and may be used by the researcher for educational purposes.

- All research materials including recordings, transcriptions, analyses and consent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed unless you decide for the audio recording and uncoded transcript to be donated to an archive, the Human Sexuality Collection at Cornell University, to be accessible either immediately upon donation or after 50 years. All electronically stored data will be password protected during the period records are stored by the researcher. We will not include any information in any report we may publish that would make it possible to identify you, unless you decide to be a named participant.

Payments/gift

- There are no payments or gifts associated with participating in this study.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, the research team will not use any of your information collected for this study. You must notify David Byers, MSW, LICSW of your decision to withdraw by email or phone by March 1, 2016. After that date, your information will be part of thesis projects conducted by research assistants, however every effort will be made to remove information you provided from the broader project unless already included in papers for conference presentations or publications.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, David Byers, MSW, LICSW at DByers@Smith.edu or by telephone at 517-531-5313. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

Named participation or confidentiality:

1. I would like to participate in this study using my name. My memories, stories, and ideas will be attributed to me by name whenever possible.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I would like to participate confidentially. My name cannot be used publicly in association with this study, and any information I contribute should be de-identified.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Audio recording of interviews:

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Destroying or archiving audio recordings and transcripts following three years of secure holding by researcher:

1. After three years, I would like the audio recording and transcript of the interview to be donated to the Human Sexuality Collection at Cornell University, to be accessible to the public after the following amount of time:

_____ **Immediately after donation to archive.**

_____ **held secure by the archive (not accessible to the public) for 50 years.**

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I would like the audio recording and transcript destroyed along with all other documents related to my participation in this study once no longer needed by the researcher.

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____