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# **“Queer Practice”**

**A consideration of some  
psychiatric/mental health  
social work practitioners’  
constructions of gay male sexualities**

**A thesis submitted in partial fulfilment  
of the requirements for a degree of  
Master of Social Work**

**at Massey University, Palmerston North, New Zealand**

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**2001**

## ABSTRACT

It has been almost three decades since the American Psychiatric Association declassified *homosexuality* in itself as a mental disorder warranting 'corrective' treatment. While *sexual preference*, as an exclusionary feature of the Mental Health (Compulsory Assessment and Treatment) Act 1992 in this country, can be seen as reflecting declassification, it does not suggest that same-sex oriented or gay men are exempt from mental ill health. It cannot be denied that positive legislation has made a difference to the lives and opportunities for many, but ongoing homophobic violence and external/internal heteronormative constructions and practices remain a primary problematic influence on the lives and wellbeing of those for whom same-sex desire or activity is a subjective reality, and bearing implications relative to, if not compounding, mental ill health.

In social work practice, we often refer to the significance of ecological assessment of the consumer *in context*, reflecting social work as psychosocial intervention focused at the interface between the consumer and his environment. However, how do we, as psychiatric/mental health social workers, understand or conceptualise or construct a consumer's context in our work with same-sex oriented men who present with mental ill health? What theoretical orientation informs our understandings of the consumer and/in his context? Indeed, how do we construct that context, and do such constructs engage a process of ongoing reflective consideration within an integrated framework of clinical psychiatric/mental health social work practice with gay male consumers? Can the theoretical ideas/frameworks upon which we base our practice adequately acknowledge and identify strategies to contest the impact of a heteronormative social context on a consumer's mental health? Indeed, is practice beyond the directly clinical permitted or possible in the contemporary practice context?

The study was two-fold. Part One consisted of unstructured interviews with psychiatric/mental health social work practitioners with regard to their integrated practice with same-sex oriented or gay male consumers in psychiatric/mental health settings. There are no right or wrong responses, no good or bad practitioners, merely an invitation to, and a reflection of, a discourse or critical debate that I hope will continue.

Part Two consisted of a half-day presentation I gave on *Integrated Queer Practice* which outlined an integrated practice framework and considered queer theorising as an example of critical social science theorising subsequently reflected in clinical theorising and the application of these in relation to a mock case study. This presentation was followed by a Focus Group discussion to consider whether or not such a practice could, would and should be applied.

The participants' self-reflective discourses reflect the diversity of understandings and challenges of practice with this consumer group within the constraints of the contemporary psychiatric/mental health social work practice context. Social work practice within this practice field reflects the extensive changes in service definition and models of delivery subsequent to the extensive reconfigurings of the health sector over recent years. This has left many of the practitioners with a "here and now" focus on the management of symptom and risk within an immediate context, significantly narrowing the scope of practice at the expense of active contestation of heteronormative social constructs impacting on the well-being of same-sex oriented consumers.

## ACKNOWLEDGEMENTS

The journey for this thesis would have been considerably challenged, or even impossible, without the support, encouragement, skills and contributions of so many.

First and foremost, my immense gratitude must go to those psychiatric/mental health social work practitioners who gave their time and energies in sharing their understandings and experiences with me. I am immensely privileged to have met each of you, and to having you share so much with me. Thank you. I can only hope that I have honoured your contributions.

Throughout the process, I enjoyed the ongoing encouragement and advice of my supervisors: Professor Robyn Munford and Carole Adamson. I owe these two so much. They listened to me, heard me, urged me on and read, reread and reread again. And every time with a range of constructive criticisms and ideas that re-energised and made me think, think again, and then again some more. Thank you. You're both amazing!

It was Dr Lynne Alice who introduced me to queer theorising. Her passion and hunger for knowledge were contagious.

The Massey University Human Ethics Committee approved this research. I thank the Committee for their assistance and recommendations.

Assistance was also made available through the Graduate Research Fund. I owe some considerable thanks to Janet Milne for her assistance in this.

My employer, MidCentral District Health Board, has been incredibly supportive throughout the years of this study program. In particular, I want to thank my Team Leaders over this time: Timoti George and Kate Aplin. They understood and cared about what I was trying to do. Thank you.

My sincere thanks must also go to my clinical supervisors at MidCentral: Keiran O'Donoghue and Jo Leamy. Your concern and compassion, and watchful eye meant so much to me. You both challenged me and taught me. Thank you

I had never engaged research with Maori before (and it may have showed), but I was immensely fortunate to have assistance from Turoa Haronga who patiently took time to explain and clarify so much of what was needed to enhance the safety of the interview process for Tangata Whenua.

I want to thank David McNabb and his team for helping me so much during the interviews. This made an incredibly stressful experience somewhat less traumatic. Thank you.

Many of the resources I have accessed, have been through the library at the New Zealand AIDS Foundation in Auckland. The librarian for NZAF, Vern Keller, is an absolute godsend to researchers. Thank you, Vern, you and your team made the search so much easier.

I was also fortunate to have the support of my local queer communities, most particularly the people from Manawatu Lesbian and Gay Rights Association. Thank you all.

Works like this are impossible without personal supports. To my friends, I extend my love and gratitude. To Grayson, what can I say? It's been an awful few years. You put up with so much. Thank you so much for being there, for listening to me ramble on, for understanding when I wasn't there, for the coffee, and for caring.

Finally, I would like to thank my Dad who taught me pride, courage, humour, patience and dignity. Your quiet encouragement and patience for me and my ways - I love you and I miss you desperately.

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## 1. INTRODUCTION

The treatment of same-sex oriented and gay men with mental ill health can be constructed as an issue drawing together diverse discourses around law, morality, ethics, biology, psychology and psychiatry, sex and sexuality, gender, culture, history, and the responses to difference and diversity within the context of health and social service delivery in Western capitalist societies. This thesis endeavours to encourage and engage such a discourse around these points through an initial consideration of a number of psychiatric/mental health social workers' constructions of same-sex oriented or gay male sexualities. This is followed by a consideration of these practitioners' reflections on their practice with such consumers who present with mental ill health within the contemporary context of psychiatric/mental health social work practice in Aotearoa New Zealand. A *queering* of practice or integration of queer theorising as an example of critical social science theorising, and whether or not such a practice should, could and would be applied in practice with this consumer group, is proposed for consideration by a focus group.

The emphasis on same-sex oriented male and gay male consumers, in this study, is a matter of my own choice, but also an attempt to maintain a clear focus in the study. In making this choice, I recognise that while there are heteronormative factors shared by many same-sex oriented men and women, gender specific factors may not be shared. For example, while lesbians and same-sex oriented women have been subjected to patriarchal controls over life and body, gay and same-sex oriented men have been subjected to legislative controls over the expressions of same-sex sexual activity. The subjective experiences and implications of these gender specific factors should not be merged under the banner of *homophobia*. This is too simple and risks understatement of the manifestations, experiences, and influences of the interplay between heteronormativity and patriarchy.

It has been almost three decades since the American Psychiatric Association (APA), following considerable challenges from gay and lesbian activists and significant debate within its own membership, agreed to declassify *homosexuality* in itself as a mental disorder warranting 'corrective' treatment. While *sexual preference*, as an exclusionary

feature relative to Section 4 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 in this country (Ministry of Health, 2000), can be seen as reflecting declassification, it does not suggest that same-sex oriented or gay men are exempt from mental ill health. In spite of legislative developments relative to decriminalisation and human rights protection, it should not be assumed that same-sex desire and activity in contemporary Western societies does not continue to raise problems that can significantly impact on the mental health of some individuals.

It cannot be denied that positive legislation has made a difference to the lives and opportunities for many, but ongoing homophobic violence and external/internal heteronormative constructions and practices remain a primary problematic influence on the lives and wellbeing of those for whom same-sex desire or activity is a subjective reality, and bearing implications for, if not compounding, mental ill health (Brown, 1998; Worth and Kelleher, 1997).

In social work practice, we often refer to the significance of ecological assessment of the consumer *in context*, reflecting social work as psychosocial intervention focused at the interface between the consumer and his environment (Brown, 1998; Prasad, 1986). However, is this *interlocking* of the sociological and psychological, to use Francis Turner's (1996) term, sufficient? Do our assessments, our understandings, our constructions of same-sex oriented or gay male consumers integrate a consideration of the consumer and his presentation *within* his social/sexual environment or context? Do our assessments include, or do the current boundaries of psychiatric/mental health social work practice allow for, the development of strategies to contest heteronormativity in that environmental context? Indeed, do we even address issues around sex and sexuality in our practice?

It must be acknowledged that the general (con)textual confines of psychiatric/mental health social work practice, in Aotearoa New Zealand, currently tend to be set around the criteria for diagnosis identified in the most recent edition of the APA's *Diagnostic and Statistical Manual of Mental Disorders (DSM)* – referred to as *DSM-IV*. In its Introduction to this text, the American Psychiatric Association (1994: XV) notes:

An official nomenclature must be applicable in a wide diversity of contexts. *DSM-IV* is used by clinicians and researchers of many different orientations (for example, biological, psychodynamic, cognitive, behavioral, interpersonal, family systems). It is used by psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals. *DSM-IV* must be usable across settings - inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations. It is also a necessary tool for collecting and communicating accurate public health statistics.

While homosexuality is no longer officially considered a psychiatric disorder, and *sexual preference* has ceased to be acceptable grounds for compulsory intervention under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Allan, 1995; Bayer, 1981; Stein, 1988), *DSM-IV* maintains that persons presenting with "...[p]ersistent and marked distress about sexual orientation" may still be diagnosed with a Sexual Disorder Not Otherwise Specified (American Psychiatric Association, 1994: 538). This retains the potential for problematising same-sex orientation and raises questions for practitioners in the field relative to constructions of same-sex orientation and practice with consumers.

### TERMINOLOGY

Throughout this thesis the terms *gay*, *homosexual*, and *same-sex oriented men* will be used interchangeably in reference to the focus consumer group of men who have sex with men or men with same-sex desires.

A *psychiatric/mental health social worker/social work practitioner* refers to a social work practitioner currently practicing in the field of psychiatry. Such a practitioner will usually be employed in a regional mental health assessment and treatment service.

The term *queer*, in this study, will primarily refer to a process of queer theorising.

Once the term 'queer' was, at best, slang for homosexual, at worst, a term of homophobic abuse. In recent years 'queer' has come to be used differently, sometimes as an umbrella term for a coalition of culturally sexual self-identifications and at other times to describe a nascent theoretical model which has developed out of more traditional lesbian and gay studies.

(Jagose, 1996: 2)

The use of 'queer' as shorthand for gay, lesbian, bisexual and transgender, or as a nationalistic identity, has been somewhat popularised in Aotearoa New Zealand. This is not without some disquiet among those for whom the word has been an instrument of abuse and humiliation, and who see the 'reclaiming' of such terms as painful and damaging to the reformist achievements of recent years (Sheppard, 1992; Watson, 1992). However, 'queer', in relation to theorising, signals a commitment to centring sexuality in social theorising, to contesting hierarchical power dynamics and structures. As Young (in Alice and Young, 1997: 3) observes:

Queer theories are conceptualisations and strategies that challenge the construction of heteronormativity, the discursive ensemble that positions heterosexual masculinity as a universal, paradigmatic social category

### THE STUDY

In my work as a psychiatric social worker, I have noted ongoing expressions of heteronormativity and even homophobia. While it must be acknowledged that the more overt practices of this kind are becoming increasingly rare, covert heteronormativity can be noted in some of the comments I have encountered among colleagues such as: *“All gays and lesbians have personality disorders”*; *“If you kept quiet about your sexual orientation, it wouldn't be such a problem”*; *“What he needs to do is settle down in a nice monogamous relationship”*; and *“I don't want to work with those people”*.

Such encounters have left me considerably saddened with a sense that same-sex orientation remains subject to heteronormative constructions, that we continue to be pathologised and encouraged to embrace the closet or assimilate. It is such experiences that have brought me to wondering: how are a practitioner's constructions of sexuality formulated, what informs his or her constructions of gay male sexualities, and how are such understandings integrated and reflected in a practitioner's practice? These are some of the points I propose to consider, with a focus on psychiatric/mental health social work.

My interest in this study is personally and professionally influenced, without suggesting the two can be absolutely compartmentalised as though each is totally alien to the other. I am an out gay/queer man and, like some others, I carry personal experiences of my

*otherness*, of being acutely aware at various points in my life that I did/could/would not fit the heterosexual standard; and carry with me experiences of heteronormative and homophobic oppression and violence, and the injustice of discrimination, powerlessness and social invisibility. I realised I was 'different' (in addition to the 'differentness' I already felt as a result of my severe vision disability) at a relatively early age. I can recall the immense confusion, self-loathing, fear and anxiety, and sense of utter aloneness I felt in those early awarenesses, in coming out, and the ready retreats to the 'closet'. At least with my disability I was already out. Where disclosure of that was warranted, the response was generally accepting.

Such experiences, integrated with my personal and professional values and my social work knowledge/skills, are reflected in and inform a commitment to actively deconstructing and contesting heteronormative structures and practices. This has been significantly enhanced, over recent years, in my encounters with gay and queer theorising, reflecting various forms of social constructionism in which sexuality is a centralised focus. In particular, I have been extremely interested in discourses and developments around gay and queer theorisings that reflect leftist principles or a critical consideration contextualising the emergence or identification of *the homosexual* in Western capitalist societies (for example, D'Emilio, 1992; Weeks, 1977, 1982, 1989). Such study, relative to social policy, social and clinical theorising, and research, has been a central feature in my preparation to engage this thesis.

How do we, as psychiatric/mental health social workers, understand or conceptualise or construct a consumer's context in our work with same-sex oriented men who present at mental health crisis centres, acute and subacute inpatient units, or community mental health clinics? What theoretical orientation informs our understandings of the consumer and/in his context? Indeed, how do we construct that context, and do such constructs engage a process of ongoing reflective consideration within an integrated framework of clinical psychiatric/mental health social work practice with gay male consumers? Can the theoretical ideas/frameworks upon which we base our practice adequately acknowledge and identify strategies to contest the impact of a heteronormative social context on a consumer's mental health? Indeed, is practice beyond the directly clinical permitted or possible in the contemporary practice context?

These were the questions I wanted to consider in this study. I wanted to hear, to discuss, and to positively engage fellow psychiatric/mental health social work practitioners in a consideration of their integrated practice: the integration of self, of critical social science and clinical theorising applied in their practice with same-sex oriented or gay men with mental ill health within the practice context. The purpose of the study was not to identify good or bad practitioners, but to respectfully engage each practitioner in a consideration of the issues in relation to practice with gay male clients in this field, to draw out themes. My agenda was an *out* one: to encourage critical debate or *discourse*.

The study was two-fold. Part One consisted of a series of unstructured interviews with psychiatric/mental health social work practitioners with regard to their personal experiences and professional practice with same-sex oriented or gay male consumers in psychiatric/mental health settings. This aimed to reflect an integrated framework of practice – an interlocking of the practitioner as a person, as a critical social science theorist, as a clinical theorist, as a clinical actor, and the reflective application of this integration at the clinical coalface.

Part Two consisted of a half-day presentation I gave on *Integrated Queer Practice* which outlined an integrated practice framework and considered queer theorising as an example of critical social science theorising subsequently reflected in clinical theorising and the application of these in relation to a mock case study. This presentation was followed by a focus group discussion to consider whether or not such a practice could, would and should be applied.

## OUTLINE OF THESIS

In preparing this thesis, and reflecting on the participants' responses, I have attempted to present this critical consideration, the discourse, in a manner that reflects the layers of an integrated practice framework. This commences in Chapter 2 with setting the stage for the thesis through a consideration of the literature and research relative to the construction of homosexuality and the presentation and treatment of same-sex orientated men within mental health/psychiatry.

Chapter 3 offers the epistemological and theoretical orientation informing this study, and the methodology and techniques applied. I have endeavoured to engage a constructivist epistemology, emphasising the diversity of understandings and realities. This is reflected through queer theorising, with its agenda of contesting polarised constructions of sexual orientations that limit understandings to heterosexual versus homosexual. In applying a deconstructive discourse analysis, I have attempted to draw out the themes and understandings offered in the participants' responses in an unstructured scheduled interview framework based around a model of *integrated practice*.

Integrated practice is proposed in this thesis as a means for practitioners to consider how their personal and professional values, experiences and knowledges are reflected in their structural and clinical theoretical orientations, and evidenced in the interventions they engage with consumers at the clinical coalface. This commences in Chapter 4 with the participants' demographic features, but more significantly a consideration of their personal and professional constructions and values/beliefs regarding same-sex oriented or gay men, and the training and reading they have engaged relative to their practice with this consumer group. This chapter establishes the groundwork of integrated practice in considering the practitioner as a person and social worker.

Chapter 5 considers the participants' reflections on the kind of issues same-sex oriented have/may bring with them, over and above the identified presenting psychiatric issues, when encountering mental health services.

In Chapters 6, I will offer the practitioners' discourses around their theoretical orientations and the integration of these in clinical practice with this consumer group. This will involve some discussion around the constructions posited within the particular theories relative to same-sex orientation, and how these theories would propose the practitioner conceptualise and address the kind of issues discussed in Chapter 5, and the practitioner's experiences in working with this consumer group.

Chapter 7 will place the previous chapters in context with a consideration of the development of psychiatry and *DSM* as its nomenclature of psychiatric disorders – the

context of psychiatric/mental health social work practice, and of local factors influencing the contemporary practice context.

This thesis engages the second part of the study in Chapter 8 where the focus group discussion considers whether or not a practice informed by a queer theorising model of critical social science could, would and should be applied in clinical practice with same-sex oriented and gay men who present with mental ill health. This discussion aims to return the study to a focus on the interface between the factors raised in the interviews and the context of practice.

The work is drawn together, in a more significant analysis of the participants' contributions, in Chapter 9. In this discussion chapter, I will offer a consideration of the material in the preceding chapters, informed by queer theorising.

Concluding with Chapter 10, this thesis will provide me with an opportunity to reflect on the research process. No research is without its limitations and implications. These too will be considered in the concluding chapter.

This thesis aims to offer a consideration of some psychiatric/mental health social work practitioners' constructions of gay male sexualities and the applications of these constructions at the clinical coalface within an integrated practice framework. There are no right or wrong responses, no good or bad practitioners, merely an invitation to, and a reflection of, a discourse or critical debate that I hope will continue.

## 2. SETTING THE STAGE: THE LITERATURE

This chapter aims to offer something of a contextualised basis for this thesis through a brief overview of the relevant research and some of the available social work literature relative to social work practice with same-sex oriented men. While much of the literature is American or British and has predominantly been published since the mid-1980s, this literature review is focused primarily on anti-discriminatory practice concepts, and on examples or models of social work practice with this client group.

### ETIOLOGICAL RESEARCH

In considering the research relative to homosexuality, it becomes apparent that the majority of such studies focus on causative factors and, in particular, relative to male homosexuality. Examples of such research have considered parental, sibling (including twin studies) and family environment factors<sup>1</sup>, childhood cross-gender behaviours<sup>2</sup>, and biological causes/influences<sup>3</sup>. A feature of such studies is that, while the results are inconclusive, the claims the researchers make construct non-heterosexual sexualities as pathological and, as such, the research is perceived to need no justification (Birke, 1985; Woods, 1994).

The American Psychiatric Association (1998) has lately taken a position opposing therapies aimed at repairing or changing sexual orientation "...that [are] based on the assumption that homosexuality per se is a mental disorder or is based on the priori assumption that a patient should change his or her homosexual orientation" (American Psychiatric Association, 2000: 1719). This reflects the American Psychological Association's 1997 stance (PlanetOut, 1998). However, there is no evidence indicating that guidelines, such as those developed by the American Psychological Association

- 
1. For example, Abe and Moran, 1969; Bene, 1965; Blanchard and Bogaert, 1996; Blanchard and Sheridan, 1992; Davison et al, 1971; Freund et al, 1974; Kendler et al, 2000; Moran and Abe, 1969; O'Connor, 1964; Parker, 1964; Pillard and Weinrich, 1986.
  2. For example, see Bene, 1965; Freund et al 1974a, 1974b; McConaghy and Silove, 1991; Saghir and Robins, 1971; Zuger, 1988.
  3. For example, see Bailey and Pillard, 1991; Dorner et al, 1991; Orwin et al, 1974.

(2000, 2000a), relative to practice with gay, lesbian and bisexual consumers, has or will be proposed by the APA.

### **Kinsey**

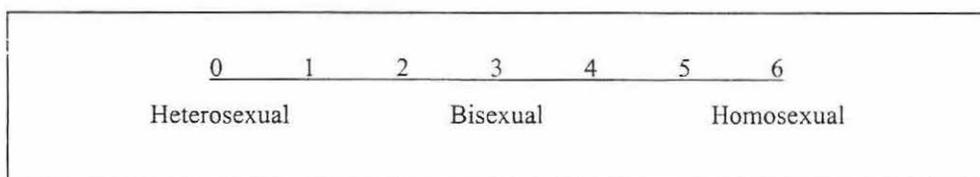
The work of Alfred Kinsey and his associates (Kinsey et al, 1948) has been of particular significance in debates around homosexuality. Based on numerous extensive interviews, their work offered a reconsideration of sexuality that was accessible to many, and challenged presumptions of contemporary morality. Kinsey's team argued that

...about 4 percent of the adult white male population of the United States is exclusively homosexual. Another 10 percent is primarily homosexual for at least 3 years between the ages of 16 and 65. A total of 37 percent of the white male population has at some time between adolescence and senility experienced homosexual orgasm. By age 55, according to the Kinsey et al. study, half of all white males have had some type of homosexual contact.

(Sarason, 1976: 551)

From this research, Kinsey and his colleagues (Kinsey et al, 1948) developed a rating scale for sexual orientation (Figure 2.1) that remains in some contemporary reference by a number of researchers and academics (LeVay, 1996; Hamer and Copeland, 1994).

**Figure 2.1 Kinsey Scale of Sexual Orientation**



(Source: Kauth and Kalichman, 1995: 82)

An example is that of the developmentally oriented study of Bell and Weinberg (1978) who interviewed a significantly sized sample of heterosexual and same-sex oriented men and women in an attempt to draw out the multiple dimensions of same-sex sexualities. Their findings are evident in the title of their text, *Homosexualities*, suggesting a contesting of the notion of a singular stereotypical construction of homosexuality, and proposing instead a diversity of same-sex experience, expression and psychosocial adjustment:

...homosexual adults are a remarkably diverse group. Seldom do we find the vast majority of a given sample responding to a particular question in exactly the same way. Whether they were reporting about an aspect of their sexual lives, their social adjustment, or their emotional feelings, our respondents tended to say widely different things.

(Bell and Weinberg, 1978: 217)

## **Brains and Genes**

Research into biological constructions of same-sex orientation has become increasingly popularised, particularly around considerations of brain structure and genetics.

This is not a new debate: it has recurred in each generation at least since Darwin's day. What is new today is the way in which the mystique of the new genetics is seen as strengthening the genetic argument. At its simplest, neurogenetic determinism argues a directly causal relationship between gene and behaviour. A man is homosexual because he has a 'gay brain', itself the product of 'gay genes', and a woman is depressed because she has genes 'for' depression... Such simplification, with its cheaply seductive dichotomies of nature or nurture, genes or environment, is fallacious. The phenomena of life are always and simultaneously about nature and nurture. Human existence and experience is always and simultaneously biological and social. Adequate explanations must involve both. Yet again and again one finds the simplistic, unqualified, determinist claim making the headlines and setting the research agenda.

(Rose, 1998: 20)

Of particular note, in considering biologically oriented etiological studies of homosexuality, is the work of Simon LeVay. In 1991, LeVay and his colleagues published a study, to become more commonly known as the 'gay brain' study, comparing anatomical aspects of the brains of a small number of deceased gay men and supposed heterosexuals, in which it was claimed that a significant difference had been noted between cells in the interstitial nucleus of the anterior hypothalamus (INAH-3) in the brains of the gay men studied and those of the heterosexual men. The study reported that this area was much smaller in the gay men than the same area in the heterosexual men but equal to that of the heterosexual women.

This study has been widely critiqued in that the gay men had died as a result of Acquired Immune Deficiency Syndrome (AIDS). LeVay is reported to have compared the gay men's INAH-3 with those of heterosexual men who had also died with AIDS

and confirmed his results, as he did in a later study in which he examined the INAH-3 of a gay man who had died of cancer. Nevertheless, LeVay's sample was very small for drawing such generalised conclusions. There is no guarantee that the heterosexual men were heterosexual and there was no clear understanding provided of exactly what/who is meant by *homosexual* and *heterosexual*, and there was no confirmation that the size of INAH-3 in the women subjects were meant to be that size or whether there is a standardised size for INAH-3 in anyone (Brown, 1993; Rose, 1996; Schulman, 1995; Watney, 1995). The point of concern, relative to LeVay's study, is that later biological researchers would cite this and similar studies as credible.

On 16 July 1993, a paper by Dean Hamer and colleagues was published in *Science* (Hamer et al, 1993). The authors claimed to have found a genetic link to male homosexuality, not specifically a gene *for* homosexuality but a linkage at a particular point on the X chromosome. The media coverage was considerable, frequently suggesting the linkage study could lead to the identification of a specific gay gene, and that this in turn might be applied in identifying gay foetuses thus giving parents the choice of heteronormatively justified termination.

Having decided what it was he initially wanted to study, that is. "...to determine whether or not male sexual orientation is genetically influenced" (Hamer et al, 1993: 321), Hamer's plan would be to identify two subject groups: a random group of gay male subjects to consider the hypothesis that homosexuality runs in families, and a second set of subjects made up of families with more than one family member identified as gay (Hamer and Copeland, 1994).

It was during this stage of his process that Hamer began to question some related factors, and to consider the value of including investigation of such matters in his research. Hamer's study was going to draw on a significant amount of in-depth data from and about the lives, families and genetic makeup of a large and distinct sample of gay men, and he saw this as an opportunity to broaden the scope of his research. He recognised AIDS was an obvious choice considering the gross over-representation of gay men in Human Immunodeficiency Virus (HIV) and AIDS-related data in the West, and he was particularly interested in the variable progression of HIV infection. While

acknowledging the potential influences of other factors, he wanted to investigate a genetic component to this with a particular focus on Kaposi's Sarcoma (KS) as an outcome of HIV infection, although he acknowledged the difficulty in identifying a specific gene involved in the development of KS in a gay man with HIV. This was aided through consultation with colleagues with whom Hamer proposed to share data and blood samples from his sample. However, there appears to be no reference in Hamer's texts to plans to seek the consent of any subjects for such exchanges, or to even inform them of this possibility (Hamer and Copeland, 1994).

In his literature search, Hamer had also noted a greater risk among gay men and lesbians than among heterosexuals for alcohol and/or drug problems, and suicidality, particularly among youth. Consequently, the parameters of the Hamer study were further extended to include a two-purpose mental health component to confirm or disprove the connection between homosexuality and depression and/or alcoholism, and to identify the genes involved in alcoholism. As before, Hamer consulted colleagues in this field (psychiatric genetics), offering an exchange of testing of their genetic findings in Hamer's families (note the emerging ownership) for Hamer making samples available to these research projects. Hamer notes.

I was becoming increasingly popular around the NIH among people who wanted to dip into the sample I hoped to collect, because gay men are a rich vein of medical information for scientists studying everything from AIDS to Kaposi's sarcoma to depression and alcoholism to sexual behavior.

(Hamer and Copeland, 1994: 36)

While Hamer recognised he was researching an extremely hot political issue, particularly in light of the debate that was raging regarding gays in the US military, he maintained that his research was scientific. Indeed, Hamer specified "scientific" as necessitating "carefully controlled observations and experiments..., it must produce specific and testable predictions... And lastly, it must ultimately be based on physical laws" (Hamer and Copeland, 1994: 14).

The specific laws and principles Hamer worked from were of particular relevance to molecular genetics and Mendel's laws of inheritance. Hamer searched the pedigrees of

the gay subjects for dominant or recessive autosomal inheritance. This required examination of extensive family trees in search of a specific inherited trait, in this case, homosexuality; and of looking at the chromosome structures, of members of the family who share the trait, for linkage markers to the trait (Hamer and Copeland, 1994; Johnson, 1993).

Hamer is reported to have found that of 76 gay men studied, 13.5% had gay brothers, and that these brothers had more gay relatives in their mother's family (Johnson, 1993; Rose, 1996). This gave rise to consideration that there might be a recessive gene

...on the X chromosome, which would mean many more men than women with the trait. This is because recessive X-linked genes are expressed in women only when they have two copies of the variant gene. The chance of this happening is remote, so recessive X-linked traits usually are not expressed in women. By contrast, men will express the trait any time they carry the relevant allele, or variant, on their single X chromosome, because there is no second X chromosome to mask it. Another feature of recessive X-linked inheritance is that it would not require either parent of a gay man to be gay.

(Hamer and Copeland, 1994: 80)

A major conceptual concern lies with Hamer's construction of homosexuality. He states that the study's subjects "...were males who self-identified as predominantly or exclusively homosexual within the context of modern American society" (Hamer et al, 1993: 326), yet his methods for confirming this suggest that such a self-identification requires the confirmation of the expert (i.e. Hamer) via application of the Kinsey scale. Thus, by focusing on the category of the homosexual and endeavouring to discover causative factors, Hamer is, in spite of his claims to the contrary, reinforcing the pathologising of non-heterosexual sexualities. Indeed, Hamer recognises that denial of same-sex object choice is understandable but, heteronormatively, appears not able to accept that a subject may deny their heterosexuality (Rose, 1996).

With Hamer's passion for the scientific, he has adopted a quantitative method which has enabled him to "...measure the reactions of a great many people to a limited set of questions, thus facilitating comparison and statistical aggregation of the data" (Patton, 1990: 14). However, this method also limits the representation of diversity and depth

warranted in a study of a subject matter so complex as sexuality. In order for a quantitative study to be valid, it would be essential to ensure the instrument to be applied effectively measures the subject matter. Hamer's application of the Kinsey model negates subjective construction of sexualities in favour of fixed points on a continuum, making it more convenient for the researchers to tabulate and categorise the lives and bodies of the subjects regardless of other relevant factors influencing a subjective construction of sexuality and sexual expression, experience, understanding, for example culture, situation, and performativity.

While Hamer and his team added further scales to Kinsey's initial model, they nevertheless maintained a focus on measuring a subject's degree of homosexuality on a continuum. They failed to recognise the fluidity of sexuality over the lifespan, opting instead to categorise subjects' experiences as exclusively or predominantly heterosexual or homosexual, thus perpetuating a bipolar construction of sexualities (De Cecco, 1985; Epstein, 1996; Golden, 1994).

Hamer's aspirations to the scientific are further flawed in the notion that science does not judge, that it is an objective consideration of the subject matter. Feminist and other scholars would contest this objectivity as an impossibility in that the subjective ideological/theoretical constructions of the researcher are reflected in the subject matter, hypothesis, subject selection, selection of co-researchers, methods applied, and how the results are analysed, read and publicised (Messing in Eichler, 1988). Hamer maintained that, while there were some fairly clear social and political aspects to the study, science is not about moralising, it is about increasing our knowledge and responding appropriately to that knowledge. Or is it that straight forward? Perhaps this desire to see knowledge appropriately applied is the kind of altruism Hamer identified as a catalyst for engaging this subject matter. Unfortunately, there is absolutely no guarantee that the findings will be of any benefit to gay men or anyone else who, for whatever part of their lifespan, does not fit the narrow construction of heterosexual (Hamer and Copeland, 1994; Ray, 1996; Rose, 1996; Watney, 1995).

Certainly, some gay men may feel more secure in themselves in Hamer's findings, but will it necessarily significantly change the structural environment of institutionalised

heteronormativity in which they live? Will it make the next queer-bashing or hate crime any less painful and traumatic? It is not that there appears to be some biological component in sexualities. That is not the problem. The problem arises when a person experiences such desires or acts on them in a society that categorises within a heteronormative hierarchy.

The political implications of studies such as Hamer's are most significant. Research cannot be considered outside the social and political context. Indeed, it can be argued that research is political from the preparation, to the funding and resource allocation, to the preparation and publicising of results, to the application or negation of the results (Bryson, 1979; Eichler, 1988; Oakley, 1981). Such studies may apply scientific methodologies and technologies but the very subject matter itself, within a heteronormative context, is political. This is clearly evident in the responses to Hamer's study. Whereas some saw it as confirmation of homosexuality as an innate variation and thus warranting legislative protection from discrimination (Rose, 1998; Watney, 1995), others saw it as a first step to "sexual cleansing" (Johnson, 1993: 12). Hamer acknowledged both, offering some hope for the former while cautioning on the ethical abuses of the study in the latter (Hamer and Copeland, 1994; Hamer et al, 1993). However, while researchers continue to seek out a cause of non-heterosexual sexualities, confirming heterosexuality as unproblematic, they perpetuate the pathologising and subjugation of all other sexualities.

### **IDENTITY STUDIES**

While not necessarily focusing on men who have been consumers of mental health services, there is a growing body of research considering the diversity of subjective constructions of their sexuality among men who have sex with men. Three major studies stand out.

Sadownick's (1996) *Sex Between Men* provides an insightful behind-the-closet-door consideration of the intimate lives, experiences and understandings of a diverse group of men. Focusing on the years since World War II, Sadownick applies a life-history narrative approach, informed by cultural psychology, in plotting these experiences and self-constructions within the social and political developments of American gay

liberation and ghettoisation. The text clearly demonstrates the multiplicity of subjective readings and performativities.

Whitman's (1996) *Queer by Choice* revisits the identity politics debates around essentialist/innate versus constructionist/choice positions relative to sexuality (see Chapter 3). Drawing on personal narratives, she exposes diversities, which significantly contest assumptions of unity, and does so in the hope that this deconstructive endeavour will encourage the consideration of multiple sexual and political possibilities. Whitman notes that the relatively small sample in this study enhanced her potential to spend more time with each subject and consider each person's subjective construction in more depth. She found that while a significant number of those whose narratives she engaged reported essentialist origins to their sexualities, the expression and experience of these sexualities was more constructionist.

*Male Call/Waea Mai, Tane Ma* (Aspin et al, 1998; Reid et al, 1997, 1998; Saxton et al, 1997, 1998, 1998a, 1999; Worth et al, 1997, 1997a, 1999) has been the most significant research project relative to men who have sex with men in Aotearoa New Zealand. It was certainly the most extensive. The project, drawing on telephone surveys with 1852 men, was the work of the New Zealand AIDS Foundation (NZAF) with a focus on improving on HIV/AIDS prevention and support services (Worth et al, 1997).

Male Call/Waea Mai, Tane Ma was the first nationwide survey of men who have sex with men in New Zealand. The Male Call survey was undertaken because at the time no large-scale data on men who have sex with men (msm) had been collected in New Zealand. While a number of other groups in New Zealand are affected by HIV, the virus is most significantly present in the group of msm, who account for over 80% of those with AIDS. At present, as there is no vaccine or cure for HIV infection, behaviour change remains the only strategy available to manage the HIV epidemic. In order to develop effective and efficient HIV prevention programmes, there has been a recognition of the need for up-to-date, accurate data on the socio-sexual characteristics of msm. Thus the aims of Male Call were to:

- describe men who have sex with men's HIV knowledge and their sexual practices with a specific focus on the adoption of safer strategies;
- examine the ways in which HIV/AIDS knowledge and safe sexual practice are related to a number of important demographic and contextual variables;

- provide baseline data on the sexual behaviour of men who have sex with men which can be used to assist in the planning and development of HIV prevention programmes; and
- develop a core set of baseline questions which could be used in future surveys of men who have sex with men.

(Worth et al, 1997: 1)

The research was published in a series of reports covering demographics (Worth et al, 1997), relationships (Worth et al, 1997a), takataapui (Aspin et al, 1998), casual sexual activity (Reid et al, 1997), identity issues (Saxton et al, 1997), geographical factors (Saxton et al, 1998), gay community (Saxton et al, 1998a), opposite-sex activity among msm (Reid et al, 1998), HIV factors (Worth et al, 1999), and sexual health factors (Saxton et al, 1999).

Of particular relevance to this thesis, the *Male Call* project participants demonstrated varied identities beyond a pure gay or non-gay binary, reflecting subjective constructs influenced by locale, age, and culture (Saxton et al, 1997). Among gay men who are Maori, for example, there is a growing self-identification, reflecting a cultural construction, as *takataapui* or ‘intimate companion of the same sex’ (Williams in Broughton, 1996: 191). In addition, the *Male Call* study note:

...more immediate and personal factors also appeared to influence identity. The degree of sexual attraction to men and women, disclosure of this attraction, and involvement in the gay community all affected identification. The gay milieu may ultimately be one of the most significant factors in the formation of sexual identity, and analysis suggests that sexual identity itself has relatively few significant effects over and above that of gay community attachment.

(Saxton et al, 1997: 37)

### **GAY MEN AND MENTAL ILL HEALTH**

Declassification of their sexuality as a psychiatric disorder does not exempt same-sex oriented men from mental ill health. There is no indication that gay men are any less likely to experience psychiatric illness than non-gay men – although gay male consumers may not readily identify as such in assessment and/or treatment. While it must certainly be acknowledged that declassification and legislative measures have

been of significant benefit, they do not immediately contest or transform heteronormative social structures and value systems impacting on the mental health of same-sex oriented men. Attempting to negotiate *coming out*, guilt or internalised homophobia, lifestyle choices, loss of support networks following disclosure, or homophobic violence and abuse (to name but a few) have been posited as significant factors for some in depression and suicidality<sup>4</sup>, or alcohol and drug problems<sup>5</sup>.

### **Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome**

Since soon after the emergence of the AIDS epidemic, initially reported by Gottlieb et al (1981), HIV has been acknowledged with growing emphasis as an issue of concern in mental health<sup>6</sup>. Indeed, Stefan and Catalan (1995) have gone so far as to consider whether or not persons with mental ill health could be considered a new risk population for HIV.

A number of studies have noted HIV seroprevalence among patients/ consumers/clients of mental health services<sup>7</sup>, while other papers have raised issues relative to treatment<sup>8</sup>. Seroprevalence rates among persons with mental ill health have brought greater focus on consideration of HIV-related risks<sup>9</sup>. As a result of this identification of risk,

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4. See Buhrich and Loke, 1988; Fergusson et al, 1999; Hellman, 1996; Proctor and Groze, 1994; Rankine, 1992; Rofes, 1991.

5. See Buhrich and Loke, 1988; Flavin et al, 1986; Kowszun and Malley, 1996; Kus, 1991, 1991a; Lapierre, 1991; MacEwan and Kinder, 1991; Zehner and Lewis, 1985.

6. For further consideration, see Abrams, 1986; Appelbaum, 1988; Baer 1989; Cates and Graham, 1993; Dilley et al, 1985; Gomez et al, 1999; Horwath, 1996; Kelly and Raphael, 1992; King, 1993; Knox et al, 1994; Nicholson, 1998; Satriano et al, 1999; Sherbourne et al, 2000.

7. For example, Ayuso-Mateos, 1997; Baer, 1989; Binder, 1987; Cournos, 1996; Cournos et al, 1990; Horwath et al, 1989; Jacobsberg et al, 1995; O'Dowd et al, 1991; Perry et al, 1990; Perry et al, 1993; Sacks et al, 1995; Susser et al, 1997.

8. Baird and Beardslee, 1990; Baker et al, 1995; Cohen, 1998; Gomez et al, 1999, Walkup et al, 2000.

9. For example Brown and Jemmott, 2000; Brown et al, 1997a; Brunette, et al, 1999; Carey et al, 1999; Carmen and Brady, 1990; Center for Disease Control, 1996a; Cournos et al, 1994; Cournos et al, 1995; Coverdale and Turbott, 2000; Kalichman et al, 1994; Kelly et al, 1992; Kelly et al, 1995; McDermott et al 1994; McKinnon, 1996; McKinnon et al, 1996; Menon and Pomerantz, 1997; Metzger et al, 1991; Sacks et al 1990; Sullivan et al, 1999.

prevention initiatives and risk assessment strategies to meet the specific education and skill development needs of persons with mental ill health have been proposed, developed and implemented<sup>10</sup>.

Issues of significant and multiple HIV/AIDS-related loss and grief<sup>11</sup>, depression and other mood disorders<sup>12</sup>, anxiety and stress<sup>13</sup>, suicidality<sup>14</sup>, obsessive-compulsive disorder (McDaniel and Johnson, 1993), neurological conditions (Baldeweg et al, 1997; Gorman et al, 1993), psychosis<sup>15</sup>, dual diagnosis (Fine and Ioannou, 1996), mixed factitious disorder (Bialer and Wallock, 1990), erotomania (Boast and Coid, 1994), and personality disorder (Broomer et al, 1993; Perkins et al, 1993) have been raised in research and practice reports although it should be noted that few of these have specifically considered gay men although gay men and men who have sex with men remain significantly represented in HIV-related statistics.

HIV is now specifically acknowledged in *DSM-IV* as a medical condition with the potential to impact on an individual's mental health. Indeed, in recognition of the growing challenge, the APA has produced HIV-related treatment and HIV-antibody testing guidelines and policies (American Psychiatric Association, 1993, 1993a, 1995).

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10. For example, Brady, 1996; Brown et al, 1997; Carlson et al, 1989; Center for Disease Control, 1995; Hajagos et al, 1998; Houston-Hamilton et al, 1989; Kalichman et al, 1995; Kaplan and Herman, 1996; Kelly, 1991; Lauer-Listhaus and Watterson, 1988; Otto-Salaj et al, 1996; Walkup et al, 1998.

11. For example, Biller and Rice, 1990; Bower et al, 1998; Gluhoski et al, 1997; Kaal, 1992; Kemeny and Dean, 1995; Lawrence, 1994; Maasen, 1998; Martin, 1988; Nesbitt et al, 1996.

12. For example, Center for Disease Control, 1996b; Ciesla and Roberts, 2001; Elliott et al, 1998; Fukunishi et al, 1997; Kelly et al, 1993; Lee et al, 1999; Lyketsos et al, 1993; Lyketsos et al, 1996; Markowitz et al, 1995; Perkins and Evans, 1991; Rabkin et al, 1988; Wagner and Rabkin, 2000; Walker et al, 1997.

13. For example, Center for Disease Control, 1997; Irving et al, 1995; Lutgendoef et al, 1997, Sewell et al, 2000.

14. For example, Alfonso et al, 1994; Flavin et al, 1986; Forbes and Cairns, 2001; Gil et al, 1998; Goldblum and Moulton, 1989; McKegney and O'Dowd, 1992; Rofes, 1991.

15. For example Doyle and Labbate, 1997; Halstead et al, 1988; Sewell et al, 1994.

## RELEVANT SOCIAL WORK LITERATURE

While the perspective of homosexuality as a pathological disorder warranting specific treatment is less widely supported, and there are now those with genuine concern for the provision of appropriate treatment for same-sex oriented men with psychiatric disorders (De Cecco and Shively, 1985; Irving et al, 1995; Martin, 1991; McLean and Roberts, 1995; Neugebauer et al, 1992; Perkins et al, 1993; Smith, 1988), the scarcity of practice literature relative to psychiatric social work practice with same-sex oriented consumers is as conspicuous as that relating to the practice field.

Again, practitioners in this country have had to rely on the few international contributions. It should be noted that there has been a gradual emergence of documented examples and considerations of practice with this consumer group (again, primarily from the United States and the United Kingdom) since the mid-1980s when the HIV/AIDS epidemic began to be more readily acknowledged as a major crisis.

While no social work literature could be found reflecting the full focus of this thesis, the literature considered, such as the *gay gene* and *gay brain* studies previously discussed, does reflect aspects of it. However, in perusing the available social work literature, it appears the writings and practice reports can be loosely considered around some of the focus points for this thesis relative to social work practice with same-sex oriented men.

### **Practitioner**

In an American study by DeCrescenzo (1985), relative to homophobic attitudes among mental health professionals, social workers scored highest in homophobic responses. However, this disturbing account of these social work practitioners' values must be considered in context. The author notes that the practitioners scored low on personal acquaintance with same-sex oriented people, and that the issue of practice with same-sex oriented consumers was particularly new to the profession. Nevertheless, it cannot be assumed that value stances around same-sex oriented consumers or colleagues has become any less heteronormative, a point evidenced in the comments made by my own colleagues (see Chapter 1) which were, in part, a catalyst for this thesis.

While most writings appear to raise the significance of the social work practitioner's values relative to homosexuality, few specifically address this in any depth. A clear exception to this is that offered by Brown (1998) in her excellent text proposing a structured anti-discriminatory practice relative to same-sex oriented consumers. She observes:

There have been, among many others, two fundamental assumptions within the traditional debates about social work values that have particular relevance for lesbians and gay men, and which are interconnected and have often been mirrored in practice. The first is the argument that social work values can be identified, articulated and have universal permanent applicability. This has been a powerful argument which has, until recently, been assumed as a social work 'truth'. The second is that social work values that can be identified and articulated are relevant to all service users, and, as a consequence, all service users are in receipt of an equivalently competent service.

(Brown, 1998: 12-13)

Brown (1998) contests these assumptions, and challenges practitioners, educators and agencies to consider and address the implications of knowledge, skills and values relative to same-sex oriented consumers. Such a contestation is somewhat reflected by Gochros who notes that:

Homosexuality poses a dilemma for social work. The profession has evolved with a dual tradition of overcoming oppression on one hand and "curing" pathology on the other.

(Gochros, 1985: 140)

Throughout the available literature, constructions of same-sex orientation, if clearly identified at all, appear to retain a view of an innate and fixed sexuality (Gochros, 1972; Lukes and Land, 1990).

### **Social Factors**

None of the available literature appears to offer a critical social science positioning, as has been outlined by Fay (1987), although structural disenfranchisement, primarily relative to homophobia, is frequently noted (Brown, 1998; Heathfield, 1988; Lukes and Land, 1990; Morrow, 1993). Possibly one of the first to raise this issue, relative to

social work, was Gochros who posited the presence of a sexual elite in American society. Gochros (1972: 16-17) noted:

The sexual elite reflects a bias toward reproduction in our society. That is, sex is permissible primarily between individuals in situations that could conceivably lead to socially desirable pregnancies. Since most sexual activity does not and should not lead to pregnancy, proscriptions against non-reproduction-oriented sex are irrational as well as destructive. Nevertheless, these proscriptions persist.

Lukes and Land (1990) offer a consideration of an adaptation of cultural theorising and bicultural socialisation theorising to same-sex orientation. The authors suggest that, while same-sex oriented people communities may not share a culture in a traditional sense, bicultural theorising potentially "...holds greater promise in increasing the understanding of the impact of cultural and ecological components on human behavior than other theories previously used to describe the homosexual experience" (Lukes and Land, 1990: 159).

### **Clinical Factors**

Bagley and Tremblay (1996, 1996a, 1996b, 1996c) and Proctor and Groze (1994) offer considerations of the risks for suicidality among same-sex oriented youth. Proctor and Groze argue for the need for clarity in research relative to potential suicide risks in this population, noting that, "...most research on gay, lesbian, and bisexual suicide has historically operated under the climate of psychopathology or psychiatric settings instead of investigating it as a response to the difficulties of a hostile environment... As a result, it has been difficult to substantiate without bias whether gay men and lesbians are at greater risk for suicidal ideation or attempts" (Proctor and Groze, 1994: 504).

Both studies noted same-sex oriented youth to be at high risk for suicidality than opposite-sex oriented youth. Bagley and Tremblay (1996) reported that same-sex oriented men (whether sexually active or celibate – the latter presenting the highest risk) were 14 times likely than opposite-sex oriented males to have attempted suicide. The Proctor and Groze (1994) study identified that other factors, beyond issues relative to sexual orientation, may influence suicidality among this population but that coping strategies, effective support networks, supportive social and family interactions, and a

positive self-image reduce such risks. While such points may seem relevant to youth regardless of their sexual orientation, the authors stressed the need for practitioners and service providers to maintain an awareness of these factors in relation to their work with same-sex oriented youth. Morrow (1993) also stressed the significance of these points, but adds that it is essential that social work practitioners address their own homophobia, and to access appropriate information and education relative to same-sex orientation, noting the significance of this in working with youth for whom issues around sexual identity may be prominent.

Shernoff (1997), in his work with same-sex oriented men, has noted the need for social work practitioners to be prepared for the diverse range of issues consumers may present. He argues that practitioners need to be aware of, and skilled in working with, the impact of the HIV/AIDS epidemic for those who are HIV+ and HIV-, grief, death and dying, homophobic violence, relationship issues, and ageing. He stresses that these must be addressed within the consumer's context of culture/ethnicity, and locale, and emphasises the significance of supervision.

In considering the implications of discrimination, Cain (1991) investigated issues for same-sex oriented consumers in disclosing their sexual identity. Cain's research contests the necessity for disclosure and the assumption that disclosure is indicative of a healthy self-image of one's sexual identity, and argues that social workers need to consider and integrate awareness relative to the socio-structural variables, impacting on same-sex oriented consumers, into their practice. Cain (1991: 73) argues:

Social work intervention that focuses on both the individual and on the social structure will help depathologize covert homosexuality, will help direct clients' attention to the broader structural forces at play, will help relate clients' individual experiences to those of other gay individuals, and will help empower clients to make their own choices about how best to manage information concerning their sexuality. One may believe it is politically or morally advantageous for gay individuals to be open with others, but such beliefs should be neither confused with scientific findings nor translated into diagnostic categories.

Wyers (1987), Shernoff (1984, 1991) and DeVine (1985) consider same-sex oriented family work. Wyers (1987), following interviews with same-sex oriented husbands and

wives, and their respective opposite-sex oriented spouses, presents the range of individual, marital and parenting difficulties experienced in the relationship and its termination for both partners and their children.

In his study of families with a same-sex oriented child, DeVine (1985) identifies a series of changes the family system engages in the adaptive process. DeVine (1985: 10) argues that, within the context of the family's framework of "...cohesion, regulative structure and family themes that govern the family's movements in the resolution of affectional preference issues", the family system engages a *subliminal awareness* in which the system endeavours to retain a semblance of all being well through a reciprocal process of avoidance and denial. Subsequent to selective disclosure, often following years of avoidance of acknowledgement a same-sex orientation, relative to the identified family member, the family system experiences *impact*, a critical stage featuring intense loss, regret, anger, disruption, anxiety, and behavioural responses, or *adjustment*, aimed at returning the system to a safer status quo – responses that may include proposals for treatment of the individual, encouragement to remain closeted, or the expulsion of the identified family member in an attempt. (DeVine, 1985: 13) DeVine (1985: 14) goes on to propose that *resolution* can only occur when the family system is positively informed so it can contest inaccuracies, myths and misconceptions, and is able to integrate the emotions and "...readjust family rules, roles and themes" toward *integration* (DeVine, 1985: 15).

Shernoff's (1984, 1991) papers discuss (respectively) disclosure issues in the family setting and the potential in family therapy to assist families in this, and a family treatment approach to the treatment of substance dependence. He notes the emergence of a more diverse construction of *family*, necessitating the social work practitioner's reflective consideration of his/her homophobia and heterosexism.

In considering the needs of same-sex oriented consumers with mental ill health, Bell (1994: 110) proposes a psychosocial "homosocialisation" groupwork intervention that recognises the failure of services to appropriately and effectively address the integrated needs of this consumer group. Bell notes resistant and homophobic responses, from colleagues and the agency, to his initial proposal, and how in-service training eased this

so that the program could progress. This group offered consumers an opportunity to consider their own identity formation, to develop supportive networks, to experience the diversity of positive and negative same-sex orientation experiences, and to develop skills in managing stressful experiences and counter invisibility in a more safe and accepting group context.

### **Agency Factors**

In an effort to improve a community mental health agency's service delivery to same-sex oriented consumers, Rabin et al (1986) undertook a needs analysis of staff perceptions of current services within the agency. The analysis evidenced that staff found issues around sex and sexuality disquieting, and that there was a significant resistance to change in service delivery or staff attitudes. In an effort to address the needs of same-sex oriented consumers and to support staff, it was proposed that the agency actively hire same-sex oriented staff, provide appropriate staff education around issues of same-sex oriented sexuality, identify gay-affirmative staff within each team as contact people, and develop networks with the local gay/lesbian communities. Messing et al (1985) emphasise that social workers have a key role to play in such service development, and promote the social worker's application of mediation, advocacy, education, and service development skills in addressing individual and institutional homophobia within the agency.

However, in considering attitudinal change, Brown (1998) observes that facilitation of the change process is necessary. While behavioural changes can be engaged with the development and implementation of policies and procedures, attitudinal change needs interpersonal engagement. Brown (1998: 3) argues:

To engage in change there needs to be dialogue, conversation. Conversation assumes an equality of engagement, the possibility of exchange, listening and contributing. Engaging in conversation is an essential component of the development of anti-oppressive practice. Anti-oppressive practice is about the breaking of new ground, entering unfamiliar spaces, where we need to move with some degree of hesitancy and humility because it is other people's lives we affect in this process. Rhetoric and retribution have little place within conversation and the development of anti-oppressive practice but, understandably, they featured in the early debates and discussions, as part of a process of being heard, to catch the attention of those who were perceived as holding power. The attention has been caught

and we are now able to enter the realms of complexity and the engagement with contradictions.

### SUMMARY

This chapter has endeavoured to set the stage for this thesis. By offering a consideration of the identification and subsequent response to homosexuality in psychiatric and related research and literature. Psychiatric/mental health social work, as a field of practice, and social work practice with same-sex oriented men, is located within that practice context.

To date, in spite of declassification as a psychiatric disorder and positive legislative measures, much of the research relative to homosexuality has sought etiological explanations, indicating a problematic pathologised construction of same-sex desire and sexual activity. These investigations have maintained homosexuality as the *other*, as *the problem*. The question should not be *why are some men homosexual?* But rather why does society respond to same-sex oriented men as it does? What potential is there for a diversity of consenting adult sexual expressions in our society? The *Male Call* project is a clear exception in its interest in gaining a greater understanding of men who have sex with men and their experiences. Such research needs to be encouraged.

The literature relative to social work and same-sex oriented men is sparse at best. While this material generally moves clear of pathologising constructions of homosexuality, the writers and researchers tend to advocate a primarily sociological/structural or psychological/clinical consideration of the issues. The critical integration of these is absent. Reference is frequently made to anti-oppressive social work practice that maintains an awareness of oppressive structures/practices, and even encourages contesting these, but informed by what? Where is the application of self, of our values in our practice? Where is our foundation in critical social science theorising reflected in our clinical theories and interventions? Where is the reflective discourse? It is thus hoped that this thesis will encourage such a discourse around integrated psychiatric/mental health social work practice with same-sex oriented men who present with mental ill health.

### 3. EPISTEMOLOGY AND THEORY, METHODOLOGY AND METHOD

This research project explores the constructions ten psychiatric/mental health social work practitioners have relative to same-sex oriented men and same-sex oriented male sexualities. It considers how these practitioners integrate, reflect and apply these constructions in their practice with same-sex oriented male consumers who present with mental ill health.

As noted in Chapter 1, the purpose of this project was not to expose *good* or *queer-safe* or *gay-safe* psychiatric/mental health social work practitioners, as opposed to *bad* or *homophobic* or *heterosexist/heteronormative* practitioners. Rather, the purpose was to understand, through a consideration of the practitioners' self-reflective narratives and the focus group discussion, and from an approach of positive regard for the participants, how the practitioners have integrated their constructions of gay men and gay/same-sex oriented male sexualities in their practice at theoretical and clinical practice levels with same-sex oriented male consumers. There could be no 'right' or 'wrong' responses in such a project, since (as I will explain in greater detail in this chapter) it is the narrative/discourse that was the focus, hence my application of a textual deconstructive discourse analysis approach, based in social constructionist queer theorising, in reading the transcripts of participants' interviews and the focus group discussion. My intention has been to encourage such discussion among practitioners, to invite a consideration of our understandings and how we reflect such understandings in practice. This reflects the style of discourse analysis to be applied in this study in which:

Participants discourse or social texts are approached in *their own right* and not as a secondary route to things "beyond" the text like attitudes, events or cognitive processes. Discourse is treated as a potent, action-oriented medium, not a transparent information channel.

(Potter and Wetherell in Gavey, 1989: 466)

As I noted in Chapter 2, it would appear that no such research project has ever been engaged in Aotearoa New Zealand. It must, therefore, be acknowledged that this is an

*exploratory* qualitative study in that the discourse central to this project is, I hope, “...breaking new ground, and... yield[ing] new insights” (Babbie, 1992: 91). That this is qualitative research is significant in that:

The key characteristic of qualitative research is that it facilitates the researcher’s understanding of the meaning assigned to the phenomena by those being studied. The direction of research is guided by the research subjects to a much greater extent than is usual with quantitative strategies.

(Buston et al 1998: 197)

In presenting the means and understandings relative to this exploration, I plan to draw on Crotty’s (1998) framework for organising a consideration of the epistemology, theory, methodology and method for this study. Crotty notes that this framework aims to enhance a clearer understanding of these interrelating layers.

This is a scaffolding, not an edifice. Its aim is to provide researchers with a sense of stability and direction as they go on to do their own building; that is, as they move towards understanding and expounding the research process after their own fashion in forms that suit their particular research purposes.

(Crotty, 1998: 2)

## **EPISTEMOLOGY AND THEORY**

It is epistemology that offers a research project a philosophical place to stand, clearly outlining “...what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (Maynard in Crotty, 1998: 8). Within this philosophical space, the theoretical orientation applied informs the methodological measures utilised.

### **Epistemology: Social Constructionism**

Central to a social constructionist epistemology is the belief that understandings and perceptions are socially constructed relative to time, place and culture, purposefully creating a plurality of realities/meanings reflected in and drawing from diverse linguistic and symbolic interactions between human minds and social objects (Schwandt, 1994). In reflecting its connections with postmodernism/poststructuralism, social constructionism actively contests notions of objective truth, and of universal knowledges (Crotty, 1998), arguing three key standpoints:

First, social reality is socially constructed. The objects that constitute social life lack intrinsic meaning. Instead, these objects take on meaning through human actions. The cultural definition, symbols and identities attached to these objects are thus acquired through the process of social interaction. Second, human interaction entails mental processes in which individuals fashion a point of view that accords with the behavior of other actors. These mental processes involve the manipulation of symbols, words, meanings, and languages. Consequently, social interaction is symbolic, emergent, negotiated – and frequently unpredictable. Third, self-reflexive conduct distinguishes human beings from other forms of life. Individuals are capable of shaping and directing both their own actions and those of other people.

(Levine, 1992: 186)

It is at this interface between people and their environment that objects are ascribed a construction or meaning, necessitating interplay of persons, mind, object and social/cultural context in the construction of shared meaning:

The world and objects in the world are indeterminate. They may be pregnant with potential meaning, but actual meaning emerges only when consciousness is engaged with them.

(Crotty, 1998: 43)

In constructionist research, the goal is to draw out understandings from the subjective experiences and constructions of those actively engaged in the focus of study (Schwandt, 1994). Gergen (cited in Tiefer, 1992; 297-298) posits that there are four key assumptions in social constructionism:

- (1) The way we go about studying the world is determined by available concepts, categories, and methods. Our concepts often incline us toward or even dictate certain lines of inquiry while precluding others, making the results more of our language than of empirical discovery. For example, the assumption that there are two and only two genders is taken for granted. We don't ask where gender conceptions come from, and gender, then, becomes only an independent variable.
- (2) The concepts and categories we use vary considerably in their meaning and connotations over time and across cultures...
- (3) The popularity or persistence of a particular concept, category, or method depends more on its usefulness (particularly its political usefulness for social influence and control) than on its validity...
- (4) Descriptions and explanations of the world are themselves forms of social action and have consequences.

The application of constructionism, as an epistemology relative to sexuality in attempts to consider the emergence and identification, and of socially constructed understandings of the social categorisation/positioning and contemporary representations/experiences of same-sex orientation, is extending well beyond the initial offerings of McIntosh (reprinted 1996). McIntosh argued that homosexuality constituted a *role* and that this "...imagery was more conducive to examining social, historic, individual sexual variability" (Tiefer, 1992: 306). However, much of the social constructionist literature, relative to sexuality and sexual orientation has been focused on an energetic and somewhat drawn out debate contesting essentialism.

...essentialists think that the categories of sexual orientation... are appropriate categories to apply to individuals. According to essentialists, it is legitimate to enquire into the origin of heterosexuality or homosexuality, to ask whether some historical figure was a heterosexual or homosexual, etc. This follows from the essentialist tenet that there are objective, intrinsic, culture-independent facts about what a person's sexual orientation is. In contrast, the social constructionist denies that there are such facts about people's sexual orientation and would agree with the exhortation that it is mistaken to look at an individual as being of a particular sexual orientation in the absence of a cultural construction of that orientation.

(Stein, 1992: 4-5)

Stein's suggestion, that an etiological consideration of heterosexuality might be considered, is an interesting one since by far the majority of such studies have focused on non-heterosexual orientations. It is non-heterosexual sexualities that are problematised or pathologised and considered warranting such investigations, placing that which is not heterosexual in a subjugated position within a binarised structure of essentialist sexuality and sexual identity. Queer theorising contests, to varying degrees, purist essentialist notions of transcultural and transhistorical fixed gender/sexual identities. Jagose (1996: 3) notes these contestations as products of "a specifically lesbian and gay reworking of the poststructuralist figuring of identity as a constellation of multiple and unstable positions."

### **Theory: Queer Theorising**

Queer theorisings have emerged, over recent years, occurring in and in response to intense debates and theorising around sexuality/sexualities in the women's and gay movements, and in the academy (Escoffier, 1990; Jagose, 1996; McIntosh, 1993; Weed,

1997). The homophile movements of the 1950s, in which sexuality (primarily homosexuality or, at least the potential for it) was considered an innate characteristic of a minority, applied the argument that homosexuality was natural and evident in most cultures throughout history, and therefore should not be considered criminal or deviant. This essentialist position was carried, to some extent, through into early gay liberation notions of identity and minority politics, particularly evident in the post-Stonewall efforts toward gay affirmative community development (Bristow and Wilson, 1993; Halperin, 1990; Seidman, 1993, 1996; Spargo, 1999; Stein, 1992, 1992a; Weeks, 1989).

Seidman (1996) proposes that, central though essentialism was to early homophile movements, the years around Stonewall also signalled the emergence of new theorisings of homosexuality in criticism of earlier perceptions of homosexuality in medico-scientific terms warranting tolerance with an assimilationist agenda. A version of social constructionism, based in symbolic interactionism synthesised with Marxist views of social history, posited that, while same-sex sexual activity has occurred throughout history and in most cultures, its construction as a specific identity or species did not exist in the West until the nineteenth century (Adam, 1995; Escoffier, 1990; Epstein, 1992; Fuss, 1989; Ryan, 1991; Seidman, 1992, 1993, 1996). Foucault (1990: 43) notes:

As defined by ancient civil or canonical codes, sodomy was a category of forbidden acts; their perpetrator was nothing more than the juridicial subject of them. The nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology. Nothing that went into his total composition was unaffected by his sexuality. It was everywhere present in him: at the root of all his actions because... it was a secret that always gave itself away.

In citing efforts to consider the social and cultural factors that contributed to the emergence of the modern homosexual identity, Seidman (1996: 9) notes that such studies "...legitimated a model of lesbian and gay subcultures as ethnic-like minorities." This stance proved to be considerably effective in the development of localised gay and lesbian communities and in the beginnings of significant legislative reforms in a number of Western states. Much of these earlier gay movements carried an agenda of

assimilation. However, the notion of a normalised assimilated gay or lesbian did not sit comfortably with all.

What about people who didn't fit the image, who weren't at home in the positive, confident, upwardly mobile world of assimilationist politics and culture? And what about the acts, pleasures and identifications that were the cause of dissent and conflict within gay communities rather than the occasion of feel-good collective self-affirmation? Bisexuality, transsexuality, sadomasochism and transgender identifications all implicitly challenged the inclusive ideal of assimilationist politics. The incompatibility can be partly interpreted in terms of respectability. If you want to be an equal part of a straight world by proving how ordinary, how 'just-like-you' (but perhaps a bit more sensitive or artistic) you are, it simply won't do to flaunt your more excessive, transgressive desires or relations.

(Spargo, 1999: 30-31)

The *ethnic-like minority* approach fostered a degree of support and tolerance and potentialised assimilation, but this was to be met with significant organised resistance from the New Right in coalitions with other anti-gay collectives and individuals. Such oppositions were to be brought centre-stage when, in the early 1980s, previously healthy gay men began presenting, in major cities in the U.S. and elsewhere in the world, with what was later to be identified as AIDS but at that time was known as GRID (Gay-Related Immune Deficiency) or Gay Cancer. Seidman (1996: 10) states:

The AIDS epidemic energized an anti-gay backlash and put lesbians and gay men on the defensive as religious and medicalized models which discredited homosexuality were rehabilitated. While the AIDS crisis also demonstrated the strength of established gay institutions, for many lesbians and gay men it underscored the limits of a politics of minority rights and inclusion. Both the backlash and the AIDS crisis prompted a renewal of radical activism, of a politics of confrontation, coalition building, and the need for a critical theory that links gay affirmation to broad institutional change.

Since its initial clinical emergence in the early 1980s, AIDS, and (particularly) the over-representation of gay men among those affected in the West, exposed the limitations of liberal tolerance and raised lengthy and costly debates. Jagose (1996: 19) argues that the AIDS crisis "...exemplifies the discursive incoherence that structures understandings of modern sexualities."

Such debates often resulted in essentialist claims in order to express unity. Indeed, such a project has continued and can be perceived in recent efforts to find some innate biological causative agent or factor in the development of homosexuality in an individual. However, as Seidman has observed:

...many activists and intellectuals moved in the opposite direction, affirming a stronger thesis of the social construction of homosexuality that took the form of a radical politics of difference.

(Seidman, 1996: 11)

This politics of difference was made even more significant with the challenges of people of colour and sex radicals who, as with lesbians before them, contested the notion of unity under *gay* as a shared identity because it did not speak to or of them. *Gay* was perceived as primarily representing white, middle-class and male (Seidman, 1993; Spargo, 1999). Out of such dissent, *queer* emerged as forms of poststructuralist and postmodernist activism and theorising contesting and deconstructing the notion of stable, exclusive social and sexual identity, in particular, the exclusive, binarised identities of *the homosexual* and *the heterosexual* (Jagose, 1996).

Queer theory is not a singular or systematic conceptual or methodological framework, but a collection of intellectual engagements with the relations between sex, gender and sexual desire. If queer theory is a school of thought, then it's one with a highly unorthodox view of discipline. The term describes a diverse range of critical practices and priorities: readings of the representation of same-sex desire in literary texts, films, music, images; analyses of the social and political power relations of sexuality; critiques of the sex-gender system; studies of transsexual and transgender identification, of sadomasochism, and of transgressive desires.

(Spargo, 1999: 9)

Queer theorisings are many and varied. There is yet to be a singular definitive *Queer Theory* identified and, perhaps such a venture should be avoided since discourse is a central feature of queer theorising. Indeed, it could be posited that the discourse *is* queer theorising. Jagose (1996) sees this resistance to definitional confinement as critical to the effectiveness of queer theorising, and notes Halperin's arguments that "...the more it verges on becoming a normative academic discipline, the less queer

“queer theory” can plausibly claim to be” (Halperin cited in Jagose, 1996: 1). Nevertheless, queer theorisings do have some shared features, strategies and posits. Queer theorisings within the academy aim to centralise discourses around sexuality; and to further establish gay, lesbian and queer theorising within critical social theory and cultural theory rather than retain the current peripheral placement as minor discourses (Seidman, 1995). Warner (1993: viii-ix) notes:

...it remains depressingly easy to speak of ‘social theory’ and have in mind whole debates and paraprofessional networks in which sexuality figures only peripherally or not at all - to say nothing of manifestly homophobic.

Queer theorising focuses on the deconstruction and dismantling of the heteronormative hierarchy, exposing its essentialist false consciousness. In queer theorising, *sexualities* are perceived as socially and culturally constructed, and in the West (since the nineteenth century sexological identification of *the homosexual*) sexuality has been constructed with *the heterosexual* as the ideal, the standard by which that which is not considered heterosexual is to be measured. Fuss (1991) describes this in the sense of an insider-outsider polarity in which heteronormativity ascribes heterosexuality as the ‘insider’, the included, while homosexuality is excluded as the ‘outsider’ because it is deemed not to be heterosexual. Fuss would argue that both polarised categories rely on one another to retain their identity, their sense of inclusion/exclusion. Thus, for queer theories, the notion of *identity* is problematic in that it fails to question or contest the hetero-homo binary, and in so doing reinforces the subjugation of that which is not heterosexual by that which is. Furthermore, such an essentialist understanding fails to adequately address or reflect the experience of all and at all times relative to culture, gender identity, ability, class. Are these others ascribed as non-heterosexual or merely excluded?

The hetero-homo binary is made even more problematic when one considers what heterosexual is. Is it purely based on opposite-sex object desire, and if so, on what level? Physical? Emotional? How, in this sense is *sex* defined? Does heterosexuality incorporate or require gender-based roles or power structures? These and related questionings expose the unstable construction of the categories and identities based on them. If we consider that heterosexuality was only identified once homosexuality had

been, then the heteronormative understanding of what heterosexual is can only be that which homosexual is not, and yet similar problems of definition lie with that category. Both categories appear to be defined relative to the biological sex of the partners involved in a sexual act, although the construction of what constitutes a *sexual act* is by no means unproblematic.

Much of the discourse within and around queer theorising continues to reflect and focus considerable energy on the debates/negotiations between essentialism and constructionism. However, a fundamentalist adherence to either view polarises the debate, and indeed both views may be, to some extent, simultaneously correct (Weinrich, 1992). As Fuss (1989: xi) observes, “The bar between essentialism and constructionism is by no means as solid and unassailable as advocates of both sides assume it to be”. There may well be some innate predisposition for homosexual desire and that sexual orientation is determined, but that does not alter how same sex desire has been and continues to be socially constructed in its presentation and the social response to it. Nevertheless, surely the etiology of same-sex sexual orientation/desire and/or activity is a risky diversion from the primary issue of the construction of that sexuality as the *other*, as subordinate to heterosexuality, in contemporary Western capitalist society. The question should not be “*How does homosexuality occur/develop?*”, but rather – “*How does/could our society construct or understand this?*” (Stein, 1992a; Weeks, 1989).

The goal of queer theorising is the deconstruction and demise of heteronormativity, and its collaborative power structures, toward the potential for broader recognition of multiple and fluid sexuality and gender constructions, diverse and safe forms of relating, and the affirmation of differentness. Thus, queer theorising informs action and activism in ways that contest, problematise, disrupt and contradict the hegemony of heteronormativity, and question constructions of sexualities and their expressions, indeed our constructions and knowledges of ourselves and others.

### **METHODOLOGY AND METHOD**

In this project, I have applied individual interview and focus group discussion techniques with a view to applying a deconstructive discourse analysis, reflecting social

constructionist queer theorising, in considering the respective transcripts/texts. Psychiatric/mental health social workers in the Auckland region were unofficially made aware that this project had been in preparation. A number knew of my Auckland-based supervisor's connection with the project, and expressed their interest to her in being involved. Potential participants were invited to participate in an indirect 'snowball' approach via professional network meetings and social work teams, senior social workers and social work team leaders, with information about the project provided in the Information Sheet (Appendix 1). The only criteria was that potential participants were to be currently practising as psychiatric/mental health social workers, and were requested to notify my Auckland-based supervisor. Ten practitioners eventually agreed to take part in the project. Participation was voluntary. The Information Sheet provided potential participants with the necessary details for each to give informed consent regarding their participation. The Consent Forms (Appendix 2) were to be returned to me via my Auckland-based supervisor.

There were two parts to the project: Part One involved an unstructured interview based around a range of demographic details and discussion points (Appendix 3). Part Two was a focus group discussion following a presentation I gave on *Queer Practice*.

### **Methodology: Deconstructive Discourse Analysis**

In Foucauldian theory, 'discourse', is not just another word for speaking, but a historically situated material practice that produces power relations. Discourses exist within and support institutions and social groups, and are bound up with specific knowledges. So the discourse of medicine produces particular practices, knowledges and power relations.

(Spargo, 1999: 73)

In acknowledging the role of discourse in social interaction, Gavey proposes discourse analysis to be a technique of drawing out the themes, and constructions in the text, of *language processes* applied relative to power structures. "Discourse analysis proceeds with the assumption that these processes are not static, fixed, and orderly but rather fragmented, inconsistent, and contradictory" (Gavey, 1989: 467).

The application of discourse analysis as a methodological framework, in this project, is primarily centred around consideration of the language and the reflected meanings presented by each participant in his/her narrative relative to the binarised construction of sexuality. Discourse analysis refers to an examination of the content and flow of a given text – in this case, the text is the transcripts of the participants’ interviews and the focus group discussion. Deconstruction in this sense refers to a consideration of what is said in the (con)text, in the language and structural positioning/situation of the narrator/author and the narrative, but it also considers that which is absent. The aim is to offer a problematising or destabilising, a contesting of that which is given or assumed to be fixed and uncontested.

### **Method: Interviews**

Behind every answer lies a question. And in order to understand why we are interested in that question rather than some other question, we must recognize that we always integrate facts and values. This is not only unavoidable but also inevitable as well as desirable. Values give us our energy to think. They inspire our curiosity because they offer attachment, concern and commitment. The more we try, as an ideal, to root values from our inquiry, the more uninteresting and pointless the inquiry becomes.

(Rein, 1983: 90)

The interviews were what Denzin (1989: 105) has identified as unstructured schedule interviews in that the same information was sought from each participant, but the order followed a discourse process and varied relative to each participant’s responses. Thus, each interview followed the flow of the participant’s narrative, as a discussion, and supported Denzin’s (1989: 106) point that, “With this approach, the interviewer will often find that the interviewees will raise important issues not contained in the schedule in one long sequence of statements.”

I interviewed each participant individually, at a time and venue identified as acceptable to the participant. Each interview took no longer than one and a half hours, and consisted of an unstructured discussion. Participants were made aware that these interviews were to be audiotaped and subsequently transcribed by a Transcriber who had signed the Transcriber’s Statement of Confidentiality (Appendix 4). They were

also made aware that I may draw on aspects of this project in preparing a chapter for a text on queer theorising in Aotearoa New Zealand, which is expected to be published in 2001. Transcripts would be forwarded to the participant accompanied by a covering letter (Appendix 5) inviting him/her to amend the transcript as desired. Participants remained under no obligation to participate, and were made aware that their consent could be withdrawn at any stage prior to returning their respective interview transcripts.

Each interview was based around the interview schedule (Appendix 3). The demographic material was generally applied by way of an introductory process to the subject matter. It clarified the subjective positioning through both interviewer and participant introducing themselves.

I commenced each interview with an explanation of the project and its purpose, and explained the code to be used in the transcript of the interview. Each interview participant would be identified by a code, (for example, A1 through A10) based on the order in which they were interviewed. At this point, I revisited the participant's Consent Form, and confirm that consent was still given.

The clarification of the participant's cultural identity was to ensure the participant felt culturally safe with the interview. While the points around the participant's age group, career factors, professional association, and current role were purely for demographic purposes, the clarification of the current role/service would also provide some understanding of the participant's practice context. The points around gender identity and sexual orientation were included to focus the participants on the subject matter and to ease into their reflective consideration of the practitioner as a person.

The remainder of the interview explored practice with this consumer group, and was guided by an *integrated practice framework*, which was also a feature of the presentation upon which the later focus group discussion would be based. Throughout my postgraduate studies and relatively brief career, I have maintained a significant interest in how psychiatric/mental health social work practitioners construct their practice: how they reflect and integrate their knowledge, skills, values and experience with their theoretical orientation and practice models at the clinical coalface.

I first encountered the notion of *integrated practice* in my undergraduate training with Dr Rajen Prasad at Massey University in 1988. Prasad's (1986) ecological practice framework placed practice within the social context of the agency and practice field, and the client's social and structural environment. In describing his ecological perspective, Prasad (1986: 101-102) notes two key elements:

First, human development is viewed as being dependent on complex interactions between the person and his/her "proximal" and "distal" environment... This view entails a conceptualisation of the various aspects of the person, the environment and the nature of the interaction. A basic principle of the ecological perspective is that the person is always in a state of transition or "becoming", adapting to and seeking to modify the environment with which he/she interacts. The interdependent relationship between the person and the social environment means that the individual cannot be fully understood apart from that context... Secondly, in striving to understand the influence of environmental factors, the ecological perspective also emphasises the subjective experience of the person.

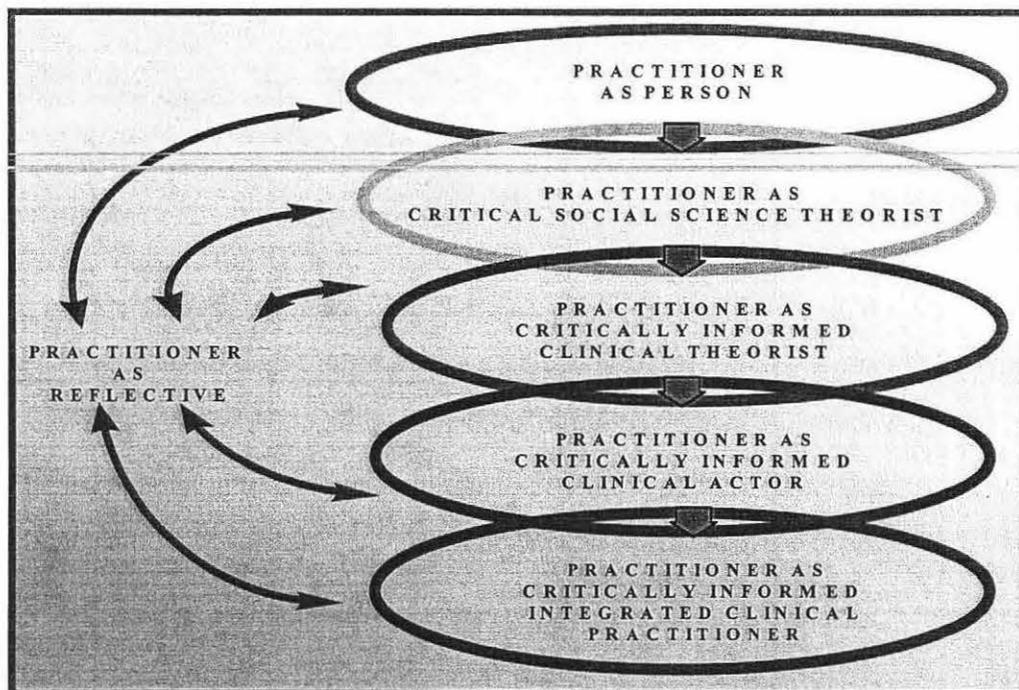
The integrated practice framework proposes an applied integration of the practitioner's personal and professional philosophical, socio-political, and psychological perspectives reflected in the various modes of practice applied in addressing the issues clients present within the context of practice. Each point must then be critically contested within a multi-level analysis of the relevance of the practitioner's framework within the context of culture, gender, class, sexuality, and (dis)ability. Integrated practice can be seen reflected in the work of others. For example, the application of a structural analysis model in community work proposed by Munford and Walsh-Tapiata (1999), and to some extent similar frameworks can be seen in the interlocking theoretical stance of Turner (1996).

As social workers practising within psychiatry, we are informed and guided by knowledge(s) specific to our own profession, and by those we share with related disciplines, but also (significantly) by the context of our practice. Social work is a diverse and ever-transforming profession, reflecting the cultural and social context in which it is practised (Payne, 1991).

While the International Federation of Social Workers has offered a contemporary construction (Appendix 6), I am always reluctant to offer a specific definition of social

work in the belief that the moment we bind the profession to a definitive statement, we deny its potential, its diversity, and we terminate the discourse. However, for the purposes of this project, my current posit of integrated clinical psychiatric/mental health social work practice would be that I see it as the culturally appropriate application of knowledge(s) and skill(s) reflecting an integration of the practitioner's personal and professional experiences, philosophy and values with critical socio-political and clinical theories informing a process of critical analysis and change-oriented intervention(s) to address problems as experienced by persons directly or indirectly affected by psychiatric illness. The primary focus for such intervention lies at the interface between the consumer (be it an individual, family, whanau, couple, group, or community) and the structural context or social environment. Intervention is applied via appropriate modes of social work practice (for example, casework, groupwork, family work, community work) with a goal of maximising human potential and social justice. I maintain that it is this integration that sets social work apart, in constructing presenting problems beyond the solely sociological/structural and/or psychological. Figure 3.1 offers an indication of how such a framework of integrated social work practice could be structured.

Figure 3.1: A Framework of Integrated Practice



### ***Practitioner as Person***

For the social work practitioner, the beginning point must lie with the *practitioner as a person* with personal and professional experiences, a cultural base, a history, a narrative, gender constructs, sexuality, beliefs, and knowledges. As is reflected in the Aotearoa New Zealand Association of Social Workers' standards for practice (New Zealand Association of Social Workers, 1993), the practitioner's self and awareness of self are the core of his/her practice, particularly in relation to an appropriately applied use of self in practice.

### ***Practitioner as Critical Social Science Theorist***

Whether the practitioner draws on one of the socialisms or radical or empowerment approaches (for example, Bailey and Brake, 1980; Burghardt, 1996; Corrigan and Leonard, 1984; Jordan, 1984; Lee, 1996; Rees, 1991; Shaw, 1994), or feminisms (for example, Nash and Munford, 1994; Nash, 1989; Nes and Iadicola, 1989; Valentich, 1996), or cultural approaches (for example, Foliaki, 1994; Nabigon and Mawhiney, 1996; Ruwhiu, 1994, 1995; Tulele, 1994); postmodernism (for example, Munford and Walsh-Tapiata, 1999), or other socio-political theorisings (for example, Andreae, 1996; Middleman and Goldberg, 1974), the *practitioner as critical social science theorist* applies in developing a construction of contextual features of presenting issues in clinical practice and social policy. It is within such a construction, reflecting the practitioner as a person and as a critical social science theorist, that the practitioner identifies a clinical theory base that reflects the practitioner's critical social science theoretical orientation and the practitioner as a person.

### ***Practitioner as Critically Informed Clinical Theorist***

Within the integrated practice framework, the *practitioner as critically informed clinical theorist* acknowledges clinical theories as the bodies of knowledge informing practice, providing the practitioner with a conceptualisation of the presenting issues (Persons, 1993). They are "...schemes for the interpretation of reality" (Gray, 1995: 58). As the foundation of practice, theory needs to be clearly reflected (if not identified outright) in the assessment of a presenting issue and the techniques and intervention strategies engaged to address these. Unfortunately, practitioners frequently neglect to

provide such an identification in texts and other writings on social work and practice (Ephros and Reisch, 1982; Sheppard, 1995).

The *practitioner as critical social science theorist* and *practitioner as critically informed clinical theorist* aspects of the framework were addressed together in the theoretical component of the interview. I was looking to see the a reflection of the practitioner's constructions manifest in the interlocking the critical social science and clinical theoretical models applied, how these informed practice with gay/same-sex oriented male consumers presenting with mental ill health, and how the key issues the practitioner identified as impacting on this consumer group were addressed within the practitioner's theoretical framework.

#### ***Practitioner as Critically Informed Clinical Actor***

All clinical theories will carry with them a range of practice strategies, but what is important is that these strategies also demonstrate an application of the critical social science theoretical stance of the *practitioner as critically informed clinical actor*, seeing the client in his context.

#### ***Practitioner as Critically Informed Integrated Practitioner***

Clinical supervision is a social worker's point of reflective accountability. It is, as Merv Hancock has stated, it is about "...self development and the maintenance of sound social work practice" (in Munford and Nash, 1994: 11). Through the supervision process, the social work *practitioner as critically informed integrated practitioner* – as a reflective practitioner, is provided the opportunity to reflect on his/her practice and what informs this, to consider the implications of practice in context, and address training and personal/professional development. In maintaining a commitment to professional development and ethical practice, it is essential that the practitioner has access to appropriate, informed, productive and safe clinical practice supervision.

It was in discussions around the practitioners' application of their theoretical framework and the clinical strategies engaged, that we were able to see the *practitioner as a clinical actor* and as a *critically informed integrated practitioner*. This was about

the practice experience at the clinical coalface with this consumer group, and the practitioners' reflections on this within the practice context.

### **Method: Focus Group**

The focus group was made up of four persons who joined me following a half-day presentation I gave on Queer Practice. The discussion (over lunch) was to consider the notion of Queer Practice as presented (see Chapter 8) and covered the following key points:

- *Could* such an example of integrated practice be applied?
- *Would* such an example of integrated practice be applied?
- *Should* such an example of integrated practice be applied?

Participants in the focus group signed the Consent to Focus Group Discussion (Appendix 7) and the Focus Group Statement of Confidentiality (Appendix 8), the latter being a key requirement for the study as recommended by the Massey University Human Ethics Committee when they considered the proposal for this study. Focus group participants were aware that the discussion was to be audiotaped, and subsequently transcribed by a transcriber who had signed the Transcriber's Statement of Confidentiality (Appendix 4), and that aspects of this discussion may be drawn on by me in preparing a chapter for a text on queer theorising in Aotearoa New Zealand which is expected to be published this year.

## **ETHICAL CONCERNS**

The Massey University Human Ethics Committee (1998) has established a number of key principles for researchers engaging in research projects with human participants. Approval was sought from the Ethics Committee for this project, and was given with a requirement for the inclusion of a Confidentiality Statement for participants in the focus group discussion.

A core theme in the Massey University Human Ethics Committee's (1998) principles relates to an obligation, on the part of the researcher, to do no harm. Central to this is the concept of informed consent, which ensures participants have all the information they need in order to feel safe and confident in their participation.

Informed consent, involves ensuring participants are aware of the mechanisms in place to maintain their *confidentiality*, again noting who will have access to their data, but also how their identifiers will be disguised in the final thesis. It was acknowledged that this project might involve sensitive material for some participants. For example, some may disclose that they are or identify as gay/lesbian/bisexual/transgender/takataapui and that they are not out. Participants may also have been heterosexual practitioners who may have found this project somewhat disquieting or intimidating. Again, sensitivity on my part was necessary to ensure these participants felt safe with the project process and with me.

Pseudonyms/codes and, wherever possible, alterations to identifying data have been used to ensure participants' confidentiality and anonymity have been maintained, and that sensitive information is respected. This was further enhanced through the feedback loop process in which participants in the interviews had the opportunity to amend or delete information. This also provided the potential for ensuring the confidentiality of related others (institutions, practitioners, and other persons). Such details were presented in an Information Sheet to be accompanied by a Consent Form for each interview participant. The Consent Form and Confidentiality Statement was implemented to ensure participants in the focus group discussion had similar protection and awareness although consent could only be withdrawn up to the time of the discussion.

With regard to this project, explicit informed consent was actively sought from all potential participants relative to the interviews and the focus group discussion. The information provided was as clearly stated as possible and endeavoured to respond to all possible concerns or questions prospective participants may have. This included a description of the research project, an explanation of my role as an MSW student and my interest in this study, a description of the process and the participant's role in this, notification that the interviews would be audiotaped and who would have access to this tape, opportunities to amend transcripts, including what is to be done with the audiotapes once transcribed, awareness of who my supervisors were and how they may be contacted, and options for withdrawing consent.

Participants were assured that all audiotapes and transcripts would be separately secured in locked filing cabinets, except when in use, in my home workspace; and that no other person, with the exception of the transcriber who had signed the Transcriber's Statement of Confidentiality, would have access to this material. All hardcopy and disks of transcripts were secured separately, and password-only access was maintained on my home computer system. No transcripts or participants' contact details were stored on this system. These were stored securely and separately on disk. When using disk copies of transcripts or participants' contact details, the disks were not left in the system unattended, and none of this information was downloaded and saved on the system. All disks are to be wiped, hardcopy versions of the transcripts destroyed, and audiotapes destroyed at the completion of the thesis.

There were Maori participants in this study, and some potential participants rightly raised questions, regarding the important point that this project involved a Pakeha interviewing Maori, with the senior social worker assisting in accessing potential participants. In recognising the essential need to engage participants in a culturally appropriate manner, I consulted with a Kaumatua who offered me clear and valuable guidance. Interviews with Maori were to be guided by processes that were comfortable/appropriate to the participant, commencement and conclusion with karakia to ensure the process was safe and that the tapu nature of the process was approached with regard and respect. Nevertheless, this remains a concern for me in that I hold that the process would have been significantly more appropriate had I sought Maori to interview Maori.

As a man interviewing women, it was also necessary for me to maintain an awareness of gender factors in the interview process. It was essential for me to consistently monitor my work, ensuring as much as was possible that the environment and my interactions were sensitive and appropriate for women participants.

In recognising that participants may indicate a preference not to discuss certain material in their interviews or the focus group discussion, it was duly noted that this possibility was accepted and that no justification would be required from the participant for this.

As part of the information provided, potential participants were informed of the types of material proposed for consideration.

It is important to note that the population from which this sample was to be drawn is relatively small. It needs to be acknowledged that there was the chance that I would know at least some of those who would volunteer for this study. In recognising this, and in order to reduce any potential for previous clinical or professional development knowledge of the proposed participants influencing the process or findings, previous and current supervisees of mine will be excluded.

It must also be acknowledged that the interviews could have proven distressing for some participants. Recalling experiences, anxiety over being tested or judged, or impact on existing personal/professional issues. In order to *minimise harm*, participants were be assured that this study was not about identifying good or bad practitioners. Throughout the interviews, I retained an awareness of each participant's subjective experience of this process. Central to this was the need to maintain *social sensitivity* to the participant's culture, gender, sexual orientation, age, belief systems, experiences and views. I needed to maintain an awareness of how I presented in the interviews: that I am a male gay Pakeha/Tauiwi, mental health professional in my early forties who holds Fabian socialist principles. I also needed to be constantly aware that I have a strong personality. With each of these factors, there was a range of constructions and preconceptions participants may have had with regard to me, and that I may have had of them. My approach, in each interview was to be one of positive regard for the participant, no matter whether I agree or disagree with their views. Again, supervision would play an important role in this.

In considering any ethical risk to myself in this project, I am a gay man, and I recognise that this project will 'out' me although I am reasonably well known as an out gay man and practitioner. However, I acknowledge that this project could be a contentious or sensitive subject matter, and that there remains a risk of rejection, judgement, negation or discrimination in this project process and subsequent to it. Nevertheless, this is an extremely important subject matter for me, and I am prepared to take such a risk with the support of my supervisors and my network.

While it was not realistically expected that the study would have major political repercussions, based on its size and the potentially limited interest in its subject matter, it must be acknowledged that research cannot be seen in a social or political void (Bryson, 1979; Oakley, 1981). In raising the question of practitioners' constructions of sexualities, and how these constructions are or are not integrated in practice, within the heteronormative socio-political context, the study invited a discourse within social work and mental health relative to practice and service delivery. Sexuality, particularly homosexuality, is frequently a contentious issue with implications for practitioners, consumers and policy makers, invoking expressions of aetiological constructs, values and belief systems, and theoretical and philosophical orientations. It is within such discourses that the proposed study potentially contributes an alternative construction of same-sex oriented male sexualities beyond those that unproblematically construct a singular and fixed heterosexuality as the norm, the standard by which sexual identity/expression/desire is to be measured, and overtly or covertly perpetuates the subjugation of all other sexualities.

Queer theorising focuses on the deconstruction of such understandings or conceptualisations, and offers alternative discourses which expose the disenfranchising hegemony of binarised sexual hierarchies. The goal is to move us beyond heteronormative agendas of assimilation (and, ultimately, invisibility) to a recognition of the immense diversity of presenting and potential sexualities. As noted, this project is not about negating practitioners but about contesting our understandings and encouraging a self-reflective practice discourse.

#### 4. "I AM WHAT I AM" - THE SOCIAL WORKERS AS PERSONS AND AS SOCIAL WORKERS: THE PARTICIPANTS

Social work is a diverse profession and encompasses a wide range of practice settings and roles provided by practitioners who bring unique personal and professional histories integrated with knowledges and skills to the clinical coalface. The appropriate application of the self is a feature of this practice. Such an application necessitates an active awareness of one's culture, experiences, body, gender, age, values, and beliefs. In particular, it necessitates a consciousness of how these influence the understandings we have, the knowledges and skills we adopt, and how they are reflected throughout our practice. This is the coalface of integrated practice. It is these features, which will contribute to the practitioner's value constructs, recognising the practitioner as part, and a product of the social context of practice (Brown, 1998). For many of us, it is such experiences and values which initially brought us to social work as a career choice, our own experiences or awareness of subjugation and oppression, of abuse and powerlessness, of living in a world of "No!", of exclusion, and of differentness/otherness. This is manifested in a commitment to values of social justice and human dignity, of the validity and worth of every person, and the contesting of discriminatory and oppressive structures.

This chapter will identify the participants' demographic features, but more significantly it will offer a consideration of their personal and professional constructions and values/beliefs regarding same-sex oriented or gay men, and the training and reading they have engaged relative to their practice with this consumer group. This chapter establishes the groundwork of integrated practice in considering the practitioner as a person and social worker.

#### DEMOGRAPHICS

At the outset of each interview, basic demographic data was sought from each of the ten practitioners. The purpose of this was to gain a snapshot of the participants relative to age, gender identity, cultural identity, career background, current practice setting, and

professional associations. Information about each participant's identified sexual orientation and personal and professional experiences relative to gay/same-sex oriented men was also sought<sup>1</sup>.

Unfortunately, the parameters of this study, as approved by the Massey University Human Ethics Committee, did not allow for similar data to be sought from outside the identified sample of voluntary participants. Consequently, the degree to which this sample is representative of social workers practicing in the mental health field in the Auckland area cannot be identified.

### Age

As shown in Table 4.1, the majority of the practitioners participating in the study (70%) were aged between 30 and 39 years of age, with the remaining 30% aged between 40 and 49 years. None of the practitioners were younger or older than these two age groups.

**Table 4.1 Age Group**

	<i>N</i>
20 – 29	0
30 – 39	7
40 – 49	3

From this data, it can be suggested that all the participants were of an adult age when Aotearoa New Zealand was legislatively addressing some significant changes regarding same-sex orientation and the social/legal response to it. I am referring here to the extensive debates in 1985-86 which resulted in the passing of the Homosexual Law Reform Act 1986 which decriminalised same-sex activity between consenting adult men. One part of the Bill for this legislation was unsuccessful at that time, but was later to be included in the Human Rights Act 1993 which provided a degree of protection from discrimination (with certain exemptions) in relation to employment, housing and access to goods and services on the basis of (among other factors) sexual orientation,

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1. While codes were used in preparing each participant's transcript, these have been replaced with pseudonyms in this thesis to ensure the participants' responses/dialogues retain a human element.

and disability, including psychiatric disability and having an organism in the body known to cause illness (for example HIV). These two pieces of legislation were significant. Not only were they the result of extensive debate – with the Homosexual Law Reform Act 1986 representing what must be one of the most heated and extensive political debates in the history of this country, but they also indicate significant change in how New Zealanders were understanding same-sex orientation, and how a society should respond to diversity. Furthermore, these debates occurred within the context of what was a relatively new and frightening epidemic that had impacted considerably on same-sex oriented men and their family/whanau/significant others in Western states. All of the participants would have been at the least entering their late teens when HIV and AIDS were first coming to the attention of the Western world.

### **Gender**

Of the ten participants, six were female and the remaining four were male (Table 4.2). As with other disciplines in health services, the majority of practitioners are women. The National Working Party on Mental Health Workforce Development (1996) reported that most psychiatrists (71%) were men, but that this situation was reversed for other disciplines in mental health. Unfortunately, this aspect of the Workforce's report only covered registered disciplines. Social workers were not considered.

**Table 4.2 Gender Identity**

	<i>N</i>
<b>Female</b>	<b>6</b>
<b>Male</b>	<b>4</b>

### **Culture**

The National Working Party on Mental Health Workforce Development (1996: 33)) reported the results of an unpublished survey, undertaken earlier in 1996 by Curson, which stated that 63% of the survey's sample of social workers practicing in mental health identified as European, 6% as Maori, and 20% as other, 11% had not reported a cultural identity. This survey was of members of the New Zealand Association of Social Workers (now the Aotearoa New Zealand Association of Social Workers), and reflects the Association's membership at that time.

Of the participants in this study, three (30%) identified to some extent as Maori, with one reporting a dual cultural identity (Table 4.3). While a further 40% identified culturally as Pakeha, the remaining three participants preferred to their cultural identify as respectively European, New Zealander, and Kiwi.

**Table 4.3 Cultural Identity**

	<i>n</i>
<b>Pakeha – born in NZ</b>	<b>2</b>
<b>Pakeha – born overseas</b>	<b>2</b>
<b>European</b>	<b>1</b>
<b>New Zealand</b>	<b>1</b>
<b>Kiwi</b>	<b>1</b>
<b>Maori</b>	<b>2</b>
<b>Maori and Pacific Island</b>	<b>1</b>

## PROFESSIONAL

### Career

As can be noted in Table 4.4, the psychiatric/mental health social work practitioners participating in this part of the study present with an extensive array of practice experience. Four of the participants reported a single site of practice experience, with the remainder acknowledging more diverse histories in social work and other fields.

**Table 4.4 Previous/Current Roles/Positions**

	<b>Previous Roles</b>	<b>Current Role</b>
	<i>n</i>	<i>n</i>
<b>Child Protection</b>	<b>1</b>	
<b>Residential Social Work</b>	<b>2</b>	
<b>Health Social Work</b>	<b>1</b>	
<b>Health Educator</b>	<b>1</b>	
<b>Community Mental Health (Adult)</b>	<b>3</b>	<b>6</b>
<b>Community Mental Health (Maori)</b>	<b>2</b>	<b>1</b>
<b>Mental Health Rehabilitation (Adult)</b>	<b>2</b>	
<b>Community Mental Health (Early Intervention)</b>		<b>1</b>
<b>Community Mental Health (Elderly)</b>		<b>1</b>
<b>Mental Health Inpatient (Adult)</b>	<b>2</b>	
<b>Mental Health Inpatient (Elderly)</b>	<b>1</b>	
<b>Alcohol and Drug (Maori)</b>	<b>1</b>	
<b>Alcohol and Drug Detox (Adult)</b>	<b>1</b>	
<b>Forensic</b>	<b>1</b>	
<b>Crisis</b>	<b>1</b>	<b>1</b>
<b>Counselling/Psychotherapy</b>	<b>1</b>	<b>1</b>
<b>Professional Leader</b>	<b>3</b>	<b>2</b>
<b>Social Work Education</b>	<b>2</b>	
<b>Trade</b>	<b>1</b>	
<b>Business</b>	<b>1</b>	

However, in considering the participant's current practice roles/settings, dual roles are a feature for four of the participants with crisis service, counselling and psychotherapy, and professional leadership roles as aspects of their community mental health social work positions. The majority of participants (80%) are current community mental health social work practitioners.

### **Professional Associations**

The most cited professional association among participants (Table 4.5) was the Aotearoa New Zealand Association of Social Workers (80%) including one participant whose membership was in process. One participant acknowledged membership of another social work professional association, while one other acknowledged no membership of any professional association for social workers.

**Table 4.5 Professional Association**

	<i>n</i>
<b>Aotearoa New Zealand Association of Social Workers</b>	<b>7</b>
<b>ANZASW in process</b>	<b>1</b>
<b>Other Social Work Professional Bodies</b>	<b>1</b>
<b>None</b>	<b>1</b>

## **SEXUAL ORIENTATION**

In discussing the practitioners' personal histories relative to same-sex sexual orientation, and interpersonal experiences of contact with gay/same-sex oriented men, I was looking to consider the impact such contacts have in the formation of constructions around same-sex orientations, and the practitioners' values and beliefs relative to same-sex orientation. This was not an endeavour to seek disclosure of homophobic attitudes, but rather a consideration of the interaction between experience of personal contact and subsequent belief systems reflected in current constructions, whether such constructions were essentialist, constructionist or a combination of these.

### **Identity**

Of the ten participants in this part of the study, a total of 60% identified themselves as other-sex oriented (Table 4.6). What was interesting in this was not necessarily the proportion of the sample, but the language they used to identify their sexual orientation.

Four of the participants (40%) stated they were “heterosexual”, a clinical term drawing its signification relative to its binarised other – *homosexual*.

**Table 4.6 Sexual Orientation**

	<i>n</i>
<b>Heterosexual</b>	<b>4</b>
<b>Straight</b>	<b>2</b>
<b>Lesbian</b>	<b>2</b>
<b>Gay</b>	<b>1</b>
<b>Not stated</b>	<b>1</b>

However, only one of the participants, who identified as *heterosexual*, maintained this clinical terminology throughout the interview when referring to same-sex oriented persons. This could suggest that in considering the issue of same-sex oriented consumers these participants were initially inclined to construct the issue clinically but, as the discussion moved on, the participants were drawn to more social terms in describing same-sex orientation. *April* noted:

*April: I guess I am always more comfortable with kind of clinical language personally, which is probably, um, from my sort of childhood, and my experiences in terms of... I think having identified as a heterosexual for a long time, that words like queer to me still feel derogatory because... I haven't owned them or used them for myself... Because of my history, so I suppose I use... gay – I guess gay is the word, which feels most comfortable with me.*

One participant did not identify any particular sexual orientation, noting that:

*Esther: I've actually never thought about it like that.*

However, others had thought about it, and thought about it a good deal, either with regard to themselves or to others dear to them:

*Claire: Well, I suppose what initially attracted me to doing this interview was that, you know, that I have a strong belief that my 15 year old son is gay – and he hasn't actually 'come out', if you like, but I think that he has a very, very strong feeling that that's the case. Um, and I came by this understanding quite recently. I think I've always had an intuition about this.*

*Gareth: I think I always knew I was different from other kids, you know, other boys in my peer group. I used to get singled out and beat up a lot, get called pansy and stuff like that. That sorta told me I was different, so I became pretty shy and was pretty reluctant to make friends. I did make some but they tended to be other boys like me - you know, quiet kids who used to get hassled and all. I guess we were sorta the nerds. I knew like at 7 or 8 that I had this attraction to older boys but I hadn't a clue what to call it, just knew it wasn't to be talked about. That's kinda strange because my parents had a number of gay and lesbian friends, so I guess those messages about keeping quiet came from the other kids.... Anyway, my Dad thought I needed to learn to get outa myself more so he encouraged me to join a club - I picked chess. I was pretty useless, but at least I met some new people - and that's where I met my first boyfriend. He was 16 and I was 14 but I knew from the moment I met him that I was really attracted to him. I don't think he even noticed me for a while but it's hard to ignore a kid who follows you around like a shadow. I did that for months and then he started talking to me and helping me with my chess - I was still hopeless, I still am. Haha! So we started hanging out together, staying over and all. My parents knew his parents and they were really great. Finally, one night, I told him how I felt about him - that I really fancied him - brave kid huh? He seemed real relieved, and told me it was mutual. We went together for like 2 years until he went on to uni. But we started to make contacts in the local gay community. There weren't really any youth groups or anything like there is now. We had to make our own way and it was real difficult because of our age, couldn't go to bars and stuff, and couldn't go to clubs or meetings. But we started to connect with other kids like us.*

It was interesting that *Gareth*, the only male interviewed to identify as same-sex oriented, was the one who would go into some depth over the development of his current sexual orientation. It is almost as though, there remains a need to explain, even when no specific explanation is sought.

## **Experience**

While experiences and ages relative to such experiences vary among the participants, there would appear to be a theme of positive personal and/or professional (colleague) contacts with same-sex oriented men.

*Fran: The most significant contact that I think I ever had, everytime I think about my contact with gay men is the chap that my mother decided I was going to marry... she introduced me to him when I was, you know, 15 or 16 and we were friends*

for, particularly when I was in my 20's, start of 20's, we went out a lot and Mum was getting more and more excited that [he] was the boy I was going to marry. And Mum finally told me one night how happy she was that [he] and I were spending so much time together, I said "[He]'s gay Mum" . "No he's not..., no he's definitely not gay, I have known [his] parents, I have known him all his life", and all these things... And he plays rugby - and coming from my background where rugby, racing and beer was a big influence... "No [he]'s definitely gay Mum". And [he] came round and Mum was a little bit weary, and [he] at this stage hadn't come out, so [he] was still dating woman and Mum was getting more and more confused by my messages... And then [he] did come out and he had an absolutely wonderful partner and [they] came round after a time and Mum got used to the idea that the boy I was going to marry was gay. So that's the most significant, you know, thing I think about, laughing about in terms of my mother having made all these decisions and how he couldn't possibly be because of all the good societal reasons as to why [he] couldn't be gay... Then I guess it was through [university]... [Having] gone to an all girls school which was called "lessies paradise", because that's just what kids say about, you know, "lessie's paradise" and "bummers" was Boy's High... I don't openly remember women coming out and whether it was comfortable for women to be gay there... I guess... just by going to university and being in a different environment made a lot more lesbian and gay friends and then particularly because of my friendship with [him], becoming a part of his circle of friends.

*Isobel:* Okay, just on the personal side, I mean I have quite a lot of experience with gay men. I mean, I have had friends over the years who are gay, I've got two children, two boys, their teachers have been gay. They had one teacher in particular most of the time while they were at primary school who was gay and I never had a problem with any of that. Um, I've also got a relative, a really close relative, who is gay.

*Janie's* experience has been painful but nonetheless positive:

*Janie:* I've got quite a long association with gay men - probably over the last 20 years anyway, I would say. And I've been in situations where I've lived with gay men, and also had long-term friendships with gay men... I guess just having some exposure to the culture, and I guess like some of the issues that really impact on gay men. Two of my flatmates in '92 and '93 passed away with HIV. Yeah, like I went through the process of working voluntarily at a hospice with them while they were going through pneumonia and things like that, and having to clean the

*sheets and change the sheets for them. So I have been through that in terms of like being exposed, with myself and a group of friends, their friends as well. So I felt like that certainly had a huge impact on me, and also just in my awareness about some of the lifestyle, and the exposure to drugs, and the exposure to the club and the sauna scene.*

## Values

One is left wondering how or to what extent such contacts and experiences impact or influence the individual's values and understandings. Where participants have identified a personal degree of familiarity with same-sex oriented men, is there a correlating value base? In reflecting on her experience with her son, *Claire* notes some challenges to her values:

*Claire: I am aware that you have got these, whatever biases you have got, you can't keep them outside of a relationship but, um, you can - with that awareness - you can kind of hold them in a place that intrudes less. You know?*

*Gareth* noted the significance of his experiences as a gay man, and other aspects of his history, on the formation and development of his values and that these are now reflected in his practice:

*Gareth: My values. Um. I don't think it could help but affect them. It's given me a really strong appreciation of.... [how] the New Zealand idea that we're all equal is a sad joke. There are so many things that have influenced my values - like coming from a working class home - that's taught me heaps about the impact and injustices of class although at the time it was just about knowing some people have and we didn't - I didn't know why. And being gay gave me first hand experiences of living in a society where I thought I had no place being. I mean, my parents were great but they weren't all there was to my experience of that society. In a lot of ways, being gay has taught me to appreciate the experiences of others who are oppressed. I remember during the Homosexual Law Reform debates of the mid-eighties, I was given a badge that said "None of us are free until all of us are free". That summed it up for me. It taught me to respect people, no matter what - that people matter, that abuse and oppression and injustice are wrong and totally abhorrent. That, and the way my parents raised me, has also influenced my value of life - that there is nothing more valuable than life, that we*

*all are at least to some extent responsible for one another, and that those in need should be cared for and helped until that help is no longer needed.*

Similarly, *Fran* and *Hamish* identified aspects of their own histories and cultures influencing their current personal and professional values:

*Fran:* *I guess because of my upbringing being so very clear about everyone being equal and everyone having the right to be individual and different. And growing up in a neighbourhood where I was different from my background, also different or what society called strange. I mean growing up in [home street] where, you know, people wrote books about how it was a bad area. And labelling it, you know... Um, making generalisations and statements about the neighbourhood, I never got into making generalisations about people, so I never had to go through a process whereby I was questioning it, you know... So I don't have any marked time in my life where I have had to question it on that level.*

*Hamish:* *Okay, both my two sisters were in psychiatric nursing, they were their first jobs, so there has always been that relationship with the gay people and health in the community. For me personally it has never really worried me. I have never said, "There's "A", the gay person." I have always just said, "There's "A". That is where it's ended. I've never been for or against them. However, I'll acknowledge in supervision you have ethical dilemmas and cultural dilemmas, and personally as an ethical dilemma it is not an issue. But as a cultural dilemma, when I was younger and playing rugby all the time, gay people were always the butt of jokes in the rugby club. In hindsight one may have suspected that half the guys in our team may have been gay. That's something that never crossed my mind at the time. Later, when I was at school doing social work... the issue came up about homophobia, because we had actually had some posters put on our whanau room... and I actually thought they were absolutely fantastic photos. It was a bunch of guys and I think it looked like they were on a gangplank and it was about safe sex. Some of the people at school objected to them being there and I couldn't work out why because I thought they were really neat photos. They were really neat guys and they were really proactive in the message they were sending out... You have to look at this really hard, because I'm talking about cultures now and if I say well there is a gay culture, I mean we have a culture within the workplace, which mightn't particularly be Maori, although we are a Maori unit. So you can have a culture within a bunch of people who have the same beliefs, it doesn't necessarily make it a culture as such. It's going to be a contemporary use of the word culture. We start to move from the paradigm of being Maori to being*

*gay. There are lots of Maoris who are gay. If I wanted to work with a gay culture Maori, I would have to be quite up to speed with my Maori culture first. So that's a speciality in itself and then if I wanted to specialise again above that in the Maori gay culture, then I would have to learn how to do that or learn the knowledge that would give me the background philosophy of how to work with them safely...*

*Isobel* picked up on an issue of over the view among some same-sex oriented men that there are links or commonalities between *gay culture* and Maori culture:

*Isobel: I find that it's hard to sympathise or whatever you are actually trying to get when they say "Well, we are exactly the same"... You know, "You've had this taken off you or that or whatever, and I know exactly where you are coming from".*

*Isobel* and others reflected a significant anti-discriminatory ethic in considering their values relative to same-se oriented men – almost an egalitarian value construct:

*Claire: I value human beings no matter what, so therefore anything that is added into that is, you know, of little consequence. That's not to say that I operate perfectly as a human being without doing and saying things sometimes that, um, are not quite what I would like to be doing, but I definitely aspire to that belief and value. That, you know, it's a human being no matter what.*

*Daniel: I know I am completely against any form of discrimination towards gay men and other oppressed people in society, so that would be the first... my main value.*

*Isobel: I think, you know, for me, I don't treat people any differently, you know whether they are. I mean, sure you take into consideration they are male or female or whatever, whether they have got families or are on their own, all those sorts of things of course make a difference. But on the face of it, people should be treated as I would like to be treated, I guess. You know, you treat them with care; you treat them to the best of your ability. Um, but certainly not without their involvement. You know, this whole thing of, "I know best". I mean, you know, and I know that goes on... So, you know - just making sure that people feel comfortable and that they have an opportunity to tell their story. And, yeh, listening to what they have to say. Because sometimes, you know, people they just need someone to hear what they are saying. And I don't think that is different for anyone... Regardless of race, creed, colour or whatever. So - to me, separating*

*people out is never, I mean there is just, I don't do it, because like that's just the way I think... and I am sure there are lots of other people who think the same, but yeh, I mean I guess it would be different for people coming from another country who don't speak the language, all of those things are so totally alien - life in a different country. Yeh, then maybe you might have to have a different approach. Certainly you would have to have someone that could support their language and you know or whatever. But for the garden variety Kiwi... I think treat people as best you can. To start with and then, yeh, listen to what they have got to say. And then continue from there.*

## **Language**

The points raised around language were important in the discourse around queer theorising and the use of different terms applied in relation to gay/same-sex oriented men. As has been noted, the use of *queer* has raised and continues to raise concern for many, primarily relative to the way this word has been applied as a term of abuse and negation (Gearing, 1997).

The contemporary slang language applied relative to same-sex oriented men was viewed as unacceptable and derogatory by the participants – although some, for example *Blair* and *Hamish*, noted the place of humour:

*Blair: ...years ago, the peer pressure would have been all the derogatory terms... But right now... to me the only word I feel comfortable with is 'normal', and that's the word. I am sick and tired of anything else, they are normal, okay? ...I don't mind it in humour, if it's used in humour, if it's genuine humour... But to me they are outdated now... I actually think that I don't like the terms – they are actually – they are too vicious.*

*Hamish: All the language is not necessarily negative. The connotations may be that, it is how you use them. A couple of our guys here are gay. We have a great time in how we use the language and I mean they are the worse culprits out of everyone, but it's in fun. You know, they are not used to denigrate anyone. When we use the language it's in a really nice way. One of our social workers I used to work with here was gay and she and I were really great friends. It was fine. Because we actually shared a lot of about who we were and in doing that, it meant that when the time arose that we could address each other's tapu, that always kept it safe... Um, my sister who is currently a midwife over in Australia, but when she was*

*training for her midwifery exams, her two flatmates were gay and one of them came out and said, "Oh, did you get your name in for the interviews for the midwifery course?", and she said, "Oh, I went and they said no". She said you go back and tell them that you are a friend of Doris. Okay. So she went back and said, "Look, I'm a friend of Doris and I want to get on it", and the guy put her straight in. But you know, so that was a term I had never heard. And um, I mean just there the other night I went to a party with some of my friends from here, just to a dinner party and they were using terms like, "oh hi girlfriend". But those were, I mean like for me they were really neat terms and I means that they were relaxed around me that they could talk like that. And like of course, there was the old alcohol going down, because I don't drink very much at all, but as the alcohol went down their throats they became looser and looser and looser. And we ended up having a real great night. And um, you know, and made sure that we addressed each other's mana in whatever we did... It comes back to that same model of practice that I utilise... But when you are doing things, you need to look at the big picture and if you are going to make fun of someone or some culture, do you understand what you are getting into, because the feedback mightn't be what you expect.*

*Isobel* noted some disquiet over experiences with men who constructed their persona around their sexual orientation, and endeavoured to connect with others through their sense of oppression:

*Isobel: I guess one of the things I have always, with some of the men that I have known over different times, the ones that are more vocal about it, I tend to get a bit, "Yeh okay, that's fine, that's what you are, that's okay, but do I have to hear about it everytime I see you?" sort of thing. That I find disquieting in that like, you know, that but don't have to keep hearing it sort of thing. So it is not so much the language but the, you know, "don't forget this is what I am" sort of thing. And I have had people even make comparisons, well you know what it's like to be a minority, "You're a Maori, and you know I am exactly the same as you." Those sort of comparisons I find a bit uncomfortable.*

Nevertheless, the participants expressed awareness that terms such as *queer* and *fag* carry a reconstructed positioning when self-referentially applied by same-sex oriented men. Some discomfort clearly remains:

- April: I feel disquiet because I think again that having identified as heterosexual that the connotations from the heterosexual point of view are really derogatory – and I guess it is about sort of owning it for yourself and being able to use it in a different context. Um, and I don't think I am quite there but there are lots and lots of years where those words were used in hateful ways.*
- Claire: Well, I'm sort of guided by what the person's okay with because I know that there is a lot of political correctness about and I think that, in a way, people are behaving more ingenuinely in a way, which I am not a great fan of. Um, because they are frightened to say something because it might not be quite the right terminology... I know language is important, because certainly in mental health it is important. I am not saying it is not important but I think you can get very hung up on language per se, but - but I am pretty well guided by what the person is most comfortable with... I think in a way I have always thought that the language in the gay community or the references... is quite provocative and I found that, you know, glaring at times - and I think of things like... the Hero Parade, which I went to one year, and I decided that it wouldn't be something I would go back and watch - and that definitely has, in the past, long before this arose, that sort of has bothered me. I mean, in a way, that I have questioned why if you feel that you are so stigmatised as a group, why do you draw so much attention to yourself in that particular way, given that there are variables of course and not everybody would want to draw attention or in a particular way?*
- Gareth: I guess words like 'gay' or even 'queer' are ok... well 'gay' is pretty safe - it's like a nice word although there are still some people who don't like that we use it, but it is probably the most popular term used to describe men who are attracted to other men. 'Queer', though, is a bit more radical. A lot of younger people seem to be using it like an abbreviation for gay-lesbian-bisexual-transsexual-transvestite, and there is a lot of strong reaction to the word - even within the gay and lesbian community because it used to be so derogatory. People remember that. There was a lot of opposition to the word in the letters to the editor in the gay press a while back. But I think too it's like taking that language or that word and owning it so that it doesn't have that negative power anymore. For many, it probably still is very negative, but for a growing number it's comfortably more 'in your face' and challenging. I think it has been a pretty successful move to own the word too because I think the only people who call me 'queer' now are other gay men. I think some straights are getting used to it too, seeing it as a word that is ok and that helps to take away that offensive aspect. It's probably more used by radical gay and lesbian people though. I guess it*

*really depends on who is using the word, and the context they're using it in and what they mean by it... A lot of the more negative terms seem to be focused around anal sex - as if we all do that, or about AIDS. That reminds me that while we have all this legal protection from discrimination and all, there are still many who would take a tragedy within our community and use it to attack us. That's sick and cruel. Words like 'faggot' are still around and that's a harsh word but there are some who are taking that word for themselves - like 'queer' - and recognising the history of that word - from the witch trials and all. I don't like the word 'homosexual' either. It's an old psych term and it reminds me of gay men being hospitalised and treated purely for their sexual orientation - and hideous and brutal attempts to 'cure' it.*

*Esther: The language that I suppose that they, that gay males prefer to use... I think there is a lot of ignorant inappropriate language as well, and I see that that is part of my personal and professional capacity to actually challenge those - you know, values, beliefs, thoughts, whatever. So that's what I can do, but the language I use is probably contemporary... [In working with a client.] I would probably ask the person to actually give me some more information about, you know, the language that they are using. And if that is, you know, if that is actually their own language or if that is something that's been sort of put onto them as a belief... so I would ask them to maybe give me some more details about their thoughts around the language and so forth.*

*Janie I hate 'faggot', I find that quite derogatory but then again like when I'm exposed to gay men, they sort of like talk about themselves in terms of I think more reclaiming a lot of language, like, "Oh, we're just a bunch of poofs" or whatever. And I sort of feel like there's a strength in that. Being queer or like being gay. I guess like throughout the 80s and that there was sort of like a huge feminist push around language and derogatory terms, trying to look at like reclaiming a lot of sort of like names that were quite hostile and quite anti-lesbian and gay men. So there was a real push in that. And so I'm finding that I'm more accepting of that language, but I guess, in a sense, it would be more or less around the way it was used. Whether it's used in a way to indulge heterosexuals or something, like derogatory sort of like put-downs - of course, I wouldn't be happy with that. And also too I think working in health, and working particularly in mental health, people are a bit more sort of sensitive. Like I don't hear a lot of put-downs as far as sort of like lesbians and gay men or transgender people. There seems to be maybe more, a little bit more exposed to difference.*

*Daniel* expressed an awareness of the emergence of *queer* in gay activism:

*Daniel: I'm probably more comfortable with 'gay'... I am interested in the title of your work. It is interesting, this "Queer Practice", and I know a couple of years ago... it was a term being used by gay groups – oh no, it was from the States wasn't it? It started in the States... Yes... it kind of turned the tables in politicising and turning the connotation of what 'queer' meant in earlier days and, you know, 10-20 years ago. But, for me, I am more comfortable with the word 'gay'.*

It was clear that most participants were far more comfortable with *gay* as a safer and less offensive term. *Gay* was emerging as a broader cultural-political-sexual identity into popular use in the 1960s with a move away from the medico-legal reference to homosexuality. However, this too had its objectors. Spargo (1999: 27-28) notes:

People were increasingly defining themselves as 'lesbian' or 'gay'. 'Gay', a term used for a woman of dubious repute in the 19<sup>th</sup> century, was appropriated as an alternative to 'homosexual' in the 1960s, much to the consternation of some people who bemoaned the corruption of an 'innocent' word. The most obvious difference between 'gay' and 'lesbian' and earlier categories was that instead of being assigned a passive position as an object of knowledge, lesbian or gay-identified subjects were ostensibly choosing or claiming a position. Being gay or lesbian was a matter of pride, not of pathology; of resistance, not of self-effacement.

## TRAINING AND EDUCATION

This aspect of the practitioner, as person, also incorporates the practitioner's development as a social worker relative to training and ongoing professional development, hence, the section in the Interview Guideline regarding the social *worker as a social worker*. At this point, I was wondering to what extent training and education programs addressed issues around sexuality and same-sex orientations, and the reading and ongoing training or related sources of information the practitioners had accessed.

### Education Programs

It would seem that most of the participants encountered some same-sex related material in their respective training programmes. Much of this appears to have been self-directed work, or specific workshops on HIV/AIDS or homophobia. *Hamish* notes:

*Hamish: We actually had a workshop on homophobia which was compulsory to attend, nearer the day most of us in the Maori group were all for it. It was great to see it there and great for us to talk about it and one of our class was openly gay and acknowledged that. For us it was about acknowledging the tapu of that person, and also the mana of that person.*

However, others noted the influence of same-sex oriented classmates or academic staff in these programs.

*Gareth: I really think that if there hadn't been gay and lesbian people in the class it probably wouldn't have been looked at at all. If it hadn't been for a few noisy classmates, people could have gone through the entire course and not even looked at it. I mean we did the homophobia workshop but social work students, and even graduates, can be so damn p.c. that they daren't say anything or question anything that might make them look a little homophobic.*

*Isobel: ...we did have someone in our class who was gay who was very vocal about it and he was a minority because there were very few Pakeha people in the class anyway because of the nature of the course. So from that point of view, I had something on a daily basis but as far as the actual learning, I am sure there were times when we had training about different cultures, different identities but it would have been fairly compact and short because I don't have any real recollection of having a model of practice, that this is the way we work with these people.*

*Blair* drew on his experience of an out teacher as a further confirmation of his earlier beliefs about same-sex oriented men and as a personal encouragement:

*Blair: ...the actual tutor was gay... Now here was another gay person who really had his lights switched on. In other words, intellectually he was really bright, and he was actually one of the better tutors – he was, in respect of getting the academic stuff out of you... He just – he was another positive in respect of reinforcing that gay people are pretty switched on, they are not all the bad stuff you hear – you may get the exception, but that's like in respect to heterosexuals... And he, you know, yeh, we got a little out of him about his life – and he struggled – and there was another struggle like sort of myself – you think... "Yeh, he's not given up".*

*April* did not train in Aotearoa New Zealand, but in an urban setting with a developed same-sex community:

*April:* ...my school was in the heart of the gay community, so I was in a pretty good space in terms of being able to do lots of learning... So yeh, I did a course for a paper on gender identity – and I also did a course on, I can't even remember what it was now, the philosophy of sex I think – that touched a lot of different sorts of issues in regards to sexuality...

*MK:* I'm just wondering... the location of your school – do you think that made a greater effect on the amount of gay/lesbian/sexuality-oriented material that came through the course?

*April:* Oh definitely, yeh – and I think – well, social work to start with, I think, hopefully has sort of broader perspectives in terms of human development and things like that. But there was probably, within my program, probably a quarter of the students identified as being a lesbian... Ah, only I didn't then – so it was really wasted.

### **Post-Graduate/Post-Training Study**

In considering in-service and post-graduate training, relative to same-sex oriented men and related issues, even the broader topic of sexuality, the majority of the participants reported none. An exception to this was *Janie* who had looked into issues around transgender:

*Janie:* I've gone to workshops through the transgender community... Basically, transgender workshops and also there was a weekend hui out in South Auckland run by the takataapui... It's with the Takataapui Kapahaka group, like they do kapahaka for transgender/gay/lesbian... Yeh. So they had a weekend workshop - it was sort of like an afternoon where you did either a substance abuse workshop or you did HIV or you sort of like did a health and wellness workshop... And they had people... from the AIDS Foundation there... Then afterwards they had a talent quest.

However, the point about specific training, whether as part of course programs or post-training, raises questions around the appropriateness of considering same-sex oriented men separate from others:

*Hamish: I don't think the way that we practice that we actually require specific training. By doing that you are saying, these are special people, they are different people. People are all the same, okay - and that's, if you take that view, and you actually adhere to it with all the concepts you use, it means that tapu is always addressed appropriately.*

*Claire: ...it seems like there is always something extra and something extra to add into the training. You know, what about this group of people, what about that group of people? It might be a good idea to cross-relate some of this. Because I think when you get into this, you could get into this thinking that this is a 'this group' and that is a 'that group'. You know, and start sort of separation of groups of people, with labels, you know... I am really quite anti-labels. Because the thing I have learnt about, you know, particularly gay homosexuality is that this is only a part of this person - it is like the mental illness is only a part of the whole person. So how a person behaves sexually with whomever is only a part of their whole being and who they are. It's how they have sex, sort of basically, um, which is only a tiny part of the whole thing. So if it's only a part of who they are and how they behave in their lives, why does it have to be such a big deal?*

## Literature

Some of the participants noted that much of the literature they had read, relative to same-sex oriented men, had been through course handout material in their respective training programs, and that any material they had read since then had been through professional journals at work:

*Blair: Well, it was more the literature I was given – you know, and we were just handed heaps. I read it all... you know, there was a mix of feminist stuff in respect to you could tell whether it was gay feminist reading. But it still, you know, I think that is where I got all the reading from... I mean, with all life experiences and that, I hadn't been reading anything up until then – even with 'coming out' and things like this. Yeh, that term, you know, I learnt that from my readings about AIDS and things like that. In respect to AIDS, you know, everyone thought it was the gay community, now even the heterosexual community has got to worry – and that was from the reading I got. Up until then I had nothing... I didn't even bother wanting to know about it.*

*Fran: I guess reading is not my forte. No, I guess if it's in an article that I am reading or, you know, like I've picked up a journal and there are gay articles in it, I*

*would read anything... But its like the unusual titles will catch my attention to want to go and find out more about. So, if someone gives me the book I will do it... I am just not so good about spending time in the library looking for it sometimes... A lot of it's practice for what I need to know at that point.*

However, others reported that they had engaged no literature in relation to this consumer group beyond such course-related handout material:

*Daniel: I don't even think I have read a book on the subject. But the only literature I can recall was probably just some handouts that we had during the course and... I couldn't actually say what they were to you.*

*Isobel: Um, probably because I am already open to accepting, I think I am quite accepting of people anyway, I haven't felt any need to sort of go and find out about this different type of person or culture. To me, it's not, I've been so sort of integrated with that whole culture of people if that's what you call it, that I haven't found any need for learning anything new about it.*

The only participants who had continued this were those who had identified as same-sex oriented, or with a personal connection:

*April: I, for some reason, really did a lot of reading in terms of gay men's literature, and sort of a lot of coming of age and coming out stuff, and enlightenment and things like that... I think things are more informed now really, in terms of sort of really keeping in touch in terms with the express and things like that.*

*Claire: Well the only reading I have done is since the situation with my son - and somebody gave me... some research material and information material on 'coming out' from the perspective of if you were a school counsellor or a counsellor. But more from a work situation.*

*Gareth: Well the only reading I did was stuff I picked up on myself - in the mid-80s there was a lotta gay-related social work stuff came out from the States - I think they were definitely for a larger American market .They didn't seem to be all that relevant to the New Zealand setting. But the issues they were covering were here too - like alcohol and drug problems, relationship problems, coming out. But I see a lot of the psych journals that come out and there's been a lot about gay men and AIDS lately. I don't see anything in the NZASW journal though. And I*

*checked out Dominic Davies' book – um, "Pink Therapy" - quite liked that. At least that gave some practice understanding rather than the usual 'let's be understanding' or the sickness focused stuff. I mean, homosexuality isn't a mental illness anymore but with some readings and some people in the field you wouldn't know it. They carry on like it's still something to be treated instead of it being like a key aspect of the person that needs to be worked within like his or her culture - not worked on.*

*Janie: Right now. I have got a lot of articles, mainly on lesbian wellness and working with families, and gay men... I sort of like working with lesbians, working with families.*

### CONSTRUCTIONS

Consideration of their respective constructions of same-sex orientations among men clearly challenged the participants. There were a number with a view that a given sexual orientation was an outcome of social and biological factors, a type of nature-nurture interface:

*Daniel: ...for me... there's the genetic argument and the social learning argument. I tend to probably go along with... a mix... You know, I suppose... I compare it maybe to issues of mental ill health. And... yet again, you get these theories, you know, genetics and social learning – whatever – stresses on life... Family, you know – there was a time when families were blamed for... producing a person with a mental ill health, schizophrenia – still happens. And I guess there has been theories around gay people as well...*

*Esther raised the matter of choice:*

*Esther: I guess that my thoughts or beliefs that I had was that... that it was their choice. That, for whatever reason, they decided their preferences. Um, behind that thought was probably a nagging sort of thought that came from my being brought up by my parents, that it is not actually okay for people to be different and to choose the same-sex relationships – but I guess I challenged these beliefs that I had and listened to the people's experiences, and talked to them... and just getting to know them, you know, and their sexual preference is one part of the person as well. And. Although a very important part, there is also a lot that... that's quite similar to myself and where I come from as well.*

Others continue to question:

*Gareth: Well, there are lots of theories but that's really all they are - theories. Like the gay gene or the small hypothalamus, or the one about having a weak father and a strong mother, or that it's a choice or because we've been abused. But I guess I think there probably is a genetic aspect but genetics don't tell us everything about ourselves, they just suggest a possibility. I think it's risky to rely solely on any one idea - that overlooks the uniqueness of the individual and their experiences. Genetics won't tell us why some people are outrageously gay and open at weekends and look really straight during the working week. They can't tell us that someone is definitely gay or anything. It reminds me of theories where people were assessed or labelled because of the size of their forehead or head or their nose. Those ideas are nonsense and are based on narrow and often racist assumptions. But I think what worries me is what is done with the results of research like the genetic and hypothalamus ones. There has got to be a real risk of that kind of research being used to discriminate or to continue to see us as sick. Why single something out, looking for it's cause and all, if you don't see it as an issue and envisage someone picking up the lead and seeking a cure? Is there going to be research on heterosexuals? I doubt it because in a homophobic society, being heterosexual isn't considered a problem.*

*Blair: What it is, either it's hereditary or whatever - I don't know. What readings I know, there is not real reason, or there is nothing defined in research why you become gay. All I accept is that it happens... You know, there is meant to be a smaller gland... Whether it's a smaller gland in the back of your head and all this sort, you know, on the base of your brain or something - ah, but that's not verified, you know, in respect to research. So what I am trying to get at is that even if you are born in the same family, if you're a homosexual, that's your norm. and a heterosexual, that's your norm.*

*Claire: I think that I had a belief that if there was a certain environment - say where a young male had been, had a particularly enmeshed relationship with his mother, that that could possibly create that orientation as an adult. Um, that because there was a lack of being able to identify with a male, that that would somehow contribute towards the situation. Probably more so than what I believed there to be any sort of physiological aspect to it... Um, and I can certainly say that that experience would have related to my son, um, but I don't know. I mean I have just been questioning all of that stuff. Whether that in fact is the reason and whether otherwise it is something quite innate and doesn't really depend too much on*

*environment. I mean, I am sure that there are males that, I mean, along the continuum, just like there is in females as well, that there is a sort of, you know, with all of this brain sex stuff that we hear about or are hearing about - that people are somewhere along that continuum. So they may have more sort of female qualities or male qualities, depending on, you know, not depending on - but if they are male or female, so you know, so that you can get quite sensitive men that are not necessarily gay men. And vice versa... So I have just opened up my thinking a lot about the whole thing.*

That point about a continuum, perhaps in reference to Kinsey's work, was also taken up by April:

*April: I see... sexuality as a continuum... And I guess, yeh, that I don't really see that there are normal and abnormal kinds of behaviour, but rather that people do what they do... and that with some people it seems to be able to be flexible and for some people not so flexible ...it is sort of the idea about not really feeling like there are really clear-cut boxes, um, but for some people I think that there are. So... I guess that, yeh, for some people it does feel really biologically predetermined and for some people that they identify at certain rates from really young ages - and that, for other people, those things are maybe determined by lots of different factors as they grow older - and the society that they live in that either lets them do what feels best or not, or the systems that allow people to experiment in some I guess roles.*

However, for others, the question was really not relevant:

*Daniel: But... to be perfectly honest with you... I don't really look at cause that much, I don't really take that on board too much. I kind of just work with what I see and what is happening... I'm not saying it's not important to gay men. But, for me, it is not quite - it is not the main issue for me.*

*Fran: I don't know, I guess, it's sounds really harsh, but I guess I don't care. I mean it is the same thing as why am I heterosexual. It's not something, I just feel really comfortable with however people define it and, um... So I guess I don't question why people are like they are.*

## SUMMARY

The degree, to which the gender mix of this sample is representative of psychiatric/mental health social work practitioners in the Auckland area, or in Aotearoa New Zealand, cannot be addressed since the access to this data lay outside the material approved by the Massey University Human Ethics Committee. However, the experiences, values and beliefs, and constructions relative to same-sex oriented men, reported by the participants in this study, effectively reflect the diversity of discourses in the field. Where some consider a consumer's sexual orientation as a matter of relevance to the consumer's socio-cultural context, others propose any focus on a consumer's sexual orientation to a problematic exercise in the potential this holds for categorising the consumer with yet another label and risking such consumers to be treated differently.

The interface between value systems and inter/intrapersonal experiences cannot be considered as a simple correlative relationship. Our experiences can both entrench and contest existing values and beliefs resulting in varying degrees of development of a stronger or modified belief system. However, a feature evident in the discourses of the participants in this study is that, for many of the practitioners, value systems around same-sex orientation reflect a more generalised commitment to anti-discriminatory stances, and of a sense of sameness in viewing the commonalities between all people relative to social justice and equitable response to need at the clinical coalface. Such value stances are reflected in the participants' degree of comfort and disquiet with the language consumers may adopt in their self-identity. While most viewed what *Gareth* referred to as "*in your face*" language as problematic, it was interesting to note a degree of acceptance of such language when validated within a consumer's self-construct. Indeed this degree of comfort/acceptance of challenging language appeared to be greater with those participants with a more significant inter/intrapersonal range of experience with same-sex oriented men.

In considering the practitioners' preparation/training for practice and ongoing professional development, a glaring void is evident. The reliance of social work training programs, in preparing students to work with same-sex oriented men, on self-directed study and the occasional homophobia workshop must raise questions of

heteronormativity with such programs in not offering an integrated consideration of same-sex orientations and social arrangements throughout courses within programs. While it must be accepted that training programs can only realistically offer a limited foundation for students to develop some awareness of the diversity of consumer issues, broader programs addressing diverse sexualities are also conspicuously absent

At the beginning of this chapter, I noted that the awareness of self, of one's culture, experiences, body, gender, age, values and beliefs and how these are reflected in the knowledges and skills we apply in practice, is the ground level of integrated social work practice. The diversity of the 'selves' who participated in this study was no less evident, in relation to practice with same-sex oriented men, than in the integration of experiences, understandings and values reflected in the participants' discourses and identified constructions around same-sex orientation.

In spite of reported gaps in training programs, and what appears to be a more necessarily pragmatic approach to the literature and training participants have undertaken relative to same-sex orientation, the participants reflected the diversity of discourses around the construction of sexualities and same-sex orientation previously discussed in Chapter 3. What was most interesting was that, while there was a majority of participants with varying views that sexual orientation may well carry endogenous and exogenous influences (reflecting the ongoing essentialist-constructionist discourse), a number had adopted a stance of viewing the discourse as irrelevant to some extent. Their stance was that how people came to be same-sex or opposite-sex oriented was not the issue; that what mattered was how a society and social workers, as change agents within that society, responded to such diversity.

## 5. EXTRA BAGGAGE - ISSUES FOR CONSUMERS

Psychiatric ill health does not present within a vacuum, void of interrelating factors, systems, experiences, and realities that are unique to the consumer. Participants were asked to consider the kinds of issues a same-sex oriented consumer may present or has presented. Such issues, which may or may not be of specific significance for all same-sex oriented consumers, were considered as carrying implications for work with this consumer group. They necessitate the practitioner's awareness of these and other issues as being interrelated or influential features, of the consumer's social and intra/interpersonal context, in practice around a given psychiatric presentation or crisis situation with same-sex oriented male consumers.

### HOMOPHOBIA AND HETEROSEXISM

It was interesting to note that, while others had alluded to it, the only participant to specifically identify homophobia as a key issue was the one same-sex oriented practitioner.

*Gareth: The men I've worked with umm - homophobia has to be the big one - and not just in their social setting but within themselves.*

Weinberg (1973) was the first to identify homophobia as the irrational fear of homosexuals and homosexuality, and the catalyst for subsequent discrimination and violence. Heterosexism is considered to be the negation of the significance of one's non-heterosexuality. This is often reflected in the encouragement to behave more like heterosexuals, to *act straight*, or settle down into monogamous couples without the provision or protection of the validity of same-sex relationships. The assumption that monogamy is commonly constructed by all, and stands as a generalisable ideal in human sexual relationships, negates the experience of many same-sex oriented men in endeavouring to develop and sustain (if indeed they desire) such relationships in an environment that fails to consider or recognise same-sex relationships as equally worthy of the benefits and supports accorded heterosexual relationships. It also assumes heterosexual relationship models to be somehow superior or more ideal (Kantrowitz,

1987). It can certainly be argued that the recent debates over the development of legislation to protect same-sex relationships in this country suggest a change in this. Yet the issue necessitated debate and brought to the surface notions of heterosexual marriage and de facto coupling as significantly more readily accepted. *Janie* notes that this focus on monogamy could raise dilemmas for some practitioners:

*Janie: I guess one of the... things... is sort of like... people's lack of understanding about multiple partners... I just call it multiple partners. I mean that is certainly something even in quite a long-term ongoing relationship can be something that a lot of people don't understand. Particularly, if you sort of like were to make a comparison with heterosexual sort of like relationships which are supposedly monogamous or they do sort of like have non-monogamy or whatever within the relationship. But I mean there's still that lack of understanding around multiple partners.*

Heterosexism and homophobia are perceived to be interrelated in efforts to control, deter or punish visibility, to promote stereotypes, to negate specific needs and differences, to maintain heterosexual superiority and negate non-heterosexual models of family, and to ultimately change same-sex oriented behaviour and prevent the development of such behaviours. While these may seem extreme, they may be manifested in various guises, including treatment (Irish, 1991; Messing et al, 1985; Smith 1988, Weston, 1997). In relation to the notion of *family*, *Fran* and *Gareth* note:

*Fran: Mental health services are very good at hiding behind the Privacy Act and saying, "No, no, we can't tell the family anything", and to the extent, you know, it is written up in the notes and reports. So we say that it's who the client defines as family and we talk to those significant others or caregivers or whatever term they want to call them. For gay clients, gay and lesbian clients coming in, for some reason some staff aren't as open towards to that definition of family. So I think that that's the first step. So for seeing how the client is perceived within the ward environment or the community environment, and then how they define their significant people... And, sadly, I think that we have... not done such a hot job of recognising same-sex partners as family. They seem to go very much on the marital line...*

*Gareth: Most staff are pretty gay-friendly though, but there's still a thing about family being blood-relatives, or describing someone's partner as his 'friend'.*

For many same-sex oriented consumers, sexual orientation is significant. Gochros (1985: 141) observed, "If not treated as sick or second best, homosexual orientations can be oppressed by being ignored." However, it has been reported that the assumption is often made by practitioners that consumers are heterosexual (until contrary evidence is presented), or that presenting issues be viewed in relation to a consumer's same-sex orientation (Ball 1994; Messing et al, 1985; Rabin et al, 1986).

*Esther: I think there is such a stigma around mental illness... But I think with people's sexual preferences and if people are gay on top of that, then there is an added... stigmatisation.*

*Gareth: There are still some who treat the client's sexuality as the problem or they try to encourage the client to be more like straights - like settle down with someone, haha as if straights have got that sorted, or by ignoring the client's sexuality they encourage the client to stay in the closet*

*Fran: I think there is still that really big perception about, um, if clients are questioning their sexuality, it's part of their mental health... You know, it can't be that.*

*Claire: I mean I guess there is almost the suggestion because you can't separate the gay issue and the mental health issue - that there is always that question mark over is this so or is this a delusion or is this, you know, I mean, I would, I am not saying that is the case - but I think that yeh. That's more the context that, that ever really sort of come up in. Rather than we have sat down ever, with anybody, and ever talking about well okay this person is, um, identifies themselves as gay, so how do we do differently or, you know, approach or, you know, blah blah blah... No, it's not really something that there is a lot of awareness about I don't think. ...we assume that [the client is heterosexual] first at least. I mean it is not something, it's one of those questions, you know, it's like the question of have you been sexually abused, I mean in initial assessments, I mean I hate that idea of having an assessment that has or poses questions to everybody. And when you haven't even, you know, built up a relationship with someone - but, on the other hand, I know that there are things that there are important to know, but I think you've still got to be very careful about how you go about that... But, yes, I think so - I think that yeh, that would be the first and foremost assumption unless something very, very obvious arose where that would be questioned.*

Homophobia and heterosexism are often cited in the literature of work with same-sex oriented consumers, although as I have noted this was not specifically commented on by most participants in this study. However, the degree of safety or appropriateness of mental health services was raised as an issue:

*April: I think that mental health more than any other field that anyone could ever be in is probably more accepting of whoever you want to be. Um, and all the co-workers and just, yeh, lots of really neat people work in mental health. Um, I think the place that I work is actually pretty safe – and if it's not, if people really have no ability to empathise or to have awareness, they are pretty quick to ask or refer to someone else who may be in a better position to do the work.*

*Janie: Ok. I don't perceive that there's sort of like, in the context of work here, there's that much safety around it. I know that there's safety in terms of gay men feeling able to actually state their sexual preferences, but I don't think so in terms of offering them support. I mean, often what we do, I guess because I work in the crisis team, is to refer out to places like the Burnett Centre or Rainbow Youth or like any of the gay and lesbian welfare agencies. Often the question is never asked. There is no process in place to ask that.*

In considering such safety factors and the potential for heterosexist assumptions in the assessment process, the issue of same-sex oriented staff was raised:

*Esther: I don't think that it is particularly appropriate that we have no one, and I don't know what that is actually based – I don't know whether the employing is taking that into account or whether we look at our demographics and see the population... and take... the demographics into account.*

*Janie: Often when I work with gay men, I'll suggest that they actually end up seeing a male counsellor because like normally I'm just the interim person. I guess like at the end of the day, sort of like what they feel comfortable with. Initially, it may be having a level of comfort with me, but then, I sort of like to use Maori as an example, that it's the same thing if you have a European working with a Maori client, when you can go to a point but then they need to sort of like deal with that as an issue... And certainly we'll always talk to them about referring on. Sometimes it's like working through their own sort of like shaming issues, and getting to a point where they're actually feeling ok. It's like moving them along.*

*Fran: Now I don't openly ask my staff their sexuality, but I couldn't openly think of a gay social worker that I had in the mental health team, I could think of them in some other teams... But, I mean, I don't think we have openly, staff who are comfortably open in saying they are gay or lesbian. And I am very aware of that because the Prof Advisor for Psychology that I work closely with despite the fact that she's only in mental health, um, is a gay ah lesbian woman and we did a management training team building experience, and... at the first session, you had to put up a symbol that identified yourself and [colleague] put up the symbol, which now I have forgotten its name..., I asked... what it was... She put that up because she said that was her... Now you can imagine there are 5 women in the mental health social work team and there were probably 30 of us in the room, um the shudders and the shakes of people who obviously, for whatever reason, had assumed [she] was heterosexual. They were so stunned by it. And [her] sexuality has nothing to do with, to me it's to who [she] is, you know... Um, her partner is a wonderful part of her life but it was like not something I had to think about, so it became really conscious to me that when I looked around the room and the attitudes that [she] copped after that from our learned colleagues in the management team... And the different perceptions, despite the fact she is strong and clear and I have always known that [she] is gay, it is not even anything different. But it's that whole bit, so I had to take that back to the social work team and think in my learning I will take that back to the social work team and the service I want to develop and like, how many of you are comfortable hearing that we have gay staff members, we have gay clients. How do we see this and it flows, you know it flows. I guess that is a good example that flows from management right down - because at the time we were just closing Tokanui and we talked about it was okay for clients to sleep together and so I sat there in the meeting and said, "Oh okay, and what if they are the same-sex clients wanting to sleep together, how do we feel about that?". "Oh, you know, we can't condone that"... I don't know. But we could condone, um, there is more... Because I remember getting really infuriated because there were obviously no other people who were gay friendly, for want of a better word, in the room. Um, I think it was more sort of the fact that they had this perception at Tokanui that gay would be, that same-sex relationship would be forced where there is a choice involved in other sex... Yeh, that would be a perception value... So it is that whole flowdown, so I've got to be really mindful of it with the staff... I don't know if I - I'm just wondering about something. Like, I am also very mindful that we have very few Maori staff... but are a really good percentage in the social work team in mental health - but at [the hospital] we had none and, um, I get betwixt and between about*

*openly recruiting some Maori staff and how we do that. But the next step along the way is how do you recruit for gay staff. You know, and if I am betwixt and between about Maori, what will I be when I get to gay men and staff? ...But it has to start having an impact... So, we will start getting gay psychiatrists soon, I am sure... We actually have one. That's the other one, we have a, um, a very out, lovely, gorgeous registrar who periodically takes the other registrars along to the gay bar in Hamilton to enlighten them and [he] can be just, oh he is just divine. Um, if you wanted to be truly homophobic you could say he's a waste in terms of his looks and his personality to be gay. A true homophobic statement um, but [he] can be the perfect um registrar. He's right by the consultant during the day, everyone loves him, he's beautiful, he is a wonderful doctor, he is a wonderful person. Um, at night you see him in frocks and all sorts of things... And I had forgotten, because I was thinking about that earlier. Thinking do we have anyone out there. So I mean [his] entry into mental health services had an impact, you know. You certainly heard about [him]. You know, "That gay registrar is coming over to us", and that was good, because [he] is confident and clear and extremely professional, but he can challenge people... He is the only one I know openly gay.*

*Gareth: I'd like to see some more out gay staff though. I think there are more lesbians moving into social work, and that's great, but not alot of gay men. I don't know of any examples of discrimination against gay people applying for positions, but I've never seen any service specifically looking for gay staff either - that would be pretty amazing.*

The assumption for some seems to be that a same-sex oriented practitioner would not carry heterosexist values. There can be no guarantee of this, or that a workplace environment is safe for a practitioner to be out.

In 1995, the fourth Australian and New Zealand Mental Health Services Conference in Auckland included a forum for lesbian, gay, bisexual and transgender mental health service consumers and practitioners (Allan, 1995). A significant outcome of this was the acknowledgement, as suspected by many, that the apprehensions associated with coming out and being out in mental health service treatment settings were common to both groups. In coming out to another, one relinquishes significant control over that information. For a same-sex oriented practitioner, coming out and being out in the professional environment poses potential risks and benefits. While such persons can be

excellent resources to an agency and to same-sex oriented consumers, they may also be subjected to homophobia within the agency and its networks, as may consumers (for example, Wanganui Chronicle, 1995). As Gonsiorek (1985b: 203) notes, "Even in a larger metropolitan area, and certainly in small ones, working as an openly gay or lesbian mental health professional is very much like working in a small town." The forum affirmed, as has been identified elsewhere (Rabin et al, 1986; Rochlin, 1985), a preference among gay and lesbian consumers for a gay or lesbian practitioner. As with any professional relationship in which social contact outside the professional setting is a potential, clear boundaries are essential for the same-sex oriented practitioner to work effectively with a same-sex oriented consumer (Anthony, 1985).

While it was felt that other-sex oriented practitioners should work with same-sex oriented consumers, an awareness of the relevant issues was considered essential:

*Esther: I think recognising and having an awareness to the power and the power issues and the control issues that have been impinged by – well, that have been taken away... by others. And just having that awareness... when we work with others to ensure that we are actually not doing that ourselves, that we are not oppressing, that we are not taking the control or the power away from our clients also. And I guess that's about recognising our abilities to work with people who are different from us, and... whether we are actually the most – whether the client can actually work with us and gain – or whether there is actually... a person that has similar experiences are able to work better I guess than other fields... We have a system where a person... comes through a referral process... I think when a person comes in, you have about an hour and a half of assessment but then there are no specific questions around sexuality. So really it is for the person, whether the person wants to or situational things come up – so it may be a relationship problem, so it comes up – or a person may actually request for a gay member of the staff to actually sit in, or they would prefer somebody that has had similar experiences to sit in.*

*Hamish: When guys come here, like I have always been quite happy to work with whoever. I mean we don't say okay this guy's gay so you get him... There are times when, this was specifically in the past, the information came in and it was quite horrific, we actually thought that specialist care was required and we picked my friend who happened to be gay and she actually addressed that issue. Because there were lots of things within the gay culture that we are not aware of*

*and that are not even talked about. Things like bashing and that sort of stuff amongst gay women, from her knowledge is quite horrific. This is something I have never thought about. I guess if you want to specialise in an area you need to ensure that the people who are doing it actually have the skill or the knowledge. I mean skills are quite generic, but the knowledge to work in a specific area, like Maori health.*

*Janie: I was gonna sort of like say something about sex too but I can't really talk about it from the gay male perspective, but there's a lot more sort of openness about sex in terms of sort of um I don't know - there's probably more exposure to things like bondage, and more exposure to things like sex toys. Yeh, but it doesn't really totally focus on sex but it's sort of like having an understanding around that...*

*Gareth: Fearing homophobic professionals like stops them getting assistance. I don't believe social workers can work with gay men without an appreciation of just how homophobia can affect so many aspects of life - and a single homophobia workshop in undergrad doesn't cut it.*

## IDENTITY AND COMING OUT

It is often noted that one of the most challenging aspects of same-sex orientation is the process we engage in 'coming out' and eventually connecting with other same-sex oriented persons. Such a process, for many, is undertaken in the absence of support or identifiable models (Donohoe, 1998; Goff, 1990; Rampton and Kinder, 1992).

*Hamish: Well... we have guys coming here and they don't know what they are. Okay, and the issues are they're not really wanting to talk about it.*

*April: I guess that some of things that I sort of keep in mind really are things like sort of... how one develops... or how one identifies or how one develops in terms of if you grow up sort of being able to be who you are and being accepted for who you are - I think that is a very different development from growing up and having to hide part of yourself and being afraid. Um, I think that that informs probably lots of things like object relations and relationships and, um, in terms of how your own self esteem and how you relate to other people - I think makes a big difference.*

An interesting feature of the participants' comments regarding coming out, was that none asked why it was necessary. It was as though coming out was a given, a requirement or an accepted factor in same-sex orientation.

In relation to coming out, *Daniel* identified a significant factor for same-sex oriented male consumers with whom he had worked:

*Daniel: I've worked, well as far as I know I have only worked with 2 gay men who disclosed that to me... You know... one of the issues that was brought up over and over again was the relationship with the person's father – the ongoing relationship with the father... And the – well, the stress that that was putting on... my clients – and that was the stress for them – in both cases, the father completely objected to their son's sexuality.*

In her excellent resource text for parents of same-sex oriented children, Stewart (1996) acknowledges the challenges facing a parent when a child comes out, and elaborates on these points with the experiences of parents. She notes:

As parents, we unwittingly internalise and assume strong heterosexual expectations for our children. Generally the ideal of caring parental love equates with the desire that our children will all marry, have 2.4 offspring and be financially successful – this, of course, will ensure their future happiness! We will then be personally validated and recognised by our peers as 'good' parents.

The day we discover or finally have confirmed to us that our child is lesbian, gay or bisexual affects us deeply. This reaction is to some extent governed by the emotional messages and information we have absorbed, by what standards we were raised to accept, and by how we have perceived sexuality: in other words, by what we have learnt to be 'good', 'bad', or 'normal'.

(Stewart, 1996: 18)

## ALCOHOL AND DRUGS

A number of participants identified contemporary factors around what may be considered relative to a same-sex oriented male social milieu. *Janie* notes:

*Janie: I think... the high incidence of the whole exposure to substances, the whole exposure to the nightclub scene, the whole pressure around like looking young and looking beautiful, and being very materialistic.*

*Janie* raises two prominent points here: the apparent higher incidence of alcohol and drug related issues among same-sex oriented communities, and the emphasis on physical appearance emphasising a youth oriented culture. As was noted in Chapter 2, a number of studies and practice reports (for example, Buhrich and Loke, 1988; Flavin et al, 1986; Kowszun and Malley, 1996; Kus, 1991, 1991a; Lapierre, 1991; MacEwan and Kinder, 1991; Zehner and Lewis, 1985) have argued that there is a higher ratio of alcohol and drug related problems among same-sex oriented men. Kus notes:

Studies conducted in the United States indicate that between twenty and thirty-three percent of the entire gay and lesbian adult population are afflicted with alcoholism or at the very least have a drinking problem... This is a far higher percent than that found in the population at large.

(Kus 1991a: 68)

Kus (1991a) goes on to consider the etiological arguments around this. He ponders whether or not these statistics could be explained relative to ongoing problems same-sex oriented persons encounter over self-acceptance, whether it may be based around the use of bars and clubs as primary meeting places for making contact with others, or perhaps some combination of these. Zehner (1985: 83-84) expands on the notion of the significance of bars and clubs in gay and lesbian communities:

The bar is often seen as, and often is, the only social institution in a community specifically for lesbian and gay people. It is here that lesbians and gays do not need to worry about feeling different or being accepted... The gathering together helps to lessen the feelings of isolation.

However, the centrality of such establishments in same-sex oriented communities cannot be identified as the only influencing factor in the apparent high statistical representation of alcohol problems among same-sex oriented persons. I would support Kus's notion of an interrelationship between the individual's history, emotions, thoughts and behaviours within a given context. An individual's substance use may or

may not be directly related to his sexual orientation, although for some it must be considered significantly relevant within a societal context and a critical personal belief system.

...drink and drug use may boost our sense of self-efficacy, our confidence, our feeling of personal power – all things that feel particularly necessary in a homophobic and misogynist world which can continually batter our self-esteem. Heavy or very regular use will, in the long term, erode our sense of self. The rejection of socially ascribed age roles, and of gender socialization, may tend to work against us if it means that we use alcohol and drugs over a longer period of time and are reluctant to seek help.

(Kowszun and Malley, 1996: 176)

## AGEING

*Janie's* second point regarding an apparent youth-oriented culture in gay communities, was shared by others in their reflections on the kinds of issues raised in practice with same-sex oriented men:

*Gareth: It's almost like there's an unwritten rule in some parts of the gay community that once you're 35 you're meant to quit the club scene. It seems that way for a lot of guys - like "you're old so piss off" - not for all, thank god. But it's tragic and a real cold aspect of our community. I guess those who behave that way prove that we can be as oppressive as anyone. And there isn't a lot out there for guys over that age... I think I'm lucky because I still go to the clubs and I haven't had that experience directly, but I often notice there aren't many of my peers there. I wish they were, but I love the music and all. I remember a meeting I attended when a guy said something like younger guys oughta be more grateful to the older guys who lead the way for them. That's only got some merit but only to a point - not all the older guys were active in 'leading the way', and still aren't, and some treat the younger guys like so abusively. Not all - I mean, that's part of the problem - when we generalise about a part of our community we concrete the barriers. Maybe it's the socialist in me, but I really believe everyone has a contribution to make, a place in our community - regardless of age or race or culture or the part of the community we're into - leather or drag or whatever. Everyone matters.*

*April: ...in terms of not identifying with the community and having a sense of "I just don't fit here". And particularly for men that were sort of moving into their forties, sort of it seems to hit about 35... I've worked with a few people and about*

*35 they start to feel, and again this is probably with about 5 men I have worked with in the last year, that they just don't fit anymore. That they aren't – again, there are lots of stereotypes that they bring in terms of what the prototypic gay community member, who is a Hero boy that has beautiful pecs, that goes out dancing until 4.00am in the morning. Um, and I think that that is perpetually the sort of things, like the express and things like that, that people get their sense of identity from in terms of the community - and what they say is that they can't meet other people that they think are like them, and so they think therefore that they are alone. So that probably is the biggest challenge that seems to be coming up in terms of the issues that I have presented for men, ah, is that as they grow older they just don't – it's almost like an existential crisis really in terms of "where do I fit?" and "who am I now?", and also sort of the issues in terms of I guess the developmental issues that lots of people who aren't in families with children face in terms of recognising that they are not going to have children, and the loss that is associated with this, and "I am not in a committed relationship, and I am going to grow old alone." And so I guess isolation really and vulnerability of growing older.*

These observations challenged me to investigate the literature regarding same-sex oriented men in mid-life. There is certainly material available regarding older same-sex oriented men (for example Berger, 1982; Gwenwald, 1985; Kelly, 1979; Ratigan, 1996), but scarcely any specifically focused on same-sex oriented men in mid-life. An exception to this is the recent work of Kooden and Flowers (2000: 16-17) who note the significant evidence of ageism in gay communities:

Gay male ageism is blatant in the sexually provocative images of youth that dominate our gay media, but we participate in ageism in less obvious ways as well. I define ageism as *using one age period as the standard of comparison for judging or describing another age period*. When we begin to measure our self-worth in terms of our age ("After fifty, no one wants you") and with even more damage, in terms of the age of others ("He doesn't want me; I'm too old for him"), we are perpetuating negative assumptions about what it means to be attractive and sexual. Examples of ageism can be explicit ("I shouldn't go out because I'm not a kid anymore") or implicit ("You don't look forty" or "You look so young"). Implicit comments can sound like compliments... but they can be just as ageist as the more blatant examples.

### SUMMARY: SO, WHAT'S THE CORE ISSUE?

What seems to be a common feature of these issues is an undercurrent of differentness, of otherness that sets a same-sex oriented man apart. This otherness is constructed in heteronormative terms in that the point of reference is that which is perceived as heterosexual. In offering some definition of heteronormativity, Spargo (1999: 73) notes:

The term specifies the tendency in the contemporary Western sex-gender system to view heterosexual relations as the *norm*, and all other forms of sexual behaviour as *deviation* from this norm.

I would argue that it is this heteronormatively-binarised construction of sexuality, as discussed in Chapter 3, that lies behind the subjugation of same-sex orientations. It is heteronormativity that requires an individual to come out in order to gain some sense of self and connectedness with others, and that results in homophobic and heterosexist attempts to ignore, negate, control and silence sexual diversities. Such diversities are constructed in opposition to and as contestations of a heterosexual hegemony.

We do not usually raise children with the possibility of a same-sex orientation in mind. In this sense, the use of substances reflects a response to a heteronormatively influenced internalised conflict between subjective ideations, desires and behaviours and idealised socially constructed codes of 'normativity', and it is this same normative process that narrowly defines constructions of beauty. Again, in considering the notion of normativity, Spargo (1999: 74) constructs it as:

A type of operation of power, that establishes and promotes a set of norms (of behaviour, of being). While the 'normal' might be statistical, norms tend to be *morally* established and have the force of *imperatives*. Heterosexuality might be 'normal' in terms of statistics, but the normativity of current understandings of sex grants it the status of a norm, defined against *ab-normal* practices and desires. The most disturbing feature of normativity is the 'normalisation' through which norms are maintained.

## 6. “OH MY GOD, THEORY!”

### - THE SOCIAL WORKERS AS INTEGRATED PRACTITIONERS

Having considered the first point in the integrated practice framework of *practitioner as person*, this chapter looks into the participants’ critical social science and clinical theoretical orientations. It considers practitioners’ integration of these; and their reflections on their practice with same-sex oriented male consumers who present with mental ill health. How would or could these theories construct same-sex orientation? What understandings and/or responses would they offer to internalised and structural heteronormativity?

The interconnectedness of theory and practice is rarely a simple linkage (Brown, 1998). As Turner (1996b) has observed, social workers may readily acknowledge the importance of theory in informing practice but demonstrating this is a somewhat more problematic endeavour. He argues that while we accept the significance of applying theory in practice, the challenge is now how we do this, and notes that theory carries a function in practice in the construction of that which is observed and in the identification of effective change strategies:

*Gareth’s* exclamation, noted in the title of this chapter, offers a snapshot response to what appears to be an ongoing dilemma for practitioners.

Social work practice has for some considerable time, shared a somewhat ambivalent relationship with its knowledge foundations. On the one hand, practice underpinned by an adequate knowledge base has appeared to offer the glittering prize of secure professional status... On the other, the prescriptions of theory have, for many practitioners often appeared distant, esoteric and hardly relevant for the complex and pressured world of practice.

(Sheppard, 1995: 265)

Shulman (1993) notes that social work practice theories are not unique to social work, particularly where the practitioner’s theoretical orientation relies primarily on either psychological or sociological/structural analysis. However, it is the integration of these with other disciplines (for example, philosophy) and social work models, within a broader integration with the practitioner’s personal and professional ‘self’, which sets

social work apart as a discipline in its own right (Abramson, 1996). Unfortunately, such an integration is rarely clearly evident and practitioners appear to present a leaning toward, or primary emphasis on, one or other aspect of this integration of theory. In writing on practice, practitioners may identify their clinical stance, reflecting a developing popularity among different approaches and models at different times, but rarely integrating these with critical social science.

In mental health the theoretical emphasis is often toward the psychological. This overlooking of the structural or social must be seen as problematic. This dilemma was evident in the participants' consideration of their respective theoretical orientations, with most identifying primarily clinical theory bases. It can be argued that, as social workers, we have as much, indeed an ethical and professional obligation, to contribute to structural/social change as we do in our direct clinical practice with clients. As *Gareth* noted:

*Gareth: Umm I think we need to be more active in challenging ourselves and the society we live and work in. As social workers, I think we have a responsibility to work with the client and his personal situation, including the challenges he may experience around his sexuality, but also to see the client in a broader social situation - to see the oppression or homophobia and to challenge it. I think we often slip into a casework role and forget our obligation to challenge oppression and discrimination. I think too that there are some social workers who look at the gay client and say they're just the same as anyone else - to them I say that if gay men are just the same as anyone else and it's no big deal, why has there been all the fuss? We can't treat any client 'like anyone else' because every client is unique. I think when we ignore the broader social situation for the gay men we work with, then we tacitly sanction that situation.*

## THEORIES

Theory gives us an orientation, a place of beginning, but it also gives us direction and purpose in our work. What, then, are the theories drawn on by the participants, and how do these construct same-sex orientations? How do they propose the contesting of heteronormativity?

### **Critical Social Science Theorising**

Of the four participants who did acknowledge a critical social science theoretical orientation, feminism and socialism were the conflict theories identified. Fay (1987: 4) broadly proposes critical social science to be “...an attempt to understand in a rationally responsible manner the oppressive features of a society such that this understanding stimulates its audience to transform their society and thereby liberate themselves”. He argues that the goal of a critical social science theory is the emancipation of an oppressed people, and identifies four conditions necessary for a theory to be considered critical:

...first, that there be a *crisis* in a social system; second, that this crisis be at least in part caused by the *false consciousness* of those experiencing it; third, that this false consciousness be amenable to the process of *enlightenment*...; and fourth, that such enlightenment lead to *emancipation* in which a group empowered by its new-found self-understanding, radically alters its social arrangements and thereby alleviates its suffering.

Fay, 1987: 30

Thus, Fay's basic scheme identifies four key components of a critical social theory relative to *false consciousness*, *crisis*, *education*, and *transformative action*; proposing this basic scheme as a framework against which potential theories might be measured.

### ***Feminisms***

*Janie* and *Esther* both acknowledged the influence of feminist theorising on their practice.

*Esther:* *Theories I draw on are probably theories like – I really try to look at the feminist theory when I am working and at the back of my mind. I really also try to work from the radical model as well, the radical theory – and I really hope that in my work I don't lose that, by the structure and the hospital system that I am working under... So I do try to include those. I think it depends on a person's perspective and... where they have come from, of how that has been explained – and I think, from where I stand, it is probably different from a gay woman who has lived through the experiences also. I think having the awareness of abuse issues which is quite massive within our clientele that we work with, sort of signifies again the power and control issues that women have experienced... and probably also a lot of males that come through also that suffer from mental illness and their abuse*

*issues also. And I think that we need to be just really aware of how that impacts on our people and what it actually means of our society... And within feminism, there are different... theories as well.*

While *Janie* did not elaborate on the type of feminism, she reflectively noted some of the cultural challenges put to feminist and other theorisings:

*Janie: I guess I could probably say I do use some aspects of feminist theory in my practice, like certainly the class/gender/race sort of aspects of that that it does address. But in a way I sort of find it's still it's very much or pretty much a white middle-class model that needs to really encompass other minority groups - and particularly um non-white experiences. So I've been a little bit down on the feminist model because I really believe it doesn't encompass other cultures and ways of being, and that it sort of like seems to think - I mean, I remember sort of like flattening with a group of women that had real difficulties around having young males around. I mean in terms of culture, that was really offensive to me. But, you know, it was like still a game like this white feminist theory was sort of like again going to override cultural aspects again.*

*Esther's* acknowledgement of a diversity of feminisms is an important one. As was evident in the heated discourses around sex and sexuality within the feminist academy and activism, not all feminist theorisings and activists constructed sexuality alike. *Esther* identified radical influences, yet even among radical feminists there were differing stances. Lesbian feminism had developed, at least to some extent, as a result of difficulties lesbians had faced in gay liberation, as a reaction to male dominance in the movement and the primacy of male-oriented agendas. Its development was also a challenge to other feminisms (particularly radical and liberal feminisms) considered to be primarily concerned with heterosexual women. Lesbian feminism posited lesbianism to be a political choice, as a potential among all women, to reject and challenge the dominance of men most apparent in the woman identified woman stance (Golden, 1994; Jagose, 1996; Seidman, 1993; Weeks, 1989). Debates and 'wars' around sex and sexuality were not to be unfamiliar in the women's movement and the feminisms of the 1970s and beyond, creating unexpected issue-based alliances and coalitions of interest, and disrupting networks over issues around, for example, pornography, abortion, male homosexuality, lesbianism, and sadomasochism (Duggan and Hunter, 1995).

Nevertheless, feminist theorists (particularly, more recently, those reflecting a postmodern influence) have taken up the challenge of attempting discourses around sexuality and same-sex orientations (for example the contributions in Weed and Schor, 1997). Practice drawing on feminist theorising emphasises an awareness and contestation of structural oppression. However, the type of feminism a practitioner engages will prioritise the focus of such analysis and intervention.

### ***Socialisms***

While both *Fran* and *Gareth* noted socialist orientations, neither identified the type of socialism. *Fran's* previously cited reflections on experiences growing up in a home situation heavily influenced by socialist and communist politics may give the impression her orientation is more in line with traditional socialist theorising. However, *Gareth's* socialist orientation is much less clear since he goes no further than to mention socialism.

The work of a number of academics in gay and lesbian studies has indicated a considerable embracing of leftist theorising (for example Altman, 1982; Cant and Young, 1982; D'Emilio, 1992; Derbyshire, 1982; Logan, 1981; Ryan, 1986; Weeks, 1977, 1982, 1989). However, there is little evidence to suggest that this has been mutual, that socialist or Marxist theorising has readily embraced same-sex orientation as a point of critical analysis.

### **Clinical Theorising**

It might be said that if one was to consider sex and sexuality from a clinical theory base, one might be drawn at least initially to psychoanalytic theorisings. It was, after all, Freud who first sought to engage the issues of same-sex orientation as an issue for clinical consideration (Freud, 1996; Isay, 1993; Murphy, 1985; Tatchell, 1989). However, none of the participants identified such a clinical theory base. Instead, there appeared to be a preference for more humanistic and psychosocial orientations.

In my work as a clinical supervisor of psychiatric/mental health social workers, and of social work students, a frequent description of the approach taken in clinical practice is that of *eclectic*, usually used to explain the application of a range of interventions

selected on the basis of the practitioner's or student's familiarity and ability with these interventions, and/or the apparent suitability of these interventions in relation to the presenting consumer issues.

*Esther: I guess I come from an eclectic approach as well where I draw from theories...*

*Fran: And I guess my biggest weakness is dividing the theories that I use when I work. I think I have, um - a weakness I would have is that a lot of my theory has become intuitive, as opposed to in my mind clearly remembering what I am doing.*

Integrated practice contests eclectic approaches as problematic applications of theories and techniques in that there is a risk that practice will slip into technicist pragmatism, of applying strategies to suit a presentation without a clear theoretical conceptualisation of the presenting problem or of why/how the proposed intervention may or may not be effective. I share Payne's (1991) view that eclecticism should be approached with caution. In a later text, he notes:

The eclectic approach suggests *either* that workers should select aspects of different theories and use them together, perhaps all at once or perhaps successively in a case *or* that workers should use different theories in different cases, depending on which is appropriate. Eclecticism enables different ideas to be brought to bear, helps to amalgamate social work theories when they make similar proposals for action, deals better with complex circumstances and allows workers to compensate for inadequacies in particular theories... [H]owever, there are theoretical and practical disadvantages. Workers may be unable to decide which set of ideas to select and how they should put them together. Also, it is difficult to know many complex theories well enough to take parts of them and use them appropriately. Social work theories may produce similar action proposals, but this often implies different ways of understanding issues.

(Payne, 1998: 130)

Without knowing of the specific theories and strategies a participant may draw on in applying an eclectic approach, it is not possible to consider the potential for addressing internalised and/or structural heteronormativity.

### *Client-Centred*

Developed by Carl Rogers, and based on his considerations of social work practices, client-centred theory is based in the following key concepts:

- Each person is located as central to his/her ever-changing environment, the experience of which is subjectively unique.
- Each person's subjective perceptions of his/her reality catalyse his/her reactions.
- That the over-riding singular need of an individual, in a given context, is toward self-actualisation.
- That reality is subjective and an individual's behaviours are aimed at meeting his/her psychological needs within a given context.
- That understanding of an individual's behaviour is made possible through empathy, based in a clear awareness of the individual's understandings and experiences.
- That an individual's behaviour reflects his/her understandings of himself/herself.
- That conflict between an individual's environment and his/her understanding of himself/herself is reflected in incongruent behaviours.
- That personal distress is the result of inconsistencies between an individual's experiences and his/her understandings of himself/herself.
- That a self-actualised individual accepts and engages experiences, and interacts with others with "...unconditional positive regard" (Rowe, 1996: 76).

*Daniel* was the only participant who stated a client-centred theoretical orientation:

*Daniel: I tend to use the client-centred approach. I am very much into the ideas of Carl Rogers... I accept there is that criticism – "too mushy" – especially from other behavioural therapies, you know, cognitive-behavioural therapists and things like that – but I think that as far as casework goes, if it's a one to one situation, building that kind of relationship with a person, I think the techniques, the simple techniques that Rogers advocated in the 50's and 60's, I mean, are just as applicable today... So... I think, get some transparency going between myself and the client. I see it really helps. It really helps them in the long run and I tend to think that a lot of the therapy, it's really the therapeutic relationship between client and worker which tends to bring results – it's kind of difficult to know how the results have come by, how we get to some, how we get from A to B – but generally it is the relationship, I think, that helps the most – and that's, you know, the very main focus of the client-centred work.*

This client-therapist relationship is significant in client-centred practice, and relies significantly on the practitioner maintaining an approach of ‘positive regard’. In this sense, the practitioner would respectfully, positively and genuinely engage the same-sex oriented consumer in enhancing his understanding of himself, of moving beyond narrow and heteronormative self-constructs, of integrating his awarenesses and experiences toward a self-actualising sense of self in context.

### *Cognitive/Cognitive-Behavioural/Rational Emotive Theories*

The cognitive spectrum of theorisings and practices has certainly become immensely more popular among mental health professionals of late. Whether or not this reflects a temporary situation resulting in the provision of more cognitively oriented training options, or that the availability of such programs has resulted in apparent contemporary popularity, is unclear. The spectrum includes purely cognitive approaches<sup>1</sup>, cognitive-behavioural therapy (CBT) with varying emphases on the cognitive and behavioural aspects<sup>2</sup>, rational-emotive behaviour therapy. (REBT/RET)<sup>3</sup>, and more recently a range of constructivist-cognitive behavioural therapies<sup>4</sup>.

*April: ...more recently, I have been working within the cognitive-behavioural framework and sort of trying to incorporate kind of developmental issues with how we see in our own world currently, and how we see ourselves... I think that again it is sort of having an understanding of developmental frameworks versus how people are now – and I don't know necessarily that they are sort of diametrically opposed – but it's about how you integrate these sorts of things. Um, and ultimately, it's about how, in the end, how one views oneself in one's relationship with an endless... world and the future.*

*Gareth: Ok um. I've had a strong interest in like cognitive approaches, right back since undergrad, that whole thing of the links between what we think and what we feel*

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1. For example Beck, 1991; Beck, 1995; Beck et al, 1993; Chadwick et al, 1996; Emery, 1993; Kuehlwein, 1993, 1994; Lantz, 1996; Lee, 1992; Perris et al, 1993; Werner, 1986.
  2. For example Cigno, 1998; Freeston et al, 1997; Gortner et al, 1998; Hawton et al, 1996; Lantz, 1996; Persons, 1993; Tiller, 1997.
  3. For example Dryden, 1987.
  4. For example Mahoney, 1995; McQuade, 1999; Neimeyer, 1993, 1995, 1995a.

*and what we do, how that's influenced by our beliefs and our environment. I've also been really looking at the narrative therapies too. I like the idea of people with their stories and how the person can relook at their story toward new ways of understanding it - that are personally empowering and offers the choices of action and change... I think it's like recognising there has to be more than one story or way of understanding a client's story, and that the way a client expresses that story or narrative is an expression of how he sees himself, what he believes about himself, what he thinks, what he feels - and that's expressed in what he does.*

*Janie: ...it would be more about I use a lot of sort of like cognitive counselling theories - particularly use a lot of the Rational Emotive sort of stuff... Which is quite challenging... But I quite like that because I quite like the way it deals with the here and now, and "what can I do?"*

*Janie explained her application of RET in a crisis context:*

*Janie: And like, often, I think when gay men and lesbians present in crisis, they really just want to know, "what can I do right in the here and now?" And it's just about addressing that particular issue or those issues - is about right here and now, like they present, particularly in crisis, it's very much a crisis intervention sort of model about - maybe just like bandaiding things but often it's about "what can I do in the here and now?" And that's why I quite like the Rational Emotive Theory. I've never actually done any of his training. I guess I was more exposed to it through substance counselling... But I think RET is quite good. I really quite like it. And I think working in the crisis area, it's more about crisis intervention*

*Gareth explained his cognitive-behavioural understanding of apparent degrees of internalised heteronormativity in same-sex oriented consumers, but he takes it that step further in seeing the consumer in a heteronormative social context:*

*Gareth: I think for a lot of the gay men I see in my work, it's like they have this picture or understanding of themselves as less than straights - like straight is normal. It's like having to come out, I mean there isn't a rule that says you have to come out but there are benefits to it - and risks, but how we do that - I mean, how many of us come out with an apology? "I'm sorry but I'm gay". The problem is one of identity. When you see yourself as a type of person that you've been raised to see*

*as not normal or as unacceptable, your view of yourself is at odds with your beliefs, the beliefs you've been socialised with. Add to that the sense of isolation, that lack of role models - that's changing in the media but being gay is still often portrayed as humourous or a problem. I mean there have been some great changes in New Zealand society, law reform and human rights and all, but that's only half the battle. New Zealand is still a pretty homophobic society, we still raise kids as though we expect they'll be straight, gay is still a put-down. Laws help but attitudes and behaviours take longer. So um with a gay client, it's about seeing that client in that broader social situation, about listening to his story, about encouraging the client to consider other explanations than ones of self-recrimination, and that there are other ways of seeing yourself or understanding your situation - it's an empowerment approach about moving from a single story or understanding to seeing other understandings, of seeing that it doesn't have to be the way the client sees it now.*

### **Role Theory**

Blair explained his application of role theory based on an understanding of the actual versus perceived role and status an individual holds within a given social context (Davis, 1996):

*Blair: I believe that we learn certain roles – okay, and I don't believe we learn a role to be homosexual. What I'm saying is that's in respect to sexual orientation, what I'm talking about is role in respect to relating people – you know, an aggressive role, or a doormat role... You know, that's where I'm coming from, role theory... Um. and I'm not saying that I use that exclusively but that's what I base my practice on... Well, I think role theory is a learned view – it's learned and you can learn it from your family. Family... the social atom of the family is the beginning, and then you'll have the other things – alcohol, social interventions, schooling, you know – all that is learnt – to learn a specific role how you act towards, let's say, if somebody is homosexual believes an empathetic social worker helps. Role theories are personality traits or personality developments we all have – even if you are gay or you are heterosexual and grew up in the same family, you... will most likely end up with similar personality traits learned from your mother or your father. The personality development that you gain through your life span is in respect to interventions or your relationship with certain people, is that the heterosexual with a bad, inconsiderate father will have certain personality traits; whereas a homosexual who gets hounded by the homophobic father, their personality traits will develop in a different way – so that's where*

*you have different roles... What I would be looking at, like I always hope to think that the gay thing would be put aside and – but the role, the role in respect to how they operate in respect to roles... would be my way of coming to understand them and how they are working. Like I do with everyone. I think I do it with everyone automatically in that this is how I operate anyway... But being gay, knowing that they are gay, would assist me in how their role development, how they operate now. I think that knowing that they are gay would make a difference. Because sometimes, when you hear about it, and certain things, you can understand why they act in a certain way. And I feel like then that gives me a better understanding of how I can work with people.*

Thus, from a role theory orientation, heteronormativity would be central in the ascribing of role and status. In recognising the diversity of roles and statuses an individual might carry in different contexts, one wonders to what extent awareness of an individual's same-sex orientation in these different contexts might variously be constructed and the individual's role and status reconsidered.

### **Practice Models**

I have differentiated here between clinical theories and practice models. It was interesting to note that some participants identified a particular practice model as a theory, yet such models are themselves informed by theories, which may shape the model's application.

It is at the point of action, that the social work practitioner applies his/her personal philosophy/construction, and critical social science and clinical theorising reflected in the practice models and related strategies implemented in meeting the client with his presenting problems. It is here, in the integrated practice framework that the practitioner considers the range of interventions he/she may engage in applying the theoretical base to work with in an effective and appropriate partnership process with the client and his specific situation. As Brown (1998: 16) notes:

To be able to work effectively also involves being able to work with the uniqueness of each individual within their own context. This requires the bringing together of knowledge, values and skills that will facilitate competent intervention, in the client/service user's interests.

## *Meditation*

In essence, meditation is the development – or discover, depending on one’s orientation – of consciousness, independent of visual and verbal symbolic thought. It is the deliberate cultivation of a mental state conducive to intuition. Meditation usually pairs a relaxed state of the body with either a concentrated or merely attentive focus of the mind.

(Keefe, 1996: 435)

While I would argue that meditation does not constitute a theory, its application as a model or technique in practice necessitates that it be informed by some theoretical understanding. While initially unclear of any theoretical orientation in her practice, *Claire* described her use of meditation approaches:

*Claire: I think what it is coming more into sync with is my spiritual practice which is a meditative, contemplative practice which doesn't have any particular religion attached to it. It's a practice of meditation... We usually don't talk about it until we have had an experience of it ourselves - and that's what's happening, and I am more interested particularly in any kind of contemplative practice that can actually be happening at the same time as anything else that might be happening which could be therapy or, you know, that there is actually a place for both at the same time because the contemplative or the theme of the contemplative practice to me it seems to be to bring oneself back to the now and the present moment. Therapy often dealing with past issues, um, which has a place too... But you can get very caught up in a lot of that sometimes and something that keeps you focused on the present moment is important as well to keep perspective and balance and all of those kinds of things. And of course you can't go round telling or suggesting to people that they practice meditation, but I think there are some subtle ways that you can introduce the concept of some contemplative type practice, even if it is walking along the beach. Um, and you actually really feel yourself and your body and, you know, just focus on your feet or heels and toes touching the sand or something like that, so it is bringing yourself back into your body and back into now sort of thing, you know something as simple as that... So there is a - I mean, I don't have a lot of theoretical stuff to base this on but it just seems to be to be a bit of a - although common-sense doesn't count for much these days. It just seems to me to, you know, it relates to a lot of other theories that would have... similar dynamics really.*

With this in mind, it would seem that meditation would engage internalised heteronormativity and some of the distress of structural heteronormativity. However, I wonder if there is potential in this reflection on the self, this calming of the spirit, to energise or engage contesting the structural.

### *Structural/Family Therapy*

*Fran's* work as a professional leader tends to be primarily organisationally oriented, yet even so she identified social work models informing her practice:

*Fran:* *I guess in my practice now, I don't feel as au fait with my clients, what client theories I would use given that I haven't done client work for 18 months. So um my theories are, alot of it comes back to simple social work theories. Because a lot of my time is spent explaining simple things, like Middleman and Goldberg [1974]. Um, and coming back to systems analysis and structural analysis because, yeh, 90% of my job is advertising what social workers do, why we need them, what impact they have and you have to come back to straight social work theories. I think as a practitioner, um, just systems analysis is never ever far from what I was doing... And, um, as much as I believe I am very task-centred and I think I still am as a, in the corporate world that I live in, um, I think that my analysis always comes back to what are the multiple systems impacting upon this person... Structural analysis and systems theory and what's another one? I think task-centred approach takes it in.*

*Fran* explained further, drawing on her personal experiences, in relation to the potential for systems theorising in addressing internalised and structural or environmental heteronormativity. In doing so, she also noted her willingness to let go of pure theory in the face of the consumer's needs.

*Fran:* *I mean, within that you are looking at the context in which that person comes. So that context has to take in all of the systems that make a person how they are. Now we don't make systems analysis or Fran's theory of it, I am not sure, but I mean integrating all of that I have to look at - I have to look at [the client] in terms of where [the client] is at now. How [he] sees himself as moving forward. When he is ready and if he is ready to move forward. Um, where [he] currently sits within his environment and why [he] is comfortable sitting in that environment... But then I have to look at in my way, has all the system that have impacted on him to make him like he is. So, you know, when you are defining. I*

*guess why I was a bit amazed... to hear that gay is linked to genes, um, cos I hadn't really thought about that... Um, it's like would you want to challenge someone about... [My friend's partner] had 2 children and um, one of my partners at one time didn't like the fact that [they] were co-raising [his] two children. Because, um, he was battling his own homophobia and doing a very good job of it I have to say. Um and [they] challenged him very hard to battle it. So he thought that because they were gay, the children would be gay... Okay, so if you go by that theory, why isn't everyone straight if everyone comes from heterosexual parents was the one question I asked. Aside from that... it would be like just look at all the systems and other bits that come in contact with the kids that they make their own choices, so you have to put it back to that and that is how I come back to my systems... So for a gay male, it would be what is your experience of the way society has impacted upon your life, or treated you within your life? And I would have to look at the way he sees that. And if some of that is going to be guided by my theory, but sometimes I might also throw out my theory if it doesn't work, you know. If, Joe Bloggs' experience doesn't fit my little box, you know it's not what I learnt at varsity, well varsity obviously needed to go beyond that. It's kind of like get into the discourse... Take away the fullstops so that we'll stick to [the client]... If his experience of the school system was the way he survived, by being the class clown – well, why did he need to be the class clown? What stopped him from just being like all the other students – was it that he felt good from his feedback that he got from his jokes – was it that he felt like he had to be the odd one because he was odd? Like, how does he define how he felt he was? And, therefore, working with [the client] and through those systems – and that would then change my analysis to work with – and, in some of that it might give me better understanding. Make my theories real.*

Perhaps reflecting some role theorising, *Daniel* explained his orientation to family therapy in a hypothetical consideration of an empowerment approach to practice with a same-sex oriented consumer:

*Daniel: I've started this family therapy training and certainly some of the... methods, some of the... different styles and methods of family therapy could be more applicable with... families where there is a member who is gay – particularly looking at... power within the family, and maybe changing that, trying to change that kind of... hierarchy within the family to help the family deal with whatever issue basically has come from having a son who is gay... trying to eliminate if a scapegoat was an issue... and... the family comes to terms with what they may perceive as a very difficult issue... I suppose using the structural model, which is*

*the model I'm talking about – it would be applicable to families of choice as well... Using empowerment, I suppose, and strategic... I suppose I would be trying to elevate the position of the gay person in the family – by maybe changing some of the structure... So trying to bring that person on the same level...*

In so doing, it seems *Daniel* is addressing the potential heteronormativity within the consumer's social context (his family).

### **Recovery**

...the word recovery refers to both the internal conditions – the attitudes, experiences, and processes of change of individuals who are recovering – and external conditions – the circumstances, events, policies, and practices that may facilitate recovery. Together, internal and external conditions produce the process called recovery. These conditions have a reciprocal effect, and the process of recovery, once realized, can itself become a factor that further transforms both internal and external conditions.

(Jacobson and Greenley, 2001: 482)

Emerging from the self-help movement of the 1970s, the psychiatric consumer movement, and psychiatric rehabilitation, recovery models are being considered more widely throughout mental health services (Mental Health Commission, 2001; Young and Ensing, 1999).

*Esther: We are actually coming from, or just starting to incorporate... the recovery theories... And so that is something that we are now positively starting to bring in and I guess that that is something that I have always carried with me in any case... that the person is able to recover and doesn't stay just chronic.*

It would seem that broad focused recovery models carry the potential to address issues a same-sex oriented consumer may engage in and around his mental ill health, but is there room within the model to consider the effects of heteronormativity. Recovery models recommend working on multiple levels with consumers and seeing the consumer within a broader context – but is the heteronormativity within such contexts considered? The question remains unanswered in the literature, including the Mental Health Commission's (2001) competencies relative to recovery, since no mention is made of issues above and beyond those specifically related to a consumer's mental ill health.

### ***Anti-discriminatory/Empowerment***

Anti-discriminatory practice is central to social work practice. It is clearly identified within the practice standards for the ANZASW (New Zealand Association of Social Workers, 1993), and is frequently identified as a key principle or theme in much of the practice literature. It was interesting, then, that while other participants alluded to it, or could be assumed to have significant anti-discriminatory influences in their practice since the majority were members of ANZASW, *Daniel* was the only participant who mentioned it specifically.

*Daniel: I am very keen to follow anti-discrimination as probably the main kind of theory I would use and keep at the back of my mind when working with gay people – and to be aware of the... overt/covert discrimination that they are probably facing in society.*

Other participants (for example *Gareth*) have mentioned empowerment theory as significant in their work with same-sex oriented consumers. Again, I would suggest that empowerment, such as that proposed by Rees (1991), is a practice model or an approach, but it is not a clear cut theory in that it's application is informed by clinical and critical social science theorisings.

### **Culturally Integrated Theorising**

It was apparent that many of the participants found the process of relating their practice through the integrated practice framework to be somewhat challenging. However, *Hamish* stepped outside this specific framework and in doing so reflected the framework in a more integrated manner. His discourse around his application of Te Whare Tapa Wha (Durie, 2001) reflected a significant integration and application of self, of a culturally informed critical worldview, of understandings of clinical presentations and subjective experiences, and of methods to address these:

*Hamish: It comes back to that same model of practice that I utilise in my workplace and that's Te Whare Tapa Wha. The whole basis of how I live. I mean like it's going to be nasty at times, but very rarely you know. Because if I infringe on your tapu, I also do that to myself at the same time... It might not come straight back. It may go through others before it gets to me. But I know that it will come back. So when I teach someone something, that's the type of, that's the life force that*

*moves... But part of how you work as a social worker, cause you know... It's a component. The teaching I had actually helped me to round off the skills that I have. Okay, and that's the important part. Like for me social work is a very small part of who I am. And it needs to be put in the right place. Those sorts of things I do, I base it around the tapu that I grew up with, the boundaries that I grew up with, the values that I grew up with. If you adhere to those, and I am not saying I've been an angel all my life, but it just may be as you grow older you learn how to deal with people... When you work within the model of practice of Whare Tapa Wha, some of the boundaries, the kaupapa around that is being able to tell the truth. The same as supervision. You need to be able to tell the truth from a supervisor or a supervisee position, because if you can't it means that with your own people with the clients you work with, it's the same reflection. So what you reflect between you and a supervisor must reflect what you picture in yourself and tangata whaiora, with the clients... But the thing is you know when you address tapu and mana and the wairua and everything else as you go through it and it's about getting them familiar with who they are as Maori. If you can get them to understand what you are trying to do. Everyone I work with actually go through along the practice and you can see the lights coming on. They are coming out of a black hole, and the lights come on and they go, "Oh I always wondered what that was. That's why I feel like that but I could never put a word to it", and that's because our words mean so many things. They don't mean one thing. So wairua doesn't mean spirit but that's one of the connotations that you can take from wairua. I mean I don't think that gay specifically, I could quite easily work with gay people in Maori and they allow me to bring that model into them. Because there is no difference, because I believe that like just off the top of my head that most people who come to us, we have another form of wairua, hinengaro, tinana and whanau. But most people who come here, what's happened is that their wairua has become diminished. Now whether you are Maori, whether you're gay or straight or female or male doesn't really matter, because there's only one way to deal with wairua, okay. And it is understanding how the model works that allows you to do that. Because part of what I do is, when I practice it's not about fixing them up; it's about giving them tools so they can fix themselves. It's really important to understand that. Like I can't empower anyone and a blind man told me that. Happened to be Maori as well. You know, he was sick and tired of people saying "Hey I'll empower you". Well the only person you can empower is yourself. If someone comes in I can easily say "I can do this, this, this and this". But the next time it happens, they have to come back and say "A8, what do I do this time?" As opposed to I can say well, "Let's have a look at this tool and I'll show you how it works." Okay. Then you figure out what you have to do, but I'll sit beside you and watch you and support you, but*

*you figure out what you have to do with that tool to address your take or your issues. That way what you are doing, is you're enabling them to enskill themselves, but you are skilling them to enable themselves to empower themselves...*

### SUMMARY

This chapter has looked into the participants' critical social science and clinical theoretical orientations and how these have been integrated in practice with same-sex oriented male consumers who present with mental ill health. I have attempted to consider how these theories construct same-sex orientation, and what understandings and/or responses would they offer to internalised and structural heteronormativity.

While four participants identified a critical social science position and could draw on theorisings with potential constructions of same-sex sexual orientation and structural heteronormativity, none were clear on this. It was apparent that, as appears to be a feature of contemporary practice in the mental health field, the theory emphasis lies primarily with clinical theorisings. Such an emphasis is problematic in that while it potentially responds to personal pain and distress, and even to addressing internalised heteronormativity, it leaves heteronormative social structures, systems and practices intact. The emphasis appears to remain on the consumer, the individual, even with the potential social-change aspects of recovery, anti-discriminatory and culturally integrative models. Is there potential for change in this? Or does the contemporary practice context limit contesting the structural? It is hoped that some clarity might be found around this in Chapter 7.

## **7. WALKING BACKWARDS INTO THE FUTURE – THE DEVELOPMENT AND CONTEMPORARY CONTEXT OF PSYCHIATRIC/MENTAL HEALTH SOCIAL WORK PRACTICE**

This chapter aims to contextualise this thesis through a brief overview of the historical development/emergence and construction of psychiatry, the development of the APA's *DSM* as a socially constructed nomenclature of psychiatric disorders, and how these have together responded to same-sex sexual orientation and same-sex oriented men. Within this context, psychiatric/mental health social work is placed as a specialist field of practice. These parts of the chapter draw on and integrate much of the study I have engaged in papers taken as part of the Master of Social Work program of which this thesis is the final work. These studies focused on critical queer social science theorising relative to social policy, clinical social work practice, psychiatry, and research.

Such a contextualising necessitates consideration of the policy and practice context. This recognises social work as operating within a broader political context which influences practice in the identification of the boundaries of a particular practice field. It identifies what is and is not the business of agencies funded by the state. Changes in policy influence the staffing levels, and resources, both within and external to the practice agency, available to meet consumer needs.

Since the early 1980s health services in New Zealand have been repeatedly reorganised from Hospital Boards, to Area Health Boards, to Crown Health Enterprises, and now to District Health Boards. Such changes are reflected in organisational structures, agendas, policies, and practice guidelines and protocols. These must meet the requirements of the government's policy stance, reflecting the means by which the service provider anticipates meeting the government's expected service-delivery outputs/outcomes. Service providers are further expected to achieve this while maintaining legislative compliance with minimal risk to consumers, practitioners, service agencies, or the government as key stakeholders. Such an objective has been further enhanced with the reflections of the participants relative to their respective practice settings. As one participant commented:

*Gareth: It's one thing when the picture changes in the workplace, but with all these policy changes and new expectations, it's more like trying to cope with the gallery changing around you. Talk about trying to get on with it on shifting sands.*

This was also an opportunity for the participants to reflect on their practice with same-sex oriented male consumers. Practitioners were asked to consider the joys and challenges of work with this consumer group. This reflection is presented in this chapter since much of the identified challenges related to resourcing issues in the contemporary practice context.

### PSYCHIATRY

Changes in traditional social structures subsequent to the development of capitalism, significant population increase, and the impoverished urban conditions of rapid industrialisation in the latter eighteenth century resulted in calls for the provision of institutional methods of addressing disquiet relative to increasingly evident indolence, crime, ill health, disability and madness. Non-institutional methods, usually church or community-based poor relief, were considered to be poorly administered and were argued to contribute to dependence (Scull, 1993). Workhouses or "...houses of confinement, a social precaution formulated by a nascent industrialization" (Sarup, 1993: 62), were the initial response but proved problematic in that they failed to 'encourage' a work ethic among the indolent and poor.

By making living conditions in the workhouses sufficiently unattractive, all save the truly needy and 'deserving' poor could be deterred from applying for relief; and the treatment of those so confined could always serve as an example pour encourager les autres. In this way the whole system might be made efficient and economical.

(Scull, 1993: 33-34)

As for those considered mad, the development of madhouses or asylums were indicative of a need to more clearly distinguish between the various populations seeking assistance, and particularly provide specific 'houses of confinement' for those deemed to pose a risk of danger or to pose some degree of threat to the new social order. Scull (1993) argues that such institutions became a practical potential because of the development of administrative techniques and the accruing of a surplus to meet the

costs. He notes that many of the early entrepreneurs privately operated such establishments with a clear profit focus.

Such, indeed, was the general character of the eighteenth-century 'trade in lunacy', which, even in the sector concerned with pauper lunatics, was a frequently lucrative business dealing with the most acutely disturbed and refractory cases.

(Scull, 1993: 40)

The development of specific sites for the containment of those perceived to be insane also provided for the emergence of a specific occupational group. That such a role should lie with medical practitioners, or those laying a claim to medical knowledge and skill, was hotly contested with debates revolving around understandings of the nature of madness, claims of insanity resulting from or indicating "...demonological, non-human, animalistic qualities" (Scull, 1993: 40) opposing claims for scientific understandings of insanity as impairment in the body (particularly the brain) (Finkel, 1976). Scull (1993) posits the relative success of this latter claim as reflecting secular thought advocating empirical sciences which had been enhanced to some degree in the development of capitalism, and further advanced by curative claims over specific pathology from practitioners who had been able to develop and test their skills on a localised sample.

The power of a profession's knowledge, its ability to rationalize, reorganize, and make sense of experience; its value as a systematized source of prescriptions for intervention; and most certainly the practical and perceived efficacy of the interventions it licenses and makes possible - constitutes a crucial foundation for efforts to secure and sustain professional dominance and control over a particular territory.

(Scull, 1993: 4)

Neurology was later to develop psychiatry as a sub-speciality. It was further aided in being identified as the profession with the appropriate knowledge and expertise for the care and treatment of the insane by various reforms focused on the standard of care in the asylums during the mid-nineteenth century. The result of these, particularly in England, was legislative requirements that asylums be state funded and supervised by medical practitioners (Sarap, 1993; Scull, 1993).

In New Zealand, reflecting similar legislation in New South Wales, the Lunatics Ordinance of 1846 was the initial legislative attempt to address the needs of the

mentally ill who had previously been incarcerated in penal institutions or, as in Wellington, pauper lunatic asylums alongside prisons (Brunton, 1985). In such institutions:

...treatment consisted of watching the patient at full moon or the use of old humoral techniques, such as shower therapy or head shaving. If the lunatics became violent, the gaolers had no choice but to restrain them with fetters, irons or straight jackets.

(Williams, 1987: 3)

The Lunatics Ordinance 1846 retained the potential for the mentally ill to be placed in prisons, once certificated, but added the options of other corrective public hospitals or asylum although there were, at the time, none of the latter. However, the construction of mental illness in New Zealand at the time reflected the Victorian moral context:

An ignorant man goes into the country, and from comparing himself and contemplating the solitude, the grand sights of nature, he becomes depressed; his hard fare and constant exposure, and newness of everything around adds to his depression; he becomes careless of food and occasionally goes without; then gets dyspepsia; he grows weak and miserable, a terrible craving for excitement seizes upon him, and if he cannot get to a public house and company, he commonly practices masturbation. The seminal discharge for a time does him good, but very soon he is quite exhausted; then comes the loss of the balance of reason, and insanity is at hand. The whole of his self respect is not yet quite gone; he has the grace to wish to conceal his degradation, and often succeeds in doing so for years; but when, from some quasi involuntary eccentricity, he is discovered and informed upon; that man becomes violent on the spot, and immuring him in a dismal lunatic asylum makes him almost incurable.

(Grace cited in Williams, 1987: 157)

The first asylum in New Zealand was established at Karori following the Constitution Act 1852, which required provincial governments to provide health services. Such asylums gradually developed or were relocated to the major psychiatric hospitals. However, these have since either considerably downsized or closed.

During the nineteenth century, there were two primary schools of thought in psychiatry. In France, the focus was on purely objective observation, of nosological description, "...avoiding speculations about aetiology or pathogenesis" (Beumont, 1992: 533). In

contrast, the German school of thought drew on Kant's construction of psychiatry, as with psychology, as a type of philosophy rather than medicine (mentalism). However, this was challenged by somatism and, later, developed in "...a more rational and empirical approach", arguing mental illness to be brain disease (Beumont, 1992: 535). However, it was the eventual adoption by the German schools of the clinical endeavours of the French that made possible the groundwork for the efforts of Emil Kraepelin who, in the latter years of the nineteenth century, "...viewed psychiatry as a branch of natural medicine" and "...set out to construct a firm nosology on which to base the search for aetiology, pathogenesis and therapy" (Beumont, 1992: 536). An example of this work lies in Kraepelin's identification of *dementia praecox* (later to be acknowledged as schizophrenia). It is Kraepelin's work that has set much of the stage for contemporary psychiatry (Andreasen, 1985). Much of the 'non-scientific' perception of psychiatry remained an issue, as one doctor noted in reflecting on his 1911 move to New Zealand:

The choice of psychiatry as a career was thought to be evidence of eccentricity and the recently qualified man who joined the staff of a mental hospital was regarded as having committed professional hari-kari. Upon the occasions of chance personal meetings with one's colleagues in general practice, one would be catechised in quizzical mood, with certain stock questions, such as: "Do your patients ever get well?" "Can you really do anything for them?" These being, of course, rhetorical questions of the kind we were taught in the Latin class to preface with the *particle num* to show that a negative reply was expected.

(Gray cited in Williams, 1987: 78)

Kraepelin had proposed a psychiatry that was medical in its orientation and methodology, "...essentially a psychiatry without psychology" (Beumont, 1992: 537). There would, of course, be those who would introduce what would now be acknowledged as psychological contributions (for example, Freud) to psychiatry, but Kraepelin's psychiatry as medical science would remain a significant feature of clinical and research practice, particularly in asylum/hospital-based practice settings where practitioners were often required to only treat the most severe presentations of mental illness. However, inpatient settings were not to be the sole sites of treatment as private practice developed and psychoanalysis (and related orientations) became more widely accepted. Other more 'medical' methods were readily employed. In considering a history of mental health care in the United States, Smoyak (2000: 31) notes:

While the energies and resources of the nation for the most part were occupied by war during the 1940s, several major somatic therapies were introduced into the state hospital system, most having their origins in Europe. Fever therapy, pentylenetetrazol (Metrazol), insulin, electric shock therapy, and lobotomies were used in almost all of the larger hospitals. Hospital records showed no comparisons of expenses or justification for their continued use by any scientific evaluative method.

The development of psychotropic medications, within a political and service delivery context that favoured deinstitutionalisation, made it possible for many who previously may have been expected to remain in hospital for lengthy periods of time, if not permanently, to return to living in the community (Cancro, 2000; Scull, 1984). Wilson (1993) notes that between the mid-1940s and mid-1970s, psychiatry began to adopt a broader psychosocial approach necessitating consideration of the patient's mental ill health within a social context. This approach represented an integration of psychoanalytic and "...the more pragmatic and environmentally oriented mental hygiene movement influenced by Meyerian psychobiology..." theories, and "...was the organizing model for American psychiatry" (Wilson, 1993: 400).

Wilson (1993: 400) goes on to note that with developments in biological research relative to psychopathology, *bio* began to prefix psychosocial, hence the *biopsychosocial* model which can be considered as signalling the re-medicalising of psychiatry and psychiatric research which would, by the 1970s replace clinical psychiatry "...as the most influential voices in the profession". Such an influence can be viewed contemporarily in discourses and research relative to biological or genetic constructs, albeit acknowledging a variously weighted genetic-environmental balance, in the development of mental ill health (Harris and Schaffner, 1992, Karlsson and Kamppinen, 1995; McLaren, 1992; Takahashi, 1994).

### *DSM*

"What is the use of their having names," the Gnat said, "if they won't answer to them?"

"No use to them," said Alice; "but it's useful to the people that name them, I suppose. If not, why do things have names at all?"

(Carroll, 1964:147)

Mathis (1992) has identified three basic objectives of a psychiatric nomenclature, it enhances communication between psychiatric and mental health practitioners; it potentialises a consideration of aetiology; and it clearly demarcates the features of a specific disorder enabling the practitioner to identify the appropriate treatment with some awareness of the effects of such intervention.

In spite of a number of attempts, it seems that there was a distinct lack of consistency among the numerous classification systems in operation prior to the development of the first edition of the *Standard Nomenclature of Disease* published in 1933 with the involvement of the American Psycho-medical Association (forerunner to the APA). However, at the beginning of World War II, the initial nomenclature and classification system in use was primarily of relevance to inpatient services.

The Armed Forces faced an increasing psychiatric case load as mobilization and the war went on. There was need to account accurately for all cases of morbidity, hence the need for a suitable diagnosis for every case seen by the psychiatrist, a situation not faced in civilian life. Only about 10% of the total cases seen fell into any of the categories ordinarily seen in public mental hospitals. Military psychiatrists, induction station psychiatrists, and Veterans Administration psychiatrists, found themselves operating within the limits of a nomenclature specifically not designed for 90% of the cases handled... No provision existed for diagnosing psychological reactions to the stress of combat, and terms had to be invented to meet this need. The official system of nomenclature rapidly became untenable.

(American Psychiatric Association, 1952: vi-vii)

In an effort to address these inadequacies and to respond to the difficulties arising from at least three nomenclatures being used (even within the same service but for different purposes), the APA, following considerable consultation, agreed to publish the first edition of the *DSM* (American Psychiatric Association, 1952). This text, which included a standardised numerical coding of diagnoses for the purposes of statistical reporting, was in fact the Diseases of the Psychological Unit section, of the fourth edition of the American Medical Association's *Standard Nomenclature of Disease and Operations*, which was also published in 1952 (American Psychiatric Association, 1952; Kirk and Kutchins, 1992).

While retaining the psychodynamic orientation of *DSM-I*, the second edition, *DSM-II* (American Psychiatric Association, 1968), developed additional diagnostic categories and sought to align classification more closely with the eighth edition of the World Health Organisation's *International Classification of Diseases (ICD)* also published in 1968. *DSM-II* refrained from using Alfred Meyer's term *reaction*, as used in *DSM-I*, with a view to moving beyond such psychobiological theoretical orientations in favour of applying "...diagnostic terms that by and large did not imply a particular theoretical framework for understanding the nonorganic mental disorders" (American Psychiatric Association, 1985: 2). *DSM-II* furthermore encouraged the application of multiple diagnostic categories to an individual patient's presentation (Kirk and Kutchin, 1992).

During the 1960s, psychiatry was significantly criticised both within its own ranks, often relative to theoretical orientation, and from outside psychiatry, particularly by those identified as the antipsychiatry movement. Psychiatric practitioners criticised the psychosocial model of psychiatry as empirically problematic and often urged a more significant realignment with medicine. Challengers from outside psychiatry, however, critiqued psychosocial psychiatry *as* medicine (Pearson, 1975).

The antipsychiatry movement comprised an ideologically and politically diverse group of critics. Common elements of the antipsychiatry critique can be summarized as follows. If the boundary between normal and abnormal is fluid (as the psychosocial model suggests), then psychiatric diagnoses must be arbitrary. Since no pathophysiologic basis can be found to explain mental illnesses, these disturbances cannot be called diseases in the conventional medical sense.... If the psychosocial model posits interpersonal and social causes of psychopathology as fundamental, then psychiatry's relation to medicine is at best indirect.

(Wilson, 1993: 402)

The challenges from the antipsychiatry movement, and the demands from within psychiatry to re-establish a medical orientation to practice and research, were compounded in the 1970s by federal and third party (insurance company) requirements for greater financial accountability in psychiatry. *DSM-II* had not established the necessary clarity in diagnosis that had been hoped for, and new and improved medications (for example, lithium carbonate) necessitated a finer focus on accurate empirically based diagnoses among practitioners. The continued alignment in *DSM-II*

with psychodynamic principles was questioned relative to the effectiveness in treating more severe psychiatric disorders, particularly when compared to the medication options available.

*DSM-III* was developed to address such critical problems. Again, it was published in collaboration with the revision of the *ICD*, but it would evidence a clear re-medicalising of psychiatry. Task forces were organised to review each diagnostic category and develop explicit criteria, and a multi-axial system was introduced. Following the challenges of the 1970s, the psychosocial/psychodynamic orientation was dropped in favour of an atheoretical stance, particular etiological theories; and some diagnostic categories were developed and rearranged, while others (for example, homosexuality which had been declassified in 1973) were discarded (Wilson, 1993; American Psychiatric Association, 1985, 1994).

While *DSM-III* was published in 1980, work on a revised edition was commenced almost immediately and *DSM-III-R* published in 1987. This revised edition was developed as a result of the experience of practitioners applying *DSM-III*, which had "...revealed a number of inconsistencies in the system and a number of instances in which the criteria was not entirely clear" (American Psychiatric Association, 1994: xviii).

*DSM-IV* is the latest edition in the series. It evidences further developments in empirical data relative to psychiatric disorders, includes new considerations (for example, disorders relating to HIV), and was developed to reflect and to coincide with the publication of *ICD-10*. *DSM-IV* carries with it a further modified definition of mental disorder. The latest definition posits mental disorder as:

...a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral,

psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

(American Psychiatric Association, 1994: xxi-xxii)

*DSM* has been established as possibly the primary nomenclature of psychiatric diagnoses in the United States and elsewhere in the West. Funders of mental health services utilise it significantly as a classification system; practitioners of all disciplines rely on it in diagnostic procedures, communication, and treatment planning; and researchers organise their investigations around it (American Psychiatric Association, 1994; Follette, 1996).

### PSYCHIATRY AND HOMOSEXUALITY

Foucault (1990) cites the initial identification of *the homosexual*, as an acknowledged category, in Westphal's 1870 article positing *contrary sexual sensations*. Since the mid-nineteenth century, and (at least) until as recently as the 1970s, same-sex object choice or homosexuality has been posited as a psychopathological or neuropsychiatric condition, particularly among those practising in psychiatry (Bullough, 1976; Cohen, 1993; Glamuzina and Laurie, 1991).

Weeks (1977) notes that this reflected well the popular imagery of inextricable links between sin and disease, creating what Szasz has described as "...the model psychiatric scapegoat" (cited in Rochlin, 1985: 27), and providing a moral and medical justification for "...the correctional zeal of the doctor" (Szasz cited in Weeks, 1977: 31). As D'Emilio notes:

Besides facing the moral condemnation of churches and the punishments imposed by law, gay men and women found themselves scrutinized by a medical profession that diagnosed homosexuality as a disease. In the 1880s and 1890s, when the scientific literature first appeared, doctors engaged in a spirited debate over whether homosexuality was a vice indulged in by weak-willed, depraved individuals, an acquired form of insanity, or a congenital defect that indicated evolutionary degeneracy. In time, advocates of the first view dropped out of the discussion, content to leave the regulation of homosexual behavior to the church and the criminal justice system. Among proponents of a medical model, a

near consensus had emerged by the early twentieth century that homosexuality was hereditary in its origins.

(D'Emilio, 1983: 15)

For much of the first half of the last century, in spite of attempts among some medical and psychiatric practitioners and early reformists to argue the innate nature of homosexuality as justification for decriminalisation, homosexuality primarily remained in the province of criminal justice systems in the West (Bayer, 1981). However, psychiatrists required to screen those enlisting for wartime military service were granted access to a wider range of the population. This was a contact that greatly influenced popular awareness of the profession and, combined with a psychoanalytic orientation, offered the potential for a re-emergence of the debates around homosexuality (D'Emilio, 1983). These practitioners were to be involved in the development of the first edition of *DSM* in which homosexuality was included in a sub-category of Personality Disorders:

#### 000-x63 Sexual Deviation

This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions. The term includes most of the cases formerly classed as "psychopathic personality with pathological sexuality." The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestitism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation).

(American Psychiatric Association, 1952: 38-39)

In *DSM-II*, homosexuality was listed as a sub-category of Sexual Deviations:

#### 302 Sexual deviations

This category is for individuals whose sexual interests are directed primarily toward objects rather than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

##### 302.0 Homosexuality

##### 302.1 Fetishism

##### 302.2 Pedophilia

- 302.3 Transvestitism
- 302.4 Exhibitionism
- 302.5 Voyeurism
- 302.6 Sadism
- 302.7 Masochism
- 302.8 Other sexual deviation
- 302.9 Unspecified sexual deviation)

(American Psychiatric Association, 1968: 44)

Freud argued that homosexuality did not constitute a mental illness but "...a variation of sexual expression" for which treatment was generally contraindicated on grounds of necessity, appropriateness or durable effectiveness, particularly where the treatment goal was heterosexuality or, at least, the elimination of homosexual behaviour (Goff, 1990: 602). In spite of this, considerable research has been engaged to find a cause and thus a potential focus for intervention (Cabaj, 1988; Smith, 1992; Stein, 1988).

Many of those presenting with homosexual behaviours or ideations have been treated in psychiatric hospitals and outpatient clinics against their will, or with an ill-informed or coerced faith in the power of the recommended 'cure', with whatever technique was currently recommended. Techniques including psychoanalytic psychotherapy and hypnosis, pharmacology, surgery (for example castration, lobotomy) and/or behavioural treatments (including aversion therapy) regimes were often the interventions of choice. Such efforts have not been limited to a focus on sexual activity but to behaviours and personality factors perceived to indicate the potential for same-sex desire and/or activity. These were gender normative interpretations which presumed a link between cross-gendered behaviours or tastes and homosexuality (Bancroft, 1969; Bancroft et al, 1974; Bene, 1965, 1965a; D'Emilio, 1983; Faas, 1983; Feldman and McCulloch, 1964; Fookes, 1960; Glamuzina and Laurie, 1991; Green et al, 1987; Gummer, 1995; Hopcke, 1989; Marks et al, 1970; O'Connor, 1964; Popper, 1997; Socarides, 1983, 1995; Virtue, 1995; Weeks, 1977; Zuger, 1988).

The potential for compulsory admission to psychiatric institutions, in New Zealand, lay with the legislation at the time. Section Two of the Mental Health Act 1969 defined mental disorder as:

...suffering from a psychiatric or other disorder, whether continuous or episodic, that substantially impairs mental health, so that the person belongs to one or more of the following classes, namely:

- (a) Mentally ill - that is, requiring care and treatment for mental illness;
- (b) Mentally infirm - that is, requiring care and treatment by reason of mental infirmity arising from age or deterioration of or injury to the brain;
- (c) Mentally subnormal - that is, suffering from subnormality of intelligence as a result of arrested or incomplete development of mind.

(Mental Health Act 1969 cited in Dawson, 1987: 10)

Following significant challenges and 'zappings' at annual meetings and lectures, in the early 1970s, a tremendously embattled APA agreed in 1973 to remove homosexuality from *DSM-II* although not without immense disquiet and the application of an unscientific and unsuccessful poll of its membership. Sexual Orientation Disturbance replaced Homosexuality, as a diagnostic entity. However, some homosexuals and their supporters from the women's movement and psychiatry remained dissatisfied with the term *disturbance* (Bayer, 1981; Mathis, 1992; Wilson, 1993).

The debate continued for another five years when the review of *DSM-II* brought about the establishment, under Other Psychosexual Disorders in *DSM-III*, *Ego-dystonic Homosexuality* as a diagnosis for individuals who were particularly unhappy with their homosexuality. This, too, was considered highly problematic, and was challenged strongly until *DSM-III-R*. "This 'Bible' of psychiatric diagnoses solved the question by eliminating all reference to it" (Mathis, 1992: 257). However, it should be noted that *DSM-IV* retains some ground, established in *DSM-III-R*, on the sexual orientation issue. In retaining this diagnostic option, *DSM-IV* potentially reflects a perpetuation of a degree of heteronormativity in that it would only be applied, in most if not all cases, in relation to distress over a non-heterosexual sexual orientation.

#### 302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include:

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity

2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation.

(American Psychiatric Association, 1994: 538)

### PSYCHIATRIC/MENTAL HEALTH SOCIAL WORK

Social work is a diverse and ever-transforming profession, reflecting the cultural and social context in which it is practised (Payne, 1991). Current efforts among practitioners, agencies, legislators, and particularly the Aotearoa New Zealand Association of Social Workers (ANZASW), toward statutory registration of social workers, begs the question of a definition of social work. Yet problems arise in ensuring such a definition encompasses the diversity of practice settings, qualifications, roles and constructions – and ensures the bicultural nature of practice in Aotearoa New Zealand is clearly reflected (Registration Project Team, 1999).

The literature relevant to psychiatric/mental health social work, and other disciplines practising within psychiatry, would suggest that social factors are now more readily recognised as being as significant in mental illness as biological and psychological factors. This should not be construed as a complete move away from the primary focus on biology/pathology but it is an indication that mental ill health is more than a medical issue, that purist biological reductionism might somehow be insufficient (Avison and Speechley, 1987; Bachrach, 1987; Bebbington et al, 1993; Benjamin, 1996; Colhoun and Maxwell, 1987; Cooper, 1992; Dawson, 1996; Forster, 1994; Harris and Schaffner, 1992; Heikkinen et al, 1995; Hillard, 1990; Jones et al, 1995; Karlsson and Kamppinen, 1995; Kessler, 1995; McLaren, 1992; Polak and Warner, 1996).

Psychiatric/mental health social work is gradually emerging as a specific or specialist field of practice in its own right, as distinct from its origins in health social work or 'generic' mental health social work (Austrian, 1995; Berg and Wallace, 1987; Butler and Pritchard, 1983; Farley, 1994; Lucas, 1992; Ramon, 1988). While its origins in the United States date back to the early 1900s, the initial appointment of social work practitioners in this field was a half-century later in New Zealand (Stuart, 1997; Williams, 1987).

There is a growing body of literature relative to social work knowledge and practice expertise in this field but Adamson's (2001) paper appears to be only one published in recent years specifically addressing psychiatric/mental health as a field of practice from practitioners in Aotearoa New Zealand. This dearth of documented knowledge reflecting and informing practice in this country has resulted in a necessity to rely on literature from the United States and Britain, and in attempts to translate this to this social, cultural and political context. *Gareth* notes:

*Gareth: Have you tried to find anything about mental health social work here? It's like every new social work book for New Zealand social workers forgets mental health – or maybe they just assume that it's the same as any other area. So we have to use American ideas which don't necessarily fit here.*

The situation is even more apparent in relation to practice with same-sex oriented consumers. Some material has been produced by practitioners working in the HIV/AIDS field (Stanley, 2000), but nothing specifically addressing practice with same-sex oriented consumers in the mental health field.

Indeed, a major concern lies with the training of social workers in preparation for this field of practice. At present, most social work education programs in this country (in order to meet the demand for practitioners with a broad practice base) focus on preparing students for more generic social work practice rather than providing specialist training. In doing so, few graduates are perceived as adequately prepared in specialist skills or knowledge for psychiatric/mental health social work practice (National Working Party on Mental Health Workforce Development, 1996). The availability of psychiatric/mental health social work practice placements or practicum opportunities are heavily relied on by potential employers (and, one would hope, the education institutions) to prepare practitioners for psychiatric/mental health social work as a specific field of practice. In the absence of such practicum opportunities, recruitment of experienced or adequately trained social work practitioners is difficult.

Other professional disciplines are now taking on roles and responsibilities traditionally associated with social work. In the light of recruitment challenges, fiscal constraints, and the emerging identification of a more generic mental health practitioner, social

work is becoming increasingly marginalised, and services that are purchased are often specific and narrow in their focus. Consequently, practitioners with a theoretical orientation beyond the purely clinical are often finding they need to toe the party line of a more client or symptom focus in order to remain employed and retain social work practitioner numbers within a climate of inquiries, restructuring and instability (Bachrach, 1987; Kulys and Davis, 1987; Fulcher, 1994; Lucas, 1992; Ramon, 1988; Schuster et al, 1994).

## THE CONTEMPORARY CONTEXT

### Policy and Legislation

In its efforts to reorganise the health services in New Zealand, the 1984 Labour Government introduced elected Area Health Boards in the late 1980s to replace Hospital Boards (Caygill, 1988). The purpose was to localise funding arrangements. This was not a new idea but Hospital Boards and primary care providers had opposed previous attempts. However, a taskforce was to recommend even greater devolution. The Labour Government considered this too extensive, but the subsequent National Government was significantly more open to the ideas. With the development of Regional Health Authorities and localised Crown Health Enterprises, the emphasis was on a more distinct separation in the funding and delivery of services, with the state primarily taking responsibility for policy, funding and monitoring of services (Kelsey, 1997; National Advisory Committee on Core Health and Disability Support Services, 1992, 1993; National Interim Provider Board, 1992; Upton, 1991, 1992).

These were the “*shifting sands*” Gareth had spoken of, and they must have been made even more problematic and disquieting with inquiries (for example, Mason et al, 1996) and media reports (for example, Brett, 1997; Dominion, 1997). It was a period of significant change in the development of mental health services throughout the country. Larger hospitals such as Carrington, Lake Alice, Tokanui, and Porirua were downsizing and closing, with a marked emphasis on community-based care of persons with mental ill health through community mental health teams and other community agencies. Short-term inpatient care was to be provided in acute wards in general hospitals.

Reflecting the changes in *DSM* and attempts to emphasise the rights of persons needing assessment and treatment, the Mental Health Act 1969 was replaced, after considerable consultation, by the Mental Health (Compulsory Assessment and Treatment) Act 1992.

This amended legislation defines 'mental disorder' as:

...an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it -

- (a) Poses a serious danger to the health or safety of that person or of others, or
  - (b) Seriously diminishes the capacity of that person to take care of himself or herself; - and
- "mentally disordered" in relation to any such person, has a corresponding meaning.

(Mental Health (Compulsory Assessment & Treatment) Act 1992: Section 2)

Both the National Mental Health Standards (Ministry of Health, 1997) and the Mental Health (Compulsory Assessment and Treatment) Act 1992 emphasised consumer rights, culturally appropriate practice, and the active involvement of family/whanau and significant others with an emphasis on community-based service delivery. Inpatient treatment is only actioned as a last resort in services provided through the mental health services operated by Crown Health Enterprises, monitored through Regional Health Authorities, and purchased through a central Health Funding Authority. These moves were noted to reflect a commitment to a recidivist ideology in which it was perceived a market-driven health sector would be more productive and efficient. It has been argued that the restructuring proved to be neither (Barrett, 1993; Fulcher, 1994; Ross, 1997, 1997a, 1997b).

In an effort to remove the competitive environment, which emerged from these changes, the Labour Government has now implemented a restructuring of the health sector. Health and disability services are now to be operated through local elected District Health Boards.

### ***Same-Sex Oriented Consumers***

While reflecting the declassification of homosexuality as a psychiatric disorder, although there appears to have been no open discourse on the matter in the development

of this legislation, Section Four of the Mental Health (Compulsory Assessment and Treatment) Act 1992 states:

4. General rules relating to liability to assessment or treatment - The procedure prescribed by Parts I and II of this Act shall not be invoked in respect of any person by reason only of -
- (a) That person's political, religious or cultural beliefs; or
  - (b) That person's sexual preferences; or
  - (c) That person's criminal or delinquent behaviour; or
  - (d) Substance abuse; or
  - (e) Intellectual handicap.

A further relevant measure in New Zealand, relative to homosexuality and to psychiatry, is the Human Rights Act 1993 in that, as of 1 February 1994, sexual orientation, HIV infection and psychiatric disability were all granted protection from discrimination in relation to access to goods and services (including health services), accommodation and employment. The Act was initially an amendment to the Human Rights Commission Act 1977, and combined this legislation with race relations legislation and added a number of additional grounds for statutory protection against discrimination – in addition to some exemptions (Parkinson, 1993).

However, with the exception of *sexual preference* as an identified exclusionary feature of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the antidiscriminatory protections available through the Human Rights Act 1993 and Consumers Code of Rights (Health and Disability Commissioner, 1999), none of the mental health related reports or assessment/treatment guidelines (for example, Mental Health Commission, 1999, 2000, 2001; Ministry of Health, 1994, 1998) appear to specifically address same-sex oriented consumers. The Ministry of Health's (1994a, 1997a) national plan for improving mental health services and the Mental Health Commission's (1997, 1998) *Blueprint* both appear to have omitted any such consideration. Even the combined efforts of the Ministry of Youth Affairs, the Ministry of Health and Te Puni Kokiri (1998) and the supporting evidence (Beautrais, 1998), in developing a program for the prevention of youth suicide, appear to have not addressed the issue in spite of submissions from gay/lesbian/bisexual groups. Is this omission an

indicator of assimilation or of heteronormative assumptions that same-sex oriented consumers do not constitute a consumer group warranting specific consideration?

However, this was seen as an issue for one Regional Health Authority. A document considering improvement in services for same-sex oriented consumers was produced through the midland Regional Health Authority (Bloomfield et al, 1995). Unfortunately, it remains unclear as to what was done with this research, if anything was done with it at all. Following consultation through interviews, groups and a workshop, a number of practice standards were identified in the research, and the authors concluded:

Gays and Lesbians have specific needs when using health and disability services. They often confront homophobia and heterosexism when they use these services. The specific standards of practice identified in this research could significantly improve safety for Lesbians and Gays. These included:

- Workshops on homophobia for health professionals.
- Sensitive information gathering mechanisms.
- A visibly Lesbian and Gay friendly health environment.
- Access to accurate information and resources about Gays and Lesbians.
- The involvement of Lesbians and Gay family support networks.
- Support for Gay and Lesbian health service providers.

By implementing these standards of practice, health and disability services will be able to provide a safe and supportive environment for Gays and Lesbians.

(Bloomfield et al, 1995: 8)

In an effort to redress inequities in relationship legislation, measures are currently under consideration regarding legislative recognition of same-sex relationships. This will have some bearing on practice with same-sex oriented consumers relative to the application of the *Health Information Privacy Code 1994* (Privacy Commissioner, 1994). Fran previously noted that some staff have or may have used this to withhold information from the partner of a same-sex oriented consumer. Legislative recognition of same-sex relationships will contest such a stance.

## Practice Environment

Almost all of the participants in this study currently practice in community mental health services. These services are generally organised into multidisciplinary teams covering psychiatry, psychology, nursing, occupational therapy and social work.

*Daniel: There's five members of the team – we cover all professions, and including a Maori care co-ordinator. So, basically, we use the case management approach. All members of the team will case manage clients and hold onto their speciality, their specialist skills, so for me it is social work. I case manage and take up any specialist kind of social work... Oh the other thing with case management... I see a lot of social work in case management as well – and some of my colleagues don't really – that have really only come to terms with it really in some respects. There's a lot of crossover also between myself and the occupational therapist, and we do a lot of work together...*

*Isobel ...there are other disciplines within the team and we prefer to work as a team that can address specific issues if they need to be - for instance, the psychiatrist can focus on medication and you know whether they are right with their thinking, that sort of thing. Whereas I am actually in a position to be able to take on, you know, other aspects of the person's improved well-being which is the goal. And to see if that meets with how the team are onboard... That's the theory. But sometimes the caseloads will be just so high, you know, a bit more practice would be nice. You know, the luxury of having that would be good - and we do get an opportunity but it's pretty frantic as you can imagine.*

*Isobel goes on to describe what appears to be a growing move toward a more generic mental health professional role, albeit retaining some specialist responsibilities suggesting a remnant of the medical hierarchy, within such teams:*

*Isobel: The people who sort of, um, well I guess the main guardians, the caregivers of that person's treatment are the psychiatrists and probably next depending on whether that person is going to have an involvement with a psychologist, those two people. Um, they don't actually play what we call a key worker role... The rest of the team do – and it's made up of psychiatric nurses, OT's, social workers – we only have 3 social workers here anyway. But the majority of staff here are psychiatric nurses. So, um, the rest of us all take on a key role – key worker role – therefore, we have an allocation of clients who we basically look after. So that role doesn't really vary... Well there is no grey area in that we all do the same*

*thing... Despite the fact that we are from different disciplines. Where the psychiatrists and the psychologists they clearly are identifiable because they don't change and they don't have the responsibility, as such, of the day to day needs of that person.*

Daniel noted some ongoing assumptions about the social work role within their respective teams:

*Daniel: It is defined by me... And not the others at all. So I am up against a huge brick wall about "social worker, you handle the negotiation with WINZ... and you do the application form" – it has only really come up once for me, and it's been an accommodation issue – a referral to supported accommodation and doing the assessment for that, and finding the appropriate accommodation...*

Gareth shared this experience but also sees a problem for social workers in engaging social factors beyond those presenting in a particular consumer's situation:

*Gareth: It's not unusual for the social worker to be allocated the benefits and accommodation issues. I think there's often a misconception that that's all we do. It's pretty silly really – would be like telling the nurses that all they do is injections, or the OT's just make slippers – it's narrow and silly and doesn't recognise that while these may be a part of the role of whatever discipline, we're a whole lot more than that. But it all seems to boil down to what is or isn't our stuff – not just as social workers but what is or isn't deemed appropriate for mental health services to deal with – like poverty and social issues. It's never really clear whether or not that's in our brief and it should be. But the other side of that is that with the caseloads we have to carry, we don't have a lot of time for the broader stuff, everything gets individualised to dealing with each case and the issues that come up in working with that client.*

What, then, has been the experience of same-sex oriented practitioners in these teams?

Both Janie and Gareth noted the use of humour in their interactions with colleagues

*Janie: Well, there's four lesbian staff here, and there's one gay male... But I do tease a lot of the [opposite-sex oriented] women here. Like they're talking away here, like they're talking about bad relationships. And I go "well, have you ever thought about jumping the fence? And they sort of like laugh and take it. And*

*they'll say something, and I'll say something like "well, I've always liked older women" haha. We've had a bit of fun that way, and "would you like to come out with me and the sisters sometime?" haha. Like we have a good time with it. I mean like even some of the guys here, I go "I think you're a lesbian" hah. And I actually use the word, and I'll go "M, do you think you're a lesbian?", and he'll like look at me and go "well, I do like women", and I say, "well, we've got something in common", haha "but you don't like rugby so I don't think you're really one of the sisters" haha. That sort of thing eh. I just practice in being I am who I am, and not a lot of people I think talk about their private life. Like I just talk about things very ordinary, like I have very ordinary interests. I mean, I guess there's like that expectation or some assumptions about the way I live. It was quite funny, because I was having one of the younger nurses on, and she was going like "you don't do girly nights, like you don't do shaving, waxing, blah blah blah". And I go, "no but I do face packs, nails and my hair", and that's a girly night in eh. It's about educating people that we're all very individual. There's no stereotypical...*

*Gareth: I think I cope by not taking myself too seriously. It's like I've worked in places where it's been real clear to me that coming out would not be a good move – even where other staff who've known I'm gay have advised me to keep it quiet. But now I just get on with it – and make light of it all – seems to put people at ease. I think there are some here who still don't know I'm gay – are they a bit thick or what? Haha! Maybe they just think everyone's straight until it's like in their face that that's not the case...But getting good supervision is a challenge. Someone who will be prepared to challenge me on my work with gay clients. I honestly would prefer a gay or lesbian supervisor because, like clients, it would make things easier by having someone familiar with the community - reduces a lot of the explaining over language and so on. But that's not always possible eh.*

### ***Coalface Experiences: Joys and Challenges***

It was interesting to note that the participant's reflections on positive aspects of their work with same-sex oriented consumers emphasised a perception of such consumers as sensitive and engaging:

*Daniel: I certainly found that with the second chap I referred to, very comfortable talking about feelings. He was very comfortable talking about his relationships with friends and his family... So I suppose from a case management position, ...it was interesting doing an assessment process... and to identify the feelings that were*

*present for him... So it was the only – well, definitely one of the clearest kind of difference I found... and I don't know that it was anything to do with sexuality. You know, but that's my assumption... But just got a very good therapeutic relationship, professional relationship – and tend to come away from visits feeling as if you have achieved something... And it is kind of difficult to put your finger on that.*

*Fran: All clients are wonderful. Um, the joys of working with gay men. Because they are so lovely, you have good times... But I know that something as an outsider to the gay community, I would say that that comes as part of the gay culture. In my definition of a culture, would be that the comfort levels of expressing and giving feedback and awhi feelings It's not love and the, you know - but awhi... And the creativity that comes with that, and the joy and the sharing and the laughter... Yeh, I mean. Just that whole comfort... is a lot clearer, depending on their mental state of course... But it's, um, but it's I think that the liberation that comes maybe. From having to be in a society where you're questioned just because of your sexuality. Being more comfortable in expressing when they are happy and then you've done right. And yeh, the creativity that comes with that astounds me... Most gay people I know are amazingly creative and in lots of ways. You know, in their writing or their flamboyancy and I mean the comfort of wearing a frock... Um, you know [a lesbian colleague]... describing to me that she was going off to get a pink fluoro tutu to wear to the Dyke Ball this weekend. I mean yeh. But I mean you tell me that 10 years ago and I might have thought what the f\*\*\* is she wearing that for? Haha! So it is just that comfort... And I mean... the registrar that I was telling you about... um, loves wearing his leathers. He can hardly walk in his leathers. but he loves wearing them. Turning up to work and being comfortable in that and you can imagine a, particularly when he was at Tokanui, an institution handles that behaviour. So it's that comfort, that flamboyancy, that, "Look, I am who I am and I'm really okay with it." ...And, um, I don't think the heterosexual community has an inner smidge on that happiness... So I think that comes back from clients.*

*April: ...the men that I have worked with have all been sort of really neat and um, intelligent, insight-oriented men who – I really like...I think gay and lesbian communities are able to – they have experienced life differently and they open in many ways to a whole sort of breadth of experience, which doesn't mean that... individual people aren't racist, aren't – I mean, again, it's about making generalisations. But... the guys that I have worked with have been really warm... so they have been very open about their experiences, and have made themselves*

*really vulnerable, and they have incredible strengths and wonderful senses of humour... But again I think that there is something about having, you know, that sort of survivor – and that they faced different kinds and maybe more adversities than other people in growing up – and that's made them multi-faceted and interesting...So there is something different but it is kind of hard to put your finger on what it is... I talked about the challenge in terms of the guys really wanting to be in relationships, and I guess the slip-side to that is just that it is so lovely to see men really interested in commitment – which I mean is just lovely...*

Gareth reflected on working within his own community:

*Gareth: I like working within my own "tribe". Like I said, I don't go totally with the gay culture thing but in many ways these are people from my community. It's not easy - is probably harder in fact. But I also enjoy working in mental health, and the overlap is great. I think, for me to work with another gay man, we need to ensure we have really clear boundaries. Working with other gay men in this country is sometimes like working in a small community - so it's important to recognise when overlaps in our networks are present and when these are a problem. That may mean that there are gay men I cannot work with. There is also a good chance that we may share common social settings, so that the client may see me out at venues. That can raise issues of confidentiality, so I try to ensure clients are aware that I am not gonna disclose anything about them to others. But clients need to be aware that those social spaces are mine too and that I'm not gonna discuss any of the work we're doing together in those social situations. It's also about recognising that we have a professional relationship and that a friendship even outside the professional setting would be inappropriate. I usually explain to clients that if I should meet them out and about, that I will greet them but not discuss anything related to their treatment - there are exceptions to that, um for example when someone is clearly in a crisis situation, but my response to that would be the same for any person I found in a crisis situation - to ensure immediate safety and contact the appropriate crisis service - I mean, surely we all have that responsibility.*

Esther makes a similar point with regard to same-sex oriented female consumers:

*Esther: ...for the gay women who come through as clients, some find it really difficult because again they know the people or are friends of friends of friends... For the women to actually have a therapeutic relationship with the worker is really*

*difficult because you need to get past confidentiality and the privacy issues... And we can't – we find it difficult to actually, you know, promise that as well within our workplace – so that's a huge issue.*

There was almost a unanimous identification of resourcing, particularly for referrals for ongoing support, in the participants' reflections on the key challenges to working with same-sex oriented consumers:

*April: I think that there are a lack of identified competent practitioners to refer to outside of our setting, so if someone needs therapy there aren't a whole lot of people that you know are really sound practitioners that I would feel comfortable referring to, sort of gay male identified practitioners, so one is sort of finding out who people are and then establishing relationships, and feeling that their practice is competent. Which is the same for anyone you refer to. Um, so it feels like a limited pool. Um, so there are, I guess, resourcing issues in terms of that. Ah, and again I think that our setting is pretty good about accepting sort of people from all sorts of different orientations and walks of life. And certainly the office I am in, there are a high proportion of gay staff. Either gay or lesbian, um. So whether or not they identify is variable, but at any given time there are lots of people around who are available to consult in terms of ranging from psychiatrists to nurses to social workers, so multidisciplinary representation is there. So I think if that wasn't there, that would be a challenge, but that's pretty good.*

*Blair: I think it's more acceptable within the mental health view of the normality of gay men, so it is not a real problem – it is actually... you know, like the services out there, as the challenge is to actually normalise it more... You know, for the NGO's. Like there are some service providers I wouldn't even consider... getting involved with. They are not tolerant in their understanding or whatever. Some – there are some facilities I know that are very understanding and don't have that homophobic problem – so that the challenge is finding the right place for a gay man... Yeh I've done it. I haven't been the key worker but we have done it for other gay men... and we have supported them... I think we've done a pretty good job. There's always been that bit of homophobic stuff in amongst it, but on the whole I think we have achieved a good result for that gay client and been fairly supportive ...Some gay older men don't want even to be associated with the younger, let's say, gay networks, or whatever it is, because they still are in the closet as such... it is just too much for them to, um – because, let's say, that the*

*gay lobby groups are quite, um – vocal... Whereas these gay people that we have are at the end of their lifespan. They have had actually quite a traumatic existence – you know, a lot of them hidden and have been living with their male partners for – or female partners – for years and they really have been, well they've really just been friends, and they've just not got married and all that sort of stuff. They are still hidden as such, and they just want to keep it that way. You know, they really just want to keep a low profile and that – and so, they have learnt in respect of their role development – that's how they learn to survive through years of, you know, being ostracised... That's their norm and in respect to challenges... it's their choice to remain that way – and, in some respects, it is not a detrimental thing... it is actually still going to protect them. It's protected them for years, so why try and change something that has protected them and they still feel comfortable with.*

*Esther: Resources in the community is quite limited as well for people experiencing mental illness who, you know, want to make their connections in the community... There are more resources for people who are financially able, rather than people who... you know, find it really difficult either on benefits and so forth, that the differences in resourcing is actually quite apparent as well.*

*Gareth: I think we also need to recognise the history - I mean in mental health, gay men have not had a positive history. For a lot, being involved with mental health services can be a problem in itself. And finding the right support resources is a major challenge - resources that are gay-positive and meet the client's needs like for gay men who are older, or the right sort of youth supports, or accommodation, or supports for parents. Most of the supports within the gay community are voluntary, and that's to the credit of the people involved, but there aren't many gay-specific services. Some would possibly say services don't need to be gay-specific but I've found that some clients are far more comfortable with the ones that are. I don't go along totally with the gay culture thing but I think that gay clients do deserve safe and appropriate and informed services - not just ones with a commitment to anti-discrimination but a proven record in it.*

*Janie: Not enough resources. It would be really good if we sort of like had gay maybe lesbian-specific positions, and maybe had - I mean, often we don't even address that as an issue. Often we go in and do an assessment, and nothing comes up about sexual orientation.*

Both *Esther* and *Fran* raised the issue of whether or not a same-sex oriented consumer may prefer a same-sex oriented practitioner:

*Esther:* *I think whether... I should be working with this guy – when we were talking about relationship issues and difficulties that he was having, I sensed that he actually found it really, really difficult to talk to me about that and I wonder whether it would have been different for him whether there was a male he could have actually talked to.*

*Fran:* *Being a female... Being a heterosexual... I think that they are challenges because I would have to own them with a guy as to are you comfortable working with me on these issues? With the fact that I don't have the experience and haven't had a similar life experience to you... Um, then the really good stuff happens I guess. Because I have been really fortunate to build relationships with clients and then you get to talk about your own life experiences, so the client can hook onto things about what makes them comfortable with you. And that you know, so you can say that, um, we don't have - I mean particularly we had no men social workers so you were working with men constantly and saying, "Look, I am really sorry, I wish that we had a male social worker that could start addressing your needs", and we would work to find a place where he was safe. But if I could access male supervision outside of it all or consultation and I could tell the client that, so there were ways to make them safe. So I think that that would be the super challenge for me is for them to be able to accept working with me and for me, um, because of being a female heterosexual that they would have to tell me more about their life experience for me to understand them and sometimes you are asking them to open up their book on the number of things that are personal that, um, that they might have to open more for me than they might be able to open to a man and better yet a gay man.*

## SUMMARY

This chapter has been an attempt to place the participants' contributions in a social and historical context. The history of psychiatry has been one of a discipline's search for place and identity within the discourse of medicine. That which has emerged is a manifestation of the perpetual nature of such discourse, in that it is an ongoing consideration and reconsideration of boundaries, roles, responsibilities and constructions. Psychiatry's response to homosexuality stands as an example of this, and places the discourse of psychiatry within a broader societal context, reflecting changes

in social constructions and the historical growth of social activism contesting power and knowledges. In this sense, social work is also a manifestation of the social and historical context in which it is constructed and practised. Psychiatric/mental health social work, as with psychiatry, is responding to the changes in the social and political context of the day. It has transformed, and continues to transform into diverse applications of knowledges and skills, of roles and responsibilities shared with other disciplines with a vested interest in meeting consumer needs.

Social and political changes have eased much that was previously problematic for same-sex oriented men. Declassification and decriminalisation, legislated human rights protection and proposed relationship recognition are essential to this. Yet the other side of this coin has been that while issues around a same-sex oriented consumer's sexuality and social context have been depathologised, the potential now remains to ignore these factors in our work with these consumers. This has been aided and abetted with the reforms of the health sector, reforms which have engendered a focus on the here and now, on immediate individual issues, on symptom management. The implications for this in the recent health reforms, aimed at removing the competitive/market features of the last decade or more, are yet to be seen. Will the District Health Boards allow for adequate resourcing to enable social issues/contexts to be engaged by coalface practitioners? District Health Board elections are to ensure localised representation to respond to local community needs. Will same-sex oriented consumers' needs feature?

## **8. QUEER PRACTICE**

### **- THE FOCUS GROUP DISCUSSION**

Part Two of this study involved a focus group discussion following a presentation I gave for mental health social work practitioners. This chapter offers the outline of this presentation, and then considers the responses of the participants in the focus group to three key questions: Could, would, and should a queer practice be applied?

#### **THE PRESENTATION: QUEER PRACTICE**

The purpose of the following presentation was twofold: to offer practitioners attending a consideration of queer theorising and its potential integrated application as critical social science in clinical practice, and to offer this material to the participants in the focus group for their discussion around whether or not a practice integrating queer theorising as critical social science theorising could, would, and should be applied.

#### **Practitioner as Person**

Practitioners engaged in work with same-sex oriented male consumers need to be aware of their own values, constructions and experiences. It is essential to be aware of how these underpin practice, and provide the basis for consideration and identification of a critical social science theoretical orientation.

#### **Practitioner as Queered Critical Social Science Theorist**

In considering a queered practice with same-se oriented male consumers, what may be needed is a critical social science theory that centralises sexuality (particularly homosexuality) and its construction as a point of critical analysis. Such a theory would hold a broader structural understanding, and would significantly contest tones of tolerance in theories. It would engage such theories in a reconsideration of their understandings of sex and sexuality and, through the experience of the application of such an integrated practice, enable practice (including the consumer's and practitioner's experiences) and theory to continuously inform one another. Thus, the challenge is for a cyclical model in which a critical social science theory informs and is reflected in a change or psychological theory, coming together and further developing in social work

practice with same-sex oriented male consumers. This would be a practice which continues to inform, contest and develop the theoretical understandings applied.

### *A Queered Theory: An Exercise in Queered Critical Social Science Theorising*

This particular queered theorising reflects conflict theories of social history in considering the identification of a species heteronormatively defined by sexual activity or desire. It offers a consideration of the identity and interconnectedness or 'community' emerging from the development of subjective and collective personal identities subsequent to that identification; and the heteronormative hegemony manifesting in homophobic and heterosexist structures, institutions, laws and practices of Western capitalist societies (particularly evident in the HIV/AIDS crisis).

The theorising encourages alternative understandings of the implications and applications of exclusive insider-outsider (hetero-homo) binaries (Fuss, 1991; Weeks, 1977). Subjective self understandings and collective experiences, rather than fixed identities, are acknowledged in a coalitional or collaborative commitment to the deconstruction, contestation, and ultimate eradication of oppressive heteronormative hierarchical binary categories, and to the affirmation of *differentness* and diversity in individuals, sexualities and desires, and expressions and representations of these (Davidson, 1994; Fuss, 1991; Goss, 1993; Lukes and Land, 1990; Phelan, 1995; Seidman, 1995; Weeks, 1989).

### *A Brief Queer (Psycho)Social History*

...the idea that there is such a person as a 'homosexual' (or indeed a 'heterosexual') is a relatively recent phenomenon; a product of a history of 'definition and self-definition' that needs to be described and understood before its effects can be unravelled.

(Weeks, 1989: 6)

There appears to remain some difference of opinion as to whether or not same-sex sexual activity occurred in pre-colonisation Maori society. Broughton (1996) cites Gluckman's reference to a tapu on homosexuality, but goes on to note:

However, some Maori would state quite categorically that the opposite was the case: for there to be a tapu on something, it must have existed in the first place.

(Broughton, 1996: 190).

While it seems same-sex desire and activity has been noted, with varying sanctions and controls in most societies throughout history, it was the development of capitalism, and the rearranging of social and economic relations in the new mode of production, that potentialised the eventual emergence of a homoerotic subculture. Capitalism provided opportunities, in the developing labour market of the new urban centres, for a wider range of same sex interactions and collectivity (Adam, 1979, 1995; D'Emillio, 1992; Epstein, 1992; Weeks, 1977).

The supposed liberal individualism in the transition to capitalism proposed that all were equal in possessing their labour power as their sole means of survival. A tolerance of difference, albeit conditional, reflected the declining emphasis on particular distinctions in the distribution of social benefits where all shared such equality in the public sphere, at least that was the theory (Fernbach, 1981).

However, such potential was accompanied by hostile contradictions in the continuing influence of patriarchy and Judeo-Christian morality which, in union with capitalism, demanded the application of social and economic controls, over the potential of collective homoerotic interpersonal solidarity, to ensure that the only sanctioned expressions of sexuality were those relative to production and reproduction (Weeks, 1977) or, as Foucault put it, endeavours to control sexuality were and are:

...motivated by one basic concern: to ensure population, to reproduce labor capacity, to perpetuate the form of social relations; in short, to constitute a sexuality that is economically useful and politically conservative.

(Foucault, 1992: 11)

Legal and religious controls of non-procreative sexual activity had been in place prior to the transition to capitalism, but it was under capitalism that these laws were most vehemently actioned. Such laws were focused on specific sexual activities (primarily

sodomy) rather than the later focus on types of persons (Boswell, 1992; Richardson, 1985; Schmidgall, 1994; Weeks, 1977).

As capitalism advanced, so did the urban centres and the increasing opportunities for same-sex connections and networks (Weeks, 1977). Adam (1995: 10) notes reports of men creating "...clandestine meeting places out of the sites of public encounters, while women tended to draw on their own networks for 'romantic friendships'". Weeks (1989: 73) observes that "...the nineteenth century saw an explosion of debate around sexuality" in Britain, to the extent that "...sexuality pervades the social consciousness".

Amidst such debates, the scandals of molly houses and private clubs providing opportunities for same-sex contact and cross-dressing, and infamous criminal proceedings, brought the spectre of same-sex activity more intensely to public awareness (Weeks, 1989). Such scandals were rare in 19<sup>th</sup> century New Zealand, although the expulsion of Rev. William Yate in 1836 is a marked example (Young, 1998). Broadened legislative controls, reflecting strong public reaction, also enhanced the development of a covert "...community of knowledge, if not of life and feeling" (Weeks, 1977: 22).

Foucault (1990) cites the initial identification of *the homosexual*, as an acknowledged category, in Westphal's 1870 articles positing *contrary sexual sensations* as a pathological condition in which the individual was perceived as biologically predetermined to experience same sex desire and be drawn to act on such desires.

Besides facing the moral condemnation of churches and the punishments imposed by law, gay men and women found themselves scrutinized by a medical profession that diagnosed homosexuality as a disease. In the 1880s and 1890s, when the scientific literature first appeared, doctors engaged in spirited debate over whether homosexuality was a vice indulged in by weak-willed, depraved individuals, an acquired form of insanity, or a congenital defect that indicated evolutionary degeneracy. In time, advocates of the first view dropped out of the discussion, content to leave the regulation of homosexual behavior to the church and the criminal justice system. Among proponents of a medical model, a near consensus had emerged by the early twentieth century that homosexuality was hereditary in its origins.

(D'Emilio 1983: 15)

Richard von Kraft-Ebing, who was the professor of psychiatry at the University of Vienna, published twelve editions of his *Psychopathis Sexualis* between 1886 and 1903 in which he documented case studies of sex offenders.

His elaborate classificatory system aimed to separate off natural sexuality, directed towards procreative ends, from its unnatural perverse forms - homosexuality, sadism, rape and lust murder.

(Segal, 1994: 76)

While this, and later, essentialist arguments were initially applied relative to the study and treatment of such individuals (in the still relatively young field of psychiatric medicine), it would later be extensively drawn on to legitimise arguments for legislative reform (Bayer, 1981). However, in defining the condition, the sexologists also defined the person and, thus, the potential for a broader focus of control. This categorisation of the homosexual:

...gave a name, an aetiology, and potentially the embryos of an identity. It marked off a special type of homosexual person, with a distinctive physiognomy, tastes and potentialities... The homosexual identity as we know it is therefore a production of social categorisations, whose fundamental aim and effect was regulation and control. To name was to imprison.

(Weeks, 1989: 92-93)

To name was to oppress but it was also to create the conditions for the development of a specific point of shared identity and consciousness, the potential for taking control of one's ascribed and subscribed existence (Cohen, 1993; Seidman, 1992; Weeks, 1977), or as Foucault (in Epstein, 1992: 250) puts it:

...a reverse affirmation, by which the stigmatised could gradually begin to organize around their label and begin to assert the legitimacy of their identity.

The paradox to the identification of the homosexual as a species and the subsequent self-identification lies in this identification process constituting "...the homosexual's disappearance - into the closet" (Fuss, 1991: 4).

Possibly the most significant of all who had proposed theories relative to homosexuality, Freud moved away from the view of homosexuality as degeneracy. Instead he saw homosexuality "...as a natural feature of human psychosexual existence, a component of the libidinal drives of all men and women" (Bayer, 1981: 21). This point set Freud apart from his predecessors and a number of theorists (claiming a psychoanalytic theoretical orientation) to follow who would pathologise homosexuality. A voice in this (particularly vocal in discussions around declassification) has been Charles Socarides who summarised a 1983 paper:

My findings reveal... that homosexuality has an etiology, symptomatology, and course of development, and in most cases responds well to appropriate therapeutic techniques. Thus, as a psychiatric disorder, it follows that if all punitive and persecutory laws were banished immediately - as indeed they should be - the suffering which arises from this condition would not stop. Those who advocate declaring homosexuality 'normal' betray the fundamental criterion of modern medicine which is devoted to correct diagnosis.

There is every reason to believe that since Freud first opened the door to treatment of the homosexual, offering the first opportunity for understanding and proper therapy of this complex condition, hope was offered to many who had often surrendered to despair. So it is today: the very real hope is that a favorable prognosis is quite possible in most cases when homosexuals choose to seek help.

(Socarides, 1983: 50-56)

The regulatory categorisation of the homosexual, and its identification in opposition to heterosexuality as identity and institution, was aimed to defend and protect in that:

...heterosexuality secures its self-identity and shores up its ontological boundaries by protecting itself from what it sees as the continual predatory encroachments of its contaminated other, homosexuality.

(Fuss, 1991: 2)

Thus, the perception of homosexuality as a pathological condition, fixed and constructed in opposition to heterosexuality remained a primary focus of responses to it, and understandings of it, throughout the latter nineteenth century and first two thirds of the twentieth (Yeatman, 1995). Indeed, the first edition of *DSM*, the text to become a primary reference in psychiatric diagnosis, identified homosexuality as an aspect of a sub-category of Personality Disorders.

The disruption of traditional gender relations, that emerged during World War II, provided the opportunity for a reconsideration of a wide range of oppressive social constructs in western capitalism, and set the stage for later more public communities of identity, of critical mass. Such communities rely on a shared sense of oppression or otherness, and on a common goal or agenda for the redress of that oppression. Such was the situation in the development of mid 20<sup>th</sup> century gay and lesbian movements, and the urban subcultures of differentness based on sexual orientation (Adam, 1995; D'Emilio, 1992; Duberman, 1994; Monette, 1994; Weeks, 1977).

The events around the riots at the Stonewall Inn in New York, in June 1969, must be identified as a key date in the development of these movements. In considering Stonewall, Johnston (1994: ix) notes:

The uprising of lesbians and gay men... marks a great watershed moment in both cultural history and the lives of many citizens... It was the event that catalyzed the modern gay and lesbian political movement. It changed the way thousands, ultimately millions, of men and women thought of themselves. It designated the beginning of the possibility of integrated lives for those who had lived divided against themselves – split between who they really were and what they knew they were supposed to be, between what they did and how they felt and what they said. It represented the birth of an identity unprecedented in society. Stonewall, we can see now was surely inevitable, the launching of the last revolution in a decade of civil disruptions by all disadvantaged minorities for rights and visibility.

Identity as gay or lesbian is both subjective or subscribed and projective or ascribed, and is often centred around the unparalleled act of *coming out of the closet* (Cohen, 1994, Warner, 1993), the closet being what Sedgwick (1994: 7) sees as, "...the defining structure for gay oppression in this century". Coming out has been actively encouraged since the heady days of Stonewall, and before, as a rebuttal to structural and internalised homophobia - and many have acted on this encouragement (at least to some extent) and have embraced the new community or tribe as their own (Cohen, 1994; Gearing, 1997; Signorile, 1994; Warner, 1993). Spargo (1999: 30) argues:

For lesbians and gay men, being 'out' or 'in the closet' became a crucial marker of their sexual politics. Coming out suggested emerging from confinement and concealment into the open, a movement from secrecy to public affirmation...

The outcome has been an increased public awareness, albeit often antagonistic, of the presence of a non-heterosexual community. The agenda for these movements has often primarily been legal reform - an agenda that has met with some success.

In 1963, the Dorian Society, a Wellington-based gay social group, established a Legal Subcommittee focused around the British Wolfenden Report of 1957. This would become the NZ Homosexual Law Reform Society and, although it was unsuccessful in its efforts toward legislative change, it was a beginning in attempts to address public opinion around homosexuality, no doubt further determined in their efforts following the murder of Charles Aberhart in a Christchurch Park and the subsequent acquittal of the six youths accused of his murder (Duff, 2000; Parkinson, 1989; Young, 1998).

Reflecting a medicalised construction of same-sex orientation in the 60's, Lord Cobham wrote, in declining an invitation to be patron of the NZHLRS:

These people are mentally sick to as great an extent as, for example, people suffering from smallpox are sick. The whole problem of legalizing this offence seems to me to hinge upon the extent to which the disease is contagious.

(Lord Cobham cited in Parkinson, 1989: 10)

It was with the development of Gay Liberation, in the US, following Stonewall, that out gay and lesbian activists took a focus for action against the APA in the early 1970s, as did gay APA members, to have homosexuality removed from *DSM-II* which had been published in 1968 with homosexuality specifically categorised as 302.9 under "Sexual Deviations" (American Psychiatric Association, 1968: 44).

In 1973, a tremendously embattled APA agreed to declassify homosexuality although not without considerable disquiet. Homosexuality, as a diagnostic entity, was temporarily replaced with *Sexual Orientation Disturbance*, and eventually with *Ego-dystonic Homosexuality* in *DSM-III* (Appendix 9), only to be removed in *DSM-III-R* (Bayer, 1981; Mathis, 1992; Ross, 1988). However, the current edition, *DSM-IV* retains some reference to sexual orientation:

### 302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia.

Examples include:

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation.

(American Psychiatric Association, 1994: 538)

In a cultural constructivist reading of *DSM*, *DSM-II*, *DSM-III* and *DSM-III-R*, Gaines (1992) observed that a diagnosis is little more than a snapshot understanding, interpretation or reading of a presenting range/combination of behaviours and experiences within a given subject (client/patient). Such a reading is bound in specific timed cultural constructions of acceptability and unacceptability. As Foucault would suggest, psychiatry had the ascribed authority, relative to its professional knowledges, to define/classify - to produce realities, truths and meanings (Sarap, 1993).

In 1972, in the wake of the emergence of Gay Liberation in the US, Gay Liberation groups were established in Auckland, Christchurch, Wellington, and Hamilton; and a National Gay and Lesbian Conference was organised (Young, 1998a). Parkinson (1989: 11) suggests a key factor in the emergence of such groups was Ngahuia Te Awēkotuku being declined entry to the US as a "...known sexual deviant". Duff (2000) notes the primary agenda of GLF to be decriminalisation with an equal age of consent, and anti-discrimination.

Within the growing gay social communities in other centres throughout the country, GLF groups would be established in the early-mid 70s with a focus on support, education, acceptance and reform, frequently with diverse emphases. Legislative equality was a key focus of such groups – to the extent that Bills to decriminalise same-sex activities between men was challenged by Gay Liberation due to the age of consent being older than for heterosexual activity (Duff, 2000; Young, 1998a).

The National Gay Rights Coalition (NGRC), formed in 1977, was more visible and political in its focus, drawing on international links, and "...developed a number of activities, promotions and campaigns that raised the visibility of lesbians and gays, at the same time giving a nationally networked focus for those wishing to achieve social and legal changes" (Duff, 2000: 31). NGRC would later produce the first AIDS prevention pamphlet in New Zealand (Young, 1998c).

Following police raids on gay saunas in Auckland and Wellington, a more public activism emerged, and the Gay Task Force was developed (OUT!, 1999; Young, 1998b). However, a more significant legislative reform attempt, with wider support following considerable consultation with the gay community, was not realised until the introduction of Fran Wilde's Homosexual Law Reform Bill 1985. The Bill proposed decriminalisation of same-sex sexual activity between men with an age of consent at 16 (equal to heterosexual sexual activity) and human rights protection. Highly charged rallies for and against the Bill were held in the main centres, and a petition against the Bill was proven to be grossly flawed in that only 350,000 of the claimed 810,000 signatures were valid. While the anti-discrimination component of the Bill was to be lost, the decriminalisation (Part 1) was successfully passed on 9 July 1986 (Young, 1998c). Anti-discrimination legislation, relative to a broad range of factors including sexual orientation and persons with potential illness-causing organisms, was passed in 1993 although the state was exempt until the end of the century (Duff, 2000; Gearing, 1997; Young, 1998d).

In spite of decriminalisation, declassification as a psychiatric disorder, human rights legislation, and consideration of relationship equity, heteronormatively institutionalised heterosexism and homophobia remain as constant reminders of the subordination of the homo to the hetero in the ongoing categorisation of the homosexual in opposition or subordination to the heterosexual. Hate crimes such as the murder of a Wellington youth in 1999, and the potential credibility accorded *homosexual panic* as a defence in hate crimes such as the attempted murder of Jim Curtis in 1995, remain as indicative of a fragile 'equality'. This has been particularly evident in the HIV/AIDS epidemic - the most challenging crisis we have had to face. HIV is a virus yet it has been socially constructed as gay and, in spite of the horrific impact this disease has had on other

communities, its history set the stage for homophobic negation and control (Levine, 1992). Watney (1996) complains bitterly that the response to the AIDS crisis in western heteronormative capitalist states has been unique in the history of epidemics in that it has presented as the prevention of prevention rather than the prevention of viral transmission.

### *Queer Theorising - Queer Action*

Gay men in western cultures have been perceived as "...marked men" (Nunokawa, 1991: 312). In the 1980s, AIDS re-energised the categorisation of homosexual men as sick, and as a contaminated threat to heterosexual society. However, the early inactivity or inappropriate responses also brought about a renewal of activism focused on deconstructing and demystifying oppressive structures and practices. AIDS has become the critical catalyst for transformative action (Seidman, 1992, 1995; Watney, 1996).

Queer action encourages transgression, resistance and active opposition to assimilation, Goss (1993: 38) urges that we must blatantly "...refuse to make concessions to heterosexist society in the interests of acceptability..., refuse to accept compulsory heterosexuality as social practice", and flaunt our cultural differentness. The goal is the affirmation of a differentness that is fluid and constantly changing, a queer planet in which the social construction of sexuality is free of heteronormative constructions and oppression, and homophobic violence. Such a transformative agenda is reliant on overcoming the perpetuation of an adherence to the hierarchical polarising of narrowly constructed sexualities and genders so that the potential for uniquely expressive self-understandings and personal narratives is broadened. A significant challenge to this lies in our application of purist identity politics that reinforce the hetero-homo binary.

Where gay liberation confronted a dialectic of identity and difference that revolved around straight/gay and man/woman polarities, currently these oppositions are multiplied a hundredfold as we introduce difference along the dimensions of race, ethnicity, gender, age, sexual act, class, lifestyle and locale.

(Seidman, 1993: 123)

Evidence of this diversity and adoption of multiple identities can be noted in a component of the *Male Call / Waea Mai, Tane Ma* study of men who have sex with men

in Aotearoa New Zealand which focused on assessing and improving HIV prevention in this country. Participants demonstrated varied identities beyond a pure hetero-homo binary, reflecting subjective constructs influenced by locale, age, and culture (Saxton et al, 1997). Among gay men who are Maori, for example, there is a growing self-identification, reflecting a cultural construction, as *takataapui* or 'intimate companion of the same sex' (Williams in Broughton, 1996: 191). Broughton (1996) notes Baker's more expansive construction of this:

The word takapui (or variations like takatapui and tapui) does not only refer to someone who is exclusively lesbian or gay. Like the word whanau... it is an inclusive term. All of these people (bisexuals and transpeople) are welcome because they are part of our whanau. My concept of whanau is everyone - takapui means the whole lot of us.

(Baker in Broughton, 1996: 191)

In addition to these factors, the *Male Call* study noted:

...more immediate and personal factors also appeared to influence identity. The degree of sexual attraction to men and women, disclosure of this attraction, and involvement in the gay community all affected identification. The gay milieu may ultimately be one of the most significant factors in the formation of sexual identity, and analysis suggests that sexual identity itself has relatively few significant effects over and above that of gay community attachment.

(Saxton et al, 1997: 37)

Seidman (1993) argues for the need to address differences among ourselves lest we return to the alienative approaches of a dialogue which was assumed to speak to the experiences and aspirations of all, but which only (to varying degrees) reflected white, middle class males who saw assimilation as the road to liberation. Queer theories identify a potential false consciousness in an uncontested assimilationist or reformist agenda of minority politics which potentially support the hetero over homo hierarchy.

The moment homosexuality was identified as a condition, the homosexual (as a biologically determined persona) was also identified and classified as pathologically impaired. This was the application of a social construction of a behaviour, a behaviour

which may have a physiological or genetic component, but one which has been constructed or read as the totality of the person.

The goal of queer theories and theorising is the deconstruction and demise of heteronormativity, and the potential for multiple fluid sexualities, diverse forms of relating, and the affirmation of differentness. Thus, queer theories direct action and activism in ways that contest, transgress, problematise, disrupt and contradict the hegemony of heteronormativity, and bring into question the way we construct sexualities and their expression - indeed, the ways we construct understandings and knowledges of ourselves and others.

### ***Radical Practice***

In drawing on leftist conflict theorising, within the integrated practice framework, the application of this queer theorising as a critical social science theory, places it within the realms of radical social work practice. Emerging in the 1960s and 1970s, and more recently experiencing something of a come-back, radical social work engaged what was seen to be an inadequacy in social work practice which focused on problems where they arose rather than at their source - however that might be perceived (Bailey and Brake, 1980; Lloyd, 1977; Shaw, 1994). Langan and Lee (1989: 2) argue that radical social work "...widened the scope of modern social work. It challenged the narrow preoccupation of traditional social work with the individual, introduced a wider set of issues, and put politics on the agenda."

Bearing some similarity to Fay's (1987) basic scheme for a critical social science theory, Shaw (1994) identifies five principles of radical social work approaches: that society, as a social construct, is characterised by intermittently conflicted social relations; that society comprises interrelated collectivities around social, political, educational (institutional) and cultural constructions, and that collective association or participation underlies societal ascription of relative characteristics; that people's problems are intrinsically structural in their origin while they are experienced subjectively; and that with such a structural view, in partnership with the awareness and readiness to work with people at an individual level, an ultimate vision of structural transformation is maintained and engaged. Thus, the consumer's experience of heteronormativity

(external or internal) is not their personal fault. Neither is their self-negation or erratic behaviour in coming out, or their internalising of grief, denial or trauma in the face of the AIDS crisis. These must be addressed with the consumer but not in the sense that the consumer is encouraged to wholeheartedly accept and address personal responsibility or of merely applying a process of adjustment.

An integration of queer theorising with clinical theories potentially expands the assessment process beyond a focus on the consumer as pathologically impaired or as a victim who lacks the skills to address his problems. Queering of practice would offer an understanding of sex and sexuality and how these have been, and continue to be, socially constructed relative to time and culture and the social context.

### **Practitioner as Queered Critically Informed Clinical Theorist**

In clinical practice with a same-sex oriented male consumer, the practitioner's clinical theory orientation, within an integrated practice framework, needs to reflect the practitioner's person and critical social science theorising.

Some clinical theories might be more effectively and appropriately queered in this integration of practice theories than others. For example, Freudian theorisings have been considered and contested in queer theorising (for example, de Lauretis, 1997; Lacan, 1996; Tyler, 1997). However, opportunities remain in developing, gay-affirmative approaches (for example, Davies, 1996), and in postmodern applications such as cognitive constructivism in clinical practice (Carpenter, 1996; Neimeyer, 1993, 1995; M. Lee, 1996), which may carry the potential for an integrated reflecting of queer theorising.

### **Practitioner as Queered Critically Informed Clinical Actor**

As an example of an application of postmodern constructivism, with considerable potential within a queered integrated practice framework and developed in Aotearoa New Zealand and Australia, is the work of White and Epstein (1990). Narrative approaches aim to assist the client in expanding his current constructions, his *story*, to consider alternatives, to *reauthor* his narrative in his context:

Narrative therapists see the clients in context, that is, part of a cultural whole, where views of self and the world are co-constructed in interaction with cultural and societal norms. Clients are invited to assess the truths they have assumed, and to challenge views which have not been useful.

(Kelley, 1996: 465)

Having reflectively heard the consumer's narrative, the consumer and practitioner engage a gradual process of deconstruction, of working in partnership in identifying problematic or incongruent constructions. Rather than a process of negation of the consumer's narrative, this is an engagement within that narrative, drawing out themes and assumptions in order to consider alternative truths (Kelley, 1996).

In reflecting the cognitive aspects of constructivist theory, Beck's Socratic questioning can be seen as a valid and effective technique in this deconstructive process (Rosen, 1993). The benefits of bibliotherapeutic strategies, in working with a same-sex oriented consumer in developing a self-construction, within a queered narrative cognitive constructivist integrated practice framework, cannot be understated. In my practice, I have drawn on contributions such as James Allan's (1996) collection of personal narratives of Aotearoa New Zealand men, and Noel Virtue's (1995) autobiography.

In narrative practice, the consumer's story is not contested, but alternatives are sought, in a *reconstructive* process to broaden that narrative to actively and collaboratively engage and reauthor the problematic, to see the problem in context, to see a problem and the transformative action to address it to be personal and structural (Kelley, 1996). Narrative interventions are not limited to casework alone. The potential beneficial experience of shared narratives in other modes of practice can be noted. In his autobiography Paul Monette (1994: 1-2) observes:

Until I was twenty-five, I was the only man I knew who had no story at all... That's how the closet feels, once you've made your nest in it and learned to call it home. Self-pity becomes your oxygen. I speak for no-one here, if only because I don't want to saddle the women and men of my tribe with the lead weight of my self-hatred, the particular doorless room of my internal exile. Yet I've come to learn that all our stories add up to the same imprisonment. The gutting of all our passions till we are a bunch of eunuchs, our zones of pleasure in enemy hands. Most of all, the ventriloquism, the learning how to pass for

straight... Forty-six now and dying by inches, I finally see how our lives align at the core, if not in the sorry details. I still shiver with astonished delight when a gay brother or sister tells of the narrow escape from the coffin world of the closet. Yes, yes, yes, goes a voice in my head, it was just like that for me.

### **Practitioner as Critically Informed Integrated Queered Practitioner**

In maintaining a commitment to professional development and ethical practice, it is essential that the practitioner (as with any other social worker) applying queer theorising in his/her practice, has access to appropriate, informed, productive and safe clinical practice supervision. Such access may well be limited, to say the least, and it is doubtful that it would be readily available within all practice settings.

While queer theorising does appear to meet the criteria for critical social science theorising within the integrated practice framework, it is not without its implications for the client or the practitioner. The key questions must then be *could*, *would* and *should* such a practice be applied?

## **REFLECTING ON INTEGRATED QUEERED PRACTICE:**

### **The Focus Group**

Following the presentation, a group of five, including me, met as a focus group to discuss the questions: could, would and should such a practice be applied. The other four participants were all Pakeha women. One was currently employed as a community mental health social worker, two were in senior practitioner or professional advisor roles, and the remaining participant was a social work educator.

### **Could a Queered Practice be Applied?**

There seemed to be a genuine acknowledgement that queered practice could be applied but that an appropriate knowledge base was needed, and this in turn raised questions around training and resources to support that training. The need for training and development in practice settings was viewed to be potentially problematic from the perspective of some managers who might consider that our training was meant to have prepared us, and that additional training and the necessary supervision would be costly. However, question of language and of *who* could apply such a practice were raised:

- FG5: *Who is queer? Who can call themselves queer?*
- FG1: *I mean I know that when the workshop was developed, I was with [a lesbian colleague], like I got the flyer... and I thought "integrating queer practice", I can't remember the title but I thought there'd been a typo, and then thought "oh hang on", and had to think about it, and then said to [colleague], "I haven't got on board" - although I have quite quickly lately got on board with it being an ok word again 'cause it meant all the negative things to me. it didn't mean a powerful thing about taking back the language.*
- FG5: *Right, so do you think in the first sense then that the language could be a deterrent in the 'could it be applied' sense?*
- FG2: *Think of the general world, yes... because I was aware that queer had come back, and I had heard it again and I feel uncomfortable with it because it was always pejorative in the past, and that's always been its interpretation - and, in fact, it's now almost like a symbol, a statement. It's something that the world probably isn't aware of. So you can take it back and grasp it and say this is that, why not? I think that there may have to be some sort of a promotion first to make it happen.*

### **Would a Queered Practice be Applied?**

- FG1: *Would it be applied? I think by social workers it would be applied, given that it is based on a lot of, a number of social work principals that we would use. Not saying eclectic but meaning it works well with a number of social work theories, and the way that social workers practice.*

Queer challenges of fixed identity were also considered, by the focus group, to be somewhat concerning:

- FG4: *...labels actually provide a security. They might be false consciousness but they provide a security of saying "ok, you may be able to identify more with this group of people than with this group of people who are rejecting you", because one of the things that people are looking for... is affinity. It is linking up an identity, identity outside yourself... I know identity comes from yourself, but it is also affirmed by other people, and by labels and things.*

The point, however, in a queered practice, is not to eliminate identities consumers may adopt but to work with the consumer in understanding these, deconstructing them to

expose the consumer's truths in relation to these, and work in collaboration with the consumer in reconstructing broader conceptualisations of these.

### **Should a Queered Practice be Applied?**

*FG1 ...yes it should be applied, but with the safety features - do you have to be a queer practitioner to apply it? Or do you need to have the access and the consultancy there available to ensure you apply that correctly and appropriately, and you are guided by the client?*

In considering a case considered in the presentation, the focus group noted some of the issues around training:

*FG1 ...he needs people who identify, who can identify with where he sees himself... and we know that there's queer theory out there, where do we as practitioners find out where that theory is, find out more about using it, find out someone to mentor and coach us and supervise us through the process? And I think that's where the woulds and shoulds kind of get a bit harder.*

At the outset it must be noted that the application of queer theorising as critical social science within an integrated framework of clinical practice in psychiatric/mental health clinical social work practice, as presented in this chapter, has not yet been tested in practice. Aspects of queered practice have been engaged, but the testing of queered practice needs to ensure its application potential is as diverse and creative as the practitioners and consumers involved. Testing must be safe and ethical, and must aim to consider integrated queered practice relative to its appropriateness and effectiveness in meeting consumer need and in contesting and deconstructing structural and inter/intrapersonal heteronormativity and homophobia.

As a new practice approach, as with any new or old approach, queered practice must remain open to debate, challenge and revision. Such an exchange and development of ideas is essential as it is in all aspects of social work practice - how else will practice develop and grow to meet new challenges?

A significant aspect of queered practice involves linking the consumer with others. This poses major implications for the consumer who has a psychiatric disorder. Again, the risk of alienation and rejection is a possibility. Queer theories are not widely acknowledged within the community, even within gay and lesbian communities (many are still addressing their disquiet over the use of *queer*), and there is no clear evidence to suggest that queer/lesbian/gay/takataapui/bisexual/fa'afafine/ transgender people will be any more ready than the rest of our society to accept those with psychiatric disorders into their midst.

The challenge is no less problematic for the queer psychiatric social work practitioner. As with other radical practice approaches, engaging structural factors may not be considered the business of the service or agency. Indeed, the provision of such treatment and intervention services for consumers, beyond solely addressing the more acute or chronic symptoms of the most severe of psychiatric disorders, may also be identified as outside the scope of contemporary services.

*FG5: The should aspect for me seems to be around those ethics of ensuring safety for the client and for the practitioner, supervision, all of those aspects.*

*FG1: Yep, and making sure the should is actually properly trained. Everyone started calling themselves narrative therapists a year or so ago... and it was like how many of them had actually done narrative therapy training?*

*FG4: And any change in direction in terms of how you treat clients and hopefully, in this change, of being inclusive to celebrate and accept sexual diversity has got to be supported by the system. So if it is just left to the client and the worker, then it is not going to be as successful as actually working with the system in lots of different ways to actually get all parts of the system to recognise and to give.*

## SUMMARY

Queer theorising provides a focus on heteronormativity and, when integrated with clinical theories, has the potential to expand the focus of our practice to broader critical analysis. Such an integration potentialises a critical social work practice - queer or queered practice. The potential for queered practice primarily lies in its identification of the validity of such an integration of the clinical and the critical as keys to that which makes social work unique, and in the application of a radical practice that meets the

consumer's narrative and seeks to transform heteronormative constructions and practices.

The bottom line is that queer theorising and queered practice are desperately in need of further investigation. Further efforts are needed in academic and practice-based considerations of the potential for queer theories to be integrated with clinical theories in order to develop a critical practice orientation that could meet the needs of same-sex oriented male consumers with psychiatric ill health. Considerable work remains.

## 9. QUEERING PRACTICE: A DISCUSSION

It has been almost three decades since the American Psychiatric Association declassified *homosexuality* in itself as a mental disorder warranting 'corrective' treatment. While *sexual preference*, as an exclusionary feature of the Mental Health (Compulsory Assessment and Treatment) Act 1992 in this country, can be seen as reflecting declassification, it does not suggest that same-sex oriented or gay men are exempt from mental ill health. It cannot be denied that positive legislation has made a difference to the lives and opportunities for many, but ongoing homophobic violence and external/internal heteronormative constructions and practices remain a primary problematic influence on the lives and well-being of those for whom same-sex desire or activity is a subjective reality, and bearing implications relative to, if not compounding, mental ill health.

In social work practice, we often refer to the significance of ecological assessment of the consumer *in context*, reflecting social work as psychosocial intervention focused at the interface between the consumer and his environment. However, how do we, as psychiatric/mental health social workers, understand, conceptualise or construct a consumer's context in our work with same-sex oriented men who present with mental ill health? What theoretical orientations inform our understandings of the consumer and/in his context? Indeed, how do we construct that context, and do such constructs engage a process of ongoing reflective consideration within an integrated framework of clinical psychiatric/mental health social work practice with gay male consumers? Can the theoretical ideas/frameworks upon which we base our practice adequately acknowledge and identify strategies to contest the impact of a heteronormative social context on a consumer's mental health? Indeed, is practice beyond the directly clinical permitted or possible in the contemporary practice context?

These were the questions considered in this study. I wanted to hear, to discuss, and to positively engage fellow psychiatric/mental health social work practitioners in a consideration of their integrated practice: the integration of self, of critical social science and clinical theorising applied in their practice with same-sex oriented or gay

men with mental ill health within the practice context. There are no right or wrong responses, no good or bad practitioners, merely an invitation to, and a reflection of, a discourse or critical debate that I hope will continue.

The study was two-fold. Part One consisted of unstructured interviews with ten psychiatric/mental health social work practitioners with regard to their integrated practice with same-sex oriented or gay male consumers in psychiatric/mental health settings. Part Two consisted of a half-day presentation I gave on *Integrated Queer Practice* which outlined an integrated practice framework and considered queer theorising as an example of critical social science theorising. This was subsequently reflected in clinical theorising and the application of these in relation to a mock case study. This presentation was followed by a focus group discussion to consider whether or not such a practice could, would and should be applied.

While I have not proposed a hypothesis to prove or disprove, since the focus of the project has been to initiate and encourage discourse, it has been my experience to date that most practitioners overtly/covertly draw on a primarily essentialist orientation in their construction, and that the integration of the practitioners' constructions in theory and clinical practice is somewhat problematic. This is based on a view that, in spite of homosexuality having been declassified as a psychiatric disorder, much of contemporary theory and clinical technique retains an inclination or the potential to exclude, minimalise, marginalise or even to pathologise gay male sexuality or same-sex orientation presenting in behaviour or ideation. It would seem that the potential for practitioners' consideration and integration of structural analyses, of heteronormative social constructions of gay men and gay male sexualities, as a feature of practice, is often limited in many contemporary practice settings.

### **PRACTITIONERS AS PERSONS AND AS SOCIAL WORKERS**

Whether or not the participants involved in this study are representative of social workers currently practising in mental health is not known. However, that three of the ten participants identified as same-sex oriented may have more to do with the subject matter than an indication of the proportion of psychiatric/mental health social workers who so identify.

## Language

In considering language factors, the majority of the participants noted a significantly greater comfort with *gay* as a term describing same-sex orientation, with a clear disquiet over the more confrontational *queer*. *Gay* has become a more comfortable term, it reflects and draws on a history of a politics of inclusion and assimilation which *queer* vehemently contests. Perhaps this is somewhat reflected in the preference for a number of the participants to maintain a value-base which perceives same-sex oriented persons as no different from any others.

Outside of the social context, this is possibly so. Yet it is the subjective engagement with heteronormative social contexts that makes the life experiences of same-sex oriented persons different. The perpetual subjugation of the binarised *other*, of that which is constructed as non-heterosexual, to a subordinate role status; the confinement of the closet; the continued threat of negation and verbal/physical violence establishes and maintains this difference. Legislative protection and declassification have not eliminated these. The risks remain, albeit less overtly. The effects of this must have some influence on same-sex oriented persons. Surely, this is what lies behind our need for challenging and affirming displays of pride and dignity, and celebration of diversity in events such as *Hero*. The heteronormative social context and construction of same-sex orientations, the perceived relative safety of the closet, and the inclusion of disclosure/coming out as a key aspect of our personal development. These are some of the signifiers of our *differentness*.

## Education Programs

This *same-as-anyone-else* value-stance may also explain the distinct lack of same-sex oriented material in the social work training programs for most of the participants. Little seems to be offered beyond basic homophobia workshops. The assumption seems to be that the theories and intervention methods students study can be readily applied in work with same sex-oriented consumers. However, it is argued here that without a conceptualisation of the consumer's context/environment, of the implications of heteronormative hegemony, how can they?

## Constructions

The participants' constructions of same-sex orientation reflected an awareness of the work of Kinsey and his colleagues (Kinsey et al, 1948) relative to a continuum of sexualities, but also of Hamer and his team (Hamer et al, 1993) in proposing a genetic marker, and LeVay's (1991) 'gay brain' theory. Such essentialist theorisings, as with earlier efforts, focus on etiological factors. However, in doing so, they maintain a pathologised construction of same-sex orientation, a construction which perpetuates the problematic nature of same-sex orientation.

Hamer went to some lengths to argue that his study was scientific, and that it had a liberating agenda. He indicated that if he was able to prove that same-sex orientation was genetic in its causes, then discrimination could be argued as unjust (Hamer and Copeland, 1994). This seems simple and straightforward, but any success in his efforts may well have been used for other agendas (Brown, 1993; Rose, 1998; Trewavas, 1993). The point raised by two of the participants was that such essentialist research is not warranted, that the issue is the way we socially construct, respond to and *treat* persons who identify as same-sex oriented in our interactions, our networks/family/whanau/society, and our practice.

This became apparent in the consideration of the key issues for same-sex oriented consumers, over and above their immediate mental ill health presentations, necessitating consideration in practice. Through the identification of the issues for consumers, as identified by the participants, an undercurrent of the influences and effects of heteronormativity flowed. Heteronormativity is the social construction of a social/sexual world in which that which is perceived as heterosexual is acknowledged as the norm, the standard, the *insider*, to use Fuss's (1991) term. It is this binarised structuring of sexualities which relegates that which is constructed as non-heterosexual as *the other*, the *outsider*. In so doing, it perpetuates the subjugation of same-sex oriented identification, desire and behaviour. Protective legislation and declassification ease the tensions, but do not immediately and actively contest heteronormative practises and constructions.

## PRACTITIONERS AS CRITICALLY INFORMED INTEGRATED CLINICAL PRACTITIONERS IN CONTEXT

### Critical Social Science

When the participants were asked about their theoretical orientations, four noted a baseline of critical social science, albeit to varying degrees. While the critical social science theories they identified (particularly feminism) have attempted to address issues around same-sex orientation, the participants did not elaborate on these points.

A possible exception to this was suggested in the *Te Whare Tapa Wha* model outlined by one participant. *Hamish's* presentation of his practice orientation was an integration of a world view, individual presentation, and engagement/intervention strategies within a cultural context.

While acknowledging this, the question remains: what has happened to our critical social analysis in social work? Have changes in the identified roles and responsibilities and configuring of service delivery moved our scope of focus in our practice away from the socio-political? These questions remain unanswered but are ones which social work research could well consider.

### Clinical Theory/Practice Models

This more constrained scope of practice was further suggested in the practitioners' ready identification of clinical theorisings as their baseline for practice. However, even in this, there appeared to be a leaning toward the identification of practice models without identification of the theories informing such models.

The clinical theories identified were not surprisingly drawn from the range of clinical theories which could be broadly acknowledged as *psychosocial* in their emphasis on the intra/interpersonal. Yet in the absence of critical social science theorisings the scope of the *social* aspect is significantly more focused on immediate networks/context. Nevertheless, the participants readily reflected on the application of their theory base in reference to their practice with same-sex oriented consumers.

There was a clear emphasis on anti-discriminatory practice models and the kind of recovery models recently advocated by the Mental Health Commission (2000, 2001). What is absent from these is an awareness and problematising of heteronormativity as a contestable factor in the well-being of same-sex oriented consumers. To oppose discrimination and oppression is central to social work, but by what means? Certainly, it might be said that anti-discriminatory practice models are critical social work, but the non-identification of the critical social science theorisings which inform such models leave one unclear of the agenda or transformative action proposed. An identified critical social science analysis would not only identify the objective or anticipated outcome, but also offer a construction of the crisis and how the proposed transformative action might meet such an outcome.

### **Context**

It could be suggested that the contemporary context of practice does not allow for such an analysis, that the restructurings and redefined boundaries of the practice field over recent years have necessitated a shift in a practitioner's focus to managing the here and now presentations. It could be argued that the scope of psychiatric/mental health social work practice has narrowed, by necessity of demand on limited resources, to a more generic role of symptom and risk management.

### **FOCUS GROUP**

The narrowing of scope of practice was reflected, to some extent, in the focus group discussion (Part Two of this study), following a presentation of an example of a potential integration of critical social science and clinical practice with a same-sex oriented mental health consumer. The questions posed were: should, would, and could such a practice be applied? The participants in the focus group discussion all agreed such a practice should be applied, but whether or not it could or would raised questions around the structure and demands of the field. Is it, after all, the business of contemporary psychiatric/mental health services to challenge heteronormativity? Is it in the brief of such services to address issues/structural variables potentially impacting on a consumer's well-being?

However, the focus group also raised a significant concern regarding the appropriate supervision of practitioners engaged in such work with same-sex oriented consumers. In an analysis of contemporary social work supervision, O'Donoghue (2001: 34) notes:

The analysis of the present in the macro assessment reveals: a) an active profession operating within a limited sphere of influence in a environment facing significant change in the form of the state registration of social workers; b) a social policy environment of high demand and low support for social work supervision; c) a service operating environment dominated by the interests of purchasers and management in which professional supervision is reconstructed by the business management and accounting paradigm.

The micro assessment reveals: 1) whilst clients are perceived to be the *raison d'être* for supervision they have no voice and little involvement in the supervision process; 2) supervisees experience a gap between the rhetoric and reality of supervision with reports of variable experiences, limited choice, and being socialised to a particular form of supervision that is arguably unresponsive to them, their practice experiences and the 'just do it' practice environment; 3) supervisors face challenges arising from role conflicts in which they manage multiple and conflicting accountabilities, responsibilities and relationships with limited access to resources that facilitate best supervisory practice; 4) agencies perceive supervision both as a production cost that needs to be managed and risk management system for the agency's protection and are caught in the double-bind of wanting to control the cost of supervision without the responsibility for the practice of supervision.

With this in mind, there are clearly significant challenges in access to queer-appropriate supervision, or to supervisors with an awareness of queer theorisings. In order for supervision to provide the practitioner with an opportunity to reflect on critical social science applications within their practice, supervision must be able to move beyond and contest the apparent "here and now" symptom and risk management focus of the contemporary practice context.

### SUMMARY

Ten psychiatric/mental health social workers were interviewed with regard to their practice with same-sex oriented male consumers, their experiences and constructions around same-sex orientation, the theories informing such practice, and the application of these within an integrated practice framework.

The participants' self-reflective discourses reflect the diversity of understandings and challenges of practice with this consumer group within the constraints of the contemporary psychiatric/mental health social work practice context. Social work practice within this practice field reflects the extensive changes in service definition and models of delivery subsequent to the extensive reconfigurings of the health sector over recent years. This has left many of the practitioners with a "here and now" focus on the management of symptom and risk within an immediate context. It could be argued that this could narrow the scope of practice at the expense of active contestation of heteronormative social constructs impacting on the well-being of same-sex oriented consumers. However, even within the contemporary practice context and the constraints on practice, practitioners maintain a commitment to the task and to providing consumers with the best possible service:

*Gareth: I dunno, you just get on with it at the end of the day. It can be frustrating but, I mean, the clients are why we're there and you just have to be creative and do what you can. I still wouldn't swap for any other kind of work.*

## 10. CONCLUSION

This thesis has endeavoured to encourage and engage a discourse around how some psychiatric/mental health social workers construct same-sex orientations, and how they reflect these constructions and the theories they draw on in an integrated framework of practice with same-sex oriented male consumers who present with mental ill health. This has been engaged, in Part One of this study, through an initial consideration of ten psychiatric/mental health social workers' reflections on their practice with such consumers within the contemporary context of psychiatric/mental health social work practice in Aotearoa New Zealand. Such a consideration is contextualised within a brief overview of the development of psychiatry and its primary diagnostic text, the treatment of same-sex oriented men within psychiatry, and the relevant policy and legislative measures which have contributed to and influence the contemporary practice context in this country.

In Part Two of the study, a *queering* of practice or integration of queer theorising as an example of critical social science theorising, was considered by a focus group following a presentation to mental health practitioners. The questions put to the focus group invited a discussion around whether or not such a practice should and would be applied in practice with same-sex oriented male consumers who present with mental ill health in Aotearoa New Zealand.

The focus of this project was to initiate and encourage discourse rather than to propose a hypothesis to be proven. However, it has been my experience that most practitioners overtly/covertly draw on a primarily essentialist orientation in their construction, and that they find the integration of their constructions in theory and clinical practice is somewhat problematic. This is based on a view that, in spite of homosexuality having been declassified as a psychiatric disorder, much of contemporary theory and clinical technique retains an inclination or the potential to exclude, minimalise, marginalise or even to pathologise gay male sexuality or same-sex orientation presenting in behaviour or ideation. It was interesting to note that while a number of the participants in this study did acknowledge an awareness of (and even some degree of adherence to) essentialist constructions of same sex orientation, others questioned such constructions.

They noted that while there may be some biological/genetic features of sexual orientation, environment and experience may also play a role.

Others contested the question of an essentialist versus social constructionist posit. For these participants, the question was not about why an individual is same-sex oriented or what causes this, but rather why it seems to be considered problematic. Indeed, it was perceived as more significant that research consider means to contest manifestations of heteronormativity and its subjugation of same-sex orientations.

Such a stance recognises that research into etiological features, while possibly carrying a liberating agenda, also carries risks in that the subsequent use of such research may be anything but liberating. An example of such a risk can be noted in the movie *Twilight of the Golds* (Marks, 1996) in which a woman learns her unborn baby may carry a gene for same-sex orientation. The movie centres around her dilemma over continuing with the pregnancy or abortion. This is the kind of risk taken in etiological research, that the results and technology may be applied to other agendas.

Furthermore, it could be argued that the potential for practitioners' consideration and integration of structural analyses, of heteronormative social constructions of gay men and gay male sexualities, as a feature of practice, is often limited or constrained in many contemporary practice settings through a policy-driven narrowing of the scope of practice. This narrowing of the scope of practice appears to have emerged through the immense reconfiguring of the health sector in which core services were increasingly targeted. The result has been that, for some practitioners, limited resources and high caseloads within a more residual welfare and practice context have necessitated a focus on the "here and now" management of risk and symptoms. Yet, in spite of this, there is a clear commitment to quality practice, and to a perpetual endeavour to provide consumers with the best possible service.

The delivery of an integrated practice, particularly one integrating a form of queer critical social science theorising, was considered by the focus group in Part Two of this study. The group proposed that while such a practice could and even should be applied, the contemporary context of practice and supervision would pose a significant challenge

in the access to appropriate supervision, and in the identification of what contemporarily constitutes the business of mental health services.

### **LIMITATIONS**

All research has its limitations, and this study is no exception. Most apparent of these limitations within this study must be the group size. A group of ten is not a particularly large number in spite of the depth of the interviews. However, this is an exploratory study, and as a qualitative study I was searching for meanings and interpretations of the experiences of social workers working with a particular population of clients/consumers.

As has been noted, the extent to which this sample is demographically representative of psychiatric/mental health social work practitioners in and around Auckland, remains an unknown factor. When this study was put proposed for consideration by the Massey University Human Ethics Committee, the proposal did not include approval for me to contact social work advisors or team leaders to access additional demographic data regarding psychiatric/mental health social workers who were not actively participating in this study.

The interviews were scheduled but unstructured. While this leaves each participant with greater opportunity to offer a broader and more diverse content in his or her discourse, it also risks the withholding of some content in the absence of questions seeking specific information. A more structured interview schedule may have drawn more information, although this would have weakened the invitation to discourse in favour of a process of answering questions. Nevertheless, it should be noted that questions were asked and clarification was sought with the participants in the interviews and the focus group.

A further limitation to the study lies with my own level of experience. This has been a significant learning experience for me. It is the first significant piece of research I have undertaken and, while I have some interviewing skills as a social worker, I was engaging in a learning process about research techniques.

### IMPLICATIONS: WHERE TO FROM HERE?

I do not anticipate that this study will shake the world, so to speak, but that was not the purpose of the project. The objective was to contest and transgress the silence encouraged by some for whom discourses around sex and sexuality which contest heteronormativity are disquieting; to invite and encourage discussion around same-sex orientation in psychiatric/mental health social work practice, and to bring considerations around same-sex orientation in from the periphery and centralise such a discourse. The comprehensive literature review on the topic and related factors, discussions with colleagues, and reflecting on my own practice were key features of this. However, to the extent that ten social work practitioners, the attendees at the presentation on *Queered Integrated Practice*, and the participants in the focus group discussion did engage such a discourse, then this objective has been realised, at least to some degree.

However, the group involved were from a larger urban area with the country's largest out same-sex oriented population. Would there be a different content to, or themes in, the discourses in another region of the country? Would the findings differ considerably if this study was to be repeated with rural psychiatric/mental health social work practitioners? Perhaps this is a study worthy of some consideration.

The findings in this study go beyond discussion around same-sex orientation and coalface practice with same-sex oriented men who present with mental ill health, since such a consideration necessitates an awareness of the contemporary practice context. For some, it would seem that a decade or more of health sector reforms have contested the scope of analysis and practice.

It could be argued that high caseloads and limited resources, a narrowing scope of what constitutes the core business of mental health services, and managerial efforts to balance quality service delivery with cost effectiveness, have left some practitioners with no choice but to pragmatically meet "here and now" presentations in order to continue to provide consumers with the best possible service. One is left wondering whether the scope will again broaden with the most recent changes in the health sector. Will the District Health Boards seek such a broadening?

As has been noted throughout this thesis, social work is about that integration of the political and the personal, the social and the individual, the structural and the clinical. Hancock observes that:

...social work takes seriously the social context in which it finds itself. At certain times the profession has attended very closely to the needs of the individual, and at other times to the social order. The social change element is right there at the heart of it. You cannot separate out individual needs from the social order... The two are inseparable and must go hand in hand.

(cited in Munford and Nash, 1994: 9)

Such questions could well be considered within a broader study of the development and contemporary constructions of psychiatric/mental health social work in Aotearoa New Zealand. There has been little published on this subject in recent years.

The application of queer theorising, as presented in Chapter 8 warrants further study. Queered Practice, as it has been presented, is at present purely academic. It has not yet been tested in practice. The closest to it are the gay/lesbian-positive approaches (for example, Ball, 1994; Biller and Rice, 1990; Davies, 1996; Irving et al, 1995; Isay, 1993; Rabin et al, 1996). The testing of queered practices needs to ensure its application potentials are as diverse and creative as the practitioners engaging it. Testing must be safe and ethical in its aim to consider queered practices relative to its appropriateness and effectiveness in meeting consumer need, and in contesting and deconstructing heteronormativity. Queered practices must remain open to discourse, contesting and revision. This is essential, as it is in all aspects of social work practice.

This thesis has focused on practitioners. However, there are other voices which must be heard from the coalface of clinical encounters. What are the experiences and understandings of same-sex oriented men who have presented with mental ill health? What works for them, and what needs to be contested? This would be an exceptionally valuable study.

This thesis poses questions, it transgresses an apparent silence around same-sex orientation and psychiatric/mental health social work practice with same-sex oriented

men, and it invites an ongoing reflective consideration and discourse. As a consumer speaking at a mental health conference noted:

To attempt to deal with the subject of schizophrenia and sexuality openly and honestly is to have to first clear a path through a huge number of unproductive and destructive myths. We must, as consumers, attempt this for in the process of “coming out” as psychiatrically disabled citizens in our society, part of the restoration of our full human dignity is the need to have our sexuality acknowledged, respected and embraced as a fundamental right central to fulfilment of our human potentials.

(Champ, 1993: 172)

## APPENDIX 1

### INFORMATION SHEET

<p><b>QUEER PRACTICE: A Consideration of Some Psychiatric/Mental Health Social Work Practitioners' Constructions of Gay Male Sexualities</b></p>
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<p><b>INFORMATION SHEET</b></p>
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Thank you for your interest in this project. It is hoped that the following information will assist you in making an informed decision regarding your involvement in the project.

#### **Who is the Researcher?**

My name is Mathew Keen and I am a gay man currently involved in preparing my thesis toward a Master in Social Work with the School of Social Policy and Social Work at Massey University (Turitea Campus).

I have worked as a psychiatric/mental health social worker since 1991 in secondary care long-stay rehabilitation, day hospital, forensic services, and (more recently) in a regional acute mental health service, where I provide social work services to inpatient clients, clients accessing the local mental health crisis service, and carry a small outpatient caseload - including facilitating an outpatient group for gay and bisexual men who have moderate-severe mental ill-health. I am also a clinical supervisor, and have recently completed the Advanced Certificate in Dual Diagnosis (CIT)

Over the past few years, I have become particularly interested in the mental health needs of gay and bisexual men. My Masterate studies have significantly focused on this - in particular on how we, as mental health/psychiatric social workers, engage and address the needs of gay and bisexual men who experience mental ill-health; and on the application of theory to practice within an integrated framework.

I am currently in the process of preparing a chapter, on queer psychiatric social work practice, for an edited text. It should be noted that I may draw on aspects of this project in that chapter.

#### **What is the Study about?**

This study is about the constructions or understandings some psychiatric/ mental health social work practitioners have of gay men and gay/same-sex oriented male sexualities, what informs these understandings and their development, and how the practitioners integrate, reflect and apply these constructions in their practice with gay/same-sex oriented male clients who present with mental ill-health.

The purpose of this project is not to identify 'good' or 'bad' psychiatric/mental health social work practitioners. Rather, the purpose is to understand, through a consideration of the practitioners' self-reflective narratives and focus group discourse, and from an approach of positive regard for the participants, how the practitioners have developed their understandings of and about gay men and gay/same-sex oriented male sexualities, and how they have integrated these understandings in their practice at theoretical and clinical practice levels with clients. There are no 'right' or 'wrong' responses, since it is the narrative/ discourse that is the focus. My intention is to encourage discourse among practitioners, to invite consideration of how we construct our understandings and reflect such understandings in practice.

### **What will Participants be invited to do?**

The study is made up of three stages: Having consented to participating in the project, based on the information provided in this Information Sheet and having had any questions satisfactorily answered, each participant would be interviewed individually, by me, at a convenient time for the participant, and possibly in rooms at the Massey University Albany campus unless there is somewhere more comfortable for the participant.

The interview will take no longer than one and a half hours. It would begin with some brief demographic data, and would then consist of an unstructured discussion around:

- the social worker as a person - values and experiences regarding gay men and gay male sexualities;
- the social worker as a social worker - training and knowledge about gay men and gay male sexualities;
- the social worker as informed by theory - the theory or theories that inform the social worker's practice and how these explain and respond to gay men and gay male sexualities; and...
- the social worker as a clinical practitioner - how the above come together in the social worker's work with gay men who present with mental ill-health.

The interview would be audio-taped and, later, transcribed - the Transcriber will have signed a statement of confidentiality. This will be with the participant's consent. The participant may withdraw consent at any stage and have the interview and taping paused or terminated on request.

Once the interview audiotape has been transcribed, the participant will be sent a copy of his/her transcript accompanied by a letter inviting him/her to amend this and return it to the me. If this is not returned to me, I will assume consent has been withdrawn.

At the conclusion of the individual interview, all participants will be invited to attend a half-day presentation in which I will offer a model of Integrated Queer Practice. Participants will also be invited to be part of a focus group discussion on the material from the presentation. Participants who are interested in attending the half-day presentation and participating in the 1½-2 hour lunchtime focus group discussion, will be invited to sign a Consent to Focus Group Participation and the Focus Group Confidentiality Statement. I am happy to discuss these with you.

The focus group discussion will be facilitated by me, over lunch, with other participants. This will be held in a room at the Massey University Albany campus, and lunch will be provided. The focus group discussion will be an unstructured discourse considering the presentation on Integrated Queer Practice - particularly around questions of '*could* such a model be put into practice?', '*would* such a model be put into practice?', and '*should* such a model be put into practice?'. The focus group discussion will also be audio-taped and that this too will be transcribed.

### **What can the Participants expect from the Researcher?**

It must be stressed that the purpose of this project is to encourage discourse around how we, as social work practitioners in mental health, work with gay men who present with mental ill-health - what informs our understandings and how these understandings are reflected in our practice. My approach is to be one of positive regard for the participants, of encouraging discourse, and later to apply a textual discourse analysis, informed by queer theorising, toward an understanding of the material participants contribute. This project is not about judging practitioners, but engaging them.

All participants, and their personal information and contributions, will be treated with the utmost respect and positive regard. I will make every effort to ensure your confidentiality is maintained, and that the process is a safe and positive experience for you.

Please feel free to contact my supervisors and discuss the project with any of them. They are:

- Associate Professor Robyn Munford  
School of Social Policy and Social Work, Massey University, Private Bag, Palmerston North - ph (06) 356 9099.
- Carole Adamson  
Lecturer, School of Social Policy and Social Work, Massey University, PO Box 102904, North Shore Mail Centre - ph (09) 443 9771.
- Dr Lynne Alice  
School of Sociology and Women's Studies, Massey University, Private Bag, Palmerston North - ph (06) 356 9099.

I am also available to provide you with any further information you feel you need, and I will make every effort to ensure all your questions are answered. Please feel free to contact me through my Auckland-based supervisor, Carole Adamson.

### **Interested?**

If you are interested in participating in this project, please complete the attached Consent Form (Consent to Interview) and forward this to me C/- Carole Adamson, Lecturer, School of Social Policy and Social Work, Massey University, PO Box 102904, North Shore Mail Centre, Auckland.

Regards

Mathew Keen

## APPENDIX 2

### CONSENT TO INTERVIEW

<p><b>QUEER PRACTICE:</b>  <b>A Consideration of Some Psychiatric/Mental Health          Social Work Practitioners' Constructions          of Gay Male Sexualities</b></p>
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<p><b>CONSENT TO INTERVIEW</b></p>
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I have read the Information Sheet, and I have had any questions I might have satisfactorily answered, with regard to this project.

I give my consent to being a participant in this project. I acknowledge the following points in this consent:

1. That I am aware that any further questions which I may have will be answered.
2. That I am agreeing to participate in an unstructured discussion with Mathew Keen, and that I am aware that this interview is to be audio-taped and transcribed. I agree/do not agree to the interview being audio-taped.
3. That I can have the audio-taping of my interview stopped/paused at any time during the interview should I have a question or concern, or wish to stop the interview.
4. That I will be sent a copy of the transcript from my interview and that I can amend this transcript and return it to Mathew Keen within 2 weeks of receiving it. I am also aware that if I do not return this to Mathew Keen, it will be assumed that I have withdrawn my consent.
5. That I am aware aspects of the information from this project may be drawn on in a chapter Mathew Keen is preparing for an edited text.
6. That I can withdraw this consent verbally or in writing at any time prior to the transcribing of the audio-tape of my interview.

Name: (Mr/Ms/Mrs/Miss/Dr) \_\_\_\_\_

Contact Address: \_\_\_\_\_

Phone: (Home) ( ) \_\_\_\_\_ (Work) ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

When is the best time to contact you? \_\_\_\_\_

When and where would you prefer to be interviewed? \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX 3

### INTERVIEW GUIDELINE

**QUEER PRACTICE:  
A Consideration of Some Psychiatric/Mental Health Social Work Practitioners'  
Constructions of Gay Male Sexualities**

### INTERVIEW GUIDELINE

#### ■ Demographic Material

- Preferred name
- Age group
- Gender identity
- Sexual orientation
- Cultural identity
- Brief career history
- Current role/service
- Professional association

#### ■ Social Worker as a Person

- Values and experiences regarding gay men and gay male sexualities
  - Experiences of contact with gay men in personal life
  - Values and beliefs about homosexuality
  - Preferred language
  - Comfort with language

#### ■ Social Worker as a Social Worker

- Training and knowledge about gay men and gay male sexualities
- Books/articles read

#### ■ Social Worker as Informed by Theory

- The issues the social worker sees as primary for gay men presenting with mental ill-health in addition to the client's mental ill-health
- The theory or theories that inform the social worker's practice
  - How these explain and respond to gay men and gay male sexualities
  - How these explain and respond to the primary issues for gay men with mental ill-health

**■ Social Worker as a Integrated Clinical Practitioner**

- How the above come together in the social worker's work with gay men who present with mental ill health.
- Context of practice
- Practice challenges in working with gay men with mental ill-health
- Positive aspects of working with gay men with mental ill-health

**■ Additional Comments or Questions from the Social Worker****■ Conclusion**

- Discuss feedback opportunity on transcript
- Discuss disposal of tape - return to participant at conclusion of thesis?
- Confirm date and venue for presentation
- Confirm date and venue for focus group discussion (if applicable)
- Ensure participant has contact numbers and addresses for any concerns
- Ensure participant has safe transport

## APPENDIX 4

### TRANSCRIBER'S STATEMENT OF CONFIDENTIALITY

**QUEER PRACTICE:  
A Consideration of Some Psychiatric/Mental Health  
Social Work Practitioners' Constructions  
of Gay Male Sexualities**

#### TRANSCRIBER'S STATEMENT OF CONFIDENTIALITY

I acknowledge that I have been employed, by Mathew Keen, to transcribe audio-taped interviews and a group discussion which were recorded by Mathew Keen for this project.

I agree to keep confidential all the information contained in the audio-tapes, and the completed transcripts.

I agree to ensure all materials in my possession, related to this project, are securely stored until all such items have been handed over to Mathew Keen.

Signed \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

## APPENDIX 5

### LETTER ACCOMPANYING PARTICIPANT'S INTERVIEW TRANSCRIPT

<MASSEY UNIVERSITY LETTERHEAD>

Mathew Keen  
C/- Carole Adamson  
Lecturer  
School of Social Policy and Social Work  
Massey University  
PO Box 102904  
North Shore Mail Centre  
AUCKLAND

<PARTICIPANT'S NAME>  
<PARTICIPANT'S ADDRESS>

<DATE>

Dear <PARTICIPANT'S NAME>

**Re: QUEER PRACTICE: A Consideration of Some Psychiatric/Mental Health  
Social Work Practitioners' Constructions of Gay Male Sexualities - Your  
Transcript**

Please find enclosed the transcript for your interview. While there may be a few typos and errors, hopefully none will change the meaning of your comments. Please correct any you find.

Now is also your opportunity to make any amendments you would like to make. Should you need to do this, please return it to me at the above address. I will really need to know of any amendments or corrections by <DATE>, so please return it to me as soon as possible. A stamped and addressed envelope is enclosed. If you choose not to return your transcript to me, by that date, I will assume that you have withdrawn your consent.

I would like to take this opportunity to thank you for your contribution to this project. Throughout the interview process, I was intensely impressed and moved by the participants' honesty and openness with regard to their professional and personal experiences. Thank you so much.

Regards

Mathew Keen

## APPENDIX 6

### INTERNATIONAL FEDERATION OF SOCIAL WORKERS

#### DEFINITION OF SOCIAL WORK

##### **Definition<sup>1</sup>**

The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

##### **Commentary**

Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and the communities they serve. Social work is an interrelated system of values, theory and practice.

##### **Values**

Social work grew out of humanitarian and democratic ideals, and its values are based on respect for the equality, worth and dignity of all people. Since its beginnings over a century ago, social work practice has focused on meeting human needs and developing human potential. Human rights and social justice serve as the motivation and justification for social work action. In solidarity with those who are disadvantaged, the profession strives to alleviate poverty and to liberate vulnerable and oppressed people in order to promote social inclusion. Social work values are embodied in the profession's national and international codes of ethics.

##### **Theory**

Social work bases its methodology on a systematic body of evidence-based knowledge derived from research and practice evaluation, including local and indigenous knowledge specific to its context. It recognises the complexity of interactions between human beings and their environment, and the capacity of people to be both affected by and to alter the multiple influences upon them including biopsychosocial factors. The social work profession draws on theories of human development and behaviour and social systems to analyse complex situations and to facilitate individual, organisational, social and cultural changes.

##### **Practice**

Social work addresses the barriers, inequities and injustices that exist in society. It responds to crises and emergencies as well as to everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities consistent with its holistic focus on persons and their environments. Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development. These include counselling, clinical social work, group work, social pedagogical work, and family treatment and therapy as well as efforts to help people obtain services and resources in the community. Interventions also include agency administration, community organisation and enacting in social and political action to impact social policy and economic development. The holistic focus of social work is universal, but the priorities of social work practice will vary from country to country and from time to time depending on cultural, historical, and socioeconomic conditions.

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1. This international definition of the social work profession replaces the IFSW definition adopted in 1982. It is understood that social work in the 21<sup>st</sup> century is dynamic and evolving and therefore no definition should be regarded as exhaustive.

## APPENDIX 7

## CONSENT TO FOCUS GROUP DISCUSSION

**QUEER PRACTICE:  
A Consideration of Some Psychiatric/Mental Health Social Work  
Practitioners' Constructions of Gay Male Sexualities**

**CONSENT TO FOCUS GROUP DISCUSSION**

I have read the Information Sheet, and I have had any questions I might have satisfactorily answered, with regard to this project.

I give my consent to being a participant in this project. I acknowledge the following points in this consent:

1. That I am aware that any further questions which I may have will be answered.
2. That I am agreeing to attend a presentation on Integrated Queer Practice to be held at the Massey University Albany campus.
3. That I am agreeing to participate in an unstructured focus group discussion with Mathew Keen and other participants in this project, at the Massey University Albany campus, and that I am aware that this discussion is to be audio-taped and transcribed. I agree/do not agree to this discussion being audio-taped.
4. That I can have the audiotaping of this discussion group stopped/paused at any time during the during should I have a question or concern, or wish to withdraw from the discussion.
5. That I am aware aspects of the information from this project may be drawn on in a chapter Mathew Keen is preparing for an edited text.
6. That I can withdraw this consent verbally or in writing at any time prior to the focus group discussion.

Name: (Mr/Ms/Mrs/Miss/Dr) \_\_\_\_\_

Contact Address: \_\_\_\_\_

Phone: (Home) ( ) \_\_\_\_\_ (Work) ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

When is the best time to contact you? \_\_\_\_\_

Lunch is to be provided for the focus group discussion. Do you have any dietary requirements which must be met? \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## APPENDIX 8

### FOCUS GROUP STATEMENT OF CONFIDENTIALITY

**QUEER PRACTICE:  
A Consideration of Some Psychiatric/Mental Health  
Social Work Practitioners' Constructions  
of Gay Male Sexualities**

#### FOCUS GROUP STATEMENT OF CONFIDENTIALITY

I acknowledge that I have agreed to participate in the focus group discussion to be facilitated by Mathew Keen, as part of this project.

I agree to keep confidential the identity of all persons within the focus group, and any information and views expressed in the focus group discussion.

Signed \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

## APPENDIX 9

### OTHER PSYCHOSEXUAL DISORDERS

#### 302.00 Ego-dystonic Homosexuality

The essential features are a desire to acquire an increased 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.

This category is reserved for those homosexuals for whom changing sexual orientation is a persistent concern, and should be avoided in cases where the desire to change sexual orientations may be brief, temporary manifestations of an individual's difficulty in adjusting to a new awareness of his or her homosexual impulses.

Individuals with this disorder may have either no or very weak heterosexual arousal. Typically there is a history of unsuccessful attempts at initiating or sustaining heterosexual relationships. In some cases no attempt has been made to initiate a heterosexual relationship because of the expectation of lack of sexual responsiveness. In other cases the individual has been able to have short-lived heterosexual relationships, but complains that the heterosexual impulses are too weak to sustain such relationships. When the disorder is present in an adult, usually there is a strong desire to be able to have children and family life.

Generally individuals with this disorder have had homosexual relationships but often the physical satisfaction is accompanied by emotional upset because of strong negative feelings regarding homosexuality. In some cases the negative feelings are so strong that the homosexual arousal has been confined to fantasy.

**Associated features.** Loneliness is particularly common. In addition, guilt, shame, anxiety, and depression may be present.

**Age of onset.** The most common age at onset is during early adolescence when the individual becomes aware that he or she is homosexually aroused and has already internalized negative feelings about homosexuality.

**Course.** There is some evidence that in time many individuals with this disorder give up the yearning to become heterosexual and accept themselves as homosexuals. This process is apparently facilitated by the presence of a supportive homosexual subculture. It is not known how often the disorder, without treatment, is self-limited. However, there is a general consensus that spontaneous development of a satisfactory heterosexual adjustment in individuals who previously had a sustained pattern of exclusively homosexual arousal is rare. The extent to which therapy is able to decrease homosexual arousal, increase heterosexual arousal, or help homosexuals become satisfied with their sexuality is disputed.

**Impairment.** There is generally no or only mild impairment in social functioning.

**Complications.** Dysthymic Disorder can be a complication.

**Predisposing factors.** Since homosexuality itself is not considered a mental disorder, the factors that predispose to homosexuality are not included in this section. The factors that predispose to Ego-dystonic Homosexuality are those negative societal attitudes toward homosexuality that have been internalized. In addition, features associated with heterosexuality, such as having children and socially sanctioned family life, may be viewed as desirable and incompatible with a homosexual arousal pattern.

**Prevalence, sex ratio, and familial pattern.** No information.

**Differential diagnosis.** Homosexuality that is ego-dystonic is not classified as a mental disorder. In addition, the attitude that "I guess life would be easier if I were heterosexual" does not warrant this diagnosis. This category is reserved for homosexuals for whom changing sexual orientation is a persistent

concern. Similarly, distress resulting simply from a conflict between a homosexual and society should not be classified here.

Individuals with **Inhibited Sexual Desire** may sometimes attribute the lack of sexual arousal to "latent homosexuality." However, Ego-dystonic Homosexuality should be diagnosed only when homosexual arousal is overt, although it may be limited to fantasy.

**Homosexuals who develop a Major Depression** may then express self-hatred because of their sexual orientation. The diagnosis of Ego-dystonic Homosexuality should not be made if the ego-dystonic quality is judged to be only a transient symptom of a Depressive Disorder.

Diagnostic criteria for Ego-dystonic Homosexuality

A. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships.

B. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

### **302.89 Psychosexual Disorder Not Elsewhere Classified**

This is a residual category for disorders whose chief manifestations are psychological disturbances related to sexuality not covered by any of the other specific categories in the diagnostic class of Psychosexual Disorders. In rare instances this category may be used concurrently with one of the specific diagnoses when both diagnoses are necessary to explain or describe the clinical disturbance.

**Examples include the following:**

- (1) marked feelings of inadequacy related to self-imposed standards of masculinity or femininity, such as body habitus, size and shape of sex organs, or sexual performance;
- (2) impaired pleasure during the normal physiological pelvic responses of orgasm;
- (3) distress about a pattern of repeated sexual conquests with a succession of individuals who exist only as things to be used (Don Juanism and nymphomania);
- (4) confusion about preferred sexual orientation.

(American Psychiatric Association, 1985: 281-283)

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