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A Public Silence

Discursive Practices Surrounding Homosexuality
in Public Mental Health Services
in Aotearoa/New Zealand

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Considerable research points to an elevated prevalence of mental health problems and suicide for men who have sex with men (MSM). Yet there is little research on how public mental health services (PMHS) does, or could, address the needs of MSM. When such literature does appear, a common suggestion is that queer staff will be necessary to improve PMHS for MSM through a process of ‘matching’. Yet, no research has specifically explored the views of queer staff or MSM clients on this. Further, a positivist trend within the existing literature contains individualising and essentialising assumptions that limit our understanding of relationships between MSM and PMHS. Adopting a critical social constructionist perspective, I argue that Foucauldian theory and its analysis of the relationships between discourses, power, and subjectivity, enables research to focus on the social and structural processes constructing mental health care for MSM. This thesis explores the discursive construction of the relationships between MSM and PMHS, and the implications of this for practice.

My analysis begins by explicating commonly circulating discourses of homosexuality, and of mental health, in New Zealand. These discourses are evidenced in (but not limited to) academic literature, governmental documents, and queer and mainstream media. They provide a framework for the analysis of interviews with 12 queer staff and 13 MSM clients of PMHS. The analyses illustrate the multiple discourses informing the MSM’s subjectivities as homosexuals and show the predominant discourses they draw on to account for their mental health problems. I suggest the term ‘homonegative trauma’ to denote this. Analyses of the staff and clients’ accounts around the ‘disclosure’ of homosexuality within PMHS reveal discursive power relations which restrain staff, and some clients, from acknowledging homosexuality.

I consider two strategies for disrupting this heteronormative silence within PMHS. I contend that the notion of ‘matching’ queer clients and staff is a minoritising one, with limited ability to counter heteronormativity. In contrast, a universalising approach requires all staff to initiate conversations with all clients about sexuality. Making a comparison between staff inquiring about sexuality, and the currently recommended practice of staff

asking about sexual abuse, I argue that this analogy provides useful resources to support such a universalising move.

I conclude by arguing for systemic and structural changes in PMHS to support staff to routinely enquire about sexuality. If done with an awareness of the discursive complexity involved, such a shift has the potential to disrupt heteronormative practices within PMHS. My analysis suggests that the power of the medical discourse in particular, will be a significant restraint to such a change. However, if heteronormative practices within PMHS remain unchallenged they will continue to silence some MSM clients, thereby, maintaining the homonegative trauma described by most of the MSM clients interviewed. This would reproduce a tendency within the medical discourse to focus on individual pathology and to evade the ways in which social marginalisation and oppression can be constructive of mental health problems.

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Preface:

Noticing a Silence Homosexuality in Public Mental Health Services

At various times in my life I have identified with (amongst other things) the terms 'homosexual', 'poof', 'gay', and more recently, in certain contexts, 'queer'. These varying labels represent how multiple discourses of homosexuality have been implicated in the production of my subjectivity and identity. For much of my adult life I have been strongly positioned by the equal rights discourse of homosexuality and its call for 'out', visible, and proud lesbian and gay people.

Consequently, when I graduated as a clinical psychologist my first job was as a designated gay counsellor within an alcohol and other drugs agency. An additional role of mine was that of 'gay community project worker'. The goal of the project was to reduce harm in the lesbian and gay community related to alcohol and other drugs (Semp & Madgeskind, 2000). I still recall being amazed and excited that a health care agency was being so proactive in inviting lesbian and gay people into their services. Accordingly, within my roles there I participated in, and was witness to, many queer conversations.

After three years I moved into public mental health services (PMHS), my current occupation, where I have worked in two different agencies for over seven years. In contrast to my time in alcohol and drug services, I became aware of a relative absence of lesbian and gay clients, and of conversations about their particular mental health needs. Yet, I was aware of the growing literature on the elevated prevalence rates of suicide and other serious mental health problems amongst lesbian and gay people. It was my noticing of this silence that prompted this research. I wanted to explore what this silence might mean? What might construct it? What might be its effects? This thesis is such an exploration.

PART ONE:

APPROACHES TO UNDERSTANDING
HOMOSEXUALITY AND MENTAL HEALTH

Chapter One:

A Troubling Absence A Critical Review of Research on Mental Health and Mental Health Services for MSM

Since the depathologising of homosexuality by the American Psychiatric Association in 1973, research on mental health issues for lesbians and gay men has proliferated. What type of research and writing has been done? What has this corpus of knowledge included and excluded? While there is a sizeable body of research on the mental health of, and mental health services for, lesbians and gay men, very little knowledge has been produced on public mental health services (PMHS) for queer people, either in New Zealand or internationally. Why might this be? What could be the significance of this omission? In this chapter, I present a critical review of the literature to consider these questions. First, I outline the cultural context and processes by which the American Psychiatric Association came to depathologise homosexuality. This history reveals the inextricable relationship between the ‘science’ of homosexuality and sociocultural context. It also provides an important context in which to reflect on the types of research produced by lesbian and gay psychology following the depathologising of homosexuality in 1973. Second, I review the literature on mental health and mental health services for queer people since the 1970s. Third, I review the sparse literature on PMHS for queer people and ask what is absent from this research and why? I conclude this chapter by considering the implications of this omission for this thesis.

Before continuing, it is necessary to comment briefly on some issues of terminology in this thesis. First, the word ‘queer’ has various and contested meanings, some of which are explored in Chapter Four. However, given my use of it above, I briefly explain my rationale for adopting it here. Within the academy ‘queer’ is commonly associated with ‘queer theory’ (Jagose, 1996; Kirsch, 2000). This theory focuses on the social construction of sexual identities and their consequences for subjectivity. Queer theory informs this thesis and is introduced in Chapter Two. ‘Queer’ is also used descriptively by many previously ‘lesbian and gay’ organisations. This seemingly represents the attempts by some lesbians, gay men,

and affiliated groups, to transcend the limitations of existing identity terms such as ‘lesbian’ and ‘gay’, and to use ‘queer’ as the basis for an inclusive politics in opposition to the privileging of normative heterosexuality (Halperin, 1995; Kirsch, 2000; Seidman, 1995; Spargo, 1999). This assumption of inclusivity is problematic¹ as Hegarty (2005) acknowledges when he says:

For me ‘queer’ continues to mean a critical engagement with politics of affinity among peoples oppressed in *different* ways by a heteronormative, patriarchal, gender-reductive world, and this engagement takes precedence over the illusion that all ‘gay’ and ‘lesbian’ people are progressive or united.

(Hegarty, 2005, p. 115, italics in original)

Drawing on these various understandings of ‘queer’, and for brevity, (while aware of its wider applicability), in this thesis I generally use ‘queer’ when referring to same-sex attracted people in a broad sense. This includes lesbian, gay and bisexual (LGB) identified people, and people with same-sex attraction who do not adopt any of these terms of identity. However, I also use the terms ‘homosexual’, ‘lesbian’, ‘gay’, and ‘bisexual’, when referring to literature that uses this terminology. Similarly, ‘men who have sex with men’ (MSM) refers to any men who have sex with men, regardless of what terms they may use to denote their sexuality (see Chapter Three).

DSM and the ‘Science’ of Pathology and Justice

Since the emergence of the term ‘homosexual’ as a label to categorise people at the end of the 19th century (Foucault, 1976/1990), science has been used to both pathologise, and to seek justice for homosexuals. These two differing trajectories of the use of science in relation to homosexuality are outlined in Chapter Four where I present discourses of homosexuality in the last 100 years in the West. What is important for now, though, is that while contradictory in their motivations, these divergent approaches to the scientific study of homosexuals share certain assumptions and implications. First, they share a commitment to science and its capacity for telling the truth. In this vein, they both supported the medical constructions of new categories of sexuality and, in turn, these sexualities defined new categories of people (Weeks, 1991). This categorisation was applied

¹ The use of ‘queer’ as an inclusive term has been critiqued as being yet another potentially essentialising term of identity for homosexuals (Halperin, 1995) and for male homosexuals in particular (Jeffreys, 2003). For a discussion of various limitations and strategic possibilities of ‘queer’ as a term, see Halperin (1995).

by doctors and others to people, and also provided new terms of identity that these people could adopt for themselves. Furthermore, these categories provided legal definitions of behaviour and of persons that continue to have implications for society more than a century later (Weeks, 1991).

Another important assumption built into this new 'homosexual' category was that it represented a deviation from a biological norm. Science undertook to discover the aetiology of this non-normative development (Weeks, 1985). The medical response was to use an illness model to look for this aetiology. Homosexuality, thus, became pathological (Bullough & Bullough, 1997). Yet, there were divergent views on the aetiology of homosexuality and many involved in the scientific study of homosexuality believed that homosexuality was innate but not pathological. Accordingly, they developed more supportive attitudes towards homosexual people. "Krafft-Ebing, Ellis, Freud and, above all, Magnus Hirschfeld in Germany, became committed to more liberal attitudes, often as active campaigners for 'sex reform'" (Weeks, Holland, & Waites, 2003, p. 4, also see Chapter Four for a fuller discussion).

Opposition to the promotion of homosexuality as 'normal' developed early in the 20th century. In 1933 the Nazis destroyed many of the files of Hirschfeld and his research centre (Kitzinger & Coyle, 2002; Lauritsen & Thorstad, 1974). In the United States, from the 1920s to the 1950s, "psychiatrists and particularly psychoanalysts dominated the study of homosexuality ... and it was from their writings that the pathology of homosexuality became entrenched in American medicine" (Bullough & Bullough, 1997, p. 9).

The result was the establishment of a circular process; psychiatrists believed that homosexuality was an illness and as they researched and treated it, they turned to their patient population for subjects and found what they believed. Anyone who disagreed with them and who was not a psychiatrist could be dismissed out of hand.

(Bullough & Bullough, 1997, p. 11)

The 1940s and 1950s were the McCarthy era in the USA. Homopositive research was difficult as it was a time when government committees were established to keep homosexuals out of government jobs (Kitzinger & Coyle, 2002). Despite this context, one study provided an influential challenge to the anti-homosexual orthodoxy of American psychiatry. Alfred Kinsey and colleagues (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) produced a large scale survey of sexual behaviour in the general population. Rather than assuming homosexuals were a distinct type of person,

Kinsey suggested that homosexual behaviour was part of a continuum of normal sexuality, and that it was people's tendencies to see things as dichotomous that made this notion a difficult one for many to accept:

Things are either so, or they are not so. Sexual behaviour is either normal or abnormal, socially acceptable or unacceptable, heterosexual or homosexual; and many persons do not want to believe that there are graduations in these matters from one to the other extreme. ... The attempt to maintain a simple dichotomy on these matters exposes the traditional biases which are likely to enter whenever the heterosexual or homosexual classification of an individual is involved.

(Kinsey et al., 1953, p. 469)

Kinsey's research "opened up a space for thinking about homosexual practice as widespread and 'natural', and powerfully disrupted a scientific tradition of looking for signs of homosexuality in certain bodies – although only momentarily" (Terry, 1997, p. 276). There was a considerable backlash to Kinsey's study often using case studies of homosexual mental patients to argue for the pathologising of homosexuals. Psychiatrists such as Bergler (1956) and Bieber (1965) produced what have been described as "the xenophobic Cold War texts attacking homosexuality as a morbid psychological condition that threatened the security of the family and the nation" (Terry, 1997, p. 277). For example, Bieber espoused a then common psychodynamic view that homosexuality was a product of "the most profound parental psychopathology", one that produced a fear of heterosexuality (I. Bieber et al., 1962, p. 310). Like many psychiatrists at the time Bieber believed homosexuality could, and should, be treated.

Accordingly, in the first version of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, sexual deviations were listed under "sociopathic personality disturbance" (American Psychiatric Association, 1952, pp. 38-39). This listed homosexuality alongside "transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation)" (American Psychiatric Association, 1952, p. 39). Then, when the DSM was revised in 1968, homosexuality was listed as a sexual deviation under the category of "personality disorders" (American Psychiatric Association, 1968, p. 44). Yet, despite psychiatry's vigorous commitment to the proclaimed truth of homosexuality's pathology, other cultural developments were to impact on this regime of 'truth'.

Following the McCarthy era the civil rights struggles for blacks, women and gays emerged. Kameny (an American homosexual) "coined the phrase 'Gay is Good' to parallel 'Black is beautiful'" (Kitzinger & Coyle, 2002, p. 11). In this vein, Evelyn Hooker (1957) provided

the type of research that activists used to argue for equal rights for gays. Hooker (1957), a psychologist, compared the mental health of a sample of homosexual men to heterosexuals and tentatively claimed that homosexuals were as psychologically healthy as heterosexuals. She argued that:

1. Homosexuality as a clinical entity does not exist. Its forms are as varied as are those of heterosexuality.
2. Homosexuality may be a deviation in sexual pattern which is within the normal range, psychologically.

(Hooker, 1957, p. 30)

This was an early example of “myth-bashing studies” that continue to this day (Gamson, 2000, p. 350). Out of this period of social change came a significant revision to the diagnostic status of homosexuals. In 1973, the American Psychiatric Association deleted homosexuality from the list of psychiatric disorders and replaced it with the classification ‘sexual orientation disturbance’.

This category is for individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation. This diagnostic category is distinguished from homosexuality, which by itself does not necessarily constitute a psychiatric disorder.

(American Psychiatric Association, 1973)

This diagnostic change was undoubtedly positive for lesbian and gay rights but what did it mean for science’s ability to speak about homosexuality? While the psychiatric profession maintained that the change was a result of scientific research, others have argued that the sociopolitical context and the work of lesbian and gay activists played a much greater role (Bayer, 1987; Greenberg, 1997; Kitzinger, 1990).

The 1960s and 1970s in the USA were times of broad social change. Bayer (1987) provides compelling evidence that rather than this change coming primarily through scientific endeavour, a combination of political protests, threats of violence, use of the media, the citing of gay affirmative research, and a series of votes within the American Psychiatric Association, were all needed to produce the change in nomenclature. While the American Psychiatric Association board of trustees approved the removal of homosexuality as a disorder on December 13th 1973, over 10,000 psychiatrists voted on the referendum that was brought about by those trying to repeal the diagnostic change. Following this referendum, those supporting the outcome affirming the depathologising of homosexuality declared that science had won over social prejudice. Similarly, those who opposed this

outcome claimed that science had been overshadowed by social and political action (Bayer, 1987). Consequently, Greenberg (1997) argues that this historical moment revealed the inextricable link between “the mental health professions’ claim to scientific authority” and sociocultural norms (p. 256). Rather than science proving that homosexuality was not pathological, Greenberg asserts that scientists changed the a priori assumptions they drew on to design and evaluate research on homosexuality; these changes were moral and political ones:

For the disease model advocates, homosexuality was always already a disease, and for their opponents it was not. This was not a scientific debate, at least as that term is normally understood. It was an ideological debate in which both sides took their conclusions as their premises to advance their cause.

(Greenberg, 1997, p. 260)

Yet, for science to retain its right to speak ‘the truth’, it needed to minimise the connection between research and social context (Greenberg, 1997). This episode in the history of the relationship between lesbians and gays,² and scientific research, highlights a broader critique of the tendency for psychology to focus on the individual as the object of study as opposed to the social contexts that, at least partly, construct individuals and their experiences (Burman & Parker, 1992c; Burr, 1995; I. Parker, 1992).

This individualising tendency in the science of the DSM is further evident in changes made to diagnoses regarding sexual orientation since 1973. In DSM-III (American Psychiatric Association, 1980), the disorder ‘ego-dystonic homosexuality’ was added as part of the ‘psychosexual disorders’:

The essential features are a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated or maintained, and a sustained pattern of overt homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

(American Psychiatric Association, 1980, p. 281)

Then in DSM-III-R (American Psychiatric Association, 1987), ego-dystonic was removed but under ‘sexual disorders not otherwise specified’ an example given is “persistent and marked distress about one’s sexual orientation” (American Psychiatric Association, 1987, p. 296). The DSM-III acknowledged internalised “negative societal attitudes toward

² At this point I change from using the term homosexuality to using the term ‘lesbians and gays’ as this reflects the changing use of language in wider society, and in research, at this time. The significance of these changes in language over time is discussed in Chapter Four which explores the various and competing discourses of homosexuality.

homosexuality” as predisposing factors in ego-dystonic homosexuality (American Psychiatric Association, 1980, p. 282), but the languaging of these two disorders pathologised individuals’ distress about their homosexuality rather than foregrounding the homonegative social contexts that produce such distress. While the DSM-III-R notion of ‘persistent and marked distress about one’s sexual orientation’ does not specifically refer to homosexuality, it seems very unlikely that it would be applied to people who were distressed about their heterosexuality, or to people who were distressed by others’ homosexuality. There were no changes in DSM-IV (American Psychiatric Association, 1994) regarding homosexuality.

Despite the critique regarding the sociopolitical process by which the American Psychiatric Association changed its nomenclature, and notwithstanding the limitations of the diagnosis of ‘persistent and marked distress about was ones sexual orientation’, the American Psychiatric Association’s moves over time to depathologise homosexuality could be seen as the heralding of a new alliance between lesbians and gays and psychological research.

A New Alliance: Lesbian and Gay Psychology

Notwithstanding psychology’s historical role in the condemnation of lesbians and gays, a new liberal story of progress can be told of the relationship between psychology and lesbian and gay people (Kitzinger, 1997). This liberal view is critiqued later in this chapter. For now though, such an account acknowledges that since the de-pathologising of homosexuality by the American Psychiatric Association, psychological research has helped release lesbians and gays from societal condemnation. Under the new regime, lesbians and gays with mental health problems are not ‘sick’ but suffering from the effects of living in a homophobic society (Greenberg, 1997), although the distress this causes lesbians and gays is only indirectly acknowledged in the DSM. Yet since the depathologising of homosexuality, many authors and practitioners, acknowledge the effects of living in a homonegative context, either via direct abuse, or more indirectly through what is commonly known as internalised homophobia (D. Davies & Neal, 1996; Garnets, Herek, & Levy, 2003; Igartua, Gill, & Montoro, 2003; Kitzinger, 1996).

‘Homophobia’ was a term coined by Weinberg (1972) as a psychological concept, implying a fear of homosexuality. Heterosexuals and homosexuals could experience this fear. However, the term ‘homophobia’ has been critiqued as providing an individualising and

psychological explanation of ‘phobia’, thus implying that homophobia is ‘abnormal’. Such a conceptualisation fails to highlight that what is referred to as homophobia is constructed from, and supported by, widespread and culturally sanctioned ideas (Herek, 1996; Kitzinger & Perkins, 1993; Peel, 2002). Cognisant of these critiques, the term ‘heterosexism’ is an attempt to encompass the cultural constitution of ideas and practices that marginalise homosexuality. “Heterosexism has been defined as the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behaviour, identity, relationship, or community” (Herek, 1996, p. 101). While there is controversy over the relative merits of these terms (Adam, 1998), they all signify experiences and practices which render homosexuality problematic. I prefer to use the term ‘heteronormativity’³ because it acknowledges the way in which normative heterosexuality is a central organising principle in Western societies (Seidman, 1993; M. Warner, 1993).

This new context led to the emergence of the field of lesbian and gay psychology (for a full discussion of this see Kitzinger & Coyle, 2002):

Lesbian and gay psychology is psychology which is explicit about its relevance to lesbians and gay men, which does not assume homosexual pathology and which aims to counter prejudice and discrimination against people who are not conventionally heterosexual and to create a better world for lesbians and gay men. As such, lesbian and gay psychology is both a scholarly scientific enterprise and, equally a clearly policy oriented, practical, real world undertaking.

(Kitzinger & Coyle, 2002, p. 2)

Two main strands of scholarship developed within lesbian and gay psychology. One approach is aligned with positivism and mainstream psychology, while the other is more informed by social constructionist ideas (Kitzinger, 1997; Kitzinger & Coyle, 2002). Beginning with social constructionist scholarship first, this has grown in the field of social psychology in particular (Burr, 1995; K. Gergen, 1985, 1999; I. Parker, 1997). Social constructionism has also been used to critique some important psychological concepts and therapeutic practices with regard to queer people. However, constructionist ideas do not yet appear to have been applied explicitly to PMHS or to systemic issues in mental health services for queer people. This may, in part, be due to the limited uptake of constructionist ideas within United States lesbian and gay psychology (Russell & Gergen, 2005) where much of the research on mental health services for lesbians, gay men, and bisexuals (LGB)

³ ‘Heteronormativity’ is discussed further in Chapters Two and Four.

is done. Furthermore, Stein (1996) claims that most mental health professionals subscribe to essentialist ideas with social constructionism being virtually excluded from the mental health field. Another likely reason for the lack of constructionist research in mental health services for queer people is the authority gained by doing research within the dominant positivist paradigm (Bohan & Russell, 1999a; Kitzinger, 1997). Accordingly lesbian and gay social constructionist scholarship is introduced in the next chapter where I discuss a social constructionist epistemology.

A second strand within lesbian and gay psychology that has remained largely committed to positivist science has become much more influential within mental health research. Kitzinger (1997) argues that lesbian and gay psychology is a successful critical psychology as it has helped lesbians and gays challenge many homonegative theories and practices within psychology, and has helped make the world more just for lesbians and gays. Some important achievements include the development of affirmative psychotherapeutic stances for working with lesbians and gay men, supporting lesbian and gay adoption rights, and supporting the legalisation of homosexuality in many countries. It is within this growing field of lesbian and gay psychology that most of the research on mental health and mental health services for lesbians and gays has been conducted. Accordingly, the scholarship reviewed in the rest of this chapter generally falls within a positivist framework.

While successful in many ways, lesbian and gay psychology has also been critiqued as being defensive and limiting. It is defensive in that it implicitly reproduces heteronormative assumptions of the normality of heterosexuality. For example, much lesbian and gay psychological research compares LGB against 'normal' heterosexuals (Bohan & Russell, 1999a; Kitzinger, 1997). An example of this is in the area of LGB parenting rights. The argument is that LGB can have parenting rights if their parenting is proved to be similar to, and as healthy as, heterosexual parenting (Clarke, 2002). Another area where lesbian and gay psychology can inadvertently reproduce heteronormative assumptions is that of prevalence studies (Bohan & Russell, 1999a). A well established trend in lesbian and gay psychology is research comparing the mental health of homosexuals with those of heterosexuals. This research has been conducted across many countries in the West and I summarise and comment on relevant findings here.

Queer Comparisons: Prevalence research

A growing body of research both internationally, and in New Zealand reports that queer youth are disproportionately over-represented in youth suicides (Fergusson, Horwood, & Beautrais, 1999; Herrell et al., 1999; Pietrantonio, 1999; Remafedi, 1999; Rotheram-Borus, Hunter, & Rosario, 1994; Sandfort, de Graaf, Bijl, & Schnabel, 2001). A New Zealand study (Fergusson et al., 1999) on the relationship between sexual orientation and suicidal ideation and behaviour found that LGB youth were at increased risk of major depression, generalised anxiety disorder, conduct disorder, substance abuse and/or dependence, multiple disorders, suicidal ideation and suicide attempts. Another New Zealand study (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003) found increased risk of contemplating suicide or completing self harm in lesbian and gay young adults. The extent of the increased risk of suicide for LGB youth across these studies is up to seven times higher than for heterosexual youth. More recently Fergusson, Horwood, Ridder, and Beautrais (2005) conducted a further stage in their longitudinal study (Fergusson et al., 1999) and reported that young male adults “classified as predominantly homosexual had an overall rate of [mental health] problems that was over five times the rate for exclusively heterosexual males” (Fergusson et al., 2005, p. 977).

Furthermore, there is a rapidly expanding corpus of research suggesting that adults with same sex attraction are at increased risk of various mental health disorders (Gilman et al., 2001; Sandfort et al., 2001; J. Warner et al., 2004). Problems highlighted in the research include: alcohol and drug use (S. Anderson, 1996; Hughes & Wilsnack, 1994; King et al., 2003a; Lewis, Saghir, & Robins, 1982; Paul, Stall, & Bloomfield, 1991; Rosario, Hunter, & Gwadz, 1997); suicidality (Cochran & Mays, 2000; Herrell et al., 1999; J. Warner et al., 2004); self-harm (King et al., 2003b; Skegg et al., 2003); mood disorders (Fergusson et al., 1999; Gilman et al., 2001; T. Mills et al., 2004; Sandfort et al., 2001); borderline personality disorder (Paris, Zwiig-Frank, & Guzder, 1995; Zubenko, George, Soloff, & Schulz, 1987); psychological distress (King et al., 2003a); and eating disorders (Carlat & Camargo, 1991; Carlat, Camargo, & Herzog, 1997; Neumark-Sztainer et al., 1996; Siever, 1994).

Hypotheses for these higher prevalence rates of mental health problems range from homosexuals being innately disposed to illness, through to mental health problems being a consequence of living in a homonegative society (Bailey, 1999; Fergusson et al., 1999; Fergusson et al., 2005; Sandfort et al., 2001). In support of the latter hypothesis, there is a

developing body of research showing that people who have experienced anti-homosexual violence, whether physical, sexual, or verbal, are at increased risk of mental health problems (D'Augelli, 2002; Herek, Gillis, & Cogan, 1999; Otis & Skinner, 1996; Rivers, 2001). Additionally some research suggests that due to the effects of marginalisation, victimisation that is assumed (by the victim) to be motivated by opposition to their sexual orientation, may have an extra impact on LGB people due to the effects of marginalisation (Herek et al., 1999). One theory is that the normal sequelae of trauma can interact with internalised homophobia, causing self blame and challenges to ones sexual orientation identity (Garnets et al., 2003; Herek et al., 1999; Klinger & Stein, 1996). This argument is consistent with research suggesting that 'minority stress' contributes to increased psychological distress for gay men (Meyer, 2003).

Thus, there is research supporting the idea that the marginalised status of LGB can have negative effects on their mental health. Even though it is now 30 years since the American Psychiatric Association removed homosexuality as a pathology from the DSM it is disconcerting that some researchers, (including LGB ones), still include in their discussions the possibility that the greater risk of mental health problems in homosexual people is due to inherent problems with homosexuals. For example, a report on a large scale study in the Netherlands, suggests that:

biological and genetic factors in the causes and development of homosexuality⁻⁵⁰ might also predispose homosexual people to developing psychiatric disorders. This is in line with the higher prevalence of bipolar disorder we found in homosexual men compared with heterosexual men, which is generally considered to be largely congenital.

(Sandfort et al., 2001, p. 89)

This reproduces a familiar heteronormative assumption that something is innately aberrant in homosexual development. "These same lines of inquiry are not asked of heterosexuality" (Ristock & Julien, 2003, p. 6). For example, can we imagine a study on bipolar disorder considering its links to heterosexuality? The continued deployment of heteronormative assumptions in positivist research risks underplaying the role stigmatisation, marginalisation, and homonegative abuse play in the lives of homosexuals, and, furthermore, risks adding power to the arguments of those who oppose homosexuality as abnormal.

Even without heteronormative assumptions being drawn upon in research discussions, prevalence figures themselves can be misused. Some religious and right wing groups could

use this information as proof of their view of homosexuality as perversity, illness, and madness. For example, (S. Murray, 1996) discusses some attempts by right wing groups to use AIDS as a way to continue, and intensify, the medicalisation of homosexuality as a public health problem. As already detailed, this pathologising view has a strong history in mental health theory, research, and practice. Yet, despite the risks of comparing the mental health of homosexuals with heterosexuals, if marginalisation does contribute to an increased risk of mental health problems for lesbian and gay people, then research which identifies the effects of this marginalisation can also be used to call for social changes to reduce such marginalisation, and for resources to help people recover from it. Relatedly a huge corpus of research has looked at the therapy experiences of lesbian and gay people. It is to this research I now turn.

A Private Affair: Research on Queer Clients' Experiences of Mental Health Services.

Since the lesbian and gay rights movement of the 1960s and 1970s, and then the challenges presented by HIV/AIDS, much has been written about the need for, and use of, mental health services by lesbians and gays. Yet, very little of this literature, and the research some of it is based on, attends to systemic issues in mental health service provision, and only two studies (Golding, 1997; Lucksted, 2004) focus specifically on PMHS. These are discussed later. Nonetheless, this body of scholarship provides the context for the current study. Therefore, I review this literature here, and consider what it tells us, and what it omits, in exploring the relationships between lesbians and gays and mental health services.

Numerous surveys, mainly in the United States, Canada and the United Kingdom, have looked at lesbians' and gays' choices of therapist and experiences of therapy (Bradford, Ryan, & Rothblum, 1994; Giugni, 1999; Golding, 1997; M. Jones & Gabriel, 1999; Josephson, 1998; J. Kaufman et al., 1997; King et al., 2003a; Liddle, 1997; Luedders, 1998; McFarlane, 1998; Modrcin & Wyers, 1990; Moran, 1996; Nystrom, 1997; Platzer, 1998b; A. Robertson, 1998; Sorensen & Roberts, 1997). Some of this research found many positive experiences of therapy. Furthermore, lesbians were found to use therapy more often and rate it more valuable than heterosexual women or gay men (Bradford et al., 1994; Liddle, 1997, 1999; Sorensen & Roberts, 1997). Additionally, significant numbers of lesbians and gay men expressed a preference for gender and/or sexual orientation matching. These

preferences were generally found to be greater for lesbians (J. Kaufman et al., 1997; Liddle, 1997; Modrcin & Wyers, 1990).

Conversely, Liddle (1999) provides some evidence that, over time, lesbians and gay men are reporting increased satisfaction with heterosexual therapists. However, caution is needed in making generalisations from Liddle's study. Her sample included 392 women and men who identified as lesbian or gay (bisexuals were excluded), and who had seen a therapist at least once. European-Americans made up 94% of the sample, 82% had a bachelors or higher tertiary degree, and the median annual income was US\$30,000. Accordingly, the sample could be described as white, middle class, and well educated. In discussing her findings, Liddle implicitly acknowledges this by suggesting that:

gay and lesbian clients may more often epitomize the ideal client: high functioning, motivated, and working to manage stress or developmental issues rather than trying to cope with psychopathology.

(Liddle, 1999, p. 135)

This statement, and the demographics of Liddle's sample, suggests that the clients in her study are those who do not have serious psychopathology and who have the cultural and financial resources to choose therapists of their preference. Liddle does not specify whether the mental health services used by the women in her sample were public or private. If however, the sample does reflect the 'ideal clients' Liddle describes above, then these lesbians and gay men are unlikely to be those who present to PMHS.⁴ In contrast with Liddle's finding, a study in New York of 67 lesbian, gay, bisexual and transgendered (LGBT)⁵ clients, who were receiving inpatient or outpatient psychiatric services, and were classified as "having a severe and persistent mental illness" (Avery et al., 2001, p. 990), found that they had significantly more dissatisfaction with mental health services than a

⁴ Much of the literature reviewed for this project uses the terms 'mental health problem' or 'mental illness' without defining them in terms of severity or otherwise. The working definition I am using is something akin to meeting the criteria for entry to a community mental health centre in the greater Auckland area. Auckland is the largest city in New Zealand with a population of approximately 1.3 million. In the current climate of under-resourcing, this means that a person must be experiencing a high level of distress, meet DSM-IV criteria for a psychiatric disorder, and usually implies the person needs to be experiencing symptoms which suggest issues of physical safety of self and/or others.

⁵ Again, I am changing terminology here to reflect both Avery and colleagues' (2001) use of language which is part of a current trend in psychological writing and research to include transgender people as a category to be studied alongside lesbians, gay men and bisexuals. This is connected to an increasing acknowledgment of diversity within queer communities (for further discussion of this trend see sections on Queer theory in Chapter Two and a Queer discourse of homosexuality in Chapter Four).

control group. This dissatisfaction was higher for LGBT “who were members of racial minority groups and those living alone” (Avery et al., 2001, p. 990).

In New Zealand, one study has considered lesbians’ experiences of mental health services (Welch, Collings, & Howden-Chapman, 2000), and, like Liddle (1999) in the United States, found that lesbians generally had many positive experiences of mental health services. Welch et al. (2000) reported that 69.9% of respondents who had used mental health services had found them useful (2000). However, while finding similar results to Liddle (1999), the New Zealand study has similar limitations. Almost 90% of the sample was European and nearly 70% were tertiary educated. Again, no indication was given whether the women used public or private mental health services. Yet, half the women said they had chosen a mental health provider based on feedback from friends. Given that generally there is no choice offered in PMHS in New Zealand, this suggests that at least half of the sample were reporting on their use of private mental health services.

Despite the limitations of the existing research on lesbians’ and gay men’s experiences of therapy, many lesbians and gays clearly do report positively on their therapeutic experiences. Yet, there is also much evidence of lesbians’ and gay men’s dissatisfaction with mental health services. Fear of mental health services, suspicion of psychiatry, and of homophobic therapists, and reluctance to disclose sexual orientation to treatment providers, were reported in many studies (Bradford et al., 1994; Giugni, 1999; Golding, 1997; Josephson, 1998; McFarlane, 1998; Nystrom, 1997; A. Robertson, 1998). As some of these studies consider systemic issues in mental health service provision for lesbians and gay men (Golding, 1997; McFarlane, 1998; A. Robertson, 1998), I discuss them later in this chapter when these issues are the focus.

One assumption in the literature on mental health services for LGB is that mental health practitioners’ attitudes towards these populations have implications for the quality of service they offer. Accordingly, another body of research considers mental health practitioners’ attitudes towards lesbians and gays (Berkman & Zinberg, 1997; Caisango, 1996; Cribben, 1996; L. Friedman, 1996; Garnets, Hancock, Cochran, & Goodchilds, 1991; Kalbac, 1998; Thoreson, Shaughnessy, Cook, & Moore, 1993; Wells, 1997). The main findings from this research are that numerous mental health service providers reflect the wider heteronormative culture, that they have homonegative attitudes and behaviours, and that many more are heterosexist and too ill informed to work effectively with LGB clients.

Numerous authors have suggested ways for practitioners to make their practice more LGB affirmative (D. Davies & Neal, 1996; Dulaney & Kelly, 1982; Faria, 1997; Josephson, 1998; Milton & Coyle, 1999; Purcell, Campos, & Perilla, 1996; Ross, 1988; Walsh, 1998). Furthermore, there is a developing literature regarding the need for, and implementation of, lesbian and gay awareness training programmes for mental health workers (L. Brown, 1996; Buhrke & Douce, 1991; M. Ellis, 1994; Flaks, 1992; Norton, 1982; Rudolph, 1988; Serdahely & Ziemba, 1984; Simoni, 1996; Stein & Burg, 1996). This literature claims variable success rates in changing the negative attitudes of practitioners. However, lesbian and gay awareness training has been critiqued for utilising individualistic conceptions of homophobia versus exploring the effects of systemic heterosexual dominance, for its problematic assumption that positive attitudes lead to positive behaviour, and for failing to adequately describe the content and process of how such training should be done (L. Brown, 1996; Peel, 2002).

Yet, despite this wealth of research on lesbians and gays and mental health services, the research contains a number of limitations for considering PMHS for queers. One limitation is that the research generally makes no distinction between private mental health services and PMHS. This difference may be significant in many ways. People using private (including insurance-covered) services may be more financially resourced and of higher socio-economic status than those using public services. In addition, people using private services are more likely to have had a choice over which services or clinicians they used. There may also be significant differences in the severity of problems presenting to private versus PMHS providers, and in definitions of mental health explicitly or implicitly used in the studies. Furthermore, quality and types of service provision may differ in these two sectors of mental health services. For example, private mental health services are more likely to involve sole practitioners or smaller organisations, whereas PMHS usually involve large organisations. Accordingly, the effects of the broader systemic issues in PMHS are generally not explored in the existing research.

In addition to the lack of focus on PMHS provision, another limitation of the research on lesbian and gay experiences of mental health services is the dominance of quantitative research and the paucity of in-depth qualitative research. This has limited the types of questions asked and types of analyses done on the data obtained. Notwithstanding these limitations, I now move on to review the small collection of research and literature considering systemic issues and PMHS for queer people.

Public and Ignored: Research on PMHS for LGB Clients

Many have called for changes in mental health systems to make them more lesbian and gay affirmative and less heterosexist (Hellman & Drescher, 2004; Hidalgo, 1995; Josephson, 1998; Klein, 1991; McDaniel, Cabaj, & Purcell, 1996; Nystrom, 1997; Platzer, 1998a; A. Robertson, 1998; Trippet, 1994). However, an extensive survey of the literature shows that very little research has been done on PMHS, or on systemic practice in mental health services affecting LGB people. In this section I review the existing literature to explore what it tells us about PMHS for LGB, and what it omits.

Some literature exists on attempts to provide specific services for lesbian and gay youth (Lipton, 1996; Medeiros, Seehaus, Elliott, & Melaney, 2004; Platzer, 1998a; Stites, 1983; Westefeld & Winkelpleck, 1983). The literature considering service provision for LGBT adults is primarily from the United States and the United Kingdom. Most of this literature is not research based but consists of reflections on practice by mental health clinicians (Ball, 1994; Garza, 2004; Gonsiorek, 1981a; Hellman, 2004a, 2004b; Hellman & Klein, 2004; Klein, 1991; McDaniel et al., 1996; Rabin, Keefe, & Burton, 1986; M. Rankin, 2004; Tate & Ross, 2003). Within the research based literature, only two studies focus exclusively on PMHS (Golding, 1997; Lucksted, 2004), therefore, I also include in this review the literature based on practitioners' reflections, along with research looking at systemic aspects of mental health service provision to LGB adults in general (King et al., 2003a; McFarlane, 1998; A. Robertson, 1998).

This systemic literature can be further divided into that on specifically lesbian and gay services (Garza, 2004; Gonsiorek, 1981a; Hellman, 2004a, 2004b; Hellman & Klein, 2004; Klein, 1991; M. Rankin, 2004), and that focussing on mainstream or PMHS for the general population (Ball, 1994; Golding, 1997; King et al., 2003a; Lucksted, 2004; McDaniel et al., 1996; McFarlane, 1998; Rabin et al., 1986; A. Robertson, 1998; Tate & Ross, 2003). First I will review the literature on specifically lesbian and gay services.

Seven authors, all from the United States, have written about specialist lesbian and gay mental health services based on their own experience as staff (Garza, 2004; Gonsiorek, 1981a; Hellman, 2004a, 2004b; Hellman & Klein, 2004; Klein, 1991; M. Rankin, 2004). Gonsiorek (1981a) discusses his experiences of systemic issues facing staff within lesbian and gay mental health agencies. Yet little is said about the relationship of staff, or the agencies, with mainstream PMHS. Klein (1991), also in the United States, comments on the

history of lesbian and gay mental health services in her country, and of their often-problematic relationships with mainstream PMHS:

The relationship between gay counselling services and mainstream agencies and government has been a tenuous, twilight existence between acceptance and annihilation.

(Klein, 1991, p. 80)

In particular, Klein focuses on a service for 'sexual minorities' where she had worked. This agency received funding from, and was audited by, mainstream PMHS. Klein's book is important in a number of ways. It is unique in being the first to explore the challenges and successes of such an agency. It also acknowledges difficulties in the relationship between the agency and the mainstream PMHS. However, Klein does not discuss attempts to improve the relationships between the services, and does not consider the quality of the service provided to lesbian and gay clients by mainstream PMHS. It is also not clear what range and severity of mental health problems were addressed in her service.

The five remaining authors (Garza, 2004; Hellman, 2004a, 2004b; Hellman & Klein, 2004; M. Rankin, 2004) are all contained within a book on LGBT issues in community mental health (Hellman & Drescher, 2004).⁶ All describe services that are either stand-alone LGBT specific programmes added on to mainstream services, or completely stand-alone LGBT services. The range of programmes encompasses peer support groups and individual therapy. The authors discuss the importance of developing services in collaboration with LGBT clients, and of the difficulty in developing services within a homonegative sociocultural context. While the services discussed are not integrated into mainstream PMHS, it is noteworthy that a number of the programmes discussed have heterosexual staff in key positions (Hellman, 2004a, 2004b; Hellman & Klein, 2004).

Turning the focus to mainstream mental health services, I have located ten references that can be broadly included in this area (Avery et al., 2001; Ball, 1994; Golding, 1997; King et al., 2003a; Lucksted, 2004; McDaniel et al., 1996; McFarlane, 1998; Rabin et al., 1986; A. Robertson, 1998; Tate & Ross, 2003). Of these, five are from the United States (Avery et al., 2001; Ball, 1994; Lucksted, 2004; McDaniel et al., 1996; Rabin et al., 1986) and one is from Canada (Tate & Ross, 2003). Only two of these six are based on research (Avery et al., 2001; Lucksted, 2004) while the others are based on reflections by clinicians. The

⁶ For a fuller review of this book see, Semp (2005).

remaining four references are for research carried out in the United Kingdom (Golding, 1997; King et al., 2003a; McFarlane, 1998; A. Robertson, 1998).

Considering the United States and Canadian reflective articles first, Rabin et al. (1986) report positively on an attempt to improve services for LGB in a community mental health district of San Francisco – a city with a sizeable and vocal queer community. The study surveyed the attitudes of staff within the mental health service. From this survey came the following recommendations:

that a client be given the option of seeing a therapist identified with or sensitive to sexual minorities. Second ... that the number of these speciality staff members be increased ... Third, ... continuing education for all staff concerning sexuality, homosexuality, and gay male, lesbian, and bisexual lifestyles. Finally, ... the appointment of a contact person within each mental health unit.

(Rabin et al., 1986, p. 296)

While significant in its uniqueness of reporting on a system-wide change in a mainstream public-funded mental health service, this project did not report on any liaison with the lesbian and gay clients, mental health professionals, or communities. It also omitted to discuss the relationships between the community mental health district and lesbian and gay mental health agencies that may have existed in the area.

In the second United States article, Ball (1994) reports on an attempt to provide a group for lesbian and gay clients with chronic mental health problems in an outpatient psychiatric day treatment program. Lesbian or gay clients who had serious mental health problems were described as having double stigmatisation to deal with. Furthermore, he reports on the service gap between queer services and mainstream psychiatric services:

If they seek counselling in a clinic that serves gay men and lesbians, they are often turned away because of their psychiatric diagnosis. In day treatment they experience the opposite problem; their psychiatric problems are recognized, but their needs related to being gay or lesbian are not.

(Ball, 1994, p. 110)

Ball (1994, p. 109) discusses some of the strategies he used to try and overcome “resistance and homophobia among staff and other clients”, and attempts to establish “the group as an integral component of a gay-sensitive treatment structure in a mental health agency”. The strategies included: in-service training by openly lesbian and gay staff, making the availability of the group widely known to new clients as part of the usual structure of the agency, and not making assumptions about the nature and consistency of how clients identify regarding their sexuality.

McDaniel et al. (1996), reflect on the treatment of lesbian and gay clients in psychiatric mental health settings including liaison services, inpatient services, and community mental health centres. Suggestions for making such services safer for lesbian and gay clients include increasing awareness of queer issues by practitioners, and asking clients about their sexual orientation. The authors of this paper also raise issues as to whether queer staff should be 'out' about their sexual orientation, and the need for all staff, queer or otherwise, to be aware of the concerns of heterosexual clients when considering making settings more gay affirmative. Yet, it is unclear from the article what the authors recommend around these issues.

In Canada, Tate and Ross (2003) report on attempts to make a university psychiatric service more homopositive. The service used a 'community building model' to develop a committee of interested staff including the campus LGBT coordinator, allies, and students. Outcomes suggested included the provision of anonymous feedback forms for clients, peer-led training on LGBT issues for staff, and improving access to staff specifically supportive of LGBT clients. One issue of note is that LGBT committee members quickly identified how the intake/assessment process needed to give clients an opportunity to disclose their sexual orientation if they wished; however, this never became a priority as some psychiatrists resisted this move. The authors consider that one reason for this may have been the psychiatrists' positioning within the biomedical model which largely minimises the impact of discrimination on the mental health of LGBT.

Turning to the two United States research articles on service provision for LGBT, Lucksted (2004) conducted qualitative research to identify gaps within PMHS for LGBT clients, while Avery et al. (2001) looked at satisfaction with psychiatric services in New York among sexual minority clients. Avery et al. interviewed 67 LGBT clients and found that they were more than twice as likely to be dissatisfied with services as a heterosexual control group. This was highlighted for LGBT who were also members of racial minority groups. Lucksted (2004) utilised multiple data sources including contact with 35 key informants to explore the effectiveness of PMHS for LGBT. Key findings in Lucksted's study were that treatment in PMHS was often homonegative, or that sexuality was totally ignored. Inpatient and residential services were identified as especially fraught areas for LGBT clients. Lucksted also commented that LGBT clients in PMHS are particularly vulnerable to negative experiences in PMHS as in addition to being often doubly

stigmatised (with homosexuality and mental health problems), they are also likely to have few financial, familial and community resources.

I now consider the four studies from the United Kingdom (Golding, 1997; King et al., 2003a; McFarlane, 1998; A. Robertson, 1998). Of these four studies, only Golding's (1997) focussed exclusively on PMHS. However, I have included the studies by McFarlane (1998), Robertson (1998) and King et al. (2003a), as they included participants who had used PMHS as well as private services, and they are unique in providing interview data of participants' views of mental health services. 'Mind',⁷ a charitable trust in the United Kingdom, was involved in three of these research projects (Golding, 1997; King et al., 2003a; McFarlane, 1998):

Mind hears frequently of people whose therapists or doctors see their sexuality as the problem; who suffer discrimination within mental health services; and who would not consider using 'mainstream' mental health services because they consider such services to be anti-gay, anti-lesbian or anti-bisexual.

(Golding, 1997, p. 1)

Based on this feedback, in the first of its three studies, 'Mind' had a goal to:

explore the subjective experiences of lesbian, gay and bisexual [LGB] users, and former users, of mental health services in order to inform a training project and to formulate recommendations for change or a 'checklist' for good practice.

(Golding, 1997, p. 4)

Despite mailing out over 9,000 flyers advertising the research, Golding received only 55 completed questionnaires.⁸ The results of Golding's study confirmed the hearsay upon which the study was founded. For example, 78% of respondents had reservations about feeling safe enough to disclose sexuality in mainstream mental health services, 88% of those who had experienced prejudice in PMHS felt unable to challenge it, and 69% received mixed or negative responses when disclosing their sexual orientation in mental health services (Golding, 1997).

Similarly to the United States authors (Ball, 1994; McDaniel et al., 1996; Rabin et al., 1986), Golding (1997) suggests systemic rather than individual change is needed. In Golding's study, 51% of respondents had found at least one mental health worker, from whom they

⁷ Mind is the name of the National Association for Mental Health.

⁸ Possible reasons for this low response rate are discussed in Chapter Three of this thesis, in the section titled 'Participants'.

had received service, to be understanding of homosexuality. Positive responses “tended to reflect the practice of individual mental health workers rather than mental health services generally” (1997, p. 16). Seventy-five percent of respondents said systemic changes were needed regarding LGB issues in mental health services. When asked what systemic changes would make mental health services feel safer, respondents suggested the following: greater understanding and less judgment by staff regarding LGB issues (33%), “equal opportunities policies and protective legislation” (14%), more ‘out’ LGB staff (14%), and making LGB issues and people more visible in mental health services (13%) (Golding, 1997, p. 32).

Respondents felt there was a need for posters, leaflets and information and generally increased visibility of lesbians, gay men and bisexuals. Others said there was a need for separate support groups/services, or ‘safe’ spaces; some stressed the importance of separate wards for women.

(Golding, 1997, p. 14)

Following Golding (1997), McFarlane (1998) produced the first published qualitative research in Britain on the experiences of LGB in mental health services. McFarlane did not focus specifically on PMHS but her study was unique on two counts. First, it included LGB mental health professionals in addition to LGB clients. Second, McFarlane used in-depth interviews and focus groups to research the views of 35 LGB clients and ex-clients and 35 mental health professionals, of whom 27 were lesbian or gay. In many ways, McFarlane obtained similar findings to Golding. The results include LGB believing that: LGB issues are not well addressed in mental health services, that some mental health professionals hold homophobic attitudes, that this affected the quality of service to LGB, and that systemic changes were needed in mental health services. Interestingly, while this study was unique in its inclusion of LGB mental health professionals, it did not specifically explore their views on the possible roles they might have with regard to LGB in mental health services. This omission repeats a significant gap in the research, especially given the research in the United States showing that many LGB prefer to see mental health professionals of similar sexual orientation (Bradford et al., 1994; M. Jones & Gabriel, 1999; J. Kaufman et al., 1997; Liddle, 1997; Sorensen & Roberts, 1997).

On a smaller scale, Robertson (1998) used focus groups and interviews to obtain the views of 10 gay men in Scotland on their mental health service needs. Robertson found similar reports to those of Golding and McFarlane. Common feedback about mental health services included fear of disclosure of sexual orientation within mental health services, and that mental health services did not make space for gay men: “thinking about the language

they use, they don't make room for you" (respondent in A. Robertson, 1998, p. 38). While little detail on actual mental health services is contained in his report, Robertson concluded, that "the dominant view was a deep distrust of professional mental health services" by gay men (1998, p. 38).

The most recent study on the experiences of mental health services by LGB is that by King et al., (2003a). As part of a larger project on the mental health and social wellbeing of LGB, this study interviewed 23 LGB on their experiences of mental health services. Unlike the findings of previous studies in the United Kingdom (Golding, 1997; McFarlane, 1998; A. Robertson, 1998), rather than overt homonegativity or the pathologising of LGB by mental health professionals, participants in the research by King et al. (2003a) reported that heteronormativity impacted more on services than did direct pathologising:

What I found really hard about the mental health service when I think about it now in retrospect is that sexuality is completely ignored unless you're heterosexual ... that it's completely assumed that everyone is heterosexual unless you particularly state otherwise.

(Female, 30s, respondent in King et al., 2003a, p. 43)

While not interviewing LGB mental health professionals' views on the role they might have with LGB clients, King et al. (2003a) found that participants in their study "who had had encounters with LGB practitioners found their potential empathy an advantage" (p. 46):

I know some lesbians who don't care and are not interested in the sexuality of their psychiatrist. But I thought ... if she was a lesbian she might be more empathetic, they'd understand some of the issues, they'd have been through coming out and all the rest of it.

(Female, 30s, respondent in King et al., 2003a, p. 46)

Recommendations from this study were similar to those by Golding (1997) and McFarlane (1998) and focussed on training mental health professionals about LGB issues.

To summarise the sparse literature on PMHS for LGB, one observation is that little of this literature is research based, with only two studies focussing exclusively on PMHS (Golding, 1997; Lucksted, 2004). Even within the broader scope of research on systemic aspects of mental health services for LGB, there is still a dearth of research. Within this, there are assumptions and findings that support the idea that having more 'out' LGB staff could be useful for improving service provision to LGB clients, but there is no exploration of LGB staff views on this. There are also calls for more training on LGB issues but few details on what specific training might be useful. The overall findings of this small body of research

are that some LGB clients are reluctant to disclose their sexual orientation, and that their sexuality is either pathologised, or, at best, ignored within mental health services.

Why have PMHS for LGB been largely ignored?

How can we account for the scant pool of research on PMHS for LGB, especially in the context of the considerable research pointing to higher prevalence of mental health problems for LGB? It seems probable that a political analysis is required to answer this question. Writing in a United States context, Meyer (2001) poses some possible problems to researching LGBT public health issues. He argues that homophobia and heterosexism place LGBT research outside of the mainstream, marginalising them in terms of allocation of research resources. Meyer also argues that even if more research were done on public health issues for LGBT, there would be risks for LGBT communities in any programmes resulting from such research. One risk is:

institutional and governmental control over the content and structure of such programs. For a stigmatized minority, this institutional control could prove limiting. The same social forces, including heterosexism and sexism that have previously led to exclusion might now lead to inappropriate and even damaging programmes.

(Meyer, 2001, p. 858)

An example of this risk is HIV prevention efforts in the United States that have “been riddled with sex-phobic messages that fail to account for the importance of sexual expression – in particular, anal sex – for gay and bisexual men” (Meyer, 2001, p. 858).

A second risk identified by Meyer (2001) is that placing sexual orientation under the lens of public health risks the re-pathologising of homosexuality. As noted earlier in relation to the discussion sections of prevalence studies, heteronormative assumptions abound in scientific practice and lend themselves to use by right wing and anti-homosexual groups. This is particularly relevant in the United States with the persistent presence of fundamentalist Christian and right wing discourses (Minton, 2002). Third, Meyer (2001) argues that a public health approach may produce research that overlooks the diversity within LGBT communities. Finally, he cautions that “the provision of institutional resources and programmes can thwart grassroots efforts, because institutions are likely to make funding conditional and more progressive efforts will be inhibited by fear of losing institutional support” (Meyer, 2001, p. 858).

In addition to the restraints on research raised by Meyer (2001), another possible reason for the limited research on PMHS and LGBT is that much LGBT mental health research has been done in the United States. Compared to other Western countries, the United States has a greater focus on private mental health services and places less emphasis on public, tax funded and free-to-user services. It is perhaps not surprising that what little research has been undertaken on PMHS for LGBT has been done in the United Kingdom, a country with a significant (yet contested) national health service which incorporates a PMHS. This is similar to the situation in Aotearoa/New Zealand where my research was conducted. So, there are likely significant sociopolitical barriers to conducting research on PMHS for LGBT. Notwithstanding these issues, let us now consider the limitations of the scarce existing research on PMHS for LGBT. Furthermore, how might these limitations relate to the history of research on mental health issues and mental health services for LGBT already discussed?

A Liberal and Private Science: Limitations of Research on PMHS and Queer People

Many of the limitations of existing research on PMHS and LGBT rest on a critique of positivist science; the science that both framed the 'homosexual' as a type of person, and has been deeply involved in the contested nature of the mental health of LGBT for over a century. In particular, I argue that positivism can work to individualise, essentialise, and make private important sociocultural and systemic issues surrounding PMHS and LGBT. At the same time I have no wish to refute the considerable value of much positivist research. I agree with Kitzinger and Coyle when they state "the oppression of lesbians and gay men can be effected by both essentialism and social constructionism alike; and equally the struggle against that oppression can make use of both (albeit logically incompatible) perspectives" (Kitzinger & Coyle, 2002, p. 21).

In considering the limitations of research on PMHS for LGBT I will restrict my discussion to the four reports from the United Kingdom (Golding, 1997; King et al., 2003a; McFarlane, 1998; A. Robertson, 1998), and Lucksted's (2004) from the United States, as these are the only research reports in the area that at least acknowledge PMHS within the scope of the research, and which make recommendations regarding PMHS. Some limitations of this research relate to its implicit use of positivist methodology. One

characteristic of positivist research is that it tends to favour quantitative data. On one level the five studies cited above, are notable in that they use qualitative data for at least part of their studies. However, when qualitative research is done within a positivist epistemology, it tends to be limited in a number of ways.

One limitation is an essentialist approach that assumes that what people say represents the 'truth' of their experience (Bohan & Russell, 1999a; Gavey, 1989). In other words, what people say is taken at face value and little attempt is made to consider how people's accounts are constructed within sociocultural systems of meaning (Gamson, 2000; Gavey, 1989; Kitzinger, 1997). Defending an essentialist approach, some argue that surely lesbian and gay psychology should allow LGBT to speak for themselves and that this is part of a process of liberating voices that science and psychology have largely silenced (for a discussion of this see Gamson, 2000). However, positivist research tends to contain implicit assumptions that can limit our ways of considering complex social relationships such as those between LGBT and PMHS. First, there is a tendency to focus attention on individuals, their attitudes, and how to change them (Burr, 1995; Kitzinger, 1997; I. Parker, 1989). In contrast, there has been less of a focus on questioning dominant sociocultural ideas and practices such as those that may operate within mental health services and within broader society (Kitzinger, 1997; Peel, 2002; Pilgrim, 1990; Stein, 1996). Consequently, dominant discourses and practices of mental health services in relation to LGBT require further exploration and challenging.

For example, because heterosexist and/or homophobic attitudes of individual staff are assumed to be the problem in mental health services, suggestions for change are based on a limited understanding of the relationship between LGBT and PMHS. Issues concerning the structure of PMHS are generally not considered. Also, research has not considered how LGB negotiate, and understand, mental health services, or how they cope with, and conceptualise, their mental health problems. Failure to ask these questions risks conceptualising LGB as passive patients within PMHS and assumes that established mental health concepts can be readily applied to LGB. The utility of this practice has been questioned by some (Gonsiorek, 1982; Kitzinger & Perkins, 1993).

The individualistic focus within positivist science engenders a related limitation within the existing research. While changes to systemic practice are suggested, barriers to change are generally not considered. This seems to be related to the liberal assumption that with

education we can simply change mental health workers' attitudes and behaviour (Peel, 2002). Perhaps because of this liberal focus, suggestions for change tend to be general and do not explore systemic restraints on individual change. For example, three research recommendations from McFarlane's study are:

Lesbian, gay and bisexual orientations should not be pathologised, ignored or denied.

LGB service users should be supported in exploring their sexual orientation if they wish.

Training needs to be given to all workers, across all sectors and at all levels.

(McFarlane, 1998, p. 122)

Similarly, King et al. (2003a) recommend that:

The core education/training and continuing professional development of health and social service professional should cover:

the relationship between sexuality and mental well being

how sexuality fits into the wider context of a person's life experiences and mental health

the increased risk of self harm and suicide in LGB people

the increased risk of substance misuse in LGB people

how to respond appropriately to LGB people in a mental health setting

(King et al., 2003a, p. 53)

The above recommendations sound useful, and may well be if implemented, however the following important questions are not considered:

1. How could mental health staff ensure they do not ignore LGB orientations?
2. How could mental health staff find out whether clients are LGB and/or whether they want to explore their sexual orientation?
3. What might impede mental health staff from identifying LGB clients?
4. What sort of training needs to be given to all workers?
5. How could mental health staff respond 'appropriately' to LGB people in a mental health setting'?

Answering these types of questions involves getting into the messy detail of how LGBT and mental health workers negotiate the relationships between each other. Furthermore, it involves looking at how the context of this relationship, within PMHS, enables and constrains both parties in this relationship.

A further assumption in much of the research and writing on mental health services for LGB is that the presence of LGB staff will necessarily improve mental health services for LGB. This assumption draws on the essentialising of LGB identities, whereby similarities and affinities between people within each identity category are assumed (Lehring, 1997; Russell & Bohan, 1999b; Seidman, 1993):⁹

If you are gay and also in the mental health field, it is important for you to acknowledge this and to use your knowledge to help lesbian/gay clients; and get hired and help other gays to get hired as a gay worker in non-gay mental health settings.

(Klein, 1991, p. 175)

Service providers should promote positive working environments which enable employees to be open about their sexuality and therefore in a position to offer empathy and support to lesbian, gay and bisexual service users.

(Golding, 1997, p. 20)

Despite these calls for LGB staff to have a specific role regarding LGB clients in mental health services, research has not explored the views of lesbian and gay staff about this possibility. In McFarlane's (1998) study lesbian and gay staff in London were asked about their views on the provision of mental health services for lesbians and gay men. However, the staff were not asked about their own role within mental health services.¹⁰ This omission limits our understanding of what it means to identify as a queer mental health professional in PMHS, and the possible implications this may have for effective service provision for LGBT.

Similarly, while LGB have been asked how they would like services to be different, the essentialising of LGB identity categories means that little consideration has been given to the significance of divergent preferences amongst LGB. For example in Golding's (1997) study, 69% of respondents said they would prefer separate mental health services for LGB, while 31% did not. How might we understand these divergent views and what might it mean for mental health service provision?

A further limitation of the positivist research on PMHS for LGBT is its largely uncritical use of identity categories (Bohan & Russell, 1999a; Gamson, 2000). Despite Kinsey's

⁹ This critique of identity politics is explored further in Chapter Four which considers a Queer discourse of homosexuality.

¹⁰ The staff included in McFarlane's study were from both public, and private, mental health services.

notion of a continuum of sexuality as early as the 1940s, most lesbian and gay psychology adopts positivist science's desire to categorise people and tends to research lesbians, gay men, and bisexuals, as if these were three distinct sexual identities¹¹ and populations. This issue of essentialising LGB identities is important and discussed further both in Chapter Three on method, and Chapter Four on discourses of homosexuality.

Reviewing specifically the four studies related to PMHS and LGBT, Robertson is aware of the importance of identity terms when he states:

The terminology used by the researcher influences the sampling and the population's perception of the researcher's stance, the use of the word homosexual having negative connotations (Donovan, 1992). This is evident in discussion over the use of terms such as 'homosexual' or 'gay' or 'men who have sex with men', (King, 1993).

(A. Robertson, 1998, p. 35)

Even though Robertson (1998) raises these issues it is not apparent how he navigated them in his research. Lucksted (2004) uses the term LGBT in her report but does not explain how this term was used in her research. The other three United Kingdom studies (Golding, 1997; King et al., 2003a; McFarlane, 1998) all seem to have used the terms lesbian, gay, and bisexual in recruiting participants, For example, in the study by King et al. (2003a), one of the inclusion criteria for the interviews was to identify as lesbian or gay. What might have been the implications of these criteria? Who might have been excluded? For example, a man who has sex with men but is in a heterosexual relationship may not necessarily identify as gay or bisexual. What might this have meant for the diversity of meanings the research produced? (Dodds, Keogh, & Hickson, 2005; Donovan, 1992; Gamson, 2000; Sell & Petruccio, 1996).

Notwithstanding the studies by Golding (1997), McFarlane (1998), Robertson (1998), King et al. (2003a), and Lucksted (2004), the small body of research on PMHS for LGBT offers limited insight into how LGBT clients negotiate relationships with staff within PMHS and on their understanding of mental health problems. We also know very little about the experiences of queer staff within PMHS, or their views on their potential role in supporting LGBT within PMHS. Furthermore, we know little about how the relationships between

¹¹ It is relevant to note here that throughout the literature, the terms 'sexual orientation', 'sexual identity', and 'sexuality' are used interchangeably. There seems to be little pattern to how they are used and I follow this multiple usage.

LGBT and staff of PMHS operate. Accordingly, the existing literature offers limited direction into specific, and systemic, practices in PMHS that could affect the provision of PMHS for LGBT internationally, or in New Zealand. While many useful sounding recommendations have been made, we do not know how to put these recommendations into practice, or how that might be for LGBT and for staff, or what might restrain such changes.

So, positivism has helped bring lesbian and gay psychology to its current position of influence within psychology, and helped achieve many important changes for queer people. However, thus far it appears limited in what it can tell us about the relationships between queer people, mental health and PMHS, and the processes by which such relationships might change. In this context there is a need for research on social and structural process involved in health care for queer people (Dodds et al., 2005), and on research that explores the relationships between social discourses and individual experience (Bohan & Russell, 1999a; Cass, 1999; Gamson, 2000). To explore these relationships requires an epistemology that explores individuals, social context, and the relationships between them. To this end, a critical social constructionism is well suited.

Chapter Two:

Queer 'Truths' Choosing Theory for Studying 'Queerness' and Madness'

Facts are not given but constructed by the questions we ask of events. All researchers construct their object of enquiry out of the materials their culture provides, and values play a central role in this linguistically, ideologically, and historically embedded project that we call science.

(Lather, 1990, p. 66)

Lather emphasises the crucial importance of language and cultural values in constructing knowledge. The central concepts of this thesis, homosexuality and mental illness, are both objects of enquiry imbued with substantial and contested cultural meanings. Battles over the status and rights of queer people continue in many parts of the world. For example, in the 2004 presidential elections in the United States, same-sex marriage was a key election issue, and in New Zealand the Civil Union Bill (2004), allowing state recognition of same-sex relationships, also caused much controversy. For instance, one political party claimed that any attempt to make homosexual relationships equivalent to heterosexual marriage would undermine the social fabric of New Zealand society (United Future New Zealand Party, 2004). Considering 'mental illness', this construct is central to an international multi-billion dollar pharmaceutical industry (Mosher, Gosden, & Beder, 2004) and many have critiqued the way current regimes of mental health diagnosis can operate to constrain peoples' lives (Duffy, Gillig, Tureen, & Ybarra, 2002; Kutchins & Kirk, 1997; I. Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995).

Given that homosexuality and mental illness are such socially significant concepts, exploring the intersections between them requires an epistemology that can navigate the relationships between individuals, institutions, and sociopolitical context. The epistemology also needs to be able to account for how certain understandings of homosexuality, and of mental illness, become more dominant than others, and the implications of these accounts for subjectivity, and for mental health practice. In the previous chapter, I argued that the existing, largely positivist research, provides a limited view on the relationships between

LGBT and PMHS, or how such relationships might change. It does this by generally taking an individualistic approach to change in mental health practice, by making essentialising assumptions about 'lesbians' and 'gay men' as supposedly homogenous groups, and by taking for granted dominant concepts and ideas within the field of mental health.

In this chapter I outline a critical (and political) approach to social constructionism and the ways in which it can enable exploration of issues surrounding homosexuality and mental illness. First I introduce social constructionism. Then I present some key Foucauldian concepts that I use in this thesis. These concepts are discourses, power-knowledge, subjectivity, and resistance. Third I briefly introduce some ideas from queer theory which are relevant to my use of social constructionism. Finally, I discuss some key critiques and political implications of the theoretical approach I utilise.

Before continuing though, it is necessary to address some issues of terminology. In the quote at the start of this chapter Lather is referring to postmodernism. Yet, the key assumptions she describes also aptly depict a social constructionist approach to knowledge. The overlaps in meaning, and in usage, of the terms social constructionism, postmodernism and poststructuralism, are considerable. For example, Burr (1995) and Gergen (1999) acknowledge how the terms 'postmodernism' and 'poststructuralism' are often used interchangeably. However, Denzin and Lincoln make the distinction as follows:

According to poststructuralism, language is an unstable system of referents, thus it is impossible ever to capture completely the meaning of an action, text, or intention. Postmodernism is a contemporary sensibility, developing since World War II, that privileges no single authority, method or paradigm.

(Denzin & Lincoln, 2000, p. 24)

Therefore social constructionism can be seen as an approach to knowledge production that has developed in the postmodern epoch and that "to a greater or lesser degree underpins" poststructuralism (Burr, 1995, p. 1). Of note, Foucault himself, did not wish to identify as belonging to a particular school of thought (1983/2003). Nevertheless, many writing within poststructural and social constructionist frameworks have used Foucault's work. In this context, and given that I am interested in how understandings and practices surrounding homosexuality and mental illness are socially constructed, I primarily use the term social constructionism or for brevity, constructionism, to refer to my chosen epistemology.

Social Constructionism: The relational construction of ‘truths’

Social order is not part of the ‘nature of things’ and it cannot be derived from the ‘laws of nature’.¹⁴ Social order exists *only* as a product of human activity.

(P. Berger & Luckmann, 1967 , p. 70, italics in original)

Social constructionism, as an approach to social science, developed from the writings of Berger and Luckmann (1967) and Kuhn (1970). “Berger and Luckmann’s anti-essentialist account of social life argues that human beings together create and then sustain all social phenomena through social practices” (Burr, 1995, p. 10). They proposed that through habituation, convention, and language, these socially constructed institutions and practices are externalised and seen as ‘objective’ features of the world. This is a direct challenge to positivist notions of essential truths. Similarly, Kuhn (1970) described the process by which ‘legitimate’ scientific endeavour is validated. In Kuhn’s view, people are inducted into the research principles of particular paradigms. Furthermore, these paradigms are not discovered; rather they are constructed and sanctioned by communities of scientists. The only way to justify ‘truth’ or ‘knowledge’ is within the rules of the paradigm. Within changing sociohistorical contexts there are ‘scientific revolutions’ and the paradigms or rules of knowledge compete and are changed. Through this process new paradigms become dominant and replace earlier ones. From this perspective, there can be no ‘true’ scientific paradigm; indeed knowledge and truth become socially mediated and, therefore, contestable objects.

Social constructionist critique has been increasingly applied within psychology (Burr, 1995; Fee, 2000b; K. Gergen, 1985, 1999; I. Parker, 1999; I. Parker et al., 1995; I Parker & J Shotter, 1990). Kenneth Gergen (1985, 1999), an important author on social constructionism and psychology, outlines some central tenets that frequently appear in various forms by those adopting a social constructionist approach to psychology. A key idea is that the language of psychology (like all language) is socially constructed, and these social processes decide which ‘truths’ count, thus laying the foundation for social action. For example, terms like ‘disorder’, ‘patient’, ‘mental illness’, all have implications for how we understand and act in regard to people experiencing mental health problems.¹²

¹² These terms are explored more in Chapter Five on discourses of mental health

Accordingly, Gergen (1985) argues that we must reflect on how we understand things and the implications of these various understandings if we wish to consider change to social practices and institutions. From this perspective, all taken-for-granted concepts in psychology become suspect; rather than supporting the status quo, constructionist psychology can become a form of social criticism. Social constructionism “direct[s] our attention to the social, moral, political, and economic institutions that sustain and are supported by current assumptions of human activity” (K. Gergen, 1985, p. 268). We can now ask of any concept and associated practices: How did this concept come to be seen in this way? What types of social relationships sustain it? What groups of people, and which social relationships does it support? And which does it suppress? What alternatives are possible? I return to these questions later when introducing the Foucauldian concepts already mentioned. With its focus on the social, historical, and culturally, located nature of knowledge, social constructionism allows us to explore the cultural formations of sexuality and of mental illness.

Homosexuality and ‘Mental Illness’ as Social Constructions

Here I briefly introduce some of the many areas where people have used social constructionism to critique prevailing concepts of sexuality and of mental illness.¹³ Many authors have used ideas consistent with social constructionism to question how widespread conceptions of sexuality function for individuals and society. Some have explored how our understandings of sexuality in general, and homosexuality in particular, are social products (Foucault, 1976/1990; Kitzinger, 1987; Sedgwick, 1990; Weeks, 1991). Others have used social constructionism to consider the implications of different strategies employed in legal battles for lesbian and gay rights (Currah, 1997; M. Rahman & Jackson, 1997). Constructionism has also been used to critique many psychological concepts and practices related to queer people. These critiques include: essentialist, Western, linear, developmental models of the coming out process for lesbians and gays that are employed by many therapists (Cass, 1999; Rust, 2003; van der Meer, 1999); the impact of essentialist assumptions about homosexuality on therapy (Haldeman, 1999; Iasenza, 1999; Russell & Bohan, 1999a; Stein, 1996; Tiefer, 1999); narrative approaches to therapy with queer people

¹³ I more fully discuss relevant aspects of this literature in Chapters Four and Five where I outline key discourses of homosexuality, and of mental health; discourses that construct the field of this thesis.

(Denborough, 2002; Logan, 2002; Simon & Whitfield, 2000); the individualising and depoliticising effects of positivist psychological research and therapy (Kitzinger, 1995, 1997; Kitzinger & Perkins, 1993); social constructions of lesbian and gay families (Clarke, 2000, 2002); and critiques of anti-homophobia training (Peel, 2002). Much of this research is relevant to, and explained further in, other chapters of this thesis.

There is also a substantial corpus of writing on the social construction of ‘mental illness’, ‘psychopathology’, and the disciplines of psychiatry, psychotherapy, psychoanalysis, and psychology. Positivist, mainstream psychological research has been critiqued as being essentialist, individualistic and often failing to take account of wider social issues (Burr, 1995; Kitzinger, 1997). Feminists have sought to illustrate the gender bias in psychological diagnoses (Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Kaplan, 1983; Kupers, 1997). For example, Borderline Personality Disorder is a diagnosis which draws attention to women’s personal ‘flaws’ and away from the significant abuse in the background of many women given this diagnosis (Herman, 1992b; Kupers, 1997). To address this issue, Herman (1992a) has suggested an alternative diagnostic term of DESNOS (Disorders of Extreme Stress Not Otherwise Specified). While maintaining the language of disorder, this suggestion attempts to shift the focus of attention onto the traumatic events that have caused mental health problems. However, Herman’s proposal has not been accepted within the DSM. Additional to these critiques of psychological ideas and practices has been the development of a sizeable movement of authors and therapists attempting to bring social constructionist ideas into clinical practice (Drewery, Winslade, & Monk, 2000; J. Freedman & Combs, 1996; Monk, Winslade, Crocket, & Epston, 1997; Neimeyer & Raskin, 2000; I. Parker, 1999; Ussher, 2000; White, 1988/89).

This wealth of constructionist research regarding mental health and homosexuality shows that social constructionism can be useful for interrogating concepts that positivist psychology generally takes for granted. For example, in Chapter One I claimed that the existing literature on PMHS and queer people generally assumes that the categories ‘lesbian’ and ‘gay’ correspond to actual groups of people with certain shared characteristics and preferences. Yet constructionism does not essentialise identities in this way (Burr, 1995; Sampson, 1993). This allows research that is more aware of its limitations. For instance, from a constructionist perspective there is room to acknowledge difference within groups that are categorised more homogenously by positivism. Similarly, concepts of ‘homosexuality’ and ‘mental illness’ are not taken for granted from a social constructionist

view. This allows for questions such as: What assumptions are built into these concepts and the social practices surrounding them? Who benefits from these assumptions and who is marginalised? How do these assumptions function for MSM? These are the sorts of questions I explore in this thesis.

Individual Experience and Change in Social Constructionism

In addition to taking a non-essentialist stance on homosexuality and mental health, another advantage of social constructionism for studying the relationships between MSM and PMHS is that individuals and their experiences are not decontextualised. Through the socially mediated process of language, all subjectivity and experience is understood as being constructed in social contexts and the contestations of power within them. For example, as outlined in the previous chapter, mainstream psychology's approach to change involves identifying people's problematic attitudes and behaviours, and then recommending modifications to them using education. While this can be a useful activity, this process tends to assume that people can know themselves in relatively straightforward ways and that they are free to change their beliefs and practices when provided with new information. Yet, Peel (2002) interviewed lesbian and gay awareness trainers and suggested that there is a tendency within such training to ignore wider social processes such as normative heterosexuality that can restrain even the most rational change. Peel's analysis asserts that instead of focussing on negative or homophobic attitudes of individual mental health professionals we need to consider the social practices that construct and perpetuate such attitudes. However, if people are a product of their social systems which powerfully restrain their behaviour and their attempts to change, how can change occur? To consider these questions I now introduce Foucauldian concepts of discourse, power/knowledge, subjectivity, and resistance.

Discourses

In any given historical period we can write, speak or think about a given social object or practice (madness for example) only in certain specific ways and not others. 'A discourse' would then be *whatever* constrains – but also enables – writing, speaking and thinking within such specific historical limits.

(McHoul & Grace, 1998, p. 31)

McHoul and Grace (1998) focus on the language-based aspects of discourse and how language constructs and limits the meanings we make of the world. Burr (1995) contends,

no aspect of human life is exempt from meaning, and the notion of discourses embraces the myriad of ways meaning is enacted. This includes such things as social interactions, clothing, architecture, town planning, the way classrooms are organised, and other institutional practices. Discourses are the fabric of how we make sense of the world and also construct the most personal aspects of our experience. Discourses then, are social, historical constructs that delimit what we can know about certain objects (I. Parker, 1997). Science, for example, is a discourse that tells us what is, and what is not, scientific. Discourses construct objects such as ‘the homosexual’ and ‘mental illness’ (I. Parker, 1997). They then construct truths about these objects that become reified as normal and natural.

While discourses construct our understanding of social objects, Foucault (1976/1990, p. 94) argues that discourses are not absolute; rather they come into being through a process of social “power relations”. There can be multiple and competing discourses on the same object, and, some discourses gain currency at the expense of others which are marginalised and subjugated (Foucault, 1980). (This point is important and explained later when discussing power/knowledge and subject positions). Discourses can also constrain our thinking so that it is difficult to think outside of them. For example, the scientific discourse has become such a dominant way of assigning ‘truth’ in the West that in most areas of life alternative discourses are necessarily seen as having less validity. Foucault showed that this notion of ‘truth’ “is supported materially by a whole range of practices and institutions: universities, government departments, publishing houses, scientific bodies and so on” (S. Mills, 2003, p. 58). For example, ‘truths’ from research based on scientific methods are more likely to be valued over ‘truths’ arising from a community-based action group or individual experience. Therefore, discourses vary in their authority (Gavey, 1989)

In summary, discourses are sociohistorical creations that construct, enable, and constrain what we can think and do in regard to the objects of discourse. What does all this mean for a research project that is interested in the individual experiences of clients and staff of PMHS, and of supporting change in their relationships with each other and within broader PMHS? To answer this question it is necessary to consider how discourses operate within Foucault’s concept of power, and its relationship to knowledge, and to subjectivity.

The Relationship between Power, Knowledge, and Subjectivity

Foucault's concept of power is markedly different from understandings of power only as something that an individual or group wields over others. Foucault (1980) referred to that sort of power as sovereign power. Sovereign power is the power that kings and queens hold over their subjects; it is a power over life or death. Foucault argued that with the rise of Western democracies a new form of power developed. Sovereign power became "one element among others" (Foucault, 1976/1990, p. 136). This new power intersected with, rather than replaced, sovereign power (A. Davidson, 1986; Gavey, 2005; Hacking, 1986). This newer form of power is not something that individuals wield over others but instead involves a web of relationships between different interests, disciplines, and discourses within a society at a particular time (Foucault, 1975/1977).

What also distinguishes Foucault's notion of power from other understandings of it is the productive nature of power. Instead of only having the power to repress, Foucault believed that power is productive, and in particular, productive of knowledge or 'truth':

Truth is a thing of this world ... Each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true.

(Foucault, 1980, p. 131)

In the 'Birth of the Clinic', Foucault (1963/1994) argued that a particular discourse of 'truth' emerged within the field of medicine. This 'truth' was defined as that which can be seen and categorised by the 'gaze', and it formed the basis of the disciplines that have become known as the human sciences (Foucault, 1977/2000c). Foucault argued that in the West, truth production "is centred on the form of scientific discourse and the institutions which produce it" (1977/2000c, p. 131). Furthermore, he argued that knowledge which gets labelled as 'truth' exerts a particular power in our society. Thus, for Foucault power and knowledge are entangled and "knowledge is not dispassionate but rather an integral part of struggles over power" (S. Mills, 2003, p. 69).

By 'knowledge', Foucault was not just referring to knowledge about things but knowledge about what it is to be a person. Foucault believed that a new type of knowledge about people developed:

A knowledge characterized by supervision and examination, organized around the norm, through the supervisory control of individuals throughout their existence. This examination was the basis of the power, the form of knowledge-

power, that was to give rise not, as in the case of the inquiry, to the great sciences of observation, but to what we call the ‘human sciences’ – psychiatry, psychology, sociology.

(Foucault, 1973/2000b, p. 59)

A key effect of this power/knowledge nexus is the production of subjects. Foucault argued that via norms generated by the disciplines such as psychiatry and psychology, power created particular categories of people (subjects). Foucault (1982/2000a) described three ways in which power makes subjects. First, knowledge about subjects must be given the status of a science; for example, the science of economics or biology. Second, subjects are divided according to categories such as sane/mad, normal/abnormal, or healthy/sick. Third, Foucault described “the way a human being [by taking up available discourses] turns him – or herself into a subject” (1982/2000a, p. 327). An example of this process is the production of the ‘schizophrenic’. First, psychiatry produces the category ‘schizophrenia’, which gets attributed to individuals. Second, this category is one of many that marks those assigned it as having a ‘mental illness’. Third, people are encouraged to adopt that description of themselves so that they can then conform to the treatments, and to lives considered appropriate for people diagnosed with schizophrenia (for critiques of the concept of schizophrenia see I. Parker et al., 1995; Read, 2004b).

As part of the process of the production of types of subjects, Foucault was interested in the ways particular discourses about people came into being and the effects they have on peoples’ lives, the way we think, the way we see others and ourselves, and the way these understandings affect our actions. Foucault theorised that once ‘truths’ about what science constitutes as ‘normal’ people are circulating, people are not only monitored by others such as institutions, but that they also monitor and compare themselves to these norms. While this may sound overly deterministic it is pivotal to remember that for Foucault, power is not just repressive; it is also productive and pleasurable:

The individual is not to be conceived as a sort of elementary nucleus, a primitive atom, a multiple and inert material on which power comes to fasten or against which it happens to strike, and in so doing subdues or crushes individuals. In fact, it is already one of the prime affects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals.

(Foucault, 1980, p. 98)

Foucault believed that people actively engage with normalising forms of power not just when they feel pressured or coerced but also because these processes of power offer them ways to feel ‘normal’ and ‘natural’. He argued that a person is ‘subject’ to power in the

sense that they are “tied to his [sic] own identity by a conscience or self-knowledge” (1982/2000a, p. 331). However, the options for subjectivity are necessarily constrained by the available discourses and the power relations in which they are implicated.

Foucault (1975/1977) referred to these monitoring and normalising processes as ‘disciplinary power’. For example, let us consider the subject position of ‘clinical psychologist’. When someone takes up this position and does the things that ‘good’ clinical psychologists ‘should’ do, they not only fulfil and reproduce the professional role prescribed by their particular sub-discipline of psychology, but they are likely to experience various other rewards. These rewards include helping people, knowing they are a ‘good’ clinical psychologist, and increased employment prospects or referrals. The power/knowledge nexus that constructs and legitimates the role of clinical psychologist constructs these pleasures. Similarly, the subject position of ‘mental patient’ can provide relief from doubt, self blame, and responsibility for one’s problems. For Foucault then, discourses operate through a power/knowledge nexus to create subjects. People’s subjectivity is then experienced and constructed in relation to these subject positions.

However, different discourses on the same object offer varying subject positions. Therefore, people’s subjectivity is constructed by multiple and potentially contradictory discourses (Gavey, 1989). To explain the complexity of subject positions, I will use an example drawn from my own experience at a New Zealand secondary school. As a young man with same-sex attraction, I was likely positioned by a conservative discourse¹⁴ of homosexuality when I was at school. This discourse was probably dominant in middle-class New Zealand at that time (late 1970s). The conservative discourse marks homosexuality with less value than heterosexuality and as something that should definitely be kept private (A. Sullivan, 1995). The subject position offered led to me feeling shameful and different, hiding my sexuality, and dating women at school. However, I felt and acted quite differently when taking up a then marginalised subject position as a gay man when visiting a gay nightclub. This later subject position was provided by the emerging equal rights discourse of homosexuality. Foucault argued that discourses offer various subject positions which provide ways for people to experience themselves and appear to others as normal,

¹⁴ A conservative discourse of homosexuality is outlined in Chapter Four

healthy, and good. Yet as this example illustrates, various discourses and subject positions are not equally available or valued.

Joan Cocks (1989) describes a useful way of thinking about subject positions. She states that differing discourses compete for our loyalty. One example Cocks gives relates well to my school experience. Cocks explains the process where people with same sex attraction may “make a show of hegemonic allegiance [to heterosexuality] to avoid those severe punishments devised for use against sexual desire at odds with heterosexual prescriptions” (1989, p. 199). Cocks refers to such people as “self-conscious loyalists” (1989, p. 198). These people know there is an alternative subject position to that of being heterosexual, but out of fear, or other strategic choice, they adopt at least an outward loyalty to a heterosexual discourse in certain contexts.

I have described only two subject positions in relation to homosexuality yet there are potentially many positions people can occupy in relation to available discourses. In this thesis, and as I will argue later, the notion of competing subjectivities is relevant for exploring the various discourses that call for the loyalty of MSM clients and queer staff within PMHS. Furthermore it is clear that these discourses do not compete on an ‘even playing field’. Accordingly, I use Foucault’s notions of discourse, power/knowledge, and subjectivity to explore how the discourses of homosexuality, and of mental illness, are constructed and the implications these have for the various subject positions that are offered to MSM clients, queer staff, and other staff in PMHS.

Resistance

If, according to Foucault, people are busy conforming to normative subjectivities and powerful discourses are demanding their loyalty, what does this mean for people’s ability to exercise agency or free will? How is change possible? For example, how can a homosexual see himself, or herself, as other than pathological? From a Foucauldian perspective, power is not absolute and “there are no relations of power without resistances” (Foucault, 1980, p. 142). In moving away from a solely repressive notion of power, Foucault did not see people as passive targets of power. Rather people are points in a web of relations of power where there is always the possibility for resistance. Foucault (1982/2000a, p. 342) argued that for power relations to operate in modern Western societies, people needed to be ‘free subjects’:

By this we mean individual or collective subjects who are faced with a field of possibilities in which several kinds of conduct, several ways of reacting and modes of behaviour are available.

(Foucault, 1982/2000a, p. 342)

At this point it is important to acknowledge that Foucault did not intend for his theory of power (and of resistance) to be applied to people in situations where they are not 'free' in the above sense. He discussed slaves as an example of people who are not free (Foucault, 1982/2000a), but this caveat could equally be applied to other contexts such as people subjected to 'gay bashings', or compulsory psychiatric treatment. Thus while language-based discourses construct our understandings of things, political, economic and other forms of power also construct and restrain the choices we have.

Even where Foucault posited that people are 'free subjects', he cautioned that we are never entirely free. We have choices but within a limited range of options. He believed that in addition to, and often in opposition to, dominant discourses, there were also "subjugated knowledges" (Foucault, 1980, p. 82); those that do not meet the requirements of normative, formal, or scientific discourses. According to Foucault (1980), these marginalised knowledges can inform us about the historical struggles between knowledges. Foucault argued that through the uncovering and re-emergence of these particular, local, and regional knowledges, resistance is possible. In particular he was interested in how these subjugated knowledges can resist the way 'truths' based on science are presented as the 'real truths' that count.

An example of resistance is the ongoing struggle over discourses of mental illness. Drug companies and the psychiatric profession advance bio-medical explanations of mental illness and, thus, the need to focus on the search for medical treatments. However, internationally, the public tend to prefer psychosocial explanations such as 'bad things can happen and drive you crazy' (Read & Haslam, 2004). In this example, the drug companies, and the psychiatric profession, have political and economic power to proclaim their view, yet other discourses enable public resistance.¹⁵ But this resistance is limited, for example, by the state (Walzer, 1986) (with the support of the medical profession and the drug companies), which can enforce medical treatments.

¹⁵ Alternative discourses to the medical one of mental health are explored in Chapter Five. These discourses are: Psy, Māori, and Critical.

So, for Foucault then, resistance is made possible as discourses compete with each other, yet, they do so in complex and often contradictory ways. For example Foucault (1976/1990) explains how in the late 19th century the medical discourse constructed a pathological discourse of the homosexual.¹⁶ This ‘sick/perverse’ subject position has implications for how homosexuals are seen by others, and for how they see themselves. On the one hand, the pathological discourse of the homosexual subject competed against earlier religious discourses whereby same-sex sexual behaviour was constructed as a sin (Foucault, 1976/1990; Weeks, 1991). However, almost simultaneous with the construction of the pathological discourse, a counter discourse emerged which, while still medical and essentialising of homosexuality, was also affirming of the rights of homosexuals to live without persecution (Terry, 1997). Foucault (1976/1990) argued that once the category of homosexual was created it opened the space for an alternative discourse of homosexuality to form, one that resisted the pathological subject position:

Homosexuality began to speak on its own behalf, to demand that its legitimacy or “naturalness” be acknowledged, often in the same vocabulary, using the same categories by which it was medically disqualified.

(Foucault, 1976/1990, p. 101)

Many people experiencing same-sex attraction then came to see themselves in terms of their sexual desires and activities and to see their identity as defined in some significant way by this. One outcome of this new category of ‘homosexual’ was the emergence of a resistant discourse of homosexual rights. From this discourse, a person could embrace a homosexual identity and fight for equal legal rights for homosexuals. This type of ‘liberatory’ action would have been less likely when there was no such category as ‘homosexual’.¹⁷ Therefore, the new medical and pathologising discourse of homosexuality competed with prior discourses of same-sex attraction, and with emerging discourses of homosexuality, each offering different subject positions. So at the end of the 19th century people could conceivably make choices between the subject positions that each of the three discourses offered.

¹⁶ This historical moment, and the subsequent emergence of multiple discourses of homosexuality, are explored more fully in Chapter Four.

¹⁷ This does not mean that without the ‘homosexual’ category, people with same-sex attraction may not have wanted nor needed liberatory action, or that this would not have taken place in another way.

Thus, in addition to the limited character of freedom and resistance within a Foucauldian view, despite our intentions, we can never be sure what the consequences of our choices will be. “People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does” (Foucault, personal communication in Dreyfus & Rabinow, 1983, p. 187). This has implications for using Foucauldian theory to consider changes to institutional practices such as in PMHS. Mills (2003) explains this point using the example of the management of government funded hospitals. While the manager of a hospital may intend for the hospital to provide excellent service, many relations of power can affect that intention. These include funding issues, community action, “constraints imposed by other agencies and constraints of previously established procedures for managing hospitals” (S. Mills, 2003, p. 51).

This elaboration of the relationship between intentionality and outcome disrupts the liberal notions of change being rational and predictable. Because this thesis is considering if change is needed, and even possible, within PMHS, it is necessary to have a theory that both allows for the possibility of change and yet cautions against seeing change as straightforward. As critiqued in the previous chapter, much existing research on lesbian and gay psychology makes general statements about affirmative change yet omits to explore the complexities of this. These complexities need to be considered in planning changes to complex power-infused institutions such as PMHS. Furthermore, Foucault's (1982/2000a) analysis of power asks us to consider how power relationships operate in institutions, while also acknowledging that such power relations arise outside the institutions. This is because “power relations are rooted deep in the social norms” (Foucault, 1982/2000a, p. 343). So, in this thesis, while I examine discourses of mental health and homosexuality in relation to PMHS, I am aware of the need to look beyond PMHS to investigate the relations of power that operate in this area.

Constructing Queer Knowledges

Foucault was a gay man and his writings on sexuality in particular have contributed much to subsequent scholarship on homosexuality (and heterosexuality). The development of queer theory has been one outcome of this (Butler, 1990; Fuss, 1991; Jagose, 1996; Sedgwick, 1990). Queer theory posits that the identity categories of ‘lesbian’ and ‘gay’ are products of binary cultural systems of meaning reproduced by institutional and discursive

practices. Sedgwick (1990) and Fuss (1991) elaborate on how homosexuality becomes the inferior partner in the binary by arguing that the homo/hetero binary operates in relationship to other binaries such as male/female, rational/emotional, strong/weak, and active/passive. This emphasising of the 'normalcy' and 'superiority' of heterosexuality has been termed 'heteronormativity' (Seidman, 1993; Spargo, 1999; M. Warner, 1993). Furthermore, Eve Sedgwick, in her book *'Epistemology of the Closet'* (1990) argues that the homo/hetero binary is a central organising feature of Western culture. By placing the homo/heterosexual binary at the centre of cultural analysis, Sedgwick argues against viewing the homo/heterosexual definition as primarily important for a relatively small part of the population (a 'minoritising view') and advocates what she terms a 'universalizing view' whereby it is of "determinative importance in the lives of people across the spectrum of sexualities" (1990, p. 1).

I outline both heteronormativity and queer theory more fully in Chapter Four on the discourses of homosexuality. Yet, it is necessary to briefly introduce them here as I frequently draw on a queer theoretical framework in the research. From this perspective, the focus is not so much on 'MSM' or 'gay men' as a minority group, but more on the social systems of meaning, "of those knowledges and social practices that organize 'society' as a whole by sexualizing - heterosexualizing or homosexualizing - bodies, desires, acts, identities, social relations, knowledges, culture, and social institutions" (Seidman, 1996, p. 13). Thus, while I am interested in the relationships between PMHS and MSM clients, I am also interested in how dominant and marginalised social constructions of sexuality are implicated in those relationships.

The Politics of Using Social Constructionist Theory: 'If it is constructed then it isn't real'.

As I have made apparent already, my intentions in doing this research are to see if practices within PMHS can be improved for MSM clients of PMHS. This is clearly a political and partial endeavour. However, considerable criticism has been levelled at the political utility of social constructionist theory and research. The criticism comes from many quarters such as feminists (Burman, 1990a; Hartsock, 1990), Marxists (Willig, 1998), and therapists (Pilgrim, 2000), and it tends to share some key features. These include a concern with relativism and what social constructionists can (and cannot) say about reality. A related

criticism is the nihilistic and apolitical standpoint assumed to flow from this relativistic approach to knowledge.

Considering relativism first, the accusation is that such an approach to knowledge means that we cannot know the truth about anything. The argument posits that social constructionism prevents us from making ‘true’ statements about such things as gender inequality, class divisions, or the oppression of other marginalised groups like blacks, lesbians and gays (Burman, 1990a; Hartsock, 1990). Critiquing Foucault’s theory of power, Hartsock argues that by having a model of power as operating across a network of social power relations “the whole thing comes to look very homogenous. Power is everywhere, and so ultimately nowhere” (1990, p. 170). Hartsock argues that viewing relations of power as everywhere, rather than wielded by particular groups over others, makes it difficult to acknowledge systemic inequality and makes it very hard for marginalised groups to make claims to truth, and to challenge power. As Burr (1998, p. 14) encapsulates, “How can we say for example that certain groups are oppressed, if these ‘groups’ and their ‘oppression’ are constructions which can have no greater claim to truth than any other?”. This question has been keenly debated amongst psychologists (see various authors in I. Parker, 1998).

Responding to the perceived ‘relativity problem’ in social constructionism, Burr (1998, p. 22) states that the concepts of ‘realism’ and ‘constructionism’ are themselves “dichotomous constructions which have limited usefulness”. Davies (1998), and Gergen (1998) also view the realism/relativism debate as a binary construction of language that is itself part of discourse. Burr (1998) argues that the ‘reality versus construction’ binary gets mis-mapped onto two other binaries. One is ‘reality as materiality versus illusion’ – this binary translates into ‘something either really exists or is just an illusion’. Second, is the ‘reality versus falsehood binary’ – this binary translates into the idea that ‘something is real and thus true or it must be false’. From this miss-mapping, Burr suggests that:

constructionism is taken as also implying illusion and/or falsehood. There is therefore a tendency to talk of things being either real or ‘merely constructed’. The constructed world thus construed is somehow less tangible, less trustworthy. It is a sham. ... Critics of constructionism here appear to be contesting the idea that the world is a figment of our imaginations and has no materiality ... which was never constructionism’s claim.

(Burr, 1998, p. 23)

The critique of social constructionism that depends on the binary of real versus constructed misses the possibility, held by many social constructionists, that things can

both be socially constructed and real (Burr, 1998; Gavey, 1989; Weedon, 1987). From a Foucauldian perspective, as noted earlier, discourses are cultural, historical, and linguistically-mediated constructions. Yet they have material affects on our lives, for how social institutions operate, and for how we experience the world and ourselves. As Gavey states “it is through discourse that material power is exercised and that power relations are established and perpetuated” (1989, p. 464). For example, the ‘homosexual’ is a constructed concept yet for a man or woman to identify (or to be identified) as a ‘homosexual’ in certain contexts can get him or her really hurt or even killed. Thus homosexuality, as a subject position, is socially constructed, yet the material consequences of this construction are very real in their material effects.

Related to the concern about relativism versus reality is the charge that social constructionism is apolitical. As already mentioned, social constructionism’s relativism makes it critical of universal statements of truth. This, for example, can make it difficult for marginalised groups to make ‘truth’ claims regarding oppression and can thus limit these groups ability to take collective action (Burman, 1990a; Burr, 1998; Hartsock, 1990). While it is accurate to say that social constructionism challenges the ‘truth’ of statements made by marginalised groups, this is not necessarily a regressive move and it does not necessarily reduce these groups’ ability to take collective action. Furthermore, a relativistic approach to ‘truth’ need not remove the political from social constructionist research. Social constructionism is not necessarily more or less political than positivism. Rather, it is how and what researchers do with their research that makes it political (Burman, 2000).

First, let us consider the ability of marginalised groups to make ‘truthful’ statements about oppression. Here I will refer primarily to feminist authors, as they have written extensively on this critique of social constructionism. Radical feminism has made many statements about patriarchal oppression of women as a group. However, radical feminism has been critiqued by many feminists for overlooking the diversity of experiences and identities between women, by homogenising and essentialising women as a group (Burr, 1998; Poovey, 1988; Weedon, 1991).

Similarly, Jagose (1996) presents a history of the critiques of lesbian and gay identity movements. These movements fought strongly for improving social conditions for lesbians and gay men. However, these political groups, like feminism, were often based on supposedly homogenous groups (of ‘lesbians’ or ‘gay men’), yet this portrayal evades the

very different ways same-sex attracted people self-identify, depending on other aspects of their subjectivity. For example, in contemporary New Zealand, the subject positions of a working class, Māori,¹⁸ takatāpui¹⁹ man and a middle class Pākehā²⁰ gay man, are likely to be very different. With a focus on multiple social positionings, such as those provided by discourses of gender, ethnicity, social class, and sexual orientation, a social constructionist critique of identity politics can reveal the potentially oppressive effects of any totalising statements or discourses, including those made by marginalised groups.

The above critique of the universality of statements made by marginalised groups does not, however, preclude collective political action. For example, feminist social constructionists have argued that, rather than searching for the essential ‘truth’ about women, it is more fruitful to look at how the multiple discourses affecting women are used (Poovey, 1988; Weedon, 1987). Through the investigation of discourses affecting women, and other marginalised groups, discourse analysis can show how things could be different and these visions can help plan political activity (Gavey, 1989; Poovey, 1988; Weedon, 1987; Willig, 1998). Additionally, Willig (1998) comments that the very choices we make over which discourses to study is a political act. So, rather than being apolitical or nihilistic, many feminist social constructionist researchers call for:

a kind of relativism or epistemological scepticism which does not eschew or efface the question of values. ... a new, principled theoretical underpinning for discourse analysis would be one in which values come to the fore, are made explicit, placed in a realm where they can be *argued* about. That is, we need a relativism which is unashamedly political, in which we, as feminists can make social transformations an explicit concern of our work.

(Gill, 1995, p. 182, italics in original)

The statement by Gill highlights the importance of researchers stating the a priori assumptions they employ in any research, and arguing for the positions they adopt in their research. The positions cannot enable claims to ‘truth’ in a positivist sense but they provide a moral/political basis for helping evaluate research. Similarly, other social constructionists argue that researchers need to be pragmatic (Burr, 1998), moral (Wood & Kroger, 2000), and strategic (B. Davies, 1998; K. Gergen, 1998) in their use of discourses to guide political

¹⁸ Māori are the indigenous people of Aotearoa/New Zealand.

¹⁹ Takatāpui is a Māori term that recognises same-sex friendship and attraction, and is inclusive of lesbians and gay men. A takatāpui discourse of homosexuality is outlined in Chapter five.

²⁰ Pākehā is a Māori term for European people.

action. Perhaps summing up a political approach to social constructionist research, Willig (1998) argues that inaction by researchers is a form of action, one that tends to lend support to the status quo:

we can only ever argue for or against, support or subvert particular practices or causes but we can never disengage ourselves from them. An attempt to disengage necessarily services to consolidate the *status quo*. ... The fact that we can never be absolutely sure about our understanding of social reality does not make our actions any less transformative of this social reality.

(Willig, 1998, p. 96)

However, Willig acknowledges that thus far “there are not many discourse analysts who have taken up the question of application [of research], and even fewer still who have attempted to formulate concrete proposals for social and psychological interventions” (Willig, 1999c, p. 9). Nevertheless, Willig’s approach to the relationship between research and the status quo is analogous to critical psychology’s view of the broader relationship between psychology and social transformation.

While there are many perspectives on what critical psychology is, or could be (see Prilleltensky & Fox, 1997; and Sloan, 2000), “critical psychologists share an interest in how power permeates professional discourse and action. Moreover, they have in common a commitment to reduce and eliminate oppression in society” (Prilleltensky & Nelson, 2002, p. 2). Kaye (2000, p. 201) elaborates on this by arguing that “psychology, far from being neutral, serves social, ideological and political interests. It privileges concepts and practices which benefit dominant groupings in society at the expense of the marginalised and less powerful”. Similarly, Sampson (2000) posits that critical psychologists should work to uncover the vested interests contained in psychological theories and practices, and to help alternative, marginalised theories and practices have a voice.

In this research I take a critical social constructionist approach to investigating the relationships between MSM clients and PMHS, and between LGBT staff and PMHS. My goals in the research are to explore how power functions in these relationships in order to highlight how dominant and competing discourses of homosexuality, and of mental illness, impact on MSM clients and on staff of PMHS. Furthermore, I want to explore the possibilities for reducing any oppressive discursive practices, particularly for MSM clients. In undertaking this research I am committed to a critical, queer-affirmative political goal. This goal assumes that the research is undertaken in a heteronormative sociocultural

context and incorporates a desire to disrupt and challenge heteronormative practices. Following these intentions, I chose discourse analysis as a methodology.

Which Type of Discourse Analysis?

Discourse analysis is part of a broader shift in the social sciences which involves exploring the power of language to construct the ways people understand and study the world (Burman & Parker, 1992b; I Parker & J. Shotter, 1990; N. Phillips & Hardy, 2002; Willig, 2001; Yardley, 1997). A key text in the emergence of discourse analysis in psychology is Potter and Wetherell's (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. Potter and Wetherell's form of discourse analysis initially focused on 'interpretative repertoires' in language use. This developed from 'conversational analysis' and involved studying the variations in the accounts people give, how their talk functions, and how talk is constructed out of existing social resources (Burman & Parker, 1992b).

Two broad strands of discourse analysis have developed in psychology (Burr, 1995; Gough & McFadden, 2001; McGhee, 2001; Willig, 2001). One approach is more closely related to Potter and Wetherell's 'interpretative repertoires'. It tends to concentrate primarily (but by no means exclusively) on the micro-sociological level and explores the "rich and varied use of language as it is produced in interactions, and highlights the rhetorical strategies people use to achieve particular ends such as justifying one's position" (Gough & McFadden, 2001, p. 49). This type of discourse analysis, focusing primarily on interpersonal communication (Willig, 2001), has been variously called 'discursive psychology' (Gough & McFadden, 2001; McGhee, 2001), 'discourse analysis in social psychology [DASP]' (Wood & Kroger, 2000), or 'discourse analysis' (Willig, 2001).

In contrast, the second strand of discourse analysis "has a more macro-sociological flavour" (Gough & McFadden, 2001, p. 52) and commonly draws on critical and Foucauldian theory. The primary focus is "upon the availability of discursive resources within a culture ... and [their] implications for those who live within it" (Willig, 2001, p. 107). Confusingly, this approach has also been called 'discourse analysis' (I. Parker, 1992, 1994), but to distinguish it from the more conversational, interpersonal strand, it is frequently referred to as 'critical psychology' (McGhee, 2001), 'critical discourse analysis' (Liamputtong & Ezzy, 2005; N. Phillips & Hardy, 2002; Willig, 2001; Wood & Kroger,

2000), or more specifically 'Foucauldian Discourse Analysis' (Kendall & Wickham, 1999; I. Parker, 1994; Powers, 2001; Willig, 2001).

Foucauldian discourse analysis (FDA) adopts a sociohistorical perspective to investigate how discourses emerge, change, and operate in a society (Kendall & Wickham, 1999; Willig, 2001). It asks "questions about the relationship between discourse[s] and how people think or feel (subjectivity), what they may do (practice) and the material conditions within which such experiences may take place" (Willig, 2001, p. 107). In other words it focuses on the relations of power between discourses, institutional practices, and the ways people are enabled and constrained by, yet also attempt to resist, discourses. People using this type of discourse analysis are often referred to as 'critical realists' (Gough & McFadden, 2001; I. Parker, 1992; Willig, 1999a) because of the way they emphasise a relationship between discourse and material reality (including social practices).

Accordingly, I chose to use FDA as it enables a focus on the issues raised in the previous chapter: discourses (such as those of homosexuality and of mental health); the implications of these discourses for subjectivities (of the clients and staff of PMHS), discursive practices (the various ways in which these discourses and subjectivities operate in PMHS), and a critical perspective (the implications for resistance and change to any oppressive practices affecting MSM clients in PMHS). FDA has also been used to explore other issues in the areas of mental health, sexuality, and institutional practices. Examples include: recovery from schizophrenia (Rudge & Morse, 2001), the use of psychiatric medication (Harper, 1999), constructions of bulimia (Burns, 2004), young women's sexuality (Holland, Ramazanoglu, Scott, Sharpe, & Thomson, 1994), secondary school bullying (Hepburn, 1997), and strategies to argue for rights for lesbian, gay and bisexual students to be safe at school (Nairn & Smith, 2003). Having chosen Foucauldian discourse analysis, the next chapter explores how I enacted and reflected on the research process.

PART TWO:

METHODS

Chapter Three:

Queer Positions

Negotiating Relationships and Analysing Discourse

No one method suits all research endeavours, rather it is important to select strategies most likely to serve identified goals (Hammersley, 1992; Yardley, 1997). My goals in this research were threefold. First, I wished to explore the relationships between MSM clients and PMHS. As discussed in Chapter One, the existing literature on mental health services for MSM has significant limitations: it generally ignores qualitative exploration of the experiences of clients in the public sector, and it tends to adopt modernist, individualistic, and essentialist assumptions in regard to sexual identities, and to understandings of mental health. This provides a limited view of the understandings MSM have of mental health problems, or of their relationship with PMHS. Furthermore, suggestions for change based on the existing research tend to be generalised, decontextualised, and lack sufficient consideration of likely barriers to change. Thus I needed a method that would allow exploration of these issues.

Second, a common idea in much of the writing on mental health services and MSM is that lesbian and gay staff will necessarily be involved in improving PMHS services for MSM. This suggestion relies on the essentialist assumption that ‘matching’ between lesbian and gay staff and clients will improve mental health services to lesbian and gay clients. Despite this assumption, there is no research explicitly exploring the ideas of lesbian and gay staff on their role in PMHS for MSM. Accordingly, I wished to investigate their views.

Third, if the research suggested that changes to PMHS might improve services for MSM clients, I wanted my research to consider likely restraints to such changes. Connected to this, I hoped my research could be used as a resource for arguing for any potentially useful recommendations in regard to the training of mental health staff in working with MSM, and in practices within PMHS which could affect MSM.

Given these goals, in this chapter I reflexively explore how I negotiated the various social relationships and meanings within the research, and how the research was constructed,

carried out and analysed. Within this I describe how I employed a queer critical social constructionist perspective and Foucauldian discourse analysis towards achieving my research aims.

Choosing Texts and Desiring Numbers: A Multi-Method Approach

Discourses are “realised in texts” (I. Parker, 1992, p. 6). For my purposes, I needed to select texts which would likely provide a window into the discursive practices within PMHS for MSM clients and for queer staff. Willig (2001) suggests that whenever a researcher is investigating a topic on which there are ‘public’ and ‘expert’ discourses (as there are with homosexuality and mental health), it is necessary to use multiple texts. Others also suggest the use of multiple sources (Liamputtong & Ezzy, 2005; Powers, 2001) in order to further the goal of “elaborating a detailed, multi-layered interpretation of a particular situation” (Yardley, 1997, p. 26).

Accordingly, I chose the following for my analysis: existing literature and research, and mainstream media texts on homosexuality, on mental health, and on the overlaps between these two areas, such as in national mental health policy documents. In addition to analysing these written texts, I conducted semi-structured in-depth interviews with two groups relevant to the research, MSM clients and ex-clients of PMHS, and queer staff of PMHS. Semi-structured interviews are commonly used in discourse analysis (I. Parker, 1992; Wood & Kroger, 2000) “and provide opportunities for the researcher and participant/s to explore areas of interest” (Gough & McFadden, 2001, p. 55). In-depth interviews are also commonly used in research on health (Bungay & Keddy, 1996; Janice M Morse & Field, 1995) and sexuality related issues (Liamputtong & Ezzy, 2005; R. Parker & Carballo, 1990; Siegel & Bauman, 1986).

The various texts described thus far have the potential to largely meet my first three research aims: to explore relationships between MSM and PMHS, to consider how queer staff are positioned within PMHS, and to consider possible queer-affirmative changes to PMHS, and any likely barriers to them. However, I was less clear that discourse analysis would serve the aim of providing a resource that could be useful in arguing for any changes within PMHS. Here, my own positionings, and those of my primary supervisor (within the discipline of psychology), further shaped the research process. Psychology is steeped in the

largely quantitative language of the scientific discourse. In this language (and the related subject position of ‘scientific researcher’), numbers count, and the textual analysis of literature, media, and a small number of clients and staff, do not seem like sufficient bases from which to advocate for change in large, modernist, institutions such as PMHS. Both my primary supervisor and I were trained in this ‘traditional’ scientific-practitioner approach to clinical psychology and research, and we thought that ‘numbers’ would add strategic weight to any recommendations which might arise from the discursive research.

This desire for ‘numbers’ within a primarily discursive research project, elicits the longstanding debate between quantitative methods (often understood as objective, apolitical, and scientific) and qualitative methods (often understood as subjective, political, and non-scientific). Yet some acknowledge that these dichotomies can usefully be disrupted (Burman, 2000; Hammersley, 1992; Yardley, 1997). Burman cautions that researchers:

should recognize their progressive politics as driving, rather than already structured within, their methods. There is indeed no necessary antithesis – in either political direction – between quantitative and qualitative research. Both are potentially as ‘scientific’ or ‘unscientific’ as each other. Rather the issue becomes how we choose to use them and what we do.

(Burman, 2000, p. 73)

Similarly, commenting on research in the area of health and illness, Yardley argues that “from a discursive perspective there is no reason *per se* why phenomena should not be described using numbers as well as words” (Yardley, 1997, p. 27, italics in original). Yardley continues, by acknowledging the potential strategic uses of quantitative research within a discursive project:

Moreover, scientific terminology, quantitative measures and statistical procedures can be viewed as a language or form of rhetoric which is very powerful in modern society (John 1992). In order to put across an argument to policy makers, the general public, or to a community of medical scientists, it may therefore be necessary to adopt this language for the purpose of persuasive communication.

(Yardley, 1997, p. 27)

In the field of sexual orientation research, Bohan and Russell (1999b) also comment that quantitative research can be usefully employed within a constructionist framework. Taking these arguments into consideration, I chose to include a survey in the research in order to provide a greater number of participants and add numerical and strategic weight to any possible conclusions or recommendations. Surveys also have the benefits of being economical, less intrusive than interviews, and anonymous (Siegel & Bauman, 1986). The

survey included qualitative as well as quantitative data (see Appendix 1). This was to enable comparison of qualitative data from the survey with that obtained from the interviews as through the use of “quantitative methods alongside qualitative analysis the rigour and credibility of both may be enhanced” (Yardley, 1997, p. 27). The survey followed typical survey conventions. However, as discussed later in this chapter, insufficient responses to the survey meant I was unable to use it in the research. Reflecting on the reasons for the low response rate to the survey connects with some of the broader issues concerning doing queer research. It is to these contextual issues I now turn.

‘Risk’ and ‘Safety’: A Queer Orientation to Research

Doing research on mental health and MSM is a potentially risky business for all involved. It involves venturing into areas known varyingly as ‘vulnerable’, ‘sensitive’, ‘hard-to-reach’, ‘hidden’, ‘invisible’ or ‘back regions’ (de Laine, 2000; Lee-Treweek & Linkogle, 2000; Liamputtong & Ezzy, 2005; Silvestre, 1999; Watters, 1993). In Chapter One I discussed numerous barriers to doing mental health research with queer people. These barriers include risks to participants, to wider queer communities, and, though less commonly acknowledged, there are also potential risks to the researcher(s), such as to their career. Risk in research can be conceptualised in many ways, including physical, emotional, ethical and professional dangers (Lee-Treweek & Linkogle, 2000).

Issues of risk and danger are traditionally hidden in research accounts (de Laine, 2000; Lee-Treweek & Linkogle, 2000), yet it is possible that some risks are brought into sharper focus when researching sensitive topics (Lee-Treweek & Linkogle, 2000). Accordingly, I now outline various methodological issues pertinent to this research, and, where relevant, consider some of the risks for all involved. The main aim was not to eliminate risk, (as this is impossible), but rather to minimise any harm from the research to participants. One way to reduce harm in research with queer people is to be cognisant of how heteronormativity impacts on the research (Herek, Kimmel, Amaro, & Melton, 1991; Honeychurch, 1996), and to resist interviewing them within a minoritising framework (Gamson, 2000), as ‘the Other’ in relation to heterosexuals (Kong, Mahoney, & Plummer, 2002).

Within a social constructionist²¹ framework, interviews are far from a straightforward gathering of data, rather they are active, social encounters whereby researchers and participants co-construct meaning within their sociohistorical locations and particular contexts (Fontana, 2002; Holstein & Gubrium, 1997; Scheurich, 1997). From this perspective, interviews can be conceived as “an interpersonal drama with a developing plot” (de Sola Pool, 1957, cited in Holstein & Gubrium, 1997, p. 120). Much of this reflexive approach to interviewing developed from feminist critiques of traditional interviewing techniques on how research can appropriate and silence women’s voices (Opie, 1992; Reinharz & Chase, 2002). Similar concerns have been raised regarding researching queer people (Gamson, 2000; Kong et al., 2002).

Following these critiques, undertaking critical social constructionist research requires the researcher to explicitly reflect on how their own relationship to the research is necessarily implicated in the production of knowledge (Fontana, 2002; Fontana & Frey, 2000; Holstein & Gubrium, 1997; Kong et al., 2002; Scheurich, 1997). Accordingly “there is no such thing as postmodern interviewing per se” (Fontana, 2002, p. 162). I will not fully explore the various approaches to postmodern interviews, instead I draw on the work of Kong et al. (2002), as they are rare in specifically considering a queer approach to postmodern interviewing. Many of their suggestions are consistent with other writers in this area (see also Fontana, 2002; Gamson, 2000; Holstein & Gubrium, 1997; Scheurich, 1997). I also contend that the issues raised in the preceding paragraphs extend beyond interviewing to broader aspects of how the research is undertaken.

Kong et al. (2002) suggest four key considerations in undertaking queer interviews. First is ‘representation’, which concerns “who is being re-presented in the interview?” (p. 245). In this regard they suggest a “greater focus on specialized and localized knowledges” (Kong et al., 2002, p. 246), and attention to the way the heterosexual/homosexual binary operates through language and constructs identities, knowledges and institutions. This means considering how heteronormativity is implicated in the research.

²¹As discussed in the previous chapter, I am employing a broadly social constructionist approach to this research. However, in the literature on conducting interviews, ‘postmodernism’ is a term commonly used to describe post-positivist or social constructionist approaches to interviewing. Accordingly, many of the authors used in this section refer to postmodern interviewing.

Second, Kong et al. (2002) raise a concern about how interview knowledge is legitimised. One process of legitimisation they describe draws on the Foucauldian strategy of exposing “how power and discourse operate together, and how subordinated knowledges can be used to resist any validity-as-authority claims” (Kong et al., 2002, p. 248). The discourse analytic approach I have used is in accordance with this. The notion of legitimisation and validity in this research is discussed later in this chapter.

Self-reflection (or reflexivity) is the third aspect of queer interviewing that Kong et al. (2002) argue is vital. They suggest that this reflection should consider such things as the context of the research and “a much fuller sense of the spaces – personal, cultural, academic, intellectual, historical – that the researcher occupies in building that knowledge” (Kong et al., 2002, p. 249). They go on to state “the doing of interviews is personal, interactional, and emotional. It is embodied work that can have implications for the researcher as well as the researched” (Kong et al., 2002, p. 250). As mentioned earlier this reflexivity is considered a critical aspect of social constructionist research and my use of it is explicated in the remainder of this chapter.

Given the contested nature of homosexuality in society, (and the moral responsibilities in any research), it is unsurprising that the need for an ethical strategy is the fourth consideration posed by Kong et al. (2002). An ethical strategy necessarily attends to minimising harm to participants (Lee-Treweek & Linkogle, 2000; Liamputtong & Ezzy, 2005; Oakley, 1981). According to Kong et al. (2002), this involves the researcher attending to issues of self-presentation, an empathic stance, and negotiation of borders and boundaries.

Having outlined Kong et al.’s. (2002) framework, I draw on their approach to reflect on the processes involved in establishing and undertaking the research. As part of this I consider some of the multiple contexts, relationships and subject positions I negotiated in the research and consider their impact on the research process. I begin by considering issues of representation in this research.

Re-Presenting MSM by Questioning Heteronormativity

In researching queer issues I am necessarily re-presenting queer people. In this sense I mean speaking as a queer person about other queer people (representing) and at the same time providing yet another public commentary on issues relevant to queer people (re-

presenting). I have already argued in Chapter One that much research on queer mental health is limited by its individualistic, essentialist and positivist framework. Furthermore, others argue that research on lesbians and gay men tends to omit reflection of how heteronormative ideas inform research questions and analyses (Brooks, 1992; Gamson, 2000; Kong et al., 2002).

Heteronormativity can affect research in many ways. In an extensive review of journal reports on gay men and lesbian women, Walsh-Bowers and Parlour (1992) concluded that attempts by researchers to be 'objective' and 'value-free' have masked and reinforced oppressive ideas and practices. For example, there is a defensive heteronormative tendency in much research to assume that the existence of homosexuality needs to be explained (Brooks, 1992; Gamson, 2000). This assumption is evidenced whenever researchers accounting for higher prevalence rates of mental health problems in queer people continue to include in their research reports explanations that frame homosexuality as a pathology or involving deviancy. One example of this was presented in Chapter One where a researcher hypothesised a similar bio-genetic link between the aetiology of homosexuality and predisposition to psychiatric disorders (Sandfort et al., 2001, p. 89). Similarly, in a recent New Zealand study, when accounting for higher rates of mental health problems in young people with same-sex attraction, the authors state:

Alternative explanations include: ... (2) the possibility of reverse causality in which young people prone to psychiatric disorders are more prone to experience same-sex attraction; or (3) the possibility that lifestyle choices made by young people of non-heterosexual orientation place them at greater risks of adverse life events, stresses and similar factors that may increase risks of mental health problems.

(Fergusson et al., 2005, p. 979)

I do not wish to reproduce heteronormative and pathologising representations of homosexuality. Therefore, a key assumption in this research is that while homosexuality is an important cultural object (with significant consequences for people and institutions), and is worthy of investigation (as is heterosexuality), the existence of same-sex attraction needs no justification. Rather, I am more concerned with the ways social constructions surrounding the hetero-homo binary might impact on the lives of MSM, on their mental health, and on their relationships with PMHS.

From the inception of the research, I reflected on how heteronormativity (and other discourses) might construct the research. One method I used when developing the

interview guidelines was to adopt a questioning style inspired by narrative therapy (Drewery et al., 2000; J. Freedman & Combs, 1996; White, 1988/89; White & Epston, 1989). Narrative therapy²² draws on Foucauldian notions of power to explore how language can construct certain versions of people's experience while subjugating others. A common strategy within narrative therapy is to talk about problems and aspects of subjectivity as if they are separate from the person (White, 1988/89). For example, instead of asking the men 'What is your mental illness?' (a question which both assumes a medical discourse of mental health and locates the problems as belonging to the individual men), I asked alternative versions such as 'How did you come into contact with mental health services?' And 'How did you understand that problem?' (see Appendixes 2 and 3 for client and staff interview guidelines). These questions assume there are multiple ways of understanding mental health problems and that people may have preferences for particular versions.

A second strategy I used to reflect on the construction of the interview guidelines was to subject them to critique by others at a gender and critical psychology group I attended.²³ For each question/topic I intended to ask about, I presented my own critique of the language used, discourses invoked, and my intentions. The group then added their critique to this. This exercise was useful and resulted in further changes to the interview guidelines.

Limits of Identity: Who are MSM?

Another effect of heteronormativity on research is how it constructs a society in which silence and invisibility are strategies MSM often utilise to maximise 'safety' by remaining in the 'closet'. Specifically this can make recruiting participants more difficult (Cass, 1999; Dodds et al., 2005). Moreover, MSM may not identify as 'gay' for reasons unrelated to issues of safety. For example, many men do not privilege 'gayness' above other aspects of their subjectivity such as ethnicity (Cutts, 1999; Eliason, 1996; Fukuyama & Ferguson, 2000; Hall, 1997; Hays, 2001; Manalansan, 1996). Accordingly, researchers have commented on the difficulty in getting broad samples of MSM (Brooks, 1992; Dodds et al., 2005; Donovan, 1992; Skinner & Otis, 1996). For instance, much research on mental health issues and MSM has been conducted with men who identify as 'gay' or 'homosexual'

²² Narrative therapy is discussed further within a critical discourse of mental health in Chapter Five.

²³ The 'Gender and Critical Psychology Group' is in the psychology Department, University of Auckland. Key staff involved are Associate Professor Nicola Gavey and Senior Lecturer Dr Virginia Braun.

and who are connected to 'gay communities' (Cass, 1999; Harry, 1986; Siegel & Bauman, 1986; Skinner & Otis, 1996). Adding to this restraint, most of the studies reviewed provided no rationale for the terminology used for sexual orientation (see Chapter One).

This bias towards researching 'gay' identified MSM is important in that it omits the wide range of MSM who do not take up a 'gay' identity. This omission has been reflected in the existing research on MSM and mental health which has generally failed to account for the diversity of MSM (Donovan, 1992; Gamson, 2000; Sell & Petruccio, 1996). Accordingly, I paid careful attention to the language used, and the methods of recruitment employed, in the research.

Literature from the HIV prevention field has helped guide the development of research materials, especially with regard to the choice of 'MSM' as an organising category for the research and an awareness of the limitations of terminology with regard to 'gay' identities. HIV crosses identity boundaries and Dowsett (1992) states that unlike other identity groups, such as these based on ethnicity, or occupation, the only thing MSM share is their sexual attraction for other men. Another possible commonality MSM may share is exposure to heteronormative and homonegative discourses (H. Campbell, Hinkle, Sandlin, & Moffic, 1983; Russell & Bohan, 1999b). As I wished to explore the impact of heteronormativity on mental health and mental health services for MSM, this was another reason to use this term in my research. Dowsett also asserts, "there is no MSM identity, like there is a gay identity. Some MSM do identify as *gay*, others think of themselves as *bisexual*, many would call themselves *heterosexual* and believe this to be the case" (Dowsett, 1992, p. 8, italics in original). Many other researchers have also adopted MSM as a term to try and overcome the limitations of sexual identities (Adam, 2000; Caceres & Rosasco, 1999; Deren et al., 2001; Doll et al., 1992; Huber & Kleinplatz, 2002; Stall et al., 2001).²⁴

Furthermore, I did not want to exclude men who experienced same-sex attraction but had not acted upon it. So in the recruitment brochures I invited participation by MSM and additionally stated that "the study also includes men who are sexually attracted to men but who have not had or do not have sex with men" (see Appendix 4 – Brochure: Adult

²⁴ In addition to using the term 'MSM' in the research resources, such as brochures and posters, I also employ it throughout the thesis. However at times I use the terms of sexual identity used by the participants I am referring to.

Clients). Similarly, I did not want to limit participation by staff to those who identified as lesbian or gay. Therefore in the staff brochures (see Appendix 5) I stated:

The study invites staff who identify (not necessarily publicly) as lesbian, gay, bisexual, transgender, or takatāpui, and staff who have same-sex attraction but do not identify with any of these terms.

(Brochure: Staff – Appendix 5)

I consulted widely in the queer and mental health communities when developing the various resources needed for the research (such as posters and pamphlets), and when recruiting for participants. Another step involved in developing the research was preparing for the interviews which I discuss now.

Minimising Risk and Maximising Safety: Preparation for the Interviews

A survey of researcher-participant relationships in 351 empirical journal reports on gay men and lesbians found that often little feedback was given to participants, that the researchers' sexual orientation was rarely stated, and that research reports "almost never indicated using data to promote social action" (Walsh-Bowers & Parlour, 1992, p. 93). Walsh-Bowers and Parlour (1992) advocate a more feminist, democratic, participatory approach to research with lesbians and gay men. Similarly, others have commented on how when doing research with disadvantaged populations, a sense of reciprocity between researchers and participants is often important (Liamputtong & Ezzy, 2005; Warr, 2004).

Considering these issues within queer research, Kong et al. (2002, p. 251) suggest that interviews often need to be conducted with a "gay and lesbian sensibility" which enables the participants to feel safe. Furthermore, interviews can be "emotionally charged experiences for everybody involved" (Warr, 2004, p. 584). Also, it seemed important to consider that MSM clients may experience the interviews as distressing. Using euphemistic and medical language to acknowledge this situation, Morse describes interviews with people with psychiatric illnesses as "interactionally compromising endeavours" (2002, p. 318).

Bearing these concerns in mind, I took the following steps to prepare for the interviews. I offered participants the opportunity to conduct the interview in a setting suitable to them. I invited them to review a copy of the interview transcript for checking and for their own personal interest. For the MSM clients and ex-clients, accompanying the Participant Information Sheet (see Appendix 6), I provided a resource sheet (see Appendix 7) to each

participant which gave information on where they could seek further support in the queer community should they wish to do so. As an additional precaution, I obtained the consent of the counselling service (*The Burnett Centre*) of the New Zealand Aids Foundation (NZAF), to provide counselling for any participants who might wish it following the interview. I also offered to send a summary of the research results to any participant who wanted it.

In the brochures inviting participation I stated that the research was looking at the possible effects of social marginalisation on MSM, and that the research “may also help in the design of social policy and other health promotion initiatives for men who have sex with men” (see Appendixes 4, 5 and 8). My intention here was to make explicit the homopositive goals of the research. For similar reasons many have recommended that queer research be done by queer researchers (L. Brown, 1989; Heaphy, Weeks, & Donovan, 1998; LaSala, 2003; Minton, 1997). Therefore, in the recruitment brochures I also stated that “the research is being conducted by a gay male psychologist”.

This self-disclosure of significant aspects of the ‘self’ by the researcher arises from a feminist tradition aimed at increasing a sense of ease and trust within interviews (Fontana, 2002; Oakley, 1981; Reinharz, 1992). This is especially important when doing research with ‘hidden’ or minority groups (Liamputtong & Ezzy, 2005; Power & Harkinson, 1993), and has also been recommended for research with MSM (Kong et al., 2002; LaSala, 2003; Siegel & Bauman, 1986). For example, Kong and colleagues report on research with gay couples where the participants felt a need to know where the researcher was ‘coming from’ before they would participate (Mahoney, 2000, cited in Kong et al., 2002). Similarly, Kong et al. (2002) suggest queer researchers adopt an “empathic emotional orientation during the interview process” (p. 252).

Establishing Relationships and Negotiating Multiple Positionings

As already mentioned I wished to interview a broader range of queer staff and MSM, not just those who identified as ‘gay’ or ‘lesbian’. Previous research aiming for MSM has found a need for diverse methods for inviting participation (Fisher, Ryan, Esacove, & Bishofsky, 1996; Sell & Petruccio, 1996; Skinner & Otis, 1996). Accordingly, I approached multiple sites

to recruit MSM clients and ex-clients. Before engaging in any recruitment, ethical approval was obtained from the relevant ethics committees.²⁵ This also included gaining the approval of the clinical directors of the three district health boards involved in the research. Advertising for queer staff was done through mental health sites, and professional and social networks to which I belong. I will now briefly describe these sites and the relationship issues they engendered.

Mental Health Sites

Brochures and posters were provided in waiting rooms of eight community mental health centres (CMHC's), and three child and adolescent mental health centres, covering the three District Health Boards in Auckland. Gaining access to these services involved meetings with each of the centre managers. I also attended staff meetings at each of the eleven centres to explain the research, ask for their support, and answer any questions. In all these meetings I privileged my positioning as a psychologist working within PMHS. Sometimes sensing wariness from staff, I explained that my intention was not to criticise staff but to explore how well 'we' as PMHS met the needs of MSM clients. In these contexts I positioned myself as a scientist-practitioner investigating the needs of an 'at-risk' group. I also emphasised my location as a fellow staff member of PMHS, rather than highlighting my queer positioning. A further mental health forum I accessed was through presenting on *Access Radio 'Take it from us'* – a community radio programme run for, and by, users of mental health services.

One issue which arose in the liaising with PMHS was difficulty gaining access to some of the child and adolescent services. Despite numerous attempts, one centre did not give permission and did not provide any reasons for this. Another centre allowed me to provide staff with brochures, who could in turn offer them to clients. Yet they would not allow me to place brochures in the waiting room. They argued that providing information about homosexuality in the waiting room may harm their already difficult relationships with parents of the young people they saw. The staff said this apprehension was heightened by adolescents and young children sharing the waiting room. Some staff of child and adolescent services were also concerned that the phrase 'men who have sex with men' was

²⁵ The Northern X Regional Ethics Committee (formerly known as the Auckland Ethics Committee) approved this research.

too sexually explicit. In order to access the child and adolescent services I had to develop an alternative brochure for child and adolescent services which primarily involved changing the language from ‘men who have sex with men’ to ‘gay men’ (see Appendix 8, Client Brochure – Youth Version). As discussed already this change in language may have had an impact on which young men replied.

Given the silence I had observed surrounding homosexuality while working in PMHS, and the findings of the existing research on queer issues in mental health services, I imagined that raising this issue with staff might provoke some anxiety for them. In particular I imagined that they might be uncomfortable and/or uncertain about how to respond if clients asked them about my research, or about queer issues. To help allay these concerns I provided a letter (see Appendix 9), introducing the research to all staff in the 11 mental health centres involved in the research.²⁶ I also provided them with the list of queer community resources that I gave to client participants (see Appendix 7). Both were distributed by managers to staff.

Queer Community Sites

I also put brochures and posters in various queer community sites. These included: the two main sex-on-site venues at that time, the *Pride centre*, *Rainbow Youth*, *Hau Ora Takatāpui* (a Māori team within the NZAF), *the Burnett Centre* (the counselling service of the NZAF), and general practitioners, counsellors and therapists, known to serve the queer communities. I also advertised in queer media. This included being interviewed on two episodes of *‘Queer Nation*, the national queer television programme in New Zealand at the time²⁷. I also had one article and one paid advert in *‘Express Magazine’*, the national queer community newspaper, and had articles in the *Pride Centre* (a queer community centre) and *Rainbow Youth* newsletters. Additionally, I advertised on a NZ Queer studies e-list. When negotiating these relationships I drew on and foregrounded my existing relationships in, and membership of, the wider queer community, more than my professional identity as a clinical psychologist within PMHS.

²⁶ This letter stated that the client interviews would be conducted first, followed by the staff interviews. However, due to the time it took to recruit client participants, this order was subsequently changed and all staff were informed of this.

²⁷ During the course of this research, *Queer Nation* stopped broadcasting.

The Participants

To participate in the research clients and staff could contact me directly; if they agreed, both were sent a participant information sheet (see Appendixes 6 and 10). The clients were also sent the survey (see Appendix 1) on which they could indicate if they were willing to be interviewed. Before commencing the interviews, consent forms (see Appendixes 11 and 12) were signed by both clients and staff. Recruitment was much easier for staff than clients. Twelve staff offered to participate fairly quickly. There were five women and seven men. Eight of the staff worked in adult mental health settings and four in child and adolescent services. The range of disciplines and roles included psychology, social work, psychotherapy, occupational therapy, nursing, management, and psychiatry. All the staff were European (Pākehā). Six of the staff were known to me from previous work or social contacts.

In contrast, recruitment of clients was much slower and took 11 months from early July 2002 until the end of May 2003. Altogether 19 completed questionnaires were returned and 18 MSM agreed to be interviewed (one of whom did not complete a questionnaire). However, two of these men were not interviewed and three interviews could not be used, leaving 13 MSM whose interviews were used in the analysis. I now briefly explain why five of the men were not included in the analysis.

One man agreed to participate but the day before the planned interview he phoned me very distressed saying he wanted to do the interview over the phone as he thought he might die soon. I did not agree to do a phone interview with him because he seemed too distressed but I did write down a brief account which he said was very important for me to hear. This account was not included in the analysis as, given we did not meet and did not actually do an interview, this man did not sign a consent form. Another man wished to participate but was in a forensic psychiatric unit and, under the terms of his placement there, he was not permitted to take part. Of the three interviews that could not be used, one man requested the interview end after about half an hour. (Issues surrounding this interview are discussed later in this chapter under the heading '*Client Interviews*'). For ethical issues, and following consultation with my supervisors, I cannot give more information about the other two interviews that were not used.

Of the 13 men included in the analysis, all identified as European or Pākehā, and of those one additionally identified as Samoan, and one as Māori. Part of my responsibility as a

health researcher in New Zealand is to try and ensure the research is accessible and appropriate for Māori, and that it is supportive of improving Māori health and wellbeing (Health Research Council of New Zealand, 1998). This responsibility also recognises the importance of the Treaty of Waitangi²⁸ as forming a basis for partnership between Māori and Pākehā (Health Research Council of New Zealand, 2005). As part of this I consulted with staff of *Hau Ora Takatāpui* (a Māori team within the NZAF). I also consulted with managers of Māori mental health services within PMHS. Accordingly, one of the criteria for participation was that participants speak English or Māori. Additionally I had arranged for Māori translators if needed. However, the Māori man who participated did not request to do the interview in Māori. The participants ranged in age from 19 to 64 (but with nine of them being over 40). Nine had incomes of less than \$20,000 per year (a very low income bracket in New Zealand).

The men had used various combinations of PMHS including inpatient, crisis, and community based services. All but two of the men reported having attempted suicide at least once. While I did not attempt to verify any diagnoses the men had been given, the range of diagnoses they reported included posttraumatic stress disorder, depression, paranoia, manic depression, bipolar disorder, schizo-affective disorder, psychosis, and schizophrenia. Seven were clients of PMHS at the time of the interview, and six were ex-clients of PMHS. However, some of those were involved in other services at the time of the interview, such as alcohol and other drug services, the *Burnett Centre* (a counselling service of the NZAF), or private counsellors.

Before discussing the interviews I will consider the low response rate to the questionnaire, and the slow process of finding participants willing to be interviewed. There are several possible explanations. First, MSM clients of PMHS are likely to be a doubly marginalised group, stigmatized both for experiencing mental health problems and by the effects of heteronormativity (Golding, 1997; Hellman & Klein, 2004; Lucksted, 2004). This positioning may make it seem like a riskier practice for men to come forward and be interviewed and was highlighted for me in the interviews. While I made it clear in the brochures and Participant Information Sheets that I am gay, many of the participants still

²⁸ The Treaty of Waitangi was signed between the British Crown and most of the Māori chiefs of New Zealand in 1840. It is often considered a founding document that among other things establishes the basis for a partnership between Māori and Pākehā (see R. Walker, 1990, for a discussion of the pervasive role of the Treaty in New Zealand politics).

checked this out with me, either on the phone or before the interviews began. Similarly, there was a very high degree of concern about confidentiality and I had lengthy discussions with participants about it before audiotaping began.

Second, some literature suggests that men are less likely to come forward and ask for help for, or talk about, mental health problems (J. Campbell, 1996; Komiya, Good, & Sherrod, 2000; McCarthy & Holliday, 2004; J. Robertson, 2001). Taking this into account, along with the stigmatisation of MSM with mental health problems, it is perhaps not surprising that other research in this area has obtained fairly small samples of men. I have only been able to find two other studies internationally with a similar client group as their focus. Both of these studies were in the United Kingdom which has a population of approx 60 million whereas New Zealand has a population of just over 4 million. The first of these studies (Golding, 1997) used a national mental health organisation to distribute brochures to 7500 households, 1500 advisory networks, 40 Community Health Councils, and to many lesbian, gay and bisexual support services. That study only recruited 27 men. Similarly, a London based study (McFarlane, 1998) only recruited 14 MSM and this study included men using a much broader range of services than PMHS (for instance, it included queer community support services, and general practitioners).

Considering both of the above points, in hindsight I think that my initial hopes of recruiting enough MSM for a survey were overly optimistic. I assumed that New Zealand's more tolerant social climate meant that a higher response rate would have been possible. Yet, given that this research was undertaken and completed by myself alone, and in a city with a much smaller population than London, or the United Kingdom, comparatively speaking, the response rate could be considered good.

The Interviews: Challenging Balancing Acts

In this section I reflect on how I negotiated the interviews with the clients and the staff. I show that this process required my dealing with challenging situations and balancing multiple subject positions:

Qualitative researchers generally understand well that they are the instrument of the research ... less attention, however, is given to the implications of this for qualitative researchers engaging on an interpersonal level with research participants. This can be an incredibly intense and, occasionally, emotionally wrenching experience.

(Warr, 2004, p. 579)

The relative lack of consideration given to the qualitative research process in research reports adds to the difficulty in anticipating the risks and challenges that can arise (Lee-Treweek & Linkogle, 2000). Furthermore, it is difficult to foresee the “multiple and overlapping roles and various types of relationships (power, intimate, social), and the necessary negotiations between self and others in professional and power relationships in fieldwork” (de Laine, 2000, p. 37). Accordingly, in this section I show that while I took considerable steps to prepare for the interviews, and to reduce risks for participants and myself (as described earlier), I was nevertheless surprised by some of the unanticipated challenges.

Despite all the preparation I did for the interviews, I was unable to anticipate the complex nature of the interviews and the multiple positions they engendered. Within a postmodern approach, interviews are an active co-construction of meanings, and the traditional “boundaries between, and respective roles of interviewer and interviewee ... become blurred” (Fontana, 2002, p. 162). Using more psychological language within a postmodern critique of interviews, Scheurich states that “the complex play of conscious and unconscious thoughts, feelings, fears, power, desires, and needs on the part of both the interviewer and the interviewee cannot be captured and categorized” (1997, p. 73). The multiplicity of subject positions that researchers and participants occupy interrupts any notions of straightforward matching in research, such as those promoted by feminist researchers. For example, class, nationality, gender, and ethnicity can impact on the research (de Laine, 2000; Heaphy et al., 1998). Similarly, within research from a queer perspective, the identity of the ‘gay researcher’ is like all queer subjectivities and:

is neither unitary nor stable; in its place, increasingly, is a “growing focus in lesbian [and gay] ethnography on the permeability of both communities and identities and on our expanding awareness of the instability of identity, particularly in complex cultural settings”

(Lewin, 1995, p. 332)

From this perspective, my ‘insider’ status as a ‘gay researcher, is far from complete and it is important to consider how I am also ‘outside’ of, and different to the subject positions of the participants (LaSala, 2003).²⁹ This multiplicity of subject positions was reflected in my experience of the research.

²⁹ In an article on issues regarding lesbians and gay men doing research with lesbian and gay communities, LaSala (2003, p. 23) discuss the notions of lesbian and gay researchers being “both insiders and outsiders” in

The Staff Interviews: Researcher/Colleague/Activist

I interviewed the staff first. Before starting the interviews I undertook an observed pilot interview. This helped clarify the types of questions I asked. It also gave me useful feedback on how the interviews may be both similar and different to therapeutic interviews I was used to (this issue is discussed later). With the staff participants I shared a non-heterosexual sexuality and employment status as a clinician within PMHS. Some of the staff were colleagues and/or friends. Yet complicating these similarities and prior relationships were noteworthy differences. Occasionally I felt that staff saw me as a radical activist intent on criticising their practice and their workplace. For my part, (and especially in the earlier interviews), occasionally I found myself surprised and unsettled when staff spoke in ways which to me seemed to privilege medical explanations of mental health problems over heteronormative and other psychosocial accounts. This was an example of the 'baggage' I brought to the interviews (Scheurich, 1997). Adding to these tensions were discipline based ones. For example, sometimes medically trained staff made comments suggesting that they thought that my training as a clinical psychologist would mean I took a particular and differing view from them on certain issues. In some instances, this was the case.

A strategy I used to reflect on these various relations of power in the interviews was to develop and complete a form (see Appendix 13) to facilitate a reflective review after each interview (Bungay & Keddy, 1996; Warr, 2004). This review included contextual information, my overall impression of the interaction, how I could improve my interviewing, and any main themes and discourses emerging. I also used this review process after each interview with the clients, and it was in these interviews with MSM clients, and ex-clients, that the multiple positionings in the research highlighted the ambiguity of the interview relationship (Heaphy et al., 1998; Warr, 2004). This ambiguity and the challenges it brings to researchers is often omitted from research accounts (de Laine, 2000; Warr, 2004). My intention in exploring it briefly here is twofold. First I wish to reflect on how it might have impacted on the research and, secondly, I believe discussion of these issues may make researchers better prepared for working with them in future.

relation to the communities and participants they study. However, I include this comment to acknowledge that LaSala does not use a social constructionist perspective to theorise this. Nevertheless, his article is useful for considering some of the advantages and disadvantages of a partial 'insider' status as a researcher.

The Client Interviews: Researcher/Gay Man/Therapist

I observed three subject positions which produced ambiguity for me in the client interviews. These were researcher, gay man, and therapist. As mentioned already for the purposes of the research I chose to identify as a gay man. From this position I began the research expecting to share some similarities with the clients. While I have not been a client of PMHS, I have attended therapy, and have at times experienced distress due to heteronormativity. My sense of shared experience with clients did seem to improve the interview relationship, mainly by helping to develop a context of familiarity and safety for the clients (and perhaps also for me).

Yet researcher/participant similarities also produced limitations. Sometimes I thought the client participants' wanted to feel understood and approved of by me as a gay psychologist. This sense, along with my empathy, invited me to offer validation of their experience and self-disclosure of my views. At times I worried that self-disclosure on my part might work against the goal of the interviews creating a space whereby the participants could provide their own accounts. However, along with the use of self disclosure and an 'empathic emotional stance' (discussed earlier), others, especially feminists, have suggested a need for acting on this sense of mutuality and reciprocity within interviews (Aitken & Burman, 1999; Bergen, 1993; Daly, 1992; Kong et al., 2002; Oakley, 1981). In this framework, using and sharing aspects of my gay subjectivity that were similar to participants helped the interview relationships. At the same time I was constantly aware of the need to temper self-disclosure and to question who's needs would be met if I chose to self-disclose (Aitken & Burman, 1999; D. Payne, 2002). For example:

Rick Yeah, I guess that's why I've told my friends and my family because I mean I've been there, you know what I mean. I mean I don't exactly, if I make a new friend I don't exactly say, you know, I'm gay, right away. It takes a little while to build trust and you've got to know how they are going to react.

DS Yeah, been there done that.

Rick Yeah. You've got to test the water and think right [client].

Here, my self-disclosure was to acknowledge and validate the process of coming out that Rick was discussing, while also keeping my disclosure brief so as not to overly move the discussion to my experiences as a gay man.

There were additional aspects of difference in the interviews between myself and the clients. These included ethnicity, age, divergent forms of masculinity, differing relationships

to the research, differing positionings within PMHS, and differing interpersonal styles. Navigating the challenges posed by these differences relates perhaps more to the subject position of therapist, which is very familiar to me. In my work as a clinical psychologist I frequently meet with people and discuss their experiences. Within my clinical practice, I am acutely aware of the power relations between clients and therapists and utilise various strategies to work with these dynamics. I was also aware of literature acknowledging how research participants can be vulnerable within the research process (Liamputtong & Ezzy, 2005; Opie, 1992; Warr, 2004). As already discussed, I specifically explored how this issue might impact on the interviews when I did the pilot interview.

On reflection I had not anticipated some of the ways that being a therapist doing research interviews with clients might be challenging for me. Thus, like Payne (2002, p. 44) I “query the automatic assumption that the researcher [necessarily] has more power in the interview”. From a postmodern perspective Scheurich (1997, p. 71) argues that “interviewees are not just the subjects of researcher dominance, they are also active resisters of such dominance ... They in fact, often use the interviewer as much as the interviewer is using them”. Furthermore, Scheurich (1997, p. 72) proposes the concept of “chaos/freedom” to acknowledge the multiplicity of occurrences in interviews that evade the dominance/resistance binary. Thus, while the therapist subject position provides many guidelines enabling me to set limits for my own comfort and safety within therapeutic sessions with clients, similar guidelines are not so available for the role of researcher.

Some have commented on the potential “in-built therapeutic dimension” within interviews (Opie, 1992, p. 64), and the possible role conflict and overlaps between research and therapeutic interviews (Aitken & Burman, 1999; Daly, 1992; de Laine, 2000; Hutchinson & Wilson, 1994; Rosenblatt, 1995). Complicating matters further, interview participants interpret interviewers in multiple ways (Jorgenson, 1991). Hutchinson and Wilson (1994) compare therapeutic and research interviews. They argue that similarities include the need for rapport and reflexivity during the interview. Yet key differences are that in a research interview there is usually less explicit discussion on the process of the interview and on the giving of advice or information.

These differences, combined with the overlap between research and therapeutic interviews, at times proved problematic for me (and possibly for the participants). For example, on occasion, when asking the client participants about sexuality and/or mental health issues

they would ask me to answer the question as they were unsure how to answer it themselves and saw me as the 'expert'. These moments were familiar to me and elicited my therapist positioning. I tried to deal with these requests by reminding them that the interview was about their ideas not mine. However, out of empathy and respect, and driven by a sense of reciprocity, I would sometimes answer their questions. My desire to provide answers was exacerbated by knowing that this was the first time some of the men had the opportunity to talk to another MSM, let alone one who was also a mental health professional. In these moments my positioning as therapist and gay man invited identification with them and a desire to express that identification. Others have noted the risk of the identification that can arise from similarities between researchers and participants (Daly, 1992; Heaphy et al., 1998; D. Payne, 2002; Siegel & Bauman, 1986).

Another issue that arose concerned sexual attraction. This is usually omitted from discussions of research (Heaphy et al., 1998; Kong et al., 2002). One participant asked for an interview to end part way through when he felt disturbed by hearing noises from a class finishing in an adjacent room (this interview was not included in the analysis). He then disclosed his sexual attraction to me when I was driving him home, told me his attraction had distracted him during the interview, and that he wanted to do the interview again in a park where no one would be around. I did not agree to do the interview in a park and used humour to acknowledge and deflect his attraction.

The reader may be wondering why I have described in some detail these various discomforts I encountered in the interviews. First, it is part of the process of employing reflexivity and an ethical stance in the research (Kong et al., 2002). Second, as mentioned already, there is insufficient discussion of these issues in research reports. I hope that by sharing these dilemmas I support further consideration of these issues. The intention is not to eradicate complexity from interviews, (an impossible and, I would argue, undesirable goal), but to alert new researchers to the sorts of issues they may well face. On reflection, some of the most uncomfortable aspects of the interviews were not so much what happened but my not having pre-empted or considered fully the complexities of negotiating the multiple positionings and interpersonal challenges that might arise. An overall strategy I learned to adopt in the interviews is summarised well by de Laine (2000) when discussing the broader topic of qualitative fieldwork:

The fieldworker is sometimes required to perform a delicate balancing act to meet the obligations and responsibilities owed to various parties, and still

promote their own research agenda. The fieldworker might be required to balance involvement with detachment, familiarity with strangeness, and closeness with distance; the fieldworker needs to be flexible, creative and willing to experiment with role and able to withstand the insecurity that can come from the indeterminacies of the field.

(de Laine, 2000, p. 119)

Preparing Texts for Analysis

When including data in the thesis, I have borrowed some of the conventions used by Potts (2002) and Potts et al. (2003). The insertion of three consecutive dots ... between words indicates that a portion of the speech has been omitted. Like Potts et al. (2003):

[I] have omitted word repetitions and all speech hesitations (i.e. all terms such as ‘um’ and ‘ah’). Quotations selected for the purpose of illustration are particularly characteristic of the discourse[s] related to the point under discussion. In light of this, multiple excerpts from a single interview may be presented because they are particularly illustrative – chosen because of the ‘typical’ form of expression of a view on a certain issue (a view also shared by other participants).

(p. 701)

Where multiple excerpts from a single interview are presented, I also separate each excerpt by three dots, but with the addition of square brackets [...]. Various researchers omit some of the messiness in interview data (J. Potter & Wetherell, 1987; Potts, 2002; Warr, 2004) as “for many sorts of research questions, the fine details of timing and intonation are not crucial, and indeed they can interfere with the readability of the transcript” (1987, p. 166). Similarly, Potts (2002, p. 12) argues that including all the details of speech can interfere with the deconstructive focus of discourse analysis, which is “to elucidate how language and culture constructs, and limits or enables ideas, understandings, and experiences”.

Ode to the Transcriber

While research reports often include the transcribing conventions used, transcribers and their role in the research receive little mention (Warr, 2004). “Transcribing is often deemed a clerical or technical task and, therefore, peripheral to the research process. Transcribers however, are not immune to the power of the stories they hear” (Warr, 2004, p. 585). Reading Warr’s article, I reflected on the woman who transcribed all the interviews. Often when collecting transcriptions from her, she would comment on, and we would briefly discuss particular stories that had touched her. While I appreciated her thoughtfulness towards the participants, I did not fully consider what her needs in the research process

might be. Cognisant of this issue Warr (2004) suggests that it can be useful to offer transcribers debriefing and the opportunity to be kept informed of major research events such as the launching of reports. My transcriber expressed an interest in the outcome of the research and I have agreed to give her a copy of the thesis when completed.

Doing Foucauldian Discourse Analysis

Given Foucault's resistance to specifying a method, the ensuing diverse approaches to discourse analysis, and the broad scope of its objects of study, it is unsurprising that there are numerous approaches to doing a FDA. Due to space limitations here, I will not review in depth the methods commonly offered for doing such an analysis.³⁰ Instead I will describe the steps I used and my reasons for using them. Mainly, I draw on ideas from I. Parker (1992, 1994), (a key advocate of critical approaches to discourse analysis), and Willig (1999b, 1999c, 2001), who has written about both doing, and applying, critical forms of discourse analysis.

Identifying Discourses and Subject Positions

A first step in doing FDA is to identify the discursive objects of study (I. Parker, 1992; Willig, 2001). In this research key discursive objects are homosexuality and mental health. Second, many advocating FDA recommend doing an historical analysis of how and where discourses emerged, and how they change (Kendall & Wickham, 1999; I. Parker, 1992; Powers, 2001). Third, it is necessary to identify the multiple discourses which construct what appears as the same object in different ways (for example 'gay man' or 'sinner'), and fourth, to investigate how various discourses relate to each other (I. Parker, 1992; Willig, 2001). A fifth step in FDA requires identifying the subject positions offered by discourses (I. Parker, 1992; Willig, 2001). This means exploring what types of people and what speaking rights discourses construct - for example 'patient' and 'survivor' conjure up different notions of what it might entail to be a user of mental health services.

In Chapters Four and Five I present these steps in my analysis. I identify key discourses circulating in New Zealand on homosexuality and on mental health. While numerous

³⁰ Readers interested in exploring some of these suggestions in more detail may consider I. Parker (1992, 1994), Willig (2001), Kendall and Wickham (1999), Powers (2001) and Carabine (2001).

authors have written about both these topics from social constructionist and poststructuralist perspectives, I was unable to locate any who had clearly delineated the various discourses of homosexuality and of mental health, or the various subject positions they offer. Furthermore, the existing literature is generally not situated in New Zealand. Accordingly, for each discourse identified I have:

1. Described the discourse
2. Explored its historical emergence
3. Considered its circulation in New Zealand and begun to consider its relationships with other discourses. These relationships are explored more fully in the Chapters Seven to Eleven which present analyses of the interviews with clients and staff.
4. Identified the various subject positions it offers

This analysis necessarily means placing a spotlight on particular aspects of subjectivity, and in the process, potentially marginalising others. These discourses of homosexuality and of mental health are not exhaustive and I acknowledge that there are many other discourses that vie for human beings' loyalty, for example, discourses on ethnicity, gender, class, and (dis)ability. Rather, I have focussed on the discourses that appear most evident in my reading of the data. Therefore, I wish to acknowledge that this analysis is necessarily partial and many other discourses will influence the subjectivities and practices discussed in this thesis.

Analysing Discourses in Action

In addition to identifying the emergence and changing character of discourses and the subject positions they offer, Parker (1992) suggests that FDA should focus on how discourses are implicated in supporting institutions and reproducing power relations, and how discourses have ideological effects. This stage of FDA engenders questions such as: How do particular discourses support particular institutions?, How do discourses challenge institutions?, What power relations are reproduced by certain discourses?, Who benefits and who is disadvantaged by these?, and What opportunities are there for resisting power relations? These are the sorts of questions I ask in Chapters Seven to Eleven which analyse the interviews. Using this critical perspective to FDA, I consider how discursive power relations within PMHS reproduce heteronormative practices which operate to continue the subjugation and marginalisation of some MSM clients.

Explicating discursive power relations involved repeated readings of the interviews. First, I looked for all instances where participants discussed particular issues (such as if, and how, sexual orientation was relevant to their identity, or if, and how, clients thought sexual orientation was acknowledged by staff). These instances were then sorted into topic headings in separate documents. Next, I re-read these collections of text looking at the various discourses being invoked in each. I was especially interested in how discourses construct different understandings and practices, and also in people's attempts to resist certain discourses. As well as this I looked for the often contradictory ways people's subjectivity is constructed by discourses. Accordingly I searched for any inconsistencies in the way individual clients or staff spoke about any given issue. Additionally, I looked for similarities and differences within, and between, each of the two groups interviewed, in the ways they talked about particular topics, or practices within PMHS.

Challenging Practice by Producing Local and Partial Knowledges

Having described how I analysed the interviews, I now consider what types of knowledge such a method can claim to produce, and what strategies are useful in validating and accounting for this knowledge. "The criteria for evaluating validity are determined by the evaluator's epistemological perspective" (D. Payne, 2002, p. 52). Therefore, I need to begin by returning to the epistemological foundations of FDA. A critical social constructionist approach cannot, (and does not intend to), produce objective truths. "Because discourse is socially constructed, it has shifting and multiple meanings" (Wood & Kroger, 2000, p. 166). Therefore "it does not make sense to ask if our analyses are valid in the sense that they are true, that is, that they correspond to an independent world" (Wood & Kroger, 2000, p. 167). Furthermore, the researcher is necessarily deeply implicated in the production of knowledge (Yardley, 1997). Therefore, instead of using 'objectivity' to guide any assessment of validity, new goals, and strategies must be used (Lather, 1993). There is clearly no one way to do discourse analysis (Cheek, 2004), yet common concepts used when validating discourse analysis include: reflexivity, coherence and multiplicity in accounts, and fruitfulness.

Reflexivity in this context refers to publicly reflecting on the processes of knowledge construction (Burman & Parker, 1992b) by "disclosing how the conclusions were derived [and] including the goals and assumptions driving the research" (Yardley, 1997, p. 39). One

step of this reflexivity then, is to be clear about my intentions in using discourse analysis. Foucauldian discourse analysis “is concerned with the social, psychological and physical effects of discourse” (Willig, 2001, p. 120). Thus while discourse analysis focuses on text, it enables “an account of the ways discourses reproduce and transform the material world” (I. Parker, 1992). This material world includes institutions and power relations within them (I. Parker, 1992; Yardley, 1997). Within the context of psychology and health related research, discourse analysis aims to provide “a detailed multi-layered interpretation of a particular situation” (Yardley, 1997, p. 26). The purpose of such an interpretation is to open up a space for new alternatives for speaking and for practice (Cheek, 2004; Cheek & Porter, 1997; I. Parker, 1992; Powers, 2001; Willig, 1999c; Yardley, 1997). This often involves questioning health experts (Cheek & Porter, 1997), providing social critique and resistance (Willig, 1999c), and in particular, “comment[ing] on social processes which participate in the maintenance of structures of oppression” (Burman & Parker, 1992b, p. 9). Throughout the research process, I have been explicit with all participants about my intentions.

In addition to being explicit about the assumptions and goals of research, reflexivity can be aided in other ways. Cheek (2004, p. 147) advocates a “decision trail”, which provides an explanation of the researcher’s understanding of discourse analysis and a rationale for the choice of texts for analysis. Wood and Kroger (2000) argue that clearly demonstrating how the analysis is grounded in the text adds ‘soundness’ and ‘trustworthiness’ to the research. Again, in my analysis, I have endeavoured to include significant examples of text from the interviews and to be as transparent as possible about the ways in which I have analysed the data. In this chapter, I have also been explicit about my choice of texts and any other significant decisions regarding the research.

In addition to reflexivity, coherence, and multiplicity of accounts, are both considered important in discourse analytic research (I. Parker, 1994; J. Potter & Wetherell, 1987; Wood & Kroger, 2000; Yardley, 1997):

A set of analytic claims should give coherence to a body of discourse. Analysis should let us see how the discourse fits together and how discursive structure produces effects and functions. If there are loose ends, features of the discourse evident in the data base which do not fit the explanation, we are less likely to regard the analysis as complete and trustworthy.

(J. Potter & Wetherell, 1987, p. 170)

In order to achieve coherence, it is crucial to account for the diversity in accounts within discourse analysis (J. Potter & Wetherell, 1987). This includes looking for typical, divergent, and contradictory accounts (N. Phillips & Hardy, 2002; Wood & Kroger, 2000; Yardley, 1997). Yardley discusses the process of selecting data for inclusion in analysis and suggests that while the focus needs to be on variability in discourse, “nevertheless some notion of typicality itself still informs the selection of ‘interesting’ material, which is interesting because it uniquely exemplifies or contradicts what is seen as typical” (1997, p. 37). This process has been criticised as anti-humanist (Burman & Parker, 1992a; Gough & McFadden, 2001), and as one where the researcher uses their power to select and analyse the ‘voices’ of participants, often producing analyses which may differ from participants accounts (Burman & Parker, 1992a; Cheek, 2004). This concern with how research texts can be presented as a professional authority, is also shared by those arguing that it can engender an appropriation of the ‘other’ in a similar way to the processes of colonisation (Heslop, 1997; Opie, 1992).

One response to the concern of appropriating participants’ voices is that a strength of discourse analysis is that it deconstructs commonsense and taken-for-granted understandings and in doing so, opens up possibilities for change (Yardley, 1997). Similarly, Parker argues that discourse analysis can “give a coherence to the organisation of language and tap institutional structures of power and ideology in a way that simple appeal to common sense reasoning could never do” (I. Parker, 1994, p. 104). A related point is that discourse analysis does not seek to make assumptions about what “participants are ‘really’ thinking” (Heslop, 1997, p. 53), or seek to “[blame] individual speakers for failing to shake off limiting discourses” (Willig, 1999b, p. 150); rather it seeks to make explicit multiple understandings, and the social and institutional structures which restrain subjectivity.

Accordingly, another response to the concern of appropriating participants’ voices is to ensure that multiple perspectives or voices are present in the analysis (Cheek, 1999; Harper, 1996; Heslop, 1997; Opie, 1992; N. Phillips & Hardy, 2002; J. Potter & Wetherell, 1987). Potter and Wetherell (1987) also suggest incorporating ‘participant’s orientation’ in the analysis by acknowledging the “distinctions participants actually make in their interactions and which have important implications for their practice” (J. Potter & Wetherell, 1987, p. 170). In each analysis chapter I have endeavoured to provide significant amounts of data and explicitly looked for similarity and difference within and between accounts. I have also

indicated the typicality or frequency of particular discursive constructions within the accounts.

A third common issue in assessing the validity of discourse analysis concerns such concepts as fruitfulness, usefulness, plausibility, persuasiveness, and credibility (Harper, 1999; J. Potter & Wetherell, 1987; Wood & Kroger, 2000; Yardley, 1997). Plausibility “refers partly to the consistency and rhetorical power of the research report, as judged by a community of academic peers” (Yardley, 1997, p. 40). Wood and Kroger suggest that plausibility “should help us to see in new ways” that seem reasonable given existing understandings of social life and literature (2000, p. 174). The idea that discourse analysis should help us to see in new ways raises the notion of the usefulness (Harper, 1999), or fruitfulness (J. Potter & Wetherell, 1987) of the analysis. Potter and Wetherell (1987) argue that this is the most powerful aspect of validity. Fruitfulness “refers to the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations” (J. Potter & Wetherell, 1987, p. 171).

One way to increase plausibility and fruitfulness is to link the analysis to discourses circulating in the wider culture and in literature (Wood & Kroger, 2000) and to enrich analysis by “approaching a topic from multiple perspectives” (Yardley, 1997, p. 39). To promote fruitfulness, at each stage of the analysis I reviewed relevant literature and explored the discursive relationships between it and the data. Throughout the research I have presented my developing analyses to, and sought feedback from, academics, consumers/survivors of mental health services, and clinicians, at conferences and seminars. This has led to publication of parts of this thesis (Semp, 2004a, 2004b). I have also used my analysis to inform teaching sessions with clinical students and clinicians. These various contexts have provided opportunities to see the potential for my analysis to generate new ideas and practices.

Having discussed the processes I used to select texts for analysis, to negotiate research relationships, and conduct discourse analysis, I now move into another key step in discourse analysis. The following three chapters draw on academic, governmental, LGBT, and mainstream (and, thus, heteronormative) texts, to outline discourses and subject positions regarding the central ‘objects’ of this thesis; namely homosexuality and mental health problems.

PART THREE:

EXPLICATING DISCOURSES
OF HOMOSEXUALITY AND OF MENTAL HEALTH

Chapter Four:

What are Ya? Discourses of Homosexuality in Aotearoa/New Zealand

‘What are ya?’ is an oft-used derogatory remark in New Zealand. It is used particularly by men to denote other men who do not measure up to normative notions of heterosexual masculinity. It implies that the man being referred to is weak, effeminate, abnormal, a sissy, or queer. This pejorative labelling is undoubtedly distressing for many who experience it. Yet what it means to identify to oneself as a queer or homosexual man, and the likely responses (internally or externally) to such a comment, depend very much on the discourses any particular man’s identity is constructed by. Similarly, what enables some people to speak negatively of homosexuals and others more positively? How can we understand those who espouse more ambivalent or positive views towards homosexuality? This chapter considers these questions by exploring key discourses on homosexuality in the West, and in New Zealand, since the late 19th century:

Same-sex behaviour is as old as desire itself, but the categories of homosexual and heterosexual are twentieth-century inventions.

(Vaid, 1995, p. 39)

Homosexuality has existed throughout history, in all types of society, among all social classes and peoples, and it has survived qualified approval, indifference and the most vicious persecution. But what have varied enormously are the ways in which various societies have regarded homosexuality, the meanings they have attached to it, and how those who were engaged in homosexual activity viewed themselves.

(Weeks, 1977, p. 2)

We must not forget that the psychological, psychiatric, medical category of homosexuality was constituted from the moment it was characterized - Westphal’s famous article of 1870 on “contrary sexual relations” can stand as its date of birth - less by a type of sexual relations than by a certain quality of sexual sensibility, a certain way of inverting the masculine and feminine in oneself ... The sodomite had been a temporary aberration; the homosexual was now a species.

(Foucault, 1976/1990, p. 43)

As Vaid (1995) and Weeks (1977) comment, same-sex sexual acts have existed in all known societies, yet Foucault (1990) argued that only since the late 19th century has the concept of homosexuality been used to refer to people engaging in same-sex acts as a type of person. It is commonplace to link the creation of the homosexual subject directly to the growing medical discipline in the late 19th century and Foucault's quote from Westphal is often used to anchor the historical moment. However, as I will argue later, the term 'homosexuality', while taken up and promulgated by the medical discipline, actually came from a non-medical person, a Hungarian named Benkert von Kertbenny (1869, original in German, cited in Herzer, 1985), who was one of the earliest speakers of the equal rights discourse on homosexuality.

Despite historical inaccuracy, Foucault (1990) made the important point that while same-sex sexual acts had clearly existed prior to 1870, there had not been a medical/scientific category for them. Prior to the creation of the 'homosexual' as a type of person, same-sex sexual behaviour tended to be considered sinful by religious prescription (Foucault, 1976/1990; Weeks, 1991). Since its invention, homosexuality has become such a widely discussed and utilised term in the West that its meaning often seems self evident. Yet as Weeks (1977) comments above, same-sex behaviour can be understood in many ways in different societies. During the last one hundred years there are many ways in which the 'homosexual' has been discursively constructed within Western societies.

In this chapter, I outline seven discourses on homosexuality that I have identified as circulating in the West, and in New Zealand, over the last century. I do not claim to explicate all discourses circulating on homosexuality, rather those that have been, or are, currently in wide circulation. These discourses are specifically about the discursive object 'homosexuality'; they are not intended to cover understandings of same-sex sexuality existing prior to the invention of the term 'homosexual'. I also focus on discourses that speak about male homosexuality. So, for example, I do not include a lesbian feminist discourse on homosexuality. I also do not attempt to cover discourses of homosexuality in non-Western countries. The seven discourses are the equal rights, pathological, conservative, liberation, Christian supremacist, Māori, and queer discourses.

All of these discourses on homosexuality have been explicated by previous authors, though not necessarily using a discursive framework. For this reason and for brevity, in this chapter I provide an overview of these discourses that is sufficient to use them as analytical

concepts for questioning the discursive objects of this thesis, which are homosexuality, mental health, and the relationships between them. These discourses are evidenced in (but not limited to) academic literature, governmental documents, and queer and mainstream (and thus heteronormative) media. The seven discourses have all circulated in New Zealand at differing times, and to differing extents; however, all but one (the Māori discourse) emerged overseas. I describe each discourse, outline its emergence, provide examples of it, and describe the subject positions it offers regarding homosexuality. Some comment is also made on the relative circulation of each discourse in New Zealand, both past and present. Before outlining each discourse I will explain the concept of heteronormativity (briefly introduced in Chapter Two), which is an overarching discourse of sexuality operating as a key cultural formation, providing the context and resource from which other discourses of homosexuality have developed.

Heteronormativity

Heteronormativity is a significant cultural discourse, not just on the object of homosexuality, but on sexuality in the broader sense. This discourse rests on the assumption of a ‘natural’ norm of heterosexuality:

In an appeal to ‘nature’ the most persuasive form of this argument is rooted in one of the oldest traditions of thought in the West, a tradition that still carries a great deal of intuitive sense. It posits a norm – heterosexual identity – that is undeniably valuable in any society and any culture, that seems to characterize the vast majority of humanity, and without which our civilization would simply evaporate; and it attempts to judge homosexuality by the standards of this norm.

(A. Sullivan, 1995, p. 21)

This emphasis on the superiority of heterosexuality as an organising principle in Western culture has been termed ‘heteronormativity’ (Seidman, 1993; Spargo, 1999; M. Warner, 1993). Sullivan (1995) traces the appearance of heteronormativity in the West to Thomas Aquinas, who in the middle ages, developed ideas from Aristotle’s notions of normative nature, into a doctrine of ‘Natural law’. For Aquinas, people’s sexuality must be linked to procreation and thus “all human beings were by human nature heterosexual; and homosexual acts were not simply against one’s own nature, or against law, but against the order of the universe” (A. Sullivan, 1995, p. 32).

Accordingly, heteronormativity constructs homosexuality as less than heterosexual. Homosexuality is considered essentially inferior and a threat to the family and the natural

social order (Cooper, 1994). This discourse posits heterosexuality as normal and homosexuality as abnormal. It has a history in psychiatry, psychology, law, the social sciences, most religions, and thus in all the institutions in Western states (M. Rahman, 2000). The operation of this discourse has provided the rationale for extensive oppression and disenfranchising of homosexuals since the development of the category 'homosexual' over 100 years ago.

Heteronormativity as expressed via notions of 'natural law' has a history in New Zealand. For example, in the lead up to homosexual law reform in the mid 1980s, the Coalition for Concerned Citizens stated:

Homosexual behaviour does not procreate and sustain the human species. While some would argue that this is a good thing, a lifestyle that, if logically extended to all, would lead to the extinction of society must be unnatural and against a fundamental goal of human life, which is to procreate itself. Typical homosexual behaviour is different from being just single and celibate, because it is an active force against marriage and family life.

(Coalition of Concerned Citizens, 1985, pp. 17-18)

More recently in New Zealand, heteronormativity informed arguments used against the Civil Unions Bill (passed in 2004), which granted legal recognition to same-sex couples:

The heterosexuality of marriage stems from the biological fact that it takes a man and woman to conceive and bear children. It is for this reason that the Marriage Act stipulates about twenty types of relationships that are specifically excluded. All have restrictions placed to prohibit progeny issuing from those relationships. Since children are not a direct consequence of gay relationships, what rationale would the proposed Civil Union Bill have as a prohibition against say, sisters being granted civil union?

(United Future New Zealand Party, 2004)

Heteronormativity provides the cultural backdrop in the West for the formation and operation of all the discourses of homosexuality laid out in this chapter. Whether they maintain, deny, or oppose heteronormativity, all discourses of homosexuality operate in relationship to it. In this thesis, I hold the assumption that the heterosexual/homosexual binary is a key organising principle in the modern West. Bearing the discourse of heteronormativity in mind, I will now outline seven discourses on homosexuality in New Zealand. They are the equal rights, pathological, conservative, liberation, Christian supremacist, Māori and queer discourses.

One: Equal Rights Discourse – “2-4-6-8 Gay is just as good as straight”³¹

Equality is the catch-cry of the equal/gay rights discourse (Brickell, 2001; Currah, 1997; Kitzinger, 1995; Seidman, 1993). Initially this equality was based primarily on the assumed natural and non-pathological condition of homosexuality. Currently equality is frequently constructed around an essentialist “ethnic minority model” (Seidman, 1993, p. 117). In this discourse lesbian and gay identities are also considered natural and genetic (Lehring, 1997; M. Rahman & Jackson, 1997) but now they are additionally constituted as analogous to other cultural identity groups (especially ethnic identities), alongside liberal, democratic, pluralist notions of ‘we are different but equal’ (Currah, 1997; Seidman, 1993). However, in the equal rights discourse:

equality is defined by the superior partner in the [heterosexual/homosexual] dichotomy; in short, equality means “sameness”. Gays and lesbians must struggle and fight to gain access to the same rights held by heterosexuals.

(Lehring, 1997, p. 193)

Thus within the equal rights discourse, the liberal principles of equality and liberty are used by lesbians and gays to support ‘cultural citizenship’ (Brickell, 2001). This has produced a movement “toward an ethnic/ethnic minority model, with an emphasis on cultural difference, community building, and identity-based interest-group politics” (Seidman, 1993, p. 117). Yet, while constructing lesbians and gays as distinct cultural groups, the liberal framework upon which the equal rights discourse is based requires homosexuals to assimilate into existing practices and institutions, thus emphasising their similarity to the norm of heterosexuals (Currah, 1997; Lehring, 1997).

Historical Emergence

The equal rights discourse on homosexuality, and the word homosexual, have a shared history. The equal rights discourse is often thought to have emerged in the 1970s. Yet there is considerable evidence that this discourse emerged in the same historical moment that the category of homosexual was created, at the end of the 19th century (Herzer, 1985; King & Bartlett, 1999; Lauritsen & Thorstad, 1974).

³¹ “2468 Gay is just as good as straight” was a common chant on lesbian and gay rights marches I took part in during the 1980’s in New Zealand. This clearly fits within the equal rights discourse.

Many authors have theorised the reason for the proliferation of research on homosexuality, at that time (Bullough & Bullough, 1997; Foucault, 1976/1990; Oosterhuis, 1997; Terry, 1997; Weeks, 1991). One theory is that with the rise of the medical disciplines, the study of homosexuality became linked to a wider “scientific interest in classifying human cultural diversity in biological terms” (Terry, 1997, p. 274). Studies of homosexuality became part of a general project to study variations from the norm of heterosexuality (Bullough & Bullough, 1997; Terry, 1997). However, additional motivations for the study of the diversity of human sexuality were varied, and as mentioned at the start of Chapter One, at least two contradictory trajectories for scientific research on homosexuals emerged. These differing understandings often shared medical, biological, and essentialising approaches to homosexuality, but the meanings they attributed to homosexuality, and its relationship to society, differed considerably. The first trajectory is an equal rights discourse and the second is a pathologising discourse outlined in the following section.

Hungarian Benkert von Kertbeny (known as Kertbenny), first published the word ‘Homosexualität’ [homosexuality] in 1869 (original in German, cited in Herzer, 1985, p. 1). Kertbenny, whose own sexuality is unknown, was not a medical professional, but a writer and translator, who wrote to the German minister of justice in support of legal rights for homosexuals (Herzer, 1985; Lauritsen & Thorstad, 1974). Kertbenny did not leave any texts explaining why he came to use the word homosexuality and there is some evidence that he may have pretended to be a doctor to try and get his ideas accepted (Herzer, 1985).³² The term ‘homosexuality’ was “adopted and popularized by Krafft-Ebing” (Bullough, 1994, p. 39) in the late 19th century. Krafft-Ebing was a German psychiatrist and a proponent of the pathological discourse of homosexuality (see next section).

Another early speaker of the equal rights discourse was Magnus Hirschfeld (discussed in Bullough, 1994). His use of the term ‘homosexual’ from the late 1800s further contributed to its common usage in Germany (Bullough, 1994). Yet, despite being able to speak with the authority of a doctor, as a self proclaimed homosexual, Hirschfeld’s publications were generally not translated into English (Bullough & Bullough, 1997). The term ‘homosexuality’ entered English usage in “the 1880s and 1890s, and then largely as a result of the work of Havelock Ellis” (Weeks, 1991, p. 16). Ellis was “a doctor, whose wife,

³² Such is the uncertainty surrounding Kertbenny’s that Lauritsen and Thorstad (1974) and Jagose (1996) refer to him respectively as a Hungarian, and a Swiss, doctor.

Edith, was openly lesbian and campaigned for lesbian rights during her lecture tour in the USA” (Kitzinger & Coyle, 2002, p. 8).

Hirschfeld’s aphorism “Per scientiam ad justitiam – Through Science to Justice” (cited in Minton, 2002, p. 271)³³ exemplifies the emancipatory research path of the equal rights discourse. The Scientific Humanitarian Committee, established in Germany in 1897 by Hirschfeld, adopted this motto (Lauritsen & Thorstad, 1974). The committee also took up the equal rights argument:

In one of the early issues of its yearbook, the Committee stated its goals as follows: (1) to win legislative bodies to the position of abolishing the antigay paragraph of the German penal code, Paragraph 175; (2) enlightening public opinion on homosexuality; (3) interesting the homosexual himself [*sic*] in the struggle for his [*sic*] rights.

(Scientific Humanitarian Committee, cited in Lauritsen & Thorstad, 1974, p. 11)³⁴

Hirschfeld used case studies, interviews, and surveys to try and prove that homosexuality was a congenital condition of physiological, but not pathological, status (Terry, 1997). Furthermore, he argued that social and legal persecution of homosexuals was unjust, damaging, and could lead to such dire consequences as suicide (Hirschfeld 1914, cited in Terry, 1997). For example, Hirschfeld (1935) wrote about the suicide of a homosexual officer on the night he married and he also makes reference to the trial of Oscar Wilde. Concerned at these injustices, and others, he made the statement: “I believe in Science, and I am convinced that Science, and above all the Natural Sciences, must bring to mankind, not only truth, but with truth, Justice, Liberty and peace for all” (Hirschfeld, 1935, p. xx).

Ulrich (1864-1879/1994)³⁵ was another man who advocated that science could promote justice by proving that ‘Urnings’ (Ulrich’s term for male homosexuals) were natural and should not be persecuted. He used biological analogy as part of his argument: “This persecution is as senseless as – if you will allow the comparison – punishing hens for laying

³³ Hirschfeld’s early work on homosexuality was published in Berlin in 1914 as *Die Homosexualität des Mannes und des Weibes* but was never translated into English (Bullough & Bullough, 1997). However, a draft of his survey on homosexuality has been translated into English (see Nunberg & Federn, 1962, pp. 379-388).

³⁴ “The Committee published a yearbook, *Jahrbuch für sexuelle Zwischenstufen* – (Yearbook for Intermediate Sexual Types), which appeared more or less regularly ... between 1899 and 1923” (Lauritsen & Thorstad, 1974, p. 11).

³⁵ Ulrich’s works were first published in Germany between 1864 and 1879. However, none of these were published in English until 1994. Between 1864 and 1865 he published under the pseudonym Numa Numantius.

eggs instead of chicks, or cows for bearing calves instead of laying eggs” (Ulrichs, 1864-1879/1994, p. 38). From the belief in the naturalness and non-pathological nature of homosexuality, Ulrich developed a moral argument for equal legal rights: “We Urnings form a small minority. But by God, we have the same rights as you, who are a powerful majority. You have no authority to take away or encroach upon our equal rights” (Ulrichs, 1864-1879/1994, p. 39). This statement can be seen as an early instance of the ‘ethnic minority’ argument in use.

Similarly in England, Ellis (1897) used research based on letters, case studies, and informants, to argue that homosexuality was largely part of the normal biological variation in human sexuality and, as such, should not be punished (cited in Weeks, 2000). Ellis was one of the first to argue the biological basis of homosexuality based on evidence that homosexuality was more commonly found in different members of the same family (for an extensive discussion of Ellis and his work, see Weeks, 2000).

The equal rights discourse was marginal in the late 19th and the first half of the 20th century (Lauritsen & Thorstad, 1974) when the conservative and pathological discourses were in relatively wider circulation (Bullough & Bullough, 1997; Jagose, 1996). The equal rights discourse, as it is constituted today, re-surfaced out of the splits within the gay liberation movement of the 1970s and the strong identity groups and visible subcultures that had formed within the period of gay liberation.³⁶ These groups, especially gay men and lesbians, turned their attention from revolutionising societal structures to fighting for equal legal rights (Jagose, 1996; Leiring, 1997; Vaid, 1995). This was part of the broader emergence of social movements such as women’s rights, and black civil rights, which saw the rise of identity politics (Currah, 1997). The dominant notion of equal rights used by lesbians and gay men has been termed an ethnic identity one as it is based on the democratic pluralist notion of ‘we are different yet equal’ (Currah, 1997; Seidman, 1993). Central to the current equal rights discourse is the notion of essentialised lesbian and gay identities, often used in conjunction with bio-genetic theories of aetiology (Leiring, 1997). This equal rights discourse of homosexuality, first advanced in Germany at the end of the 19th Century, is still used by lesbian and gay rights campaigners internationally over 100 years later.

³⁶ The liberation discourse of homosexuality is discussed later in this chapter.

Circulation

From this equal rights discourse, lesbians and gays have fought for, and often won, equal access to various existing social institutions and practices such as the decriminalisation of homosexuality, equal age of consent for sex, adoption rights, and inclusion in anti-discrimination laws. In New Zealand, Brickell (2001, p. 212) argues that the main approach to the betterment of the lives of lesbians and gay men is based on an “egalitarian myth which imagines all New Zealanders to be given equal opportunities to participate in an essentially equal society”. The equal rights discourse circulates widely in New Zealand. It was successfully deployed during the campaign for homosexual law reform in the 1980s (Guy, 2002), and, more recently, in the campaign for legislation supporting same-sex couples (C. Young, 2003). The website advocating the bill clearly used equal rights language:

The Civil Union Bill proposes a new type of relationship model for New Zealand. If successful, it will grant registered civil union couples recognition and relationship rights which are equal to those granted through marriage. For the first time ever, it will enable same-sex couples access to full legal equality.

(The Civil Union Bill Campaign Committee, 2004)

This equal rights discourse has also entered into the National Mental Health Standards in New Zealand (Ministry of Health: Manatu Hauora, 1997). Standard three on cultural awareness, requires that:

The mental health service recognises cultural differences and responds non-judgmentally in its delivery of treatment and support on the basis of a consumer’s age, gender, culture, sexual orientation, socioeconomic status, religious beliefs, psychiatric diagnosis and physical or other disability.

(Ministry of Health: Manatu Hauora, 1997, p. 5)

The mental health standards adopt the ethnic identity model within the equal rights discourse by categorising homosexuals alongside other cultural groups requiring respect and tolerance. The equal rights discourse is currently a prevailing one in the West. Lehering states that “arguably, most of the gay and lesbian political movement today, seek integration, not (dis)integration, and assimilation with cultural institutions, not their obliteration” (1997, pp.185-186).

Kitzinger (1997) argues that much lesbian and gay psychology has successfully used science within an equal rights discourse to support legislative change for homosexuals. A common strategy is the use of research illustrating that homosexuals are as psychologically healthy as

heterosexuals. An early example of this was Hooker (1957) (discussed in Chapter One). But Kitzinger argues that relying on discourses of science and equal rights has also limited what lesbian and gay psychology has achieved. In particular, Kitzinger (1997, p. 215) contends that the individualistic focus of lesbian and gay psychology, and the equal rights discourse, have largely failed to address “structural and institutional power” and the role the discipline of psychology plays in reproducing that. The lack of research on PMHS for MSM, or on systemic issues in mental health services for lesbians and gay men supports Kitzinger’s argument. Another way in which the equal rights discourse is evident in the literature on MSM and mental health services is the call for matching of clients and clinicians based on sexual orientation (Golding, 1997; Klein, 1991). Matching assumes similarity within identity groups and that this similarity will improve mental health services to lesbian and gay clients.

Subject Positions

The equal rights discourse offers lesbians and gay men individual and group identities. These identities are essentialist and follow an ethnic/minority identity model (Currah, 1997; Lehring, 1997). This discourse provides resources to fight for equality, and for visible lesbian and gay communities. Implicit within the equal rights discourse is the assumed similarity within identity groups such as lesbians or gay men. But, despite these clear identities and rights, there are limits to what can be fought for from an equal rights discourse. While one can ask for equal rights, it is much harder to justify anything that may appear as ‘special rights’ (Brickell, 2001; Currah, 1997).

Implicit, within the equal rights discourse is that heterosexuality is the norm which determines what constitutes a right. If homosexuals are denied rights assigned to heterosexuals then homosexuals can ask for them. In this way the equal rights discourse does not directly challenge heteronormativity and, thus, limits what homosexuals can fight for (Brickell, 2000, 2001; Lehring, 1997; M. Rahman & Jackson, 1997). From this discourse, lesbians and gay men need to emphasise their similarity to heterosexuals (Currah, 1997; Lehring, 1997). Furthermore, the liberal notion of sexuality as private encourages lesbians and gay men to keep their sexuality relatively private; as long as they have the same legal rights as heterosexuals they have no reason to highlight their sexuality (Brickell, 2000, 2001; Lehring, 1997). For example, in New Zealand Brickell argues that heterosexuality remains ‘unmarked’ in public spaces, while the public omnipresence of heterosexuality is neither acknowledged or challenged. Thus when lesbians and gays take up public spaces via

parades or television programmes for example, this is often seen as ‘going too far’ and imposing homosexuality on the (heterosexual) public. Similarly, it allows moves such as including sexual orientation in anti-discrimination law to be critiqued as ‘special treatment’ and the granting of extra rights to minorities, in excess of the rights of the heterosexual majority (Brickell, 2001; Currah, 1997).

Two: Pathological Discourse – Homosexuality as sickness

The pathological discourse of homosexuality uses the language of science, and of medicine in particular, to define homosexuality as an illness. It categorises the ‘homosexual’ as a type of person and, through varying aetiological theories diagnoses homosexuality as abnormal in relation to the assumed ‘natural’ norm of heterosexuality. Theories of aetiology include hereditary disposition, developmental disorder, and acquired perversion.

Historical Emergence

As discussed earlier, Foucault’s (1990) attribution of the birth of the concept of homosexuality to Westphal and the medical is not historically accurate. Westphal actually coined the phrase “*conträre Sexualempfindung* [contrary sexual feeling]” to describe same-sex attraction in 1869 (original in German, cited in Herzer, 1985, p. 17). However, while Westphal did not create the term homosexual, as a German psychiatrist, he was the first to embark on formal medical study and treatment of those who became known as homosexuals (Bullough & Bullough, 1997). The term ‘homosexuality’ entered the medical discourse in 1887 through Krafft-Ebing’s citation of an 1880 publication by a zoology professor, Jager who mentioned it (Herzer, 1985, p. 7).

The pathologising discourse of homosexuality emerged when it was absorbed into medical terminology at the end of the 19th century. With the decline in the power of the church and the rise of the secular state, various sociohistorical changes created a context for a new concern with sexuality in general, and homosexuality in particular. The 19th century saw the rise of large cities. With growing cities came increased concern for issues such as public health, the need to police populations, and a concern with pressure being placed on traditional institutions such as marriage and the family (Bullough & Bullough, 1997; Foucault, 1963/1994; Terry, 1997). Homosexuals were seen as one of many threats to traditional societal structures (Terry, 1997; Weeks, 2000). A related issue concerned the

debates about democracy and who should, or should not, have newly created legal rights (Terry, 1997; Weeks, 1991). For example, Terry suggests that at the end of the 19th century, fears about radical changes such as the suffragette movement and the abolition of slavery provided motivation for science to use biology to prove that social inequality was natural. This context produced a scientific and moral quest to study the perversion of homosexuality in the body, and by doing so, to protect the status quo (Terry, 1997). In this approach homosexuality was assumed pathological.

An early example of writing within this pathological discourse is that provided by Krafft-Ebing (1906). He reviewed the literature on homosexuality at the time, and used that, along with case studies, to assert that homosexuality was “a partial manifestation of a neuro-(psycho-) pathic state, in most cases hereditary” (Krafft-Ebing, 1906, p. 338). Furthermore, Krafft-Ebing stated that homosexuality was against natural law, and, as such, “must, from the anthropological and clinical standpoint, be considered as a manifestation of degeneration” (1906, p. 349). Likewise, Westphal (1869, cited in Bullough & Bullough, 1997, p. 5)³⁷ “initiated formal medical study, i.e., case presentation, diagnosis, and treatment of what he termed patients afflicted with ‘contrary sexual feeling’”. Another important assumption built into this new medical category of ‘homosexual’ was that it represented a deviation from a biological norm. Science took as its responsibility the goal of discovering the aetiology of this ‘non-normative’ development (Weeks, 1985). The medical response was to use an illness model to look for this aetiology; homosexuality thus became pathological (Bullough & Bullough, 1997). Science may have overtaken religion in the right to speak the truth but the assumption of the unnaturalness (previously sinfulness) of same-sex behaviour remained (Weeks, 1991).

However, controversy over aetiology emerged from the outset of this research. While most researchers of the time held the belief that homosexuality was biological in origin (Westphal, 1869, discussed in Bullough & Bullough, 1997; H. Ellis & Symonds, 1897/1975; Hirschfeld, 1935; Krafft-Ebing, 1906; Ulrichs, 1994), Krafft-Ebing (1906) also thought that homosexual feeling could be acquired by such things as fear of infection in heterosexual intercourse and youthful masturbation. For example, discussing the process by which masturbation could cause homosexuality, Krafft-Ebing (1906, pp. 286-287) wrote:

³⁷ Original article published in German ‘Die conträre Sexualempfindung. Archiv für Psychiatrie und Nervenkrankheiten 2, (1869), 73-108’.

Nothing is so prone to contaminate – under certain circumstances, even to exhaust – the source of all noble and ideal sentiments, which arise of themselves from a normally developing sexual instinct, as the practice of masturbation in early years. It despoils the unfolding bud of perfume and beauty, and leaves behind only the coarse, animal desire for sexual satisfaction. If an individual thus depraved, reaches the age of maturity, there is wanting in him [*sic*] that aesthetic, ideal, pure and free impulse which draws the opposite sexes together. The glow of sensual sensibility wanes, and the inclination toward the opposite sex is weakened.

Adding to the psychological, yet still pathologising, approach to the study of homosexuals were theories of ‘developmental delay’ by people such as Moll and Freud (Bullough & Bullough, 1997). Freud’s position on homosexuality is contested. Lewes (1989) argues that while Freud’s later works and statements were often supportive of homosexuals, his theory of homosexuality left a legacy of “a somewhat confused and equivocal understanding of the relationship of homosexuality and ‘normal’ functioning and behaviour” (Lewes, 1989, p. 47). Despite this uncertainty, there was enough in Freud’s theory to offer support to a pathological discourse. Specifically, Freud’s referring to homosexuality as an ‘inversion’, linking it to inhibition in ‘normal’ development, and to Oedipal fears of castration, all contributed to the pathological discourse of homosexuality (Bullough & Bullough, 1997; Lewes, 1989; G. Taylor, 2002). Unlike Freud, who did not believe homosexuals were inherently sick (G. Taylor, 2002), Moll (1897, cited in Bullough, 1994),³⁸ a sexologist, believed homosexuality was an illness that delayed ‘normal’ heterosexual development and could, and should, be treated.

Yet within this debate over aetiology, many researchers thought that homosexuals ‘were born that way’ and this belief engendered the idea that we should not punish someone for something for which they are not responsible. For example, Moll viewed homosexuality as a perversion because it hindered “the propagation of the species” (1931, p. 182). However, Moll became more convinced of a congenital predisposition towards homosexuality and, thus, while open to the idea of the state internment of homosexuals who acted in ways harmful to society in insane asylums, he was opposed to calling homosexuals criminals: “The homosexual urge may be neither caused nor suppressed voluntarily. The individual who experiences it is therefore not responsible” (Moll, 1931, p. 210). This concern for proving

³⁸ Original published in German by Albert Moll as *Untersuchungen über die Libido Sexualis* (Berlin: Fischer’s Medicinische Buchhandlung, 1897).

the biological basis of homosexuality continues into the 21st century – see Rahman (2003), Bohan (1996) and Hershberger (2001).

Circulation

The pathological discourse was adopted by the Nazis to support their slaughter of tens of thousands of homosexuals (Haeberle, 1981; Lauritsen & Thorstad, 1974). Psychiatrists were involved in the selection of people to be murdered (Seeman, 2005). The pathological discourse was particularly strong in psychoanalytic and psychiatric professions in the United States in the 1950s (Katz, 1976; Terry, 1997). For example, Bergler (1956), a psychiatrist, used case studies to claim that homosexuality was a developmental disease that affected a person's whole personality, not just their sexuality. Accordingly, Bergler attributed the following characteristics (amongst others) to homosexuals:

masochistic provocation and injustice-collecting; ... defensive malice; ... flippancy covering depression and guilt; ... hypernarcissism and hypersuperciliousness; ... refusal to acknowledge accepted standards in non-sexual matters ... [and] general unreliability.

(Bergler, 1956, p. 49)

Bergler was so confident in attributing these characteristics to homosexuals that he stated, “The most interesting feature of this sextet of traits is its universality. Regardless of the level of intelligence, culture, background, or education, all homosexuals possess it” (Bergler, 1956, p. 49). This widespread circulation of the pathological discourse was also evident in early versions of the DSM (see Chapter One).

Since the de-pathologising of homosexuality by the American Psychiatric Association in 1973, this discourse is less common within the mental health professions; however, proponents of it still exist (for an example see Socarides, 2002). The pathological discourse also continues to be implicit in some recent psychological research. For example (as discussed in Chapter One), a recent large-scale study on mental health issues for homosexuals suggests that the increased prevalence of bipolar disorder for homosexual men may be related to the genetic causes of homosexuality (Sandfort et al., 2001). The assumption here is that homosexuality is a marker for ill-health, while heterosexuality is implicitly equated with good health.

The pathological discourse has had a considerable impact on psychiatric and psychological treatments for gay men. There is evidence from the United Kingdom (King & Bartlett,

1999; King, Smith, & Bartlett, 2004; Smith, Bartlett, & King, 2004), and from the United States (Katz, 1976; Silverstein, 1996), of numerous attempts to 'treat' homosexuality. These so called treatments have included psychoanalysis to undo 'arrested development', aversion therapy including electric shocks and induced nausea, covert sensitisation using imagery, and even castration, and lobotomies. While considerably less research has been done on this area in New Zealand, McNab (1993) provides evidence of pathological ideas towards homosexuals being espoused in *'The New Zealand Science Review'* 1949, *'The New Zealand Family Doctor Medical Journal'* 1963, and the *'New Zealand Medical Journal'* in 1967. In the latter publication in 1967, Basil James, a lecturer in psychological medicine at the University of Otago, advocated aversion therapy for homosexuals.

Subject Positions

Within the pathological discourse, homosexuals have limited options. Regardless of whether they view themselves as homosexual by organic, developmental or other causes, their homosexual status marks them as 'abnormal' and 'inferior' in relation to heterosexual norm. The pathologising discourse constructs homosexuals as innately 'abnormal' and, generally as not having chosen their sexual orientation. This removes responsibility for homosexuality from individuals, and accordingly, generally does not favour criminalising homosexual behaviour. However, this removing of responsibility for homosexuality, while still maintaining its pathology, parallels the move from 'evil' to 'sick' for mental patients. People considered not responsible for their abnormal behaviour are rendered 'deficient'. Options open to homosexuals include treatment, or surviving their 'affliction' as best they can, while not acting in ways to encourage the spread of homosexuality in wider society.

Three: The Conservative Discourse – 'What they do in private is their own business'

The conservative discourse states that homosexuality should be tolerated as either a relatively harmless lifestyle choice or as a naturally occurring variation in human sexuality. However, in this discourse (and unlike the equal rights discourse), homosexuality is clearly 'subordinate' and 'inferior' to the norm of heterosexual and, as such, homosexuality should not be presented as equal to homosexuality. Speakers of this discourse tend to profess liberal views on the private rights of homosexuals, yet do not go as far as to claim equality

for homosexuals in the public domain (A. Sullivan, 1995). This discourse asserts heterosexuality as the normative and desirable sexuality for society to promote. Heterosexuality is seen as enabling procreation of the species, monogamous marriage, and being the basis for stable family life and, through that, healthy societies.

The naming and defining of this discourse is contested. Jagose (1996) refers to the homophile movement (discussed below) as a more conservative precursor to a gay liberation discourse of homosexuality. However, the way in which Jagose describes the conciliatory, appeasing style of the homophile movement is similar to Sullivan's (1995) description of a 'conservative' position on homosexuality. Guy refers to homophile New Zealand groups as having a "conservative approach" (2002, p. 107). Similarly, Vaid (1995) describes some of the early homophile groups as conservative. In contrast, others focus on the liberal aspects of this discourse. Lehring (1997) and Guy (2002) link the marking of homosexuality as a largely private matter, as part of liberalism. Brickell (2000, 2001), similarly associates the public/private split regarding sexuality as a liberal one.

Amidst this contested terminology, I use Sullivan's (1995) term of 'conservative' for this discourse (over 'homophile' or 'liberal') for the following reasons. First, the homophile movement, as described by Jagose (1996) and others, was also informed by discourses of liberation and of equal rights. Furthermore, the liberal characteristic of this discourse emphasising individual liberty, and limiting the role of the state in individuals' private lives, is also shared to some extent by the equal rights discourse. Yet I argue that the discourse I define in this section is fundamentally more conservative than the equal rights discourse. The conservative discourse works to explicitly conserve the superiority of heterosexuality over homosexuality. Homosexuality is not celebrated (Seidman, 1993); it may be tolerated in private but equality is out of the question.

Historical Emergence

Jagose (1996) describes a homophile movement, originating in the early 20th century, with the primary goals of increasing tolerance towards homosexuality and sometimes decriminalising it. Jagose suggests that an early example of the homophile movement in action was Hirschfeld's Scientific Humanitarian Committee set up in Germany in 1897. Hirschfeld and his committee described homosexuality as a 'third sex' and "emphasised both the harmless nature of homosexuality and the needless suffering caused by its

criminalisation” (Jagose, 1996, p. 23). Yet, as discussed earlier, while emphasising the ‘harmlessness’ of homosexuality, the Scientific Humanitarian Committee was also involved in goals more akin to an equal rights discourse (Lauritsen & Thorstad, 1974).

The conservative discourse was evident in “the 1924 charter of the Chicago Society for Human Rights which is the earliest recorded American homophile organisation” (Jagose, 1996, p. 24):

to promote and to protect the interests of people who by reasons of mental and psychic abnormalities are abused and hindered in the legal pursuit of happiness which is guaranteed them by the declaration of Independence, ... The Society stands only for law and order; it is in harmony with any and all general laws insofar as they protect the rights of others, and does in no manner recommend any acts in violation of present laws nor advocate any matter inimical to the public welfare.

(Katz, 1976, p. 385)

This quote is conservative in balancing the promotion of ‘interests of’ and tolerance towards homosexuals, while deferring to, and exhorting to protect, the normative ‘public welfare’. In this quote, homosexuals are an abnormal group requiring tolerance but also needing to commit not to disturb the general public.

Circulation

Writing in the United States, Sullivan (1995) describes the conservative discourse as advocating a delicate balance between liberty, pluralism, and freedom on the one hand, and affirming certain social and moral values on the other. Sullivan (1995, p. 98) suggests that due to the difficulty in logically arguing for this balance “it is hard to find texts or authors who explicitly defend it”. Accordingly, the conservative discourse may be more common than its representation in literature, and in overt political movements, may suggest.

Nevertheless, Sullivan (1995) presents some public accounts of this conservative discourse. One example is that given by Professor of Natural Law, John Finnis of Oxford University. Sullivan summarises Finnis’ arguments as follows: the state’s role is not to encroach upon the private behaviour of adults, while at the same time, not supporting a social norm “that says sex is about personal gratification and not about marital procreation” (1994, cited in A. Sullivan, 1995, p. 100). Finnis’ concern is shared by other speakers of the conservative discourse; this is that public support of homosexuality will damage the institutions of

marriage and the family and, furthermore, will lead to the increase of homosexuality. Retired Harvard psychologist Pattullo³⁹ clearly espouses this view:

Surely decency demands that those who find themselves homosexual be treated with dignity and respect. But surely, too, reason suggests that we guard against doing anything which might mislead wavering children into perceiving society as indifferent to the sexual orientation they develop. ... Hence to the extent that society has an interest both in reproducing itself and in strengthening the institution of the family – and to the extent that parents have an interest in reducing the risk that their children will become homosexual – there is a warrant for resisting the movement to abolish all societal distinctions between homosexual and heterosexual.

(Pattullo, 1992, pp. 22-23)

A further argument supporting public disapproval of homosexuality is that support for homosexuality would endanger society, as it would be the “thin edge of the wedge” (A. Sullivan, 1995, p. 116). Conservative commentator, Arkes,⁴⁰ argues that if homosexuality is publicly supported, then society may find itself having to support other activities such as paedophilia, multiple partner marriages, sex with animals and “the steamier versions of sado-masochism” (Arkes, 1993, p. 45).

A more recent example of the conservative discourse is the ‘Don’t ask, don’t tell’ policy in the United States military. Unable to deny the existence of lesbians and gay men in the military but wanting to preserve the public superiority of heterosexuality, the military attempted to enforce the conservative public/private split on homosexuality. It did this by creating a policy whereby homosexuals who were public about their homosexuality were to be discharged and those who kept it private were not. To support this precarious balance, military personnel were requested not to ask other personnel whether they were homosexual (Lehring, 1997; A. Sullivan, 1995).

In New Zealand there is also evidence of a conservative discourse on homosexuality. Guy (2002) argues that in the 1960s New Zealand’s relative isolation from other Western nations was reduced by the rise of international travel and the increased availability of television. These changes exposed New Zealanders to the liberal trends towards homosexuality occurring elsewhere. Concurrently many other social issues were debated

³⁹ E.L. Patullo was, until his retirement in 1987, director of the Center for the Behavioral Sciences, associate chairman of the department of psychology, and director of the psychological laboratories at Harvard University (footnote in Pattullo, 1992).

⁴⁰ Arkes is a Professor of Jurisprudence and American Institutions at Amherst College.

within New Zealand including, “military involvement in Vietnam, abortion, Māori issues, second-wave feminism, film censorship” and broader changes in sexual mores (Guy, 2002, p. 50). However, amidst the many cultural changes occurring in New Zealand in the 1960s, the liberalisation towards homosexuality was often of a conservative nature. Guy describes the beginnings of the homosexual law reform movement in New Zealand and argues that a common strategy at the time “was to approve of legal reform while expressing personal abhorrence of such activities” (2002, p. 41):

Taranaki Methodist minister, Richard Hendry, for example, in supporting the New Zealand Homosexual Law reform Society petition in 1968, referred to homosexuality as ‘unnatural’ a condition which ‘afflicted’ people, and which was ‘just a bare shadow of an effective heterosexual relationship’.

(Guy, 2002, p. 41)

Also, in the 1960s, Basil James, a lecturer in psychological medicine at the University of Otago was vice president of the New Zealand Homosexual Law Reform Society yet advocated aversion therapy for ‘treating’ homosexuals (McNab, 1993). More recently, Brickell (2000) explores the public/private distinction in regard to homosexuality in New Zealand media. For example, commenting on opposition to a queer pride parade:

One parade opponent, Auckland City Councillor Phil Raffles, wanted to draw a clear boundary between public and private and to limit the parade to a private space. He suggested that the parade should be staged at a city racecourse ... so nobody would come across it by accident while going about their daily business.

(Television New Zealand, 1998, cited in Brickell, 2000, p. 167)

In the United States, Sullivan argues that the conservative discourse has become less publicly evident due to the rise of other discourses (1995). In the 1970s the lesbian and gay subcultures became so strong and visible that the public/private distinction was challenged (Currah, 1997; A. Sullivan, 1995). Visibility of homosexuals was further increased by HIV/AIDS which both made individual homosexuals visible and brought discussions of homosexuality into mainstream media (A. Sullivan, 1995; Vaid, 1995). In New Zealand, the multiple, liberalising social debates of the 1960s, and the increasing exposure to pro-homosexual literature, were key factors that contributed to the increasing influence of liberation and equal rights discourses of homosexuality (Guy, 2002).

Subject Positions

A conservative homosexual is one who keeps their homosexuality private. Conservative homosexuals may engage in homosexual behaviour as long as they do so in ways that do

not trouble heterosexual society. This means engaging in homosexual sex in the privacy of their own homes, or in gay 'haunts' and ghettos (A. Sullivan, 1995). However, public displays of homosexual behaviour, and the public promotion of homosexual identities as 'normal' or 'good' is discouraged (Seidman, 1993) lest it promote homosexuality in the 'vulnerable' young and threaten the heterosexual basis of 'good' society:

Homosexual members of society could be fully integrated – as schoolteachers, librarians, soldiers, manual workers, scholars, artists, and so on – so long as they never disturbed the public conventions of discretion. They were confirmed bachelors or spinsters, funny uncles and eccentric aunts, prickly brothers, or just village characters.

(A. Sullivan, 1995, p. 121)

In New Zealand, Brickell (2000, p. 163), writing about the conservative aspects of a liberal approach to homosexuality, argues that homosexuals who make their sexuality public in any way, challenge the way public spaces are routinely heterosexist. In doing this homosexuals are seen as “forcing a politicisation of both the public sphere and the metaphorical space of the private, heterosexual mind. A discursive inversion occurs whereby the homosexual subject becomes powerful and tyrannous, and the heterosexual is coerced and oppressed”. Similarly, while using the label of 'liberal', Lehring describes a 'good' homosexual as “one who appeared to be in a long-term, monogamous relationship, who never uttered the word 'gay', and who for all intents and purposes was 'just like everyone else'” (1997, p. 182).

Sullivan (1995) also argues that within this discourse the homosexual subject is defined as having, by nature, less moral character and value than a heterosexual one. Homosexuals are assumed to be promiscuous, have unsatisfactory short term relationships, be subversive of gender norms, and live lives that are generally hedonistic and lonely (Herek, 1991; A. Sullivan, 1995). Unsurprisingly, adopting this subject position has been associated with the experience of guilt and shame (G. Kaufman & Raphael, 1996). So a conservative homosexual subject is one who accepts a subordinate and private place in society by seeking tolerance and assimilation into 'normal' society without confronting the ways in which heteronormativity defines homosexual subjects.

Four: Liberation Discourse – 'Stick it in your ear!'

We are a revolutionary group of men and women formed with the realisation that complete sexual liberation for all people cannot come about unless existing social

institutions are abolished. We reject society's attempt to impose sexual roles and definitions of our nature. We are stepping outside these roles and simplistic myths. We are going to be who we are. At the same time, we are creating new social forms and relations, that is, relations based on brotherhood, cooperation, human love, and uninhibited sexuality. Babylon has forced us to commit ourselves to one thing – revolution.

(Gay Liberation Front, Statement of Purpose, July 31, 1969, cited in D'Emilio, 1998, p. 234)

Rejecting a conservative, homophile discourse of tolerance by the mainstream, the gay⁴¹ liberation discourse directly resists and challenges the status quo (D'Emilio, 1998; Jagose, 1996). In particular, it asserts distinct, visible and proud gay identities encapsulated in the defiant and proud use of the term 'gay' in preference to 'homosexual' which had become associated with pathology and conservatism. This approach was encapsulated in the slogan 'Gay Power' (D'Emilio, 1998, p. 232). Liberation discourse challenges taken-for-granted social institutions and practices such as traditional gender roles, monogamy, marriage, and the ways in which heterosexuality is assumed to be the norm by which all other sexualities should be measured (Lehring, 1997; Seidman, 1993). Liberation discourse holds the constructionist position that the categories of homosexuality and heterosexuality are social constructions and oppressive ones in that they hide the natural polymorphous sexuality of all humans (Jagose, 1996). Accordingly, one goal of gay liberation was the eventual discarding of these artificial and limiting sexual categories (Jagose, 1996; Lehring, 1997).

Vaid (1995) summarises four key ideas from a liberation discourse. One that 'coming out' and being visible was central to gay freedom. This posed a challenge to the public/private split of the conservative discourse. Second, gay liberation would profoundly change "gender roles, sexism, and heterosexual institutions like the family". Third, gay liberation needed to relate to other social issues such as race, gender and economics. Fourth, "that the creation of a gay and lesbian counterculture was an essential part of establishing lesbian and gay identity" (1995, p. 57).

⁴¹ In the liberation discourse, the term 'gay' was often used to refer to men and women. This changed with the development of the lesbian feminist movement. As Seidman (1993, p. 111) comments "Gay liberation theory was not necessarily produced by and for men. Many lesbian-identified women participated in its creation. In contrast, lesbian feminism was created by and for women".

Historical Emergence

The birth of radical gay liberation discourse is often linked to the Stonewall riots of 1969 when the “police raided a New York gay and drag bar” (Jagose, 1996, p. 30). What characterised the gay and drag communities’ responses to the police raid, compared to earlier homophile reactions to harassment, was a radical defiance. One of the earliest gay liberation organisations was the Gay Liberation Front (GLF) formed in New York in 1969 in response to the Stonewall incident (D’Emilio, 1998). “Word of the Stonewall riot and GLF spread rapidly among the networks of young radicals scattered across the country, and within a year gay liberation groups had sprung into existence on college campuses and in cities around the nation” (D’Emilio, 1998, p. 233).

Notwithstanding this historical event, gay liberation emerged within the broader social context in the 1960s where numerous other “New Left social movements” were occurring (Jagose, 1996, p. 31). These movements included black power, students, counterculture, and women’s liberation (D’Emilio, 1998; Jagose, 1996; Lehring, 1997; Seidman, 1993; Vaid, 1995). Gay liberation emerged in the context of these other social changes and in response to dissatisfaction with “the quietist position” of many homophile organisations (Jagose, 1996, p. 30):

Gay liberation and the feminist movement challenged mainstream homophile thinking. They contested the notion of homosexuality as a condition of a segment of humanity; repudiated the idea of homosexuality as symptomatic of psychic or social inferiority; and rejected a politics of assimilation.

(Seidman, 1993, p. 111)

Circulation

The liberation discourse thrived in the 1970s and was most evident in the media, the development of gay subcultures and in political activism (D’Emilio, 1998). The *Advocate*, which began printing in the United States in 1968, was “a hard-hitting newspaper whose contents evinced an aggressive pride in being gay” (D’Emilio, 1998, p. 227). In terms of political activism, one great success of gay liberation was the protests and disruptions of American Psychiatric Association meetings resulting in the depathologising of homosexuality (Bayer, 1987, see also Chapter One of this thesis). D’Emilio asserts that by the end of the 1970s over half a million people were involved in gay liberation events in the United States and that a gay subculture had “moved aggressively into the open” (1998, p. 239).

Dennis Altman (1982) argued that the liberation discourse in the United States significantly influenced the development of gay culture internationally. In New Zealand, the first gay liberation group was probably the inaugural meeting of the University of Auckland gay liberation group on 21st March 1972 (Guy, 2002). This was followed by the establishment of similar groups elsewhere in New Zealand and the first gay liberation conference in New Zealand in Auckland that year (Guy, 2002).

New Zealand gay liberation had a stridency similar to its United States counterpart as is evidenced in the following excerpt from the Gay Liberation Front (GLF) brochure in 1973:

We demand that the oppression of gay people stops ... We do not intend to ask for anything. We intend to stand firm and assert our basic rights. Remember – Gay is good. Gay is beautiful. Gay is angry. Gay is proud.

(cited in Guy, 2002, p. 91)

The Auckland GLF was also involved in similar activities to its overseas counterparts. It supported “the formation of self help counselling services for homosexual people run by homosexual people, the distribution of stickers, leaflets and pamphlets and the organisation of gay pride weeks and marches” (McNab, 1993, p. 139). After thriving in the 1970s, the liberation discourse began to decline in its influence. Various reasons have been suggested for this decline. One is that the lesbian and gay male communities split, and in their own ways both moved towards the essentialist ethnic/minority identity model that has become integral to the equal rights discourse (Jagose, 1996; Seidman, 1993; Vaid, 1995). Seidman (1993) argues that the gay male subculture became focussed on hedonistic individualism and consumerism. Vaid (1995) suggests that the decline of the New left movements, the appearance of HIV, and a conservative shift in the United States, all encouraged a move to a lesbian and gay movement focussed primarily on legislative change (Vaid, 1995). In this context the focus was on securing legal rights within the mainstream rather than broad societal transformation (Jagose, 1996; Vaid, 1995). Leiring (1997) argues that the equal rights discourse has become almost hegemonic in the West.

Subject Positions

During the height of the liberation discourse’s ascendancy, Kahey (1976, cited in Jagose, 1996, p. 31) argued: “Lesbians and gay men are rapidly replacing *mea culpa* with ‘stick it in your ear’”. This defiant gay liberation subject is urged to be ‘out’ and ‘proud’, to engage in politics of confrontation, have a desire to change any societal structures that support

lesbian and gay oppression, and to assert difference rather than similarity with heterosexuals; thus to assert lesbian and gay identities and subcultures (Evans, 1995; Jagose, 1996; Lehring, 1997; Seidman, 1993). 'Coming out' and being visible as gay people is central to this discourse (D'Emilio, 1998; Jagose, 1996). However, a tension within the liberation discourse is that while gay subjects are urged to assert lesbian and gay identities and break the public/private split of the conservative discourse (D'Emilio, 1998; Lehring, 1997), the constructionist argument within gay liberation argued that these sexual identities need not be fixed or stable (Lehring, 1997). From this radical discourse, lesbians and gays have sought to change how society is structured; they are not willing to settle for just recognition and equality (Seidman, 1993). As part of this a 'liberation' lesbian or gay man can fight for affirmative action and revolutionary change to social institutions and practices (Lehring, 1997).

Five: Christian Supremacist Discourse – Homosexuality as 'sin'

The Christian supremacist discourse marks homosexuality as sinful. This assertion relies on a number of key assumptions. Perhaps the most important of these is that there is one god, he is male, and Christian. The word of god, as represented in the bible, is taken literally. Within this theological framework, heterosexuality expressed within monogamous marriage is considered our god-given nature, the basis of the reproduction of the species, the heart of family life, and the building block of the Church and of society. From this discourse, homosexuality is sinful as it is an impediment to the continuation of the species, a threat to the stability of the family and, thus, society, and an affront to god's plan for humanity.

Because of the way this discourse advocates prohibition of homosexual behaviour, Sullivan (1995) refers to those speaking from this discourse as 'the prohibitionists'. Yet, Vaid (1995) argues that it is important to call this discourse a supremacist one as it highlights the idea that speakers of this discourse do not support the separation of church and state and wish to impose this discourse on all people within a society, if not the world. A statement from Pat Buchanan of the Christian Coalition in the United States illustrates this point well. "Our culture is superior. Our culture is superior because our religion is Christianity and that is the truth that makes men free" (1993, cited in Vaid, 1995, p. 307).

Historical Emergence

In some ways, this discourse of homosexuality predates all the others in this chapter. However, I position it here as the contemporary ‘homosexual’ object of this thesis emerged from the equal rights and pathological discourses. Also, since the emergence of homosexuality as a concept in the late 19th century, the contemporary Christian supremacist discourse did not become politically strong until the 1970s. Yet, biblical disapproval and religious persecution of people engaged in same-sex sexual behaviour has a very long history (Coleman, 1980; Crompton, 2003). Sullivan (1995) contends that the biblical references most commonly used to support the sinfulness of homosexuality are Leviticus from the *Old Testament*:

Thou shalt not lie with mankind, as with womankind: it is abomination.
(Lev. 18:22 King James Version)

If a man also lie with mankind, as he lieth with a woman, both of them have committed an abomination: they shall surely be put to death; their blood shall be upon them.
(Lev. 20:13)

and from the *New Testament*, Saint Paul:

For this cause God gave them up unto vile affections: for even their women did change the natural use into that which is against nature: And likewise also the men, leaving the natural use of the woman, burned in their lust one toward another; men with men working that which is unseemly, and receiving in themselves that recompense of their error which was meet.
(Rom. 1:26-27)

In the 20th century, a strong and visible Christian supremacist discourse has circulated most visibly in the United States since the 1970s (Fetner, 2001; Vaid, 1995). This became evident in the start of an explicitly Christian based political movement. “in the nineteen seventies, when conservative-movement activists made a conscious effort to involve theological leaders in politics” (Vaid, 1995, p. 310). The ‘Moral Majority’, followed by the ‘Christian Coalition,’ are two specific political movements which have promoted this discourse in the United States (Wilcox, DeBell, & Sigelman, 1999). Speakers of this discourse maintain the admonishment of homosexuality even when science makes claims of the naturalness of homosexuality. For example, in a document called ‘*Declaration on Certain Questions Concerning Sexual Ethics*’ issued by the Catholic Church in 1975, a distinction is made between acquired and innate forms of homosexuality, yet the document still stated “Homosexual acts are

intrinsically disordered and can in no case be approved of' (cited in A. Sullivan, 1995, p. 34).

Circulation

"Most societies in the modern world are still distinctly prohibitionist with regard to homosexuality. Until very recently, homosexual acts were illegal in Great Britain; and they are still illegal in many states of the United States" (A. Sullivan, 1995, p. 22). Some of the most vociferous advocates of this discourse in the West are the fundamentalist Christian churches and political groups influenced by them (Hunt, 2003; Patton, 1993; Vaid, 1995; Yip, 2003).

Vaid (1995) claims that in the United States speakers of this discourse are not seen as radical by many; however, the situation may well be different in New Zealand. The Christian supremacist discourse is spoken in New Zealand and probably had its most vocal period at the time leading up to the passage of the Homosexual Law Reform Bill in the mid 1980s. The main opposition to the bill was by fundamentalist Christians (Gearing, 1997; Guy, 2002). A coalition of speakers of this discourse generated a huge petition⁴² which was presented to parliament accompanied by the singing of the New Zealand national anthem which symbolically starts with the line 'God of nations at thy feet'. At that time, a group called 'The Coalition of Concerned Citizens' produced a booklet on the social dangers of homosexuality to New Zealand (1985). This booklet claimed that homosexuality was evil, harmful to homosexuals and to society, that homosexuals were selfish, predatory of children, and that homosexual behaviour led to diseases such as AIDS.

Gearing (1997) presents a recent history of Christian anti-gay actions in New Zealand and argues that they are presented by the mainstream media, and by many widely respected Christians, as intolerant. For example, a former Governor-General and Archbishop of New Zealand, the Most Reverend Sir Paul Reeves made the following statement in a document supporting homosexual law reform:

Even if the Christian position is that homosexual acts are immoral (which we say cannot be stated categorically as Churches and Christians disagree on this), it is nevertheless wrong to impose that view on the rest of the community ... A wide

⁴² The petitioners claimed 750,000 signatures (Lesbian and Gay Archives of New Zealand, 1996). This was out of a New Zealand population of approximately 3,307,000 at that time (Statistics New Zealand, 2002).

range of values is accepted in New Zealand today. Christians are in no position to expect their narrow standard or for that matter their own wider standards to be adhered to by the majority of the non-churchgoing population.

(from 'The Christian and Homosexual Law Reform', 1985, cited in Gearing, 1997, p. 173)

However, while perhaps not as politically powerful as in the United States, this discourse is still circulating in New Zealand. In the foreword to a book chronicling the experiences of gay Catholics in Australia and New Zealand, Felix Donnelly states that "the amount of pain that gay people experience at the hands of the Church is indescribable" (cited in Rosser, 1992, p. ix). Rosser (1992) concludes the book by claiming that a common theme amongst the men interviewed for the book was of feeling oppressed and victimized by the Catholic Church. Continuing in this tradition, there is a counselling organisation in Auckland, (the largest city in New Zealand) called Exodus. This organisation claims to offer treatment for converting homosexuals into heterosexuals (Denham, 1991) and, until recently, was being advertised in the *Community Resources Directory* produced by Lifeline (2002-2003) which is a significant provider of counselling services in Auckland.⁴³ A further example of the supremacist discourse is Destiny Church, (and it's political arm, Destiny New Zealand), which opposes the recently passed Civil Union bill allowing state recognition of same-sex relationships (New Zealand Herald, 2005).

Subject Positions

While there are variations on this position, such as the Catholic version of 'love the sinner and hate the sin' (A. Sullivan, 1995), the homosexual subject in this supremacist discourse is essentially sinful. For speakers of this discourse, homosexual behaviour is associated with shame and guilt. This discourse admonishes homosexuals to seek to become heterosexual or, at the very least, to abstain from homosexual behaviour. It is considered wrong for homosexuals to seek equal rights with heterosexuals as this would undermine the god-given structure of society. Furthermore, speakers of the Christian supremacist discourse claim that equal rights for homosexuals are not justified even with the logic of a broader human rights discourse:

Like everyone else, homosexuals have those rights which are based on their humanity; this is the basis of equality for all. Homosexuals do not have *additional*

⁴³ In 2003 I made a complaint about this service being advertised by Lifeline. Exodus is not included in the current Community Resource Directory (Lifeline office, personal communication, October 25th 2005).

rights based on, or flowing from, their homosexuality. Consequently, when it is said, for example, that *every sign of unjust discrimination in their regard should be avoided* (Catechism of the Catholic Church, para. 2358), this means that they should not be deprived of any of the rights that belong to them as human beings. It does not mean that they have any special entitlements *because* they are homosexuals.

(New Zealand Bishops, 2004, italics in original)

Here a distinction is being made between supposedly ‘human rights’ and any “*additional*” rights which might be specifically associated with homosexuality. Within this discourse a wide variety of behaviour towards homosexuals is advocated, ranging from punishment (such as invoking the death penalty), to pastoral counselling to help them abstain from homosexual behaviour or conform to heterosexuality (Gearing, 1997; A. Sullivan, 1995; Vaid, 1995). Regardless of the severity of the response, this discourse calls on people to prohibit homosexual behaviour (A. Sullivan, 1995).

Six: Takatāpui Discourse – A Māori Discourse of Homosexuality

Thus far, all the discourses described have their origins in the West. Yet, there is at least one contemporary discourse of homosexuality that is unique to New Zealand. This indigenous discourse is a Māori one (Aspin, 2002; Leap & Boellstorff, 2004; D. Murray, 2003, 2004). Before writing this section I wish to acknowledge that I am writing this as a Pākehā, and I am drawing on texts readily available through printed media. Accordingly, I do not have access to the many oral Māori knowledges of homosexuality, and I do not claim to represent all Māori discourses of homosexuality. Similarly, in the following chapter I do not claim to represent all Māori discourses of mental health.

Takatāpui is a term used by some Māori to provide “a culturally appropriate means of defining their sexual and cultural identity” (Aspin, 2002, p. 91). However, it is important to note that takatāpui is not the term most commonly taken-up by Māori to acknowledge their homosexuality (Aspin, 2002; D. Murray, 2003, 2004). Many Māori use other discourses of sexuality, such as those already delineated. For example, in a study of MSM which included 170 Māori, on average, the respondents chose 2.6 labels in regard to their sexual identity (Aspin et al., 1997):

The most popular identity term was “gay”, with just over two thirds of all Māori respondents choosing it. Second most popular was the term “homosexual”, at 58.8% (Aspin, Hughes, Reid, Robinson, Saxton, Segedin, Worth, 1997: 7). However, the report also notes that proportionately fewer Māori than non-Māori chose gay or homosexual, indicating that these terms are not appropriate to all

Māori by any means. The third and fourth most popular identity terms amongst Māori respondents were “bisexual” and “queer” respectively, followed by *takatāpui*, which was chosen by 31.1% (1997: 8).

(D. Murray, 2003, p. 237, italics in original)

For Māori who choose ‘gay’ to denote their sexuality, it is likely that they are drawing on the currently prevalent equal rights discourse of homosexuality (D. Murray, 2003). Similarly, their choices of other terms suggest that Māori are subject to various discourses of homosexuality in circulation.

In this section I focus specifically on *takatāpui*, its origins, its circulation, and the subject position it offers Māori. There are few written texts on this topic, thus I draw heavily on Aspin (2002) and Murray (2003). Versions, definitions and usage of *takatāpui* are evolving (see Aspin, 2002; D. Murray, 2003) but in its broadest sense currently, “*takatāpui* is used as a term to describe gay men, lesbians, bisexuals and transgendered people who also identify as Māori” (Aspin, 2002, p. 96).

Historical Emergence

Māori are indigenous to New Zealand, which was colonised by the British in the 19th century. Therefore, any discussion of contemporary Māori ideas on sexuality needs to account for this post-colonial context (Aspin, 2002). The limited written texts on homosexuality and Māori show evidence of a struggle for who gets to tell this particular story:

It is postulated that homosexuality was unknown in pre-European New Zealand. The evidence for this postulate will be considered from the mythological, historical, philological and clinical viewpoints. Clinically homosexuality is common in the modern Māori.

(Gluckman, 1974, p. 121)

From Gluckman’s perspective homosexuality is a perverse behaviour introduced to Māori by European contact. She claims that lack of a Māori word for homosexuality means that homosexual behaviour did not exist in pre-European Māori society (Gluckman, 1974). However, there are other possible explanations for Gluckman’s stance. First, “absence of a word equivalent to ‘homosexual’ in some languages does not mean the absence of homosexual behavior” (Arboleda & Murray, 1985, p. 129). Another possible explanation for the dearth of written history about Māori homosexuality concerns the European

missionaries who produced written Māori histories and dictionaries (Arboleda & Murray, 1985; Aspin, 2002). Aspin argues that:

the imposition of the colonialists' view of sexuality has meant traditional views and understandings of Māori sexuality have become blurred, misinterpreted or lost completely. Moreover, the missionaries and early commentators set about recording Māori society through Victorian eyes, taking particular care to omit those features which might cause offence.

(Aspin, 2002, p. 93)

Through this process the heterosexual/homosexual binary was imported into the Pacific, and indigenous conceptualisations of gender and sexuality were distorted, suppressed, or lost (Aspin, 2002). A similar process has occurred for other peoples such as Native American societies (D. Murray, 2003).

Given this colonisation of Māori sexuality, how has the notion of takatāpui developed in current usage? Murray (2003) suggests that three sociohistorical trends help explain the emergence of takatāpui in the 1980s and 1990s. One of these was the New Zealand homosexual law reform movement. Murray (2003) argues that while the media did not acknowledge the role of gay Māori in this movement, that indeed many Māori were involved. A second influence was HIV/AIDS. In the 1980s infections rates were rising, and disproportionately more so for Māori (D. Murray, 2003). One outcome of this was the establishment of the Te Rōpu Tautoko Trust as a Māori organisation parallel to the New Zealand Aids Foundation. Policy statements from Te Rōpu Tautoko “specified *takatāpui* as their key target clientele” (D. Murray, 2003, p. 239). The third development Murray argues as significant in the emergence of takatāpui was the Māori renaissance. This movement came from Māori activists “who were changing the political and cultural landscape both within Māori society and at a national level” (D. Murray, 2003, p. 239). Central to this was a focus on te Reo (Māori language):

Thus *te Reo Māori* has occupied centre stage in much public discourse around the “revitalization” or “renaissance” of Māori culture and identity at the same time as “homosexual” culture and identity have been increasingly circulated in public discourses, a confluence that has resulted in some segments of Māori society developing and/or adopting new sexual terminologies from *te Reo Māori*.

(D. Murray, 2003, p. 239, italics in original)

In this context, “takatāpui identity is an attempt to reconcile the present with the past” (Aspin, 2002, p. 93). The earliest known appearance of takatāpui in a dictionary is the *Williams Dictionary of the Māori Language*:

Ka moea taku tuakana e toku hoa takatapui.
[My older sibling slept with my close friend (of the same sex)].
(cited in Aspin, 2002, p. 92)

However, Aspin (2002) cautions that the meaning of takatāpui in 1834 “does not equate to the terms homosexual or gay as we understand them today” (Aspin, 2002, p. 92).

Circulation

As mentioned already, research suggests takatāpui is used by a significant minority of Māori MSM to refer to their sexual identity (Aspin et al., 1997). Others attest to its daily usage from their conversations with Māori MSM (Aspin, 2002; D. Murray, 2003). Takatāpui has also circulated in more public sites. In 1992, Te Waka Awhina Takatāpui was established as a support group for Māori gay men (Aspin, 2002). Contemporary notions of homosexual Māori identity have also appeared in novels such as *The Uncle's Story* by Witi Ihimaera (2000, cited in D. Murray, 2003). On Māori television there is a programme called ‘takataapui’,⁴⁴ dedicated to takataapui issues. Takatāpui is also present in Gearing’s (1997) book on queer culture in New Zealand in the 1990’s.

Subject Positions

A takatāpui discourse on homosexuality offers Māori homosexuals an identity which reconciles and celebrates both their culture and their sexuality (Aspin, 2002; D. Murray, 2003). As part of this, a takatāpui discourse invokes “an association with an authentic cultural identity” (D. Murray, 2003, p. 234).

It is also/always a political statement when it occurs in public (English) discourse as it conveys information about the current status and import of te Reo in Aotearoa in relation to English, which simultaneously conveys a political message about Māori cultural identity in relation to Anglo/Pākehā cultural identity.
(D. Murray, 2003, p. 241, italics in original)

In addition to providing a political identity, takatāpui offers an opportunity for Māori to reclaim takatāpui as part of their pre-colonial heritage (Aspin, 2002). Connected to this, a takatāpui identity supports Māori homosexuals to be “well integrated into their whanau, hapu, and iwi networks” (Aspin, 2002, p. 102). Reporting on conversations with takatāpui,

⁴⁴ This spelling of ‘takataapui’ illustrates some of the diversity in Māori words for homosexuality. Others include ‘tōingo’ and ‘takāpui’ (Learning Media: Te Pou Taki Korero, n.d.). I use ‘takatāpui’ as it is the most commonly used spelling in the publications I have drawn on.

Aspin states “claiming takatāpui identity meant they were able to look to their cultural heritage to facilitate this process of whanau reintegration” (Aspin, 2002, p. 102).

Seven: Queer Discourse – ‘We’re here, we’re queer, get used to it.’⁴⁵

A queer discourse on homosexuality uses the theory and language of social constructionism. Because this is the epistemological frame of this thesis, aspects of this discourse were briefly introduced in Chapter Two. Queer discourse, and queer theory, are often used to refer to the same thing. I will use these terms interchangeably in this chapter depending on its usage by the authors I am referring to. All the previously outlined discourses constitute the homosexual as an object with an identity that we can say things about and can be relatively easily used for various political ends. In contrast, a queer discourse resists reifying the notion of the homosexual object, and any identity categories that have emerged since its invention. As I will explain, this feature of a queer discourse is one that is often used to criticise its political usefulness.

A queer discourse views homosexuality as a cultural construct that is linguistically, and thus structurally, in a binary and subordinate relationship to heterosexuality. Furthermore, this binary opposition of sexual identities is theorised as dependent on and supportive of the ‘cultural fictions’ of the relationship between sex and gender (Jagose, 1996). Judith Butler’s book *Gender Trouble* (1990) is often cited as a key text of queer theory (Jagose, 1996; Spargo, 1999). While Foucault (1976/1990) focussed predominantly on the social construction of male homosexuality, Butler advanced Foucault’s ideas and developed an argument that the concept of homosexuality was one effect of current social constructions of gender.

Butler (1990) posits that if we accept that gender is a cultural construct, then we also need to consider the binary notion of two sexes as neither an inevitable nor an essential organising category. Furthermore, Butler argues that ‘gender’ and ‘sex’ are discursive practices based on compulsory heterosexuality. Butler introduced the notion of ‘performativity’ to describe the process by which people achieve their gender identity through the adoption and repetition of social norms. “This repetition is at once a

⁴⁵ This slogan is used by Spargo (1999, p. 37) as a sub-heading in her book on queer theory. It gives a flavour of the often defiant quality of people taking up a queer subject position.

reenactment and reexperiencing of a set of meanings already socially established; and it is the mundane and ritualized form of their legitimation” (Butler, 1990, p. 140). While using the term ‘heterosexism’ rather than heteronormativity, Leonard (2005) provides a succinct summary of a queer understanding of the connection between sex, gender, and sexual orientation. This account has as its focus:

a social system that privileges heterosexuality and that uses this heterosexual presumption to justify discrimination against alternative sexual and gender identities. Heterosexism assumes that sex and gender and the relationship between the two are fixed at birth: Men are born masculine, women are born feminine and sexuality is an attraction between male and female.

(Leonard, 2005, p. 95)

Within a queer discourse, homosexuality, and the identity categories of lesbian and gay, are products of binary cultural systems of meaning reproduced by institutional and discursive practices. Sedgwick (1990), and Fuss (1991), elaborate on how homosexuality becomes the inferior partner in the binary by arguing that the hetero/homo binary operates in relationship to other binaries such as male/female, rational/emotional, strong/weak, and active/passive. Eve Sedgwick, in her book *Epistemology of the Closet* (1990) argues that the hetero/homo binary is a central organising feature of Western culture:

Epistemology of the Closet proposes that the many major nodes of thought and knowledge in the twentieth-century Western culture as a whole are structured – indeed, fractured – by a chronic, now endemic crisis of homo/heterosexual definition ... The book will argue that an understanding of virtually any aspect of modern Western culture must be, not merely incomplete, but damaged in its central substance to the degree it does not incorporate a critical analysis of modern homo/heterosexual definition.

(Sedgwick, 1990, p. 1)

As mentioned in Chapter Two, by placing the hetero/homo binary at the centre of cultural analysis, Sedgwick argues against viewing the homo/heterosexual definition⁴⁶ as primarily important for a relatively small part of the population (a ‘minoritising view’) and advocates what she terms a ‘universalizing view’ whereby it is of “determinative importance in the lives of people across the spectrum of sexualities” (1990, p. 1). This emphasising of the

⁴⁶ Sedgwick (1990) inverts the relationship between heterosexuality and homosexuality, when she adopts the term ‘homo/heterosexual definition’. This move works against the way in which the heterosexual/homosexual binary privileges the first term in the binary. However, this reversal does not fully encompass a deconstruction of the heterosexual/homosexual binary. “Rather a deconstructive analysis would highlight the inherent instability of the terms, as well as enabling an analysis of the culturally and historically specific ways in which the terms and the relation between them have developed, and the effects they have produced” (N. Sullivan, 2003, p. 51).

'superiority' of heterosexuality as an organising principle in Western culture has been termed 'heteronormativity' (Seidman, 1993; Spargo, 1999; M. Warner, 1993).

Therefore, the various authors who have been termed queer theorists (such as Butler, Fuss, and Sedgwick) have in common a desire to deconstruct or denaturalise any taken-for-granted categories that create our ways of understanding sex, gender, and sexuality. When these categories are deconstructed there tends to be a focus on peculiarity and difference. Queer theory aims to deconstruct and denaturalise the ways in which homosexual identities are socially constructed, performed, and re-produced.

Historical Emergence

The use of the word 'queer' in relation to homosexuality predates the more recent queer theory. Jagose (1996) cites Chauncey's research claiming that in the early 20th Century, 'queer' was used by some male homosexuals in New York to mark themselves by their attraction to men rather than by any feminine gender characteristics. Jagose (1996) also acknowledges that 'queer' has possibly been the most common term of abuse towards homosexuals in the 20th Century. Queer theory and queer discourse are, however, much more recent developments and connected to broader cultural changes. Three key influences have been identified in the emergence of a queer discourse of homosexuality. They are the fracturing of unitary lesbian and gay identities and communities, the increasing influence of social constructionist theories of sexuality and subjectivity, and the challenges brought by HIV/AIDS.

First, since the gay liberation movement of the 1970s significant disruptions have emerged within homosexual communities. One major difference was over which political goals to pursue. Lesbian feminists wanted to focus on building a women's culture to be liberated from the patriarchal conceptions of women, while other lesbians and gay men focussed on liberation from sexual and gender role oppression (Seidman, 1993). However, since then, the identity categories (and assumed corresponding communities) of lesbians and gay men have experienced further challenges. While the equal rights discourse, based on an ethnic model of lesbian and gay identities, has had much success, it has been accused of exclusionist tendencies through its blindness to other axes of identity such as class, ethnicity, and sexual activity preferences (Jagose, 1996; Seidman, 1993). Similarly, Spargo

(1999) comments that bisexuality, transsexuality, and transgender identification, all implicitly challenged the neat identity categories of lesbian and gay.

Furthermore, the differences that prompted challenges to established lesbian and gay identity categories were often about differences within these identity groups. For example:

Disagreements culminated in what are known as the 'sex wars', in which lesbian sado-masochists, women in butch-fem relationships and anti-censorship feminists loudly contested the idea of a united lesbian sisterhood. While the mainstream conception of gay male identity acknowledged diverse sexual practices, including non-monogamous and group sex, it too was seen by some as promoting a restricted, respectable ideal of the committed relationship.

(Spargo, 1999, pp. 32-33)

Second, in addition to multiplying diversity and discontent within lesbian and gay communities, a broader cultural emergence played a part in the construction of queer theory. Since the late 80s social constructionist and poststructuralist critiques of social sciences became more prevalent (Kirsch, 2000; Seidman, 1993; M. Warner, 1993). In this context, the critique of existing homosexual identity categories was partly "a consequence of the constructionist problematising of any allegedly universal term" (Jagose, 1996, p. 74). More specifically, queer theory is often linked to key texts by Butler (1990) and Sedgwick (1990). Queer theory within the academy developed primarily out of the writings of Foucault and especially his notion that sexualities, as we understand them today, are not a liberation of our 'true' sexualities but our embracing of culturally constructed and available categories of sexuality.

A third factor in the emergence of a queer discourse on homosexuality is HIV/AIDS (Jagose, 1996; Jeffreys, 2003). AIDS generated an intensification of homonegative discourse (and, corresponding homosexual-oppressive behaviour) along with new challenges to lesbian and gay communities. One significant outcome of this has been a return to focusing on sexual behaviour rather than sexual identities. For example, (and discussed in Chapter Three), those providing safe-sex education soon discovered that terms of identity familiar to liberation and equal rights discourses were problematic categories for dispensing educational messages. Thus the behavioural term 'men who have sex with men' was developed to speak to men who do not identify as gay, bisexual or homosexual (Dowsett, 1992). HIV also led to a need for coalitional politics between previously disconnected identity groups "and thus included not only lesbians and gay men but also bisexuals, transsexuals, sex workers, PWAs (People with AIDS), health workers,

and parents and friends of gays” (Jagose, 1996, p. 94). These, and other ramifications of HIV/AIDS, contributed to the various forces already challenging the unified subject of the ethnic model of lesbian and gay identities (Seidman, 1995).

Circulation

The queer discourse circulates most identifiably in the academy amongst a disparate collection of academics, but most commonly in women’s studies, cultural studies and lesbian and gay studies departments (Kirsch, 2000; Seidman, 1993). A queer discourse was not apparent in any of the literature I reviewed on mental health and MSM, but it has begun to inform some queer research practices (Gamson, 2000; Kong et al., 2002, see also Chapter Four), and the development of queer health policy (Leonard, 2005). Outside the academy a queer discourse has been linked to some activist groups (Halperin, 1995; Spargo, 1999). Most notable is ACT UP which staged numerous public and disruptive protests about AIDS policies to resist “the effects of power and knowledge as they were manifested in medical institutions, welfare provision, insurance companies and numerous other contexts” (Spargo, 1999, pp. 35-36). However, Jeffreys (2003) argues that the militant strategies of ‘AIDS activism’ were similar to those from within the liberation discourse of the 1970s.

Another sign of a queer discourse is the use of the term queer by many previously lesbian and gay organisations. For example ‘Queer Nation’, founded in New York in 1990, publicly celebrated the name ‘queer’, that had hitherto been a term of abuse (Jagose, 1996). This may have represented the attempts by some lesbians, gay men, and affiliated groups to transcend existing identity politics and use ‘queer’ as the basis for an inclusive politics in opposition to the mainstream (Kirsch, 2000; Seidman, 1995; Spargo, 1999).⁴⁷

In New Zealand, a queer discourse is evidenced in Gearing’s (1997) book *‘Emerging Tribe’*, which traces trends in ‘gay culture in New Zealand in the 1990s’. One of Gearing’s informants justifies using the term queer as follows:

⁴⁷ As discussed briefly in Chapter One, the use of ‘queer’ as an inclusive term has been critiqued as being yet another potentially essentialising term of identity for homosexuals (Halperin, 1995), and for male homosexuals in particular (Jeffreys, 2003). For a discussion of various limitations and strategic possibilities of ‘queer’ as a term, see Halperin (1995).

What unites queer people is the diversity of us. There is no typical gay man or lesbian, but there is something that unites us. What we have in common is the way society perceives us and this is what causes problems, specifically with alcohol, drugs and suicides.

(Semp in Gearing, 1997, p. 42)

This quote displays a problematising of the meanings of lesbian and gay identities while acknowledging a common and oppositional relationship to heteronormativity. Gearing (1997) goes on to chronicle the emergence of queer studies in universities, and the increasing use of the term queer by disparate groupings in New Zealand urban centres. In the academy, queer is used in research, such as Quinlivan's (2002) exploration of the implications of secondary schools attempts to support lesbian and gay students, and Nelson's work on utilising queer theory in teaching (2002). *'Queer in Aotearoa'* is a collection of largely queer essays on various aspects of New Zealand culture (Alice & Star, 2004). Furthermore, 'queer' has appeared in the media, with 'Queer Nation' being the name of a national television programme about LGBT issues.

Subject positions

Of all the subject positions on homosexuality, the queer subject is the hardest to define. In many ways a queer subject is defined by what it is not. Jagose (1996) in her oft-cited introduction to queer theory refers to a queer identity as one without essence. Similarly, Halperin states, "*there is nothing in particular to which it necessarily refers*" (1995, italics in original). Queer resists both the validity and liberatory nature of sexual identities, claiming that they simply reproduce a heteronormative cultural system (Seidman, 1993). Elaborating this idea, Halperin argues that while 'coming out' may be liberatory in some ways, it also involves "exposing oneself to a different set of dangers and constraints" (1995, p. 30).

Because of its anti-essentialist stance, few have attempted to define the queer subject. However, following notions of subjectivity as something that "is not an essential property of the self, but something that originates outside of it" (Jagose, 1996, p. 70) a queer subject is more likely one who is defined by their behaviour rather than any assumed identities or properties. Accordingly, some authors have focussed on the likely activities of a queer subject. For example, Seidman argues there is often a focus on "deconstructive textual practices" (1993, p. 132). Hennessy, (1994) claims that queer aims:

To speak from and to the differences and silences that have been suppressed by the homo-hetero binary, an effort to unpack the monolithic identities 'lesbian'

and 'gay', including the intricate ways lesbian and gay sexualities are inflected by heterosexuality, race, gender, and ethnicity.

(cited in Jagose, 1996, p. 99)

Perhaps where descriptions of the queer subject coalesce is in their desire to upset, protest, resist, and oppose, many of the notions of 'normal' sexual, gendered, and other behaviour (Jagose, 1996; Seidman, 1993; Spargo, 1999; M. Warner, 1993). However, the difficulties of translating this subject position into practice, and for informing collective political and progressive change, are some of the key critiques that have been levelled at queer theory and that have likely contributed to its limited circulation outside of the academy (Jeffreys, 2003; Kirsch, 2000; M. Rahman, 2000; Seidman, 1995).

So, 'What are Ya?'

In this chapter I have outlined seven discourses on homosexuality commonly in circulation in the West, and in New Zealand, since 1869. I have identified their sociohistorical development and their circulation in New Zealand. Where relevant, I have indicated how these discourses are taken up in research and practice surrounding homosexuals and mental health. As stated at the start of this chapter, these discourses are not meant to be exhaustive of homosexual identities, and I again acknowledge that there are many other discourses constructing subjectivity, for example, discourses on ethnicity, gender, class, and ability. Yet I argue that these seven discourses are key cultural resources from which we can begin to understand how people think of, act as, and respond to, 'homosexuals' and 'homosexuality' in New Zealand today.

Accordingly, at times in this thesis I will refer to specific discourses of homosexuality. Yet, additionally, I will sometimes use the term 'homosexuality' or 'homosexuals' to denote homosexuality in a broader sense. Therefore, unless otherwise specified, the use of the term 'homosexuality' is not meant to imply a discrete group of people with a clearly defined sexual orientation, nor is it meant to imply a preference for this term over others. Rather it refers to the theoretical link to the discourses outlined in this chapter. As I am investigating the relationships between MSM and PMHS, I want to explore how these discourses of homosexuality produce and constrain these relationships. However, in order to do this I also need to identify key discourses on mental health. That is the purpose of the following chapter.

Chapter Five:

Cultures, Minds, and Bodies Discourses of 'Mental Illness' in New Zealand

We are terribly judgmental of mental illness and we should not be because it's just an illness.

(Paul Holmes, Broadcaster, in Ministry of Health: Manatu Hauora, 2002a)

This statement is a key message in a recent destigmatisation campaign regarding mental illness in New Zealand. Eight months after the advertisements were aired, 46% of 759 people surveyed remembered the notion that "it's an illness like any other" (Vaughan & Hansen, 2004, p. 116). This idea is clearly constructed from a medical discourse of mental health and implies a truth about emotional and psychological difficulties, as if no other explanation were needed or even reasonably possible. However, there are at least four discourses of 'mental illness' currently circulating in New Zealand, all of which are introduced in this chapter.

There are fewer discourses of mental illness in common circulation than there are of homosexuality. This may represent the almost hegemonic dominance in contemporary understandings of mental illness by medical and psy discourses. In this chapter I outline these two discourses before delineating two other discourses of mental illness that, while present, are relatively marginalised, especially in the provision of PMHS. These are a critical discourse, and a Māori discourse, on mental illness. For each discourse I discuss the implications they have for staff working in, and MSM clients using, PMHS.

Before proceeding, an important proviso regarding terminology in this chapter concerns the way I describe the relationships between discourses and subject positions. I introduced these concepts in Chapter Two, but given the ease with which assumptions are made according to the discipline and training of mental health professionals, it is necessary to clarify these within the specific context of this chapter. Disciplines, such as psychiatry, tend to be constructed around particular discourses. For psychiatry, this is currently the medical discourse. But confusion can arise in assuming that all psychiatrists necessarily speak from a medical discourse. Within a discursive framework, discourses can circulate widely and

people's subjectivity is constructed from multiple discourses. Thus, it is entirely possible for a psychiatrist to speak at times from a medical discourse and at times from a psy discourse (N. Rose, 1999). Similarly, a psychologist may speak from both a psy and a medical discourse if they take a commonly held position of advocating psychotherapy for disorders such as anxiety and depression while consigning psychosis to the domain of medicine.⁴⁸ Therefore, when I describe the subject positions offered by each discourse in this chapter, I am not suggesting that any particular individual or occupational group will necessarily take up these positions. This issue is explored further in the following chapter.

One: The Medical Discourse – The Gaze that Heals

The medical discourse is one of mental illness, doctors, psychiatrists, nurses, drugs, and other physiological treatments such as electro-convulsive therapy (ECT). Many have written about the medical discourse, and regardless of their views on it, all agree on its dominance in the field of psychopathology in the West (Banton, Clifford, Frosh, Lousada, & Rosenthal, 1985; Kitzinger, 1997; I. Parker et al., 1995; John Read, Loren R Mosher, & Richard P Bentall, 2004b; Svensson, 1995; Tuffin, Tuffin, & Watson, 2001).

Historical Emergence

Modern psychiatry often presents itself as the proud product of the modernist move from superstitious and religious approaches towards 'madness', to more 'objective' and scientific approaches. Psychiatry claims that its 'rational' search for the 'truth' about mental illness has brought humane improvement in the quality of life of those suffering from 'mental illness' (I. Parker et al., 1995; Read, 2004a). However, a critical history of the development of psychiatry suggests that the medical discourse is as intertwined with its cultural context as the religious approaches that preceded it.

Certain characteristics of the current medical discourse were circulating as early as the classical era:

Men [*sic*] ought to know that from the brain and from the brain only arise our pleasures, joys, laughs, and jests ... Those who are mad through phlegm are

⁴⁸ Parker (1995, p. 33) argues that this division of labour developed in the 1970's when psychologists were "struggling to create an autonomous identity separate from psychiatry".

quiet, and neither shout nor make a disturbance; those maddened through bile are noisy, evil-doers, and restless, always doing something inopportune.
(Hippocrates, 1931, cited in Read, 2004a, p. 11)

Here Hippocrates links mental states with physiological dispositions. Read (2004a) argues that the fall of the Roman Empire, and the rise of Christianity led to much stronger links between the church and the state. With this came a decline in historical versions of the medical discourse and a rise in religious approaches to illness, symbolised with the image of Christ the healer, and a strengthening of patriarchy and lessening of women's role in healing (Read, 2004a). The return to science did not occur until the Renaissance and the start of the separation of the church and state (Foucault, 1961/1988; Read, 2004a).

Foucault charted the social conditions and medical practices in the West from 1500-1800 that paved the way for the emergence of the contemporary medical discourse of mental illness. In *'Madness and Civilisation'*, Foucault (1961/1988) argued that the origins of psychiatric hospitals were connected to large buildings left empty by the decline in leprosy. This coincided with rising unemployment, and an increasing concern about the government of large populations. Consequently, in 1656, the Hôpital Général opened in Paris, for "the poor of Paris of both sexes, of all ages and from all localities, of whatever breeding and birth, in whatever state they may be, able-bodied or invalid, sick or convalescent, curable or incurable" (Foucault, 1961/1988, p. 39). At this stage then "the mad were locked away not for being mad but for being poor" (Read, 2004a, p. 16). The inmates of these places of confinement included prisoners, the unemployed, and anyone considered to have poor morals or to have scandalised their families (Foucault, 1961/1988). These institutions were also established elsewhere in Europe under police jurisdiction (I. Parker et al., 1995). This was a period when madness began to be seen as a social problem with regard to people not fitting in, which thus presented a problem for society.

Foucault (1963/1994) argued that the increased importance given to the observation of illness was also significant in the construction of modern psychiatry. Medicine became institutionalised as a discipline where certain people (doctors) were imbued "with the power of decision and intervention" (Foucault, 1963/1994, p. 89). Through this new discipline, the medical gaze became "the eye that knows and decides, the eye that governs" (Foucault, 1963/1994, p. 89). For Foucault, the clinical truth of the medical gaze was "synthetic" (Foucault, 1963/1994, p. 50) and focused on diagnosis of pathology/disorder.

Foucault argued that doctors focused more on looking for symptoms of disorders already presumed to exist, rather than exploring the unique relationship between an individual and the problems they were experiencing - “it is a question not of an examination, but of a deciphering.” (Foucault, 1963/1994, p. 60). This focus on the individual, separate from their social context, is one of the key critiques of the medical discourse (Fee, 2000a; John Read, Loren R. Mosher, & Richard P. Bentall, 2004a; Ussher, 2000).

As with physical illness, understandings of madness also changed. Foucault (1961/1988) contended that during the Enlightenment period reason became more valued and unreason was pathologised. This shift meant that a ‘mad’ person must “feel morally responsible for everything within him [*sic*] that may disturb morality and society, and must hold no one but himself [*sic*] responsible” (Foucault, 1961/1988, p. 246). Foucault (1961/1988) also argued that the great houses of confinement were uneconomic and that by the 19th century, only the ‘mad’ were confined. The previous practice of confining the ‘mad’ and prisoners together only stopped because of endless complaints by prisoners (Foucault, 1961/1988). Thus, political changes combined with a new interest in the alliance between morality and reason contributed to the creation of ‘madness’ as an illness (Foucault, 1961/1988).

Further, doctors, and later psychiatrists, became authorities over madness through the development of a new discourse on madness, not by scientific discovery. Initially doctors were brought into the asylums, not because madness was seen as an illness, but because doctors’ authority in society was considered helpful for imploring the ‘mad’ to conform to society’s moral code (Foucault, 1961/1988). Pinel in England, and Tuke in France, typified this practice, known as the “moral treatment” (Foucault, 1961/1988, p. 247). As Read (2004a) comments, this represents a brief moment when psychiatry was explicit about its role in social control. However, as psychiatry became imbued with positivism in the medical discourse of mental illness:

from the beginning of the nineteenth century, the psychiatrist no longer quite knew what was the nature of the power he [*sic*] had inherited from the great reformers, and whose efficacy seemed so foreign to his [*sic*] idea of mental illness and to the practice of all other doctors.

(Foucault, 1961/1988, p. 274)

In other words, psychiatry forgot its beginnings as a willing agent of moral authority and control. Instead, in the new medical discourse of mental illness, psychiatrists claimed they were practicing objective science (Foucault, 1961/1988; I. Parker et al., 1995; Read, 2004a). The medical discourse of mental illness has since told a story of ongoing progress and

development within the auspices of the medical gaze. This discourse, developed in 18th century Europe, is evident in New Zealand PMHS at the start of the 21st century.

Circulation

In New Zealand (as in the United Kingdom and Australia), PMHS are considerably constructed by the medical discourse. They are funded within health budgets, and the chief executive officer of each District Health Board presides over hospitals and mental health services. Furthermore, mental health services are a subset of the hospital system within organisational hierarchies. In addition, the dominance of the medical discourse and the medical gaze is evident in current practice within PMHS in New Zealand. The diagnostic system used is the DSM (American Psychiatric Association, 1994). This diagnostic system fits well with Foucault's notion of the gaze. To determine a diagnosis, clinicians need to extract symptoms of disorders from the story the client tells of their problems. There are five axes of diagnosis in DSM-IV (the current version of the DSM): Axis I refers to clinical disorders and other disorders that may be the focus of clinical attention; Axis II refers to personality disorders and mental retardation; Axis III refers to general medical conditions; Axis IV refers to psychosocial and environmental problems; Axis V is a number from 1-100 representing a Global Assessment of Functioning (GAF Score).

The multiaxial system was introduced in DSM III to provide a more comprehensive evaluation of mental health disorders, but, initially "only the first three axes ... constitute[d] 'an official diagnostic evaluation'" (Williams, 1985, p. 177). This meant that psychosocial and environmental problems were not crucial for diagnosis. Furthermore, Axis V has been criticised as being hard to evaluate and too aetiological for a supposedly "theoretical diagnostic manual" (Williams, 1985, p. 179). In DSM-IV all axes appear to be relevant to diagnosis; however, it provides the option for clinicians to use a nonaxial format. Four examples of this nonaxial format are given and only one of them includes a psychosocial or environmental stressor. Also, it is the first two axes referring to disorders, which are commonly the focus of attention when talking about clients within PMHS.

In terms of its discursive construction, I need to make two important caveats regarding the DSM. I have placed it within the medical discourse, for the reasons already explained and because it was developed by a medical profession, psychiatry. However, DSM-I (American Psychiatric Association, 1952) represented the ascendancy of psychoanalytic ideas in

psychiatry at that time. Accordingly, it was constructed primarily using psychoanalytic language such as reactions and defense mechanisms (Kutchins & Kirk, 1997). However, the medical discourse was also present. For example, the title of the first section was “Diseases of the psychobiologic unit” (American Psychiatric Association, 1952, p. 1). Further, DSM-IV claims to adopt a neutral position regarding the definition and aetiology of mental disorders. In the introduction to DSM-IV, “each of the mental disorders are conceptualised as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress” (American Psychiatric Association, 1994, p. xxi). This definition is further clarified by the statement: “Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual” (American Psychiatric Association, 1994, pp. xxi-xxii). These attempts to define mental disorders clearly include psychological understandings and thus it is incorrect to attribute the construction of the DSM solely to the medical discourse. Unsurprisingly, in addition to its use by speakers of the medical discourse, the DSM is frequently used by those loyal to the psy discourse.

Returning to clinical practice within PMHS, here the medical discourse is prominent. Drugs still dominate treatment within psychiatric services, at the expense of psychological interventions (P. Campbell, 1999; I. Parker et al., 1995; Pilgrim & Hitchman, 1999). Of note, New Zealand and the United States are the only two countries in the Western world which allow direct-to-consumer advertising (Mosher et al., 2004).⁴⁹ Talking specifically about schizophrenia, Bentall (2003, p. 499) argues that mental health services tend to rely on anti-psychotic drugs and there is “little or no effort to respond to patients’ psychological needs”. Bentall also comments that even though a significant minority of patients do not benefit from drugs, the drug companies spend millions on biased research which exaggerates the benefits of drugs. Also, “drug company influence is pervasive and expanding” (Mosher et al., 2004, p. 116). For example, between 1990 and 2000, there was an 800% increase in spending on antidepressants, and a 600% increase in antipsychotics, with a total spending on psychotropic drugs in 2000 reaching US\$23 billion (Mosher et al., 2004).

⁴⁹ This is currently under review in New Zealand (Mosher et al., 2004).

Another example of the dominance of the medical discourse in PMHS is that clinical directors of services are almost always psychiatrists. Moreover, in New Zealand, at least one medical practitioner is required to commit someone under the Mental Health Act. It is also difficult to gain access to PMHS without being referred by a doctor. Further, Mullen (1998) argues that biomedical understandings predominate psychiatric research. For example, and as discussed in Chapter One, biomedical assumptions are present within prevalence research on the aetiology of mental health problems for MSM. Similarly, there is dominance in mainstream media of medical perceptions of mental health issues. A recent example is the “Like Minds” campaign, a large television campaign by the Ministry of Health (Postlethwaite, Ackroyd, & Wyllie, 2001) attempting to de-stigmatise mental illness. As quoted at the start of this chapter, this campaign uses the language of ‘mental illness’. Similarly, a recent study found a predominance of the medical discourse in media coverage of mental health issues in New Zealand (Coverdale, Nairn, & Claasen, 2002).

Subject Positions

For mental health professionals, the medical discourse requires a position of knowledge, expertise, authority, and objectivity. Professionals should use these qualities and knowledges to diagnose and treat symptoms of illness (Banton et al., 1985). As I will illustrate in later chapters, this subject position constructs significant restraints for how queer staff may use their ‘queerness’ in their clinical work within PMHS. Furthermore, the primary causes of mental illness are assumed to be biological and, thus, the search is for the right drug or other medical intervention (Banton et al., 1985; Davison & Neale, 1990; Svensson, 1995). Similarly, the primary location of mental illness is seen to be within the patient (Fee, 2000a; Foucault, 1961/1988; I. Parker et al., 1995). In this discourse, users of mental health services are patients who knowingly or otherwise, are suffering from mental illness (Hodgkiss, 2000). The patients’ role is to passively allow the professional to diagnose their illness and to then “co-operate with the treatment” (Banton et al., 1985, p. 194). ‘Patients’ refusals to accept diagnoses are often referred to as ‘lack of insight’. Following Turner (1987, cited in I. Parker et al., 1995, p. 13), Parker et al. describe this subject position as requiring the patient “to be responsible for aiding the process of cure and then to accept diagnosis and medication in suffering silence”. In this subject position there is little space for MSM clients to assert that issues regarding their marginalisation as MSM are relevant to their experience of mental health problems.

Two: The Psy Discourse – Creating and Maintaining the Norm

The psy discourse focuses on the mind/‘psyche’ rather than the body, and privileges aetiological explanations such as prior experiences, social development, learning, and meaning, rather than genes and/or biology (Banton et al., 1985; Davison & Neale, 1990; I. Parker et al., 1995). Furthermore, Rose (1985) distinguishes between the norms of the medical discourse, which are based on “a disturbance in its object, the body itself” (N. Rose, 1985, p. 229), versus psychological norms which are population based; thus, an abnormality is constructed “in terms of a norm of functioning specified by particular social apparatus” (N. Rose, 1985, p. 229). Consequently, instead of focussing on ‘mental illness’ based on norms of the body, the psy discourse constructs notions of normal and abnormal behaviour (I. Parker et al., 1995; N. Rose, 1999), based on norms of society.

Similarly to the normal/abnormal distinction, both the psy and the medical discourse use the language of ‘dysfunction’ and ‘disorders’. Thus as mentioned earlier, both the medical and the psy discourse use the DSM classification system. However, as explained above, the object of abnormality is constructed differently by each discourse. Also, the psy tends not to use the language of ‘illness’, and instead focuses on ‘distress’ or ‘problems’ (Beck, 1993; N. Rose, 1996). Thus, from the psy discourse, mental health problems are not ‘lack of sense’ due to biological malfunction; instead, problems are conceptualised as meaningful distress due to stressful events including early childhood experiences. This places the contemporary psy discourse in the liberal humanist tradition because of its emphasis on the search for a better, freer, self through increased understanding of ourselves and others (Kitzinger & Perkins, 1993; I. Parker et al., 1995; N. Rose, 1999).

As with the medical discourse, in considering the psy discourse I do not limit this discussion to the disciplines of psychology, clinical psychology, or, indeed, any particular discipline or therapeutic modality. Rather I refer to the broad areas suggested by the term the ‘psy-complex’, posited by Rose (1985), and more recently defined by Parker (1997) as including:

the network of theories and practices that comprise academic, professional and popular psychology, and it covers the different ways in which people in modern Western culture are categorized, observed and regulated by psychology, as well as the ways they live out psychological models in their own talk and experience.

(p. 287)

Here Parker privileges the term ‘psychology’, even though he is referring to the broader psy-complex. Similarly, Rose’s use of terminology around the ‘psy’ is a little confusing at times. For example, in *Inventing ourselves: Psychology, power and personhood* (1996), he states that a major focus of his study is the “history of psychology, or rather, all of those disciplines which, since about the middle of the 19th century, have designated themselves with the prefix psy – psychology, psychiatry, psychotherapy, psychoanalysis” (N. Rose, 1996, p. 10). This quote includes the discipline of psychiatry, which is commonly associated with the medical discourse. But then Rose talks primarily about psychology for much of the book. As such, in outlining the ‘psy’, he does not include the medical discourse. It is possible to see commonalities between psychology, psychotherapy and psychoanalysis (discussed later in this section), and to conceptualise psychology as the currently more dominant term of the three, so this may explain why Rose appears to privilege the psychological within the psy. Thus while in other places Rose clearly delineates between the psy and medical discourses (N. Rose, 1985, 1999), his inclusion of psychiatry within the above quote may help explain a related conflation that some authors make between the medical and psy discourses (see Chapter Six for an elaboration of this).

Historical Emergence

A pre-modern condition for the development of the psy discourse was Descartes’ dualistic splitting of the mind and the body in the 17th century (I. Parker et al., 1995). Descartes privileged the mind and its ability to reflect on itself (I. Parker et al., 1995). Similarly with the medical discourse, the Enlightenment’s move towards increasingly viewing the human individual as an object of scientific study provided a further ingredient for the development of the psy sciences (Foucault, 1976/1990). Additionally, in the context of the broader modernist turn, reason and the rational subject became paramount (Foucault, 1961/1988).

With the rise of the rational subject, and the rise of populations, Foucault argued there was a need for additional and new forms of discipline. As discussed in Chapter Two, these new forms of power operated through processes of normalisation and self-discipline. The power of the ‘norm’ was inscribed both by various disciplines, including psychiatry and psychology, and by the desires of individuals to be ‘normal’ (Foucault, 1975/1977). This new form of discipline, along with the notion of the rational self, supported the idea of people taking responsibility for their own self-regulation (N. Rose, 1999). Foucault (1976/1990) argued that the Catholic confession provided a template by which the psy

disciplines could encourage people to take responsibility for themselves and confess to their 'abnormalities' in the search for their 'true' and better selves:

The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling with the greatest precision, whatever is most difficult to tell. One confesses in public and in private, to one's parents, one's educators, one's doctor, to those one loves; one admits to oneself, in pleasure and in pain, things it would be impossible to tell anyone else.

(Foucault, 1976/1990, p. 58)

This confessional theme is present in many forms of the psychotherapies (N. Rose, 1999), but was pioneered by Freud, who developed the 'talking cure' of psychoanalysis (Forrester, 1980). Although a medical doctor himself, Freud distinguished between what Parker et al. (1995) refer to as physical lesions versus "the lesion of an idea" (p. 20). For Freud, hysteria developed when current experiences resonated with earlier repressed memories, not easily accessible in word form. Therapy was to help the patient put these repressed experiences into words and, through this practice, be cured (Forrester, 1980; I. Parker et al., 1995). Thus, in psychoanalysis a key emphasis is on early life experiences affecting the construction of the mind, rather than on biological flaws. This 'talking cure' set a precedent for the development and expansion of the psy discourse.

Circulation

Since the emergence of psychoanalysis, numerous psychotherapies have developed (N. Rose, 1999). These include, but are not limited to, therapies practiced by psychotherapists, psychologists, psychiatrists, counsellors, and clinical social workers. The psy discourse therefore includes models and practices that at first seem quite disparate, such as psychoanalysis, behaviourism, family therapy and cognitive behavioural therapy (Burr & Butt, 2000; I. Parker et al., 1995; N. Rose, 1999). But what they have in common, to a greater or lesser extent, is a liberal construction of the self as searching for meaning and satisfaction, and the role of the psychotherapies is to enable this self to reflect on itself, and change for the better (N. Rose, 1999).

Given the epistemological similarities between the psychotherapies (N. Rose, 1985, 1999), I will not describe them here. Instead I introduce cognitive behavioural therapy (CBT) developed by Beck (1976). While different psychotherapies propose differing styles of

therapeutic relationships (N. Rose, 1999), CBT is arguably the psychotherapy most likely to be encountered in PMHS in New Zealand. CBT is commonly offered by psychologists, yet many mental health professionals who are not psychologists have familiarity with, or undertake courses on, CBT. Parker et al. (1995) describe a similar situation in the National Health Service in the United Kingdom.

In CBT, key ingredients of the confessional mode are alive. CBT focuses on dysfunctional thoughts and core beliefs. Like psychoanalysis, these cognitions are considered familial and cultural in origin (Javel, 1999). Individuals' thoughts are theorised to cause problems by being negative and distorted (Javel, 1999). The therapist's job is to help the client realise the errors of their thinking. Thus, while there are differences in the language and process of CBT and psychoanalysis (E. Jones & Pulos, 1993), CBT still involves confessing one's thoughts and hopes to a professional, in search for the 'truth' of a person; a 'truth' which has been clouded by earlier life experiences which distorted a person's thoughts. Thus, despite some difference in models and practice, the various psy-therapies share an overarching theme, which is the promise of such things as 'personal growth', 'empowerment', and achieving our 'full potential' (Kitzinger & Perkins, 1993; N. Rose, 1999). This liberal, humanistic paradigm has been influential in many strands of the psy-therapies (N. Rose, 1999). Rose (1999) argues that this search for the 'authentic' self is central to the psy-complex, but it is not only in the psychotherapies that the psy discourse operates, rather it circulates widely within contemporary Western societies.

For instance, Parker argues that "the psy-complex is part of a particular 'regime of truth' which makes our talk and experience about 'the self,' 'personality' and 'attitudes' make sense" (I. Parker, 1997, p. 287). Thus, the psy discourse has come to play a huge part in contemporary Western culture. Rose (1996, p. 34) uses the term "psy" to refer to psychological knowledges and practices in the broadest sense. He argues that psychology has been very successful at lending its knowledge to various professional groups and that "it has become impossible to conceive of personhood, to experience one's own or another's personhood, or to govern oneself or others without psy" (N. Rose, 1996, p. 34). Elaborating on the influence of psychology Rose argues:

Over the past half century, in the liberal democratic and capitalist societies of what we used to call the West, the stewardship of human conduct has become an increasingly psychological activity. Psychological experts, psychological vocabularies, psychological evaluations, and psychological techniques have made themselves indispensable in the workplace and the marketplace, in the electoral

process and the business of politics, in family life and sexuality, in pedagogy and child rearing, in the apparatus of law and punishment, and in the medico-welfare complex.

(N. Rose, 1996, p. 81)

The psy has become part of everyday life. One example of this is “through media, such as magazines which often feature quizzes and questionnaires inviting readers to assess their own personalities in some way” (Burr & Butt, 2000, p. 192). The vast range of self help books, motivational speakers, and self improvement courses all inviting us to become better, more psychologically sound people are further evidence of the widespread circulation of the psy discourse (N. Rose, 1999). The internet has also become a significant resource for psychological information (Godin, Truschel, & Singh, 2005; Zuckerman, 2003). Almost every aspect of human experience is now labelled in terms of psy. For example, the media and psychological research commonly refer to ‘homophobia’ as a fear of homosexuality. This has been critiqued as being an individualising and ‘psy’ way of describing culturally sanctioned homonegative and oppressive discourses (Kitzinger & Perkins, 1993). Alternative terms such as ‘anti-homosexual discrimination’ or ‘homonegative trauma’ might recognise the influence of cultural context. Similarly, much of the research reviewed in Chapter One uses psy concepts and focuses on the use of psy-therapies by queer people. The psy is now part of how many in the West think of themselves and others.

We make daily use of the language of feelings, stress, grief, depression, and anxiety etc. Furthermore, the psy discourse suggests that individuals’ sense of identity can be understood through these feelings, and that people can (and should) use psy strategies to regulate their experiences and be ‘normal’. In this context, it is not surprising that internationally, the public tend to prefer psychosocial explanations of mental health problems over medical ones (Read & Haslam, 2004). Yet, despite the widespread public circulation of the psy discourse of mental health, this does not necessarily reflect its circulation within PMHS. Parker (1995, p. 18) refers to psychoanalysis as “psychiatry’s rival and twin”. He also argues that the psychotherapies (including those practiced by clinical psychologists) have to compete with the dominance of drugs and “the demand that psychotherapy should be available as an alternative to drug treatments is still a radical demand” (I. Parker et al., 1995, p. 20). This relation of power between the medical and psy discourses of mental health is explored in the interview analysis chapters of this thesis and so is not explored further here.

Subject Positions

Similarly to the medical discourse, a psy mental health professional is an ‘objective’ expert in the diagnosis and treatment of mental health disorders (Hare-Mustin & Marecek, 1997; I. Parker et al., 1995). This often involves the use of supposedly atheoretical diagnostic systems such as DSM. Thus, like the medical professional subject, this position provides restraints to how queer staff can use their ‘subjective’ and ‘queer knowledges’ in PMHS (this issue is explored in detail in later chapters). Furthermore, the treatment should be based on sound, scientific, evidence-based practice (Beck, 1993; Davison & Neale, 1990; N. Rose, 1996). Problems, while often considered to originate in relationship with others, are nevertheless often located within the faulty cognitions of those diagnosed (Kitzinger, 1997; I. Parker et al., 1995). However, unlike the medical mental health professional, the humanistic strand of the psy discourse requires the mental health professional to be client centred and collaborative in helping the person experiencing problems (Corsini & Wedding, 1989; Padesky & Greenberger, 1995; Safran & Segal, 1996).

Unlike the ‘patient’ subject of the medical discourse, the psy discourse constructs its subjects as ‘clients’, ‘consumers’, or ‘users’ of mental health services. However there is little agreement on which of these terms is preferred by academics (I. Parker et al., 1995), mental health staff, or the people they serve (Hodgkiss, 2000; Neuberger, 1999).⁵⁰ Most importantly in this discourse clients are encouraged to speak of their troubles and it is through speaking that a cure will be found (I. Parker et al., 1995; N. Rose, 1999). Within the psy discourse, people have a moral responsibility to seek treatment and to better themselves (I. Parker et al., 1995; N. Rose, 1999). One version of this approach to moral responsibility is encapsulated in an often repeated joke: ‘Question: How many psychologists does it take to change a light bulb? Answer: It doesn’t matter how many you have, the light bulb has to want to change’.

In the psy discourse the client is not the passive subject of the medical discourse but an active participant in their treatment (I. Parker et al., 1995; N. Rose, 1999) under the

⁵⁰ This terminology has been influenced by neo-liberal beliefs about public choice, rights, and a desire to encourage active participation by people who use mental health services (Neuberger, 1999). This issue is discussed further when looking at a Critical discourse of mental health later in this chapter. Most literature reviewed thus far uses the term ‘client’, and likely reflecting my own positioning as a psychologist, this is the term I use most frequently in this thesis.

benevolent guidance of a parent or teacher-like professional. Within this discourse, a key goal is for clients to 'self actualise', 'grow', or 'fulfil their potential', by recovering or attaining their 'true self' (Burr & Butt, 2000; Kitzinger & Perkins, 1993; N. Rose, 1999). The search for one's 'true self' is also constructed by the modernist notion that people should have relatively coherent and stable personalities (Burr, 1995; Burr & Butt, 2000; N. Rose, 1999). The 'promise' of the psy, is that in searching for this 'true', coherent, self, people will become freer (N. Rose, 1999). Accordingly, there is room within this discourse for MSM clients to explore how issues of sexual orientation are relevant to their identity and to their mental health.

Three: Critical Discourse of Mental Health – Constructions of Disorder

In contrast to the biological illness of the medical discourse, and the more cognitive or meaning based conception of disorders or problems in the psy discourse, the critical discourse has politics, ideology, power, inequality and individual's relationships to society as its primary foci (Banton et al., 1985; Hare-Mustin & Marecek, 1997; Prilleltensky & Fox, 1997; Prilleltensky & Nelson, 2002; Svensson, 1995). A central tenet of a critical approach to 'disorder' is that all constructions of disorder, such as those enshrined in diagnostic systems like DSM, are necessarily political (Fee, 2000a).

In outlining this critical discourse on mental health I draw primarily on four strands of writing. By drawing on these various traditions, I am necessarily focusing on their similarities in the way they construct 'disorder' and related practices. Hence, I do not explore the significant differences between these traditions. One strand is the anti-psychiatry movement of the 1960s and early 70s (for reviews see Banton et al., 1985; I. Parker et al., 1995; Svensson, 1995). Second is literature written mainly by feminists (Burman, 1990b; Chesler, 1972; Kitzinger, 1997; Marecek, 2001a; Sturdivant, 1980; Ussher, 2000; Worell & Remer, 2003), and more recently by critical psychologists (Nelson, 2002; Nightingale & Neilands, 1997; I. Parker, 1999; Prilleltensky & Fox, 1997; Sloan, 2000). A third tradition often present in both of these strands is the turn to a focus on the role of language and discourse in the construction of 'disorders' and of therapeutic practices (Burr, 1995; Foucault, 1975/1977, 1961/1988, 1976/1990; K. Gergen & McNamee, 2000; Neimeyer & Raskin, 2000). Narrative therapists in particular have tried to apply this

constructionist approach to therapeutic practice (Drewery et al., 2000; Neimeyer & Raskin, 2000; White, 1988/89).⁵¹ The fourth strand is writing from the variously named consumer/survivor/service user, or recovery movement (P. Campbell, 1999; Corrigan & Ralph, 2005; L. Davidson, Sells, Sangster, & O'Connell, 2005; Deegan, 1988, 2001; Lunt, 2004; McGruder, 2001; Pilgrim & Hitchman, 1999; Ralph & Corrigan, 2005; Wallcraft & Michaelson, 2001).

Historical Emergence

The anti-psychiatry movement of the 1960s was connected to the broad critique of established institutions that took place in the West at that time (I. Parker et al., 1995), and to representations of psychiatric hospitals as inhumane places of forced containment (Svensson, 1995). Despite divergent political stances, two key people in this movement were R. D. Laing in the United Kingdom, and Thomas Szasz in the United States. Laing was informed by the French existentialist Sartre and was responsible for publishing Foucault's (1961/1988) 'Madness and Civilization' in the United Kingdom (I. Parker et al., 1995). Laing's central thesis was that human "discourse of all kinds – even 'psychotic' discourse – makes sense if it is listened to" (Banton et al., 1985, p. 68). Furthermore, Laing argued that the world is such a crazy place that madness is a sane response to it. Laing's theory thus defied biological explanations of mental illness and instead linked "the most painful personal experiences with a political account of the world" (Banton et al., 1985, p. 69).

Szasz also critiqued the medical concept of mental illness (I. Parker et al., 1995). For Szasz, psychiatry made the mistake of emphasising similarities between physiological and mental illnesses, and minimising the differences. Further, Szasz argued that mental illnesses were defined by social and moral norms and values, not by the scientific methods used to discover physical illness (Svensson, 1995). Consequently, Szasz believed that 'mental illnesses' were labelled and constructed in social contexts and that a more appropriate term to use was "problems in living" (cited in Svensson, 1995, p. 18).

⁵¹ Strictly speaking, narrative therapy has its origins in the social constructionist writings of Foucault (see White, 1988/89). However, many writing and practicing from this perspective seem to deploy Critical Theory concepts like oppression and marginalisation. It is because of this that I include their ideas and practices within the critical discourse of mental health.

Similarly, (and as discussed earlier), Foucault (1961/1988, 1988) tracked changes in the social construction of madness in the West from 1500-1800. Foucault argued that over this period, madness moved from a philosophical perception to a medical one. As already noted, once reason became more valued in the Enlightenment period, unreason became pathologised. Foucault's critique of mental illness was part of the broader challenge to modernism, positivism, and science discussed in Chapter Two.

Since the 1970s the feminist movement has also challenged existing understandings and practices surrounding mental health. '*Women and Madness*' by Chesler (1972) was a key critique:

Chesler spelled out what she saw as a double-bind for women. Traditional femininity was extolled as the ideal mental health for women at the same time that such diagnostic categories as hysterical personality and dependent personality disorder rendered femininity as disorder.

(Marecek, 2001a, p. 305)

Feminist perspectives on mental health have proliferated in the last 30 years and constitute a wide diversity of approaches including (but not limited to): radical (Burstow, 1992), lesbian (Kitzinger & Perkins, 1993), postmodern (M. Gergen, 2001; Marecek, 2002; Ussher, 2000), women of colour, liberal, and socialist perspectives (see Enns, 1997; Worell & Remer, 2003). A key challenge for these diverse feminist approaches is how to balance talking about women as a group (and often in essentialising ways), while accounting for the multiple ways in which women's lives are mediated by other variables such as class, ethnicity, and sexual orientation (M. Gergen, 2001; Worell & Remer, 2003). Despite these differences a foremost commonality in feminist approaches to mental health includes a focus on how socially constructed notions of gender affect women's lives (Enns, 1997; Marecek, 2001a; Worell & Remer, 2003). Correspondingly, this means that the theories and practices of mental health as applied to women are always political acts (Brabeck & Brown, 1997; Hill, 1998; Marecek, 2001a; Worell & Remer, 2003).

For example, feminists have critiqued the gender bias in the construction of disorders in DSM (L. Brown, 2000; Kaplan, 1983; Kupers, 1997; Marecek, 2001b). Ussher argues that describing women's distress as madness:

reifies notions of madness as discrete, consistent, and homogenous clinical entities ... This acts to deny the social and discursive context of women's lives, as well as the gendered nature of science, which defines how women's bodies and lives are studied.

(Ussher, 2000, p. 210)

L. Brown (2000) provides an illustration of how diagnostic categories can be harmful to women. For example, posttraumatic stress disorder (PTSD) can be applied to women who have been subjected to abuse by men. The traumatic response to this abuse is then called a 'disorder', when it can be considered a normal response (L. Brown, 2000). She then asks "if the distress were seen as the norm, rather than as a pathology or disorder, how might that shift cultural vision, social policy, and collective action?" (L. Brown, 2000, p. 299). Similarly, (as discussed in Chapter One), the changing diagnostic status of homosexuality over the last 100 years attests to the cultural forces shaping constructions of mental illness (Bayer, 1987; Greenberg, 1997; Kitzinger, 1990; Kupers, 1997; Schmidt, 1995).

Users/survivors of psychiatric services have also been active in the emergence of a critical discourse of mental health. Since the 1980s grass roots resistance to psychiatric practice, and to the medical discourse of mental health in particular, has grown (P. Campbell, 1999; Corrigan & Ralph, 2005; McGruder, 2001). Initially there were direct connections with the anti-psychiatry movement of Laing (P. Campbell, 1999). This consumer-led movement is often based on the concept of 'recovery' (C. Brown, 2001; P. Campbell, 1999; Corrigan & Ralph, 2005; Deegan, 1988, 2001; McGruder, 2001). The notion of 'recovery' as it is used in New Zealand is explored in the following chapter.

There is much diversity within the consumer movement, not the least of which is what to call it (P. Campbell, 1999). I address some of these issues of language later when discussing subject positions. However, here I outline some key ideas from the consumer movement. One is a challenge to the normal/abnormal dichotomy regarding mental health, and to the use of diagnostic labels in ways which produce marginalising and stigmatising identities (Corrigan & Ralph, 2005; Deegan, 1988; Wallcraft & Michaelson, 2001). Users of mental health services want to be seen as much more than their diagnoses (P. Campbell, 1999; L. Davidson et al., 2005; Deegan, 2001; Wallcraft & Michaelson, 2001). Rather than assuming the outcome of treatment being 'normalcy', the consumer movement advocates greater attention to the process of how people make meaning of mental health problems, and to a more holistic understanding of their lives, their strengths, and their relationship to wider society (Corrigan & Ralph, 2005; L. Davidson et al., 2005; Deegan, 2001; McGruder, 2001). Further, there is considerable focus on consumer rights (P. Campbell, 1999; Wallcraft & Michaelson, 2001), and consumer choice within mental health services, including the choice not to use such services (Corrigan & Ralph, 2005; Deegan, 1988; Lunt, 2004).

Circulation

When the anti-psychiatry movement began, psychiatric textbooks largely ignored its proponents (I. Parker et al., 1995). It is in the areas of feminist therapy, and the consumer movement, that a critical discourse of mental health has probably had most impact. The last three decades has witnessed a huge development of feminist theorising, research, and practice regarding women's mental health. The goal has been to empower women and help them resist oppressive societal practices affecting women (Worell & Remer, 2003; Wyche & Rice, 1997). Many women, and, arguably, some men (Marecek, 2001a; Worell & Remer, 2003) have applied feminist principles to clinical practice. Marecek (2001a) argues that "the practice of feminist therapy has far outstripped both theory development and research" (p. 306). Feminism has also had an impact on mainstream mental health organisations. For example, Wilkinson and Burns (1990) provide an account of the establishment of British Psychological Society's 'Psychology of Women Section'.

The consumer/recovery movement has also circulated a critical discourse within the area of mental health. Numerous consumer led organisations have developed (P. Campbell, 1999; Corrigan & Ralph, 2005; I. Parker et al., 1995). One example of this is the 'Hearing Voices Network' from the United Kingdom. This developed from the work of a psychiatrist (Marius Romme) and a patient of his (Patsy Hage) (I. Parker et al., 1995). This network is not illness - or diagnosis - driven; acknowledges the voices referred to by psychiatry as 'auditory hallucinations' as real; supports people to live with, rather than suppress voices; and has attained central funding (I. Parker et al., 1995). Recently there have been some moves in New Zealand to offer a similar approach within PMHS. The consumer/recovery movement has also enabled the practice of employing service users in mental health services, the widespread development of charters for consumer/patient rights, and the development of alternatives to hospitalisation (P. Campbell, 1999; Wallcraft & Michaelson, 2001). Furthermore, the philosophy of 'recovery' has become part of mental health policy (but not necessarily practice) both internationally (Diamond, Parkin, Morris, Bettinis, & Bettsworth, 2003; Pilgrim & Hitchman, 1999; Thornicroft & Tansella, 2005), and in New Zealand (Kriebler, 2003; Lapsley, Nikora, & Black, 2002; O'Hagan, 2001).

Parker et al. (1995) argue that family therapy has also been a key site for the circulation of a critical discourse. Like Laing's concept of "schizophrenogenic" families (1965, p. 190), family therapy views psychopathology as arising in family structures and processes, not in

individuals. Accordingly the focus of treatment is on meaning and structures (I. Parker et al., 1995), not disordered bodies. However, critics of family therapy have charged it with failing to adequately account for how broader sociocultural values such as patriarchy are reproduced in families (Goldner, 1993). Partly in response to these criticisms, narrative therapy was developed which takes the discursive ideas of Foucault and applies them to therapeutic practice (Drewery et al., 2000; J. Freedman & Combs, 1996; White, 1988/89). Some of these practices are described when I outline the subject positions offered by a critical discourse of mental health below.

Other critical literature on mental health picks up on some of the issues raised by the anti-psychiatry moment, especially notions of the social construction of mental illness (Kitzinger, 1995; Raskin & Lewandowski, 2000; Read et al., 2004a). One recent example regards schizophrenia, one of the most debated areas in psychiatry (Read et al., 2004b). Read et al. (2004b) provide a summary of scholarship and research challenging the dominant medical model of schizophrenia. Their account utilises critical approaches to the history and construction of 'mental illnesses'. Critical literature also explores the application of these understandings into therapeutic practice (Besley, 2002; Ussher, 2000; White, 1988/89), and the connections between inequality, oppression, and mental distress (Hare-Mustin & Marecek, 1997; Prilleltensky & Fox, 1997; Read, 2004c). Some also highlight the power of the drug companies to influence research, treatments, and publicly available information on mental illness (McGruder, 2001; Mosher et al., 2004).

Notwithstanding the influence of feminism, and the consumer/recovery movement, the impact of a critical discourse on mainstream mental health services has been limited. Critical approaches have "often operated as subjugated and subversive forms of knowledge" (I. Parker et al., 1995, p. 36). Campbell argues that "it is difficult to argue that service user/survivor groups have significantly affected the practice of ECT or drug treatment, the two mainstays of mental health care" (1999, p. 205). Similarly, Pilgrim and Hitchman state that "bio-medical notions [of mental illness] retain favour in central policy formation" (1999, p. 185). Yet, in the following chapter I explore how this critical voice is constructive in the development of New Zealand national mental health policy.

Subject Positions

For the critical mental health professional, this discourse suggests they should become aware of the power of their position, and their power to create and maintain dominant and oppressive meanings through their talk (Deegan, 2001; Drewery et al., 2000; Hill & Ballou, 1998; Marecek, 2001a; McGruder, 2001). The practice of mental health professionals becomes a political act with a responsibility to work against inequality (Enns, 1997; Hare-Mustin & Marecek, 1997; Nightingale & Neilands, 1997; Worell & Remer, 2003; Wyche & Rice, 1997). This discourse thus potentially provides queer staff with the opportunity (if not responsibility) to use their knowledge of being queer in a heteronormative society to inform their practice. It also offers heterosexual staff the responsibility for practicing in ways that minimise the oppression of queer people.

Following a feminist tradition where “the client is the ‘expert’ on her own feelings and experiences” (Sturdivant, 1980, p. 82), a critical mental health professional is encouraged to eschew an expert position, and instead to adopt a ‘not knowing’ approach (H. Anderson, 2000) where meanings are collaboratively created with users of mental health services (P. Campbell, 1999; L. Davidson et al., 2005; Deegan, 2001; Marecek, 2001a; Wallcraft & Michaelson, 2001). However, while ‘not knowing’ what is necessarily best for any one client, critical clinicians should promote hope (Corrigan & Ralph, 2005; Deegan, 1988), and should know about sociocultural practices of oppression (Prilleltensky & Nelson, 2002; Sloan, 2000).

Both staff and consumers should have access to objective and subjective knowledges about personal and political oppression. They should both draw on their subjective experiences to unearth marginalised stories of mental health problems and create knowledge about empowerment, survival and resistance (Corrigan & Ralph, 2005; Deegan, 1988; Drewery et al., 2000; Enns, 1997; Haraway, 1988). This type of ‘situated objectivity’ is similar to feminist notions of situated moral and political objectivity (see Haraway, 1988). This notion of situated objectivity was developed within a ‘feminist standpoint’ position (Harding, 1986) which challenged ‘objective science’ as being androcentric. The goal was to replace it with woman inspired truths, where “knowledge is derived from experience” (M. Gergen, 2001, p. 20). However, this idea has since been critiqued from within feminism for failing to account for the ‘truths’ of differing groups of women (M. Gergen, 2001).

One strategy feminists have used to explore issues of oppression and marginalisation, is encouraging women to locate the source of problems in patriarchal power structures (Marecek & Kravetz, 1998; Ussher, 2000; Worell & Remer, 2003). Another strategy for furthering the goal of uncovering oppressive societal practices is advocated by narrative therapists (J. Freedman & Combs, 1996; White, 1988/89); they try to help the mental health service user resist dominant stories, create preferred stories, and liberate subjugated ones (J. Freedman & Combs, 1996). A common technique developed by White (1988/89), involves externalising the problem from the person, moving “the spotlight from the individual onto the system of concepts that holds them in place and holds them in their distress” (I. Parker et al., 1995, p. 108). This practice is consistent with the consumer movement’s critical approach to diagnosis. In relation to MSM clients, such an approach could involve inviting them to explore how cultural ideas about sexuality impact on their lives and how they can resist the negative effects of this (Logan, 2002; Simon & Whitfield, 2000).

Consistent with a focus on the constructive power of language in regard to mental health, the terminology used to describe people who use mental health services is contested. Some commonly used terms include: ‘consumer’, ‘survivor’, ‘psychiatric survivor’, ‘ex-patient’, and ‘user of mental health services’ (P. Campbell, 1999; Corrigan & Ralph, 2005; McGruder, 2001). Reviewing the literature, ‘consumer’ currently seems to be the most commonly used term both internationally (P. Campbell, 1999; Corrigan & Ralph, 2005; Deegan, 2001; McGruder, 2001; McLean, 1995), and in New Zealand (Kriebler, 2003; Lapsley et al., 2002; Ministry of Health: Manatu Hauora, 1997).⁵² Yet, McGruder (2001, p. 78) points out, “the very irony of the now popular term ‘consumer’ of mental health services cannot go unremarked, when so many have literally no choice of health care provider or facility – let alone whether to be treated or not – and hence no real consumer power”.

Similar to the psy client, the critical consumer of mental health services is seen as active, resilient, competent, and very much involved in the solutions to problems (P. Campbell, 1999; Deegan, 2001; Enns, 1997; I. Parker et al., 1995; Worell & Remer, 2003). While conceptualised as being oppressed and/or restricted by social discourses of inequality,

⁵² However ‘service user’ is the term used in the *‘Recovery Competencies for New Zealand Mental Health Workers’* (O’Hagan, 2001).

consumers are also seen as having agency to at least partially resist these practices (Drewery et al., 2000; Marecek & Kravetz, 1998). This agency can involve being able to construct alternative and preferred meanings of their situation leading to resistance of oppressive societal practices within certain constraints (H. Anderson, 2000; Enns, 1997; Ussher, 2000). It also includes consumers advocating for better mental health services, and developing and participating in consumer-led support organisations (Alexander, Muenzenmaier, Dumont, & Auslander, 2005; P. Campbell, 1999; Deegan, 1988; McLean, 1995; Wallcraft & Michaelson, 2001).

Four: Whare Tapa Wha⁵³: A Māori Discourse of Mental Health

Māori are the indigenous people of New Zealand. Accordingly, it is important to delineate a Māori discourse of mental health. Māori continue to experience the effects of colonisation by Europeans. It is in this context that the current Māori discourse of mental health has emerged. Over the last two decades Māori authors have pointed to issues of oppression and culture as central to understandings of mental health (Durie, 1988, 1995; Marsden, 1988; Potaka-Dewes, 1988; J. Rankin, 1986). In this regard, there is considerable similarity between Māori and critical discourses of mental health. However, the Māori discourse has different origins and is particular to New Zealand.

Historical Emergence

Prior to colonisation, Māori had an understanding of health where mental and physical health were integrated rather than distinct (Durie, 1995). In this section I focus on the currently circulating Māori discourse of mental health. Durie (1988) suggests that the earliest post-colonisation definition of Māori mental health is that by Sir Apirana Ngata, who was an important Māori leader and one of the first Māori members of parliament:

Grow up, o tender plant, for the days of your world,
Your hand to the tools of the Pākehā for the welfare of your body,
Your heart to the treasured possessions of your ancestors, as a crown for your head,
Your spirit to God, the creator of all things.

(Sir Apirana Ngata, 1949, in Durie, 1988, p. 3)

⁵³ 'Whare Tapa Wha' refers to the four dimensions or cornerstones of a Māori model of mental health. These cornerstones are explained later in this section.

Durie (1988) argues that this proverb suggests that for Māori, good mental health in a post-colonial society requires integration of technology and the material world, Māori culture and ancestors, and a spiritual dimension. This definition of Māori mental health contains two features which recur in subsequent descriptions.

First, the definitions commonly refer to the role of culture in Māori mental health and often distinguish themselves from Pākehā notions of mental health. Marsden (1988) stated “culture is the most powerful medium in the patterning processes of the individual’s mind” (p. 5). Lawson-Te Aho (1993), also commented on the socially constructed nature of abnormal psychology, and the harm caused, when Pākehā psychological and psychiatric labels and practices are imposed on Māori. Furthermore, some Māori mental health terms reflect the importance of culture. Potaka-Dewes (1988) and Durie (1988) both distinguish between ‘mate Māori’ and ‘mate Pākehā’. Broadly speaking, ‘mate Māori’ is conceived as the result of acting against restrictions of *tapu*. “A person, article, building, or area was regarded as *tapu* if it had been declared ‘special’, requiring respect, often avoidance, and a cautious approach” (Durie, 1995, p. 332). In contrast, ‘mate Pākehā’ refers to “diseases introduced by the Pākehā” (Potaka-Dewes, 1988, p. 8). From a liberation theology perspective, Potaka-Dewes argued that racism was a “deadly infection” (1988, p. 8) causing mental health problems for Māori.

The second commonality amongst definitions of Māori mental health is that they usually involve the positing of various aspects of life that need integrating to maximise wellbeing. Mental health, and general health, are not considered separate within a Māori discourse of mental health (Durie, 1995). This holistic perspective is frequently contrasted with the Western individualistic and dualistic approach of mind and body (Durie, 1988; Potaka-Dewes, 1988; J. Rankin, 1986) As mentioned earlier, Sir Apirana-Ngata thought technology, Māori culture, and spirituality needed to be integrated. Durie (1986) reported that Māori leaders thought whenua (land), whanau (family), and reo (language) were key components. In a later article, Durie states that :

a Māori perspective has always acknowledged the unity of the soul, the mind, the body and the family: the four cornerstones of health: te taha wairua, te taha Hinengaro, te taha tinana, te taha whanau.

(Durie, 1988, p. 2)

This Māori understanding of mental health is known as ‘Whare Tapa Wha’ (Mental Health Commission, 1998). A Māori discourse on mental health thus has culture as a central

element. Key facets of Māori culture are considered necessary to a person's wellbeing. Furthermore, this wellbeing is considered not only at the level of the individual, but at whanau, and at wider cultural levels.

In 1988 the Mental Health Foundation of New Zealand produced a resource called "*Māori Mental Health: A Resource Kit*" (Mental Health Foundation of New Zealand, 1988). This kit contained numerous articles on Māori mental health, mostly written by Māori. These articles typify the proliferation of writing on Māori mental health which has occurred since the 1980s. One reason for the emergence of this discourse in written form was the statistics pointing to Māori being severely overrepresented in markers of distress. For example, Reverend Potaka-Dewes (1988) drew on Mental Health Foundation statistics and commented that 50% of inmates of prisons, and 30% of people admitted to Oakley mental hospital in Auckland, were Māori. These alarming statistics were generally understood to be indicative of the results of colonisation on Māori:

the continued and persistent deprivation/oppression/intrusion/imposition/manipulation/exploitation of the tangata whenua (indigenous peoples) by the dominant culture/society/government, poses a serious threat to the self-esteem/humanity/identity which leads to serious disorders – social/organic/mental/spiritual.

(Marsden, 1988, p. 1)

Colonisation affects Māori at all levels of society including their subjectivities. Colonisation is seen to contribute to mental health problems for Māori through the "submergence of Māori health values in favour of Western thinking and practices" (Durie, 1986, p. 2). Durie argued that this process separated Māori from "traditional institutions that had nurtured them and maintained standards of health, including mental health" (1986, p. 2). An example of this was the *Tobunga Suppression Act* of 1907, which was not repealed until 1967. Tohunga were traditional healers in Māori society and the effect of the Act was "to totally denigrate Māori views of health and mental illness" (Durie, 1995, p. 334).

Despite this history of colonisation and oppression, other sociohistorical forces led to the contemporary re-emergence and re-construction of a visible Māori discourse of mental health. Along with other civil rights movements in the 1970s, there were new developments in Māori political activity in New Zealand that are often referred to as a Māori "cultural revival" (R. Walker, 1990, p. 186). Many of these changes built on earlier Māori political movements (R. Walker, 1990). The changes incorporated a renewed focus on Māori land rights, and an increasing focus on the need to revive Māori language and

culture. Outcomes of these movements included the Treaty of Waitangi Act of 1975, along with the creation of the Waitangi Tribunal. It is in this context that the current predominant Māori discourse of mental health emerged.

Circulation

The Māori discourse on mental health outlined thus far has emerged from sociohistorical changes in New Zealand which in the last three decades have seen the continued visibility of Māori issues in New Zealand politics and mainstream media. A Māori discourse of mental health has been used to construct some mental health services, and to inform mental health practice. Rankin (1986) reports on 'Whai Ora – A Māori Cultural Therapy Unit' established at Tokanui psychiatric hospital in the 1980s. Many district health boards in New Zealand have specific Māori services within their structure. Further circulation of a Māori discourse of mental health was evidenced in a special issue of the *New Zealand Psychological Society Bulletin* in 1993. This issue featured articles on “the Treaty of Waitangi and/or bicultural issues facing psychologists in the teaching, research, and practice of psychology in Aotearoa” (New Zealand Psychological Society, 1993, p. 7).

The Mental Health Act 1992 also shows influence of a Māori discourse:

Section 5, reinforced by section 65, requires that any court or tribunal exercising power under the Act must have respect for a person's cultural and ethnic identity, language, and religious or ethical beliefs. Proper recognition of the importance of family ties, as well as *wbanau* (extended family), *hapu* (sub-tribe) and *imi* (tribe) affiliation must also be afforded to patients; and there is provision for translation of information into Māori.

(Durie, 1997, p. 25, italics in original)

More recently, in the national strategic framework for Māori mental health, a key goal is to “ensure that active participation by Māori in the planning and delivery of mental health services reflects Māori models of health and Māori measures of mental health outcomes” (Ministry of Health: Manatu Hauora, 2002b, p. vi). Justifying the need for this goal, the plan states “recent developments in Māori mental health clinical practice have highlighted the importance of cultural identity as an essential component of health care. For Māori, effective services must reflect all dimensions of wellness” (Ministry of Health: Manatu Hauora, 2002b, p. 4). Furthermore, the *Blueprint for Mental Health Services in New Zealand* says that for mental health services to be effective, they must “reflect and respect the four cornerstones of Whare Tapa Wha” (Mental Health Commission, 1998, p. 57).

However, the circulation of this discourse is unfortunately not synonymous with improvements in the mental health of Māori, or in mental health services for Māori. “Since 1975 Māori rates of mental illness have increased, while the rates for Māori for a number of primary health problems such as heart disease and infant mortality have declined (Durie, 1997, cited in Ministry of Health: Manatu Hauora, 2002b, p. 4). Also, the *Blueprint for Mental Health Services for New Zealand* (Mental Health Commission, 1998) comments on rising and disproportionate numbers of Māori in psychiatric services, higher rates of re-admission for Māori, and Māori being significantly under-represented in the mental health workforce. Accordingly the report states, “Māori have many needs which are not being met by mental health services” (Mental Health Commission, 1998, p. 56). Furthermore, illustrating the influence of the medical discourse (and of racism), a survey of 247 New Zealand psychiatrists found that 11.3% “believed that Māori were biologically or genetically more predisposed than others to mental illness” (Johnstone & Read, 2000, p. 135).

Subject Positions

Similar to the critical discourse, mental health workers acting from a Māori discourse are enjoined to think culturally and politically. They need to act in accordance with the Treaty of Waitangi, and with knowledge of and respect for Māori cultural values (Mental Health Commission, 1998). To do this, mental health professionals working with Māori need to promote a sense of pride in Māori identity and membership of Māori cultural heritage (Durie, 1997; J. Rankin, 1986).

There are various ways in which mental health workers can enact this support for Māori. They include employing Māori protocol, developing networks with Māori colleagues and service providers, supporting participation by whanau (extended family), and facilitating access to cultural assessment, kaumātua (elder; wise, and experienced older member of a whanau), and/or tohunga (traditional healers) (Mental Health Commission, 1998). Because a Māori discourse of mental health acknowledges mate Māori and mate Pākehā, supporting psychiatric and traditional Māori treatment concurrently is possible (Durie, 1995). Within this discourse, notions of biculturalism and partnership offer Pākehā a role in supporting Māori mental health. Yet, there is an assumption that having more Māori mental health professionals will increase the provision of culturally appropriate mental health services to Māori (Durie, 1995; Ministry of Health: Manatu Hauora, 2002b). This assumption is based

on assumed similarity between Māori staff and clients, and is similar to the assumptions about matching lesbian and gay staff and clients (as discussed in Chapter Two).

The subject position offered for “tāngata whaiora (people seeking wellness, mental health service users)” (Ministry of Health: Manatu Hauora, 2002b, p. iv) is also similar in some important ways to that for clients within a critical discourse. The notion of partnership (used in relation to biculturalism and the Treaty of Waitangi) is often employed as a metaphor for the relationship between tangata whaiora and mental health services (Durie, 1995; Ministry of Health: Manatu Hauora, 2002b; Thomas, 1993). This metaphor implies that tangata whaiora should participate in collaboration regarding treatment rather than having it imposed on them (Mental Health Commission, 1998; Ministry of Health: Manatu Hauora, 2002b). As part of this collaboration, tangata whaiora should be provided with choices, such as whether to access Māori services within mainstream mental health services or whether to access separate Māori mental health services (Mental Health Commission, 1998). Also, as with the critical discourse, tangata whaiora are conceptualised as oppressed and/or restricted by inequality. Yet by re-connecting with their identity as Māori, and by balancing the various parts of that identity, they are seen as able to achieve recovery and wellness.

The Dis-ordering of Discourses

Thus far I have introduced four discourses of mental health currently circulating in New Zealand: the medical, psy, critical and Māori discourses. My discussion of the circulation of each discourse suggests that the medical discourse predominates in the field of mental health services and operates to marginalise the other discourses. The medical discourse constructs biomedical explanations as the ‘truth’ of ‘mental illness’, and is perpetuated by the social, economic, and political power of medicine, and of the thriving drug companies. Consequently, despite international and New Zealand public opinion favouring psychosocial explanations of mental health problems, PMHS remain primarily the domain of psychiatrists, nurses, and drug treatments. Also, (and ironically), the medical discourse pervades the language of campaigns to reduce discrimination against people living with mental health problems. But because of the way it individualises and essentialises mental health problems, it helps conceal sociocultural explanations of distress. Yet the dominance of the medical discourse is far from complete. I have described many ways in which the psy

discourse informs all our lives, everyday. I have also shown that critical and Māori discourses work to resist the ways that medical and psy discourses can negate, or minimise, the role of sociocultural context in constructing mental health problems. In the following chapter I begin to investigate the relationships between these discourses more fully and to consider how they operate within PMHS in New Zealand.

Chapter Six:

Uneasy Companions Relationships between Discourses of Mental Health

Discourses construct the same object in different ways, yet they also overlap, draw on other discourses, and potentially compete for our allegiance. Furthermore, often multiple discourses of mental health are taken up simultaneously. In this chapter I begin to explore how the discourses of mental health outlined in the previous chapter commonly interact. This provides a context for Chapters Seven to Eleven which analyse the interviews with queer staff and MSM clients to explore the operation of these discourses in PMHS, and the implications for service to MSM clients.

First, I claim that the relevant literature often fails to delineate clearly between the medical and psy discourses and, in so doing, can misrepresent each of them. In this thesis I wish to explore how each discourse constructs mental health and associated practices. Accordingly, delineating between them is important. Second, I introduce and critique the commonly referred to biopsychosocial model that is often purported to be a holistic amalgamation of discourses of mental health. Third, despite the predominance of the medical discourse in the structure and provision of PMHS, I explore how all four discourses of mental health introduced in the previous chapter are implicated in the construction of national mental health policy in New Zealand. These policies have potential implications for any recommendations which arise from this research.

A Tale of Two Psy's: The relationship between psychiatry and the psy-therapies.

Having worked in PMHS for ten years now I have been surprised to find that the medical and psy discourses of mental health are not clearly delineated in the literature. With the exception of Rose (1985, 1996, 1999), the literature tends to emphasise the similarities, and elude the differences, between them. My surprise was founded on memories of countless times where I have witnessed and partaken in conversations with colleagues from various

disciplines in PMHS about the ongoing struggle and tension between the medical and psy discourses. Nevertheless, the merging of the medical and psy discourses appears to be based on a focus with the practices of the disciplines usually associated with them; i.e. medical/psychiatry and psy/psychology. Both disciplines focus on diagnosing disorders of the individual (Burr & Butt, 2000; I. Parker et al., 1995), and on sharing practices which endeavour to separate reason from unreason (I. Parker et al., 1995). Additionally, through these practices, psychiatry and psychology have been important disciplines for governing the individual (Foucault, 1975/1977; N. Rose, 1999). Despite the similarities between psychiatry and psychology as disciplines, I do not wish to reproduce the conflation of the medical and psy discourses, as to do so risks misrepresenting both of them.

One example of an author not delineating clearly between medical and psy discourses of mental health is Harper (1995). Harper analyses a psychiatrist's discussion of diagnosis. He labels talk that is critical of diagnosis as 'liberal', and talk which is affirmative of diagnosis as 'psychiatric'. Explaining the effects of this dual operation of discourses (liberal, and psychiatric), Harper states that, "it paradoxically strengthens the 'psy complex' in maintaining the practice of psychiatric diagnosis" (Harper, 1995, p. 352). While it is quite possible for a psychiatrist to draw on both the medical and the psy discourses (N. Rose, 1999), Harper does not delineate between these discourses here. Instead, he links psychiatric diagnosis, (often associated with the medical discourse), with the psy-complex. As discussed in Chapter Five, one possible reason for this slippage between psychiatry and the medical, and psy, discourses is the ambiguity which can be read in how Rose (1996) defines the psy-complex.

Another example of conflation between the medical and psy discourses of mental health is in the book '*Deconstructing Psychopathology*' by Parker et al. (1995). While offering many thorough critiques of positivist approaches towards psychopathology, the authors do not clearly delineate between a medical and a psy discourse of mental health:

The spread of para-medical institutions offering psychoanalysis or psychotherapy as a treatment alongside or as an alternative to drugs gives psychiatry a human face, and then directs attention to the importance of 'talking things through'.
(I. Parker et al., 1995, p. 12)

In this quote, Parker et al. refer to psychiatry as synonymous with the medical discourse. Also, by calling institutions offering psychoanalysis and psychotherapy 'para-medical', they subsume these psy-therapies within psychiatry. Given the association they make between

psychiatry and the medical discourse, they also implicitly locate these psy-therapies within the medical discourse. Perhaps one of the reasons for the conflation is that Parker et al. are discussing ‘psychiatry’ as the practice of a professional group rather than specifically delineating discourses:

The common core of both medical and psychoanalytic variants of psychiatric practice, though, is that the abnormal is experienced as something which is *internal* to the person.

(I. Parker et al., 1995, p. 13, italics in the original)

Here Parker et al. (1995) emphasise the similarity between medical and psychoanalytic psychiatry, by highlighting how at the “core” they both focus on symptoms “internal” to people. Historically, there are many connections between psychiatry and psychoanalysis (Hale, 1995; Paris, 2005). In the United States psychoanalysis drew on the power of medicine and it was a requirement for psychoanalysts to be medically trained (Hale, 1995). Thus, in the United States “until about thirty years ago, the majority of psychoanalysts were psychiatrists” (Paris, 2005, p. 6). Furthermore, psychoanalysis, especially in its early forms, was itself based on essentialist assumptions about instinctual drives (Hale, 1995; Wachtel, 1997). Yet, the current psy discourse is much broader than psychoanalysis, and as discussed in the previous chapter, the character of this internal entity is constructed very differently in the medical and psy discourses. For the medical discourse this entity is a biological pathology whereas for the current psy discourse it is primarily distress caused by meanings based on life experiences.

Furthermore, Parker et al. (1995) rightly comment that as psychiatrists have often been involved in medicine and psychoanalysis, both practices can be considered part of psychiatric practice. This does not mean however that both practices derive from the medical discourse. As discussed in Chapter Two, and at the start of this chapter, discourses are not confined to particular groups or individuals but can be taken up by differing speakers and across various contexts. Additionally people’s subjectivity is often informed by multiple discourses. I suggest that this dual practice by psychiatrists represents the medical and psy discourses of mental health vying for attention within psychiatry. Pilgrim and Treacher (1992) have traced out this tension within British psychiatry in the post-war period. Further, Rose (1999, p. 218) comments that the psy discourse has become so influential that it is evident in psychiatric hospitals, nursing practice and “even in the practices of some psychiatrists”.

Undoubtedly, another reason for the conflation of medical and psy discourses is the fact that in practice “nearly all encounters with the mental health system and with psychologists who work within it start with an assessment of clients’ difficulties. This assessment often results in a formal diagnosis” (Hare-Mustin & Marecek, 1997, pp. 106-107) and, thus, has a direct overlap with the medical discourse. Another similarity between the psy and medical discourses of mental health is to do with their professed relationship to the discourse of science and ‘scientific discovery’. As in the medical discourse, psy practice is ideally ‘evidence based’ and developed from psy research; this is research that is positivist, empirical, objective, and by and large focuses on the experience and behaviour of individuals (Davison & Neale, 1990; Kitzinger, 1997; Pilgrim & Treacher, 1992; Prilleltensky & Fox, 1997; N. Rose, 1996; Ussher, 1990).

While I have been at pains to delineate between the medical, psy, and other discourses introduced in this chapter there have been attempts to bring together these various discourses and develop more holistic practice within the area of mental health. A common way this has been attempted is through the biopsychosocial model. Given the commonplace status of this model, I introduce it here as it provides a way of understanding the interactions and power relations between the various discourses of mental health.

Doctors First: The Biopsychosocial Model

Amidst the critiques of psychiatry in the late 1970s, Engel (1977) claimed there was a crisis in the relationship of psychiatry to medicine. For Engel, the crisis included the growing public dissatisfaction with the insensitivity of doctors, and the reductionistic approach to mental health problems that limited medicine’s ability to account for psychological and social factors affecting illness. Engel described two common responses to this crisis. There were those like Szasz who, as described in the previous chapter, argued that ‘mental illnesses’ were created by social norms rather than discovered by science and, thus, would simply “exclude psychiatry from the field of medicine” (Engel, 1977, p. 129). Alternatively, some thought psychiatry should embrace the medical model more completely by approaching mental illnesses like physical diseases (Engel, 1977). Engel proposed a biopsychosocial model to deal with this crisis:

To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he [sic] lives, and the

complementary system devised by society to deal with the disruptive effects of illness, that is, the physical role and the health care system ... the boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations.

(Engel, 1977, p. 196)

Engel's focus on the ways social contexts construct the boundaries between health and disease suggests he envisioned the biopsychosocial model as being holistic and interactional. Indeed, many have viewed the biopsychosocial model as heralding the arrival of a new and productive approach within psychiatry. Some saw it as a welcome movement away from the medical model (Mosey, 1974), and an opportunity to see the "patient as a person" (Reiser, 1980, p. 141). It has even been suggested that the biopsychosocial model could "cut across race and ethnicity" and provide a way of meeting the needs of the Third World (Lolas, 1985, p. 1337). The biopsychosocial model was adopted by the American Psychiatric Association, who produced two manuals on how to use the model for diagnosis and treatment (Amchin, 1991; Pies, 1994). Furthermore, the model continues to be put forward as representing a holistic, "humanitarian psychiatry" (A. Freedman, 1995, p. 397). However, despite appearing to be an integration of medical, psychological and critical discourses of mental health, the biopsychosocial model, as commonly practiced, portrays a much more unequal and uneasy relationship between the discourses.

A major criticism of the biopsychosocial model is perhaps represented symbolically in the ordering of its components; bio comes first, with psycho and social in second and third place respectively. All three might be important, but first place is coveted. This privileging of the medical discourse within biopsychosocial research has been critiqued (Alonso, 2004; Antonovsky, 1989; Mullen, 1998; Read et al., 2004a). Mullen (1998) suggests that a power, and a danger, in the biopsychosocial model is that it uses a scientific sounding term and is now "being seen by most mental health professions as an obvious truth" (p. 95). Commenting on the increasing role of biological approaches, Mullen (1998, p. 96) states "psychiatry is being taken over by multicoloured pictures of brains in whose shifting hues we are invited to recognise schizophrenia, the hallucination or even the origins of the restless child's distress". Mullen then goes on to suggest a changing of priorities and, perhaps, even a renaming to a "sociocultural psychobiological model" (1998, p. 96).

Alonso (2004, p. 244) also remarks on the "secondary place" accorded to the biopsychosocial model in medical practice. In her review of medical research over the last

two decades, Alonso concluded that “although a change towards a more holistic concept of health has occurred in academic and institutional contexts ... there does not appear to have been a parallel change in the practical domains of medicine” (p. 239). However, she acknowledges research suggesting more change has occurred in the nursing profession. She suggests this is due to nurses having to “deal with the ill person as a whole and take responsibility for the patient’s general well-being” (Alonso, 2004, p. 243).

Focusing more at the epistemological level, McLaren (1998) critiques the biopsychosocial model as not having an adequate theory or methodology for integrating its various components:

What everybody wants to do is to drag mentalist psychology and sociology into the scientific arena so these ephemera can be lassoed by the ropes of current (positivist) scientific knowledge. Throughout the history of modern Western science, this has proven impossible.

(McLaren, 1998, p. 91)

McLaren (2002) then tries to account for the continued belief in the biopsychosocial model despite its shortcomings. He suggests that the notion of a biopsychosocial model (even if not reflected in practice) provides a rhetorical comfort for psychiatrists. McLaren comments on a proponent of the biopsychosocial model (Harari, 2001, discussed in McLaren, 2002), and states, “he needs to believe in it. Like all good psychiatrists, he would have trouble practicing if he did not believe he had a holistic model which could explain the diverse and slippery phenomena of mental disorder” (p. 701).

Read et al. (2004a) offer an incisive summary of these critiques of the biopsychosocial model:

Since the 1970s’ the illusion of balance, of an integration of models, has been created by the so-called ‘bio-psychosocial’ approach. An integral part of this has been the ‘vulnerability stress’ idea that acknowledges a role for social stressors but only in those who already have a supposed genetic predisposition. Life events have been relegated to the role of ‘triggers’ of an underlying genetic time bomb. This is not an integration of models, it is a colonization of the psychological and social by the biological. The colonization has involved the ignoring, or vilification, of research showing the role of contextual factors such as stress, trauma (inside and beyond the family), poverty, racism, and so on in the aetiology of madness. The colonization even went so far as to invent the euphemism ‘psycho-education’ for programmes promulgating the illness ideology to individuals and families.

(Read et al., 2004a, p. 4)

Here Read et al. (2004a) comment on how the ‘trigger’ or ‘vulnerability’ theory prioritises the importance of biology (and the medical discourse), while marginalising psy and critical origins in the aetiology of mental health problems. This notion of biological vulnerability has been in circulation for some time now. In the 1970s Zubin and Spring (1977) suggested a vulnerability-stress model for schizophrenia. Interestingly, they theorised that this vulnerability could incorporate both “genetic inheritance” and “acquired propensities” (Zubin & Spring, 1977, p. 109). However, since then, the focus in the field has been on biological vulnerability. For example, Paris (1999) promoted a diathesis-stress model to account for the role of inherent vulnerability in the aetiology of personality disorders. What Read et al. (2004a) also emphasise is how the biopsychosocial model has become so accepted within the psychiatric professions that even though it is dominated by the medical discourse, it can pass itself off as representing the psy and the social.

The medical discourse may be the most dominant in the biopsychosocial trilogy but this does not mean the others are not present. One area where a more holistic version of the biopsychosocial model is being utilised is the research on emotional and psychological trauma and its effects. Sometimes referred to as the ‘traumagenic neurodevelopment model’ (Read, Perry, Moskowitz, & Connolly, 2001), this research suggests that trauma of many kinds (including physical and psychological) can significantly affect the development of the brain and subsequently mental health problems (Bremner & Vermetten, 2001; Christopher, 2004; De Bellis et al., 1999; Glaser, 2000; Read et al., 2001; Schore, 2001; Solomon & Heide, 2005; Thomson, 2004; Waterhouse, 2004). By assigning trauma, (and the social contexts that enable it), a primary role in affecting biology and aetiology of mental health problems, this literature resists the tendency towards biological reductionism in much so-called biopsychosocial research.

In addition to research and practice, another area where discourses of mental health compete for space is in mental health policy. Given that this thesis is concerned with PMHS in New Zealand, in the final section of this chapter I turn to national mental health policy in New Zealand to explore if and how all four discourses of mental health introduced thus far are present.

Discourses of Mental Health in New Zealand Mental Health Policy

I have chosen three guiding policy documents to refer to regarding New Zealand mental health policy. These are *The National Mental Health Standards* (Ministry of Health: Manatu Hauora, 1997), the *Blueprint for Mental Health Services in New Zealand* (*Blueprint*) (Mental Health Commission, 1998), and the *Recovery Competencies for New Zealand Mental Health Workers* (*Recovery Competencies*) (O'Hagan, 2001). Before exploring whether the various discourses of mental health co-construct these policy documents, I will briefly outline the purpose of each document.

The mental health standards were introduced by the Minister of Health at the time with the aim to “upgrade the quality of our mental health services and ensure consistency for every New Zealander who needs to use the mental health service” (Hon. Bill English, in Ministry of Health: Manatu Hauora, 1997, p. iii). The standards are, therefore, about the general quality of services that should be provided. The Mental Health Commission produced the *Blueprint* and this is the document commonly referred to in media coverage of mental health issues in New Zealand. The *Blueprint* builds on the mental health standards and describes “the mental health service developments required for implementation of the Government’s National Mental Health Strategy” (Mental Health Commission, 1998, p. vii). This document has been endorsed by government as detailing service specifications needed (Ministry of Health, 2004). A key principle set out in the *Blueprint* is a ‘recovery approach’ to mental health. Consequently the *Recovery Competencies* were also produced “to describe the competencies mental health workers need to acquire when using a recovery approach in their work” (O'Hagan, 2001, p. 1).

Recovery is the Goal: But what are people recovering from?

Moving on to the content of these policies, I will begin with the notion of ‘recovery’ as it is a key concept in both the *Blueprint* and the *Recovery Competencies*. ‘Recovery’ is a relatively recent term used in conjunction with mental health policy in New Zealand. Recovery does not appear as a distinct approach in the mental health standards of 1997, but it is a core tenet of the *Blueprint* in 1998. Yet, despite the increased circulation of this term, its meaning is ambiguous. While the notion of ‘recovery’ does not define ‘mental illness’, it is generally

used in relation to it. As such, it draws on and speaks to the various discourses of mental health already introduced:

Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that can come in its wake, such as isolation, poverty, unemployment, and discrimination.

(Mental Health Commission, 1998, p. 1)

At first reading, this definition of recovery appears to be holistic and constructed from the medical discourse (through use of the term ‘mental illness’), the psy discourse (through acknowledgment of ‘losses’), and a critical discourse (via acknowledgment of sociocultural factors such as ‘discrimination’). However, while there are psy and critical notions of recovery, the structure of the definition seems to suggest that mental illness is much like any other illness, and that the losses and social context of the person with the mental illness are a consequence of, and not necessarily constructive or constitutive of, mental illness. The notion of ‘mental illness’ implicit in this definition of recovery, then, is not necessarily constructed from a psy or critical discourse but a medical one dressed up in the now familiar language of the biopsychosocial model

Yet, it would be incorrect to simply argue that the medical discourse dominates notions of recovery. For example, later in the *Blueprint*, recovery is described in the following way:

The concept of recovery can be applied to most beliefs about the nature of mental illness – biological, psychological, social, or spiritual. It can also easily be applied to holistic approaches such as the Whare Tapa Wha model which identifies four dimensions of health ... Some people believe the origins (or at least the prolonging) of mental illness does not just lie in the person with the illness but in the world around them. It may be their family, social injustice, unresponsive services, or a traumatic event. In these cases recovery does not just need to happen in the individual; the people and systems that contribute to the person’s illness also need to change to enable that individual to live a better life.

(Mental Health Commission, 1998, p. 15)

Here, again, there is the privileging of the medical discourse with the use of the term ‘mental illness’. However, there is also clear reference to the components of the biopsychosocial model, and to a Māori discourse of mental health. But of significance, the psy and critical discourses are also operating here. There is the notion that there are different “beliefs about the nature of mental illness,” and the idea that the origins of mental illness may lie outside the person and in their social contexts instead is a direct challenge to the largely internalising, biomedical approach of the medical discourse.

There is also other evidence that the critical discourse is circulating and constructing definitions of recovery. The *Recovery Competencies* (O'Hagan, 2001), contains an updated definition of recovery as “the ability to live well in the presence or absence of one’s mental illness (or whatever people chose to name their experience)” (O'Hagan, 2001, p. 1). While the language of mental illness remains, there is now an acknowledgment that this may not be an appropriate term for some people. Similarly, in a recent document on recovery, produced by “people with experience of mental illness’ (Mental Health Commission, 2004), there is also evidence of resistance to the medical discourse and its right to name mental health problems. In their definition of mental illness they state:

Mental illness did not have universal support from the tangata motuhake [people with experience of mental illness or distress] involved in this document because it reinforces the dominance of biological approaches. Some wanted to reclaim the word ‘madness’ but a few found this word either too colloquial or offensive.

(Mental Health Commission, 2004, p. 9)

One might wonder how the recovery concept became so strong in New Zealand mental health policy. While this is not my focus here, some clues to this history are given in the *Recovery Competencies* document (O'Hagan, 2001). Recovery is explained as having three origins: first the 12-step, self help, and new age movements; second, the mental health service user movement (see previous chapter on a critical discourse) with its focus on human rights; and third, from the arena of psychiatric rehabilitation. The document explains that ‘recovery’ has been adapted for the “contemporary New Zealand context” (O'Hagan, 2001, p. 2). While the document does not go on to explain this fully, it makes reference to the importance of the Treaty of Waitangi, and to New Zealand having a relatively “stronger tradition of state provision for the vulnerable and marginalised” (O'Hagan, 2001, p. 2). What all this suggests is that ‘recovery’ is a term constructed with reference to a particular sociohistorical context. In this sense, it is not a medical term; rather it is more congruent with critical, Māori, and to a lesser extent, psy discourses of mental health. Later in this chapter I will show that this has implications for the provision of PMHS for MSM.

Moving away from the concept of recovery specifically, and into the wider content of the mental health policies, discursive struggles are still evident. The first aim listed in the *National Mental Health Standards* is “to promote the mental health of the New Zealand community and where possible minimise the incidence of mental illness and mental health

problems” (Ministry of Health: Manatu Hauora, 1997, p. vii). The distinction between ‘illness’ and ‘problems’ is defined in the glossary as follows:

A mental *illness* may be defined as a significant impairment of an individual’s cognitive, affective and/or relational abilities which is a recognised medically diagnosable illness or disorder.

[...]

A mental health *problem* is a disruption in the interactions between the individual, the group and the environment producing a diminished state of mental health.

(Ministry of Health: Manatu Hauora, 1997, p. 54, italics added)

These definitions are interesting in a number of ways. First, the definitions seem somewhat circular and are hard to distinguish from each other. A ‘mental illness’ is defined as an ‘impairment’ of an individual and their relationships, if it “is a recognised medically diagnosable illness or disorder”. That is like saying ‘a chair is something you sit on and is recognised as a chair’. Yet, in contrast, a ‘mental health problem’ is a ‘disruption’ also affecting an individual and their relationships (but not called a mental illness). One possibility for the lack of clarity between the two definitions is that they represent two discourses, the medical and the psy, each of them constructing distress in different ways.

Another notable aspect of the definition of a mental health problem, is that the ‘disruption’ causes a ‘diminished state of mental health’, but one question which arises is to what: the individual, the group, or the environment? This wording may well reflect the operation of Māori, and critical discourses, both of which would recognise distress and dis-ease in sociocultural contexts rather than just in individuals. While these discourses co-construct the mental health standards, the medical discourse does seem to be given precedence over the others. For example, the third aim of the standards is “to ensure the rights of people with mental illness” (Ministry of Health: Manatu Hauora, 1997, p. vii). What about the rights of the people with mental health problems who were mentioned in the first aim?

This co-existence of various discourses is evident elsewhere in the policy documents. Often the documents use the language of mental illness alongside holistic approaches that are constructed from multiple discourses of mental health. For example, in the foreword to the *National Mental Health Standards*, the then Minister of Health stated:

The promotion of optimal quality of life for people affected by mental illness, a recognition that we all have unique physical, emotional, spiritual and cultural dimensions, and an emphasis on coordinated and individualised care were guiding principles in the development of the standards.

(Hon. Bill English, in Ministry of Health: Manatu Hauora, 1997, p. iii)

Here, the minister uses the language of the biopsychosocial model which draws on multiple discourses of mental health. This likely reflects the fact that the standards involved considerable consultation with consumers and other interested people. In the *Recovery Competencies*, within competency 1.3, mental health workers are expected to demonstrate the “ability to see people in the context of their whole selves and lives, not just their illness [and to demonstrate] the ability to adopt the story teller’s frame of reference” (O’Hagan, 2001, p. 9). This competency does not undermine the notion of mental illness but it does require mental health workers to engage in psy and critical understandings of people’s lives. Furthermore, competency 3 requires mental health workers to demonstrate “knowledge of different explanations [of mental illness] – spiritual/moral, psychological, sociological, biological” (O’Hagan, 2001, p. 13). This competency not only asks mental health workers to know about diverse views on mental illness, but notably, it lists biological considerations last. As discussed earlier, this is not common with the tradition of the biopsychosocial model.

In this context, while not wishing to invalidate any of the benefits that may have come from the medical discourse, or the intentions of many practitioners working from this framework, I primarily use the term ‘mental health problems’. I do not suggest that this term is necessarily less problematic than ‘mental illness’; rather it marks a distance from the medical discourse. However, I use the term ‘mental illness’ when referring to literature that employs it.

Returning to mental health policies, within the discursive mix constructing them there are certain aspects of particular relevance for this thesis. These are some of the ways Māori, psy, and critical discourses of mental health have emerged. As discussed earlier, the Treaty of Waitangi, and the context of colonisation, is central to the Māori discourse. In recent years the Treaty and its role in mediating the relationship between Māori and Pākehā, has had considerable circulation in New Zealand. This has been reflected in mental health policies and has been one of the ways sociocultural understandings of mental health such as colonisation and marginalisation have been raised. Correlatively, it is evidenced in the ways aspects of the policies speak directly to the relationship between mental health services and sexual orientation.

Queer Mental Health Policy in New Zealand

Surprisingly, despite a paucity of literature on the mental health of queer people in New Zealand, sexual orientation is present in mental health policies. Standard 3 of the *National Mental Health Standards* is about sensitivity to sociocultural values (Ministry of Health: Manatu Hauora, 1997). Parts of this are directly relevant to MSM:

Staff of the mental health service will have knowledge of which cultural and social groups are represented in their local community and an understanding of those social and historical factors relevant to their current circumstances.

Notes and examples: ... collaboration with individuals and organisations with expertise in transcultural mental health, lesbian and gay communities

[...]

The mental health service recognises cultural differences and responds non-judgmentally in its delivery of treatment and support on the basis of a consumer's age, gender, culture, sexual orientation, socioeconomic status, religious beliefs, psychiatric diagnosis and physical or other disability.

(Ministry of Health: Manatu Hauora, 1997, p. 5)

This standard constructs sexual orientation as an important part of a person's identity (drawing on both psy and equal rights discourses), and behoves services to be cognisant of the sociohistorical factors relevant to MSM (consistent with a critical discourse). Thus, in the mental health standards both sexual orientation and the social context of sexual orientation are considered directly relevant to mental health and mental health services.

Sexual orientation is also mentioned in the *Blueprint*, along with an emphasis on working against discrimination:

The Commission advocates zero tolerance of discrimination. This means refusing to accept it, in any shape or form. A discrimination free environment is necessary if the Government's Mental Health Strategy is to be implemented.

(Mental Health Commission, 1998, p. 19)

This focus on discrimination is followed up in the *Recovery Competencies*. Competency number six admonishes mental health workers to "understand discrimination and social exclusion, its impact on service users and how to reduce it" (O'Hagan, 2001, p. 18). Much of this competency asks mental health workers to understand discrimination regarding mental illness, but competency 6.4 states that mental health workers should:

Demonstrate an understanding of other kinds of discrimination and how they interact with discrimination on the grounds of mental illness. For example, they demonstrate: understanding of discrimination on the grounds of ethnicity, gender, sexual orientation, religious beliefs, and other disabilities as a contributor

to mental illness ... understanding the impact of multiple discrimination on service users.

(O'Hagan, 2001, p. 19)

This competency is important in that it uses both psy and critical discourses of mental health that frame discrimination as something that can contribute to the construction of mental illness. Furthermore, it acknowledges that the dual stigma of being homosexual and having a mental illness can be a difficult burden for some clients. Now I will turn to the implications of these policies, and the multiple discourses that construct them, for MSM clients of PMHS.

Oppression, Colonisation, Distress, and Illness: Competing Discourses of Mental Health

I have argued that mental health policy in New Zealand is constructed from multiple and competing discourses of mental health. Yet it is infused with the language of the medical discourse of mental health and mostly uses the term 'mental illness'. In the previous chapter I suggested that the social, economic, and political power of the medical profession, and of the drug companies, helps explain the ongoing ascendancy of this discourse. However, psy, critical, and Māori discourses are also present and play a significant part in resisting the medical discourse and in constructing New Zealand mental health policies. The critical discourse in particular has enabled issues concerning sexual orientation to be specifically included. However, it is unclear how much these discourses have influenced practice within PMHS in New Zealand. The next five chapters will explore how this discursive mix constructs the provision of PMHS to MSM. This will be explored through analyses of the interviews with MSM clients and ex-clients of PMHS, alongside those of lesbian and gay staff of PMHS. The analyses will focus in particular on how discourses of homosexuality, and discourses of mental health, operate in the construction of the accounts of the staff and clients.

PART FOUR:

ANALYSIS OF INTERVIEWS
WITH QUEER STAFF AND MSM CLIENTS

Chapter Seven:

Contested Identities MSM Talk about Sexual Orientation and Mental Health

This chapter is the first of five that analyse the interviews with queer staff, and MSM clients, to explore the discursive construction of PMHS and its implications for services to MSM clients. This chapter focuses on the interviews with the MSM clients, their understandings of their sexual orientation, and their experiences of mental health problems.

The history of the ongoing struggles for homosexual emancipation and gay liberation has consisted largely in the story of how lesbians and gay men fought to wrest from non-gay identified people control over such matters as who gets to speak for us, who gets to represent our experience, who is authorized to pronounce knowledgably about our lives.

(Halperin, 1995, pp. 56-57)

The struggles over knowledges about homosexuality have resulted in a multitude of cultural discourses, some of which were outlined in Chapter Four. Turning to the field of this research, the psy sciences are one of the key cultural sites in which homosexual experiences have been contested. On the one hand, the psy sciences claim to be concerned with the careful observation, description, analysis, and categorising of symptoms of mental illnesses, and of differing population groups considered 'at risk'. This categorising of groups of people is exemplified in the prevalence studies discussed in Chapter One.

However, notwithstanding critiques of diagnostic symptoms, and a focus on symptoms (such as those constructed by a critical discourse; see previous chapter), this interest in accurate categorisation is not reflected in some important aspects of research on MSM and mental health. As discussed in Chapters One and Three, much research on MSM and mental health uses taken-for-granted terms for sexual orientation, and for mental health, without exploring the meaning of either of these for the participants themselves. The absence of clients' perspectives has also been noted in other areas of mental health such as schizophrenia (Geekie, 2004), and post-traumatic stress disorder (Alexander et al., 2005). The mental health service consumer movement developed partly as a result of this

inattention (P. Campbell, 1999; Corrigan & Ralph, 2005; Deegan, 1988; McGruder, 2001). Yet, thus far, the consumer movement does not seem to have represented MSM consumers. There is also some evidence that MSM consumers fear and experience marginalisation from other consumers (Lucksted, 2004; McFarlane, 1998). These multiple omissions limit what we know about MSM's experiences of mental health problems, and our knowledge of how to best prepare mental health systems and clinicians for working with MSM.

Accordingly, this chapter will first consider the various ways the MSM participants spoke about their sexual orientation, its relevance to their lives, and how they understood the social contexts of sexual orientation. First, I illustrate the numerous discourses that construct the participants' understandings of sexual orientation. Second, I explore the various ways the participants accounted for their experience of mental health problems. In this section I show that these accounts are constructed by multiple discourses of mental health (see Chapter Five). Third, I argue that this multiplicity of meanings of both sexual orientation, and of mental health, that the MSM participants use has important implications for their relationships with clinicians and with PMHS.

Sticks and Stones may break my bones but names – well that's another story ...

One of the criteria for participating in the current research was to be “a man who has sex with men or a man who is sexually attracted to men but has not had or does not have sex with men”. Behaviour (attraction and/or sexual activity), rather than identity status, was the criteria for participating (see Chapter Three). Yet, during the interviews, the men were asked about their preferences for languaging their sexual orientation and for how relevant they thought sexual orientation was to their lives.

Nathan It doesn't worry me if straights call me queer or faggot and it doesn't worry me if Māori call me takatāpui and it doesn't worry me if people just call me queer or homosexual. So it doesn't worry me with the four [client].

Nathan said he didn't mind what term people use for his sexual orientation. However Nathan was unique amongst the MSM participants in stating no strong preference over terminology. As the only Māori man interviewed he did, however, prefer I use the term takatāpui during the interview.

In discussing sexual orientation the men often spoke about their relationship to others and to wider society. They had varied ways of talking about this. I will demonstrate how these diverse meanings are constructed within the power relations of cultural discourses of homosexuality. Furthermore, I will also try to show how these understandings are often not unitary or stable. For example, the same men use different understandings in different contexts, and individual men attribute different meanings to the same language. I shall also illustrate the ways some of the men were able to speak about their understanding of sexual orientation from what Foucault refers to as “subjugated knowledges” (Foucault, 1980, p. 82).

‘Gay’ is a term of identity that, while sometimes used within a liberation discourse of homosexuality, is now most commonly used by lesbian and gay rights groups either to refer to lesbians and gay men generically or, more frequently, to refer specifically to gay men. It is also increasingly used in the mainstream media. Given the current widespread circulation of the equal rights discourse of homosexuality it is not surprising that ‘gay’ was the preferred term for almost half of the men interviewed. However, the meanings they attached to the term demonstrated differing understandings of what it is to be a ‘gay’ man:

Evan Well I usually use ‘gay’. I know *Queer Nation*⁵⁴ and big city gays tend to be using ‘queer’ these days but it is just not acceptable up here [provincial town] you know. It is still a term of abuse isn’t it. It always is up here [client].

Ralph I use the words ‘queer’ or ‘gay’ as being more meaningful for me. ‘Gay’ because of its lightness and its breeziness and its kind of floatiness [client].

Jim Well for a start I’m male, David, and a very masculine male, but I know I’m ‘gay’. Only men attract me. I don’t even see women most of the time but, but I have been married and I’ve got three grown up children. My generation had to cope with the [unclear word], but it is a little easier today with the stigma of being ‘gay’. It definitely is a derogatory term.

DS⁵⁵ That ‘gay’ is a derogatory term?

Jim Yes. Well in my day it was ‘poofter’ or ‘queen’ [client].

Evan shows his awareness of multiple terms for talking about homosexuality. In his context (living in a provincial town), he considers ‘queer’ an undesirable subject position. Instead, ‘gay’ enables a more homopositive positioning of himself. Additionally, Ralph

⁵⁴ ‘Queer Nation’ was the name of a New Zealand national queer television show.

⁵⁵ When I include my speech in data excerpts I use ‘DS’ to denote David Semp

connotes 'gay' using buoyant and carefree language. This positioning likely reflects the way 'gay' has been used in more affirmative discourses such as lesbian and gay rights, rather than the often pathological and judgmental use of 'homosexual' that he is familiar with. In the third extract Jim shows the cultural instability of identity when he acknowledges 'gay' is current compared to other terms he grew up with. Jim also illustrates the limits of any positioning when stating that 'gay' is still a pejorative term. Thus while 'gay' may have positive connotations for some, (like Evan and Ralph), it may not have the same meaning for others. Jim also asserts his masculinity alongside his gayness. In a heteronormative, and patriarchal society, where gender and sexual orientation are conflated, homosexual men are often associated with femininity (Cass, 1999). Both homosexuality and femininity are the devalued 'other' in the respective hetero/homo and male/female binaries. In this context, Jim's desire to deploy masculinity is understandable.

While many of the men utilize 'gay' in ways that reflect its present wide circulation, there are examples of men resisting this dominant discourse of homosexuality. However, they resist it in different ways for different purposes:

- Pete It depends on how confrontational I want to be. I don't like the word 'gay' because I really don't feel gay, in the sense of happy, joyous and those sorts of things. And I think it has become overused, that word, and it tends to come across to most mainstream – even people who are open to the homosexual orientation tend to view it with frivolity. I think it is a little bit frivolous. So 'queer' I like because I like the sound of it and sometimes it upsets, causes more of a reaction.
- DS Yeah, tends to.
- Pete I don't run around saying I'm homosexual or queer. I mean it is irrelevant to me unless I am looking for a sexual partner really [client].

Pete rejects 'gay' because of its "frivolity" and its overuse. Instead he deploys both a 'queer' label and a queer discourse of homosexuality which often enables an oppositional and confrontational position to the mainstream. However, this confrontational subject position is not consistent for Pete as he also draws on a conservative discourse to emphasise the privacy of his sexual orientation by stating that he does not "run around" saying he is queer. This is an example of the ways in which the subject positions that people take up are often contextual.

Other MSM also drew on a queer discourse, but without identifying with the term 'queer', when they focused on sexual behaviour rather than labels to denote their sexuality. Yet, they used this discourse for very different reasons:

- Daniel I don't think of a label. It is just who I am. [...] I have sex with men, I am attracted to men. I've never really specified myself as gay. People say 'are you gay?' and I say 'yes' because I have sex with men. If that is the label for it then 'yes'. But personally I don't see a real label [...] It is just, I want to know more about it. Maybe when I understand and accept the fact that I'm not going to be that movie character person, that is not going to be my life, maybe then I will be able to sit there and say 'yes, I'm gay', and get that label in my head.
- DS So at the moment it is pretty important to you because you are kind of sorting all that out for yourself. Is that kind of what you are saying?
- Daniel Yeah. I'm still working through what it means, who I am [client].

For Daniel, denying a label is a way of him making space to explore his sexual orientation and to decide if he wants to take up the label 'gay', and thus denote himself as other than the heteronormative norm. However, he reports saying "yes" if asked whether he is gay, as he knows this is the current terminology for MSM. Mark talked about sexual identity in yet another way:

- Mark No I don't have a term at all for the way to describe who I am, neither homosexual or those terms they use, myself but 'attracted to men' definitely would be a description which would fit me [...] I don't act on my attraction to anybody.
- DS So it's just an attraction but it's something that's kind of a small part of your life.
- Mark Yeah because I find it too difficult to cope with. [...] Like I'm definitely not bi-sexual, though I'm married with children. It is a lifestyle I prefer and is safer for me to be in [client].

Mark specifically denies the category of bisexual because he is not attracted to women. Instead he prefers the term 'attracted to men' as it allows him to acknowledge his attraction without acting on it, or taking on a non-heterosexual identity that feels unsafe for him.

Another sexual orientation category available to the men was that of 'homosexual'. Two of the men spoke of using this, at least in some contexts. John spoke about it being a "scientific term", one that he would be more likely to use with his mother. He said he used 'gay' the rest of the time, as it "is a bit more - the register is a bit lower". This seems to acknowledge that 'gay' does not have the same discursive associations for John as 'homosexual'. Charles also described the formal qualities and specificity of 'homosexual':

- Charles 'Homosexual' has got more the, horrible expression, 'dictionary definition' than any others. Others are meant to be compliments or insults depending on how you choose to receive them. And also they are words that cross again boundaries like queer crosses so many boundaries. 'Gay' can cross so many boundaries, it doesn't - 'homosexual' just seems to fit one definition.
- DS So there is something kind of quite formal about it, like defined about it?

Charles Yeah. A bit like being an Englishman [client].

The scientific formality that Charles and John speak of indicates the discursive history of the term homosexual. Over the last century it has been taken up most noticeably by the medical and psychiatric professions. These professions are imbued with the discursive power of 'truth' telling (Foucault, 1973/2000b, 1977/2000c). Yet, for much of that time the 'truth' they told was one that pathologised homosexuality. This pathologising use of the term 'homosexual' has been utilised by other homonegative discourses such as the Christian supremacist and conservative discourses. Unsurprisingly then, for some of the men the term 'homosexual' held negative connotations:

Ralph With 'homosexual', for too many years that has had a kind of negative connotation. Society used it when they berate gays, they'd say 'homosexual'. Christians would call them 'homosexual' and that is a term of abuse kind of thing. So I don't use the word homosexual very much, no [client].

Brian Yeah, and, of course, the old one 'homosexual' you know. That's awful.

DS What is it you find awful about that?

Brian Oh it is just the way it has been sort of like used over the years [client].

So far, I have shown some of the diversity of ways in which the men interviewed categorised and understood their sexual orientation. They use differing terminology, for differing reasons, in various contexts, and attribute different meanings to the same terms. Yet, there are also commonalities in the ways the men understood their sexual orientation. Regardless of which labels they prefer, all of these labels are constructed in relation to various discourses of homosexuality, and in relationship to a heteronormative society. These discourses have implications for subjectivity, so I want to consider the various ways the men talked about the relative significance of sexual orientation to their identity, and to their relationship with wider society.

'Just sex' or something more meaningful?

In Chapter Four I argued that with the increased prevalence and influence of the equal rights discourse of homosexuality since the late 20th century, the modern homosexual has become imbued with many of the characteristics of an ethnic group. This way of thinking about homosexuals has become part of much of mainstream lesbian and gay psychology. However, some, such as Butler (1990) and Harwood and Rasmussen (2004), argue that this tendency to essentialise lesbian and gay identities as yet another discrete 'cultural' group

obviates how this continues to construct them as 'other' than the heterosexual norm. Furthermore, the ethnicising of lesbian and gay identities has been critiqued for failing to acknowledge diversity within these constructed group identities (Jagose, 1996; Seidman, 1993). In this section I show the ways in which the men interviewed took up the ethnic homosexual subject of the equal rights discourse, and the ways in which they have resisted it.

Consistent with the current dominant ethnic discourse many of the men spoke of 'gay' as being integral to their identity:

Jim Look, I think your sexuality is what you are. It is a part of you and you can't get away from it. ... It's a major part of life. Sex is like eating, breathing ... and it is in the top 10 of living, it is like breathing and eating [client].

Rick I think it is quite important because it differentiates me from other people. Yeah, I think sexuality is quite a big part of an individual's life. [...] when my identity or whatever is being talked about I wouldn't say 'I'm a student', I would say 'I'm gay'. So it would come in there [client].

John Well I think your sexuality is very important and it does define who you are. ... it is part of your psychic footprint [client].

Many of the participants took up the essentialising position offered by the equal rights discourse. For Jim, being gay is one of the top ten things in his life, alongside the basic, essential needs of existence. Rick describes it as more important than his identity as a student. This suggests a more encompassing part of his identity in much the same way as someone might describe his or her ethnicity. This is similar to the earlier quote from Charles who likens describing his identity as 'homosexual' to saying he is an Englishman. While acknowledging the formality he associates with the term 'homosexuality', he went on to say that his 'homosexuality' accounted for 90% of his identity. Using more psychological language, but still within an essentialising discourse of gay identity, John says his sexuality is definitive of him in significant ways. All these descriptions of the centrality of sexual orientation to one's identity are enabled within an equal rights discourse of homosexuality.

Even though the ethnic model of identity found in the equal rights discourse was common in the interviews there were other ways in which the men understood their sexual identity. For example:

- Ralph Nietzsche said “the degree and kind of a person’s sexuality reaches up into the ultimate pinnacle of his spirit” [...] Oh, well sexuality isn’t biologically determined. It is soullually determined
- David It is?
- Ralph Soul-u-ally - determined in your soul. It is determined by soul. You made that choice to be gay from before you were born and that you are, that God made you a gay soul. It wasn’t something - your biology may have helped you focus it but you were a gay soul before you were born so there is that vastness behind it and you are meant to learn something from being gay. If it is about the vicissitudes of society, the way society hates you, then you have to learn something from that about yourself and that you are in a minority situation [client].

Ralph deploys multiple discourses of homosexuality to resist the Christian supremacist discourse and its positioning of homosexuality as sinful, despite this having constructed much of his experience. Similarly to the equal rights discourse, he describes his sexuality as central to his life. But, he draws on philosophical and gay affirmative discourses of spirituality to do so. These subjugated discourses offer Ralph a subject position where learning from the trauma of being hated by society is constructed as a god-given challenge. This is a more validating subject position than that offered by the Christian supremacist discourse. These discourses that resist the Christian supremacist discourse were not outlined in the chapter on discourses of homosexuality because of their limited circulation. Nevertheless, they are important resources for Ralph and examples of subjugated knowledges on homosexuality. For an historical summary of the wide range of Christian views towards homosexuality, see Coleman (1980); for examples of resistance to homonegative Christian discourses of homosexuality see Rodriguez (2000) and Yip (1997, 1999); and for writings on broader approaches to gay spirituality see Walker (1980) and Thompson (1995).

Further resistance to the prevailing equal rights discourse of homosexuality is evidenced in the men who did not view homosexuality as central to their identity, and those who explicitly critiqued the notion of gay men as an ethnic group:

- Jack You have to eat, you have to clean houses, you have to drive around, you have go to the supermarket, you have to use the internet, you do that, and you have sex, like such a small percentage of time of all the other things. I can’t see how it can be an important thing unless you are a very - I think it might be a little bit different - I’m being quite interested to have this conversation with somebody as knowledgeable as you [laughter]. It may be different for a very ‘out there’ gay sort of person [client].

Pete I know about the Burnett Centre⁵⁶ yes. I tend to avoid situations geared specifically for the gay community. I mean I really object to the idea of my life being dominated by my sexual orientation. People say ‘oh you are homosexual’ and I say ‘well what about my spirituality, what about my guitar playing, what about?’ [...] No. I don’t like being marginalised or compartmentalised. I see myself as a human being first. If I limited my horizons like that, I mean, you know, a lot of American gay philosophers have pointed out that the ghetto was just a bigger closet [client].

Daniel I just think gay men are really closeted. When I go to parties, its a BBQ in a back garden with a big 6ft fence, you go to some one’s house and the doors are shut and the windows are shut and maybe the back door is open it is just - I’ve always felt really closeted since I came out. I’m out of the closet but I felt I’ve sort of stepped into a bigger closet [client].

In the above excerpts Jack and Pete contest the notion that sexual orientation is central to their lives. Their way of talking about sexual orientation as ‘just sex’, and as one of the many behaviours they engage in is consistent with a queer subject position. This positioning resists situating identity within the limited, and heteronormative, cultural definitions available for describing sexuality. However, Jack also acknowledges that there are other discourses of homosexuality available, ones that he suggests may be more likely for a “very out there gay sort of person”. Despite denying sexual orientation as being central to his life, (a position enabled by a queer discourse), when talking later in the interview about how he made sense of his mental health problem he attributed much of it to the shame he experienced for being gay (a position enabled by psy and critical discourses through their accounting for the effects of homonegative discourses). This is an example of how people’s subject positions can often be contradictory.

Expounding another idea from within queer discourse, Pete and Daniel challenge the liberatory notion contained within the equal rights discourse that ‘coming out’ leads to a state of increased freedom. They resist this by commenting that in coming out gays are not free but step into “a bigger closet” with its own limitations. In a similar vein, Halperin (1995) argues that when people come out as lesbian or gay they make themselves “into a convenient screen onto which straight people can project all the fantasies they routinely

⁵⁶ The Burnett Centre is a free to users counselling and support service run by the New Zealand Aids Foundation. It is not part of the PMHS but some of the men had used this service as well as PMHS. Permission has been obtained from the manager of the Burnett Centre to name the centre when participants refer to it in the interviews.

entertain about gay people” (p. 30). However, while speaking from a queer subject position and resisting ‘being marginalised or compartmentalised’ as a ‘gay man’, Pete also stated:

Pete Yeah, see most of the people I know, even the dead ones, were pretty ‘out’ people. I mean I really haven’t had too much time for closeted individuals and whilst I’ve met a few bi-sexual men, I haven’t got too much time for that either [client].

Here Pete makes distinctions between different categories of MSM and distances himself from those he does not approve of; closeted individuals and bisexual men. In this moment he takes an equal rights subject position advocating the value of coming out and having a clear sexual orientation. Bisexuality for Pete, and for the equal rights discourse, interrupts the notion of gay men being a distinct ‘ethnic like’ group. Pete’s use of both queer, and equal rights, discourses of homosexuality further illustrates the sometimes complex ways in which the men’s understandings of sexual orientation are constructed.

Thus far, this chapter has explored some of the differing ways the men identify and make meaning of their sexual attraction to men. These multiple meanings are constructed out of the various available discourses of homosexuality but in unpredictable ways. This means that when a man says he is ‘gay’, ‘queer’, or ‘homosexual’, we can not know what he means by that, other than he is likely to be attracted to men. Despite these multiple ways of making sense of their sexual orientation, most of the men spoke in ways acknowledging a relationship between their sexual orientation and the heteronormative context in which they live. In other words, they described their various homosexual identities as constructed in a social context that is largely homonegative.

‘It’s equality, Jim, but not as we know it ... ’

Equal rights may currently be the prevailing discourse of homosexuality but this does not mean that the MSM who speak from, or are aware of, this discourse necessarily think that the wider community also speaks it. When talking about the importance of being ‘gay’ the men often commented on experiences of oppression, and on sociohistorical changes that have influenced the construction and significance of their sexual orientation:

Evan Well, in the last 10 years particularly it [sexual orientation] has come to dominate because it has been so clear that it is my sexuality that causes people to treat me so badly and particularly the people who are supposed to

be my protectors. You know, I really don't think that I have been protected by the cops or by WINZ⁵⁷ but instead victimised for my sexuality and it is them, those people, who are acting criminally. That outrages me. You know I've waited since 1958 just to be a legal citizen.

DS It is a long time, eh?

Evan Yeah, and to have a few rights. Well it is about 44 years I think. And I really believed when I came back in 1991 that I at last had those rights and I have had 10 years of abuse from the cops [client].

Evan's references to rights, and to legal changes, refer to the equal rights discourse of homosexuality. However, despite homosexual law reform in New Zealand, and Evan using an identity category consistent with it, he still experiences government agencies as acting in homonegative ways. Regardless of the terminology the other MSM deployed to describe their sexual orientation, many of them think New Zealand society is still homonegative in significant ways:

Jim Where I parked there was a toilet there, I used to go to the beat [gay cruising or pick-up area] there. I don't go there now but there was a couple of young Polynesian kids there and they were going in and out and in and out of that place and I thought 'what the hell are these kids doing'. And there was a chap walked in and they came out and they were calling him 'poofta', 'wanker', and I thought 'well this is still going on'. These bloody kids, you've still got this same thing. And that part doesn't change. You know the world is still not very nice [client].

Ralph Yeah but there's still, the law has made a change - it may be okay for gays, gay men to have sex with one another now, [it] may be legal, but there is still that under-pinning social homophobia [client].

Daniel I would say it is a lot better but there is still work to do. But having said that you can't change a mindset, you can't change someone's mind. So there is always going to be a level of discomfort for people seeing two men together [client].

Sometimes the MSM used the 'out and proud' subject position of the equal rights discourse to construct a role for themselves in relation to this homonegative cultural context. Accordingly, when talking about the importance of sexual orientation in their life, some of the men described a responsibility to defend gay people against homonegative discourses:

Nathan I come straight to the point that I am [gay] and then if anyone feels that they are uncomfortable about people like me then I sort of explain to them that you know, it is not as bad as what it is or what people feel about gay people.

⁵⁷ WINZ is the abbreviation for Work and Income New Zealand. This is a government department responsible for administering unemployment, sickness and other state welfare payments.

It is just like an article in Sunday's Herald about a cub master called Ian Clark. A lot of people will give the views that a lot of gay people are sort of paedophiles [client].

Charles Also I find you end up defending the term 'gay', or gay people, as well which is a bit of a nuisance but I feel obliged to do so. Sort of stamp out some forms of ignorance on the way [client].

Nathan refers to a newspaper article he read that he believes will support a pathologising discourse linking homosexuality with paedophilia. Nathan suggests implicitly that he has a role to educate people about homosexuality while Charles is explicit in feeling "obliged" to try and "stamp out" ignorance.

Two of the men said they had never been subject to anti-homosexual discrimination but they attributed this largely to their ability to appear heterosexual rather than to homopositive changes in society:

Pete If people get upset about it [homosexuality], it is their problem not mine. I don't put it in people's faces because it is not relevant unless I am looking at it like from a sexual context. And I can honestly say I've experienced very little discrimination in my life.

DS That's good.

Pete I mean I think perhaps if I was a screaming queen and running around flapping wrists and doing all that, I mean I might have been on the receiving end of a little bit of an adverse reaction [client].

Jack Well I think it is a choice you make really. [pause] I mean I just think people sort of put themselves right in somebody else's face and go well 'I'm different'. You know there are things about me that - I'm different to you - well you are going to have to expect some prejudices to arise because people, whereas I think if you just blend in, I mean why aggravate a situation if it really doesn't require aggravating? [client].

Pete's references to not confronting people with homosexuality, such as by displaying 'effeminate' behaviours, illustrates that he is aware of how non-traditional forms of masculinity are marginalised by heteronormative discourses of masculinity, and associated with male homosexuality. Similarly, Jack says that he has not experienced prejudice because he does not appear 'gay'. Jack further argues that gay people make a "choice" and if they do not conform then they should expect prejudice. Here he speaks the conservative discourse of homosexuality which admonishes homosexuals to keep their homosexuality private so as not to offend the public good. He also draws on the liberal humanist notion that people are relatively free to make rational choices about how they want to be. These examples illustrate how hegemonic forms of masculinity support heteronormativity while providing

some protection from homonegative discrimination for some MSM. These instances of the men's talk are enabled by both conservative and equal rights discourses of homosexuality, both of which emphasise the need for homosexuals to fit in to heterosexual society.

However, the subject positions the men adopted regarding their homosexuality were not always consistent. Pete, for example, (as discussed earlier), denies a gay label and prefers what he describes as the confrontational character of 'queer'; this would seem at odds with his adopting a more conservative approach of blending in by not getting homosexuality "in people's faces". Another man who spoke from contradictory positions was Jim:

Jim But for all that it [homosexuality] is not something you flaunt, talk about, do anything else about. Again like breathing and eating, it is just you, it is just me. People know about me now and I don't give a shit anymore about what, if they want to have me on, I don't care. But now, not when I was 30 years younger [client].

Earlier in the interview Jim made a point of identifying himself as a "masculine male" and here he deploys the conservative catch cry that homosexuality is okay if kept private. Yet, while advocating not flaunting sexuality, he also says that he no longer cares about how people might respond to his homosexuality. This example shows a tension within the equal rights discourse that Jim often speaks from; on the one hand it advocates valid public gay identities, yet a conservative strand within this discourse admonishes gay people to blend in to, and not unsettle, mainstream society (Brickell, 2000, 2001; Lehring, 1997).

Having explored some of the ways the men spoke about their sexual orientation and the meanings they make of it, I now make some interim conclusions, namely that names do matter and that the 'justice' offered by the equal rights discourse is contested. Homosexuality is such a disputed concept in the West that the language used to describe homosexual identities has multiple and often significant meanings for the people it is applied to. Furthermore, because language is unstable in meaning, and because individuals are subject to multiple discourses, the MSM interviewed often made discrete meanings of the same terms.

In addition to the meanings of the labels the men preferred to describe their sexuality, to be a homosexual currently means that one's sexual orientation identity is very much negotiated, and thus contested within a heteronormative context. The MSM participants described a variety of understandings about what their sexual orientation means for them. They often wanted to see themselves, and be seen as, certain types of homosexuals and not

others. Despite this diversity of meaning, some commonalities between them are that these understandings are often central to their sense of identity, and these identities are often a struggle for the men to attain and often require defending against attack from others. Conversely, some of the men resisted this essentialist view of 'gay' identity and talked about their sexual orientation as not central to their personhood.

For these reasons carefulness around use of language when thinking about and discussing sexual orientation is important in order to be respectful of the multiple meanings MSM make of sexual orientation. As I will argue in the next section, this is even more salient given that all but one of the men understood their sexual orientation to be implicated in the construction of their mental health problem.

Making Sense of Distress: MSM talk about mental health

The empirical validity and logical inconsistencies of the disease model of homosexuality, as well as the human suffering and clinical malpractice arising out of practice within the disease model, have lent themselves to the logical error that if diagnosis of homosexuality as a disease entity is faulty and destructive, then diagnostic concepts applied to homosexual individuals, and perhaps diagnosis itself, is faulty and destructive.

(Gonsiorek, 1982, p. 9)

Gonsiorek alerts mental health professionals to a tendency to throw the diagnostic baby out with the bathwater, bathwater contaminated by years of practice from within the pathological discourse of homosexuality. Correspondingly, in the two decades since Gonsiorek wrote his cautionary article, research has reported lesbian and gay clients of mental health services claiming that either their homosexuality was pathologised, over-implicated in their mental health problem, or totally ignored (Golding, 1997; King et al., 2003a; Lucksted, 2004; McFarlane, 1998). Thus, the issues that Gonsiorek raised regarding the relationship between homosexuality, diagnosis, and treatment, are still current today. Despite this, research has not yet explored how MSM make sense of their experience of mental health problems.

The remainder of this chapter explores the ways the MSM interviewed accounted for their mental health problems. I show that despite the dominance of the medical discourse of mental health in popular media and in clinical practice, most of the MSM drew on psy, and critical discourses, of mental health to understand their experiences and to draw clear connections between heteronormativity and their experience of mental health problems. I

argue that using these discourses, along with an equal rights discourse of homosexuality, enables the men to largely resist the medicalising of their distress. In particular, they draw on the notion from the equal rights discourse that gay identities are an essential part of people's 'true' selves. This notion overlaps with the psychological discourse and its description of human subjects as having relatively stable and coherent identities.

Discourses of Dis-connection and Dis-orientation

The men interviewed described receiving various, and often multiple, diagnoses through their contact with PMHS. Perhaps not surprisingly, given the predominance of medical and psy discourses, even the men who could not recall being given a diagnosis often used medical or psy terms to label their distress. Eleven of them spoke of depression, two of bipolar disorder, four of psychosis, one of posttraumatic stress disorder, and one reported experiencing panic attacks. All but two reported having attempted suicide at least once. This suggests that for many of the men the severity of their distress, and their mental health problems, has been high.

However, regardless of their given diagnoses, or the terminology they used to describe their experience of distress, there were some common themes in the men's understandings of their mental health problems. Frequently their accounts gave a central role to homonegative discourses, and to the disconnection and distress resulting from the subject positions those discourses offered them. All but one of the men spoke about their experience of mental health problems at least partly in this way:

- Evan I suppose I did think about it as depression but it was also tied in with my sexuality I think and the fact that there just seemed to be no rights for gays at all [...] Well it might be chronic depression but that is just the outcome of everything else.
- DS So what makes most sense to you to explain this series of overdoses in your life?
- Evan Just injustice really [client].

Evan reported repeated harassment by the police leading to depression and suicidality. His account uses the medical/psy terminology of "chronic depression" but deploys critical language of "injustice" to explain his distress. He also speaks the equal rights discourse to describe a marginalised position of gays and, thus, himself in society.

Jim also labels his distress as depression and speaks about it, and a suicide attempt, as the effects of the subject positioning provided for him by the Christian supremacist discourse:

- Jim I found out about a group called Exodus, which was supposed to convert you to being straight again.
- DS Yeah, I've heard about them.
- Jim So I went along to that for a year and went to all their meetings and my wife came too which I hated. Occasionally, not all the time. Because every week you had to say, 'I've had a good week, I didn't do anything', and oh God, I did. I used to walk past toilets and go back past and go in and then immediately beat myself up again for giving in to it.
- DS It sounds like a real struggle.
- Jim Even when, so it was almost a year, almost exactly. I decided I couldn't go any further, so I decided to kill myself, and tried [client].

When positioned in the Christian supremacist discourse Jim had sought a 'cure' for his homosexuality. Despite the American Psychological Association (1997) highlighting the serious ethical problems with any attempts at 'conversion' or 'reparative' therapies, some Christian organisations continue to offer such interventions, often presenting them using the language of treatment and therapy from the medical and psy discourses (for an example of this see, Rosik, 2001). The Christian supremacist discourse offers homosexuals a 'sinful' subject position. Jim attributes his inability to abstain from sex with men, while also attending a Christian group where he felt a need to conform to heterosexuality, as becoming intolerable and leading to his suicide attempt.

Other men also explained their mental health problems as related to the tension between their attraction to men and heteronormative discourses. Often they used a psy discourse to do this:

- John The other issue, that really was a mental health issue for me, was being in that environment where I was just doing my thing but I was sort of like living my work life and on the weekends I would be going out and partying, which I wanted to do, and which I enjoyed, and had a great time. And yet there were two different lives going on, not integrated [client].

John, who had experienced what he called panic attacks and paranoia talked of mental health problems resulting from having to live two "different" and "not integrated" lives. Here he draws on the notion within both the psy and the equal rights discourses of stable, coherent identities. Within the psy discourse, barriers to experiencing such unified identities are understood to potentially cause mental health problems. Other men also spoke in similar ways about their mental health problems:

- Brian Well it [being gay] is something that I've always probably been but during my working life and my social life - that's what I'm doing now, I'm just trying to break down walls. And this is what I'm in the process of doing now because I had all these different personas; not split personality, but [...] It is terrible,

you know, you've got your parents and what your parents see and immediate family, then you've got your straight friends face, you've got your work face, you've got your gay friends face, you've got your partners face, you know, and you can only juggle so many balls in the air at once [client].

Rick Yeah. I mean I think when you suppress things or repress things, consciously or subconsciously, that kind of leads you to become depressed when you can't fully express yourself. I think I wasn't really coping with my attractions, you know, because in a kind of standard family they kind of expect you to marry and have kids kind of thing, and all that [client].

Brian, who reported experiencing depression, talks of the distress of having to manage different subject positions. Again, within psy and equal rights discourses, inconsistent parts of people's lives are associated with psychological distress. Rick had experienced 'psychosis' and accounts for it by using psychological notions of suppression and repression.⁵⁸ Also in the interview he explicitly resists a medical discourse which would pathologise his mental health problems:

Rick Yeah. It is kind of nice, you know, having a label and saying "I'm depressed, and one in five New Zealanders suffer from mental illness", that kind of thing. But also I think [it] locates the problem in the individual rather than society, or whatever, and, therefore, you think oh my goodness it's me [...] I like to say when people say "oh do you suffer from a mental illness?", I don't like the word 'illness', I say "I've got mental health issues". That's how I like to put it. Because illness sort of sounds like cancer or something [client].

Rick acknowledges the potentially normalising comfort that can result from medical diagnosis. However, Rick deploys a critical discourse to differentiate his problems from the concept of illness and open a space for them to be considered as connected to, or arising from, society. His approach utilises a critical discourse of mental health that considers the social construction of mental health problems.

Within psychiatric research and literature some 'illnesses' are considered more biomedical than others. Two, in particular, that are often considered this way are bipolar disorder and schizophrenia. Because of this, I now provide a case study of one man who had been diagnosed with both of these 'illnesses', but who was able to both take up and resist these medical descriptions of his experience. However, before presenting the case study I introduce the terminology I will use for the rest of the thesis to acknowledge the ways the MSM participants predominantly accounted for their mental health problems.

⁵⁸ This language could also be constructed within a critical discourse of mental health with its focus on issues of marginalisation, oppression, and repression.

Theorising Homonegative Trauma

Thus far I have shown that many of the explanations given by participants use psy and critical discourses of mental health to explain the relationship between their sexuality and their mental health problems. However, current terminology in the mental health literature does not adequately represent these accounts. Commonly explanations refer to the psychological impact of ‘homophobia’ and heterosexism and the consequent development of ‘internalised homophobia’ (D. Davies, 1996; Dodds et al., 2005; Garnets et al., 2003; Igartua et al., 2003; King et al., 2003a). However, as discussed earlier, the term ‘homophobia’ has been critiqued for offering an individual account of a phenomena that has its origins in anti-homosexual social systems of meaning (L. Brown, 1996; Kitzinger, 1997; Peel, 2002). An alternative term, combining psy and sociological language is ‘minority stress’ (DiPlacido, 1998; Meyer, 1995, 2003). This however, does not acknowledge that the stress relates to homonegative discourses.

In this thesis I will use the term ‘homonegative trauma’ to refer to the distress MSM participants considered as ensuing from the effects of homonegative discourses. I use this term for a number of reasons. First, it draws on psy and critical discourses (which were the ones most commonly employed by the men). Second, in the psychological literature ‘trauma’ tends to be used to acknowledge the consequence of a wide range of events, which can occur singly or repeatedly, and have long term effects (for recent examples see Caffo, Forresi, & Lievers, 2005; Vostanis, 2004). This depiction seems to characterise the types of experiences the men described. Third, ‘trauma’ commonly implies something originating externally to the person experiencing it, and, thus, has the potential to depathologise individuals by resisting a more biomedical explanation of mental health problems. Fourth, the term ‘homonegative trauma’ specifically acknowledges the productive role of homonegative discourses in the mental health experiences of the MSM interviewed. I now present a detailed case study of one man’s account of homonegative trauma.

Deconstructing Psychosis: A case study in Homonegative Trauma

The schizophrenic is someone who has queer experiences and/or is acting in a queer way, from the point of view usually of his [sic] relatives and of ourselves

That the diagnosed patient is suffering from a pathological process is either a fact, or an hypothesis, an assumption, or a judgement.

To regard it as fact is unequivocally false. To regard it as an hypothesis is legitimate. It is unnecessary either to make the assumption or to pass judgement.

(Laing, 1967, pp. 104-105)

As arguably the leader of the anti-psychiatry movement of the 1960s and 70s, Laing (1967) contended that schizophrenia and madness in the broadest sense were understandable in a crazy and destructive world. Thus, he advocated a political account of experiences that had generally been subjected to psychiatric diagnosis. Laing's use of "queer" in the above quote was meant in a different sense to its current usage within discourses of homosexuality. However, its reference to behaviour, and experience, that is counter-normative, yet believed or assumed to be pathological, is relevant to the accounts of psychosis and distress given by Ralph.

Ralph is a man from a very religious Christian background. He had been married and has children. He had been a client of PMHS for over 10 years and had been a user of acute services and a CMHC⁵⁹. At the time of the interview he was still a client. Over the course of Ralph's time as a client of PMHS he reported being given various diagnoses. Two he discussed in particular, were manic depression and schizo-affective disorder. First I present how Ralph described his experience of psychosis. I will then show how Ralph reported initially making meaning of these diagnoses, and then how his explanations of his mental health problems have changed:

Ralph I had hallucinations and I had the worst kind of hallucinations a gay man could ever have. All the men in the world were eliminated and there were only women. [...] I was just having all these hallucinations and voices in my head saying 'they're going to get you, they're going to get you, you can't be killed, you are invulnerable, you'd never die' and that 'the only true world is the world of women' and that freaked me out.

DS The only true?

Ralph World is the world of women. And that freaked me out. And I heard these voices and they were voices of Satan telling me about people, that they're

⁵⁹ CMHC is a common abbreviation for Community Mental Health Centre.

going to get me and I was fearful of people. I think it lasted two weeks while I went psychotic [client].

Through a critical discourse of mental health, Ralph's description of his experience of psychosis can be read as constructed within the subject position offered by a Christian supremacist discourse. As a 'gay'⁶⁰ man positioned by that discourse, he was alone, unsupported, and denied any man who could be the object of his erotic love and desire. This subject position admonishes his attraction to men and specifies that he should be with women. Furthermore, within a Christian supremacist discourse penalties for being gay include persecution and association with the devil.

Thus far I have argued that Ralph's account of his psychotic experiences can be read through a Christian supremacist discourse of homosexuality. Notwithstanding the later explanations Ralph constructed of his experience of mood changes and psychosis, his initial understandings of the diagnoses he was given were described in the following way:

Ralph Well I didn't know what it was at first. I thought, I didn't know it was to do with mood swings. But once I discovered what it meant it kind of explained my whole life pattern and it was some sort of label I could latch on to, as part of that search for myself kind of thing. So it was something I could hang on to and understand myself somehow. [...] I felt I belonged. It explained everything about me and I thought they were professionals caring for me, making sure I take my medication. There was no psychotherapy going on at all, there was none of that kind of probing into why you behave the way you do. [...] Well, I had immediately accepted the definition, schizo-affective, and I knew that there was a biological disorder, brain disorder, or that it was chemical in some way, so I thought, well yes, okay, I'll accept the clinical diagnosis. This had meaning for me at this point and it meant that I'm this and a whole raft of other things as well and I accepted that. I accepted it. I accepted the physiological definition. Even though I was curious about what the psychological impact of it was and why there was a common ground for experiences of schizophrenics [client].

Ralph describes adopting the ideal 'patient' subject position offered him by staff through the medical discourse, being accepting of diagnosis, and medication, and trusting of health professionals. This subject position gave him an identity and some reassurance by offering him a means to understand himself. However, revealing resistance to the model 'patient' subject, Ralph reports that he was nevertheless curious about the psychology of psychosis and common experiences between people with schizophrenia. This use of psy and possibly critical discourses (through the idea of 'common experiences') to understand schizophrenia

⁶⁰ I use the term 'gay' in this case study as this was Ralph's preferred terminology for his sexual orientation.

is similar to current debates within psychiatric literature that challenge biomedical explanations of schizophrenia (see Read et al., 2004b).

Since then Ralph reported utilising more psy and critical understandings of his mental health problems. Similar to the other men interviewed, Ralph described heteronormative discourses of homosexuality as constitutive of his mental health problems. In particular, the Christian supremacist discourse and the subject position it offered him were central to his account:

Ralph There was a strong sense of disconnection with my body yeah. And because of the church teachings I was morally compelled to believe what they said. That I was wrong, I was a sinner, I was evil and I was bad, and all those kind of things came up with my association with the church. And it still is there, that kind of moral force is still there. [...] It was kind of, I found I was quite detached with myself, inside myself. I felt like I was two kind of people. One who had this secret sexual life and one who had the appearance of being normal. And that kind of dissonance I felt [...] Well it created, it made me feel alienated inside myself. I really felt strongly alienated. I didn't feel I belonged to my body or belonged to me or belonged to anybody else [client].

The text clearly describes the subject position offered Ralph by the Christian supremacist discourse; “wrong”, “sinful”, “evil” and “bad”. Yet Ralph also uses psy language, such as “detached”, and “dissonance”, and the more critical concept of “alienation” to explain how this subject position made him judge the part of him that was attracted to other men. His use of psy and critical discourses of mental health here enable him to adopt a questioning approach to how homonegative discourses have constructed his life and mental health problems:

Ralph Everything was focused about being gay. I was depressed because I was gay and because I didn't have a strong identity, a strong ego and I felt I was susceptible to what society wanted, the norms of society. I felt there was a massive imbalance there. A massive contradiction. [...] I think, I think my psychosis was based on fear. Fear of, I have what I call ontological crisis, I've always had ontological crises, crises of identity and being. And so basically what my psychoses brought out were my worst fears, they came into my mind. Fear of there being no men, a fear of people and their judgment and condemnations, and a fear of my own being, being afraid of myself kind of thing [client].

The psy discourse constructs healthy people as having strong identities and egos. Ralph deploys the psy discourse, along with critical notions (about the heteronormative standards of society), and philosophical concepts (ontological crises), to explain his mental health problems. His use of these discourses enables him to resist the Christian supremacist discourse by refusing its negative construction of homosexuals as sinful and shameful.

Instead, Ralph places responsibility for his mental health problems on the homonegative subject position the Christian supremacist discourse offered him. Further, the alternative discourses enable Ralph to construct a more homopositive identity.

Ralph's accounts illustrate the way that an experience of distress that could be diagnosed and deemed bio-genetic within a medical discourse, can also be accounted for in terms of competing discourses (Crowe & Alavi, 1999). In this case, psy and critical discourses of mental health, and a Christian supremacist discourse of homosexuality, provide an alternative reading for the construction of Ralph's distress; one that can be connected to homonegative trauma. Furthermore, this understanding has had important explanatory value for Ralph and for his recovery. For example, one of the strategies he now uses to support his recovery is writing positively about his sexuality in a journal. But, as will be discussed in the following chapter, this homopositive understanding has not been supported by PMHS.

Other Explanations of Mental Health Problems

While common, psy and critical discourses about the discordance between same-sex sexual attraction and homonegative discourses were not the only ones constructing the men's accounts of mental health problems. In this section I show some of the other explanations that the men drew on, sometimes overlapping ones to do with sexuality, in order to explain their experiences of distress and trauma. The other explanations used by the men included notions of inadequacy, experience of sexual abuse, family, and environmental circumstances, and loss. All these concepts, and related experiences, were theorised as contributing to trauma; however, as they have been extensively discussed elsewhere, and do not necessarily relate to sexuality, I do not fully explore those issues here.

Jim was discussed earlier in relation to his experience of trying to convert to heterosexuality and the trauma he associated with that. He also had other explanations for his distress and why, since the age of 10, he had wanted to kill himself:

Jim To realise that I'd always had a feeling of being inadequate. From childhood. I've never been, I just don't feel good about me. I'm not very good looking, and I'm not very clever. I'm not intelligent, I have nothing to offer anybody and I feel totally worthless. [...] I didn't think I was very clever. I wasn't good enough. My dad was a very good sportsman, excellent, I mean he was a New Zealand representative at [name of sport] and I wasn't good at all ... I knew I didn't feel worthwhile. I wasn't good at anything, I wasn't, - my mother was a strict lady, very strict, and although I know she loved me, - was

I trying to hurt them? I don't know. Was I trying to say 'notice me or something'? I'm not sure [client].

Jim draws on psy notions of 'inadequacy' and other personal attributes as constitutive of his distress. Concepts such as 'inadequacy' and 'low self esteem' abound in psychological literature and have been critiqued from a critical discourse as locating problems within individuals rather than sociocultural contexts (see L. Brown, 2000; Kitzinger & Perkins, 1993). Jim also compares himself negatively to a heteronormative masculine subject who is excellent at sport. As discussed earlier, in a patriarchal, and heteronormative, society, homosexual men are often doubly positioned as feminine, and as not-heterosexual; both positions are negatively valued and can be experienced as distressing. Additionally, Jim utilises a psy discourse to consider parental factors that might have affected his development. This idea has a long history in psychology, and while it begins to look at problems outside of the individual it generally does not extend its explanation to wider sociocultural systems of meaning and practices. Overall, Jim's various accounts of his mental health issues illustrate the multiple discursive positionings that can be constructive of, and used to account for, distress.

Sexual abuse, and subsequent posttraumatic stress disorder (PTSD), was another explanation that two of the men used alongside descriptions that attributed homonegative discourses as central to their mental health problems:

Mark As I said I think a lot of it is related around, the whole thing is related around post traumatic stress disorder and with that I think it has clouded a lot of the other issues which were not explored at the time, so, therefore, I've ended up – well the depression will set in anyway, that will set in to anybody [client].

Daniel Yeah, I was molested by my brother at a young age and that does affect - a lot times I stop and think, 'I'm not gay I'm just doing it because of my brother' [client].

In addition to talking about the problems of being sexually attracted to men in a heteronormative society, Mark reports being sexually abused by his father and by nursing staff in hospital on multiple occasions. He considers his depression to be an expected and normal response to traumatic issues that had not been 'explored'. This account locates the cause of trauma outside of the individual experiencing it and is consistent with psychological discourse as articulated in current theories on the common effects of sexual abuse (Briere, 1996, 2002; Courtois, 2000).

Also figuring sexual abuse as causative of distress, Daniel wonders if sexual abuse by his brother contributed to him being 'gay'. This account relies on psy notions of learned behaviour, and on a heteronormative and pathologising premise that homosexuality is not normal and can be 'caused' by traumatic or abnormal events (see Eskin, Kaynak-Demir, & Demir, 2005; Newton, 1992). It constrains Daniel from viewing his sexual orientation as independent of the sexual abuse. In contrast, (and to highlight this point), I have never heard it suggested that sexual abuse of women by men causes women to be heterosexual. Rather, it is more common amongst those speaking from homonegative discourses to argue the reverse, that women's negative experiences with men lead to homosexuality in women (Baker, 2003).

A third account offered in regard to the aetiology of mental health problems concerned family and environmental circumstances:

Stephen And it was a negative environment - I felt that if I didn't get my UE [university entrance] accredited I would have to come back the next year so it was like a dog chasing its tail sort of style and my father had been up on a [name of crime] charge or something - way back there were 3 people were killed in [description of a work related accident] of and some of the kids at school called me names and said "your father is a murderer" and that didn't help a great deal.

Elsewhere in the interview Stephen also talked about his brother dying. This way of accounting for mental health problems, by multiple stressors, is consistent with a psychological discourse. However, Stephen also offered this account alongside one that placed the centrality of heteronormative discourses in the construction of his mental health problem:

Stephen Well my sexuality had a lot to do with it [depression] and guilt about sexuality. I'd had quite a active sexual life with different people when I was quite young [...] Rejection - and rejection is one of the biggest things in my mental health really. Rejection in a big way. My own mother even wrote a letter against homosexuals [client].

Pete was the only man to offer an account of his distress that did not include the effects of homonegative discourses.

Pete Well let's see. About 10 months after my partner's death I was becoming more and more, I was retreating, becoming more and more reclusive. I mean really in a big way, which is unusual for me because I've always been kind of gregarious and social and all that. And concurrent with that was a feeling of a very bleak outlook, let's put it that way, for a variety of reasons. So I thought about it for quite a while and I thought well I've got to do something about it. I mean I can't seem to be able to control this, or shake it myself, so I went to my doctor after considerable deliberation, because it was quite a hurdle for

me to go and talk to my doctor about what I saw as something of my mind rather than a physical complaint or an illness. [...] I mean everything seemed very negative, and the whole variety of factors, not merely the death of my friend. The other friends' deaths, and being of an age too, I suppose, I was finding employment opportunities were really, and they aren't, believe me at this point 50% of men in New Zealand over 50 are unemployed. More if you are Polynesian [client].

Pete uses psy and critical discourses of mental health to account for his distress. The psy discourse constructs loss, and grief, as 'normal' parts of human experience, which can be cumulative, complicated, and lead to psychopathology (Gray, Prigerson, & Litz, 2004; Lichtenthal, Cruess, & Prigerson, 2004). Yet Pete also deploys a critical discourse to situate his problems within a sociocultural context acknowledging issues of age, ethnicity, and employment. This account enabled him to view his problems as psychosocial rather than biological, and to take up a more agentic position in relation to his problems.

Thus far I have illustrated a variety of ways in which the MSM participants made sense of their experiences of mental health problems. In the next section, I consider which discourses predominate in the men's accounts, which are less frequent, and what this might mean.

Not What the Doctor Ordered

Despite the dominance of the medical discourse of mental health in psy research, in the media, and in practice within PMHS, the MSM interviewed rarely used this discourse to explain their experience of mental health problems. Although using medical, and psy, terminology to label their mental health problems, often using the diagnoses they were given by mental health professionals, only one of the men directly attributed part of his mental health problem to biomedical causes:

DS Have you ever been given a diagnosis or been told that this is what your problem is?

Nathan Schizophrenia

DS And how well does that explain the problems for you? Does that make sense?

Nathan Well it is mainly based on, because my mother had the actual illness herself in the early 70s I think. She was in and out of [name of acute psychiatric hospital] [client].

Given the frequency of the medical discourse in public media, in mental health research, and in clinical practice within PMHS, how might we explain the relative lack of this

discourse in the accounts of the men interviewed? There are a number of possible explanations. First, it is possible that the context of the interviews may have had an impact on the telling of some accounts and not others. For example, the participants knew I was a psychologist and not a doctor or psychiatrist. Accordingly they may have thought that I would be more approving of psychological and social accounts of distress. Yet, often during the interviews the participants would disagree with things I said and they frequently had very strong views about particular issues. This suggests that the interviewees felt comfortable expressing views that they perceived to be different from mine.

Second, it is possible that the questions were biased towards psychological and critical understandings of mental health. One attempt I made to reduce this was taking my interview schedule for analysis by an interdisciplinary group of staff and students involved in qualitative research. I specifically asked them to look for any assumptions built into the questions I was planning to ask⁶¹.

Third, the paucity of medical accounts may relate to the self selection of participants into the research, and to the method of invitation. Men were invited to participate in research by brochures delivered widely in Auckland. An excerpt from the brochure is:

Sexuality and how we and others view it is often an important part of our lives. Male to male sexuality is criticised or ignored in many areas of society. The aim of this research is to find out how this social marginalisation may impact on mental health, mental health problems and PMHS for men who have sex with men.

(MSM client brochures – see Appendixes 4 and 8)

The research invitation specifically asked men to talk about issues of sexual orientation as it may relate to mental health. It is, then, not surprising that the men who did participate produced accounts of marginalisation related to sexual orientation and its relationship to their mental health problems. Furthermore, it is possible that MSM who had a predominantly medical view of their mental health problems would be less inclined to participate in the research, as I did not use the term ‘mental illness’. However, the brochure did not directly bias against the widespread biopsychosocial (or stress-diathesis) model of mental health that allows people to frame mental health issues as biological predispositions that are triggered by social stresses.

⁶¹ My goal here was not to eliminate assumptions, (an impossibility), but to be aware of which ones I was deploying.

A fourth possible explanation for the paucity of medical accounts is the considerable international research showing that public views of mental health problems are consistently more psychological and social than medical. Read and Haslam (2004) have extensively reviewed the research on this topic. They found that internationally, “while members of the public understand that many factors influence our mental health, they place much more emphasis on adverse life events than on biology or genetics” (Read & Haslam, 2004, p. 133).

Similarly, a fifth, and likely, reason for the relative lack of medical accounts in the interviews is the availability and circulation of competing discourses. The interviews, and this chapter, show that the men used a variety of discourses to privilege understandings of their experiences of mental health problems other than medical ones. The most evident were psychological, and critical, discourses of mental health, and Christian supremacist, and equal rights, discourses of homosexuality.

To conclude this chapter I begin to consider the implications of this discursive reading of the men’s accounts of their attraction to men, and of their mental health problems, for practice within PMHS.

Summary: Ways of Speaking - Identities and Problems.

Recapping the first half of the chapter, I argued that the men’s ways of understanding their attraction to men, and their preferred labels for this attraction, were constructed out of diverse and sometimes contradictory discourses of homosexuality. The men often spoke strongly about which terms they preferred to use for their homosexuality, and which they did not like, or actively denied. Furthermore, the same terms often had different meanings for different men. For example, the term ‘homosexual’ was a clear, precise term for some and a term understood as oppressive by others. The men were sometimes equally clear about what sort of homosexual they thought they were, or were not – “screaming queen”, “out there gay sort of person” or “masculine”, are some examples. Thus when a man says he is ‘gay’ or ticks ‘homosexual’ on a form, we cannot know what that term means for him other than his likely attraction to men. This diversity of meaning is usually absent from research on MSM and mental health.

In addition to questioning terminology, this chapter raised another issue in regard to comprehending the relationships between MSM and their mental health problems. This issue is the relevance of homosexuality to individual MSM. Some of the MSM described homosexuality as central to their identity as a person. This was often framed in the equal rights discourse language of ethnic identity, and through using essentialist psychological notions of the 'true self'. However, some of the MSM described homosexuality in other ways, such as 'just sex', but not being central to their identity, or to being uncertain about its importance. Again, this has implications for clinical practice. In particular, it is vital not to make any assumptions about how important, or unimportant, a particular identification regarding sexuality is for a MSM.

Despite the diversity of understandings between MSM regarding their homosexuality and its relationship to identity, there was a significant commonality amongst the ways many of the MSM spoke about their sexual identity (whatever terminology they preferred). This commonality was that their homosexual identity was constructed in a heteronormative context, one that often made the attainment of their sexual identity a struggle. Furthermore, many of the MSM described New Zealand society as still constructed within heteronormative discourses in significant ways that continue to cause distress for many MSM.

The second half of the chapter considered the ways in which the MSM participants accounted for their mental health problems. The foremost implication of these readings is that for all but one of the men, psy, and critical, discourses of mental health predominated in their accounts. In particular, they used these explanations to make links between their sexual attraction for men, homonegative discourses of homosexuality, and the construction of their mental health problems. Accordingly I have suggested the term 'homonegative trauma' to refer to the accounts most of the MSM participants gave connecting homosexuality and mental health.

Because homosexuality was significant to many of the MSM interviewed and because of the ways they resisted medical accounts and instead linked homonegative trauma to mental health problems, it is important to consider the ways these identities and understandings are, or are not, acknowledged within PMHS. However, as I will argue in the next chapter, the accounts the men gave of their understandings of their attraction to men, and of their mental health problems were often subjugated by discursive power relations operating

within PMHS. These can serve to minimise, and deny, the importance of the understandings MSM have of themselves and of their mental health problems.

Chapter Eight:

A Public Silence Staff Constructing Invisibility for MSM Clients

This chapter⁶² explores how queer staff talked about the potential significance of sexual orientation and the visibility of MSM clients in PMHS. I will argue that the staff's talk illustrates discursive practices that help construct the invisibility of MSM clients in PMHS. In the previous chapter I demonstrated that same sex attraction was frequently central to MSM's understandings of their identity, and of their mental health problems. The MSM commonly used psy and critical discourses of mental health to explain how this distress occurs. Their accounts suggest that the effects of heteronormative discourses function to construct their sexuality as negative, and often invisible. This invisibility occurs through homosexuality being disconnected from other facets of their lives, especially public ones. I contend that when MSM are made invisible inside PMHS, this can function to perpetuate, rather than help alleviate, their distress.

Visibility of MSM in PMHS can be important for a number of reasons. First, it is important to highlight that all but one of the MSM clients considered invisibility, and invalidation, due to homonegative trauma to be, at least partly, constructive of their mental health problems. They described this as having contributed to their living a partly disconnected life, one where their private sense of queerness was hidden for fear of public disapproval. Given this, clinicians need to know about MSM's views of the role homonegative trauma plays in their lives in order to be respectful of clients' understandings of their world. The need for this understanding is enshrined in one of the *Recovery competencies for New Zealand mental health workers*, where they need to "demonstrate knowledge of and empathy with service user recovery stories or experiences" (O'Hagan, 2001, p. 9).

Second, if PMHS unwittingly function to continue the public/private split regarding sexuality for MSM, then it also might operate to maintain the distress of MSM rather than

⁶² An earlier version of this Chapter has been published (see Semp, 2004b)

reduce it. Further, (as discussed in Chapter Six) the *Recovery Competencies* also require that mental health workers understand how discrimination and social exclusion may impact on service users, and how to reduce it (O'Hagan, 2001). Thus, if homonegative trauma is involved in constructing MSM's mental health problems then treatment done without knowledge of this risks being mis-informed at the very least, or harmful at worst.

Third, if the frequently considered notion that clients should be matched with clinicians of similar sexual orientation is to be of any practical use then it, too, must rely on some sort of system to enable the visibility of the homosexuality of both the clients and the staff. This possibility of 'matching' is explored in Chapter Ten.

In this chapter I explore further the public/private split regarding homosexuality and its implications for practice within PMHS. I claim that discursive power relations inside PMHS operate to limit the visibility of MSM clients and, thus, the ability of PMHS to support these clients in their recovery. To support this claim I consider how queer staff talked about the ways queer conversations are negotiated in PMHS. Social constructionist authors on mental health practice contend that all dialogues between clients and clinicians have the potential to construct particular accounts, and to deconstruct, or deny, others (Drewery et al., 2000; McNamee, 2000; M. Payne, 2000; White, 1995). Yet, from a Foucauldian discursive understanding, not all conversations are equal. Some conversations are likely to seem more 'proper'. By this I mean they are less likely to break the rules of particular discourses. Other conversations then become subjugated.

By focusing on two views of how queerness can become visible in PMHS, this chapter explores some of the discursive power relations that operate to mediate conversations about homosexuality and, thus, the visibility of MSM clients inside PMHS. First, I examine how queer staff conceptualised the relationships between queerness, mental health problems, and PMHS. Second, I investigate how queer staff talked about the ways they, and their colleagues, identify MSM clients. I conclude this chapter by considering the implications of these accounts for both MSM clients and for staff of PMHS.

For the remainder of this chapter I will use the term 'disclosure' to refer to any process by which clients inform clinicians within PMHS about their homosexuality. I use this term for brevity whilst acknowledging that I am referring to communications often more diverse than just stating one's sexual orientation. For example, it can include any acknowledgment of same-sex attraction irrespective of what terms clients may, or may not, use to denote

their sexuality. As discussed in the previous chapter, the multiple discourses of homosexuality produce various and situated use of terms for homosexuality. But, returning to the thesis of this chapter, I first consider how the queer staff talked about the relationships between sexual orientation, mental health, and PMHS.

DSM: Prioritising Bodies and Symptoms before Contexts and Meanings

The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification. It would not be a dialogue.

(Foucault, 1961/1988, p. 250)

Foucault argued that during the 18th century the emerging medical discourse invested the psy disciplines with the power to categorise, name, and have discipline over ‘mental diseases’. He contended that what were described as ‘diseases’ were, in fact, constructed out of the moral imperatives of the time. Furthermore, people diagnosed with mental diseases were admonished to accept the diagnosis. Within this medical discourse, and as discussed in Chapter Four, for much of the 20th century homosexuality was pathologised by the psy disciplines. However, since 1973, this has not been the case in the DSM. Despite the official depathologising of homosexuality, all but one of the MSM clients interviewed theorised links between the effects of heteronormativity and their mental health problems. Thus, while the DSM no longer directly links homosexuality and mental health problems, most MSM participants did (in various ways). Accordingly, in this section I explore the ways the staff conceptualised the relationships between homosexuality, mental health problems and PMHS. I suggest that the ways in which these relationships are conceptualised are likely to impact on how important staff think it is to discuss sexual orientation within PMHS .

Consistent with psy and critical discourses on mental health, at times during the interviews most staff talked in ways supporting a sociocultural perspective on understanding mental health problems for MSM:

Patrick Those that work in a family therapy basis often are better at it [working with MSM] because some of the factors that lead to self harm can be about sexuality and a struggle with it can be about parental reactions to their sexuality, can be about that they are getting in to high levels of alcohol and drugs as a reaction to shame and guilt and all sorts of things really [staff].

Simon I think that you can't work with queer people and not have an appreciation, you can't work with them effectively and safely without an appreciation of the wider sociocultural context that the people live in and grow up in and I think that is one of the main areas where psychiatry went so very wrong when it came to queer people because it got sort of really hooked on looking for an intra-psychic cause for homosexuality and a very pathologising one and it couldn't, in any way, appreciate the impact of homophobia and the wider culture. I mean although some doctors did, and advocated for that, but, by and large, psychiatry became an instrument of conservative forces rather than a challenging one [staff].

Patrick deploys psy understandings of intra-psychic, and familial, conflict causing distressing emotions in order to conceptualise the mental health problems of MSM. Simon adopts a more critical discourse by acknowledging the sociocultural context, and the impact of heteronormativity, in the construction of mental health problems. These enable him to critique the individualising medical discourse which advocates the search for individual causes of homosexuality. Such psy, and critical, conceptualisations of mental health enable a sociocultural perspective on service provision to MSM users of PMHS. This would open a space for giving greater importance to discussions about the possible relationships between heteronormativity and mental health.

However, sometimes the staff also spoke in ways that prioritised the medical discourse with its focus on diagnosing and treating disorders:

Diana I mean same as anybody else, we are all going to get it [schizophrenia] one day or other, or not, you know, if we are in that group. You know, genetic disposition to schizophrenia, it doesn't matter if you are gay, or not gay, you can still get it. It is just the same as whether you are black or white or rich or poor [staff].

Matt Well I think first, and foremost, the service is designed for people with mental health issues and I suppose Axis I, and Axis II, diagnosis. The sexual orientation would fit in probably on sort of as a secondary [staff].

Diana describes disorders within a bio-genetic medical discourse in stating that regardless of sociocultural variables, anyone "can still get it". Matt also speaks of the medical discourse in specifying the primary role of mental health services as dealing with disorders as defined by DSM. Their role as clinicians, as constructed by the medical discourse, makes talking about sexual orientation "secondary" to talking about mental illness. This move reduces the chance that staff may see such conversations as important or relevant to their work. Instead, the medical discourse requires them to focus on diagnosis.

The diagnostic system most commonly used in New Zealand PMHS is the DSM. As introduced in Chapter Five, in this classification system the symptoms needed to diagnose

'mental disorder' are categorised on Axis I or II. These diagnoses are often pivotal in guiding treatment. Within this framework, the heteronormative contexts theorised by the MSM clients as central to their mental health problems would go on Axis IV. Axis IV is for "Psychosocial and Environmental Problems" (American Psychiatric Association, 1994, p. 29) and is not, in itself, considered diagnostic of a 'mental disorder'.

From a critical discourse of mental health, this hierarchical ordering of information in DSM reveals how the medical discourse, with its emphasis on symptoms of disorder, is given greater discursive power to define problems and, thus, to define the focus of clinical attention. The DSM also reinforces the medical discourse by conferring the right to name 'disorders' on mental health clinicians rather than on the people experiencing mental health problems (Madigan, 1999; Raskin & Lewandowski, 2000). Through these processes 'disorders' are generally understood in ways that minimise or deny sociopolitical context (L. Brown, 2000; Duffy et al., 2002; Fee, 2000a; Ussher, 2000). Accordingly, many have argued that despite its claims to be atheoretical, the DSM is a discursive practice that constitutes rather than simply describes disorders (Crowe, 2000; K. Gergen & McNamee, 2000; I. Parker et al., 1995).

The medical discourse, through the DSM, thus provides arguments contrary to both the psy and critical discourses which construct more holistic and sociocultural forms of mental health service provision; ones that might prioritise a focus on heteronormativity. This discursive tension is produced by multiple, and contradictory, discourses, and may explain the complex positions some staff occupied during the interviews. For example, Ella draws on multiple discourses when discussing the role of PMHS in relation to MSM:

Ella I think that it is important to gay and lesbian clients that they do receive service from people who may be better able to understand the issues that they go through. I feel that I am able to provide that better than some other people might be able to [staff].

Here Ella uses the equal rights discourse, and its essentialist assumption of similarity and shared understandings between queer people, to argue that she, and other queer staff in general, should have a specific role with MSM clients. This positing is also supported by a critical discourse of mental health enabling Ella to use her lesbian identity for clinical, and political, purposes. Yet, later, she asserts that the medical model determines the primary role of PMHS:

Ella We see ourselves as a facility that treats mental illness, that is usually from an illness perspective that responds to medication that has usually more of a

biological predisposition and so that is a predominant model that we see that we are funded to treat [staff].

However at another point, Ella resists a solely medical approach to the mental health of MSM as providing an insufficient account of sociocultural factors:

Ella I think it is a very simplistic model. It is kind of the model that we work with in the system because we have limited resources and we do the best we can with what we have. But I certainly don't see that that model is enough in terms of understanding the development of mental health problems and that the environmental factors that contribute to the vulnerability of the biological predisposition. And so I don't think it is that simplistic but, again, it is sort of this is what we have to offer and that we do kind of have to follow along to that. There is also the thing for me about kind of the concept of stigmatizing a normal reaction that most people would have as a mental illness. So I don't know if that makes any sense [staff].

Ella uses a common version of the biopsychosocial model. Accordingly, this account privileges genetic factors over psychosocial ones. Ella justifies the predominance of the medical model as necessary due to resource constraints. This could be a reference to the relative ease of providing drug treatments as opposed to other interventions such as psychotherapy. Within current practice in PMHS, doctors can see many more people each day than psychologists or psychotherapists. Complicating things further, Ella draws on psychoanalytic and critical discourses when she says she is concerned at "stigmatizing a normal reaction". Similar concerns have been raised within lesbian and gay communities about not pathologising the expected psychological consequences of living in heteronormative societies (Gonsiorek, 1981b; Kitzinger & Perkins, 1993). Perhaps, not surprisingly, given the multiple discourses operating, Ella finishes this extract by saying "so I don't know if that makes any sense".

Other staff also talked in ways that showed that their conceptualisations of the mental health problems of MSM were constructed out of multiple discourses of mental health:

Edward It [homosexuality] may well be an issue that they [a client] would like to have dealt with but it is not the core of, not sort of that organic thing. I know that when you refer to organic you are usually talking about actual physical damage but I mean if you look at the schizophrenia and bi-polar disorders, which can be medically treated as opposed to therapised, I don't think sexuality - this is personal here, however, there are bound to be studies out on it - but I don't think sexuality actually is critical to bring them to wellness. I don't think that a schizophrenic person becomes psychotic because they are gay but certainly being gay may well be a stress that could contribute to an onset of psychosis. How's that? So it is something that, perhaps, they would want dealing with but it is not core to the reason that they are here. Whereas somebody who is deeply depressed because they can't adjust to their

sexuality, that is and that would - so then it becomes very apparent very quickly that this is what this person needs to deal with [staff].

Similarly to Ella, Edward provides an account drawing on both medical and psy explanations. He separates mental illnesses, in a bio-medical sense, from situations where profound distress could result from intra-psychic conflict about their sexuality. However, Edward is less clear about the possible connections between mental illness and stress due to heteronormativity. He uses the biopsychosocial model to try and account for this by categorising 'gayness' as a stress that can trigger a genetic predisposition to schizophrenia, thus privileging medical explanations over psy and critical ones. The "stress" of being gay can trigger a pre-existing disposition to psychosis but it cannot cause it by itself. Of note, Edward's explanation of the causes of schizophrenia, contrasts with the explanation given by the client Ralph in the previous chapter. Ralph theorised that it was the effects of heteronormativity that constructed his experience of psychosis. Nevertheless, by deploying a medical discourse, Edward, like Ella, constructs mental illness in the biological sense as being the "core" of the work staff need to do in PMHS.

Yet, while talking in ways that maintain the authority of medical conceptualisations of mental health and PMHS, Edward also feels constrained by the medical discourse:

Edward Yeah, but there is also the barb that I'm essentially working in a medical practice, working in a medical model, and I'm trying, and in many respects as a social worker I try and actually buck the system and get away from the medical model. Because if I followed the medical model all I'd be, would be a glorified nurse that knows how to go to WINZ.

DS And reminding people to take their medication.

Edward Precisely. So I, and that 'clinical' - the use of the word 'clinical', and it is all about language, of course, but the use of the word 'clinical' implies a medical model, and in many ways I don't work within a medical model. I work within a social justice model and I think that's where perhaps that blurring of the clinical versus personal comes into it. Because I mean like I am much more personally open to my clients than my nursing colleagues [staff].

Edward complains that the medical construction of PMHS limits his role as a social worker. In order to assist his clients, and to not become a pseudo-medical clinician, he describes resisting the medical discourse by trying to "buck the system" and following a "social justice model". Here Edward uses language from his social work training that is constructed more within a critical discourse of mental health. Further, to distinguish himself from his nursing colleagues Edward challenges the objective clinician subject of the medical discourse and instead advocates a more subjective "personal" one. This distinction

is discussed further in Chapter Ten where I consider how staff talked about the possibilities of disclosing their sexual orientation to clients.

The examples from Ella and Edward illustrate that queer staff can have competing, and contradictory, loyalties. They may be loyal to both psy and critical discourses of mental health, which construct the effects of heteronormativity as potentially central to mental health. However, they may also be constrained by the medical discourse which operates to minimise the place of sexual orientation in the proper business of PMHS. Most of the staff spoke in ways that acknowledged this discursive complexity within PMHS.

Queer staff's divided loyalties also raises another question. From an equal rights discourse of homosexuality, and from psy and critical discourses of mental health, queer staff are theorised to have a greater ability and interest in supporting queer clients within mental health services due to their sense of belonging to a minority group with a shared identity. Thus, their dual locations as queer on the 'inside' of their identities, and queer inside PMHS, are assumed to help them support queer clients. This essentialising assumption is explored further in Chapter Ten. But if queer staff do not necessarily consider sexual orientation a priority within the practice of PMHS, then what does this suggest about how important non-queer staff may consider it to be, if they even consider it at all? To begin to address these questions I now explore how queer staff talked about the ways in which they, and their colleagues, ascertain if homosexuality is relevant to clients' mental health issues, or whether homosexuality is even considered.

To Ask or Not to Ask? That is the Question

Sometimes staff in PMHS already know about the sexual orientation of clients from information sent by referrers such as doctors.

Ella Or if there was a GP referral. Often a GP would say, 35 year old gay male, that kind of thing. So if the referral makes reference to it. But the system that I work with wouldn't necessarily elicit that information of itself [staff].

Yet this was something that few of the staff mentioned. Instead they tended, like Ella, to say that they, (and their heterosexual colleagues), did not usually ask clients about sexual orientation. However, the reasons they gave for this varied. In this section I consider how the staff talked about initiating conversations about homosexuality, and what discursive conditions enable and constrain such conversations.

‘Knowing’ Clinicians and ‘Fragile’ Patients

Within both medical and psy discourses, the subject positions of mental health professionals require that clinicians use their ‘clinical judgment’ to guide their interactions with clients. This is clearly one of the ways in which queer staff spoke about deciding whether or not to initiate conversations about homosexuality with clients:

Ella I think when I say that it [sexual orientation] wouldn’t be asked, I don’t think it would be asked in the initial interview but, certainly, once you had a key worker or a therapist I think that it would be – it would never probably be explicitly asked but it would become obvious [staff].

Edward They probably wouldn’t be necessarily asked - I mean you don’t ask every person if they are gay but there are enough, there is enough information gathered that one would ask that if it was apparent that relationships were an issue, and then that would bring you into sexuality questions and then it would become either black or white I mean even if the person lies you more often can tell [staff].

A medical discourse positions users of PMHS as passive recipients of ‘knowing’ practitioners. From this discourse, clinicians assess what is important in treatment. Ella says that sexuality would be apparent without explicitly asking, and Edward says that it would become clear to staff if sexual orientation was relevant, even if a client actively denies it. Both staff talk about mental health professionals as the ‘knowing’ clinicians of the medical and to a lesser extent, the psy discourse. From this position they can determine if a client is homosexual and/or if sexual orientation is an issue for a client. One might wonder what signs enable them to make this assessment. An example of this is given by Luke:

Luke They’ll say, “I think he might be gay because he’s got long fingernails”. That was an example that they gave to me and I just sort of said “oh right, is that the only reason you think this guy might be gay?” and then they were going, “oh well I don’t mean it like that” [staff].

Luke describes some of his colleagues using heteronormative assumptions about the ‘femininity’ of MSM to guide their assessment. As noted already, heteronormative masculine discourses construct a man with recognizable ‘feminine’ features as a potential homosexual.

However, even when ‘knowing’ clinicians thought that homosexuality might be relevant for a client, they often had reasons for being very cautious about discussing it with clients. Clinicians have a responsibility for minimising harm to their clients. Not surprisingly then,

concern over possible harm to clients was often cited by queer staff as a reason for them, and for non-queer staff, to be reticent in starting conversations about homosexuality:

Diana I mean our job is to suss out how people are. I mean if we can suss out that it would be probably okay for this person to, for us to say look, “have you thought about your sexuality?” Being quite open about it in a careful way. If we can tell that this person would totally freak then [we would not ask about sexual orientation] [staff].

Patrick Well, my expectation of that would be not for them [clinicians] to raise it. I would consider that too threatening an interpretation and it could be wrong to start with [staff].

Philip Yes. And I usually ask, first of all I ask about the young person’s friends and what they do, and who their friends are, and get names of them, and then I ask about what they do with their friends, what they do to hang out, what they do to get their kicks and stuff. And then I just ask if any of the names that they gave me are particularly close friends and sometimes they say “Yes” or “No”, and sometimes they say, “What do you mean?”, and so I get more explicit and yes, sometimes with some young people I say “Do you have any boyfriends or girlfriends who are close friends?” And sometimes I, if I get a feeling that the young person isn’t ready to hear that I sort of skirt around it a bit more and ask in a more indirect way [staff].

Diana portrays the ‘knowing professional’ subject of both the medical and psy discourses by arguing that it is important for clinicians to determine if a client will panic if asked about homosexuality. Patrick was in a senior role and had earlier talked about clinicians developing hypotheses about clients’ sexuality. He said that he hoped staff would not raise such possibilities with clients as it would be “too threatening”. Even Philip, who gives a detailed explanation of how he tries to open up space to discuss homosexuality, ends by saying that if he discerns that the young person is unprepared to discuss sexuality then he uses indirect approaches. These excerpts illustrate how staff often do not ask patients about their sexual orientation. They also suggest that even when staff do try and raise the topic, they may do so in ambiguous ways. Combined, these practices work to maintain a silence around sexuality. How might we understand these practices?

One possibility is that the references to clients freaking out, feeling threatened, or challenged, or being unprepared, make sense in relation to heteronormativity. Heteronormativity marks homosexuality as ‘abnormal’ and ‘inferior’ to heterosexuality. In conjunction with the responsibility of being ‘knowing’ mental health professionals seeking to ‘do no harm’, asking an already distressed person if they might be homosexual can be seen as just too risky, or as one staff member stated “I mean we can’t be too blatant because they are too fragile” [Diana].

This positioning of clients as “fragile”, (while present in the psy discourse), is particularly accentuated in the patient subject of the medical discourse. In this discourse clients passively need care and support from professionals. Constructing clients as fragile renders them easily broken, vulnerable, and debilitated. This positioning works to strengthen the medical mental health professional’s role of needing to protect clients from an assumed serious harm. However, much is omitted from this positioning. It fails to consider that clients may benefit in the long term from addressing their sexuality. It fails to conceptualise clients as able to tolerate distress. Also, it fails to consider how this practice supports the continuing invisibility of homosexuality within PMHS, even when it might be relevant to the mental health problems being considered. These issues are explored further in the next chapter which considers how MSM clients understood staff’s behaviour around homosexuality. For now though, I turn to another discursive restraint that operates to support the invisibility of MSM clients in PMHS.

No Sex Please ... We’re In Public!

Some research suggests that pathologising approaches to homosexuality may be decreasing within the mental health services (King et al., 2003a; Liddle, 1999). Yet, much research has documented homophobia, or heterosexism, amongst mental health professionals (Berkman & Zinberg, 1997; Caisango, 1996; Garnets et al., 1991; Golding, 1997). Consistent with this, some staff envisioned restraints to non-queer staff initiating conversations about homosexuality with clients:

Cath Any good initial assessment should include, give people the opportunity to say how they feel about their sexuality, just as it should include any things about previous abuse, or things like that, and then I know that that doesn’t always happen, that people feel uncomfortable asking it in a way that people can answer it with dignity, or still be honest, and not necessarily still be – I know it doesn’t happen but it should [staff].

Patrick I don’t think it would be okay to say, “Are you gay? What’s going on, are you not able to talk about it?” Some practitioners would feel much safer doing that than others, or more skilled at that. Some won’t even go there and I wouldn’t name names and I wouldn’t necessarily say they are homophobic but they are uncomfortable about raising that question [staff].

Cath says that not only do staff, in general, feel “uncomfortable” asking about sexuality but that even if they managed to do it they wouldn’t know how to do it in a way that made it easier for clients to answer “with dignity”. In arguing that staff should be able to ask about sexuality she likely draws on holistic notions of what constitutes a ‘good’ assessment and

makes reference to the way staff also need to ask about abuse. The many parallels between asking about abuse and asking about sexual orientation are discussed in Chapter Eleven. Patrick also posits that staff could feel discomfort in discussing homosexuality without being “homophobic”. One way of understanding his comment is that in a heteronormative society it can be awkward for anyone to talk about homosexuality, regardless of how queer-affirmative their own views may be. Or, from a queer discourse, if heteronormativity is a key cultural formation constructing Western societies, can anyone be immune from it?

But, it is not only difficult to discuss homosexuality within PMHS. In a society where sexuality based rights, sexual abuse, and particularly professional sexual abuse, are often in the media, talking about sexuality at all can be problematic in PMHS. Research suggests a relative lack of, and yet need for, discussions about sexuality in mental health settings (Assalian, Fraser, Tempier, & Cohen, 2000; Bhui & Puffet, 1994; Cort, Attenborough, & Watson, 2001; Maurice, 2003; Park Dorsay & Forchuk, 1994; K. Rosenberg, Bleiberg, Koscis, & Gross, 2003). Some staff spoke in ways indicative of this restraint. For example:

Luke I think that people shy away from it [sexuality] because they feel uncomfortable about it, and that is why they don't want to talk about it but I think that it is a really important area for everyone, and because it is the sort of thing that is steeped in not just gay sexuality but sexuality in general, and also I guess staff's feeling about those issues, and those sorts of taboo subjects, but also about their own personal safety and how they might perceive, you know, this client and this client's sexual needs, and will they misinterpret these sorts of things? [...] And, also, I think that they would probably be worried that perhaps the clients might misconstrue their concerns about sexuality as you know, “Does this client fancy me?” or “Will this client then misinterpret our professional relationship?” [staff].

Here Luke acknowledges a general restraint to discussing sexuality with clients at all. One specific concern is that in raising sexuality for discussion a client may misread the clinician's intentions and wonder if therapeutic boundaries are being overstepped. Luke thus constructs clients as active participants and ‘readers’ of what staff say. This highlights a social constructionist notion of the multiple readings that can be made out of any given text. Some literature suggests that discussions around sexuality are fraught for many clinicians (Gutheil & Weisstub, 1996; Hedges, Hilton, Hilton, & Caudill, 1997; Pope, Sonne, & Holroyd, 1993; Tansey, 1994). These concerns are yet further restraints that work to invisibilise MSM clients in PMHS.

Similarly, Beth reflected on the effects of these restraints when working in a child and adolescent mental health setting:

Beth Yeah. And I think it is, that whole, you know, ... the difficulty in talking about sexuality fullstop. And, also, too, with this age group there is an awkwardness about it developmentally anyway and I think we kind of lend ourselves to that awkwardness by not kind of having kind of a nice way of dealing with it really or bringing it up. You know, you go through your initial assessment, “Was he cuddly as a baby?”, “Did he walk and talk on time?” and all that sort of stuff, and when it gets to the bit, “Who do you fancy, love?”, we kind of become blubbering idiots [staff].

Beth draws on the psy discourse which posits puberty and adolescence as significant and potentially challenging times regarding one’s sexuality (Paikoff, McCormick, & Sagrestano, 2000; Sharpe, 2003), especially for queer youth (Graber & Archibald, 2001; Price, 2003). Beth agrees that clinicians reproduce any unease young people may feel by their own discomfort and unpreparedness. Interestingly, Beth uses the phrase “Who do you fancy?” to denote asking about sexuality. This wording focuses on sexual attraction rather than the meaning a person may make of it. This issue of how to question clients about homosexuality is explored fully in Chapter Eleven. There is also some literature suggesting that these issues may be even more complex for queer therapists. For example, queer therapists are more likely to unintentionally see queer clients outside of the therapy session, within the relatively small queer communities (Bettinger, 2002; Shernoff, 2001). Furthermore, they may see them in overtly sexual environments within queer communities (Shernoff, 2001).

‘Converting our Children?’

Additionally, Beth talked of another restraint for queer clinicians in particular. That is, that in discussing homosexuality with young people, there can be a fear of being accused of ‘recruiting’ young people into homosexuality. There is a notion that lesbian and gay people are more likely than heterosexuals to sexually abuse children (Herek, 1991; Newton, 1992), are out to recruit new members to their ‘sexual club’, and that exposure, either to homosexuals or to information ‘promoting’ homosexuality, unwittingly leads to the creation of more homosexuals (Herek, 1991). This heteronormative notion is in wide circulation and is most commonly voiced from speakers of the Christian supremacist, pathological, and conservative discourses of homosexuality. These discourses assume that homosexuality is morally inferior to heterosexuality and often attribute antisocial intentions, (or at least effects), to homosexuals in general, and to ‘out’ homosexuals in particular. Within these discourses, anything that might be seen as ‘promoting’ homosexuality as ‘healthy’ and ‘normal’ is discouraged. Beth’s awareness of these

discourses is present in the following excerpts where she talks about the possible implications of discussing homosexuality with her clients in a child and family mental health setting:

Beth I may well have my clinical view, and have years of literature to prove that it was important to ask that question, but it still doesn't mean the family is going to like what I did. [...] And, also, too, where I – see then it becomes personal as well in that if they then find out that the person who's been asking that question is also a lesbian, "So are you trying to convert my daughter or are you trying to convert my son?" or whatever. So there is that whole layer of that too [staff].

Beth shows an awareness of cultural discourses against discussing homosexuality with young people, and how it could potentially lead to accusations from the young person's family about her trying to "convert" their child. These discourses might be more keenly experienced by queer staff. Beth was the only staff member to explicitly acknowledge a concern about being accused of converting children. However, other staff from child and family mental health settings did talk about needing to be very careful when discussing homosexuality with young people, and needing to be mindful of their families' responses to those conversations. In fact, one child and adolescent mental health centre declined to participate in the research because of this issue. The reason given was that relationships between mental health staff and parents are fraught enough already; having queer brochures in the waiting room was considered likely to hinder those relationships even more. Correspondingly, in the third extract Beth describes how she imagines justifying her behaviour to her manager if a family gets upset.

Beth I think that if I could justify that it was clinically important to know [about a client's sexuality], my manager would stand by that. I think where the issue would fall for me would be in terms of how I did it, you know. So rather than whether or not it is to be done, it is how you do it and that is what, of course, I would be reflecting on myself too. If that scenario happened I'd be thinking shit!, how could I have done this better without ending up with this really irate mum? Because that is actually not helping the kid and not helping me in not having the family at all. So it would force me to reflect on what was it about the way I did that enquiry because I know clinically it is important, but what was it about the way I did it that really misread where this family was at with it [staff].

Beth's imagining of this potential scenario shows some of the power relations operating when homonegative discourses of homosexuality come up against discourses of mental health. From critical, and, to a lesser extent, psy discourses of mental health Beth may justifiably discuss homosexuality with a young person because these discourses enable an argument that discussing homosexuality can be helpful for a young person. Such

conversations can help reduce the silencing and oppression of clients as people who may be experiencing homosexual desires and the homonegative discourses that abound. However, in a heteronormative context, Beth feels compelled to justify her actions, even when the family's distress can be explained as homonegative, and, even oppressive of, and possibly contributory to, their child's mental health problem. Furthermore, the response Beth imagined getting from her manager may well depend on the discourse of mental health that most influenced her/him. For example, it would be harder to argue for Beth's actions from a medical discourse with its reductionist minimising of social context. Given the heteronormative context of society in general, and the prevalence of the medical discourse in the construction of PMHS, Beth's reservations about giving primacy to a more critical practice are understandable.

'They'll Tell Us If They Need To'

Thus far I have presented many instances of staff talk depicting ideas and practices arising from the 'knowing' subject positions of the medical, and to a lesser extent, the psy mental health professional. I have argued that due to the complexity and fraughtness of the discourses surrounding homosexuality, and mental health practice, staff described how they, and their colleagues, do not commonly initiate conversations about homosexuality. In contrast, they often spoke in ways that suggested this might be easier for MSM clients than it was for them. These ways of talking frame clients within the more agentic, and collaborative, subject positions offered by the critical, and to some extent, psy, discourses of mental health:

Matt I think it is only a case of maybe relying on the individual then to open up and put that to the worker, the key worker. I think it is also about how, what kind of rapport that you build with the client you are working with really. If you are an open and warm person yourself then hopefully that's going to open up that person to maybe talk more openly to you [staff].

Edward Because if the sexuality is clinically significant then it crops up somewhere along the line pretty soon after you've met the person, if not during the initial assessment then shortly thereafter.

DS And how do you think that normally crops up?

Edward Because the client wants it to be known [staff].

Matt speaks from a psy discourse when he suggests that if clinicians build a trusting therapeutic relationship then MSM clients are more likely to self-disclose and initiate conversations about homosexuality. This highlights the collaborative nature of therapeutic

relationships that is assumed within a psy discourse. Similarly, Edward says that sexuality will surface if the client wishes it. Both speak in ways suggesting active subject positions for clients.

Other staff described ways in which queer clients do take up active subject positions and make themselves visible in PMHS:

Diana If the person is out and is saying “I am a lesbian woman with a depression or a psychosis or whatever”, if they are voicing it, or a gay male, that's fine. We would say to them, “Right, would you like to see, is it going to be better for you to see a gay nurse or a straight nurse? You have the option. We can offer you that” [staff].

Sarah I was thinking about other experiences I've had where someone has obviously been triaged through and a person has done the triage and while I was working as [name of specific role Sarah was in] has said, “Look this person has identified with sexuality identity issues and would like to speak to a woman, would you be happy to see them?”, or something like that. So there is some attempt to um assist people but it is not so clear – but we don't publicise our ability or our willingness [staff].

In both examples the staff discuss a practice whereby if clients initiate disclosure of their queerness, then staff may try and offer them queer staff on the assumption that they would be more able to assist them. These examples illustrate a discursive practice enabling the matching of clients and clinicians with regard to sexual orientation in some circumstances.⁶³ As discussed earlier, the active client subject is supported by both the psy, and critical, discourses. Yet this matching is not straightforward. Sarah says “but it is not so clear – but we don't publicise our ability or our willingness” to offer matching. But what happens if MSM clients do not feel able to take up these active subject positions and to initiate conversations about homosexuality?

Summary: A Continuing Silence

The queer staff discussed two main discursive practices for how MSM are identified within PMHS. One strategy relies on the subject position of the ‘knowing clinician’ of the medical, and to a lesser extent, the psy discourse. From those subject positions, staff are responsible for discerning if homosexuality is an issue for clients, and for assessing the risks of talking

⁶³ The possibility of matching is explored in Chapter Ten.

about it to ‘fragile’ patients. In contrast, a second strategy is for clients to initiate disclosure. In talking about how MSM clients will disclose their homosexuality if they need to, staff see themselves as responsible for establishing trusting relationships in which clients are offered the active subject positions of the psy and critical discourses of mental health.

However, as I have argued, many of the ways the staff talked about the processes surrounding identifying MSM clients in PMHS are constructed within heteronormative discourses of homosexuality. These discourses construct staff talking about homosexuality as problematic and risky for clients, and, in some cases, for staff themselves. A further restraint to staff doing this is the predominance of the medical discourse which constructs the ‘core business’ of PMHS as dealing with bio-medical mental illnesses. Within this understanding, issues regarding homosexuality become ‘secondary’ or, at best, ‘triggers to genetic vulnerability’. Another obstacle identified to staff initiating conversations about homosexuality with clients is a general constraint within mental health services about discussing sexuality of any sort. An additional restraint is the heteronormatively-constructed fear that asking young people about homosexuality might be construed as trying to ‘convert’ them, especially if the staff member involved is queer.

Staff also provided accounts which resisted the heteronormativity of the medical discourse, often using psy, or critical discourses. However, the predominance of the reductionist medical discourse, combined with a heteronormative context, limits how effective such resistance can be. One outcome of these discursive power relations is a relative silence by staff regarding homosexuality. Some of the staff talked about this and its effects:

Sarah It gives them the message that, you know, we are not aware of differences in sexuality – there isn’t an invitation to talk about those issues whether they be an issue, or not, to a person [staff].

Beth Well I think perhaps it gets down to the culture of the agency too, that it is not something that, even though you know better it is easy to fall back into bad ways and I think that gets supported by the fact that kind of no-one is doing it, and so you get drawn back into the bad habits because it is the bad habits actually that are what exist [staff].

Sarah says that the silence around sexuality means that discussion of homosexuality is not fostered. Reflecting on her own practice, Beth reports that this silence becomes so automatic that it develops into part of the “culture of the agency”; so much so that she ‘forgets’ to initiate conversations about homosexuality even though clinically she thinks such conversations can be important. What Beth is describing is a process whereby,

through heteronormative discursive practices, silence around homosexuality is reproduced. Clinicians do not raise the topic of homosexuality because it is uncomfortable or risky; then, because other staff do not talk about it, they omit to even consider it.

These ways of thinking and behaving support the assumption that staff will somehow just know if homosexuality is relevant to a client. For example, when visiting mental health teams to publicise my research and recruit participants, I recall one moment in a meeting with the staff of a large child and adolescent mental health service where one staff member said that they were unlikely to have clients who were willing to participate in the research as the agency did not see many young people with sexuality issues. The logic implicit in the staff member's comment was that because staff have not identified many clients with sexuality issues, then such clients must not be in the service. No one in the meeting challenged this. This assumption has been noted by other researchers as one of the ways the importance of sexual orientation to mental health services is minimised (Perkins, 1995; Rabin et al., 1986). Another possible way of understanding the lack of identified queer adolescents in that setting is that they may not have disclosed because they did not know if it was safe to do so (M. Rosenberg, 2003).

In this context, how do MSM clients perceive staff's abilities to support conversations about homosexuality? Given the discursive restraints to staff initiating conversations about sexuality, how able do MSM feel to take up the active client subject and initiate such conversations themselves? When they do, how do they describe the consequences? When they do not, what are the implications of that? These are the questions considered in the next chapter.

Chapter Nine:

Queer on the Inside MSM clients inside PMHS

This chapter explores how MSM negotiate their same-sex sexuality within PMHS, and how they perceive staff negotiating this issue. All but one of the MSM participants spoke about their experience of mental health problems in ways indicating they were constructed, at least partly, from the effects of homonegative trauma (Chapter Seven). Thus, it is worth considering if, and how, these understandings are incorporated into their relationships with PMHS. However, in the previous chapter I argued that staff described two main strategies for identifying MSM clients. Staff expect that they may accurately assess clients' homosexuality without having to ask about it, and, that failing that, clients will disclose their concerns regarding their sexual orientation should they need to. Furthermore, I have argued that various heteronormative discursive practices reduce the chance that staff will initiate conversations about homosexuality. Accordingly, of the 13 MSM interviewed, only one reported a clinician explicitly instigating a conversation regarding homosexuality:

- DS So when you say 'it came up', the fact that you were gay came up?
- Jack I think he [a psychiatrist at CMHC] may have asked me, or I think I might have had to tick it on a form or something. I can't remember but I know somehow it came up and then [name of staff member] sort of said to me, "Would you prefer [a lesbian or gay counsellor]?" I said "I don't care." So I went and actually saw a guy called [name of counsellor] who wasn't, he is not gay at all.

In this excerpt Jack is discussing the process by which during an assessment in a CMHC, he was provided referral information to Community Alcohol and Drug Services (CADS). CADS offers all new clients the opportunity to see a lesbian or gay counsellor (Semp & Madgeskind, 2000). (The possibilities of the strategy of matching are explored in Chapter Ten). However, it is of note that the staff member at the CMHC knew of this service and was, thus able to offer it.

That only one of the 13 MSM reported being asked about sexuality is not surprising. First, it is consistent with the existing research which shows that often homosexuality is silenced

in mental health services (King et al., 2003a; A. Robertson, 1998). Second, it is congruent with the many discursive restraints to staff initiating such conversations in PMHS discussed in the previous chapter. It is in this context of staff silence about homosexuality that MSM who want to have their homosexuality acknowledged within PMHS need to find a way to speak. Yet, despite this silence, ten of the thirteen MSM participants did describe initiating disclosure. Their taking up of the active client subject positions of the psy, and critical, discourses of mental health can be read as offering support for some of the ways in which staff talked about MSM visibility in PMHS – in particular the notion of, “they’ll talk about it if they need to”. However, I argue that the process and outcomes of disclosure were far from straightforward for many of the MSM. Furthermore, three of the thirteen MSM did not find a way to disclose, and to resist the heteronormative silencing of homosexuality within PMHS.

Accordingly, this chapter explores the conditions under which many of the MSM were able to disclose, the unpredictable consequences of these disclosures, and the instances of the MSM who reported not disclosing. In doing this, I compare the ways the MSM talked about disclosure with the discursive practices described by the queer staff. I characterised two main ways in which the MSM described disclosing. They are ‘assertively’ and ‘desperately’. I also explore how some MSM discussed the effects of the heteronormative silencing of homosexuality within PMHS. Finally, I consider a strategy employed by both staff and clients for trying to resist heteronormativity in PMHS; namely ‘gaydar’. I close this chapter by discussing the significance of these issues for service provision.

‘Coming Out’ Inside PMHS: Conditions of Visibility for MSM Clients

In a tolerant society, aware of the existence of a number of different sexualities and regarding these as ‘normal’, the issue of disclosure would not be raised. The broader society would not assume that all people are heterosexual and the institutions within that society would be geared towards the needs of all people, regardless of sexuality. In such a society there would therefore be no need to come out.

The reality is, however, that whilst deep-rooted attitudes remain as they are, and whilst society makes an assumption that all of its members will be heterosexual, there will always be a need to come out or to disclose sexuality. Coming out within a hostile society often exposes lesbians, gay men and bisexuals to prejudice, discrimination, harassment and sometimes even violence.

(Golding, 1997, p. 8)

Golding describes 'coming out' as both necessary and fraught in a heteronormative society. Many texts attest to the significance of coming out for many queer people (Anhalt & Morris, 2003; D. Davies & Neal, 1996; Jansen, 2004; Russell & Bohan, 1999a; Weinberg, 1972). Further, many have written about the complexities, and limitations, of the assumptions underlying the imperative to come out of the closet. One critique is that coming out often implies claiming a specific and fixed sexual orientation and associated identity. This contrasts with the fluidity of some people's sexuality (Cass, 1999; Jansen, 2004; Russell & Bohan, 1999a; Rust, 2003; van der Meer, 1999). These identity categories fail to acknowledge the diversity of ways in which sexuality is understood in different cultural groups (Jansen, 2004; Rust, 2003). Furthermore, the requirement to specify a sexual orientation is seen to promote a hetero/homo binary that reproduces homosexuals as a marginal minority (Eliason, 1996; Rust, 2003).

Coming out models also tend to ignore the multiplicity of 'queer' identities that may be useful for different people. For example, (as discussed in Chapter Seven), due to historical and political considerations some MSM understandably prefer a 'gay' to a 'homosexual' identity. These complexities regarding identity, and coming out, lead to a need for a broad definition of what it might mean to come out or disclose same-sex attraction within PMHS.

Another consideration is that the literature on 'coming out' frequently implies that the consequences of doing so are necessarily worthwhile and 'freeing'. Yet in some contexts there are considerable disadvantages to doing so. For example, coming out can be risky for teachers by reducing their credibility (Russ, Simonds, & Hunt, 2002) and also for queer youth who can experience homonegative bullying and violence (Rivers, 2001; Rivers & D'Augelli, 2001; Ryan & Rivers, 2003), and rejection from friends (Anhalt & Morris, 2003; Harris & Bliss, 1997). Accordingly, given the potential for rejection and other risks and challenges in coming out, without sufficient support disclosure can actually precipitate a crisis for adolescents (Fontaine & Hammond, 1996; Ford, 2003). Although there are numerous perspectives and considerable literature on coming out in various settings, there is very limited literature about coming out in PMHS.

Research provides what appear as conflicting stories about how enabled queer clients are when it comes to disclosing their sexuality to mental health staff. Nystrom (1997) reports that 98% of 600 gay men and lesbians in the United States who had seen a mental health provider in the previous 12 months had disclosed to at least one provider. Similarly, a New

Zealand study (Welch et al., 2000) found that 89.7% of 561 lesbians who had used mental health services were 'out' to their providers. These two studies suggest very high rates of disclosure to mental health providers.

However, some sample characteristics may account for these high rates of disclosure to mental health providers. In the United States study (Nystrom, 1997) most participants had strong connections with other lesbian and gay people and had health insurance. This suggests that they had some community support, and that their insurance would afford them some degree of choice over their service provider. In the New Zealand study (Welch et al., 2000), 51.2% of respondents who had used mental health services had chosen the provider based on recommendations by friends. Again, this suggests a high degree of choice over service providers. This, however, is not usually the case in PMHS where clients are generally allocated a doctor and/or keyworker based on limited available staff. Other results of the studies also caution against making assumptions that automatically link disclosure with improved satisfaction with services. In Nystrom's (1997) sample, despite a 98% level of disclosure, 24.3% of the participants thought that the quality of their health care had been negatively influenced because of their sexual orientation. Thus, high disclosure did not necessarily mean high rates of satisfaction with services.

In contrast to the context of insurance-funded and private mental health services, research that includes PMHS suggests that disclosing to providers in such settings is more problematic. The only previous quantitative study specifically focusing on PMHS, (Golding, 1997), found that 78% of respondents had reservations about feeling safe enough to disclose their homosexuality in PMHS.⁶⁴ Although 80% did report disclosure to mental health workers or service users, 69% reported either a mixed or negative response to their disclosure. However, interestingly, 60% reported hiding their sexuality at some stage within PMHS or letting "a worker's assumption of their heterosexuality go unchallenged" (Golding, 1997, p. 35). This suggests that some participants are involved in both disclosing to some staff, and non-disclosing to others. Other research which included PMHS has also found that coming out in mental health services can be fraught. Main concerns cited included fear of discrimination by staff, and lack of support or encouragement for coming out (King et al., 2003a; McFarlane, 1998).

⁶⁴ Other aspects of this research were discussed in Chapter One.

Furthermore, not only might it be difficult for queer clients to disclose their homosexuality in PMHS, some may not seek help at all. One study found that some lesbians avoided seeking counselling altogether for fear of discrimination (Bradford et al., 1994). Notwithstanding the challenges to, and risks of, disclosing for queer clients in PMHS, many do disclose, at least some of the time. What enables them to do this and how does it work for them?

Assertive Voices

The men who spoke about disclosure of their homosexuality in the most assertive and straightforward ways tended to do so in language that acknowledged their rights either as homosexuals, or as consumers of mental health services:

Pete I was very direct about what the situations in my life had been. I talked about my partner's death, I talked about his declining illness, I talked about my past, not in detail but I talked about my past of course. As far as my sexual life, I talked about friends who had died, I talked about all those things then. [...] Well I mean he [the psychologist] knows that I am gay. He knows if I want an HIV test, he knows why I want it, right. And I have a good, he knows about my standard of education too because I am very demanding of my health care givers. I make it clear at the beginning that I know quite a lot about not only physiology and anatomy but I also know a lot about pharmacology and I'm not an easy patient. I don't sit there, even at the [name of mental health centre] [client].

Pete describes himself as being very exacting of mental health staff and credits his level of education as supporting his assertiveness as a client. Here he speaks from the active client subject offered by both the psy and critical discourses. This enables him to resist the more passive patient subject of the medical discourse. Also, later in the interview Pete commented that knowing his legal rights as a homosexual in New Zealand supported his expectation of being treated well as a homosexual within PMHS, and, thus, his being forthright about his homosexuality. While being 'out' as a queer man was important for Pete, he was the only MSM client interviewed who did not describe homonegative trauma as related to his mental health issue.

Nathan, however, did understand homonegative trauma as significant in his experience of mental health problems. He describes resisting silence and invisibility by disclosing his sexual orientation in response to a question about gender:

Nathan Well I actually told the person that I was gay. They said "what sex are you?" and I said "I am a gay male" instead of just male [...] Well I always have the

view that, you know, that you should speak up instead of just sort of living in the closet. If I didn't write gay male and just wrote male then you know, I'd probably be sort of in a closet situation.

DS And where did you get that idea from that it was good to kind of just be out there?

Nathan It was from an aunty who I spoke to. She sort of mentioned to me, like "if you are what you are, then just speak up about it. Just be normal" [client].

Nathan accounts for his disclosure in the emblematic language of the equal rights discourse. This discourse urges MSM to 'come out of the closet'. Thus, despite theorising that homonegative discourses had constructed much of his distress, Nathan drew on the equal rights discourse to enable disclosure of his sexual orientation in PMHS. For MSM like Pete and Nathan, disclosure of their sexual orientation in PMHS is congruent with the idea expressed by some staff that, "they'll tell us if they need to" (see Chapter Eight).

Additionally, both Pete and Nathan described staff responding in affirmative ways to their disclosure. Pete says he "certainly didn't experience any discrimination or anything like that", and Nathan describes a psychologist he had as being very supportive:

Nathan Because the thing is he read my file and he knew that I was a gay male because it was written down there. So he said "Is it alright if, you know, about me accepting you as a gay person? And I'm not trying to put you down being gay but I'm not gay myself" he said and, "I'm trying to understand how gay people in the service cope".

DS And what was that like when he said that to you and asked you about that?

Nathan Well it sort of made me feel better and sort of invited me to sort of speak to him, sort of then I felt there was no barrier. I was quite open and direct about what I was talking about [client].

Having taken an opportunity to disclose his sexual orientation during the assessment phase, Nathan reports that his psychologist responded to that information on his file by explicitly stating his acceptance of Nathan as a homosexual. Here the psychologist takes a critical stance by acknowledging the devalued position of homosexuality in society, and explicitly expressing his support of homosexuals. Nathan interpreted this as an invitation to be trusting of his psychologist and unguarded about his sexual orientation.

So, of the MSM who did disclose in PMHS, some took up the active positions offered by the equal rights, psy, and critical, discourses. However, for many of the men disclosure was often far from straightforward either in its enactment or consequences. For example, Nathan's talk suggests that disclosure is an ongoing process needing to be reconsidered with each new staff member. While acknowledging that he had previously disclosed his

sexual orientation (and, thus, it being in his file), Nathan's indicates that he is aware that barriers to being open and direct about homosexuality are present in society, even if not with the particular clinician he is talking about. Similarly, others have commented that coming out is an ongoing process that often needs to be re-considered in each new context (Golding, 1997; McFarlane, 1998; Rust, 2003). Respondents in McFarlane's study (1998) also described the issue of coming out to mental health staff in this way.

Complexities of Disclosure

Halperin (1995) describes further complexities of coming out in acknowledging that coming out is not always a transition from a state of repression to one of freedom:

On the contrary: to come out is to expose oneself to a different set of dangers and constraints, to make oneself into a convenient screen onto which straight people can project all the fantasies they routinely entertain about gay people, and to suffer one's every gesture, statement, expression, and opinion to be totally and irrevocably marked by the overwhelming significance of one's openly acknowledged homosexual identity.

(Halperin, 1995, p. 30)

I agree with Halperin's sentiment about the complexities of coming out, however, I would argue that it is not only straight people whose fantasies of "gay people" are constructed within heteronormative discourses. As illustrated in Chapter Seven, MSM also speak of and make judgments about, diverse types of homosexuals as constructed by the multiple cultural discourses of homosexuality. Nevertheless, following Halperin's caution regarding coming out, in this section I explore some of the complexities involved in disclosure for MSM within PMHS.

Desperate Voices

In contrast to the assertive disclosure enabled by the equal rights discourse, (and by psy, and critical, discourses of mental health), some MSM disclosed under different conditions; that is, under conditions constructed more by homonegative discourses:

- Jim That was why I went there (PMHS). I was still in the marriage, I was trying to cope with that and I was trying to get better.
- DS When you say get better what do you [mean]?
- Jim I mean straight [laughter].

DS Straight, yeah. I didn't want to assume. And did you, when you went and told them, did you kind of know that they would be okay about it or did you have any ideas on how they would respond?

Jim No, none at all. At that stage I was beyond caring [client].

Jim went to mental health services hoping to convert to heterosexuality. His desire can be understood as being constructed out of homonegative discourses. Such discourses would construct Jim as unhappy to be homosexual, and wanting to become 'normal', which, in a heteronormative society, means heterosexual. Further, his hope that PMHS would help him change is constructed out of a pathologising discourse of homosexuality. As discussed in Chapter Four, there is a long history of mental health services attempting to 'cure' homosexuality. Yet, Jim got an unpredictable but useful response:

Jim They offered no judgment and they just said to help me, they, I can't remember exactly - in the finality the good thing was that the psychologist or something, he said "You have to make your mind up. You can't go on beating yourself up". He said, "If you don't do that I'm going to have to commit you". I called him several names at the time because I really was not in a really good situation. I was very bad. But they put me in a room and gave me some drugs of some kind.

DS This would be at [name of inpatient hospital]?

Jim Yeah and I came out very quickly to be honest. Because I'd made that decision. I was going to be me [client].

This account makes sense in a heteronormative context. The lack of homonegative judgment from staff, coupled with the homosexual identity constructed by the equal rights discourse, and offered by the staff, provided Jim with a way to begin to resolve his dilemma and his distress. He also seems to suggest that medication was necessary and useful for him at that time. In this moment he speaks from the 'patient' subject position of the medical discourse, who unable to make decisions for himself, requires medical clinicians to decide what needs to be done. Thus, in this account the staff seem to be deploying practices from both medical and psy discourses. While they used drugs for acute distress, their verbal responses appear to be constructed out of a psy understanding where 'internalised homophobia' hinders a stable identity and causes mental distress. This combination appears to have supported Jim to adopt the essentialised, integrated subject of the equal rights discourse when he says, "I was going to be who I am".

In contrast, another MSM disclosed in desperation, but with a very different outcome:

DS Did they ask about your sexuality?

Ralph No. But I did say at the end of my suicide note, I'm Samoan, I am mad, I am bad, I am dirty, I am sullied, I am gay. And that - I did say that [client].

Ralph, has been a client of PMHS for over 10 years, and reports never talking with any of his mental health clinicians about his sexuality. Ralph said that he really wanted to die at the time of the suicide note, and, thus, he did not expect to have to deal with people's responses. As discussed in Chapter Seven, much of Ralph's subjectivity was constructed out of a Christian supremacist discourse of homosexuality. In this discourse homosexuality is often construed as evil and bad, so it is understandable that within this context Ralph might have imagined being unable to cope with people's responses to his disclosure. However, he did survive his suicide attempt and Ralph reports that no clinician ever mentioned sexuality to him either before, or after, writing the suicide note. Ralph had multiple ways of accounting for this:

Ralph I don't know. Maybe because I might have given off signals I didn't want to be probed about it [client].

This account is similar to the ideas present in the staff's talk about 'knowing clinician's' deciding if client's are 'too fragile' to be asked about their sexuality. Yet here Ralph suggests he might have been active in constructing such 'fragility'. In this sense, his non-disclosure was not simply the passive role of the patient offered by the medical discourse. Instead, this can be read as Ralph regulating his responses based on his assessment of the heteronormative environment. However, at other points in the interview Ralph had other ways of describing why homosexuality was not raised by him, or by staff, post disclosure in his suicide note:

DS Was there anything at all that was said or done or you saw while you were in the [name of inpatient unit] which might have made you think, gosh maybe it is okay here to talk about that?

Ralph No there wasn't. There was nothing there, no. I think, talking about my sexuality, talking about your body - we live in a society that is bodyphobic or sexophobic or homophobic.

Ralph utilises critical and psy discourses of mental health to explain the lack of invitations in the hospital for creating a context that supported discussing sexuality in general, not just homosexuality. The critical discourse locates the problems in wider society, and the psy discourse provides a language of phobia to describe this. For Ralph, staff silence is read as further proof of his perception of society's unwillingness to discuss sexuality in general, and homosexuality in particular.

Also, Ralph theorises that staff separate out issues to do with mental illness from those concerning the effects of homonegative discourses:

Ralph I'm not sure they connect mental illness with being gay. I don't think they think there is a strong connection there [client].

As discussed in Chapter Eight, within a medical discourse of mental health this separation is not surprising. The medical discourse diagnoses individuals, not society; thus, there is not space to account for the effects of heteronormativity. However, there is another possibility why mental health staff may be unwilling to connect homosexuality and mental health problems. People have used the equal rights discourse to fight hard to have homosexuality depathologised. They have literally demanded that medicine, and psychiatry, stop diagnosing homosexuality as illness. In the previous chapter one of the staff (Ella) referred to the desire not to pathologise normal reactions to living in a heteronormative society. This concern is also present in the psychological literature (Gonsiorek, 1982; Kitzinger & Perkins, 1993). This may be a further reason why staff do not ask about sexuality, but only Ella mentioned this.

Unpredictable Responses to Disclosure

In addition to Ralph, other MSM reported finding the responses to their disclosure unhelpful. One MSM describes his process of disclosure on admission to an inpatient mental health hospital:

- Charles Looking back again on homosexuality and mental health, they said to me, "Have you got money problems, are you drinking, are you gambling?" "No I'm a poof". "Are you sure you haven't got money problems?". "No, I'm a poof". The problem wasn't sexuality, so they told me.
- DS So again when you look back at that, why do you think they responded in that way? How do you understand the way they responded?
- Charles [identifying material omitted] they didn't want to deal with it. Looking back, I think they didn't want to deal with it [...] You became very aware very quickly you were just a cog in the system. ... You had a broader spectrum of society and you had in there, what's the expression, quote, my words, criminals all awaiting psychiatric examination, sitting next to people who were coming to terms with their homosexuality, next to women who had been beaten shitless by their husbands. I stopped thinking about my sexuality. I started thinking about survival. And that is all it was. They just medicate you, sedate you, and pills or whatever [client].

During admission, Charles reports disclosing that issues surrounding his sexual orientation were central to his understanding of mental health problems. But he describes the clinicians' responses as coming from within the medical discourse of 'knowing clinicians' deciding what is and is not important. Charles accounts for this using a critical discourse of mental health. He acknowledges various sociocultural reasons for people being in hospital;

criminals, physically abused women, and homosexuals struggling with homonegativity. He also attributes the staff's ignoring of his homosexuality as them not wanting to contend with this issue, and with them being more preoccupied with medication and sedation. This analysis of the staff's responses positions them within the medical discourse and its minimising of psychosocial issues. Charles' critique of the prioritising of the medical discourse in the construction of treatment recurs in the talk of other MSM interviewed (and is discussed later in the chapter). So while Charles did initiate disclosure of his homosexuality, this did not mean that clinicians' responses enabled him to feel that the disclosure was respected.

A further example of the ongoing, and often unpredictable, consequences of disclosure was given by another MSM. Evan had prior experience of a psychiatrist, whom he liked, and who had been supportive of his homosexuality, thus facilitating his disclosure. Yet, with another psychiatrist he had quite a different experience:

Evan It may have been just sheer ignorance, but it may have been homophobia. You see I was telling her about the different hassles I'd had with the cops and I said, "You don't know what it is like". I said, "I was walking down [name of road]. I'd been to the supermarket and I was walking back down the road to my flat", and I said "this cop car came up, was travelling very fast, and as soon as he saw me he slowed, not to the usual crawl but he still slowed noticeably to take a look at me". And she said, "oh this is just paranoia" [client].

Previously Evan had been physically abused by the police. Yet the psychiatrist's response was medicalising and pathologising of Evan's experience. By speaking from this medical position, the psychiatrist failed to consider the sociocultural context in which Evan's experience can be understood as realistic oppression rather than paranoid ideation. Consequently, her talk further marginalised Evan's experience of homonegative trauma.

The Timing of Disclosure

Another complexity to MSM disclosing their sexuality is how long such disclosure can take:

DS Have they [staff] said or done anything over the years that have kind of confirmed your worries that they might not support same sex sexuality?

Mark No they haven't. No, not at all but you sort of, when you're into the degree of paranoia which I've got, which is a high degree of paranoia, you wonder all the time. Because you don't know. You see I don't know any gay people. I do not know one single gay person.

- DS Is there anything, even with the kind of paranoia that you say you experience around that issue, is there anything that you think that staff could have done that might have helped made it -
- Mark Yeah they could have, in actual fact the person who was the key leader, the principal person who was looking after me, or the person, the key nurse whatever you call them, what's the name for it could have identified the situation.
- DS How could she have done that?
- Mark From the files. If someone had read the files, identified the situation and put me at ease. [...] She could have said, "Well, I support you while you are here and how you feel and your behaviour and whatever else".
- DS So if someone had said, "Look, you are not going to be judged for this".
- Mark Yeah, yeah, whatever. That would have made a huge difference. I'm dead scared of getting judged for being that way [client].

Mark reports not experiencing any overt anti-homosexual comments by staff. Yet much of his talk is constructed by homonegative discourses and, from this position, he describes needing to assess what people are thinking. Mark's labelling of his concerns as "paranoia" uses both medical, and psy, language that individualises and pathologises his experience. Yet, in a largely heteronormative society, Mark's homonegative interpretations of the silence about homosexuality in PMHS, and his expecting to be negatively judged for having same-sex attraction, are understandable. Homonegative discourses construct homosexuality as undesirable and as something that will likely elicit judgment.

Mark says that it would have been helpful if staff had spoken into the silence around homosexuality and made it safer for him to disclose. In this sense, he wants staff to adopt a critical position by being aware of the social positioning of homosexuality, and by acting to denote PMHS as homopositive. Mark reported that there was historical information on his file that should have alerted clinicians to the possibility that homosexuality was an issue for him. Similarly to Nathan's earlier account of needing to ascertain the safety of disclosing sexual orientation with each new staff member, this example from Mark again illustrates how having disclosed at some point in the past within PMHS does not mean that disclosure continues to feel possible for MSM clients. This suggests that in a heteronormative context he needed a clear signpost that he would not be negatively judged for being MSM. When asked why he thought staff had not asked about homosexuality, he said:

- Mark People are scared of it. You come from a different era – how old are you? [client].

Mark uses psy language to describe staff's fear of talking about homosexuality. This is consistent with the term 'homophobia', commonly used in psychological research, and in the media, to describe people's aversion to homosexuality. At the same time, in assuming that I was younger than him, Mark refers to changing social contexts, implying that he makes sense of the staff's silence in terms of historically contingent discourses of homosexuality. Yet, Mark did disclose and, thus, his account partially supports the staff's notion of, "they'll tell us if they need to". However, the discursive processes that made this disclosure take so long complicate this approach to supporting visibility of MSM in PMHS. It seems that the heteronormative discursive relations that construct staff silence about homosexuality also contributed to Mark's disclosure taking so long.

In addition to the various complexities already discussed in relation to the MSM who did disclose, it is, perhaps, unsurprising that three of the MSM interviewed reported not disclosing their sexuality at all within PMHS. Within a heteronormative context, the medical discourse in particular was seen as a barrier to this.

Silent Voices: Their Construction and Effects

In Chapter Eight, I showed how staff, drawing on the psy discourse, thought their establishing of trusting relationships with MSM would make it easier for MSM to disclose. But many of the men talked about significant barriers to obtaining such relationships within PMHS. In particular, some of the men described the effects of the medical discourse of mental health as a particular restraint to getting the sort of relationships in which they might have addressed the issues they were experiencing with homonegative trauma:

- Daniel My experience was a mass production line, in, prescription, out, drugs.
- DS So what would you say to gay men who were going to that place?
- Daniel Personally I would never even go back there. I would say, "Stay away from it. Go somewhere else" [client].
-
- Rick I just don't think you get a lot of time to talk personally. They just say, sort of "Right how is your medication going? Are you sleeping, are you eating?" They just go through all those symptoms [...] I guess that's why I've told my friends and my family because I mean I've been there, you know what I mean. I mean I don't exactly, if I make a new friend I don't exactly say, "You

know, I'm gay", right away. It takes a little while to build trust and you've got to know how they are going to react [client].

Daniel and Rick were the two youngest MSM interviewed. Daniel's contact with PMHS was brief and Rick's was of two years duration. Neither disclosed their homosexuality in PMHS. They both spoke in ways attributing some of the restraints to disclosure as being a result of being subjected to the medical discourse. In these instances, Daniel and Rick describe being offered the patient subject positions of the medical discourse. From this discourse a central focus is on controlling the symptoms of disorder, rather than on the meaning people may make of their symptoms, or on the relationship between clients and clinicians. These were not conversations that they felt engendered the sort of trusting relationship in which they could talk about the difficulties they were having with homonegative trauma. From this position, homosexuality was silenced.

Rick also described other restraints to disclosure. Rick has been involved with an early intervention service following a psychotic experience. In contrast to the near total silence regarding homosexuality described by other MSM, Rick recalled seeing something about the connection between depression and being gay in a brochure he was given. Yet, none of the nine clinicians he saw over two years raised the issue. In addition to the staff's silence, other discursive power relations contributed to Rick's silence:

Rick I thought if I say [I'm gay] that they'll just think 'right he's another one of those', if you know what I mean, because I think a lot of gay people struggle, you know what I mean, when they are in that coming out stage I think they probably get quite down [client].

Rick imagined that staff could draw on psy and equal rights discourses which construct 'coming out' as a time when homosexuals commonly feel distressed. He was concerned that staff might assume all his problems were related to coming out, and in so doing, ignore other issues. This concern has been raised by participants in other research (King et al., 2003a). Yet another restraint was that of heteronormative masculinity:

Rick The psychologist was a real like staunch guy, you know what I mean, and I find it, even now I find it quite hard to – he'd be like 'oh my goodness is this guy a queer guy or not', you know? [client]

Within heteronormative notions of gender, 'traditional' men are constructed as heterosexual, "staunch" (tough), and are expected to disapprove of male homosexuals, who (as discussed earlier), are associated with devalued 'femininity'. In this sociocultural context, Rick's reading of his psychologist as 'staunch', enabled him to interpret his psychologist's silence about homosexuality as probable discomfort and/or disapproval. Another restraint

to disclosure for Rick was that he thought that staff might disclose his homosexuality to his parents.

Despite these various restraints, during the two years he has been attending mental health services Rick managed to come out to his family and friends but had still not discussed his homosexuality with any of his mental health clinicians. Rick reflected on why this silence had remained:

Rick I think maybe they were scared, they didn't want to – Mum reckons they didn't want to jump the gun you know, because if they had said it, I don't know, because if I was straight and someone said, "Oh are you gay?" I would be quite offended, which is stupid [client].

The explanations Rick and his mother developed are constructed within homonegative discourses of homosexuality. In these discourses homosexuality is marginalised and undesirable. From this position, if clinicians initiate conversations about homosexuality, then they risk potentially offending heterosexual clients. Rick also commented on the possible implications of his experience of silence and invisibility inside PMHS about homosexuality. He thought that had he been able to discuss it with staff, then he might have got support on how to come out to his parents, so that when he did he might not have ended up back in hospital.

Similarly, reflecting on his assessment at a CMHC, Daniel thought that the dominance of the medical discourse significantly restricted the usefulness of his contact with PMHS:

Daniel He was asking me about if I wanted to be dead. "Why did I want to be dead?" He actually asked how I would do it again if I was going to do it in the future. And that was just all these questions about being dead and I knew it because I'd read the form. He just filled in these boxes because I was reading it myself and saying it.

DS Was there anything on that form about your sexuality?

Daniel No.

DS So was there anything in that environment that said to you this is going to be okay to talk about this?

Daniel No there was nothing at all [...] Those three weeks, they had me on so many sleeping pills I couldn't walk I was just a zombie and the theory was that they would just sedate me so I wouldn't do it again. And I told my father that I wasn't living my life like this because I couldn't go to work, I couldn't get out of bed, just couldn't be bothered [client].

Daniel's account illustrates the medical focus on suppressing symptoms, (and the ignoring of psychosocial issues), and the lack of any signs to tell him that it would be okay to discuss his sexuality. He then explains the ways in which medical treatment was not helpful as it

just kept him sedated. This description conforms to a stereotyped version of the docile patient subject, and contrasts negatively with his report of his experience at a gay-affirmative counselling service that his GP told him about:

- Daniel If that had been my first experience with mental health I would never go back there. I would never turn to it again.
- DS And if you'd never gone back what might that have been like for you? What do you imagine?
- Daniel There has been a third suicide attempt after a break up with a partner but I just dealt with that myself and called [name of counsellor at Burnett Centre]. She's given me things to think about and tools to calm myself down and get myself out of the mood [client].

Daniel says he would never return to PMHS and contrasts this with the service he got from the Burnett Centre. His description suggests that the Burnett Centre provided treatment within a psy discourse, with a focus on thinking, and on learning strategies to cope with various emotions. The psy discourse offers Rick a much more active and self healing subject position than the one he experienced under medical treatment within PMHS. He also suggests that this psy support was important in surviving his third suicide attempt.

In addition to the silence constructed by non-disclosure (as with Rick and Daniel), silence can also return after disclosure, as with Ralph. As mentioned earlier, following disclosure in a suicide note Ralph reported that his homosexuality had not been raised once either by him or by staff. Ralph thought that he could have discussed his sexuality in PMHS if he had been offered a lesbian or gay staff member. He also thought there had been implications for his mental health, and for his recovery, of not being able to discuss his sexuality in PMHS:

- Ralph That would have made a tremendous difference. I would have been more accepting of myself. I wouldn't have gone through bouts of depression or bouts of self-doubt, or massive and chronic dystonia, or whatever it is [...] and I would have become more accepting of myself far more easily and far more quickly than I have now. It has taken 46 years to actually accept myself. [client].

Ralph uses a psy discourse to account for the connection between his distress at being gay and his experience of depression. He also draws on psy notions of integrated identities, and the equal rights discourse which equates visibility and acceptance of ones gayness with good mental health. Ralph reasons that if staff had helped him to draw on these discursive resources earlier it could have considerably hastened his recovery.

These accounts by Ralph, Rick, and Daniel illustrate how, in a heteronormative context, silence surrounding homosexuality by clinicians can be interpreted by MSM in ways that support MSM to participate in their own silencing. This reading of silence was characteristic of a number of the men's accounts and is understandable in a heteronormative society where silence can be read as neglecting to consider homosexuality, suppression of homosexuality, or negative judgment about it. Some of the staff also acknowledged that it might be very difficult for MSM to speak into this silence:

Beth Yeah. And I guess too there is, so I think that is where it doesn't meet the needs of those particular clients is that the information isn't kind of actively sought so it would be up to either a roaming gaydar to pick it up or for the client themselves to you know, get to the point of, "Well what I really want to talk to you about is that I fancy the hell out of my science teacher". And I just think shit, well that's frigging hard for a kid to do, you know, it is quite hard for anyone to do [staff].

Here Beth refers to the silence around homosexuality and the lack of explicit assessment of it. She explains how this leaves the responsibility with MSM to take up the active client subject and raise the topic themselves. Beth sees this responsibility as really difficult for clients and staff. However, Beth also refers to another practice used to try and resist the silence which can make queers invisible; that practice is 'gaydar'.

'Gaydar': Behind Enemy Lines

'Gaydar' is a term used in lesbian and gay communities to refer to a commonly held belief that some people have the ability to detect if other people are lesbian or gay (Ambady & Hallahan, 2002; DiLallo & Krumholtz, 1994; Saghir & Robins, 1973; Shelp, 2002; Stewart, 1995). Before investigating how MSM clients, and queer staff, talked about gaydar, I review the research on this topic. I argue that this research illustrates, and maintains, discursive practices that both construct the notion of gaydar and which overstate its utility as a concept, and as strategy for identifying 'gays'. In exploring 'gaydar' and associated research, I am not assuming the existence, or usefulness, of 'gaydar'. Rather I am interested in its social construction and the effects of this.

The Science of Detection

The research on gaydar is clearly within the positivist framework. It often involves getting 'raters' (people who identify other's sexual orientation) to assess the sexual orientation of

'targets' (people whose sexual orientation is being assessed). The studies compare such things as the accuracy of ratings (Ambady & Hallahan, 2002; Ambady, Hallahan, & Conner, 1999; G. Berger, Hank, Rauzi, & Simkins, 1987), beliefs about gaydar (Carroll & Gilroy, 2002), and relative accuracy of gaydar according to 'rater' and 'target' characteristics such as gender and sexual orientation (Ambady & Hallahan, 2002; G. Berger et al., 1987; Shelp, 2002). What appears to be at stake in this research is not whether gaydar is a useful concept, but who is best at it, and how it is performed. How might we understand these preoccupations?

Clues to some of the assumptions constructing gaydar are evidenced in the definitions provided:

gay-dar: the instinctual ability to ascertain that another guy [*sic*] is gay, even in the absence of telltale signs.

(DiLallo & Krumholtz, 1994, p. 218)

gadar [*sic*] From gay and radar. The intuitive force that allows gay men [*sic*] to recognize one another.

(Stewart, 1995, p. 94)

A special intuitive or perceptual sensibility (sense-ability) of gay people to detect subtle identifying characteristics in other gay people, the development of which is motivated by the desire to remove feelings of isolation many have experienced growing up gay, and the basic human need for association with like others.

(Shelp, 2002, p. 2)

The first two definitions indicate the male lineage of gaydar. DiLallo and Krimholtz (1994), and Stewart (1995), specifically define gaydar as pertaining to gay men. This may reflect the use of gaydar from a time when the gay liberation discourse was at its peak in the 1970s. Within this discourse, 'gay' was often used generically to refer to homosexual men and women.⁶⁵ In one study 71% of homosexual men believed they had gaydar (Saghir & Robins, 1973).⁶⁶ More recently, Shelp (2002) suggests gaydar has an even wider coverage. In his internet based study of 249 gay men, he found that 94% had heard of gaydar and 86.7% believed they had it. Interestingly, 79% of the gay men in Shelp's (2002) study also

⁶⁵ For a fuller discussion of this discourse, see Chapter Four on discourses of homosexuality.

⁶⁶ Berger, Hank, Rauzi, and Simkins (1987) make the following interesting comment about this statistic. "This ability to recognize other homosexual males easily is somewhat questionable since the authors also reported that more homosexuals who claimed they reliably recognized other homosexual men were entrapped and arrested by plain-clothes police and were robbed or attacked because of sexual advances made to wrong choice partner than were those who did not claim reliably to recognize other homosexuals" (G. Berger et al., 1987, p. 84).

thought that straight people could have gaydar. Supporting this notion, a comparative study found that “gay/lesbian and heterosexual judges were not significantly different in their accuracy in judging” sexual orientation (Ambady & Hallahan, 2002, p. 324).

Thus, ‘gaydar’ may have originated from within the early ‘gay liberation’ movement, but it has been taken up by lesbians (Ambady & Hallahan, 2002; G. Berger et al., 1987; Carroll & Gilroy, 2002), and is also considered to be useable by heterosexuals (Saghir & Robins, 1973; Shelp, 2002). This widespread circulation of the concept of gaydar is evident in the interviews with queer staff and clients (discussed later in this section).

Essentialist notions of innate abilities, and identity, are present in the above definitions of gaydar and in research on it. DiLallo and Krumholtz refer to gaydar as an “instinctual ability” (1994, p. 218). Similarly, Stewart (1995) and Shelp (2002) talk of gaydar involving intuition and perceptual abilities. These ways of talking posit gaydar as an intrinsic ability that people, and lesbians and gays in particular, have. A combination of evolutionary, and sociocultural, theories propose that homosexuals need gaydar to identify ‘similar others’ in a potentially hostile, homonegative environment (Ambady & Hallahan, 2002; Carroll & Gilroy, 2002; Shelp, 2002). For example, Shelp (2002) proposes that “adaptive gaydar” is specific to gay and lesbian people and motivated by “the desire to remove feelings of isolation many have experienced growing up gay, and the basic human need for association with like others” (p. 2).

Shelp’s (2002) assertion that lesbian and gay people have a need for association with “like others” (p. 2) draws on the equal rights discourse, and its construction of lesbian and gay people being similar in ways akin to ethnic groups. He also utilises essentialist notions of “basic human needs”. In this vein Shelp writes of lesbian and gay people being of the same “family” or “tribe” (2002, p. 4). Shelp also refers to research suggesting differences between gay and straight men in areas such as speech patterns, personality types, and penis size. As speakers of the queer discourse argue, this reifying of lesbian and gays as similar maintains heteronormative constructions of homosexuals, and denies the huge diversity within people with same sex attraction. Yet, much of the gaydar research relies on this assumed similarity between homosexuals, and their difference from heterosexuals.

In studies of gaydar, the findings reveal an ignoring of diversity within queer communities, and a tendency to rely on heteronormative stereotypes of homosexuals. For example, in the study by Carroll and Gilroy (2002):

For both lesbian and gay male participants several other variables emerged as significantly helpful in terms of identifying gay men: clothing style and fit, jewelry, facial expressions, posture, body-type, walk or gait, and both the types and frequencies of gestures.

(Carroll & Gilroy, 2002, p. 120)

These characteristics are consistent with heteronormative depictions of gay men. As discussed previously, a heteronormative gay man is a man who, being attracted to men, (which is 'normal' for women), must somehow be more like a woman, and, thus, within a patriarchal gender system, be feminine (Cass, 1999).

A related limitation within gaydar research concerns the nature of the samples often used. These samples largely represent 'out', self-identifying homosexuals, with connections to lesbian and gay communities (see G. Berger et al., 1987; Carroll & Gilroy, 2002; Shelp, 2002). What do these samples tell us of the reliability of gaydar for identifying the full diversity of MSM, including those who do not identify as gay, and who do not frequent gay venues? Cultural boundedness is also a feature of gaydar research. Shelp (2002) acknowledged that gaydar may not operate across cultures and, thus, in his research raters and targets were all 'American'.⁶⁷ Given these various limitations, there are understandably diverse results on the reliability of gaydar in the research. Ambady et al. (1999) found that gay and straight judges typically made correct judgments about sexual orientation nearly 70 percent of the time. In a later study, Ambady and Hallahan (2002) found that accuracy for male 'targets' was less than chance (i.e. below 50 percent) when 'targets' tried to hide their sexual orientation. Despite this, they began their conclusion by saying, "judgments regarding sexual orientation can be made accurately from a mere slice of behaviour" (Ambady & Hallahan, 2002, p. 329). Data from other research also questions the efficacy of gaydar. Berger (1987) found that only 20 percent of 'raters' exceeded chance in their identifying of sexual orientation. There was no significant difference in the accuracy of gay or straight raters.

'Gaydar', then, is constructed within an equal rights discourse which posits gay men and lesbians as distinct, identifiable, cultural groups – a 'gay family'. It is theorised to offer gay people, in particular, a way of identifying similar others in a hostile world. However, the

⁶⁷ The definition of 'American' Shelp used was "an individual who has grown up in the continental United States, speaks English as a primary language and has not studied overseas before the age of eighteen" (2002, p. 11).

research paints a different picture, one which calls into question the usefulness of gaydar as a concept, and as a strategy for identifying ‘gay’ people. Neither straight, nor gay, people seem to possess particularly accurate gaydar. Accuracy is improved for homosexuals who identify as gay, are connected to gay communities, conform to heteronormative stereotypes of homosexuals, and are not trying to hide their homosexuality. This is a bit like having a radar in war which only picks up planes painted in bright colours, with large identifying emblems, and when they are close up, (i.e. not especially useful). Accuracy seems to be reduced when homosexuals try to pass as straight. Returning to the war analogy, this means a radar that tends not to spot the enemy unless they want to be spotted.

‘Gaydar’ in Operation: Some uses of ‘gaydar’ within PMHS

Bearing in mind the critique of gaydar as a concept, and a critique of the research investigating it, I now examine some of the ways queer staff, and MSM clients, spoke about this strategy for resisting the discursive practices that work to make them both invisible:

Diana Yeah we talk about gaydar. You know. And then we start to think ‘okay, now do you think’ - we may think ‘okay that guy is gay yeah, that is what his problem is okay. Let’s see how we can best work this out for him’. So that would be like, it is obvious that he is gay to us, because of how he appears, how he looks, what he is saying, and he is freaking out about - so what his problem is [is] his sexuality. He is not able to say it or voice it or whatever so you need to be really careful because you can’t just say to him, “Well you know, your problem is because you are gay, you know, go out and find yourself a boyfriend and you will be sweet” [staff].

Nathan They [staff] didn’t have to tell me myself, I just actually picked it up.

DS How did you know?

Nathan The way they speak, the way their body language is, the way they sort of go about things like there was one actually a transvestite – yeah, it is mainly the body language and how they talk and go about things that I picked it up [client].

Gaydar relies on observable signs of homosexuality. Diana says it would be apparent that a male client was gay because of his appearance. Similarly, Nathan, while not explicitly using the term ‘gaydar’ says he can identify queer staff by their observable behaviours. As discussed earlier, these descriptions of gaydar are constructed within the equal rights discourse of homosexuality and its essentialist assumption of stability and similarity across lesbian and gay identities. These similarities are assumed to be especially observable by people with similar characteristics (other homosexuals). Furthermore, some staff extended their definition of gaydar to being a strategy that non-queer staff could use too:

Diana Just tuning in with the people around them and I think that all psychiatric nurses have the ability - most of the people that I work with, and good psychiatric nurses, have the ability to do that. To become on the same level as that person and so the same as the homosexuality, we can pick it up, gaydar we call it [staff].

Edward At least straight men's gaydars are usually fairly good - well usually it is okay. People with, and I guess people with strong religious beliefs, their gaydar is probably going to be a very personal thing anyway [staff].

A majority of the MSM clients, and almost half of the queer staff, talked about using gaydar. Gaydar was more frequently described as useful by staff. They thought it could influence their treatment, or help them advise their colleagues on working with MSM clients. Yet both staff and clients talked of gaydar as problematic in countering heteronormative silence in PMHS:

Edward The problem I think with men who have sex with men is that they are reluctant, you know, there is a reluctance there for that to be known because if they are reluctant to have it known then they would either be identified as bisexual or gay you know. So if there is a reluctance there, and I don't think the clinicians are good at, I don't think their gaydars are very good and I don't think they spot the people for whom this might be an issue [staff].

Edward points to one limitation of gaydar. As it relies on essentialist notions of what a 'gay' identity is, he suggests it is less useful for identifying MSM who do not self-identify as gay, and who may be withholding any potentially visible signs which might mark them as other than heterosexual. This idea is supported by Ambady and Hallahan (2002) who found that accuracy of gaydar was below 50% when people tried to hide their sexual orientation. As was apparent in much of the talk from the MSM clients, in a heteronormative society, and in PMHS where there is often silence from staff regarding homosexuality, many MSM are reluctant to disclose. Many MSM are also very uncertain about their same-sex attraction and how, or if they wish, to identify in relation to it, either privately or publicly. As Edward comments, in this context gaydar seems an unreliable method for staff to identify men for whom homosexuality may be related to their distress.

Even for the MSM clients who are not trying to evade detection by gaydar, there is the issue of whether an MSM client would ever come in range of a working gaydar within PMHS:

Beth And that concerns me because there is that kind of, you know the whole gaydar thing and I think we [homosexuals] have it and they [straights] don't and so I am aware that, right so what happens for all these other kids where it is not happening? [staff].

Beth acknowledges the limitations of gaydar for assessing if sexuality is relevant for a client. She reasons that for this strategy to work it requires staff that have ‘working’ gaydar, (which she considers to be primarily a characteristic of queer staff), in order for MSM clients to be identified.

Regardless of whether gaydar is accurate or not, clients also talked in ways suggesting that even if they thought, or knew, a staff member was ‘gay’, this knowledge is problematic for improving MSM visibility in PMHS:

Rick Yeah, I think there was one nurse I think who was gay.

DS What made you think that he or she was gay?

Rick I think he told, I’m not sure, he told someone anyway. Because he was one of my friend’s nurses, he was never my nurse. I think he was down in the other wing. But I wasn’t likely to run up to him and say, “Oh hey, I’m gay, but I don’t even really know you” [client].

Rick, who had not disclosed his homosexuality within PMHS, explains how he thought he became aware of a gay clinician. However, he also describes how, as a patient, he felt unable to approach the staff member and disclose his homosexuality. The subject position most commonly available to patients in hospital does not support staff-patient interaction based on shared sexual identity status. Consequently, Rick’s knowledge that a staff member might be ‘gay’ did not help him disclose his homosexuality within PMHS. Other MSM clients also spoke about the limitations of gaydar, specifically in relation to the restraints they theorised existed for queer staff disclosing their queerness. These accounts are considered in the following chapter which explores the discursive restraints to clinicians disclosing their homosexuality to clients.

From the discussion thus far, though gaydar can be seen as a potential means to resist the ways in which homosexuality is often made invisible in heteronormative contexts such as PMHS. Sometimes staff utilise their gaydar to inform their clinical practice or the clinical practice of their colleagues, but, this method of identification is very limited in its effectiveness. It is limited for a number of reasons.

One limitation of gaydar relates to its discursive construction. The term ‘gaydar’ reflects the essentialising language of the equal rights discourse. ‘Gay’ becomes a generic term for lesbians and gay men, and it assumes observable characteristics that particularly other gays can spot due to their similarity as gays. Yet, as discussed in Chapter Seven, MSM appear in many forms. For example, some can be read as ‘screaming queens’ and some as ‘masculine’

men. Furthermore, often MSM do not identify as 'gay' and are reluctant to disclose their homosexuality, or actively hide it for fear of judgment. It is not hard to imagine which of these forms of MSM that gaydar will be better at spotting. Therefore, gaydar is limited to identifying MSM that in some way conform to dominant and heteronormative ideas of what a gay man is. These conceptualisations of MSM are limited and not very inclusive.

A second limitation of gaydar for increasing the visibility of MSM in PMHS is that it relies on MSM coming within the range of working radar. As it is debatable which staff do, or do not, have this faculty, this also complicates gaydar as a strategy for identifying MSM clients. A further limitation of gaydar for both staff, and clients, concerns what one can do with the information it provides. Even if MSM clients, or staff, think they have identified another 'gay', the discursive practices constructing the behaviour of patients, and clinicians, make acting on such information both fraught and risky. In the following chapter I consider the ways in which queer staff described acting on 'gaydar' as risky. For now though, I turn to considering the combined effects of the discursive power relations discussed in this chapter and which construct how the visibility of MSM clients' is negotiated in PMHS.

Summary: Limited Visibility – Proceed with Caution

This chapter explored the discursive power relations constructing how MSM clients negotiate their visibility inside PMHS, and how they understand staff to be implicated in this. Such visibility is important given that all but one of the MSM described homonegative trauma as, at least partly, constructive of their mental health problems. The context for this negotiation was argued in the previous chapter; where I contended that discursive practices in PMHS operate to marginalise sexuality from the core business of PMHS and also operate to minimise the chance that staff will initiate conversations about homosexuality.

Consistent with the staff's accounts of rarely, (if ever), asking about homosexuality, only one of the MSM clients (Jack) said that a staff member had explicitly initiated a conversation supporting initial disclosure of his homosexuality. However, also consistent with the staff's accounts, many of the men did manage to initiate their own disclosure. This can appear to lend support to the psy notion, offered by staff, that MSM clients 'will tell us if they need to'. But, in this chapter I have argued that neither the enactment, nor the consequences of disclosure, were straightforward for many MSM clients. Furthermore,

some MSM found the heteronormative silence around homosexuality such a restraint that they did not disclose their homosexuality, despite believing that it was important to their mental health problems.

In a heteronormative society, disclosure of homosexuality always carries the risk of a homonegative response. This restraint was evident in many of the ways MSM spoke of disclosing in PMHS. For example, even MSM who had disclosed at some point in PMHS talked about needing to reconsider disclosure with each new staff member. These considerations are a sign of the ongoing circulation of homonegative discourses in New Zealand society. Consequently, even without the overt pathologising of homosexuality by staff, for some of the MSM the silence of staff around homosexuality was easily read as ‘we don’t want to discuss it’, or ‘we don’t approve’. For these men, disclosure did not occur. Interestingly, two of these three men were the youngest of those interviewed; suggesting that the influence of heteronormative discourses of homosexuality continues to be constructive in the experience of the younger generation of MSM.

Additionally, many of the MSM talked in ways suggesting that the predominance of the medical discourse in mental health is a particular restraint to their establishing therapeutic relationships in PMHS that are likely to engender disclosure. The focus on symptoms and the lack of attention to psychosocial issues, characteristic of the medical discourse were experienced as significant barriers to disclosure. For the MSM who did not disclose, or for whom disclosure was unnecessarily delayed, they all believed non-disclosure had negatively affected their recovery.

One strategy both clients, and staff, utilised to try to resist the silencing and invisibilising of homosexuality, was ‘gaydar’. I have critiqued this concept and the research on it. I then explored how both queer staff, and MSM clients, used gaydar to try and identify each other. This strategy is covert and constructed within the equal rights discourse that assumes similarity within identity groupings based on sexual orientation. Because identification depends on this assumed similarity it often relies on essentialist and heteronormative notions of what ‘gay’ people are like. Accordingly, it is limited for identifying the diversity of men identifying as MSM. Furthermore, the research on gaydar suggests it has limited accuracy. Additionally, even if queer staff, or MSM clients, think they have correctly identified each other discursive power relations limit what they can do with this assumed visibility.

Thus, the visibility of MSM clients inside PMHS is a complicated issue. The combined effects of the discursive power relations constructing the behaviour of staff, and MSM clients, works to support the invisibility of some MSM clients inside PMHS, and often complicates any visibility that is achieved. Both queer staff, and MSM clients, reflected on this state of affairs:

Ella And I guess that we probably have lots of people that come through that their sexual orientation isn't identified and the degree to which it affects their treatment is completely unknown [staff].

Ralph Tied in with my emotional wellbeing was my sexual wellbeing and I think what I was really wanting was an environment that was safe enough for me to talk about my emotional and sexual kind of wellbeing [client].

Thus, while homosexuality is no longer officially pathologised within PMHS, the visibility of homosexuality is still very problematic. At least two sets of discursive power relations operate to limit the visibility of MSM clients within PMHS. First, heteronormativity, and the medical discourse, make the topics of homonegative trauma and sexual orientation secondary to symptoms of disorder. Second, homonegative discourses denote homosexuality as a problematic category; one that may be unsafe, risky, or uncomfortable for clients or staff. These sets of power relations reduce the chance that a clinician, or an MSM client, would initiate conversations about sexual orientation. Consequently, discussions about sexuality are often avoided by staff, and, thus, rendered the responsibility of the client.

Yet, despite the heteronormative and homonegative discursive power relations discussed in this chapter, by deploying various other discourses, many MSM do manage to disclose their sexuality within PMHS. But even when they do disclose, the same discursive power relations make what follows unpredictable. Further, some MSM feel unable to disclose given current discursive restraints and related clinical practices illustrated in this chapter. As a result, despite homonegative trauma being central to many MSM's understandings of their mental health problems, various discursive practices operate to limit the visibility of MSM clients inside PMHS. Both MSM clients, and queer staff, described this as a problem. Accordingly, both groups had ideas on how this situation might be improved and it is these possibilities that are considered in the next two chapters.

Chapter Ten:

A Queer Match Relationships between Queer Staff and MSM Clients

How is it possible to create a context in which MSM are visible, and homosexuality is open for discussion, in an institution where many people who work in it, or who use it, think it is uncomfortable, scary, risky, or dangerous to do so? This is the scenario portrayed in the previous two chapters by the talk of the MSM clients, and queer staff, of PMHS. The accounts the queer staff provided about their own, and their colleagues', behaviour concur with the accounts of the MSM in a significant way. These portrayals suggest that, by and large, neither queer staff, nor non-queer staff, initiate conversations about homosexuality within PMHS. Only one of the 13 MSM clients interviewed reported that a clinician had initiated their initial disclosure of their homosexuality. This silence can limit the ability of PMHS to reduce MSM clients' distress at best, and may even add to their distress at worst. Both queer staff, and MSM clients, thought this was a problem and had ideas on how things could be better.

This, and the following chapter consider two key strategies for improving PMHS for MSM. These strategies for change can be understood as falling within two perspectives. Here I draw on a theoretical distinction about approaches to sexuality made by Sedgwick (1990). This was introduced in Chapter Four where I outlined a queer discourse of homosexuality. To recap, Sedgwick (1990) argues that a minoritising view of homosexuality considers the homo/hetero binary “as an issue of active importance primarily for a small, distinct, relatively fixed homosexual minority” (p. 1). In contrast, a universalizing view posits the homo/hetero binary “as an issue of continuing, determinative importance in the lives of people across the spectrum of sexualities” (Sedgwick, 1990, p. 1).

As discussed in Chapter One, much of the existing literature on improving mental health services for lesbians, gay men and bisexuals (LGB)⁶⁸, makes particular assumptions. First, it assumes that some (a minority of) mental health workers need to improve their attitudes to homosexuality. It is also assumed that this will translate into improved practice with the ‘special’ (minority) population of LGB clients. A third assumption is that more LGB (minority) staff will improve mental health services for LGB (minority) clients by providing a type of matching. This literature thus largely represents a minoritising perspective by advancing the notion that the homo/hetero binary is primarily relevant to LGB mental health staff and clients, or to mental health staff who work with LGB clients and/or have negative attitudes towards homosexuality.

The notion of ‘matching’ and thus advocating roles for queer staff in improving PMHS for MSM is one of the most common recommendations of the limited research and writing in this area (see Chapter One). Yet to date, no research has explored the views of queer staff of PMHS on this issue. In this chapter⁶⁹ I show how the strategy of matching is constructed through the talk of MSM clients, and queer staff, and what it offers. I then claim that matching for sexual orientation ignores the multitude of ways in which queer staff, and MSM clients, differ. I suggest that these differences trouble the idea that matching will necessarily improve mental health services for MSM. Next, I argue that, in addition to the differences between queer staff and MSM clients, there are considerable restraints to queer staff disclosing their homosexuality to clients, and to making themselves available for matching.

A Perfect Match: A Fairy Tale about Queer Clients and Queer Staff

The notion of matching clients and mental health staff along sexual orientation lines arises out of a tradition which has explored matching along other axes of identity such as gender, ethnicity, and language (Alladin, 1994; Atkinson, 1983; Bowman, 1993; Felton, 1986; Flaskerud, 1990; Gottheil, Sterling, Weinstein, & Kurtz, 1994; E. Jones & Zoppel, 1982;

⁶⁸ This literature mainly focuses on lesbians, gay men, and bisexuals. For this reason here I use the term ‘lesbians, gay men and bisexuals (LGB)’, versus a more inclusive term such as ‘queer’.

⁶⁹ An earlier version of this chapter has been published (Semp, 2004a).

Parker-Sloat, 2003; Shin et al., 2005; Sterling, Gottheil, Weinstein, & Serota, 1998, 2001). Proponents of matching often use social influence theory (proposed by Simons, Berkowitz, and Moyer, 1970, cited in Flaskerud, 1990) which “proposes that source (therapist) credibility, attractiveness, and influence are a function of similarity between the source (therapist) and the receiver (client)” (Flaskerud, 1990, p. 322). Concluding a review of matching research, Flaskerud (1990) argues that results are inconclusive (these results are discussed later). Nevertheless, she acknowledges that the origin of, and continued interest in, matching can be understood within a social movement to “force American psychiatry to examine its racist, sexist, and ethnocentric paradigm and behaviour” (Flaskerud, 1990, p. 332).

Perhaps an area where the idea of matching has been most taken up is in the sphere of feminist therapy. Much feminist therapy is based on assuming a certain sameness between women:

When a woman chooses a woman therapist she is asking for someone who is the same as her; her assumption is that someone who shares her experience of being in the world as a woman will understand her better.

(Ernst, 1997, p. 26)

Ernst (1997) later acknowledges “the surprise, disappointment and resistance (which can occur) when either party discovers that, in spite of gender or other similarities, they are actually two separate people” (p. 27). Despite the many differences between women, such as those along ethnicity, class, and political lines, feminist therapy holds on to the assumption of some similarity between women. Because of this, feminist therapists are assumed to be women, and the matching of therapist and client for gender is generally taken-for-granted.

Similarly, (and as mentioned in Chapter One), lesbian and gay staff are presumed to improve mental health services by creating a lesbian and gay affirmative environment, by ‘matching’ with lesbian and gay clients:

Many gay, lesbian, and bisexual patients may wish to see a therapist who is also gay, lesbian, or bisexual. The patient may believe that he or she can avoid the overt effects of homophobia and more easily develop a sense of trust, safety, openness, and personal comfort with a gay, lesbian and bisexual therapist. The patient may also believe that a gay therapist will share common experiences and know more about gay issues. Gay, lesbian, or bisexual therapists, in turn may hold similar beliefs: that homophobia can be avoided, that a special rapport can be established quickly, and that a shared base of knowledge and experience exists when gay, lesbian, and bisexual patients and therapists work together.

(Cabaj, 1996b, p. 516)

This excerpt is from a key text on homosexuality and mental health. While in the rest of his chapter, Cabaj goes on to explore some of the problems with matching, his description clearly illustrates how ‘similarity’ between lesbian, gay, and bisexual, people is one of the key assumptions of matching. That assumption is constructed by the equal rights discourse of homosexuality. In its current form (as outlined in Chapter Four), it emphasises an almost ‘ethnic’ similarity based on commonality and sameness, thus enabling trust, safety and rapport between LGB people. Accordingly LGB staff and clients are thought to share similarities that will make their therapeutic work together easier.

The psy discourse also helps construct matching as useful. For example:

Creating an environment where staff are able to be ‘out’ would also help visibility, indicate acceptance of non-heterosexual identities and provide positive role-models.

(McFarlane, 1998, p. 95)

This excerpt is from a study in the United Kingdom on the experiences of LGB in mental health services. It illustrates that the psy notion of “role models” lends support to the possibility of matching, and to LGB staff increasing visibility and acceptance of LGB identities in mental health services. Within a psy discourse, public acceptance of our identities is constructed as important for our mental health. Additionally, a critical approach to mental health offers the possibility that lesbian and gay staff can use their LGB identities and knowledges to help clients reduce the effects of oppressive heteronormative cultural practices.

Speaking of Sameness: MSM clients and Queer Staff Advocate Matching

Most of the queer staff, (to differing extents), and all the MSM clients, spoke in ways supporting the idea that queer staff could have a role in improving PMHS for MSM clients, both directly and indirectly:

Philip Sure. Because I think a queer mentor can provide some role modelling and some ideas on how to negotiate that particular pathway whereas a non queer mentor or straight mentor couldn't. It is like having a Pākehā mentor for a Māori person [staff].

Edward It completely depends on the significance of the issue for the client. If it is a significant issue then it is no different to Tikanga Māori [Māori customs] or a Pacific person's perspective that it is more appropriate to put a person of the same culture to match the clinicians and the clients within their cultures [staff].

Philip uses psy concepts of modelling, and mentoring, to progress the idea that queer staff could have visible roles with MSM clients in aiding them to traverse issues of sexual orientation. Essentialist notions of shared identity from the equal rights discourse lend support to this view. Similarly, Philip and Edward explicitly draw a parallel between matching for ethnicity and matching for sexual orientation. These ways of talking clearly attribute LGB people with the status of an ethnic group. Furthermore, within such reasoning, this cultural positioning is one which LGB staff and clients are assumed to share.

This comparison with ethnicity was also frequently utilised by the MSM clients when discussing the possible roles they thought LGB staff could have:

Mark Because you know people say "Well we are all pretty well the same", but the difference between heterosexuals and homosexuals is the difference between black and white, not male and female, there is nothing two things the same about the way their minds are made up, the way who they are, how they address their issues, what they feel about life. The comparison is huge so you get a clinician that has an understanding of it but a heterosexual is going to be no use to you at all to a degree [client].

Brian I worked in a bank right, and when the Asian immigration happened in this country, within 6 months we were offering translators free of charge ... If we are going to be accepted we should be actually having exactly the same rights as they do [client].

Daniel Why should Māori people have someone who can speak Māori? Why should Samoan people have Samoan handbooks and people who can speak Samoan? If we are going to put it down to a language, getting someone who speaks

fag.⁷⁰ It's just my outlook. They've already segregated the society why not have one more segment? [client].

Mark uses the equal rights discourse to describe the perceived similarity between MSM clients and LGB staff. His description emphasises similarity to such an extent that he considers heterosexual staff to be almost useless for MSM clients. Also drawing on the assumption of similarity amongst LGB people, both Brian and Daniel use the comparison with ethnicity to explain matching. Brian uses the analogy of banking services to draw on both consumer and equal rights discourses in justifying matching. Acknowledging the tendency within identity politics for the multiplication of identities within society, Daniel takes the ethnicity analogy even further and argues he should have the right to a clinician “who speaks fag”. This comparison with ethnicity, made by both queer staff and MSM clients is also evident in the literature. Summarising the potential benefits of matching, Cabaj (1996b) states:

In the best circumstances, the comfort and rapport that were described earlier in relation to ethnic minority patients working with therapists from the same ethnic minority group can result when patients and therapists who share a common sexual orientation work together.

(p. 520)

Accordingly, some MSM clients thought that matching would have enabled easier, quicker, more supportive, and effective, clinical interactions:

Ralph Fundamentally I am gay and it has taken me a long time to accept it, but I would have accepted it more quickly and more readily if I had talked to someone who was a gay counsellor [...] It could have saved me time, a lot of time, and a lot of psychological torment because I have gone through psychological torment about it. I would have been at more ease and more fluidic with my approach to others as it were.

Rick I just think it would have been, even this year it's been quite liberating just saying “Hey, I'm telling my parents”, and all that kind of thing. So even just telling them it would have taken a bit of a weight off my shoulders [client].

Ralph had been using PMHS for over 10 years and thinks that if he had had an LGB staff member to talk with it would have saved him considerable time and distress. He contended that the perceived absence of LGB staff contributed to his experience of homonegative trauma being prolonged and hidden from mental health services. Rick had only been using

⁷⁰ ‘Fag’ is short for faggot, which is often used as a derogatory word for homosexuals. However, as with ‘queer’, some MSM have deployed this term in more resistant ways.

PMHS for two years but he thought that had he been offered a queer staff member, it would have taken the pressure off him and helped him come 'out' to his parents.

Therefore, both MSM clients, and queer staff, thought that queer staff could have specific roles in supporting MSM clients. Both the psy, and the equal rights, discourses work to emphasise connections between sameness, integrated LGB identities, public acceptance, and good mental health. For this possibility to occur, though, queer staff would need to be 'out' within PMHS, and supported by their colleagues. Accordingly, I now consider how the queer staff talked about being queer in PMHS.

'Out and Proud': Queer Staff in PMHS

From an equal rights, or a liberation, discourse of homosexuality one would expect a strong identification as a member of a marginalised group. All of the staff reported being 'out' with colleagues, and spoke in ways consistent with these two discourses when talking about the importance of this outness in their workplaces:

Luke I couldn't be in a work place where I couldn't be at least out to my colleagues because I think it just takes too much time and energy ... they are going to ask you what you did in the weekend and if you can't actually say "Well I spent some time with my partner," and you know it is almost impossible [staff].

Diana I couldn't work there. I couldn't work where I couldn't be out. I couldn't assume, I couldn't think that people would assume that I was straight. I wouldn't like that [staff].

Edward Oh yeah, absolutely. Yeah, and I make a point of that to all - I mean when I first started here it took me a couple of months to get off my hobby horse but I do make a point of indicating it, even if it is just by way of gently in the conversation. I make sure that everyone who starts afresh at here knows that because I'm not going to have that come out as a surprise later down the track. People need to know who I am and those aspects of me that may have affect or influence with them straight up I think [staff].

In these excerpts the staff speak from the essentialising LGB subject of the equal rights discourse. In this discourse homosexuality is an integral part of your identity that must be validated in order for you to have a satisfactory life. All three describe the impossibility of being 'in the closet' with colleagues. Both the psy, and the equal rights, discourses construct hiding one's sexual orientation as detrimental to one's mental health. These accounts given

by staff are congruent with those of the MSM clients as found in Chapter Seven. Furthermore, these discourses provide the staff with subject positions from which they can assert their LGB identities in the workplace.

Not only were queer staff clear about needing to be 'out' with their colleagues, they also stated they were prepared to go to some lengths to ensure that their 'outness' was respected:

DS It sounds like you figured out pretty quickly that it [being out] was going to be okay though?

Patrick Absolutely, and if it wasn't well I'd make it okay. I mean I would be more highhanded if I felt that it needed challenging [staff].

Matt I am not the sort of person that would put up with any kind of hostility because I would be quite, probably confrontational with somebody who was hostile towards me, or, you know, sort of was derogatory about my sexuality, because, or gay people in general, because I don't think that's acceptable [staff].

These examples show that for all the staff interviewed it was essential for them to assert their LGB identities in the workplace. Furthermore, in order to support their 'outness' at work, Patrick and Matt are prepared to fight for it. Their stance reiterates the significance of sexual orientation for identity within the equal rights discourse. This is similar to the accounts of MSM clients (see Chapter Seven). Patrick's and Matt's positions requiring the strident challenging of heterosexism are enabled by liberation, and equal rights, discourses of homosexuality with their construction of 'out' and 'proud' LGB identities.

While there has been no research specifically on queer staff within mental health services, Cabaj (1996a) suggests that in the United States there are many difficulties for queer clinicians coming out in mental health settings. However, the queer staff interviewed in this research reported finding it relatively easy to be out with colleagues. This may reflect a more liberal social climate in New Zealand's largest city than in many parts of the contemporary United States sociopolitical context. Furthermore, many of the staff interviewed said that they expected PMHS to be a workplace characterised by tolerance and an acceptance of difference. Many also said they had initially been interviewed for their position by 'out' queer staff, or that there were many visibly 'out' queer staff in their place of work once they started their job. Both of these forms of queer visibility were seen to help them know they could be out with colleagues in PMHS.

In addition to being comfortably out in PMHS, many queer staff said they were already having a queer-affirmative impact on PMHS, which they thought could, in turn, improve service to MSM clients. This influence was by way of challenging and consulting with their colleagues about queer issues. While not formally specified, some queer staff felt obliged to take up this role, thought it was appreciated by colleagues, and that it could be put on their performance appraisal as a particular strength they offered the service:

Ella I think that I am not only a social worker. I am also a lesbian on the team and I am a resource and I am also keeping that agenda there when it needs to be there in terms of services for people that come in. I might be more inclined to see a lesbian client and things like that [staff].

Patrick The ways I see that the staff have a role in this service is on a number of levels. Firstly, on a level like [name of gay colleague] and I suppose myself to encourage, maybe even coerce discussions around gay men and particularly to encourage discussions in – within supervision. To, to probably promote a culture where it can be discussed [staff].

Both staff suggest they adopt a ‘queer’ identified role with a sense of responsibility to queer communities, and a need to resist heteronormativity and increase queer visibility. This stance illustrates the multiple subject positions offered to staff. In addition to their discipline-based positions within PMHS, the equal rights, and psy, discourses posit the essentialist nature of queer identities and support people in acting with ‘integrity’ from within them. The critical discourse of mental health, in particular, enables staff to use their marginalised identities, and knowledge of oppression to reduce its impact on the lives of service users and educate other staff.

More support for the possibility of matching came from MSM clients who had experienced it, and from staff who described it happening on an informal basis in PMHS. Some of the MSM interviewed had, in addition to using PMHS, seen gay male counsellors, either privately, or through an alcohol and drug agency that routinely offers matching based on sexual orientation (for a discussion of this agency see Semp & Madgeskind, 2000). The MSM who had experienced this matching found it very useful. In Chapter Eight I showed how a psy discourse of mental health can offer an active role for clients. Speaking from this discourse, staff said that when clients assert that sexuality is an issue for them, or when clients specifically request a lesbian or gay staff member, then there is often a willingness to provide it, if possible. However, as discussed in Chapter Nine, in a heteronormative context it can be very difficult, and sometimes impossible, for MSM clients to adopt such

an active position regarding their sexuality and to request matching. It is to these, and other, problems with matching that I now turn.

Gaps in the Match: A More Complicated Story about Queer Clients and Queer Staff

From the equal rights-infused talk of the MSM clients, and queer staff, considered so far, we might assume that the practices of matching, and of promoting more 'out' queer staff, within PMHS would indeed improve service to MSM clients. Accordingly, we might also expect that many queer staff within PMHS would disclose their sexual orientation within therapeutic relationships, at least with queer clients. Yet according to the staff interviewed, this is rarely the case. So, what might be going on here? As I argued in Chapters Seven and Nine, visibility is perceived as very risky by many MSM clients. Now I argue that despite the tolerant, accepting, working environment in PMHS described by queer staff, they also perceived visibility in their clinical relationships as a very risky business.

In this section I trace out the complexities surrounding the idea that queer staff will necessarily improve mental health services for MSM clients. First, I consider the limited research on sexual orientation matching. Second, I draw on conclusions from preceding chapters, to illustrate how various discourses challenge matching as a practice. Third, I provide some examples of significant ways in which queer staff, and MSM clients, may differ. Fourth, I explore the discursive restraints to queer staff disclosing their sexual orientation to clients.

Matching assumes a sameness which provides mirroring, but there are many things to fracture such a mirror. In a review of the research on gender and ethnicity matching, Flaskerud (1990) concluded that results were contradictory and unclear. But she also commented that there was some evidence suggesting that women prefer women therapists. As Flaskerud (1990) suggests, this may be due to culturally-specific beliefs about feminism and the roles of women. Yet, despite some support for the notion that gender was a relevant factor in matching, Flaskerud (1990) found that matching for gender or ethnicity was a poor predictor of therapy outcome and that studies generally failed to account for within-group differences in therapist preference.

Similarly, (and as briefly discussed in Chapter One), a few surveys (mainly in the United States), have considered matching for sexual orientation. While the studies found that many lesbians and gay men did prefer a therapist of the same sexual orientation, there were many who did not. For example, one study of 83 gay and lesbian clients found 49% preferred sexual orientation matching while 39% said sexual orientation of therapist did not matter (McDermott, Tyndall, & Lichtenberg, 1989). In a larger study of 609 lgb individuals (J. Kaufman et al., 1997), a majority of the lesbians, and almost half of the gay men, expressed a preference for a therapist of the same sexual orientation.⁷¹ In contrast, Jones and Gabriel (1999) surveyed 600 lgb clients and found that only 26% “thought that a therapist must be gay or lesbian in order to provide gay/lesbian affirmative therapy” (p. 215). Gender was also found to be a significant variable affecting choice of therapist. For example, a study of 1925 lesbians (Bradford et al., 1994) found that 89% preferred to see a woman, while only 66% preferred to see a gay or lesbian therapist.

Thus, like the gender and ethnicity studies, the sexual orientation studies provide some broad information on preferences but do not explore how these preferences are constructed. The studies do not investigate differences in preferences within, and between, lesbian and gay client groups. For example, why do some lesbian and gay clients prefer sexual orientation matching and some do not? Connected to this, there has been no research on how people with same-sex attraction but who do not identify as lesbian, gay or bisexual, construct their preferences for therapists. Furthermore, there has been no research specifically considering queer clinicians’ views on matching or on what discourses, other than those related to homosexuality, may affect their ability to ‘match’ lesbian and gay clients.

Notwithstanding the lack of research on queer clinicians’ views, some therapists have used case studies to explore the issue of matching for sexual orientation in therapy (Atkins & Townsend, 1996; Kooden, 1991). Cabaj (1996b) considers some of the potential problems with matching in psychotherapy. For example, he argues that the assumption of similarity between therapist and client can:

⁷¹ In the article by Kaufman et al. (1997) the sample is split into two groups, labelled an ‘e-mail sample’ and a ‘traditional sample’. While percentages are given for responses of each sub group, no percentages are given for the combined overall sample.

Facilitate a false sense of trust and openness that is not derived from a shared therapeutic experience, which could be used in understanding transference and countertransference reactions. Many parts of the patient's life may in fact be avoided or not explored as a result of a conscious or unconscious collusion to sidestep painful material by assuming a mutual understanding of words or experiences.

(Cabaj, 1996b, p. 518)

Here the assumption of similarities between client and therapist based on sexual orientation are construed as potential restraints to therapeutic endeavour. Accordingly when considering 'matching' as a strategy for improving PMHS for MSM it is important to consider possible differences between MSM clients and queer staff.

Differing with Sameness

In this section I begin to contest some of the theorised benefits of matching clients and staff for sexual orientation by drawing on findings from the previous three chapters. In particular I argue that MSM clients, and queer staff, differ in some significant ways that trouble the potential benefits of matching.

In Chapter Seven I showed that all but one of the MSM clients gave explanations for their mental health problems that attributed the effects of homonegative trauma as, at least partly, constructive of their distress. These explanations were similar, irrespective of reported diagnoses. Furthermore, these explanations are constructed from predominantly psy, and critical, discourses of mental health which give sociocultural contexts a significant role in the understanding of psychological distress. However, in Chapter Eight I showed that queer staff deploy similar and different discourses of mental health to MSM, sometimes in contradictory ways.

First, staff often spoke in ways similar to the psy, and critical, understandings of the MSM when talking about the construction of mental health problems for MSM clients. Yet, at times some also spoke the language of the medical discourse, in ways that separated mental illness (as a bio-medical entity) from the psychological distress caused by the operation of homonegative discourses in the lives of clients. Correspondingly, some of the queer staff said that PMHS either should not, or could not, deal with problems related to homonegative trauma. This means that even if matched for sexual orientation, MSM clients, and queer staff, may have quite mismatched ideas about how relevant

homosexuality and heteronormativity is to mental health, and to the primary business of PMHS.

A further potentially significant difference between MSM clients and queer staff relates to the ways each group views their respective worlds. In Chapter Seven I showed how, for most of the MSM clients, much of their understandings of the contexts they live in is constructed by homonegative discourses. According to the MSM, pathological, Christian supremacist, and conservative discourses of homosexuality, and their effects, cause them considerable distress, and make them very wary of others. What's more, the men bring this suspicion of others into their contact with PMHS. In contrast, as I have shown earlier in this chapter, the queer staff were more likely to talk about the relationship between their queerness and their lives in ways constructed by more homopositive discourses, and by the equal rights discourse in particular. Accordingly, they were all comfortably 'out' in their workplaces, most expected this to be the case, and some felt resourced enough to challenge any colleagues they perceived as anti-homosexual. It is fair to say, then, that the queer staff and MSM clients are located in very different, rather than similar subject positions.

Third, the differing relations of power between clients and staff may also help explain the contrasting positions the staff and clients occupied regarding the initiating of conversations about homosexuality. In Chapter Eight I showed that staff frequently thought that MSM clients would raise the issues of sexuality if they thought it necessary. In the equal rights discourse that the staff are primarily positioned in within PMHS, it is understandable for them to think that MSM clients would discuss homosexuality if they needed to. However, from the positions constructed by the homonegative discourses that most of the clients were generally more familiar with, it is equally understandable that the MSM clients were much less likely to see initiating conversations about sexual orientation as uncomplicated. Therefore, the differing ways in which queer staff, and MSM clients, are positioned in relation to discourses of homosexuality, demonstrates yet another gap in the notion of matching.

A fourth and related difference between the MSM clients and queer staff concerns how they are positioned in PMHS with regard to discourses of mental health. In Chapter Eight, I argued that queer staff often used the language of the medical and psy discourses to explain their (and their colleagues practices) around discussing homosexuality. One position they commonly espoused was the 'knowing clinician' stance of the medical and

psy discourses. They used this to decide whether it was safe to raise the topic of sexuality, or not. In these instances they position MSM clients as passive and fragile. Yet at other times the staff positioned the clients as able to disclose their sexual orientation if they needed to. This confers the clients within the more active subject positions offered by the psy, and critical, discourses of mental health. However, in Chapter Nine, some of the MSM clients described not feeling able to take up this active subject position. Instead they felt positioned within the more passive patient subject of the medical discourse. This positioning, along with a heteronormative context, contributed to their silence around issues of sexual orientation. Thus, in another significant way, (that is, their positions within PMHS), queer staff and MSM clients differ.

In addition to differences in relation to discourses of homosexuality, and of mental health, other discourses complicate the notion of matching between queer staff and clients:

Brian I'd choose the lesbian.

DS Because there would still be that closer experience?

Brian No, not because of that, because I've always been able to, I don't know, I've always been able to relate and talk to women better. Maybe it is because there are more women in the bank or maybe I, there is some part of my psyche that translates, and it is not all rugby, beer, racing [client].

Charles But it took me a long time to convince them or the mental health services that I could not relate to female doctors in any way, shape or form and I would not talk about my sexuality with female doctors. [...] Lesbian, black, white, you name it. No matter what it was, I'm not going to do it [client].

Brian expressed a preference for matching but was clear he would prefer a lesbian than a gay man. He accounts for this using a discourse of gender. He does not identify with the heteronormative image commonly associated with men in New Zealand. He also does not assume that gay men necessarily differ from the male gender norm in this respect. In contrast, Charles also supported matching as a practice but was adamant he would not see a women doctor, whether she was lesbian or not. While I did not explore this preference further with him, gender was more significant for him than simply matching according to sexual orientation. The significance of a clinician's gender for many clients is one of the findings of the matching research cited earlier.

Another positioning which troubles matching by sexual orientation is that of ethnicity. Ironically while many speaking from a equal rights discourse construct 'gayness' as an ethnicity, for some MSM this is not the case:

Nathan If there was a Māori person on board I would see [them], but I know that I haven't experienced any Māori on board at [name of service]. There might in other areas. So if I hadn't seen that, I would just probably request someone who was gay if there was one [client].

Nathan identified as takatāpui and said he would choose a Māori clinician in preference to a gay Pākehā. This is consistent with literature showing that lesbians and gay men do not automatically privilege their sexual orientation over other discourses constructing their identity, such as ethnicity (Cutts, 1999; Eliason, 1996; Fukuyama & Ferguson, 2000; Hall, 1997; Hays, 2001; Manalansan, 1996).

Staff also identified differences between queer staff, and MSM clients, that might reduce the effectiveness of matching by sexual orientation:

DS So if, so you have this idea that lesbian and gay staff may have more experience to offer this particular client group?

Matt But not always because you know you get lesbians and gay men that are pretty rigid in their thinking as well and you get a lot of gay men who are pretty misogynistic and whatever [staff].

Philip But I wouldn't automatically get allocated to be with that person like that because there might be lots of other things going on in their life that I don't have much skill with, for instance, abuse. I don't have any skill in abuse areas so it would be better to be working – or he might have huge separation and attachment issues so he would be better to be working with one of the psychotherapists [staff].

Matt states that being lesbian or gay does not offer any guarantee that the clinician does not hold discriminatory views about other facets of a client's subjectivity. Here he is acknowledging that there is the potential for anyone to be exposed to the range of discourses circulating in society. So for example, a lesbian-feminist client matched with a gay male doctor who speaks from patriarchal and medical discourses would probably not be a good match. Then, Philip acknowledges that a client and clinician may share their sexual orientation, but this does not mean the clinician has the skills or knowledge that the client needs for their particular mental health issues.

Despite the different ways queer staff and MSM clients can be positioned in relation to multiple discourses, an important similarity they share is difficulties surrounding disclosure of sexual orientation. In Chapter Nine I showed that some MSM clients found disclosure of sexual orientation difficult, or impossible, within PMHS. Similarly, queer staff also struggled with disclosure. This difficulty and how it is constructed is a further barrier to matching.

'Objective' Clinicians Equals Invisible Queers

How might clients be harmed if they find out their mental health worker is 'straight'? When is it okay for clinicians to disclose their heterosexuality to clients? For example, should heterosexuals wear wedding rings to work and how should they reply if a client asks them if they are married? Should a pregnant social worker conceal the fact that her partner is a man? How should the registration board deal with a complaint from a family that a psychologist let slip that he was heterosexual before establishing that their child was certain about his own heterosexuality?

These questions are not generally debated in the literature on therapists' self-disclosure of their sexual orientation.⁷² They may even seem ludicrous to some readers. That is because the therapy world is constructed within the broader heteronormative context of our society. Within such a society heterosexuality is the norm and is public. The very notion of 'self-disclosure' constructs a public/private distinction in the therapeutic context:

Public – that which is known, that which is revealed – is the antithesis of private – that which is confidential and not to be made known publicly. The problem with private with respect to one's sexual orientation is that it is often accompanied by a multitude of negative feelings, memories, experience, and images (not the least of which is shame).

(Gabriel & Monaco, 1995, p. 161)

Heterosexuality is normally public and not usually associated with negative feelings such as shame. Unsurprisingly then, disclosure of heterosexuality in therapeutic contexts is not debated. Disclosing something already assumed to be public is unnecessary and does not cause concern. However, despite the rise of the equal rights discourse of homosexuality, heteronormativity continues to mark homosexuality as private in many aspects of society (Brickell, 2000; Lehring, 1997). Because of this, the issue of queer therapists, consciously or otherwise, disclosing their sexual orientation causes considerable debate. Therefore, this debate is not really about disclosure of sexual orientation per se, it is about disclosure of homosexuality (Gabriel & Monaco, 1995).

Mostly the debate over self-disclosure of homosexuality has occurred within the psychotherapeutic literature (Frommer, 1999; Gabriel & Monaco, 1995; Houston, 2000;

⁷² A few papers have been written about the effects of therapist disclosure of their heterosexuality (for a review see P. J. Taylor, 1992).

Meissner, 2002; Raines, 1996, 1997; Streaan, 1997; P. J. Taylor, 1992), and more recently in the broader field of mental health (Townsend, 2001) and in the area of general medical practice (J. E. Potter, 2002). Because of its psychotherapeutic heritage, nearly all the literature I refer to here discusses self-disclosure in the one-to-one therapy dyad. I could not find any research explicitly investigating self-disclosure of sexual orientation by staff in PMHS. Accordingly, in this section I explore this debate, show how it is discursively constructed, and how it is present in the current research. My aim is not to argue for or against clinicians disclosing their homosexuality; rather, I wish to illustrate why this is such a fraught and worrisome issue for clinicians, and clients, to negotiate, and the implications of this for matching.

As discussed earlier in this chapter, the queer staff were unanimous in asserting the importance of being out with their colleagues. They also experienced PMHS as supportive of them disclosing their sexual orientation to their colleagues. Yet the staff were almost as equally clear about the issue of whether to disclose their sexual orientation to clients. Generally they said they did not. This at first seems contradictory given that many of them espoused the likely benefits to an MSM client of working with a queer staff member. So how did they explain their reluctance to make themselves visible, and how did they negotiate invitations from clients to be public about their homosexuality?

Patrick I lean to less self-disclosure; that's my training. Because for me the time is for that young person and how they are able to use it. [staff].

This raises an often used clinical principle to consider who disclosure would serve; the client or the clinician? (Cerbone, 1991; Houston, 2000; P. J. Taylor, 1992). A related concept used in considering disclosure is that of clinical boundaries:

Matt Within my work, because I am gay I think I can perhaps be of more empathy with somebody who is, has a different sexual orientation from the norm so if they do present as being homosexual or bisexual then – but I never disclose my own sexuality because I feel it is irrelevant, and also because of my own professional boundaries with individuals [staff].

Beth I think they [other staff] respect me first, and foremost, as a clinician really so I think they would be knowing when I operate here that when I work with young people I'm working as a clinician, not as a lesbian disguised as a clinician, kind of thing [staff].

Despite thinking that his homosexuality may give him greater understanding for MSM clients, Matt draws on the medical, and psy, notion of professional boundaries to support

non-disclosure of his homosexuality. Beth also describes a boundary in her practice by explaining how she thinks her colleagues trust that she prioritises her clinician subjectivity at work, rather than being an ‘under-cover’ lesbian with an ulterior motive. The stance of all three clinicians (Patrick, Matt, and Beth), may be understood from both medical, and psy, constructions of them as ‘objective experts’ who should limit personal disclosure. But how could disclosure of homosexuality harm a clinician’s objectivity?

A common argument against disclosure of homosexuality is that disclosure damages the neutrality of the therapist and interrupts the therapeutic process (Strean, 1997). This position arises, in part, from a traditional psychoanalytic view where analysts are meant to present themselves as a ‘blank screen’ upon which clients can project their anxieties and fantasies (Frommer, 1999; Gabriel & Monaco, 1995; Raines, 1996; P. J. Taylor, 1992).⁷³ Exemplifying this view, Strean (1997) states that when clients ask about therapists’ sexual orientation “invariably they are masking doubts and anxiety about the therapist and the therapeutic process” (p. 365). Here the analyst is the objective clinician who ‘knows’ about clients’ anxieties and pathologies.

However, unspoken in the prescriptions against clinicians disclosing their sexual orientation, is that it is really an admonishment about self-disclosure of homosexuality, not of heterosexuality. For example, there is a long history of psychoanalytic training institutes requiring their candidates to be heterosexual (Drescher, 2002; M. Ellis, 1994; R. C. Friedman & Downey, 1998; Hale, 1995); thus the heterosexuality of analysts was public and already disclosed. Commenting on this context, Gabriel and Monaco (1995) state that “in fairness the heterosexuality of the therapist is not only assumed by the patient, but historically has been psychiatrically, professionally, and socially expected and sanctioned” (p. 166). Thus, in our society heterosexuality is largely uncontested and, thus, not controversial. Accordingly, it is also implicit within the subject position of the ‘neutral’, ‘objective’, clinician. Therefore, within the heteronormative medical, and psy, discourses, when a clinician discloses that they are homosexual they transgress the assumed, normative, objective, (and thus heterosexual), clinician and become not-heterosexual, subjective, and therefore, biased.

⁷³ For an extensive review of the psychoanalytic view on self disclosure, and some more recent variations to that, see Taylor (1992).

This bias associated with clinicians disclosing their sexual orientation is often seen to be detrimental to the therapeutic process. This was particularly the case for staff working in child and adolescent services:

Philip I think that because most of the young people I meet here who may be sexuality-questioning, are in the bracket of they may be, and it is not clear that they are, but they may be, but it is certainly not up front, and I think for me to come out to them would maybe muddy the waters when they are already pretty muddy.

DS In terms of making them feel a bit more pressure or something like that?

Philip Yeah, and also sometimes because of homophobia, some people, if I came out to people, or their families, would immediately make certain judgments about me which would get in the way of me forming an effective therapeutic alliance with them and that would be therapeutically counter-productive [staff].

Luke I think that, yeah, sometimes it might be that the client would be alright but the client might tell their parents and their parents might say, “Oh God we can’t have that”, so yeah I guess those are the issues [staff].

Philip talks about how disclosure of his homosexuality may “muddy the waters” for young clients who are uncertain about their sexual orientation. He reflects a wider concern amongst therapists that if clients know their therapist is homosexual they may find it harder to address negative thoughts and feelings about homosexuality, and, if questioning their own sexual orientation may also feel some pressure to adopt a lesbian or gay identity (Cabaj, 1996b; Houston, 2000). This concern may be heightened at a time when the equal rights discourse of homosexuality, with its emphasis on out, lesbian and gay identities, is in wide circulation.

A second concern of Philip’s is that if he disclosed to clients, then due to homonegative discourses, clients’ families might make disapproving evaluations about him that could then impair therapy. Similarly, Luke acknowledges that while a client might be accepting of his self-disclosure, her/his parents might be very disturbed by it. Here Luke shows his awareness of homonegative discourses, all of which mark homosexuals as less than ideal candidates to be working with children. In particular, these discourses construct a fear about homosexuals unduly influencing or ‘converting’ people, especially young people into homosexuals, something that the ‘objective’ heterosexual clinician is not assumed to do.

Clients are also aware of the objective clinician subject position constructed by the medical, and psy, discourses. This is evident in the ways some of them considered the possibility of clinicians disclosing their homosexuality:

John Actually I would have been a bit disappointed. I'd rather have someone from the outside community because it becomes too sort of, I think it might be, I'm not going to get the real feedback I want from someone who fully understands me.

DS What makes you think that you wouldn't get the real feedback.

John Oh you'd get real feedback but you'd get it from a gay person so.

DS So how would that make it different?

John Well they would probably be too understanding and they wouldn't give you the real advice that probably I really needed to know from someone from the outside community [client].

Here John says he would have been disillusioned if a clinician disclosed their homosexuality to him. He relates this to the idea that the clinician would not give objective feedback⁷⁴ because they would be overly empathic, and thus biased. He suggests that a clinician external to the LGB community (thus, heterosexual) would be more objective. Here homosexuality is marginalised in relation to the heterosexual norm through the medical, and psy, discourses. Thus, speaking from such a marginalised position can be labelled as biased. In contrast, how likely is it that a heterosexual client would feel a need to have a homosexual therapist in order to get objectivity? Differing from John's position regarding staff disclosing their homosexuality, there were a few times in the interviews where MSM clients acknowledged that their clinicians had disclosed their heterosexuality but this was never mentioned in a disapproving way. Within the heteronormative space of PMHS, clinicians' heterosexuality is not problematic; rather, it is assumed.

Coming Out as 'Dangerous'

In addition to concerns that disclosure of homosexuality might break professional boundaries, and harm therapeutic endeavours, clinicians and clients were also concerned about how it might expose queer staff to harm:

Ella The issues are sometimes quite tricky in this setting too because with some of the degree of mental illness that we see, I mean some of clients who we get are really psychotic and have really, really anti gay sentiments, and for a long time one of the reasons I wouldn't march in the Hero march⁷⁴ and things like

⁷⁴ The Hero parade was an annual queer community parade in Auckland.

that was because I had a client that was – I would have been placing myself at risk if he knew I was lesbian. And often there is with sort of some of the psychotic stuff allegations made of someone being inappropriate sexually with you, that come out of unwellness, and so like in the [name of programme] I might not want, if I have a lesbian client, I might not want her to know that I am a lesbian, or another client who might get psychotic and paranoid and make allegations that I have been inappropriate [staff].

Ella acknowledges possible dangers in coming out to clients. First, through the idea that clients who experience psychosis and who have anti-gay thoughts, may pose a physical threat to her. This concern relies on Ella's knowledge of homonegative discourses, and on the occurrence of anti-gay violence, commonly referred to as 'gay bashings'. It also draws on the notion, often portrayed in the media, of 'mental patients' being dangerous.

While the possibility of anti-gay attacks is real, it is worth noting that most people who commit anti-gay violence are not psychotic, or diagnosed with any mental illness, when they do so. Rather they are commonly men who are enforcing dominant forms of masculinity (Herdt & Van der Meer, 2003; Tomsen, 2002). Often the people who commit these crimes are referred to as suffering from homophobia (a psy term). But homophobia is not a currently diagnosable disorder and, (as discussed previously), the term itself has been critiqued for turning anti-gay practices into individual pathologies, thus hiding their origins in heteronormative oppressive social structures (Adam, 1998; Kitzinger, 1996; Kitzinger & Perkins, 1993).

A second concern Ella raises is that by coming out to clients she would expose herself to accusations of being sexually inappropriate. We can wonder why knowledge that a clinician is homosexual might be understood to increase their risk of such an accusation. We might be especially curious about this given that the history of professional sexual abuse within the mental health professions appears to be predominately one of heterosexual men abusing women clients (Berland & Guskin, 1994; Ehlert, 2003; Hankins, Vera, Barnard, & Herkov, 1994; Pope, 1990; Quadrio, 1996). One explanation is that homonegative discourses construct homosexual identities as focused primarily on sexuality, and homosexuals as sexual predators (Herek, 1991). Thus, people often equate homosexuality with sexual acts and sexual aggressiveness. This association also relates to the concern discussed earlier where clinicians worry that by initiating conversations about homosexuality, they might be seen as trying to convert young people into homosexuals. Often people speaking from conservative, and Christian supremacist, discourses of homosexuality claim that homosexuals aim to 'convert' children to homosexuality.

Also drawing on homonegative discourses, Matt raises the notion that if a client discovers that he is homosexual this would leave him exposed:

Matt There is no way that – I don't want them to know anything about me. So I would talk very openly about their sexuality and be supportive, but about my own, I just always put my professional boundary there and I am just not prepared to kind of open up because I don't want to be manipulated and I don't want them to find areas where they might be able to kind of try and manipulate me [staff].

This account relies on homosexuality being something negative, something that can be used against people.

In contrast MSM clients had much more mixed views on staff disclosure of homosexuality. Many of them thought it would have been very supportive of them for similar reasons to how they thought matching could be useful. But some of them also considered that disclosure could be risky for staff:

Jim One or two of the male staff that were there that I knew were gay, gaydar comes and goes, but they weren't [supportive] because they knew I was and they didn't want to jeopardise themselves. That's what I felt [client].

Daniel I think it would be good of them [staff] to come out but you have to be so careful ... They need to, yeah, think about themselves and just how it is going to affect this person. If they are really feeling that this person is going to accept it, and, then go ahead [client].

Jim reflects on his time in an inpatient unit. He reasons that some male staff who he thought were gay, were less supportive of him because they did not want to make themselves vulnerable by having their homosexuality made visible through association with him. Daniel voices a similar concern when he says that while he thinks it can be useful for staff to disclose their homosexuality they also need to be careful of this because of how clients might respond to them.

Due to the ongoing circulation of various homonegative discourses, and the fears they produce for clinicians, disclosure of their homosexuality also raises the possibility of professional censure. Below Beth reflects on how she decides whether to disclose her homosexuality to clients:

Beth Gut. Is this going to benefit this young person in knowing that bit of information? Am I doing this for them or am I doing it for me. If the shit hits the fan, am I able to stand before the Board and justify why I did it and actually sound reasonably kosher. But I think by and large it comes to a point where I feel that it would be useful to do so [staff].

Here Beth is uncertain about how supportive her professional body would be of her disclosing her homosexuality. Yet, it is hard to imagine a clinician having to defend a client's knowledge of their heterosexuality to a professional body. While clinicians are clear about the multiple problems with disclosing their homosexuality, other discursive practices also make the process of non-disclosure problematic.

Neither Confirm Nor Deny

Most, if not all homosexuals, including queer mental health staff, have had some experience of concealing their sexuality and the often uncomfortable feelings that accompany such a need to hide it. In response to this the liberation and the equal rights discourses of homosexuality, have encouraged 'out and proud' lesbian and gay identities. This desire to be visible is also supported by psy discourses premised on the notion of relatively stable, coherent identities and the need to be 'true to oneself'. As discussed earlier in this chapter, all the queer staff used these discourses to negotiate their relationships with their colleagues. Knowing this, it is unsurprising that while generally not disclosing their homosexuality to clients, they wanted to find a way to do it that did not compromise their homosexual identities or their integrity:

Luke I think I probably would have, like I think I would have done something quite avoidant I think, I would have probably said, "Why is it that you want to know?". Or just, "Does that worry you?. Would it worry you that I'm gay?" I wouldn't want to confirm or deny. I certainly wouldn't deny it. [...] I think it is just integrity, I think for my own personal integrity I'm not going to lie about who I am. Just like I wouldn't lie about having [name of country] parents. I'm sort of proud of that and I wouldn't lie about that and I think it probably comes down to integrity [staff].

Philip It's an internal thing isn't it? Well for me it is an internal thing about remaining true to myself [staff].

Luke describes a 'neither confirm nor deny' strategy regarding his homosexuality if asked by a client. He also calls on the psy notion of "integrity" to explain his position. Similarly, Philip's desire to be "true" to himself, is another example of a strong discomfort queer staff imagine experiencing if they felt required to not only hide their homosexuality, but to deny it. Thus, the 'neither confirm nor deny' strategy can be understood as an attempt to balance their allegiance to medical, and psy, discourses which construct them as objective experts (and thus, non-disclosing queers), while maintaining their allegiance to their 'true' gay identities as constructed within psy, and equal rights, discourses. Yet, this strategy

works to invisibilise homosexuality, and reinforce heteronormativity, and is similar to the conservative, ‘don’t ask, don’t tell policy’ used by the United States military to preserve the public/private split between heterosexuality and homosexuality (see Chapter Four).

The most common therapeutic strategy the staff described for dealing with client requests about their sexual orientation is to reflect the curiosity back:

Patrick If they [clients] are curious about you, well then it is important to reflect their curiosity [staff].

This tactic involves asking the client questions such as why it is important for them to know this information, and what they think knowing would mean to them. This strategy is the traditional psychodynamic one and is theorised as enabling clients to explore their own views on homosexuality (Stearn, 1997). Yet this strategy is not without complications:

Edward If you fudge that’s, you know, you might as well say, “yes”. [laughter] And it would be totally against my core beliefs of being hypocritical you know [...] But again, you know, if you fudge or go neutral then you are answering the question. And if there was a client who I thought it would be detrimental to give that personal information I think, and I have sort of done this in the past but in other things I’ve turned it round and challenged back.

DS How would you do that?

Edward “Why?”

DS “Why do you want to know?”

Edward Yeah. And you just go off and start another conversation and, hopefully, by the time you get to the end they’ve forgotten the question (laughs) [staff].

Edward comments that avoiding disclosing, by reflecting back the question to the client, can be read by clients as saying, “yes, I am gay”. This raises the notion that regardless of what clinicians explicitly state to clients they cannot control how clients will read their behaviour. Similarly, Luke (staff) talks about how he thinks his strategies for concealing his homosexuality are interpreted by, and affect, his relationships with clients:

Luke I guess I am an open person, so it sort of goes at odds with how my personality is normally. Probably if I was straight they would have known a little bit more about me and I think probably in some ways I think it [concealing homosexuality] is quite helpful actually because it does enable a bit more distance for me between the clients but sometimes I think they are probably less likely to come to me when they are stressed and they might go to someone they feel they know a bit better [staff].

Luke comments that his hiding of his homosexuality contradicts his usual openness. Consequently, he imagines that his clients experience him as more restrained than his ‘straight’ colleagues, and, therefore, might be less likely to ask him for support. Thus, the

practice of non-disclosure of homosexuality, in an attempt to prevent some feared consequences, can produce other, often unpredictable, outcomes. As Raines comments, “all of us reveal ourselves both through the questions we ask and the interpretations we provide. We ‘disclose’ more than we can ever imagine” (1997, p. 368). While agreeing with Raines, I would emphasise that the things we do not say, and do not ask, can also be revealing of us. And, as argued in Chapter Nine, the silence surrounding homosexuality in PMHS is interpreted as homonegative by many MSM clients.⁷⁵

Related to the idea that we can never successfully be a totally ‘blank screen’, some argue that when clinicians refuse to disclose their homosexuality, it can reinforce for clients the injunction of homonegative discourses to hide homosexuality (Gabriel & Monaco, 1995; Raines, 1997), and can lead to clinicians feeling guilty about this (Frommer, 1999). Furthermore, the assumption that clients’ curiosity about clinicians’ homosexuality always reflects client’s pathologies, fails to acknowledge the history of the mental health professions and homosexuals. Many mental health professionals have practiced, and continue to practice in homonegative ways. Accordingly, clients’ question about clinicians’ sexual orientation may reflect not their pathology but the social context of mental health practice. Supporting this interpretation of clients asking about clinicians’ sexuality, the mental health user movement, and the psy, and critical, discourses of mental health, offer clients an active role in their treatment. In this vein, Raines states:

I have found that many clients have tried various other means of getting help before coming to treatment and many of these (both books and persons) suggest asking the prospective therapist some pertinent questions. They come as educated consumers and should be respected as such.

(Raines, 1997, p. 367)

When Is It Safe To Come Out?

Notwithstanding the discursive limitations to queer staff disclosing their queerness to clients, there are some situations in which the staff said they might divulge their sexual orientation. As argued earlier, within psy, and critical, discourses of mental health, clients

⁷⁵ Given these issues, I wish to acknowledge my own current practice in this area. If asked about my sexual orientation by clients, I usually engage them in a discussion of how they consider my sexual orientation may be of significance to them. Yet I preface these discussions with the statement that, following the discussion, I am happy to tell them if they still wish to know. I do this to work against the operation of heteronormativity in my practice.

are seen as active, collaborative partners. This has implications for the visibility of the sexual orientation of both clinicians, and clients, in PMHS:

Ray I don't think it [matching] is done deliberately. Sometimes if triage picks up that there are issues around it [sexual orientation] or if the client, after an initial assessment, voices that there are issues then we try to do realignment [staff].

Simon If it's a client who is quite sure of their sexuality in terms of being gay, or bisexual, or queer, and so on, I, by and large would let them know that I was queer too. As I said, people who weren't sure I would be perhaps a little cautious about doing that and not spook them [staff].

Both Ray and Simon state that they are more likely to come out to MSM clients if they are aware that the client is also queer or if clients assert that issues regarding sexual orientation are important to them. This practice of disclosure was also raised by staff in Chapter Eight. Given the multiple restraints on the disclosure of homosexuality for the 'objective' expert of the medical, and psy, discourses, clients' assertions of queer issues seems to make staff feel safer about making their queerness visible, as the perceived risks to themselves, and to clients, are considered to be less in these situations.

However, these strategies for enabling queer clinicians' visibility in PMHS require queer clients to assertively declare that sexuality is an issue for them, or to be certain of their sexuality and to make that clear. This positions clients as active and agentic, in line with the psy, and critical, discourses of mental health. Yet, this was frequently not how MSM clients felt positioned within PMHS. Furthermore, (and as explored in Chapters Seven and Nine), 'sureness' in regard to their sexual orientation, (as required by Simon), was not something some MSM experienced.

Summary: Private Queers and Public Fears - Far From a Perfect Match

I have claimed that there are many barriers to the minoritising approach of matching by sexual orientation as a strategy for improving PMHS for MSM. Matching advocates the harnessing of similarities between queer staff and clients but fails to acknowledge differences between these two groups. In particular, matching does not acknowledge the way queer staff and clients may be positioned discursively in quite different ways within PMHS, and within their respective worlds. Second, for matching to work it requires that

MSM clients and queer staff are visible to each other. Complicating this, in Chapters Eight and Nine I showed how MSM are often made invisible within PMHS. Similarly, in this chapter I have argued that heteronormative discursive practices also work to make queer staff invisible to clients. If matching is so problematic, why does it appear in the literature and why was it supported as an idea by both MSM clients and queer staff?

Matching arises from an identity politics of the equal rights discourse. This emphasises sameness between homosexuals. Without doubt, this discourse has produced many political advances for lesbian and gay people, and is currently an influential discourse of homosexuality. Furthermore, (as discussed in Chapter One), most of the matching literature comes from the United States where the predominant context for research on mental health services is private psychotherapy. In this context, clients generally have greater choice over which therapist they see. When clients choose to see a queer therapist, they are choosing to make the most of what matching has to offer, but from a position of choice.

However, PMHS are in the public sphere and, on a practical level, clients are much less likely to have any choice over their mental health worker(s) and whether they can access psychotherapy. Further, New Zealand is a heteronormative society which marks homosexuality as private, not public. Within PMHS this relegation of homosexuality to the private sphere is maintained by homonegative discourses, and by medical, and psy, discourses of mental health, through their heteronormative notion of the 'objective clinician'. Thus, the homosexuality of staff and clients is more likely to be silenced. In this context of silence, and the invisibility it invites, matching does offer at least partial resistance as it enables queer people (clients and staff) to speak to each other about homosexuality. Yet heteronormative practices within PMHS also provide a significant restraint to such matching.

One possible solution to these restraints to matching in PMHS would be to structurally make available queer staff to queer clients. But, there are significant problems with this proposal (notwithstanding the implementation of a system to make queer staff available across teams and services). First, the differences between homosexual clients and staff discussed in the first half of this chapter would still exist. So matching might occur at the level of sexual orientation, but this may not necessarily help the client. Second, implementing matching would require a method for offering this service to queer clients.

But this returns us to the situation of identifying who these clients might be in the first place. In Chapters Eight and Nine, I have shown that current practices do not enable this. One solution to this problem would be to offer this matching to all clients. This strategy has been tried in alcohol and drug services in New Zealand (Semp & Madgeskind, 2000). It is an option which begins to move us from marginalising strategies, concerning mainly queer clients and staff, to more universalising ones where all clients and all staff are implicated. In the next chapter I consider strategies for change within a more universalising perspective.

Chapter Eleven:

'Out There but 'Not In Your Face' Questioning Heterosexuality in PMHS

Thus far I have argued that PMHS are a cultural site in which the heteronormativity of the medical, and psy, discourses of mental health, along with homonegative discourses of homosexuality, can compel clinicians and clients into silence surrounding homosexuality. Furthermore, I have claimed that these discourses can silence queer-affirmative staff, not just staff with 'homophobic' attitudes that much 'diversity training' has targeted. This chapter considers how to break the silence surrounding homosexuality in PMHS, and make PMHS more queer-affirmative.

The previous chapter explored the often suggested identity-based strategy of matching lesbian and gay staff and clients. I argued that matching can be conceptualised as a minoritising strategy because it views homosexuality as relevant only to a minority of staff and clients. I contended that this strategy, while useful for some, is limited in various ways. Matching relies on the equal rights discourse of homosexuality with its assumptions of similarities in experience and identity among homosexuals. Yet this theorising evades many important differences between queer staff and clients. Matching also relies on identifying those to be matched (i.e. queer staff and clients), but the heteronormative discursive practices operating in PMHS, (and described in the last three chapters), make this identification highly problematic. Instead, these practices operate to generally maintain the assumed heterosexuality of staff and clients, and to marginalise homosexuality. In an attempt to try and move beyond a minoritising view, in this chapter I consider universalising strategies for improving PMHS for MSM.

Questioning Heterosexuality

From a universalising perspective, the practice of “forms of social exclusion and discrimination of the ‘sexual other’ are sites at which heterosexual identities are reproduced and maintained” (Richardson, 2004, p. 402). From this perspective, the discursive strategies

identified thus far, which encourage silence about homosexuality in PMHS are not simply an omission of homosexuality but a reproduction of the heterosexual norm. Yet the normative status of heterosexuality remains “invisible as an organizing principle of social organization and personal identity” (Richardson, 2004, p. 402). Therefore, even without formal pathologising in the DSM, the heteronormativity of the medical and psy discourses of mental health, and the ongoing circulation of homonegative discourses, construct homosexuality as the marginalised ‘sexual other’ within PMHS. Accordingly, universalising strategies for improving PMHS for MSM need to deconstruct practices which assume heterosexuality and render homosexuality the silent sexual other.

In this chapter I explore universalising approaches to breaking the silence surrounding homosexuality in PMHS. These strategies are concerned with making the context of PMHS one in which MSM clients are more likely to speak about their sexuality, and homonegative trauma, if it is important to their recovery from mental health problems. Yet, these strategies do not rely on assuming that homosexuality and homonegativity is only of significance to a minority of staff or clients. Universalising strategies concern all staff and clients as all operate within heteronormative discourses which construct heterosexuality as normative and homosexuality as marginal. Accordingly, any client might experience same-sex attraction, have been negatively affected by homonegative trauma, and/or see issues of sexuality as important to understanding their life, or their mental health problems.

However, in exploring universalising strategies, I do not propose a good/bad dichotomy between universalising and minoritising approaches. I agree with Sedgwick (1990), and others (Chambers, 2002; Nairn & Smith, 2003), who argue that the marginalising/universalising dichotomy is a useful analytical tool, but need not represent mutually exclusive approaches. Rather, I contend that it is important to use both approaches strategically and ethically to support queer-affirmative goals.

First, I will introduce some common strategies suggested in the literature on improving mental health services for queer people. These strategies focus mainly on improving mainstream services for queer people by making the physical environment of PMHS queer-affirmative, and providing training for staff in LGBT issues. I explore how the MSM clients, and queer staff, interviewed, viewed these suggestions. Next, I consider the possibility of including sexuality in all assessments. Within each section I consider barriers to effecting these strategies within PMHS.

Mainstreaming Homosexuality

Before discussing universalising approaches it is necessary to consider the MSM clients' views on a further minoritising strategy for improving PMHS. This is the idea of providing separate, and/or specialist, mental health services for queer clients, and is frequently suggested in the literature. For example:

The dominant cultural group in the clinic, as defined by heterosexual identity, was not aware that LGBT patients participated in relation to it. The groups coexisted within the CMHC, but the LGBT proto-community had no "space" of its own. There were no LGBT activities, no LGBT signifiers, no LGBT groups and, therefore, no opportunity for LGBT people with mental disabilities to nurture a cultural identity as members of a sexual minority community within the mental health service environment.

(Hellman & Klein, 2004, p. 71)

This excerpt is from a report on establishing a programme for LGBT clients within a CMHC in the United States (Hellman & Klein, 2004). It displays the use of the equal rights discourse to account for what is missing in mental health services for LGBT. As discussed in Chapter Four, the equal rights discourse constructs homosexuals as an almost 'ethnic like' group. Accordingly, Hellman and Klein (2004) conceptualise LGBT clients as a community needing to develop their minority cultural identity within a politics of sameness.

Previously, I noted that the ethnic aspect of the equal rights discourse of homosexuality is in wide circulation in the United States (Lehring, 1997; Seidman, 1993). Within this line of reasoning it is perhaps not surprising that in the recent and first United States handbook on LGBT issues in community mental health (Hellman & Drescher, 2004), all the programmes described are either stand-alone LGBT-specific programmes added on to mainstream PMHS, or completely stand-alone LGBT services. There are no accounts in the handbook of programmes which integrate care for LGBT clients within existing mainstream PMHS. It is likely that another reason for the lack of mainstreaming in the United States is the ongoing circulation of homonegative discourses, particularly in vocal and politically powerful groups such as the right wing Christian lobby, and the current federal government.

In the United Kingdom over the last 20 years, the political position of homosexuality has also been fiercely contested. In 1988 the conservative government passed Section 28 which prohibited local authorities from promoting positive views on homosexuality. The law was not repealed until November 2003. Also, lesbians and gay men did not achieve an equal age

of consent for sexual activity until 2000. Given this political context, and similarly to the United States, it is not surprising that there continues to be a call for separate PMHS for queer people in the United Kingdom:

Service providers should consider providing a separate 'safe' space in order to enable lesbian, gay and bisexual service users to meet together for mutual support.

(Golding, 1997, p. 20)

Resources to be made available to allow the development of specialist LGB services in those areas identified by the research.

Training, information provision, advocacy and 'watchdog.'

Crisis services, particularly crisis housing as well as longer term housing.

Counselling and therapy.

LGB MH service user groups

(McFarlane, 1998, p. 123)

In New Zealand, the status of homosexuality is still debated publicly; however, significant legal gains for queer people are comparatively well established. New Zealand achieved an equal age of consent for sexual acts in 1986, and sexual orientation was added to anti-discrimination law via the Human Rights Amendment Act in 1993. In this sociopolitical context, all the MSM clients asked about the issue of separate services were adamant that they wanted to receive their mental health care within mainstream PMHS:⁷⁶

Jim You see once you start separating things you start getting into an apartheid type situation where if you go there, "Oh you're gay are you", you know. I don't want that. I want us to be, we are sick, we are New Zealanders and we go [to mainstream PMHS] [client].

Pete No. I don't like being marginalised or compartmentalised. I see myself as a human being first. If I limited my horizons like that, I mean, you know, a lot of American gay philosophers have pointed out that the ghetto was just a bigger closet [client].

Brian Because you are disassociating yourself from the mainstream. I mean you've had these people demanding rights, or all of us have been demanding rights and you've gone through a referendum and everything, why split them? It has got to be - if they want gay people to be accepted in the community they've got to basically be in the community area [client].

⁷⁶ I asked eight of the men about this issue. Of those eight, all said that they would prefer it if mainstream services were able to meet the needs of MSM clients. One said he thought both should be available.

Here I have included a number of examples as they illustrate the intensity with which many of the MSM clients spoke against the idea of separate LGBT mental health services. Separate services, for them, conjured up notions of being separated from the broader community. The language used by the MSM is consistent with a discourse of human rights, and of the equal rights discourse of homosexuality. New Zealand has a long history of involvement in human rights issues. For example, in the 1980s there were massive nation-wide protests regarding a tour by the South African rugby team to New Zealand. Along with the circulation of a strong discourse of equality (Brickell, 2001), apartheid was considered anathema to many New Zealanders. Accordingly 'equality' was a powerful discourse deployed during the campaign for homosexual law reform (Guy, 2002) and the more recent 'Civil Union Bill' (C. Young, 2003). Furthermore, it is worth noting that these locally-situated ways of taking up the equal rights discourse work against the potentially ghettoising tendencies of the ethnic identity aspect of the discourse (see Chapter Four). Brian encapsulates this when he argues that equal rights means becoming part of the mainstream, not being split off into separate groups.

In addition to articulating the disadvantages of separate services, some of the men also spoke about the benefits of mainstreaming:

Rick No. I don't think so. I think it should be, they shouldn't have to be separate because I think everyone should learn to be accepting, you know what I mean. Because then in separating it is like the people who are not part of this whatever gay mental health service, they will think, 'right we don't even need to bother about it' [client].

Mark I think it's [separate services] wrong. I think that integration is the most important thing. And people should be made to feel at home no matter where they are, and that they can mix with people [client].

The arguments made by these men are examples of combining both marginalising and universalising approaches. Here, the minoritising idea is that a minority group, such as LGBT, should have equal rights. Yet the universalising approach is the idea that mainstream (universal) PMHS, and all clinicians within them, should be able to meet the needs of LGBT. This is similar to the strategy described by Nairn and Smith (2003) where they argue that a liberal, rights-based approach, can be utilised to argue for all New Zealand schools to take responsibility for making themselves safe places for LGBT students. This strategy in turn, requires making schools, and in the case of the current research, making

PMHS, spaces where homosexuality can safely be present. In the next section I consider suggestions as to how to make the space of PMHS more queer-affirmative.

Advancing Homosexuality

The few studies that I could locate on systemic issues in mental health services for queer people do offer general directions for improving mainstream services. To recap (from Chapter One), common suggestions include:

- Making the physical environment queer affirmative by including LGBT in posters, pamphlets, and forms (Golding, 1997; McFarlane, 1998).
- That LGBT should not be pathologised or ignored (Golding, 1997; King et al., 2003a; McFarlane, 1998).
- That LGBT should be supported to explore their sexual orientation (McFarlane, 1998).
- That staff should be aware of LGBT issues (Golding, 1997; King et al., 2003a; McFarlane, 1998).
- That staff should be aware of how to respond appropriately to LGB people (King et al., 2003a).

Yet, as argued in Chapter One, these recommendations do not aid staff in how to do these things, or consider what might hinder them in their attempts to provide appropriate services to LGBT. In the previous three chapters I have argued that this is a central issue to address if the silencing of MSM clients in PMHS is to be broken.

First, I consider the strategy of making the physical setting of PMHS more queer-affirmative:

Service providers should ensure that their premises are lesbian, gay and bisexual 'friendly'. The existence of same-sex relationships should be acknowledged in all areas, particularly information resources and posters/images on display in the premises.

(Golding, 1997, p. 25)

Positive images of LGBs should be on display in all parts of the service. These should reflect the diversity within LGB communities. ... LGB literature and information needs to be visible. ... Any advertising of services should make reference to lesbian, gay and bisexual service users.

(McFarlane, 1998, p. 122)

This approach can be seen as a universalising strategy in that it potentially at least, makes the topic of homosexuality visible and present to all staff and clients. It does this by bringing homosexuality from the sphere of the private into the public; the idea being that it helps create an environment where queer clients are more likely to feel welcome, and more likely to disclose their sexual orientation. Some of the staff and clients interviewed had opinions about this possibility:

Ella I think it is a tricky one but I think that something on a brochure that talks about the services, that says if you have specific needs in regards to requesting a gay and lesbian therapist key worker, that they can be considered [staff].

Mark I think there should be some sort of advocate available to the [inpatient psychiatric] ward. I think that somebody with some psychological training, not necessarily a psychologist but somebody who has some academic background and understanding of life, or a very good social worker, who is homosexual, should be an advocate attached. You know, like all the big pink things up saying you could ring this person and if you are attracted to men and you require an advocate, ring this person [client].

Ella and Mark suggest that brochures could be a way to make clear that there are lesbian and gay staff available for LGBT clients. This combines the universalising strategy of brochures for all clients, with the marginalising strategy of offering matching based on sexual orientation. It is worth noting that this strategy still relies on clients taking up the active client subject of the psy and critical discourses of mental health through first noticing the brochures, and then seeking out and requesting the ‘matching’ being offered. Some MSM also spoke in ways suggesting that the strategy of ‘queering the setting’ could work:

Rick Yeah. So that’s why – when I saw your brochure I was like ‘wow’, it was so ‘out there’ you know what I mean, because no-one had even really talked about how it might be an issue or, and I thought ‘yeah’, I began to think how it really was.

DS So it sounds like you were quite surprised to see the brochure.

Rick Yeah. I was like ‘wow they actually stuck it up there’. That was my attitude [client].

Rick reported that seeing the brochure for this research was both a surprise and useful. It helped him reflect on how his sexual orientation might be implicated in his mental health problem. He reported having seen nine psychiatrists, none of whom had enquired about his sexuality. Yet the research brochure gave him permission to speak about his sexuality, (at least to me as a researcher), and to consider its relevance to his mental health.

Similarly, Daniel had earlier discussed a very disappointing contact with PMHS (see Chapter Nine). He subsequently saw a heterosexual woman therapist at a specialist lesbian and gay counselling agency and found her extremely useful:

- DS Okay. And yet it [matching] hasn't been important for you.
- Daniel I knew it was a gay-friendly environment to go in there. So it's not, yeah, as long as it is gay people or people, that they know that can
- DS So how did you know it was a gay-friendly environment?
- Daniel My GP told me [client].

Despite earlier proclaiming the importance of matching client and therapist for sexual orientation (see Chapter Ten), Daniel said this did not matter in the specialist agency as his general practitioner had told him it was gay-affirmative. This example suggests that a queer-affirmative environment, regardless of the sexual orientation of the clinicians, can also achieve the safety and trust assumed to be one of the key benefits of matching.

However, both staff, and clients, saw limitations with the strategy of using posters and brochures to invite queer clients to speak about their sexuality:

- Luke I noticed that here already, in your room, that these are sorts of things that can alert a gay person, like posters about being gay or straight, and they automatically make people feel that they are in an environment that will accept [them] -
- DS That's my intention
- Luke Yeah, and I think that is a sort of thing, like in our reception I don't know if we still have Rainbow Youth pamphlets but we used to and I think that someone who is gay or lesbian and is not feeling well supported, they will pick up those sorts of things and will see them and I think those sorts of things are really useful. But in saying that I think that I wouldn't want to see every community mental health service plastered with these posters because I think that the environment has to reflect that sort of message, so I think that if you were sort of incongruent really.
- DS That there were posters out there but staff didn't really know how to talk about those issues it would actually be inviting people to reveal in an unsafe kind of environment?
- Luke Yeah I think it would make it worse [staff].

Luke begins by commenting on the queer-affirmative posters I have on the wall in my office where we had our interview. These posters were not put up specifically for the interviews. I put them on the wall of my office years ago to help create a queer-affirmative environment. He then voices a concern that inviting MSM clients to speak about their sexuality is not necessarily a good thing if staff do not know how to have these conversations once they arise. In Chapters Eight and Nine there is some evidence that these conversations are not easy for staff to initiate. Further, in Chapter Nine the MSM clients reported very mixed responses from staff to their disclosures.

Another limitation of posters and brochures concerns whether they are seen, and how they might be read by clients:

- DS I was interested too, you said that you don't think posters and brochures is the answer and I wondered what made you think that wouldn't be useful?
- Pete It strikes me as too superficial. I mean people may read - some are illiterate, they may see a poster if they are in the right place. But I mean
- DS They may miss it completely.
- Pete They miss it completely, and then they reject it, you know. They may be closeted in a way that they think 'its not me' but it really is them, and that is why I think the GP or something like that would be helpful.
- DS A personal approach?
- Pete Yeah, and more effective too [client].

Pete comments on a number of problems with posters and brochures. An assumption with this environmental strategy is that people will read and identify the resources as relevant to them, or not. Furthermore, they would be required to do this in a public setting such as a waiting room. Yet, the heteronormativity of public spaces, and the multiple and ambivalent identifications people have, may work against this. Another possibility not raised in the interviews is that posters, (simply by being put up in PMHS), could reinforce the pathologising discourse and the idea that homosexuality is a sickness or contributes towards mental health problems. Alternatively, Pete's last recommendation of a more direct approach by a health worker that the client knows, such as their general practitioner moves us towards another universalising strategy for making PMHS more queer-affirmative. This strategy involves staff initiating conversations with all clients about sexual orientation.

‘Out There’ but ‘Not in Your Face’: Staff Initiating Conversations about Sexuality

Only one of the 13 MSM clients interviewed could recall an instance where a clinician had initiated a conversation about sexual orientation (see Chapter Nine). In this section I explore the possibility of all staff inviting conversations with all clients about sexual orientation. This strategy has the potential to break the silencing of homosexuality in PMHS, and to help identify when issues of homonegative trauma are relevant for a client’s recovery. Additionally, it does not rely on the provision of specialist staff, or on MSM clients taking up the active positions of the psy and critical discourses of mental health. This seems important given that some MSM clients find themselves unable to take up the assertive psy, and critical, client subject positions (see Chapter Nine).

While the heteronormativity of mental health services is widely acknowledged (see Chapter One), very little has been written about the need for clinicians to inquire about issues of sexual orientation, or how they might conduct such an assessment. A notable exception is that of Hellman (1996) who reflects on psychiatric inpatient practice with lesbians and gay men. He contends that “the presence of chronic mental illness in someone who is homosexual may modify [and increase] known risks for morbidity and mortality” (Hellman, 1996, p. 1093). Furthermore, Hellman (1996) argues that the common lack of acknowledgment of sexual orientation in psychiatric settings can reinforce any social marginalisation that homosexual clients may already have experienced. Also, by highlighting higher prevalence rates for some mental health problems for homosexual people, Hellman makes a case for the more frequent assessment of sexual orientation and homonegative trauma. He acknowledges that the focus of inpatient admissions is the stabilisation of crises, but states:

Nonetheless it is essential to consider issues of sexual orientation among persons who have been admitted for suicide attempts, among victims of physical and emotional abuse, and among those experiencing drug abuse crises. ... During the hospital stay, the clinician should assess and share any concern that sexual orientation may be related to hospitalization.

(Hellman, 1996, p. 1095)

Following this recommendation, Hellman (1996) offers an extensive range of areas to cover in such an assessment. These include:

Qualitative evaluation of reported homosexual activities ... to determine if such activities reflect a sexual orientation, a decompensated state (such as manic

hypersexuality, delusions, or command hallucinations), undifferentiated object relations, or limited availability of partners. ... ask about sexual partners, if any, and whether the patient self-identifies as homosexual, heterosexual, or bisexual. The clinician should assess whether the patient is confused about his or her sexual identity and ... determine the extent of congruity among sexual identity, behaviour, sexual fantasy and romantic attachments. The clinician should inquire about [the patient's] discomfort with the larger heterosexual culture. Any affiliation with the gay and lesbian community should also be assessed.

(Hellman, 1996, pp. 1095-1096)

This would require a huge shift from clinicians' current practice of generally not asking about sexual orientation at all. One concern I have about Hellman's instructions is the suggestion that clinicians try and assess if the client is 'really' homosexual, or if their homosexual behaviour represents one or another form of pathological state. This represents a heteronormative, and pathological, construction of homosexuality where any homosexual behaviour needs to be explained and accounted for. In contrast I cannot imagine Hellman would recommend that clinicians routinely make the same assessment of clients' reported heterosexual behaviour. A second concern is how Hellman's recommendations ask staff to focus on homosexual behaviour, sexual identities, and congruence between these things. These suggestions are likely constructed within equal rights and psy discourses which posit a healthy homosexual as one who has a congruent and 'out' homosexual identity. However, this focus on behaviour, identity, and congruence, evades exploring the multiple meanings a person may make about their same-sex sexuality. This is at odds with the diversity of ways the MSM spoke of their sexual orientation in Chapter Seven.

Yet another question about Hellman's quote regards his suggestion that clinicians assess clients' "discomfort with the larger heterosexual culture" (1996, p. 1095). Little explanation is given as to what Hellman means by this. However, given that heteronormativity constructs homosexuality as discomfoting to society, it seems peculiar to phrase the question this way. Perhaps it would be more useful for clinicians to enquire about how clients have experienced the larger heterosexual society's discomfort with, and treating of, them, and their same-sex attraction.

A further limitation of Hellman's (1996) account of assessment of sexual orientation and homonegative trauma is the limited attention to process. The only comment Hellman makes about the process of such questioning is, "Patients may be reluctant to proceed along such avenues of inquiry, but a firm message that conveys the importance and

potential benefits of such information facilitates the treatment planning process” (Hellman, 1996, p. 1095). The use of the term “patient” and the requirement for clinicians to give a “firm message” to patients, suggests that Hellman is speaking from the medical discourse at this point. In this discourse the clinician’s role is to tell patients what is best for them; the patient in return, is expected to comply.

Notwithstanding my concerns about many of Hellman’s suggestions, some of the areas he recommends for assessment could be fruitful:

The clinician should also determine the extent to which sexual orientation has been a source of conflict in family relationships, friendships, past treatment programs and other personal endeavours, and whether stressful homosexual issues correlate with the development of psychiatric symptoms or substance abuse. The extent to which the patient has been the victim of antihomosexual remarks or violence should also be examined.

(Hellman, 1996, pp. 1095-1096)

These suggestions relate to issues the MSM clients raised in my interviews with them, and to the assessment of what I have earlier termed homonegative trauma. They show the deployment of psy and critical approaches to mental health in accounting for the psychological consequences of homonegative discourses circulating within society.

Returning to the broader research literature on PMHS and queer clients, little is said about how to assess issues regarding sexual orientation. However, the training of staff in LGBT issues is often recommended (Golding, 1997; King et al., 2003a; McFarlane, 1998). The few suggestions I found on the content of such trainings do not appear to address the issue of staff initiating conversations about sexuality. The closest I could locate were references to using non-heterosexist or inclusive language:

Staff should refrain from asking heterosexually biased questions: for example, ‘do you have a boyfriend?’ Use neutral terms such as *partner*, and never make assumptions relating to a person’s sexual orientation. ‘Coming out’ is not a single event – because of assumptions about heterosexuality, a person will have to come out over and over again.

(Golding, 1997, p. 19)

The language used in assessments, on forms and in interviews must be inclusive of LGB lifestyles and relationships.

(McFarlane, 1998, p. 122)

Even if staff were careful to use gender-neutral and non-heterosexist language, would that necessarily help MSM clients feel safe enough to disclose their sexuality if it was relevant?

Also, if, as Golding (1997) suggests, staff should not assume a client is heterosexual, does that mean this will somehow be conveyed to the client? In other words, will clients know that they can safely speak about issues of same-sex attraction? This seems unlikely given that in Chapter Nine I showed that staff silence about homosexuality was often read as homonegative by the MSM clients. Accordingly, I asked the MSM clients what they thought staff needed to do to make it safer for them to discuss their sexuality.

All of the 12 clients⁷⁷ who spoke about this issue thought that it could be useful for staff to initiate conversations about sexuality in general, as it could be very relevant to clients' mental health issues. However the men saw this as a complex issue requiring careful thought about how this should be done, and the problems it might cause for MSM clients, other clients, and staff. In this section I explore the possibilities and complexities the clients anticipated in staff adopting this strategy.

Benefits of Staff Initiating Conversations about Sexuality

The MSM clients supported the idea of staff initiating conversations about sexuality and saw it as significant in the provision of effective mental health services to MSM. I will now give some examples of the reasons they gave for this stance:

Rick I think I would have got it [sexuality] out then and so later, even this year, when I basically came out or whatever I ended up in hospital again because my parents just weren't coping with it and I couldn't cope with their reaction to [my] being gay or whatever. So I think if I had got it out there then, you know what I mean, it [issues regarding sexuality] would have been all there [client].

Rick was a young man who had been involved for two years in an early intervention for psychosis service. In that time he had managed to come out to his family but had not felt able to discuss his sexuality with any of his mental health workers. He implies that being asked about his sexuality would have made it much easier for him to talk about it. Rick also suggests that this might have enabled him to get more support when dealing with his parents' struggle with his being gay. He connects this stress with his being re-admitted to hospital. Then he comments that if staff do not raise the issue of sexuality it is very difficult for clients to. This suggests that, in this moment, Rick is speaking from the medical patient

⁷⁷ When reviewing the interviews I discovered I had not asked one MSM about this issue and he did not raise it of his own accord.

subject position which makes it difficult for patients to be active in their recovery. The strength with which Rick experienced this position is exemplified when he says:

Rick Well if they [staff] are not easily going to raise it then who is. It is kind of like we are in their contact and they have the power to make or break us basically [client].

In a less intense way Jack also commented on the power relations in PMHS regarding clients disclosing same-sex sexuality:

Jack Or even just by some people saying certain things, it opens the door a little bit. So, yeah, I mean I would - and this is purely speculative, but I would imagine that the percentage of gay men that have mental health issues would be more in the shy retiring type of man as opposed to the pretty 'out there' sort of gay guy who is very accepting, or appears to be very accepting of everything about them. I don't think they would be the people. So it is not always going to be an obvious thing [client].

Jack acknowledges how MSM can be positioned differently according to the multiple discourses of homosexuality (see Chapters Four and Seven). Jack also reasons that the type of gay man who uses PMHS might be more likely to be private with his sexuality, and would potentially benefit from staff raising the issue of sexuality, as it may not be apparent. Homonegative discourses of homosexuality construct homosexuality as private and needing to be hidden, cured, or erased. It is these discourses that most of the MSM drew on when accounting for their mental health problem (see Chapter Seven). Within this context, Jack's suggestion that these MSM may find it hard to disclose their sexuality within PMHS is understandable.

In addition to being useful, some MSM thought that it was essential that staff asked about sexuality:

DS So if you'd gone to mental health services and they hadn't asked that question?

John Then it wouldn't really be doing its job because that is part of the issue, being gay. There is a definite mental health dimension to it and, as I said, I feel I have to be in a country where it is safe to be me. It is as basic as that. Do you know what I'm saying? [client].

John had attended a support group within PMHS where he had remained closeted. He had not had an assessment in PMHS but is reflecting on what he would have hoped for if he had. He acknowledges how sexuality was central to his mental health issue and that he thought that if it had not been assessed then PMHS would be negligent. John's comment is representative of the way many of the men viewed the significance of homonegative trauma to the construction of their mental health problems.

Similarly, Daniel reasons that if staff do not ask about sexuality at the start of treatment, that it could waste considerable time:

- DS What about the third option, which is mental health services saying nothing about it [sexuality], not mentioning it at all unless the client brings it up?
- Daniel That's just never going to work [laughter] because you could be six months down the track with somebody and they could go, "Oh, I'm also gay", and they go "Oh well maybe I should refer you on". We've just done six months worth of work and I should refer you on now [client].

Daniel's response echoes earlier comments made by Rick and Jack that due to the power relations of the patient subject position of the medical discourse, staff not raising the issue of sexuality, can make it very hard for clients to broach it. Additionally, Daniel's notion that a client might need to be transferred to another worker on disclosure of their homosexuality is constructed out of heteronormative discourses which position homosexuality as a marginal 'other' requiring specialist staff. Daniel was a young man who was referred to PMHS following a suicide attempt that he related to concerns about his sexuality and HIV. He experienced PMHS as a place that was not at all interested in his sexuality and consequently he refused to have further contact with them. Fortunately, his general practitioner told him about a specialist lesbian and gay affirmative counselling service where he reported getting the support he needed.

Asking Without Reifying Sexual Identity

As discussed earlier, Hellman (1996) suggested that clinicians should ask if clients identify as homosexual, heterosexual, bisexual or confused. This requires clients to pick one of four options. In contrast, while recognising some benefits to being invited into conversations about sexuality, many of the MSM clients thought that the type of questions asked, and the language used in such questions, would be very important in influencing how effective such a move might be. In particular, the clients thought it was important to be careful about questions that invite clients to take up any particular sexual identity:

- Daniel I think it is really hard to ask people their sexuality.
- DS Yeah. What makes you think that? Like it sounds like you've seen that happen sometimes.
- Daniel Well for a long time I didn't even know how to answer the question and when I first came out, I mean, yes here I was sleeping with men, but still didn't really – 'well I'm not gay, I'm just playing around'.
- DS Okay, so if someone had said to you, "What's your sexual orientation?", would that have been too hard a question to answer?

- Daniel Yeah.
- DS If they'd said, "Is sexuality an issue for you at the moment?", what would that have been like?
- Daniel I think that would have been easier. It is just wording it so that it is not an in your face question [client].

Daniel points to the complexity of asking about sexuality. He acknowledges how his sexual identity has changed over time and as a result, he rejects questions that would require him to declare a particular identity. Daniel reasons that useful questions might give MSM more space to describe their sexuality in their own language. This suggestion highlights the value of a social constructionist and approach to understanding and questioning clients about sexuality, and resonates with the multiple and shifting ways in which the MSM language their sexuality in Chapter Seven. Other MSM spoke similarly about the importance of the language used in asking about sexuality:

- DS What sort of training do you think would be useful for GPs?
- Pete Perhaps when they are just generally, when they are talking to their patients, just saying, in a general, non-threatening way, "Any problems with sexuality, sexual orientation?" [client].
- Stephen "Is there anything about your sexuality that needs addressing or you can't come to terms with or anything like that?", rather than coming straight out and saying "Hey are?" –
- DS - "Are you gay?" So something more general?
- Stephen Yes [client].
- DS What about the option of if they asked you as part of the assessment what your sexual orientation was, if they actually asked that?
- Brian I think that you might get a few people still saying, "I can't say it." I mean if you are given something like an option it is your decision, but if somebody comes out, "Are you gay?" ... Well you might be bisexual and things like that. I've met so many married guys that are gay, I mean it is ridiculous [client].

These accounts posit that questions inviting MSM to occupy a sexual identity (such as those offered by the equal rights discourse) might be considered too threatening to clients. Such questions require MSM to adopt identity labels from the various discourses of homosexuality. For many reasons this may be something they do not wish, or need, to do. Alternatively, the MSM clients suggest that staff could raise the topic of sexuality without requiring the person being asked to specify any particular sexual identity. Rather they propose the focus should be on any concerns the MSM have regarding sexuality.

Thus, many of the MSM were aware of a need for clinicians to respect the diversity of ways in which MSM may make sense of their sexuality and the ways they language them. This approach is also universalising in that it enables the decentering of heterosexuality and the “production of sexual differences beyond the usual opposition of heterosexuality to homosexuality” (Meeks, 2001, p. 325). Importantly it does this without the reification of particular sexual identities. This lesson has already been learnt in the HIV prevention field with the development of the term ‘MSM’ (see Chapter Three).

Asking Without Offending

Notwithstanding the need to ask about sexuality in ways that respect diverse understandings in a heteronormative society, asking anyone to consider their sexual orientation is a significant, and potentially unsettling, act for the both the person asking and the person being asked:

- Rick Yeah. I mean the thing is then he [the psychologist] might think that I might get offended if, you know, but that’s the thing if a person is not gay and that subject is brought up they might get offended and think, “Oh you are thinking I’m gay”
- [...]
- DS Can you think of any ways, what advice would you give to mental health services about how to raise it in a way that doesn’t leave people like you missing out but also doesn’t offend other people? How could they do that?
- Rick I mean again they could say “If you have got issues around your sexuality you can talk to this person”, or I’m not sure [client].
- Daniel I think the easiest way would be to, because gay people can get scared by the thought of being asked, I’ve seen people get asked about their sexuality and they freak. But straight people - to insinuate that they might be gay some of them will go off the plot too. So just to be able to say “We do have gay staff available, would you prefer to be seen by one of them?”, and then if they are completely homophobic and go, “No, no I don’t want to see a queer” [client].

Both Rick and Daniel struggle with the idea that on the one hand they want staff to raise the issue of sexuality but on the other, they realise that this might cause offence to the people being asked. Rick cautions that if someone is asked about their sexual orientation and they are heterosexual, they might infer that the clinician thinks they are homosexual. In a heteronormative society, such an inference is potentially read as negative. Daniel emphasises this point when he suggests that such a question could cause some heterosexual clients to become furious. This concern by both men is understandable as, in a

heteronormative society, heterosexuality is assumed and, thus, not questioned (Nairn & Smith, 2003; Richardson, 2004). Asking someone to consider their sexual orientation immediately raises the possibility of their heterosexual identity not being taken for granted, and, by implication, being questioned. Given the hierarchical and binary relationship between heterosexuality and homosexuality, the spectre of having one's heterosexuality questioned could be potentially decentering and destabilising to some people.

Both Daniel and Rick suggest that staff try to overcome this possible difficulty by offering people an option to see lesbian or gay staff if they wish. Such a strategy gives clients an option to state whether or not homosexuality is relevant to them, and whether or not they wish to see lesbian and gay staff. One problem with this approach is that sometimes the person doing the assessment will be queer, thus a potentially problematic situation. Also, implicit in this strategy is that heterosexual clients should have a right not to see queer staff. In this sense such a strategy could be seen as reproducing heteronormativity and marginalising queer staff. Another concern with this suggestion is that it relies on the service being able to offer matching and the limitations of that as a strategy already discussed (see Chapter Ten).

This concern that asking about sexual orientation may offend some clients was also raised by the staff in Chapter Eight. Hellman and Klein (2004) have also acknowledged a similar concern. Yet they comment that following the establishment of a separate programme for LGBT clients within a mainstream mental health service in New York, “no one, to our knowledge, in the general [non lgbt] client population has regressed or decompensated because of the inclusion and public availability of LGBT information in the clinic” (Hellman & Klein, 2004, pp. 76-77). Nevertheless, the concern raised by the staff is understandable. Consequently, later in this chapter I consider barriers and strategies for implementing this strategy of all staff asking all clients about sexuality. As part of that I consider arguments that utilise widely circulating discourses, that services, and individual clinicians may use strategically to justify asking about sexuality, and, hopefully, reduce any offence such asking may potentially generate.

Asking Without Pathologising

While asking about sexuality may be uncomfortable for heterosexual clients, it can also be unsettling for MSM. As noted earlier, coming out is something that queer people often

have to do repeatedly, particularly in new situations (McFarlane, 1998; Rust, 2003). Each time a person considers disclosing their queerness there is a risk of being pathologised, or rejected and enduring discomfort because of the ongoing circulation of homonegative discourses in a heteronormative society (Halperin, 1995). Given this societal context, and the historical pathologising of homosexuality by mental health services, some MSM clients said that, when discussing sexuality with clients, staff need to be explicit in stating an affirmative and non-pathologising position on homosexuality; in other words, for the MSM, absence of negative judgment does not equal explicit support for their sexual orientation:

- DS If you could give any advice to staff at mental health services about how to best help homosexual clients, what advice would you give them, to the staff?
- Stephen Not to be judgmental. Not to preach. Encourage them [the client] to talk about themselves, draw the person out a bit. Endorse the fact that they are not judgmental.
- DS So it sounds like that would be the most important thing eh?
- Stephen Yes. The guys [clients] are only going to sort of back off otherwise [client].
- Nathan I think the best thing would be staff to say “If you, what sexual preference are you?”, And “I have nothing against you [or] what you write down”. That’s how I think it should go [client].
- Rick Maybe if he [the psychologist] like kind of brought it up, like bring it up as a positive thing and said, “Its okay if you are”, you know [client].

This explicit validation and affirmation of homosexuality that the men are advocating requires more of staff than simply not using heterosexist language as is often suggested in the literature. All three accounts display a wish for staff to explicitly affirm support for homosexuality. Such a move would require staff to take up psy and critical discourses on mental health and could directly challenge widely circulating homonegative discourses. As discussed in Chapter Nine, the silence left by lack of statements from staff about homosexuality is often read by MSM as negative judgment of homosexuality. Therefore, attempts by staff to adopt a ‘neutral’ position about homosexuality, and to try and discuss it without affirming it, are easily read negatively by some MSM. For example:

- Charles Now that I have stopped and thought about myself and my own mental well-being, and mental health services, not once during the ‘suicide years’ did any member of mental health services tell me that being gay was not a mental health problem; that is to say, I thought that I was mentally ill because I am sexually attracted to men – no one told me otherwise. Unless attitudes have changed, and even if they have, staff may need to be reminded that what they know is something the client does not know. I believe that all staff members

should assure the 'client' that 'we,' mental health services, are not going to try to cure you of your homosexuality, or words to that effect. Homosexual desire is not a mental illness [client].

Charles is making similar points to those raised in Chapters Nine and Ten. In Chapter Nine I argued that despite the official depathologising of homosexuality in 1973, the ongoing circulation of homonegative discourses means that some MSM clients will not be aware of the many queer-affirmative discourses informing staff working within PMHS since that time. In contrast, in Chapter Ten, I argued that the queer staff interviewed seemed more likely to have their experience of the world constructed by homopositive discourses. Along with the discursive restraints to discussing homosexuality discussed in Chapter Eight, this may help explain why staff are less likely to feel the need to explicitly make affirmative statements about homosexuality to clients.

Thus far, I have presented data supporting the benefits that could arise from all staff initiating conversations about sexuality with all clients. The main potential of this practice would be the breaking of the silence about homosexuality in PMHS and the concomitant disruption of the assumption of heterosexuality. This could enable clients who understood sexuality, or homonegative trauma, to be relevant to their mental health problem, to get more appropriate and timely help in their recovery. Further, it is also a strategy that does not rely on clients initiating conversations about sexuality through having to take up the psy and critical subject positions of mental health. As discussed in Chapter Nine, these are positions some MSM find hard, or impossible, to occupy.

Furthermore, I have argued that in contemplating this universalising strategy for improving PMHS for MSM, there are some important things to consider. One is the use of language in ways that do not reify particular identity categories such as gay, bisexual, or for that matter, heterosexual. Second, staff need to be mindful that some clients may be offended by their questioning of clients' sexuality because of the way it disrupts the assumption of heterosexuality. Third, due to the wide circulation of homonegative discourses, and the pathologising history mental health services have with regard to homosexuality, staff would need to *explicitly* affirm their support of homosexual sexualities. This strategy thus requires that staff in PMHS take an active role in regard to discussing sexuality. Accordingly, in the next section I consider some of the implications of staff taking up a more active role and initiating queer-affirmative conversations.

‘Special Treatment’ or ‘Best Practice’? Barriers and Strategies for Talking about Homosexuality.

For the universalising strategy of all staff initiating conversations about sexuality with all clients to work, it would clearly involve the willingness of staff to participate. This, in turn, would require staff feeling justified in, and capable of, initiating and negotiating such conversations. As demonstrated in Chapter Eight, there are many discursive barriers to staff adopting such a position. In this section I consider another discursive barrier to staff doing this and then consider arguments that can be used to support such a move. These arguments support the use of both minoritising and universalising approaches through the adoption of discourses that are already in wide circulation within PMHS. First I focus on the implications for MSM of how sexuality in general is neither considered relevant nor addressed within mental health and psychiatric services (an issue raised in Chapter Eight). Secondly, I make a comparison between asking about sexuality and the process and issues surrounding asking clients about childhood sexual abuse. I argue that this comparison offers many discursive resources, and practical ideas, to support staff in making the initiating, and negotiating, of conversations about sexuality a normal part of best practice.

‘We’re All The Same’ and ‘Gays Don’t Need Special Treatment’

One of the restraints to staff asking clients about clients’ sexuality relates to the egalitarian notion that all clients should be treated the same. This idea is also enabled by the equal rights discourse of homosexuality, and the depathologising of homosexuality in general:

Raymond I don’t think that men who have sex with men have different mental health needs than other people and, in as much I, I don’t see a difference in the way staff treat men or women who have same sex relationships.

DS So they get the same treatment as everyone else? They have the same needs as everyone else?

Raymond Yeah [staff].

DS Do you think from what you have heard about the way PMHS were in the bad old days towards lesbian and gay people, do you think things have improved?

Ella Well, short answer ‘yes’. In the same kind of way that we may feel that acceptance generally. And just sort of the declassification of it as a mental health problem, it seems really evident that that would be one thing that was pretty important. But in one way I do wonder if it has swung to the ‘we’re all the same’, we all have the same experiences, there is nothing about being gay

or lesbian that should make them any different in terms of how we want to treat them [staff].

Raymond argues that MSM have the same needs as other clients, and, accordingly, should get the same treatment. Similarly, and commenting on sociohistorical changes, Ella describes a shift that she thinks has occurred in the treatment of MSM in PMHS. She posits that there may have been a shift to the view that because homosexuality is no longer considered pathological, then we must not discriminate in any way towards homosexuals by treating them differently. Such thinking is constructed within the equal rights discourse of homosexuality which emphasises equality, primarily understood as sameness, between homosexuals and heterosexuals (Brickell, 2001; Currah, 1997).

Additionally, the “we’re all the same” line of reasoning is enabled by heteronormativity. Heteronormativity ignores how discursive power relations between heterosexuality and homosexuality privilege heterosexuals and can result in significant differences between how heterosexuals, and those with same sex attraction, are positioned in the world. For example, Chodorow (1994) comments on this disparity when critiquing psychoanalytic theory. She notes that discussions of homosexuality tend to focus specifically on sexual behaviour and a “conscious sexual identity” (Chodorow, 1994, p. 35). In contrast:

accounts of the development or experience of normal heterosexuality seem to mean something more than or “larger than” sex: we are in the realm of “falling in love,” “mature love,” “romantic passion,” “true object love,” or “genital love.” This love may *include* sexual pleasures and meanings, but it goes beyond them. It is as though heterosexuality is more a matter of erotic or orgasmic satisfaction, whereas other sexualities are not.

(Chodorow, 1994, p. 35, italics in original)

In a heteronormative society, heterosexuality is assumed to be part of the fullness of someone’s life and is taken-for-granted. Therefore, when clinicians do not ask about heterosexuality in assessments, this is unlikely to be noticed by heterosexual clients. Their whole life is generally assumed to be heterosexual. However, homosexuality is marginalised, often remaining unacknowledged and relegated to the private sphere. Thus when staff in PMHS reconstruct this omission of homosexuality from public space, this inadvertently maintains the marginalisation of MSM clients. When homosexuality is omitted for MSM it is not just their sexual behaviour that is ignored; rather, many other aspects of their lives are also ignored such as their relationships, important aspects of identity, and their experience of homonegative trauma.

Returning to the ‘let’s treat everyone the same’ argument, this approach to equality has an ongoing history in New Zealand in relation to the treatment of Māori:

Cath They [MSM clients] get treated the same as everyone else and I don’t think that that is a good thing personally. It is like the old days of ‘New Zealand doesn’t have any race relation problems. If you treat the Māoris just like you treat, just the same as us, they’ll be fine’. So I think they get treated just the same [...] I still think that it is – the specialness isn’t acknowledged and the whole person isn’t – that sort of bland ‘he’s gay, he’s not, do the same, whatever’ [staff].

Cath refers to a widespread approach to relations between Māori and Pākehā in New Zealand which is to treat everyone the same. This was a significant argument in the last New Zealand election in 2005 and is often associated with the phrase, ‘one law for all’. However, as others have noted, this usually meant treating everyone according to Pākehā cultural norms, which did not result in equal rights or equal outcomes for Māori (Chaplow, Chaplow, & Maniapoto, 1993; Durie, 1995; Dyall, 1997; Lawson-Te Aho, 1993). Rather the particular experiences and needs of Māori were ignored by such a strategy. Yet these ideas still circulate within the field of mental health. In a survey of psychiatrists’ views on Māori mental health issues comments included:

I don’t think of my clients in terms of their culture. All people are the same. [...]
The similarities between all human beings are far more important than any difference. [...]
My effectiveness as a psychiatrist is not dependent on the colour of my skin, my culture, nor my understanding of bloody Māori culture.

(respondents in Johnstone & Read, 2000, p. 141)

In this context, Cath argues that just treating MSM clients the same as other clients risks ignoring the particular experiences and mental health needs of MSM clients. But, as discussed in Chapter Four, the equal rights discourse encourages lesbians and gay men to highlight their similarities with heterosexuals. From this position, anything that can be seen to highlight the distinctiveness of homosexuality, or offer different treatment to homosexuals, is harder to justify (Brickell, 2000, 2001; Currah, 1997; Lehring, 1997). Furthermore, in the equal rights discourse, the dominance of heterosexuality and its implicit visibility in all public spaces is not challenged (Brickell, 2000). In this framing, highlighting homosexuality at all can be viewed as ‘special treatment’ for homosexuals.

Given the widespread circulation of the equal rights discourse, internationally, and in New Zealand, how is it possible to support the need for clinical practice that explicitly invites acknowledgment of homosexuality and the ‘specialness’ of this for some MSM clients? I

now turn to some arguments which draw on widely circulating ideas, and can be used to advocate for universalising practices regarding homosexuality in PMHS. In other words, arguments that can be used to support all staff to ask all clients about sexuality.

A Queer Comparison: Sexual Abuse and Homonegative Trauma

In this section I draw on the literature surrounding the ways in which issues of abuse in general, and sexual abuse in particular, have been addressed within mental health research and practice. I argue that this comparison provides numerous resources to both support the need for staff to routinely ask about sexuality, and to suggest ways they might negotiate such conversations. When considering the possibility of asking about sexual orientation, three of the staff made the comparison with sexual abuse. Reflecting on this after the interviews, I could see many useful similarities. However, when I initially contemplated exploring this issue as a discursive resource to argue for change in this thesis, I considered such a move very risky.

My concerns about making parallels between sexual abuse and homonegative trauma were twofold, and both concerned the possibility for the re-pathologising of homosexuality. First, sexual abuse is rightly considered an undesirable and harmful occurrence with negative consequences for individuals, and for society. But heteronormative, and homonegative discourses also posit that homosexuality is an undesirable and harmful occurrence with negative consequences for individuals and for society. However, this is not a comparison I wish to reinforce. Second, (as mentioned in Chapter Eight), a common myth is that homosexuality is caused by sexual abuse from a perpetrator of the same sex as the survivor (Eskin et al., 2005; Newton, 1992). Therefore, making any comparison between sexual abuse and the problems MSM might experience, risks tarnishing homosexuality with the same stigma as sexual abuse. Yet through exploring the literature on how sexual abuse is addressed in mental health services, and then comparing this with the issues raised thus far in this thesis, I have located ways in which such a comparison may be made without re-pathologising homosexuality.

How Sexual Abuse and Homonegative Trauma are Related To Mental Health Problems

To begin, I want to consider the relationship between mental health problems and sexual abuse, and how this may parallel the issues of some MSM presenting to PMHS. Sexual abuse is a behaviour perpetrated upon an individual without their consent. It is an act of power over another and is considered a crime.⁷⁸ Further, it is now widely acknowledged that sexual abuse can negatively affect the survivor's mental health (Agar, Read, & Bush, 2002; Briere, 2002; Read, in press; M. Young, Read, Barker-Collo, & Harrison, 2001). In one New Zealand study, 69% of clients who reported having been abused made a connection between their experience of sexual abuse and their mental health problems (Lothian & Read, 2002).

Similarly, heteronormativity and homonegative discourses construct sociocultural practices that impact on the lives of all of us, and on the lives of people with same-sex attraction in particular. For MSM, these discourses enable homonegative violence, many forms of discrimination, and psychological effects such as isolation, to name but a few consequences. In Chapter One I reviewed the literature showing that homonegative violence, and victimisation, can have negative effects on the mental health of queer people. Furthermore, it is likely that the higher prevalence rates of suicidality, and other mental health problems, for MSM are related to homonegative trauma. In support of this, in Chapter Seven I argued that most of the men spoke in ways suggesting that they considered homonegative trauma to be constructive of their mental health problems.

Thus, survivors of sexual abuse, and MSM who have experienced homonegative trauma, may both present to PMHS with mental health issues related to problems which are constructed in oppressive social contexts. However, mental health staff may not necessarily share this belief in the role of such contexts in the aetiology of mental health problems. For example, one study (M. Young et al., 2001) found that clinicians with stronger beliefs in the bio-medical aetiology of mental health problems were less likely to ask about abuse. This finding potentially mirrors the process described in Chapter Eight where I argued that the medical discourse provided staff with ways to separate issues regarding sexual orientation

⁷⁸ Perpetrators of sexual abuse may also be diagnosed within the paraphilias section of DSM IV (American Psychiatric Association, 1994) e.g. Pedophilia. However, the inclusion of sexually abusive behaviours as disorders, does not remove legal responsibility from perpetrators.

from mental illness, which was thought to be bio-genetic and of primary importance in PMHS. Because of this, Read (in press) suggests that any training teaching staff how to incorporate questions about abuse into their clinical practice should include information on the links between abuse and mental health problems as a way of increasing clinicians' motivation to ask such questions. A similar strategy is suggested by Hellman (1996), and may be required if staff are to routinely inquire about sexual orientation and homonegative trauma.

How the Invisibilising of Survivors of Sexual Abuse, and of Homonegative Trauma, Occurs

While the problems of sexual abuse survivors, and MSM survivors of homonegative trauma, originate in socially constructed practices, this does not diminish the 'reality' of the way they are experienced. A common part of this experience is the way in which both groups are encouraged to be invisible. One New Zealand study of 191 women found that on average they took 16 years to tell anyone about their experience of sexual abuse (Read, McGregor, Coggan, & Thomas, in press). Perpetrators often tell the people they abuse that 'telling' will lead to negative consequences (McGregor, 1994). Additionally, when survivors of sexual abuse do disclose their abuse to family, teachers, or others, they are often ignored, disbelieved, or have their experience invalidated in other ways (Agar et al., 2002; McGregor, 1994). With regard to assessing for homonegative trauma, one concern I noted earlier regards Hellman's (1996) suggestion that clinicians need to assess if clients are 'really' homosexual, or if their same-sex sexual behaviour is just a symptom of psychopathology. Such an approach has the potential to invalidate the client's experience of their sexuality, and of any homonegative trauma, in a similar way to how abuse survivors can have their abuse invalidated.

The silencing of survivors of sexual abuse is also constructed by the fact that the abuse is usually done in private, and its effects are often not clearly visible. Research shows that often PMHS have maintained the invisibility of the effects of sexual abuse by not enquiring about it (Agar et al., 2002; Lothian & Read, 2002; Read, in press; Read et al., in press; S. Rose, Peabody, & Stratigeas, 1991). It is for this reason, along with the mental health consequences of abuse, that researchers internationally (Acierno, Resnick, & Kilpatrick, 1997; Jacobson & Richardson, 1987; Janssen et al., 2004; Mitchell, Grindel, & Laurenzano, 1996; S. Rose et al., 1991), and from New Zealand (Agar et al., 2002; Cavanagh, Read, &

New, 2004; Lothian & Read, 2002; Read & Fraser, 1998a; M. Young et al., 2001) advocate making inquiry about abuse a standard part of mental health assessments. Furthermore, research indicates that asking directly about abuse increases the rates of disclosure in both inpatient (Read & Fraser, 1998a), and outpatient, settings (Agar et al., 2002).

Similarly, MSM suffering from the effects of homonegative trauma often fear, or actually experience, discrimination from family, and others, if they disclose their same sex attraction. Thus, like survivors of sexual abuse, the homonegative trauma of these men is often made invisible by their understandable fear of discrimination. Furthermore, I have argued that many discursive restraints operating within PMHS maintain this invisibility within PMHS. Many MSM bring an expectation of negative judgment from staff of their same-sex sexuality. Staff also, and seemingly unwittingly, contribute to the invisibility of MSM clients by not asking about sexuality. As discussed in Chapter Nine, this silence is often read by MSM clients as a sign for them to remain silent about their sexuality, and, thus, also about any homonegative trauma they may have experienced.

How to Address Staff Fears about Discussing Sexual Abuse, and Homosexuality

In the literature on the reasons why health professionals frequently omit asking about abuse, a common restraint identified were staff fears about upsetting their already distressed clients (Acierno et al., 1997; Cavanagh et al., 2004; Read & Fraser, 1998a; Sugg & Inui, 1992; M. Young et al., 2001). Similarly, (and as outlined in Chapter Eight) many of the staff interviewed for this thesis cited concern that asking about homosexuality could be too upsetting for ‘fragile’ patients. Here they are positioning clients within the more passive subject position of the medical discourse. In contrast, some research shows that most clients are accepting of clinicians asking about many aspects of their lives including abuse and trauma (L. S. Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Shew & Hurst, 1993). Furthermore, there is some evidence that for many New Zealand clients not being asked about abuse is perceived as inadequate care (Lothian & Read, 2002).

The abuse research contains guidelines regarding how and when to ask about abuse and how to respond to client’s replies (Agar & Read, 2002; Agar et al., 2002; Read, in press; Read & Fraser, 1998b; M. Young et al., 2001). This acknowledges clinician’s worries about upsetting clients by asking about abuse. Some of the suggestions made in the abuse literature relate well to the concerns raised by the MSM earlier in this chapter. One

suggestion is that the language used when asking about abuse should be specific and behavioural (Read, in press; M. Young et al., 2001). For example, Read states:

Training programmes should stress that asking “Were you sexually (or physically) abused” is an ineffective form of inquiry. Many clients will not have used that term in relation to their experiences. Questions should be about specific behavioural events. For example “As a child, did an adult ever hurt or punish you in a way that left a bruise, cut or scratches?” and “As a child, did anyone ever do something sexual that made you feel uncomfortable?”

(Read, in press, p. 26)

Importantly Read acknowledges that clients may not have used the term ‘abuse’ to describe their experiences. Similarly, the MSM thought it was important that clients were not asked, “Are you gay?”, as this question requires clients to accept or deny, a term of identity in relation to their sexual orientation. Behavioural questions could focus more on such things as same sex attraction, and any concerns about that, or about experiences of homonegative discrimination or abuse. MSM could conceivably discuss these matters without needing to adopt a specific sexual identity. Other suggestions for clinicians asking questions about abuse include not enquiring about abuse during a crisis (Agar et al., 2002; M. Young et al., 2001), and not asking when family members are present (M. Young et al., 2001). Though not specifically discussed with the MSM interviewed, these guidelines may well be useful for asking about sexual orientation.

While how to ask about abuse is important, how to respond is an equally significant consideration if clinicians are to conduct such enquiries sensitively (Read, in press). Finding out if someone has been abused is only part of the assessment. Researchers and clinicians advocate that a variety of other issues also need to be considered. These include previous disclosures of abuse and how they have been received, and the context and extent of the abuse (Briere, 2002; McGregor, 2001). In a New Zealand training programme for staff, Read (in press) presents six principles to guide effective responses to disclosures of abuse:

1. [It is] not necessary to gather lots of detailed information
2. Affirm that it was a positive thing that they told you
3. Offer support
4. Check current safety
5. Check emotional state at end of session, and
6. Offer immediate follow-up/check in.

(Read, in press, p. 35)

In these guidelines there is an explicit acknowledgment that disclosing abuse can be an emotionally vulnerable time for clients. Given the context of secrecy and shame often surrounding abuse, guideline number two is suggested to help counter shame and fear that clients may feel following disclosure. Accordingly Read states:

Survivors of abuse often experience self-blame. If self-blame does occur it is important to affirm that self-blame is a common reaction; and, if appropriate, to state that any abuse they have experienced is not their fault.

(Read, in press, p. 34)

Self-blame and shame are also common consequences of homonegative trauma (D. Davies, 1996; Downey & Friedman, 1996; Herek, 1996; G. Kaufman & Raphael, 1996; Stein & Cabaj, 1996). This shame, (often referred to as 'internalised homophobia'), is constructed out of homonegative discourses and their effects. As illustrated in Chapter Seven, MSM are well aware of these discourses and, (as discussed in Chapter Nine), accordingly, the men often bring with them an expectation of negative judgment by mental health staff in PMHS. Unsurprisingly then, and as discussed earlier in this chapter, some of the men thought it crucial that if staff enquired about homosexuality, they also needed to make it clear that they were supportive of same-sex sexuality. As already discussed, staff attempts at 'neutrality' are likely to be read by clients as negative judgment. Therefore, the recommendations that staff be explicitly affirmative of disclosure in regard to abuse may also apply to disclosure of same-sex sexuality and homonegative trauma.

How Abuse and Homonegative Trauma May Differ

Having made many parallels between enquiry about sexual abuse, and enquiry about sexual orientation and homonegative trauma, it is also important to consider differences between the contexts of these two lines of questioning. One difference is the position that sexual orientation, and homonegative trauma, may play in someone's identity compared to that of abuse. As discussed in Chapter Four, many discourses of homosexuality posit homosexuality as central to a person's identity. Subject positions offered to homosexuals include those that construct them as 'evil' (Christian supremacist discourse), 'sick' (pathological discourse), or 'proud' (as in the currently ascendant equal rights discourse). For some MSM clients, then, their sexual orientation may be an integral (albeit problematic) part of their identity. Further, this identity may be something they want to hold onto long after having addressed whatever mental health problem brings them to PMHS. For example, 'gay' can become a positive, and public, identity for many MSM. In

contrast, survivors of abuse may find it important at some point to actively relinquish subject positions that place their abuse as central, and public, aspects of their identity (A. Phillips & Daniluk, 2004).

The public subject position of some survivors of abuse may also differ significantly from that of survivors of homonegative trauma. Very few people would publicly advocate physical, emotional, or sexual, abuse (though many advocate practices that some define as abusive).⁷⁹ Relatedly, perpetrators of sexual abuse against children are, arguably one of, if not, the most vilified groups in New Zealand society. In contrast, it is still neither uncommon, nor illegal, for public figures and groups to advocate homonegative practices in New Zealand. Recent examples include actions of the Catholic Church and Destiny New Zealand. Internationally, the Catholic Church continues to publicly discriminate against homosexuals by denying them equal rights to participate in the church, and by lobbying against equal rights legislation for homosexuals in state laws. Locally, Destiny New Zealand is a political party associated with Destiny Church, which publicly advocates the Christian Supremacist discourse on homosexuality. Destiny New Zealand was very active in opposing the Civil Union legislation, which was passed in December 2004. In this sense, for MSM clients struggling with the effects of homonegative trauma, the trauma, while not often acknowledged, is likely to be perpetrated in public, and to be ongoing.

Summary: Assessing Heteronormative Trauma by Questioning Heterosexuality

I began this chapter with the aim of exploring universalising practices for breaking the silence surrounding homosexuality in PMHS. Through data from interviews with the MSM clients, I investigated two ways of doing this. One is to provide visual cues such as posters and brochures to make the environment of PMHS more homopositive. However, I argued there were significant limitations to this strategy. A second strategy is for all staff to ask all clients about sexual orientation and homonegative trauma. This practice involves questioning the often taken-for-granted status of heterosexuality in PMHS. Both clients, and the staff, imagined many barriers to such a move. A predominant concern was that

⁷⁹ An example of this is the debate in New Zealand over the repeal of section 59 of the Crimes Act. This bill would remove from adults the right to use physical punishment to discipline children.

staff inquiring about sexual orientation might be distressing for both parties. I outlined some key ideas the clients had about how clinicians might ask about sexuality in ways that might minimise discomfort or distress.

Next I considered yet another barrier to staff inquiring about sexual orientation with clients. This restraint was the idea that queer people do not need ‘special treatment’ and should be treated the same as everyone else. I argued that this position is a heteronormative one that ignores the discursive power relations that make many queer people’s experiences of the world significantly different from heterosexuals. I also argued that, in comparison with heterosexual clients, MSM are likely to be disproportionately affected by the omission of sexuality from assessments.

Finally, I traced an analogy between assessing for effects of sexual abuse, and assessing for sexual orientation and homonegative trauma. I contended that this analogy provides useful resources for supporting staff to negotiate conversations about sexual orientation. Furthermore, the strategy of all staff initiating conversations about sexual orientation with all clients addresses questions raised at the start of this chapter regarding how to break the silence surrounding homosexuality in PMHS. This practice would require staff to take up a critical discourse of mental health, in addition to other positions such as those offered by medical and psy discourses. Taking up this position would require staff to understand, and act upon, knowledge of heteronormativity, homonegativity, and how this affects the lives of all of us, and MSM clients in particular.

PART FIVE:
IMPLICATIONS
FOR RESEARCH, POLICY, AND PRACTICE

Chapter Twelve:

Starting Queer Conversations

This research began from my noticing an absence of conversations about queer people within PMHS, an absence that troubled me given my awareness of research indicating higher rates of suicide and serious mental health problems for MSM. Subsequently, it is my engagement in numerous queer conversations that have produced this thesis. I have explored MSM's understandings of serious mental health problems, and of their relationships with PMHS. I also interviewed queer staff about these issues, and how they see their role in PMHS as, thus far, their views on this have not been canvassed. This chapter summarises my various analyses of these queer conversations (Chapters Seven to Eleven), and further considers their implications for policy and practice within and surrounding PMHS. My analysis shows that MSM clients, and queer staff, within PMHS are subject to multiple, and often contradictory, discourses which work to produce and constrain conversations about homosexuality in PMHS. In particular, I contend that discursive power relations within PMHS work to silence some MSM. This silencing can prevent them from getting the support they need to recover from homonegative trauma. I begin, however, by acknowledging the limitations of the local and partial knowledges this thesis constructs.

Research Limitations and Possibilities

One of the limitations of this research is that I have focussed only on MSM clients. All of the discourses of homosexuality, introduced in Chapter Four, are also discourses which have been involved in the construction of the subjectivities of lesbians, and women who have sex with women (WSW). However, additional discourses are likely to be important in the construction of WSW's experiences of homosexuality and heteronormativity. Discourses of gender in particular are likely to be highly significant. For example, a radical feminist discourse has been found to be influential in the construction of lesbian identity

(Barnard, 2005; Kitzinger, 1987). Accordingly, similar research on WSW who use PMHS would be an invaluable addition to research in this area.

A further constraint of this thesis is that I have not interviewed heterosexual staff. The only accounts of heterosexual staff practices are those provided by the MSM clients, and the queer staff. These accounts are congruent with some of the existing research suggesting that even mental health staff who do not pathologise homosexuality may misunderstand, or overlook, its possible relationship, via homonegative trauma, to serious mental health problems (Golding, 1997; King et al., 2003a; McFarlane, 1998). Thus, while this research might be the first to explore queer staff's views on the possible role they could have in PMHS, there is also a dearth of, and need for, research on the understandings heterosexual staff might have on the potential relationships between sexual orientation and PMHS.

Third, the survey questionnaire developed for MSM clients and ex-clients could not be used due to limited responses (see Chapter Three); however, quantitative research would also be useful in this area. It could provide information on the extent of the issues raised in this research and might provide the persuasive power of numbers to influence policy makers. Further, this research has shown that queer people draw on multiple discourses of homosexuality when accounting for their sexuality. Thus, any future research in this area would benefit from careful consideration of the use of language regarding sexuality and sexual orientation, especially when recruiting participants.

Another limitation regarding this research concerns ethnicity. Of the 13 clients and 12 staff, all of the staff, and all but two of the clients, identified their ethnicity as European. With the exception of the Māori discourses, the discourses of homosexuality and of mental health introduced in Chapters Four and Five are European ones. However, discourses of sexuality are culturally-specific and, additionally, they often draw on discourses from other cultures (Boellstorff, 2001; Kim-Puri, 2005; Massad, 2002). Accordingly, I have been unable to consider how the accounts and strategies presented in this thesis would be apt for people from non-Western cultures.

Also, it would be useful to have research that explores the experiences of MSM who live in non-urban areas which could be compared to the findings of this study. This research was carried out in the largest city in New Zealand; one that has relatively visible queer communities. It is possible that the accounts of clients, and staff, of PMHS may well differ in rural and provincial areas where there is less queer visibility in the local communities.

Research considering how MSM cope with serious mental health problems, (with or without the support of mental health services), would also increase our knowledge of the range of resources and strategies that MSM may draw on. It is currently absent from the research literature. I had initially hoped to explore this issue in this research but during the interviews I realised this was an overly ambitious hope given the other topics covered.

Maintaining Heteronormative Silence: Staff

A recurring theme in this thesis has been the silence surrounding homosexuality in PMHS. As reviewed in Chapter One, despite considerable evidence of the increased prevalence of serious mental health problems for MSM, the literature contains a virtual absence of research on MSM and PMHS. In Chapters Eight and Nine, I argued that the accounts of the clients and staff portray how the heteronormativity of the medical and psy discourses of mental health, along with the ongoing circulation of homonegative discourses, produce a relative silence from staff regarding homosexuality in PMHS. Only one of the 13 MSM clients could recall a staff member inviting the initial disclosure of his homosexuality.

The staff accounts revealed various discursive power relations which restrain them from initiating conversations about sexuality. First, from the expert subject position of the medical and psy discourses, staff may implicitly assess whether they think sexuality is an issue. This unspoken assessment frequently relies on staff's 'gaydar'; the supposed ability to identify homosexuals intuitively. Yet this concept and strategy is constructed out of the essentialising equal rights discourse, which posits homosexuals as identifiable from observable signs of difference from others, much like an ethnic group. Accordingly, regardless of whether 'gaydar' is 'real' or not, it is a limited strategy for identifying MSM who do not conform to dominant constructions of homosexuals.

Second, even if staff think sexual orientation may be relevant to a client, the medical and psy discourses require them, in their 'expert' subject position, to assess if the client is 'too fragile' to be asked about their sexuality. Here, staff's awareness of the ongoing circulation of homonegative discourses combines with discourses of mental health to construct homosexuality as too dangerous to discuss.

A third restraint to staff discussing homosexuality relates specifically to the medical discourse. The objects of the medical discourse are 'mental illnesses', their symptoms, and

their treatment, usually through medication. When speaking from this discourse, the staff talked in ways that separated mental health problems connected to homonegative trauma from the primary business of PMHS, which, within the medical discourse, is constructed as ‘mental illnesses’. Here, the dominance of the medical discourse relegates homonegative trauma to a secondary factor; one that is considered relatively unimportant for PMHS.

‘They’ll tell us if they need to’ is another way by which staff thought MSM clients would be identified if necessary. This strategy is constructed within a psy discourse whereby if mental health professionals create trusting relationships then clients will raise whatever issues they need to. Yet this strategy fails to account for the power relations in PMHS where some MSM feel positioned as the relatively passive ‘patient’ subject of the medical discourse. From this position, some MSM do not feel able to take up such an assertive role regarding their homosexuality. Thus far, the discursive power relations identified in the staff’s accounts help explain why few of them ever inquire about sexuality. The medical and psy discourses fail to appreciate how heteronormativity and homonegativity constrain both staff, and clients, within PMHS.

Resisting Heteronormative Silence: Clients

Fortunately, many of the MSM clients did manage to resist the heteronormative silence surrounding homosexuality in PMHS, and to disclose issues surrounding homosexuality. Yet, importantly, for some disclosure was very problematic. For others it was not possible at all (see Chapter Nine). The men considered that this restraint on disclosure compromised their recovery from mental health problems.

In Chapter Seven I showed that the MSM interviewed had multiple ways of accounting for the place of sexuality in their lives, and their sense of identity. For example, over half of the MSM described their sexuality as central to their identity, while others did not. They also drew on multiple discourses of homosexuality to language their accounts. Yet, despite the diversity of accounts, a significant commonality was that their sexual identity was constructed in a heteronormative context, one that frequently made the negotiation of their sexual identity a considerable struggle. Furthermore, many of the men described contemporary New Zealand society as still being constructed within heteronormative discourses that continue to cause distress for them.

In this context, all but one of the MSM utilised primarily psy and critical discourses of mental health to partly, or wholly, explain their mental health problems. Their accounts described a disruption to their sense of identity, and their connections with wider society through homonegative and heteronormative discourses. In this sense they were resisting both homonegative and medical understandings of their mental health problems. Throughout this thesis I have used the term 'homonegative trauma' because I think it encapsulates the MSM's accounts of the effects of homonegative and heteronormative discourses on their lives and their well-being. This term draws on the queer notion of homonegativity to signify the social power relations providing the context for the experiences the men described. The term also uses the psy notion of trauma to signify the consequences for the individual of their societal marginalisation. Little research has explored MSM's views on serious mental health problems but the MSM's accounts in this thesis are consistent with research suggesting that people who have experienced anti-homosexual violence, whether physical, sexual, or verbal, are at increased risk of mental health problems (D'Augelli, 2002; Herek et al., 1999; Janssen et al., 2003; Otis & Skinner, 1996; Rivers, 2001). Given this, it seems imperative that MSM feel able to discuss, and get support, for the effects of homonegative trauma within PMHS.

In Chapter Nine I explored MSM's accounts of how they negotiated disclosure of their sexuality within PMHS. Of the MSM who did disclose their sexuality within PMHS, they tended to adopt the assertive subject position offered by the equal rights discourse of homosexuality, and the agentic client/consumer/survivor subject positions of psy and critical discourses of mental health. However, for some MSM clients disclosure was made extremely problematic by their awareness of homonegative discourses, coupled with the heteronormative silence of staff. For example, Mark's fear of imagined homonegative responses by staff meant that his disclosure took many years and wasted much time. Further, Ralph's disclosure occurred in a suicide note. Yet, even after the ensuing suicide attempt, Ralph reports that no staff member ever raised the topic of sexuality. He read their silence as disinterest in, and disapproval of, homosexuality and he has since remained silent for fear of imagined homonegative responses by staff. Thus, in a heteronormative society, where homonegative discourses circulate, not all MSM clients feel able to adopt the assertive client positions of the psy and critical discourses, or the equal rights discourse.

The medical discourse was specifically implicated by MSM as an additional restraint to disclosure. The two youngest men interviewed both talked of this. They found that the

focus on symptoms, inattention to the relationship between clients and staff, and staff silence surrounding homosexuality, all helped maintain their silence within PMHS. Rick contended that seeing numerous staff over two years, none of whom raised the topic of sexuality, did not provide him with the sort of context in which he felt he could safely disclose. In that time he managed to come out to his family but thought that process might have been made easier, and the associated suicide attempt avoided, had he had the support of staff. Similarly, Daniel contended that he was very fortunate to find a gay counselling service because he would not have returned to PMHS, despite feeling suicidal again.

These various accounts of the MSM interviewed suggest that disclosure is least likely for those experiencing significant adverse effects of homonegative trauma and, thus, would most benefit from receiving support with this. But the combined accounts of the clients and staff reveal how the heteronormativity of the medical and psy discourses, combined with homonegative discourses, work to keep homonegative trauma hidden. In this context Chapters Ten and Eleven considered possibilities for queer-affirmative change in PMHS.

Matching: A Marginalising Possibility for Change

The presence of queer staff, and subsequent matching of them with queer clients, is commonly suggested as a way of improving PMHS (Golding, 1997; Klein, 1991; McFarlane, 1998). This strategy essentialises LGB identities by assuming similarities and affinities between people within each identity category. Both MSM clients and queer staff thought this could be useful (see Chapter Ten). However, my analysis suggests that discursive power relations within PMHS trouble this strategy and position even queer-affirmative lesbian and gay staff in ways that constrain matching.

All of the queer staff interviewed were 'out' about their sexuality with their colleagues and frequently utilised the equal rights discourse to justify this outness. They also used essentialising and psy language to denote that being 'out' in the workplace was imperative for their integrity and wellbeing. Accordingly, they stated a willingness to ensure they were accepted in the workplace even if it required conflict with colleagues. Further, positioned by the equal rights discourse, which emphasises an 'ethnic like' similarity between queer people, and by the psy notion of the importance of role models, the queer staff considered they could have a positive function in supporting MSM clients.

However, the staff's accounts revealed barriers to the strategy of matching. In contrast to their 'outness' with colleagues, all the queer staff reported they rarely, if ever, disclosed to clients. One possible reason for this is that within the heteronormative medical and psy discourses, mental health professionals are required to be 'objective' experts whereby their sexuality is constructed as 'personal' and outside the professional realm. In a heteronormative society the heterosexuality of professionals is assumed, and therefore, its disclosure goes relatively unnoticed. Yet, within the medical and psy discourses, disclosure of homosexuality becomes subjective, political, and potentially dangerous to clients and staff. Additionally, the staff were aware of numerous homonegative discourses which could make their disclosure risky. For example, Beth imagined parents positioning her as unduly influencing their child if she disclosed her homosexuality. Thus, while generally supporting the idea of matching, queer staff felt restrained from disclosing to MSM clients.

For their part, some MSM also thought it could be helpful to offer matching. For example, Mark suggested it could be useful to have posters offering a queer resource person within inpatient units. Undoubtedly, this would be helpful for some MSM. Yet, unless matching is offered to all new clients, there is currently no way to determine which clients are MSM and, thus, who to offer matching to. Due to this restraint, currently matching is more likely to happen if clients assertively request it. Again, like disclosure of homosexuality, the responsibility for matching lies with the clients. But given the various ways some MSM feel positioned by the medical and psy discourses, coupled with their fear of homonegative responses, not all MSM who might prefer matching may feel able to request it.

Further, other discursive complexities of matching make it problematic as a strategy. For example, if offered matching, Brian (client) said he would have chosen a lesbian. He accounted for his preference in terms of heteronormative notions of gender, which assume a lesbian would not display traditional forms of masculinity that even gay male therapists may ascribe to, which he felt uncomfortable with. In contrast, Charles (client) was adamant that he would not see any woman, even a lesbian. Acknowledging the multiplicity of positionings within identity, Nathan (client) said he would have preferred a Māori heterosexual clinician over a non-Māori gay one. Complicating matching even more, Philip (staff) commented that, when matching for sexual orientation, it would still be necessary to ensure the clinician had the necessary expertise in the areas the client wanted to discuss.

Matching, then, is a strategy based primarily on the essentialising assumptions of sameness within the equal rights discourse of homosexuality. Yet from a queer theoretical perspective (Sedgwick, 1990), this focus on sameness eludes the many ways in which queer people differ (Jagose, 1996; Seidman, 1993). Thus, while matching may be useful to some MSM clients, matching for the various aspects of queer identities would be difficult to offer at a practical level in an already stretched PMHS. Matching can also be critiqued as being a minoritising strategy, one that makes issues to do with sexuality of concern to only a minority of clients and staff. Thus, it may do little to challenge the heteronormative silence surrounding homosexuality in PMHS. Accordingly, in Chapter Eleven I considered strategies which do have the potential to interrupt such a silence.

Questioning Heterosexuality: A Universalising Possibility for Change

A universalising perspective on homosexuality argues that the hetero/homo binary is a central organising principle in our society and, as such, has implications for all of us, not just queers (Sedgwick, 1990). From this perspective, the practices within PMHS identified thus far, which maintain silence about homosexuality in PMHS, are not simply an omission of homosexuality, but a reproduction of the heterosexual norm. Therefore, even without the pathologising of homosexuality, the heteronormativity of the medical and psy discourses of mental health, and the ongoing circulation of homonegative discourses, construct homosexuality as the marginalised 'sexual other' within PMHS. Accordingly, universalising strategies for improving PMHS for MSM need to deconstruct practices which assume heterosexuality and render homosexuality the silent sexual other.

Indications that the MSM clients interviewed would prefer a universalising approach were noted in their responses to the idea of separate services for queer people. This strategy has been called for in other research (Golding, 1997; McFarlane, 1998), and is frequently adopted in the United States (see Hellman & Drescher, 2004). However, drawing on an equal rights discourse, many of the men were adamant that they should receive appropriate, homopositive treatment within mainstream PMHS. Notions of egalitarianism and equal rights circulate widely in New Zealand (Brickell, 2001), and the establishment of separate services for homosexuals was seen by the MSM as marginalising and a type of apartheid.

One universalising strategy suggested in the sparse literature on PMHS for MSM is the provision of brochures and posters marking services as queer-affirmative (Golding, 1997; McFarlane, 1998). It has recently been taken up in the broader arena of health in Victoria, Australia, with the establishment of *'Gay and Lesbian Health Victoria'*. This is a health resource unit for gay, lesbian, bisexual, transgender, and intersex people. Among the resources they have produced are two posters for waiting rooms. The text of one of the posters is, "You don't have to tell us if you're gay or lesbian. But you can. Gay, lesbian, bisexual, transgender and intersex people and their families are welcome at this service" (Gay and Lesbian Health Victoria, n.d.). However, both clients and staff were doubtful of the usefulness of this strategy. Their concerns were that it relies on clients noticing the posters, identifying with the language in them, and then taking the assertive step to disclose to a clinician who may, or may not, be supportive of the sentiments of such posters or brochures, and/or know how to respond usefully to such a disclosure.

An alternative universalising strategy requires all staff to ask all clients about sexuality, and also about homonegative trauma. Such a strategy directly interrupts the assumption of heterosexuality and the silencing of homosexuality. The MSM clients generally supported this idea, and some even saw it as essential to providing good service. But given the complex discursive restraints to discussing homosexuality discussed thus far, MSM thought that such a move by staff would need to be well considered.

MSM clients also thought it important that staff find ways to ask about sexuality that, while explicit and 'out there', were not imposing of particular understandings of homosexuality. They thought it especially important that staff do not ask about sexuality in ways that require clients to adopt an identity category. Thus, general questions such as "Is sexuality an issue for you at the moment?" were considered more useful than asking people if they were gay or straight. This concern is congruent with the multiple ways in which the MSM understood and languaged the place of sexuality in their life (see Chapter Seven).

Given the long history of pathologising, and homonegative treatment, of homosexuals by mental health services, and the ongoing societal circulation of homonegative discourses, a further constraint to MSM clients disclosing is that they may anticipate a negative reaction if they do disclose, even if the disclosure is invited. Accordingly, some of the men suggested it was important for staff to explicitly affirm homosexuality whenever discussing it. For example, Rick suggested that if his psychologist had asked him about his sexual

orientation he could have included something like, “It’s okay if you are [gay]”. In a heteronormative society, an absence of pathologising statements is not necessarily read by clients as a presence of a queer-affirmative position. A related concern was that some clients may be unsettled at having the assumption of their heterosexuality being questioned. Again, this seems understandable in a heteronormative society.

Staff also considered there were restraints to having conversations about sexuality become part of normal practice. First, given the passing of various homosexual rights laws in New Zealand since 1986, many staff may think that society is much more tolerant and, thus, it is no longer important to consider homosexuality as an issue because this notion invisibilises the effects of the ongoing circulation of homonegative discourses within society. Further, the equal rights discourse has advocated that homosexuals are, in many respects, just like everyone else. This discourse overlaps with the egalitarian notion that it is good to treat everyone the same; anything else would be ‘special treatment’ (Brickell, 2001). But, from a queer perspective, such reasoning ignores how in a heteronormative society, heterosexuality is assumed to be part of the fabric of someone’s life and to be public knowledge. Therefore, when clinicians do not ask about sexual orientation in assessments it is unlikely to be noticed by heterosexual clients. This continues to marginalise homosexuality within the public sphere. So, when staff in PMHS reproduce this omission of homosexuality from public space (by leaving it out of assessments), this inadvertently maintains the marginalisation of some MSM clients, and ignores the effects of any homonegative trauma they may be experiencing.

Discourse, Power, and Reform

Before concluding the implications of my analysis for practice within PMHS, I would like to consider the possibilities and limitations for using critical discourse analysis (CDA) to guide reform. Willig (1999c) has commented that few discourse analysts have taken up the issue of application either during or following their research. She argues that instead they have offered critiques of existing power relations and have considered that their identification of counter-discourses provides opportunities enough for resistance to institutionalised discourses and practices. However, Willig argues that these critiques are typically circulated via academic publication and offer little in the way of strategic interventions. She contends that an alternative strategy used by discourse analysts is

exploring “opportunities for active resistance inside and outside of institutions” (p. 12). Yet, according to Willig, this critique is limited through its preference for diversity of localized interventions, and because it assumes a grass-roots approach that can make it hard for individuals and small groups to achieve lasting change. Similarly, when commenting on power relations regarding psychiatric medication, Harper (1999) argues that while critique can be useful, researchers need to be able to offer practical alternatives. Given the discursive framework I am using how, then, do I justify the recommendations I offer?

As discussed in Chapters Two and Three, CDA aims to provide a multi-layered, yet coherent, account of social power relations, in order to deconstruct taken-for-granted understandings; in this case within the institution of PMHS. The political purpose of this is to “comment on social processes which participate in the maintenance of structures of oppression” (Burman & Parker, 1992b, p. 9). There is also a desire for CDA to “help us see in new ways” that seem useful and reasonable given existing understandings of social life and literature (Wood & Kroger, 2000, p. 174). As discussed in Chapter Three, throughout this research I have presented my developing analyses to, (and sought feedback from), academics, consumers/survivors of mental health services, and clinicians, at conferences and seminars. This has led to publication of parts of this thesis (Semp, 2004a, 2004b). I have also used my analysis to inform teaching sessions with clinical students and clinicians. These various contexts have provided opportunities to see the potential for my analysis to generate new ideas and practices. From this perspective, I end this thesis by adopting a position towards some reform of PMHS. Willig posits that:

Discourse analysis as a guide to reform seeks to expose the ways in which language is used ideologically to maintain unequal power relations in society, but it also aspires to bring about positive change in social and institutional practices.
(Willig, 1999c, p. 15)

Accordingly, and following Harper (1999), the proposals I suggest are based on my analysis of the accounts of the MSM clients, and of the queer staff. In particular I have examined these accounts to consider their effects on practices within PMHS, and on MSM clients. My analysis has revealed power relations which restrain clients, and staff, from discussing sexuality. This results in the further marginalisation of some MSM clients, and contributes to their experience of homonegative trauma. In making the following suggestions I am not under the idealistic illusion that there are perfect interventions (Harper, 1999). For example, I am mindful of Willig’s caution regarding systemic limitations to change: “An

'applied discourse analysis' which does not attend to the institutional basis of discourse and subjectivity runs the risk of overestimating its ability to effect change" (Willig, 1999b, p. 147). Rather, (and similar to Wodak's (1996) description), I am offering accounts which, through revealing discourses and power relations, open up spaces for changing practices within PMHS. This has the potential to advance the interests of some clients who lack power within PMHS, and to enable staff to be more supportive of them in their recovery from mental health problems.

Implications for Policy, Training and Practice

Being mindful of the limitations discussed earlier, it seems that current discursive practices in PMHS operate to make it difficult, or even impossible, for some MSM to get support with their recovery from homonegative trauma. Even when staff are not overtly pathologising of homosexuality (of which there were very few accounts in this thesis), the heteronormativity of the medical and psy discourses, alongside the ongoing circulation of homonegative discourses in PMHS and in wider society, can restrain staff, and clients, from discussing matters of sexual orientation. These practices work against the recovery of these clients from serious mental health problems. They also go against some aspects of national mental health policy (see Chapter Six).

In particular, the accounts given in this thesis suggest the following national recovery competencies are not being met consistently. One recovery competency requires staff "to see people in the context of their whole selves and lives, not just their illness [and to demonstrate] the ability to adopt the story teller's frame of reference" (O'Hagan, 2001, p. 9). Furthermore, competency three requires mental health workers to demonstrate "knowledge of different explanations [of mental illness] – spiritual/moral, psychological, sociological, biological" (O'Hagan, 2001, p. 13). Additionally, competency six requires mental health workers to "understand discrimination and social exclusion, its impact on service users and how to reduce it" (O'Hagan, 2001, p. 18). Discrimination on the grounds of sexual orientation, and knowledge of its contribution to mental illness, are specifically included in this competency. When MSM do not feel invited to discuss homonegative trauma none of these competencies are met.

Some of the reasons why staff do not meet these competencies include the various discursive restraints to asking about sexuality and homonegative trauma already identified.

A value of a discursive approach is its focus on systemic and institutional restraints rather than blaming individuals for these omissions (Willig, 1999a, 1999b). Consequently, when I have presented my ideas to staff I have emphasised the discursive restraints they might face, thus inviting them to consider alternative practices without judging them as being 'homophobic' or inadequate clinicians. However, initiating affirmative conversations about homosexuality invites staff to adopt a critical position that acknowledges the power of mental health professionals (and PMHS) to silence, or encourage acknowledgment of, MSM and their experience of homonegative trauma. Accordingly, staff are likely to need structural support in order to change their practice towards a more queer-affirmative stance.

In Chapter Eleven I drew an analogy between my suggestion that all staff ask all clients about their sexuality, and the established processes of including sexual abuse in all assessments. I argued that this comparison provides many useful resources that can be drawn on by staff so they can also routinely enquire about sexual orientation as part of best practice. Interestingly, this recommendation was suggested in a recent review of general health inequalities experienced by lesbian, gay and bisexual people in the United Kingdom (Douglas Scott, Pringle, & Lumsdaine, 2004). The following points are likely to be important if such a strategy is to be adopted and all would require consultation with relevant consumer representatives and groups. Given the research limitations already discussed, it would be important to consult with specific cultural services within District Health Boards, such as Māori services, to consider the implications of the research for their services:

1. Establish a policy at District Health Board (or equivalent) level which requires staff to incorporate assessment of homonegative trauma into standard assessments. It would be important that the focus is on homonegative trauma rather than on clients needing to adopt any particular sexual identity.
2. Establish and provide training to all mental health staff on how to assess for issues relating to homonegative trauma. Such training would likely need to include:
 - a. A rationale for including sexual orientation in non-crisis assessments. This could include research on the prevalence of mental health problems for queer people, and any connections between homonegative trauma and mental health problems. However, it would be important to caution staff on the risk of re-pathologising

homosexuality by automatically linking homosexuality with trauma. For example, for some MSM homonegative trauma may not be currently relevant to their lives or their mental health problem (even if it was previously significant). As part of this, it would be important to consider how homonegative trauma might be acknowledged within the DSM classification system generally used within PMHS. As discussed in Chapter Eight, while the medical discourse prioritises symptoms and disorders, within the DSM there is space for homonegative trauma to be highlighted on Axis IV (psychosocial and environmental problems).

- b. Suggestions for how to frame questions about sexual orientation. This would require knowledge of the many ways MSM may understand their sexuality. One useful framework could involve an introduction to some of the multiple discourses constructing homosexuality (see Chapter Four). It would also require knowing how to be explicitly supportive of homosexuality. As discussed in Chapter Eleven, the absence of homonegative statements by staff (through the use of non-heterosexist language) is not necessarily read by MSM as the presence of homo-affirmative staff.
 - c. Suggestions for how to respond to any responses staff might receive to their enquiries about sexuality. For example, when I have enquired about sexuality in my clinical practice, clients have sometimes asked “Why are you asking that?”. As part of this, staff would need to know what resources are available within, and outside of, PMHS to provide support for any issues raised. Part of the response could usefully include how the effects of homonegative trauma may be incorporated into treatment planning.
3. Similar training could also be usefully incorporated into the programmes of academic and professional institutions training mental health professionals such as social workers, occupational therapists, clinical psychologists, psychotherapists, nurses, and psychiatrists. As general practitioners are key referrers to PMHS, and as they often have longer term relationships with clients, it would be useful for them to receive such training as well.
 4. Queering the setting of PMHS, and other suggestions of MSM clients, could be useful. This might include queer-affirmative posters and brochures. It could also include the provision of lgb contact people, and offering (but not imposing) ‘matching’ with lgb

staff, where possible. These would need to be clearly advertised and visible so that clients could access them if they wish. However, my analysis suggests that these strategies are secondary to supporting the practice of all staff initiating conversations about sexual orientation with all clients.

In offering these recommendations I am aware that there may be significant barriers to their implementation and efficacy. These barriers coalesce around the medical discourse of mental health, and the power relations and practices it engenders, within both PMHS and wider society. As exemplified by the accounts of Daniel and Rick in Chapter Nine, and discussed throughout this thesis, the medical discourse, with its focus on diagnosing disorder and controlling symptoms, evades exploration of oppressive homonegative discursive practices, and their psychological effects (such as homonegative trauma). This focus, along with its assumptions of the bio-genetic aetiology of mental health problems, encourages PMHS to primarily address symptoms of ‘mental illness’, through administering drugs. Such an approach was reproduced by a number of staff in their accounts of the role of PMHS (see Chapter Eight).

This individualising and decontextualising process has implications not just for homosexuals but also for many other people that are psychologically, (and socially), affected by practices of discrimination and oppression. Examples include people positioned differently by multiple axes of oppression such as gender, ethnicity, class and disability (Janssen et al., 2003; I. Parker et al., 1995; Read, 2004c). If PMHS continues to be structured primarily around the medical discourse, and its illness/symptom/drug focus, then it will end up maintaining the status quo, and, concomitantly, the power of dominant groups in society. The effects of abuse, discrimination, alienation, and oppression, will be reconstructed as ‘mental illnesses’, thus, turning social problems into individual ones. Challenging this process is a central tenet of a critical discourse of mental health (see Chapter Five).

Therefore, while the changes I am suggesting include a focus on the role of homonegative trauma, if these were implemented in isolation they may make little difference to the efficacy of treatment MSM clients receive in PMHS. For example, it would be possible to determine that an MSM was currently struggling with the effects of homonegative trauma, yet, if this assessment, and ensuing disclosure, was followed only by medical treatment the benefits of such a disclosure would likely be minimised. Rather, if PMHS are to do all they

can for people suffering the effects of trauma, and discrimination, there is a need for an increased focus on psy and critical discourses in the assessment of, and provision of, services for all clients. One important way this could be practically advanced is the provision of more psychotherapy, and related services, for clients in PMHS. Despite public support for psychosocial explanations of mental health problems (Read & Haslam, 2004), such a shift in emphasis is likely to be resisted by the drug companies and others who benefit from the dominance of the medical discourse. Yet there is evidence that psy and critical discourses are making some inroads into mental health discourse in New Zealand such as in national mental health policy (see Chapter Six).

Furthermore, public campaigns about mental health issues have the potential to offer a broader range of discourses of mental health for circulation rather than primarily reproducing the medical discourse as they currently do. For example, the recent 'Like Minds' campaign to reduce discrimination against people with mental health problems uses the language of 'mental illness' to frame its understanding of mental health issues (see Chapter Five). Thus, while encouraging people not to stigmatize those with mental health problems, such medical languaging does little to acknowledge that discrimination and oppression can be constructive of mental health problems. Through this omission the pathologising of individuals continues, and harmful social practices, (such as those leading to homonegative trauma), are ignored. In this regard, future education initiatives might benefit from broadening the discourses used to account for mental health problems.

Returning to my queer-affirmative political intentions, I wish to comment on a strategy for furthering the sorts of reforms I have suggested. My analysis has led me to propose a universalising strategy for change, one which fits within a queer discourse of homosexuality and its mistrust of practices which support the hetero/homo binary through constructing homosexuality as an issue of concern to only a minority of people. However, the critical Foucauldian perspective I also employ enables consideration of unequal power relations and their material effects on marginalised groups (see Chapter Two). Thus, as discussed in Chapter Eleven, I agree with Sedgwick (1990), and others (Chambers, 2002; Nairn & Smith, 2003), who argue that the marginalising/universalising dichotomy is a useful analytical tool but need not represent mutually exclusive approaches.

Accordingly, when advocating for change I recommend utilising both universalising and minoritising arguments strategically, and ethically, to support queer-affirmative goals. For

example, coming from a universalising perspective, I recently asked a woman in a clinical assessment if she had any concerns about her sexuality or sexual orientation (a question I usually ask all new clients). She replied that she saw herself as heterosexual but that she had been raped by a woman and since then she sometimes had sexual thoughts about women. She reported that my question had been useful in opening up a space for her to discuss something which often worried her but that she had been uncomfortable to raise previously. Thus, asking about sexual orientation can potentially benefit many clients not just those who identify as homosexual.

Yet, importantly, it is likely to be strategically useful to draw on multiple, and sometimes minoritising, discourses to advance queer-affirmative changes, by highlighting the unequal power relations affecting MSM clients in PMHS. Rick, one of the MSM clients, gave a very clear account of how he felt positioned by heteronormative practices and power relations within PMHS:

Rick Well if they [staff] are not easily going to raise it then who is. It is kind of like we are in their contact and they have the power to make or break us basically [client].

Here Rick speaks from the passive patient subject position of the medical discourse. This discourse imbues staff with the power to direct conversations. Rick wants them to use this power to create a space to discuss homosexuality. Discourses such as equal rights, consumer/clients' rights, and the psy and critical discourses of mental health, can usefully be employed to expose the construction and effects of staff silence surrounding homosexuality. These discourses afford MSM clients the right to be, and feel, supported to deal with the psychological effects of homonegative trauma. Furthermore, from these discourses PMHS, and staff within them, have a responsibility to stop institutional practices that silence MSM clients, and the trauma these clients may be coping with. By stopping such practices staff can potentially disrupt, rather than maintain, trauma and marginalisation that MSM clients may be experiencing.

In conclusion, I contend that critical discourse analysis offers a means of understanding the complexity of ways in which clients and staff in PMHS understand homosexuality, mental health, and the relationships between them. It also offers a framework for understanding how the various discourses of homosexuality, and of mental health, enable and constrain both clients and staff in ways that can work to silence homonegative trauma within PMHS. Some MSM clients manage to resist this silence but some do not. For their part, staff are

also constrained from breaking this silence. Because of this, I argue there is a need for more queer conversations in PMHS. Further, for queer conversations to flourish in PMHS, commitment and support at an institutional level appears vital. Initiating these queer conversations needs to become part of 'best practice' within PMHS.

I hope this thesis provokes more conversations regarding homosexuality, and homonegative trauma, in PMHS. Yet, at least initially, the process and outcome of these conversations may be uncomfortable and unpredictable for staff and clients, queer or otherwise. This is because such conversations contest the widespread assumption of heterosexuality; an assumption that is often unacknowledged and unchallenged by the medical and psy discourses of mental health. However, if left unchallenged, heteronormative practices within PMHS can suppress, and, thereby, maintain the often traumatic effects of homonegativity. I contend that queer conversations, if thoughtful, have the potential to disrupt heteronormative power relations within PMHS. These conversations could, in turn, increase the possibility for MSM like Rick to receive acknowledgment of their understandings and experiences of homonegative trauma. Such acknowledgment, especially if accompanied by the provision of psychosocial services, could enable the staff of PMHS to support MSM in their recovery from such trauma.

Appendix 1:

Questionnaire Speak Your mind

Speak Your Mind – Questionnaire⁸⁰: Experiences of public mental health services by men who have sex with men

Thank you for agreeing to participate. The aim of this research is to explore the experiences of men who have sex with men in seeking help from public mental health services. It will also explore how men who have sex with men understand mental health problems and how they cope with them.

The term **public mental health services** refers to any mental health service provided by the three main providers in Auckland i.e. A+, Auckland Healthcare (Central & East), South Auckland Health, or Waitemata Health (North & West). It does not include Alcohol and Drug services or general hospital services.

Instructions for filling out this questionnaire

To answer most questions you will need to tick a box. Some questions ask you to give a written answer. For these please PRINT your reply. Please try to answer all questions. You may however choose not to answer any specific question/s. Any information, which could identify you or anyone else, will be removed. You may return the questionnaire anonymously if you wish i.e. without your name on it.

When you have finished the questionnaire, please post it in the stamped addressed envelope provided or hand to the researcher.

Please return to:

**David Semp, Psychology Department, University of Auckland,
Private Bag 92019, Auckland.**

⁸⁰ The formatting of this questionnaire has been significantly amended in order to include it in the thesis formatting.

Demographics

1. Your age: _____
2. Which **ethnic group(s)** do you belong to?
- New Zealand European or Pakeha
- NZ Maori
- Iwi: _____
- Pacific Island
- Please specify: _____
- Asian
- Please specify: _____
- Other
- Please specify: _____
3. What is your **highest** level of education?
- Primary school
- High school/secondary school
- Polytech or similar
- University
4. What was your **personal** income and your **household's** total income before tax for the past 12 months?
- | | Yourself | Total Household |
|--|--------------------------|--------------------------|
| Less than \$20,000 per year (less than \$385 per week) | <input type="checkbox"/> | <input type="checkbox"/> |
| \$20,001-\$40,000 per year (\$386 - \$769 per week) | <input type="checkbox"/> | <input type="checkbox"/> |
| \$40,001-\$70,000 per year (\$770-\$1,346 per week) | <input type="checkbox"/> | <input type="checkbox"/> |
| \$70,001 and over per year (\$1,347 and over per week) | <input type="checkbox"/> | <input type="checkbox"/> |
5. Which of the following terms would you use to **define your sexuality to yourself?** (you may choose more than one)
- | | |
|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Gay male | <input type="checkbox"/> Takataapui |
| <input type="checkbox"/> Queer | <input type="checkbox"/> Homosexual |
| <input type="checkbox"/> Straight | <input type="checkbox"/> Bisexual |
| <input type="checkbox"/> Heterosexual | |
| <input type="checkbox"/> Other: _____ | |

Experiences of Public Mental Health Services

6. Are you **currently a client** of Public Mental Health Services in Auckland?
- Yes No
- (If 'no' please indicate when you last had contact with Public Mental Health Services in Auckland)
- Year _____ (approx. or actual)
7. Which service did you last have contact with? (If currently a client, tick your current service)
- Waitemata Health
- Auckland Healthcare (A+)
- South Auckland Health
8. Which type of Public Mental Health Services have you used in Auckland (you may tick more than one)
- Inpatient/Acute Hospital/Unit
- Crisis Team
- Outpatient/Community Service
- Please specify: _____
- Other
- Please specify: _____

- a. Please describe in your own words what led to your contact with Public Mental Health Services?

- b. How important is it that staff know your sexuality in order for them to be helpful? (Please circle one number only)

Not at all important Very important

1 2 3 4 5 6 7

- c. How comfortable do you feel about acknowledging your sexuality within public mental health services? (Please circle one number only)

Very uncomfortable Very comfortable

1 2 3 4 5 6 7

- d. How useful have Public Mental Health Services been for you? (Please circle one number only)

Very unhelpful Very helpful

1 2 3 4 5 6 7

- e. How user-friendly do you think public mental health services are to men who have sex with or are attracted to men? (Please circle one number only)

Not at all user-friendly Very user-friendly

1 2 3 4 5 6 7

Your Feedback and Ideas

Based on your experience please answer the following questions in regard the **effectiveness of public mental health services for men who have sex with men**:

14. What has been most helpful in this regard?

15. What has been least helpful in this regard?

16. What suggestions (if any) do you have for improvements in public mental health services for men who have sex with or are attracted to men?

Are you willing to be interviewed about these issues in more detail?

Yes Name: _____

Maybe, but I would like more information Address: _____

No _____

If you ticked **'No'**, thank you for participating in the research. Please return the completed questionnaire to me in the envelope provided.

Ph and/or email: _____

If you ticked **'Yes'**, or **'Maybe'**, please fill in your contact details and post the questionnaire to me in the envelope provided. I will then contact you about the interview. You can also contact me by writing, by email or by phone.

Thank you – from David Semp, Psychology Department, University of Auckland, Private bag 92019, Auckland
Email dsemp@ihug.co.nz Ph 845-0947 (work)

Appendix 2:

Interview Guidelines Clients

Speak Your Mind – Interview guidelines for men who have sex with men, who have been or are clients of public mental health services.

In this interview, I will ask three types of questions and roughly in the following order: I will also ask you for more expansion on some of your ideas.

- Questions about your sexual orientation
- Questions about your experience of mental health issues before you had contact with pmhs
- Questions about your experiences and views on pmhs for msm clients

Setting a context

1. What mental health services have you/do you currently use?
2. How do you describe your sexuality (identity or orientation) to yourself?
3. Is your sexuality important to how you see/think of yourself? If it is, in what ways?
 - Are there any other important areas of your identity?
 - How important is sexuality in comparison with these differences?

Experience of Mental health problems and coping, before contact with pmhs

4. What is your understanding of how you came into contact with pmhs?
 - Look for use of language re ‘mental health’ and ‘mental illness’
 - How do you define them?
 - How relevant are they to you?
5. Can you tell me about your understanding of (use interviewees term for mental health problem) before you had contact with public mental health services
 - How did you understand that issue before you had contact with pmhs?
 - How did you respond to the issue? What did you do? How well did they work?
 - Was your sexuality or sexual identity relevant to the mental health problem? If so, how?

Experience of Public mental health services

6. How did you come into contact with (name of service e.g. Taylor Centre)?
 - What did you think might happen?
 - What outcome did you expect?
 - What were these expectations based on?
7. Can you tell me about your contact with public mental health services? What has it been like for you?
 - What was useful about it? How was it useful?
 - What was less useful? How was it less useful?
8. Was your sexuality part of the interaction in any way?
 - Was it important for you that it was acknowledged or not?
 - Was your sexuality or sexual identity acknowledged by pmhs? How? What was the process of acknowledgment, or not? How did it happen?
 - How respectful was that for you?
 - Did it make any difference to the effectiveness of the service you received? If so, how?
 - Did you change your behaviour with staff or other clients in pmhs because of your sexuality? E.g., did you limit how much you told staff about your life as it related to your sexuality?
9. Has your experience or understanding of mental health issues changed through your contact with pmhs? If so, how?
 - Has this been useful or not? How?
10. What role, if any, do you think lgbtt staff should have in public mental health services?
 - Why should they have this role?
 - Were you aware of having contact with any lgbtt staff?
 - Do you think all lgbtt staff are able to take this role?
 - Do you think they should they be out to clients? Why/why not?
 - What about the role of non-lgbtt staff with msm?
11. Have you heard or read about any mental health issues in relation to msm or the risk of mental health issues for this group of people? (for example suicide or depression)
 - What do you think of this?
 - Why do you think this might be?
12. Are there any changes you would like to see in pmhs that would have or could serve you better as a msm? i.e. if you were to use the services again? e.g. environment, practices, advice to staff?
 - What are these changes? How would they work?
 - What do you think about being asked about sexual orientation in an assessment?
 - What do you think about being offered a lesbian or gay clinician?
 - What do you think about separate services for lgbtt?
 - Is there any advice you would give to staff?

13. Given the way pmhs are now, what (if any) advice would you give to other msm who have mental health issues?
- About contact with pmhs?
 - About how to cope with the mental health problem?

Closing

14. Is there anything at all that you want to add?
15. Do you have any questions or comments about how this interview has gone or for ways of improving these interviews? – You can write this down and send it to me if you prefer. At the end, tell people they can if they think of any things after the interview that they want to say about the things we've talked about, I would be happy for them to write it down and post or email to me.
-

Interview Guidelines Staff

Speak Your Mind – Interview guidelines for clinical staff of public mental health services who are lgbtt and/or who have same-sex attraction.

In this interview, I will ask three types of questions and roughly in the following order:

- Questions about your work and your sexuality
- Questions about your views on public mental health services for msm clients
- Questions about any recommended changes to pmhs

I want to start with some questions about your work and your sexuality

1. Tell me about your role(s) in public mental health services – current and past
2. Do you have a way of describing your sexuality (identity or orientation) to yourself? What is it?
3. Is your sexuality significant to you? In what ways?
 - Is it relatively more or less significant than other areas?
4. In your training. How was same-sex sexuality acknowledged/not acknowledged?
5. What is it like to be lgbtt in your workplace? What do you think about that?
 - Is it important for you to have your sexuality respected in your workplace? E.g. being ‘out’; or acknowledging same-sex partners to colleagues
 - How did you come to the position you have about being ‘out’ or not at work?
 - What about in supervision?


Views of public mental health services for men who have sex with men

6. How does your organisation meet the mental health needs of msm?
 - On what do you base this?
 - How does the organisation know if clients are msm?
 - How do you think this came to be? And what do you think about it?
 - What are the implications of this for msm clients?
 - How important do you think it is to know a clients sexuality in order to provide good mental health care? Why? How should it be asked or made space for?
7. Do you think there any relationship between suicidality and being a msm?
 - Why do you think this might be?
 - What about for other mental health problems? Ie are there particular problems that might be more likely for msm?

- What are the implications of this for treatment?
8. How are mental health problems usually talked about in your work setting? Ie what kind of language or models?
 - How do you relate to these ways of understanding?
 - How relevant are they for understanding mental health problems of msm?
 - How relevant is DSM for understanding mental health problems of msm?
 - What are the implications of this?
 - How do you prefer to think about mental health problems?
 9. Are things getting better for non-heterosexual people in public mental health services since homosexuality has been officially de-pathologised?
 - How/how not?
 - How do you understand this change/lack of change?
 10. What, if anything, do you think lgbtt staff have in particular to offer msm clients?
 - How did you come to believe this?
 - Does this apply to all lgbtt staff?
 - What about you in particular?
 - What do you think about lgbtt staff being 'out' to their clients?
 - What do you think heterosexual staff think of this?
 - How does working in a small community impact on this?
 - How does your organisation impact on this?
 11. Do you think lgbtt staff are over represented in public mental health services?
 - How do you make sense of this?
 - What is your sense as to how many are 'out' in their workplace or not?
 - Why do you think this is?


Changes to pmhs and anything relevant we haven't covered

12. What changes (if any) do you think are needed to improve pmhs for msm? ie to services, staff (hetero & lgbtt), District Health Board and Govt. policy.
 - How do you think these changes would make a difference?
 - If they suggest inclusion in assessment, ask how it would be for clients – ask for details of this
13. What barriers do you imagine to these changes?
14. Given how pmhs are now, what advice would you give to msm who may use pmhs?
15. Given how pmhs are now, what advice would you give to lgbtt staff who may choose to work in the services?
16. Is there anything at all that you want to add?
17. Do you have any questions or comments about how this interview has gone or for ways of improving these interviews

 THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

Speak Your Mind
A study about public mental health services for men who have sex with men*

client & ex-client brochure



An invitation to take part in a study exploring how men who have sex with men in Auckland get their mental health needs met.


*The study also includes men who are sexually attracted to men but who have not had or do not have sex with men

Confidentiality

If you decide to take part in this study, you can be sure that no information that can identify you will be on the final report or any related publications. All information you give in the questionnaire in this invitation or in an interview will be kept secured at all times.

If you wish to contact a supervisor of this study you can phone
Dr. John Read, Psychology Dept. on (09) 373 7599 ext 5011

If you have any queries or concerns about your rights as a participant in this study, you may wish to contact ,
The Health Advocates Trust
Ph. 0800 555 050
(covers Northland to Franklin).

 THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

This study has received ethical approval from the Auckland Ethics committee.


What is involved in the study?

If you would like to participate in the study, contact me by phone, mail or email. I will then contact you to answer any questions you may have and send you the questionnaire and information sheet about the study.

While I do want to interview up to 30 men, you can complete the questionnaire without agreeing to be interviewed.

As this research will be asking personal and sensitive questions about your experience of mental health problems, I would ask you to consider carefully whether you would like to participate in this project.

Contact Details:
David Semp
Psychology Department
University of Auckland
Private Bag 92019 Auckland
Email: dsemp@ihug.co.nz
Phone (09) 845-0947 (work)



► Speak Your Mind About the study



Hi,
My name is David Semp and I am doing my PhD research with the University of Auckland, Psychology Department.

The research explores how men who have sex with men understand and cope with mental health problems and how they get support for mental health problems from public mental health services.

Sexuality and how we and others view it is often an important part of our lives. Male to male sexuality is criticised or ignored in many areas of society. The aim of this research is to find out how this social marginalisation may impact on mental health, mental health problems and public mental health services for men who have sex with men.

The research is being conducted by a gay male psychologist



Why is the research being done?

There is very little research overseas on how men who have sex with men experience public mental health services or their experience of mental health problems.

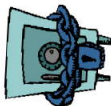
There is no research on how public mental health services in New Zealand meet the needs of men who have sex with men or on their experience of mental health problems.

This research will be useful in exploring how men who have sex with men can best get their mental health needs met. It may also help in the design of social policy and other health promotion initiatives for men who have sex with men.



The aim is to improve support for men who have sex with men and also have mental health problems

I invite you to take part if you...



- Are aged 16 or over
- Are a man who has sex with men or a man who is sexually attracted to men but has not had or does not have sex with men
- Have used (in the last five years), or are currently using public mental health services in Auckland

All information about you will be kept confidential

- Are willing to complete a brief questionnaire on these issues. At the end of this questionnaire you can indicate if you are willing to be interviewed about these issues.

Participation is voluntary




THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

This study has received ethical approval from the Auckland Ethics committee.

**THE UNIVERSITY OF AUCKLAND
NEW ZEALAND**

Speak Your Mind
A study about public mental health services for men who have sex with men*



An invitation for staff** of public mental health services to take part in a study exploring public mental health services in Auckland for men who have sex with men.

*The study invites staff who identify (not necessarily publicly) as lesbian, gay, bisexual, transgender, or transsexual and staff who have same-sex attraction but do not identify with any of these terms.
**The study includes clinical and non-clinical staff

Confidentiality

If you decide to take part in this study, you can be sure that no information that can identify you will be on the final report or any related publications. All information you give in an interview will be kept secured at all times.

If you wish to contact a supervisor of this study you can phone
Dr John Read, Psychology Dept. on (09) 373 7599 ext 5011
or
Dr Heather Worth, Institute for Research on Gender on 373 7599 ext 7042
at the University of Auckland.

If you have any queries or concerns about your rights as a participant in this study, you may wish to contact ,
The Health Advocates Trust
Ph. 0800 555 050
(covers Northland to Franklin).

**THE UNIVERSITY OF AUCKLAND
NEW ZEALAND**


This study has received ethical approval from the Auckland Ethics committee.

What is involved in the study?

If you would like to participate in the study, contact me by phone, mail or email. I will then contact you to answer any questions you may have and send you an information sheet about the study.

The management of Auckland, Counties-Manukau and Waitemata District Health Board's Mental health Services have given approval for this study to be carried out.

Contact Details:
David Semp
Psychology Department
University of Auckland
Private Bag 92019 Auckland
Email: dsemp@itug.co.nz
Phone (09) 845-0947 (work)



Speak Your Mind About the study



Hi,

My name is David Semp and I am doing my PhD research with the University of Auckland, Psychology Department.

The research explores how men who have sex with men understand and cope with mental health problems and how they get support for mental health problems from public mental health services.

The research is being conducted by a gay male psychologist

An important part of this research is to interview staff working within public mental health services who can give their views on both how they see service provision to men who have sex with men and how it is to work within public mental health services as non-heterosexual and/or transgendered staff. It is hoped that your views and knowledge on this topic will provide valuable information to add to research, theory and practice in this area.

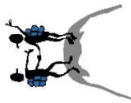
Why do this research?

There is very little research overseas (and none in New Zealand) on how men who have sex with men experience public mental health services or their experience of mental health problems.

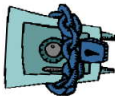
There is also very little research on the experiences of lesbian, gay, bisexual, and transgendered staff of public mental health services or of staff who have same-sex attraction but do not identify with the above terms.

The aim is to improve support for men who have sex with men and also have mental health problems

It is important to explore the experiences of non-heterosexual and/or transgendered staff as they may be in a unique 'insider' position from which to comment on service provision to men who have sex with men.



I invite you to take part if you ...



- Have worked for (in the last five years), or are currently working for public mental health services in Auckland. (This does not include alcohol and drug services.)

All information about you will be kept confidential

- Identify (not necessarily publicly) as lesbian, gay, bisexual, takatāpui or transgendered, or you have same-sex attraction but do not identify with the above terms.

- Are willing to be interviewed about these issues.

Participation is voluntary



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

This study has received ethical approval from the Auckland Ethics committee.

Participant Information Clients/Ex-clients

Speak Your Mind – A Study About Public Mental Health Services For Men Who Have Sex With Or Are Attracted To Men

What is this research about?

You are invited to participate in research on the provision of public mental health services to men who have sex with or are attracted to men. My name is David Semp and I am doing my PhD research with the Psychology Department, at the University of Auckland. I also work as an 'out' gay clinical psychologist in public mental health services. The research explores how men who have sex with or are attracted to men get support for mental health problems from public mental health services and how they understand and cope with mental health problems. I am inviting men who have sex with or are attracted to men to complete a brief questionnaire on these issues. I will be interviewing up to 30 men for this research. I will also be interviewing staff of public mental health services about their views on these issues.

Invitation to participate

You can participate in one of two ways.

1. You can just complete the attached questionnaire and post it to me.
2. or You can complete the questionnaire and agree to take part in a semi-structured interview.

If you agree to an interview, I would ask you to talk about your experience of public mental health services and mental health problems.

The interview will take approximately 1-1½ hours and will be conducted at a place suitable to you (e.g., your home, workplace, community setting or a private room at the university). You may write any ideas about the interview, afterwards and send them to me if you wish. I would like to audiotape the interview, which will then be transcribed into written text for analysis. If you would like, I will send you a copy of the transcript for your own checking and interest. All information you provide will be stored without your name on it. The consent form, which you would sign, would be stored separately from any other information.

You are under no obligation to take part in this study. If you do decide to take part, you do not need to answer all the questions in the questionnaire or interview. You can withdraw at

any stage, without giving a reason, up until three months after the interview. Participation or non-participation in this study will not affect any future care or treatment.

In this study, the term ‘**public mental health services**’ refers to any mental health service provided by the three main providers in Auckland i.e. Auckland DHB - A+ (Central & East), Counties-Manukau DHB (South Auckland Health), or Waitemata DHB (North & West). It does not include Alcohol and Drug services or general hospital services.

For this study, the term ‘**men who have sex with or are attracted to men**’ includes any man meeting the following criteria: speaks English or Maori; aged 16 or over; has sex with men (or is sexually attracted to men but does not have sex with men); and have accessed (in the last 5 years) or are accessing public mental health services in Auckland. Past or current clients of the researcher are not eligible for this study.

How will confidentiality be protected?

This research is part of my PhD degree and may also lead to further publications. In my thesis and in any publications that arise from it (and in any talks about the research) I am likely to present quotes from the people interviewed. Any details that could identify you will be altered to protect your anonymity. I will ask all interviewees to choose a pseudonym they would like me to use in the research write-up. During the analysis, your full transcript will only be seen in detail by my two supervisors, Dr John Read and Debbie Payne, and myself. At all times your confidentiality will be maintained. The exception to this would be if I have any significant concerns regarding the safety of you or others

Because this research will be asking personal and sensitive questions about your experience of mental health problems, I would ask you to consider carefully whether you would like to participate in this project. It is possible that discussing your experiences of mental health problems and of public mental health services could be uncomfortable or distressing to you. If you do choose to participate, and later wish to discuss anything relating to your participation in the research, you are welcome to contact:

The Burnett Centre, to make a time to speak with one of the counselling staff. This is a free service. Ph (09) 309 5560 Email burnett@ihug.co.nz

Address: 1/3 Poynton Terrace, Newton, Auckland

At the end of the research write-up I will write a summary of the results of the questionnaires and the interviews. I will send this to any participant who requests it. Please note there is likely to be a considerable delay between the end of the interviews and the final writing up of the study, this may be 2-3 years. I hope this research results in a positive contribution to the research on mental health problems for men who have sex with or are attracted to men and on practical knowledge of how public mental health services can best support men who have sex with or are attracted to men.

Thank you for taking the time to read this information sheet.

Compensation Declaration

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations. If you have any questions about ACC please feel free to ask the researcher for more information before you agree to take part in this study.

Where can you get more information about the study?

If you would like more information regarding this study or have any concerns, you may contact:

David Semp

Psychology Department, University of Auckland
Private Bag 92019 Auckland
Ph: (09) 845-0947 (work) Email: dsemp@ihug.co.nz

Dr John Read,

Psychology Department, University of Auckland
Private Bag 92019 Auckland
Ph:(09) 373 7599 ext 5011 Email: j.read@auckland.ac.nz

Debbie Payne

School of Nursing and Midwifery, Auckland University of Technology
Private Bag 92006 Auckland
Ph: (09) 917-9999 ext 7112 Email: debbie.payne@aut.ac.nz

If you have any queries or concerns about your rights as a participant in this study you may wish to contact: Health Advocates Trust 0800 555 050 (Northland to Franklin)

THIS STUDY HAS RECEIVED ETHICAL APPROVAL FROM THE AUCKLAND ETHICS COMMITTEE.

Please feel free to contact the researcher if you have any questions about this study.

Resource Sheet LGBT Support Services

Lesbian, Gay, Bisexual, Takataapui* & Transgender Support Services, Auckland

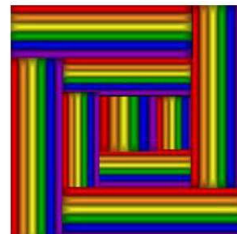
- Δ [The Burnett Centre](#) — counselling, HIV testing, support and info. (part of the New Zealand Aids Foundation). Unit 1-3 Poynton Tce, Auckland ph 09 309 5560
- Δ [Gayline, Lesbianline](#), Auckland—Information, support referrals and telephone counselling. Ph 09 303 3584 10am-10pm weekdays 5pm-10pm weekends
- Δ [Rainbow Youth](#) - a group of young people who run an organisation providing support, contact and education for Gay, Lesbian, Bisexual, Transgender, Fa'afafine and Takataapui youth. Ph 09 630-7282
- Δ [Hau Ora Takataapui](#) - Maori organisation within New Zealand Aids Foundation. Takataapui support, outreach, kapa haka and information. Ph 09 303 3124
- Δ [The Pride Centre](#) - LGBT community information and resource service, meeting space and lending library. A number of support groups operate at the Pride centre building. 281 Karangahape Rd, Auckland Ph 09 302 0590
- Δ [CADS](#) - Community Alcohol and Drug Services. This regional service has lesbian and gay counsellors available. They will also have info for lesbian and gay AA meetings. Ph CADS Central 623-2323
- Δ [The Women's Centre](#) - information and advice for women. 4 Warnock St, Grey Lynn. Ph 09 376 3227

In addition to the above resources, there are many other LGBTT groups eg gay bridge club, gay pool club, a gay social Sunday walks group, gay men's rugby team, gay Runners (mixed), gay sport New Zealand (mixed), swimming team (mixed), ten pin bowling, gay Asian support group, lesbian and gay churches, and lesbian and gay student groups at Auckland University and Auckland University of Technology.


*“The word Takataapui has been around before colonisation but it is only in the last decade that the Maori Gay, Lesbian, Bi-sexual and Transgender community have adopted the word to identify as being Maori and queer.”

Hau Ora Takataapui, New Zealand Aids Foundation


COMPILED BY DAVID SEMP AS
PART OF THE 'SPEAK YOUR
MIND' RESEARCH PROJECT 2002



**THE UNIVERSITY OF AUCKLAND
NEW ZEALAND**



Speak Your Mind
A study about public mental health services for gay males*
client & ex-client brochure



An invitation to take part in a study exploring how gay males* in Auckland can best get their mental health needs met.

*the study includes males who are attracted to males but who do not see themselves as gay, bisexual or takatāruapi


Confidentiality

If you decide to take part in this study, you can be sure that no information that can identify you will be on the final report or any related publications. All information you give in the questionnaire in this invitation or in an interview will be kept secured at all times.

If you wish to contact a supervisor of this study you can phone
Dr John Read, Psychology Dept. on
(09) 373 7599 ext 5011

If you have any queries or concerns about your rights as a participant in this study, you may wish to contact ,
The Health Advocates Trust
Ph. 0800 555 050
(covers Northland to Franklin).

**THE UNIVERSITY OF AUCKLAND
NEW ZEALAND**



This study has received ethical approval from the Auckland Ethics committee.


What is involved in the study?

If you would like to participate in the study, contact me by phone, mail or email. I will then contact you to answer any questions you may have and send you the questionnaire and information sheet about the study.

While I do want to interview up to 30 men, you can complete the questionnaire without agreeing to be interviewed.

As this research will be asking personal and sensitive questions about your experience of mental health problems, I would ask you to consider carefully whether you would like to participate in this project.

Contact Details:
David Semp
Psychology Department
University of Auckland
Private Bag 92019 Auckland
Email: dsemp@iitug.co.nz
Phone (09) 845-0947 (work)



Speak Your Mind About the study



Hi,

My name is David Semp and I am doing my PhD research with the University of Auckland, Psychology Department.

The research explores how males who are attracted to males understand and cope with mental health problems and how they get support for mental health problems from public mental health services. Sexuality and how others view it is often an important part of our lives. Male to male sexuality is criticised or ignored in many areas of society. The aim of this research is to find out how this social marginalisation may impact on mental health, mental health problems and public mental health services for males who are attracted to males.

The research is being conducted by a gay male psychologist.



Why is the research being done?

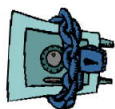
There is very little research overseas on how males who are attracted to males experience public mental health services or their experience of mental health problems.



There is no research on how public mental health services in New Zealand meet the needs of males who are attracted to males or on their experience of mental health problems. This research will be useful in exploring how males who are attracted to males can best get their mental health needs met. It may also help in the design of social policy and other health promotion initiatives for males who are attracted to males.

The aim is to improve support for males who are attracted to males and also have mental health problems.

I invite you to take part if you...



All information about you will be kept confidential

- Are aged 16 or over
- Are a male who is sexually attracted to males
- Have used (in the last five years), or are currently using public mental health services in Auckland
- Are willing to complete a brief questionnaire on these issues. At the end of this questionnaire you can indicate if you are willing to be interviewed about these issues.

Participation is voluntary



THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

This study has received ethical approval from the Auckland Ethics committee.

Appendix 9:

Initial Information Staff

18th December 2001

Managers, Team Leaders & Teams
Auckland Healthcare
Community Mental Health Centres

Re: Research project by David Semp, on public mental health services for gay men.

This letter is to introduce myself, and some research that I will be conducting across the three main mental health service providers in Auckland. This letter is also to clarify the assistance I am wanting and to provide information for staff who may have questions about the research.

My name is David Semp. I am doing my PhD with the Psychology Department of the University of Auckland and I work at St Lukes Community Mental Health Centre (Auckland DHB) as a clinical psychologist. My supervisors are Dr John Read and Dr Heather Worth. For the research, I will be exploring the relationship between men who have sex with men⁸¹ and public mental health services. There is growing evidence that this group in the community are at greatly increased risk of suicide and possibly of other mental health problems related to and/or exacerbated by marginalisation and oppression. However, there is no research in New Zealand and little internationally on the effectiveness of public mental health services for these clients, or on these clients experiences of mental health problems.

The research will involve two parts.

1. The first phase will be in early 2002 and is to invite men who have sex with men who are current or past clients (within the last 5 years) of public mental health services in Auckland, to complete a brief questionnaire on these issues and to indicate if they would be willing to be interviewed about these issues. I intend to interview 20-30 clients/ex-clients.
2. Secondly, hopefully in mid-late 2002, I will invite staff⁸² who identify (not necessarily publicly) as lesbian, gay, bisexual, transgender, or takataapui and staff

⁸¹ In this study I will use the term “men who have sex with men” (msm) as previous research has found that this helps include men with same sex behaviour and attraction, but who do not identify as gay.

⁸² The study includes clinical and non-clinical staff.

who have same-sex attraction but do not identify with any of these terms, to be interviewed about these issues and their experiences of public mental health services. I intend to interview 12 staff members.

I have included copies of brochures and flyers that will be used to invite clients and staff to participate; and a copy of the questionnaire for clients. This questionnaire will be sent to clients who request it. The Auckland Ethics Committee and management of Auckland DHB have approved the research. Please do not distribute the brochures or the questionnaire. I will copy and bring more brochures and posters in 2002.

I am asking for your support for this research.

1. For phase one, I would like to be able to make brochures and small posters inviting participation in the research available in outpatient settings in places where clients would likely see them.
2. For phase two I would like to be able, to make brochures and small posters inviting participation in the research available in outpatient settings in places where staff would likely see them.

With this letter I have also included a resource sheet of some of the main support services for lesbian, gay, bisexual, takataapui and transgender people in Auckland. I would like to make a version of this letter and the included resource sheet available for staff so they know about the research and can use this information if clients ask questions.

Please contact me if you have any questions about this research. Thank you again for offering your support for this research on the effectiveness of public mental health services for this one of many high-risk client groups.

Yours sincerely

David Semp

Phone: 845-0947 (work)

Email: dsemp@ihug.co.nz

PhD Student & Clinical Psychologist

Participant Information Clinical Staff

Speak Your Mind – A Study About Public Mental Health Services For Men Who Have Sex With Or Are Attracted To Men

What is this research about?

You are invited to participate in research I am doing on the provision of public mental health services to men who have sex with or are attracted to men. My name is David Semp and I am doing my PhD research with the Psychology Department, at the University of Auckland. I also work as an 'out' gay clinical psychologist in public mental health services. The research explores how men who have sex with or are attracted to men, get support for mental health problems, from public mental health services, and how they understand and cope with mental health problems. It also explores the views and experiences of lesbian, gay, bisexual, takataapui, and transgender staff on these issues.

Invitation to participate

You are invited to participate in the research. This would involve agreeing to take part in a semi-structured interview on the research topic. During the interview, I would ask you to talk about your experience of working in public mental health services, your training, your views on same-sex sexuality and your views on how public mental health services meet the needs of men who have sex with or are attracted to men.

The interviews will take approximately 1-1½ hours and will be conducted at a place suitable to you (e.g., your home, workplace, community setting or a private room at the university). You may write any ideas about the interview, afterwards and send them to me if you wish. I would like to audiotape the interviews, which will then be transcribed into written texts for analysis. If you would like, I will send you a copy of the transcript for your own checking and interest. All information you provide will be stored without your name on it. The consent form, which you would sign, would be stored separately from any other information.

You are under no obligation to take part in this study. If you do decide to take part, you do not need to answer all the questions in the interview. You can withdraw at any stage, without giving a reason, up until three months after the interview.

In this study, the term '**public mental health services**' refers to any mental health service provided by the three main providers in Auckland i.e. Auckland DHB (Central & East),

South Auckland DHB, or Waitemata DHB (North & West). It does not include Alcohol and Drug services or general hospital services.

For this study **eligible staff** includes any staff meeting the following criteria: identify (not necessarily publicly) as lesbian, gay, bisexual, transgender, or takataapui and staff who have same-sex attraction but do not identify with any of these terms; have worked (in the last five years) or are currently working for public mental health services in Auckland; and are willing to be interviewed about these issues.

How will confidentiality be protected?

This research is part of my PhD degree, but it may also lead to further publications. In my thesis and in any publications that arise from it (and in any talks about the research) I am likely to present quotes from the people interviewed. Any details that could identify you will be altered to protect your anonymity. I will ask all interviewees to choose a pseudonym they would like me to use in the research write-up. During the analysis, your full transcript will only be seen in detail by my two supervisors, Dr John Read and Debbie Payne, and myself. At all times your confidentiality will be maintained. The exception to this would be if I have any significant concerns regarding the safety of you or others

At the end of the research write-up I will write a summary of the results of the questionnaires and the interviews. I will send this to any participant who requests it. Please note there is likely to be a considerable delay between the end of the interviews and the final writing up of the study, this may be 2-3 years. I hope this research results in a positive contribution to the research on mental health problems for men who have sex with or are attracted to men and on practical knowledge of how public mental health services can best support men who have sex with or are attracted to men.

Thank you for taking the time to read this information sheet.

Compensation Declaration

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations. If you have any questions about ACC please feel free to ask the researcher for more information before you agree to take part in this study.

Where can you get more information about the study?

If you would like more information regarding this study or have any concerns, you may contact:

David Semp

Psychology Department, University of Auckland
Private Bag 92019 Auckland
Ph: (09) 845-0947 (work) Email: dsemp@ihug.co.nz

Dr John Read,

Psychology Department, University of Auckland
Private Bag 92019 Auckland
Ph: (09) 373 7599 ext 5011

Ms Debbie Payne

School of Nursing and Midwifery, Auckland University of Technology
Ph (09) 917-9999 ext 7112 Email: Debbie.payne@aut.ac.nz

THIS STUDY HAS RECEIVED ETHICAL APPROVAL FROM THE AUCKLAND
ETHICS COMMITTEE.

Please feel free to contact the researcher if you have any questions about this study.

Appendix 11:

Consent Form Clients/Ex-clients

Title: Speak Your Mind: A Study about Public Mental Health Services for Men Who Have Sex With or are Attracted to Men

I have read and understand the information sheet dated 23-8-2002 for volunteers taking part in the study designed to explore public mental health services for men who have sex with or are attracted to men. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw myself or any information traceable to me at any time up to three months after the interview, without giving reasons, and this will in no way affect my future health care. I also understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. The exception to confidentiality would be if the researcher has any significant concerns regarding the safety of others or myself.

E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero **Ae / Kao**

I understand the compensation provisions for this study.

I have had time to consider whether to take part.

I know who to contact if I have any questions or concerns about the study.

I agree to the interview being audio taped.

I would like to be sent a copy of the interview transcript for my own interest: **Yes / No**

I wish to receive a summary of the results of the research: **Yes / No**

I _____ hereby consent to take part in this study.

Date

Signature

Signature of witness

Full name of researcher David Semp Name of witness

Contact phone number for researcher work 09 845-0947

Project explained by David Semp

Project Role Researcher

Signature

Date

APPROVED BY THE AUCKLAND ETHICS COMMITTEE

Appendix 12:

Consent Form Staff

Title: Speak Your Mind: A Study about Public Mental Health Services for Men Who Have Sex With Or Are Attracted To Men

I have read and understand the information sheet dated 23-8-02 for volunteers taking part in the study designed to explore public mental health services for men who have sex with or are attracted to men. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw myself or any information traceable to me at any time up to three months after the interview, without giving reasons, and this will in no way affect my continuing/future employment. I also understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. The exception to confidentiality would be if the researcher has any significant concerns regarding the safety of others or myself.

E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero **Ae / Kao**

I understand the compensation provisions for this study.

I have had time to consider whether to take part.

I know who to contact if I have any questions or concerns about the study.

I agree to the interview being audio taped.

I would like to be sent a copy of the interview transcript for my own interest: **Yes / No**

I wish to receive a summary of the results of the research: **Yes / No**

I _____ hereby consent to take part in this study.

Date

Signature

Signature of witness

Full name of researcher **David Semp** Name of witness

Contact phone number for researcher work **09 845-0947**

Project explained by **David Semp**

Project Role **Researcher**

Signature

Date

APPROVED BY THE AUCKLAND ETHICS COMMITTEE

Appendix 13:

Reflective Review for Interviews

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|--|
| Overall impression of the interaction e.g. non-verbal cues, body, setting, tension, process |
| Reflect on how the interview went: what went well? What went less well? How could I improve my interviewing? |
| Reflect on the main themes and/or discourses constructing the interview |
| Any other thoughts/ideas |

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