

Questioning heteronormativity: using queer theory to inform research and practice within public mental health services

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Queer theory is often maligned as being inadequate for advancing social justice. So, how might queer theory guide research and practice in public mental health services (PMHS)? Within the research on mental health issues for lesbians, gays and bisexuals (LGB) there are calls for making mental health services more LGB affirmative. Mostly this scholarship is from the field of 'lesbian and gay psychology'. This tends to have an individualistic, positivist and essentialising focus. As such, it is limited in exploring how heteronormative cultural discourses impact on research, mental health systems and clinical practice. For example, common recommendations include separate LGB services and matching clients and clinicians along sexual orientation lines. Utilising a queer perspective on the homo/hetero binary, this article argues that such strategies are minoritising, in that they make homosexuality relevant to only a minority of clients and staff. When applied to mental health practice, minoritising strategies have limited scope to effect change for the wide group of same-sex attracted clients within PMHS. Based on research with same-sex attracted clients and staff of PHMS in Aotearoa/New Zealand, this article explores how a queer theoretical perspective can usefully inform research and clinical practice in ways that affirm queerness by questioning heteronormativity.

Keywords: queer theory; mental health; lesbian, gay and bisexual; public mental health services

Queering lesbian and gay mental health

At first glance queer theory and clinical practice within public mental health services (PMHS) for same-sex attracted people may appear worlds apart. The difficulties of translating queer theoretical conceptualisations of same-sex attracted subjectivities into practice and for informing political action and progressive change are some of the key critiques that have been levelled at queer theory and that have likely contributed to its limited circulation outside of the academy (Jeffreys, 2003; Kirsch, 2000, p. 21; Rahman, 2000; Seidman, 1995). Yet I contend that queer theory has much to offer regarding research and practice in the area of PMHS for same-sex attracted people. I begin by outlining queer theoretical constructs that informed my research. Second, I briefly review queer¹ mental health research, observing what is often assumed and overlooked. Third, I illustrate how I utilised queer theory in my own research and briefly consider the implications of this for practice within PMHS. Through this, I provide examples of how queer theory can be a resource for

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psychologists (and others) concerned with social justice for same-sex attracted clients of PMHS.²

Constructing queer knowledges

Queer theory posits that the identity categories of ‘lesbian’ and ‘gay’ are products of binary cultural systems of meaning reproduced by institutional and discursive practices. Sedgwick (1990) and Fuss (1991) elaborate on how homosexuality becomes the inferior partner in the binary by arguing that the homo/hetero binary operates in relationship to other unequal binaries such as male/female, rational/emotional, strong/weak and active/passive. This emphasising of the ‘normalcy’ and ‘superiority’ of heterosexuality has been termed ‘heteronormativity’ (Seidman, 1993; Spargo, 1999; Warner, 1993).

Furthermore, Sedgwick (1990) argues that the homo/hetero binary is a central organising feature of Western culture. By placing the homo/hetero binary at the centre of cultural analysis, Sedgwick argues against viewing the homo/hetero definition as primarily important for a relatively small part of the population (a ‘minoritizing view’) and advocates what she terms a ‘universalizing view’ whereby it is of ‘determinative importance in the lives of people across the spectrum of sexualities’ (Sedgwick, 1990, p. 1).³ Moreover, following Foucault’s (1976/1990) critique of modernist sexual identities, queer theory interrogates the various sexual (and other) identity categories which have developed since the emergence of the term homosexuality (Hegarty, 2007; Warner, 2004).

Thus, while I am interested in the relationships between PMHS and MSM⁴ clients, I am also interested in how dominant and marginalised discourses of sexuality are implicated in those relationships. From this perspective, my focus is not so much on ‘MSM’ or ‘gay men’ as a minority group, but more on the social systems of meaning, ‘of those knowledges and social practices that organise “society” as a whole by sexualizing – heterosexualizing or homosexualizing – bodies, desires, acts, identities, social relations, knowledges, culture, and social institutions’ (Seidman, 1996, p. 13).

A liberal yet heteronormative science: limitations of research on PHMS and queer people

Although there is an extensive literature on mental health issues for lesbians, gays and bisexuals (LGB), it contains noticeable limitations. First, this literature focuses primarily on private mental health services in the United States (for a review see Semp, 2006). Second, the few studies which included PMHS (Golding, 1997; King et al., 2003; Lucksted, 2004; McFarlane, 1998; Robertson, 1998) are limited by their implicit use of positivist and essentialising epistemology.⁵

Lesbian and gay psychology has developed two main strands. One is aligned with positivism and mainstream psychology, whereas the other is informed by social constructionist ideas (Hegarty, 2007; Kitzinger & Coyle, 2002). Yet, with few exceptions (Platzer, 2006; Semp, 2006) constructionist ideas are rarely applied to systemic issues in mental health services for LGB. This may be partly because of the limited uptake of constructionist ideas within United States lesbian and gay psychology (Hegarty, 2007; Russell & Gergen, 2005) where much LGB mental health research is done. Furthermore, Stein (1996) claims that most mental health professionals subscribe to essentialist ideas, with social constructionism being virtually excluded from the field of mental health service provision. Another possible restraint to constructionist research in mental health services for LGB is the authority gained by doing research within the dominant positivist paradigm (Bohan &

Russell, 1999; Kitzinger, 1997). It is also likely that research grants criteria tend to favour essentialist practices. For example, funding is unlikely to be granted unless there are clearly identifiable groups in the research proposal.⁶

One limitation of positivist research on LGB psychology is its uncritical use of identity categories (Bohan & Russell, 1999; Gamson, 2000; Warner, 2004). Since the emergence of the 'homosexual' label at the end of the nineteenth century (Foucault, 1976/1990), positivist science has adopted essentialist categories of sexuality (Weeks, 1991). Despite Kinsey's notion of a continuum of sexuality in the 1940s, much research tends to assume LGB as three distinct sexual identities⁷ and populations. This has many implications, an important one being who the research represents. For example, much research on mental health issues and MSM has been conducted with men who identify as 'gay' or 'homosexual' and who are connected to 'gay communities' (Cass, 1999; Harry, 1986; Siegel & Bauman, 1986; Skinner & Otis, 1996).

Another assumption of the 'homosexual' category was that it represented a deviation from a biological norm. Science undertook to discover the aetiology of this non-normative development (Warner, 2004; Weeks, 1985). Within a heteronormative framework, homosexuality thus became pathological (Bullough & Bullough, 1997). Positivist research generally ignores heteronormativity and can unwittingly reproduce heteronormative assumptions (Bohan & Russell, 1999). For instance, a report on a large-scale prevalence study in the Netherlands suggests that

biological and genetic factors in the causes and development of homosexuality might also predispose homosexual people to developing psychiatric disorders. This is in line with the higher prevalence of bipolar disorder we found in homosexual men compared with heterosexual men, which is generally considered to be largely congenital. (Sandfort, de Graaf, Bijl, & Schnabel, 2001, p. 89)

This reproduces a familiar heteronormative assumption that something is innately aberrant in homosexual development. 'These same lines of inquiry are not asked of heterosexuality' (Ristock & Julien, 2003, p. 6). For example, can we imagine a study on bipolar disorder considering its links to heterosexuality? The deployment of heteronormative assumptions in research risks underplaying the role marginalisation and homonegative experiences play in the lives of queer people and risks adding power to the arguments of those who pathologise homosexuality.⁸

A further limitation of positivist LGB mental health research is an essentialist individualistic approach (Bohan & Russell, 1999). Little attempt is made to consider how people's accounts are constructed within sociocultural systems of meaning (Gamson, 2000; Kitzinger, 1997). For example, because homophobic attitudes of individual staff are assumed to be the problem in mental health services, suggestions for improvement commonly rely on the liberal assumption that education can simply change mental health workers' attitudes and behaviour (Peel, 2002). Accordingly, recommendations for change tend not to account for systemic and discursive restraints to individual change within PMHS.

Another common assumption in the literature is that LGB staff will necessarily improve mental health services for LGB. This hypothesis relies on the essentialising of LGB identities, whereby similarities and affinities between people within identity categories are assumed (Lehring, 1997; Russell & Bohan, 1999; Seidman, 1993):

Service providers should promote positive working environments which enable employees to be open about their sexuality and therefore in a position to offer empathy and support to lesbian, gay and bisexual service users. (Golding, 1997, p. 20)

This assumption of ‘matching’ clients and staff along sexual orientation lines is also minoritising in that it assumes sexual orientation in mental health services is primarily important for a relatively small part of the population of clients and staff.

Similarly, while LGB have been asked how PMHS could be improved, the essentialising of LGB identities means that little consideration is given to divergent preferences amongst LGB. For example, in Golding’s (1997) study, 69% of respondents said they would prefer separate mental health services for LGB, whereas 31% did not. How might we understand these divergent views and what might it mean for mental health service provision for MSM in New Zealand? These issues are explored later in the article.

Queer positionings: challenging heteronormativity in mental health research

Thus far I have argued that positivist, individualising and essentialist assumptions limit much research on queer people and PMHS. I now present my attempts to address these limitations utilising queer theory. Queer theoretical research necessitates attention to the way the heterosexual/homosexual binary operates through language and constructs identities, knowledges and institutions (Warner, 2004). This means considering how heteronormativity is implicated in the research.

Heteronormativity can affect research in many ways. In an extensive review of journal reports on gay men and lesbian women, Walsh-Bowers and Parlour (1992) concluded that attempts by researchers to be ‘objective’ and ‘value-free’ have masked and reinforced oppressive ideas and practices. For example (and as described earlier in regard to some prevalence studies), there is a defensive heteronormative tendency in some research to assume that the existence of homosexuality needs to be explained (Brooks, 1992; Gamson, 2000). In opposition to this, a key assumption in my research was that while homosexuality is a cultural object (with significant consequences for people and institutions) and is worthy of investigation (as is heterosexuality), the existence of same-sex attraction needs no justification. Rather, I was more concerned with the ways social constructions surrounding the hetero–homo binary might impact on MSM and on their relationships with PMHS.

From the start, I reflected on how heteronormativity (and other discourses) might construct the research. For example, when developing the interview guidelines I adopted a questioning style inspired by narrative therapy (White, 1988/1989; White & Epston, 1989). Narrative therapy draws on Foucauldian notions of power to explore how language constructs certain versions of subjectivity while subjugating others. A common strategy within narrative therapy is talking about aspects of subjectivity as if they are separate from the person (White, 1988/1989). For example, instead of asking MSM ‘What is your sexual orientation?’ (a question which assumes the recipient has a unitary sexual orientation and locates the sexual orientation within the individual), I asked alternative versions such as ‘How do you describe or think of your sexuality or sexual orientation to yourself?’ This question assumes there are multiple ways of understanding sexuality, that people may have preferences for particular versions and that these preferences may differ depending on the context. The significance of this for the MSM participants is discussed in the next section on identity.

Further examples of questioning informed by a narrative therapy perspective are ‘Is your sexuality important to how you see/think of yourself?’ ‘If it is, in what ways?’

and ‘Are there any other important areas of your identity?’ These questions do not make assumptions about the relationship between any particular sexual identity/orientation a person may identify with and other aspects of their subjectivity.⁹

A second strategy for reflecting on the interview guidelines was to subject them to critique by others at a ‘gender and critical psychology group’.¹⁰ For each question, I presented my own critique of the language used, discourses invoked and my intentions. The group then added their critique to this. This exercise resulted in further changes to the interview guidelines.

Limits of identity

Heteronormativity constructs a society in which silence and invisibility are strategies MSM often utilise to maximise ‘safety’ by remaining in the ‘closet’. This can make recruiting participants more difficult (Cass, 1999; Dodds, Keogh, & Hickson, 2005). Moreover, MSM may not identify as ‘gay’ for reasons unrelated to issues of safety. For example, many men do not privilege ‘gayness’ above other aspects of their subjectivity such as ethnicity (Cutts, 1999; Eliason, 1996; Fukuyama & Ferguson, 2000; Hays, 2001; Manalansan, 1996). Further, these factors undoubtedly interact in complex ways. Accordingly, researchers have acknowledged difficulties in getting broad samples of MSM (Brooks, 1992; Dodds et al., 2005; Donovan, 1992; Skinner & Otis, 1996). This essentialising bias towards researching ‘gay’-identified MSM has been reflected in the existing research on MSM and mental health which generally fails to account for the diversity of MSM (Donovan, 1992; Gamson, 2000; Sell & Petruccio, 1996). Accordingly, I paid careful attention to this issue.

‘MSM’ as an organising category developed within the HIV prevention field. HIV crosses identity boundaries and Dowsett (1992) states that unlike other identity groups, such as those based on ethnicity, or occupation, the only thing MSM share is their sexual attraction for other men. Another possible commonality MSM may share is exposure to heteronormative discourses (Campbell, Hinkle, Sandlin, & Moffic, 1983; Russell & Bohan, 1999). Many researchers have adopted the MSM category attempting to overcome the limitations of sexual identities (Adam, 2000; Caceres & Rosasco, 1999; Deren et al., 2001; Doll et al., 1992; Huber & Kleinplatz, 2002; Stall et al., 2001).¹¹

Many of the MSM client participants did have strong and diverse preferences for identity terms regarding their sexuality. These preferences also changed across contexts as evidenced in the following examples:

It depends on how confrontational I want to be. I don’t like the word ‘gay’ because I really don’t feel gay, in the sense of happy, joyous and those sorts of things. And I think it has become overused, that word, and it tends to come across to most mainstream – even people who are open to the homosexual orientation tend to view it with frivolity. I think it is a little bit frivolous. So ‘queer’ I like because I like the sound of it and sometimes it upsets, causes more of a reaction. [Pete – client]

No I don’t have a term at all for the way to describe who I am, neither homosexual or those terms they use, myself but ‘attracted to men’ definitely would be a description which would fit me [. . .] I don’t act on my attraction to anybody. [Mark – client]

Similarly, although interested in the views of queer staff, I did not want to limit participation by staff to those who identified as LGB. Therefore, in the staff brochures I stated:

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

Negotiating relationships

Kong, Mahoney, and Plummer (2002) argue that self-reflection (or reflexivity) is vital in queer interviewing and should consider such things as the context of the research and ‘a much fuller sense of the spaces – personal, cultural, academic, intellectual, historical – that the researcher occupies in building that knowledge’ (p. 249). A related issue for Kong et al. is the need for an ethical strategy.

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

Within queer research, Kong et al. (2002, p. 251) suggest that interviews need to be conducted with a ‘gay and lesbian sensibility’ which enables the participants to feel safe. Accordingly, in recruitment brochures, I stated that the research was looking at the possible effects of social marginalisation on MSM, and that the research ‘may also help in the design of social policy and other health promotion initiatives for men who have sex with men’ (Semp, 2006, p. 336). My intention was to make explicit the homopositive goals of the research. For similar reasons, many recommend that queer research be done by queer researchers (Brown, 1989; Heaphy, Weeks, & Donovan, 1998; LaSala, 2003; Minton, 1997). Therefore, I also advertised that ‘the research is being conducted by a gay male psychologist’ (Semp, 2006, p. 336).

This self-disclosure of significant aspects of the ‘self’ by the researcher arises from a feminist tradition aimed at increasing a sense of ease and trust within interviews (Fontana, 2002; Oakley, 1981; Reinharz, 1992). This is especially important when doing research with ‘hidden’ or minority groups (Liamputtong & Ezzy, 2005; Power & Harkinson, 1993) and has been recommended for research with MSM (Kong et al., 2002; LaSala, 2003; Siegel & Bauman, 1986). Some client participants reported that knowing my ‘gay’ identity was essential in enabling them to participate.

Yet, within a postmodern approach, interviews are an active co-construction of meanings, and the traditional ‘boundaries between, and respective roles of interviewer and interviewee . . . become blurred’ (Fontana, 2002, p. 162). The multiplicity of subject positions that researchers and participants occupy interrupts any notions of straightforward matching in research, such as those promoted by feminist researchers. For example, class, nationality, gender and ethnicity can impact on the research (de Laine, 2000; Heaphy et al., 1998). Similarly, within research from a queer perspective, the identity of the ‘gay researcher’ is like all queer subjectivities and

is neither unitary nor stable; in its place, increasingly, is a ‘growing focus in lesbian [and gay] ethnography on the permeability of both communities and identities and on our expanding awareness of the instability of identity, particularly in complex cultural settings’. (Lewin, 1995, p. 332)

From this perspective, my ‘insider’ status as a ‘gay researcher’ is far from complete and here I consider how I am also ‘outside’ of, and different to, the subject positions of the participants (LaSala, 2003).¹² Reflecting on the interviews with clients and staff, I consider that despite my queer theoretical position, I entered the interviews with one particular marginalising assumption. That is, my shared ‘queerness’ with staff and clients would minimise difference between me and participants. This assumption essentialises queer identities and in some ways left me unprepared for differences and discomforts that arose. I now provide two examples of these:

During interviews with queer staff, occasionally I felt they positioned me as a radical activist intent on criticising their practice and PMHS. For my part (especially in the earlier interviews), sometimes I found myself surprised and unsettled when staff spoke in ways which seemed to privilege medical explanations of mental health problems over accounts which acknowledged heteronormativity and other psychosocial explanations. This was an example of the ‘baggage’ I brought to the interviews (Scheurich, 1997). Adding to these tensions were discipline-based ones. For example, sometimes medically trained staff made comments suggesting that they thought that my being a clinical psychologist would mean I took a particular and differing view from them on certain issues. In some instances, this was the case.

In the client interviews other complexities arose. I identified three subject positions which produced ambiguity for me in the interviews. These were researcher, gay man and therapist/psychologist. As mentioned already, in the research I chose to be identified as a gay man.¹³ From this position I expected to share some similarities with the clients. My sense of shared experience with clients did seem to improve the interview relationships, mainly by helping to develop a context of familiarity and safety for the clients (and perhaps also for me).

Yet, sometimes I thought the client participants wanted to feel understood and approved of by me as a gay psychologist. In these moments, I felt positioned as an ‘expert’. For example, one client participant responded to some of my questions about mental health by asking me to answer the questions as he was sure I knew more than him about the topic. I responded by reminding him that the interview was about his ideas not mine. Nevertheless, this was an intermittent tension in the interview. Further, in the service of the ‘gay sensibility’ of the interviews (Kong et al., 2002), at times I inadvertently deployed the therapist subject in ways which meant I was constructing objects being discussed. For example, in discussing how one man made sense of his experience of mental health problems I constructed his story as a ‘struggle’:

- Jim I found out about a group called Exodus, which was supposed to convert you to being straight again.
- DS Yeah, I’ve heard about them.
- Jim So I went along to that for a year and went to all their meetings and my wife came too which I hated. Occasionally, not all the time. Because every week you had to say, ‘I’ve had a good week, I didn’t do anything’, and oh God, I did. I used to walk past toilets and go back past and go in and then immediately beat myself up again for giving in to it.
- DS It sounds like a real struggle.
- Jim Even when, so it was almost a year, almost exactly. I decided I couldn’t go any further, so I decided to kill myself, and tried. [client]

This example also shows me deploying a therapist discourse that requires me to summarise and empathise with what clients say. These types of responses by me did not necessarily

impair the research, rather they are examples of reflecting on the many ways in which interviews are co-constructed and shaped by various discourses.

To reflect on these various relations of power in the interviews, I completed a reflective review after each interview (Bungay & Keddy, 1996; Warr, 2004). This review included contextual information, my impression of the interaction, how I could alter my interviewing and main themes and discourses emerging. This reflection highlighted the ambiguity of the interview relationship (Heaphy et al., 1998; Warr, 2004). This ambiguity and the challenges it brings to researchers are often omitted from research accounts (de Laine, 2000; Warr, 2004).

While in some ways unprepared for the complexities of the interviews, these experiences helped orient me towards a queer theoretical perspective in analysing the transcripts. This meant exploring heteronormative and essentialist discourses constructing participants' ideas and the implications of these for clinical practice. I explore some of these in the following and final section of this article.

Questioning heterosexuality: implications of queer theory for mental health practice

As already discussed, much existing LGB psychological research makes essentialist and normalising assumptions about queer people. This is apparent in many of the suggestions made for improving mental health services. In particular, two common recommendations are employing more queer staff and/or providing separate services for LGB. Both of these strategies rely on the essentialising of LGB identities and assumed affinity between LGB. They also assume relatively straightforward ways of matching LGB staff and clients. In this final section, I provide examples of how I utilised a queer theoretical approach to analyse the existing literature and the views of the queer staff and clients I interviewed. I illustrate how heteronormativity structures PMHS and the implications of this for staff and clients.

A queer match: minoritising and essentialising strategies

Reading much of the literature on mental health services for LGB clients, one would be forgiven for thinking that such clients enter services with a sexuality label attached. There are innumerable articles on issues to consider in doing therapy with LGB clients, but virtually nothing about how clinicians identify such clients. Yet within the limited research on PMHS for LGB it seems that often clients' sexuality is ignored and/or clients feel unable to disclose same-sex sexuality, even when they deem it relevant to their mental health problems (Golding, 1997; King et al., 2003; McFarlane, 1998). In my own research all but one of the MSM clients considered that some or all of their mental health issues were due to the effects of homonegativity. Yet, only one reported he had been asked by staff about sexuality.

In this context of queer invisibility, I asked queer staff about how they perceived their role in PMHS and their practices regarding identifying same-sex attracted clients. Whereas most of the staff thought their queerness meant they had something special to offer clients, all the staff reported rarely if ever directly asking about sexuality. Within a heteronormative context such questions were considered dangerous:

I mean our job is to suss out how people are. I mean if we can suss out that it would be probably okay for this person to, for us to say look, 'have you thought about your sexuality?' Being quite open about it in a careful way. If we can tell that this person would totally freak then [we would not ask about sexual orientation]. [Diana – staff]

Diana portrays the ‘knowing professional’ subject of both the medical and psy discourses by arguing that it is important for clinicians to determine if a client will panic if asked about homosexuality.

Another restraint to inviting conversations about homosexuality is a fear of being accused of ‘recruiting’ young people into homosexuality. This heteronormative notion is in wide circulation (Herek, 1991; Newton, 1992) within various homonegative discourses of homosexuality.¹⁴ These discourses assume that homosexuality is morally inferior to heterosexuality and anything interpreted as ‘promoting’ homosexuality as ‘healthy’ and ‘normal’ is discouraged:

I may well have my clinical view, and have years of literature to prove that it was important to ask that question, but it still doesn’t mean the family is going to like what I did. [. . .] And, also, too, where I – see then it becomes personal as well in that if they then find out that the person who’s been asking that question is also a lesbian, ‘So are you trying to convert my daughter or are you trying to convert my son?’ or whatever. So there is that whole layer of that too. [Beth – staff]

Working in a child and family mental health setting Beth shows an awareness of cultural discourses against discussing homosexuality with young people and how it could potentially lead to accusations from the young person’s family about her trying to ‘convert’ their child. These discourses might be more keenly experienced by queer staff.

In the absence of direct questioning of clients some staff thought ‘gaydar’ helped them identify same-sex attracted clients. ‘Gaydar’ is a term used in lesbian and gay communities to refer to a commonly held belief that some people have the ability to detect if other people are lesbian or gay (Ambady & Hallahan, 2002; DiLallo & Krumholtz, 1994; Saghir & Robins, 1973; Shelp, 2002; Stewart, 1995). The concept of gaydar can be critiqued for the essentialist and heteronormative assumptions of homosexuality that it relies on (Semp, 2006).¹⁵ Yet, here I focus on how the concept was used by staff and clients. A number of queer staff discussed this. For example,

Yeah we [staff] talk about gaydar. You know. And then we start to think ‘okay, now do you think’ – we may think ‘okay that guy is gay yeah, that is what his problem is okay. Let’s see how we can best work this out for him’. So that would be like, it is obvious that he is gay to us, because of how he appears, how he looks, what he is saying, and he is freaking out about – so what his problem is [is] his sexuality. He is not able to say it or voice it or whatever so you need to be really careful because you can’t just say to him, ‘Well you know, your problem is because you are gay, you know, go out and find yourself a boyfriend and you will be sweet.’ [Diana – staff]

Here, Diana describes the use of gaydar to identify a client struggling with issues regarding his sexuality. Yet, she also acknowledges that identifying the client does not necessarily make it any easier to raise the topic with him. Similarly, MSM clients acknowledged gaydar and its limitations as a way of them enlisting the support of queer staff:

Rick Yeah, I think there was one nurse I think who was gay.

DS What made you think that he or she was gay?

Rick I think he told, I’m not sure, he told someone anyway. Because he was one of my friend’s nurses, he was never my nurse. I think he was down in the other wing. But I wasn’t likely to run up to him and say, ‘Oh hey, I’m gay, but I don’t even really know you’. [client]

Rick, who had not disclosed his homosexuality within PMHS, explains how he thought he became aware of a gay clinician. However, he also describes how, as a patient, he felt unable to approach the staff member and disclose his homosexuality. The subject position most commonly available to patients in hospital does not support staff–patient interaction based on shared sexual identity status.

Even if queer matching was to somehow be achieved, essentialist notions of identity do not account for the multitude of differences that can exist between queer people (Jagose, 1996; Seidman, 1993; Spargo, 1999). For example, even though some of the MSM clients thought matching with LGB staff could be helpful, their preferences reveal discursive complexity to this matching. For example, if offered matching, one client said he would have chosen a lesbian. He accounted for his preference in terms of heteronormative notions of gender, which assume a lesbian would not display traditional forms of masculinity that gay male therapists may ascribe to, which he felt uncomfortable with. In contrast, another client was adamant that he would not see any woman, even a lesbian. Acknowledging the multiplicity of positionings within identity, a Māori¹⁶ client said he would have preferred a Māori heterosexual clinician over a non-Māori gay one.

These various restraints to the notion of matching queer staff and clients illustrate some of the limitations of a marginalising approach when considering queer affirmative changes in PMHS. Such an approach assumes similarity within essentialised identity categories and elides differences. Paradoxically, a minoritising approach also ignores how a heteronormative context can work to marginalise same-sex attracted clients.

Mainstreaming homosexuality (by questioning heteronormativity)

A further minoritising strategy often appearing in the literature on making mental health services queer affirmative is separate LGBT¹⁷ services (Golding, 1997; Hellman & Drescher, 2004; McFarlane, 1998). For example,

The dominant cultural group in the clinic, as defined by heterosexual identity, was not aware that LGBT patients participated in relation to it. The groups coexisted within the CMHC,¹⁸ but the LGBT proto-community had no ‘space’ of its own. There were no LGBT activities, no LGBT signifiers, no LGBT groups and, therefore, no opportunity for LGBT people with mental disabilities to nurture a cultural identity as members of a sexual minority community within the mental health service environment. (Hellman & Klein, 2004, p. 71)

This excerpt discusses establishing a programme for LGBT clients within a CMHC in the United States. It displays the use of the equal rights discourse to account for what is missing in mental health services for LGBT. The equal rights discourse constructs homosexuals in essentialist ways as an almost ‘ethnic like’ group (Currah, 1997; Seidman, 1993; Semp, 2006). Accordingly, Hellman and Klein (2004) conceptualise LGBT clients as a community needing to develop their minority cultural identity within a politics of sameness. For similar reasons, a study of 55 same-sex attracted PMHS users in the United Kingdom (Golding, 1997) found that 69% would prefer separate services for LGB.¹⁹

Undoubtedly, the sociopolitical landscape differs across countries and contexts. In the United States where conservative and fundamentalist Christian opposition to homosexuality is vocal, perhaps the call for separate LGBT mental health services is not surprising. However, in New Zealand, the situation may be quite different and such a minoritising strategy may be less effective.

In New Zealand, the status of homosexuality is still debated publicly; however, significant legal gains for queer people are comparatively well established. New Zealand achieved an equal age of consent for sexual acts in 1986, and sexual orientation was added to anti-discrimination law via the Human Rights Amendment Act in 1993. In this sociopolitical context, all the MSM clients who asked about the strategy of separate services were adamant that they wanted to receive their mental health care within mainstream PMHS²⁰:

- Jim You see once you start separating things you start getting into an apartheid type situation where if you go there, 'Oh you're gay are you', you know. I don't want that. I want us to be, we are sick, we are New Zealanders and we go [to mainstream PMHS]. [client]
- Pete No. I don't like being marginalised or compartmentalised. I see myself as a human being first. If I limited my horizons like that, I mean, you know, a lot of American gay philosophers have pointed out that the ghetto was just a bigger closet. [client]
- Brian Because you are disassociating yourself from the mainstream. I mean you've had these people demanding rights, or all of us have been demanding rights and you've gone through a referendum and everything, why split them? It has got to be – if they want gay people to be accepted in the community they've got to basically be in the community area. [client]

Here I have included a number of examples as they illustrate the intensity with which many of the MSM clients spoke against boutique LGBT mental health services. Separate services, for them, conjured up notions of being segregated from the broader community. The language used by the MSM is consistent with a discourse of human rights, and of the equal rights discourse of homosexuality. New Zealand has a long history of involvement in human rights issues. For example, in the 1980s there were massive nation-wide protests regarding a tour by the South African rugby team to New Zealand. Along with the circulation of a strong discourse of equality (Brickell, 2001), apartheid was considered anathema to many New Zealanders. Accordingly 'equality' was a powerful discourse deployed during the campaign for homosexual law reform (Guy, 2002) and the more recent 'Civil Union Bill' (Young, 2003). Furthermore, it is worth noting that these locally situated ways of taking up the equal rights discourse work against the potentially marginalising and ghettoising tendencies of the ethnic identity aspect of the discourse. Brian encapsulates this when he argues that equal rights means becoming part of the mainstream, not being split off into separate groups.

In addition to articulating the disadvantages of separate services, some of the men also spoke about the benefits of mainstreaming:

- Rick I think it should be, they shouldn't have to be separate because I think everyone should learn to be accepting, you know what I mean. Because then in separating it is like the people who are not part of this whatever gay mental health service, they will think, 'right we don't even need to bother about it'. [client]
- Mark I think it's [separate services] wrong. I think that integration is the most important thing. And people should be made to feel at home no matter where they are, and that they can mix with people. [client]

The arguments made by these men are examples of combining both marginalising and universalising approaches. Here, the minoritising idea is that a minority group, such as LGBT, should have equal rights. Yet the universalising approach is the idea that mainstream (universal) PMHS, and all clinicians within them, should be able to meet the needs of LGBT. This is similar to the strategy described by Nairn and Smith (2003) where they argue that a liberal, rights-based approach can be utilised to argue for all New Zealand

schools to take responsibility for making themselves safe places for LGBT students. This strategy, in turn, requires making schools, and in the case of the current research, making PMHS, spaces where homosexuality can safely be present.

However, although the MSM participants expressed a preference for the provision of services for them within mainstream PMHS, this argument does not negate the significant limitations to enacting such practice. In New Zealand, as elsewhere, PMHS are primarily structured around a medical discourse of mental health (Semp, 2006). Thus in addition to the many discursive restraints to challenging heteronormativity in PMHS, the dominance of the medical model remains a significant barrier to enacting critical and psychological approaches to mental health for many clients (Semp, 2006).

Queering mental health practice

So how might this queer theoretical perspective inform homopositive practice within PMHS? Although it is not the intention of this article to explore this issue in detail, I provide some examples arising from this queer reading. In the New Zealand context, it seems likely that using the marginalising discourse of human rights could be utilised to argue for the need for change, to redress the impact of marginalisation and homonegativity on LGB clients. This queer analysis also alerts us of the need to be mindful of the heteronormative context that structures PMHS and, in particular, the types of conversations that commonly occur between clients and staff.

Heteronormativity constructs conversations about homosexuality as potentially dangerous for clients and staff. This greatly reduces the chance that staff (including LGB staff) will initiate such conversations even if they think them useful (Semp, 2006). To counter this and to avoid the problematic strategy of making this the responsibility of LGB staff, all staff could be supported to enquire about sexuality with all clients as ‘good practice’ and a matter of course. This is a universalising strategy which directly challenges the assumption of heterosexuality and makes homosexuality relevant to all staff. Further, the MSM clients I interviewed considered it useful and necessary for clinicians within PMHS to initiate such conversations (Semp, 2006). As one young MSM client said:

Rick Well if they [staff] are not easily going to raise it then who is? It is kind of like we are in their contact and they have the power to make or break us basically. [client]

There is considerable precedence for such a move in PMHS. For example, despite concerns about the sensitivity of the subject, it is now policy (and common practice) in many PMHS to ask all clients about sexual abuse. This was in response to research showing that reporting increased dramatically with staff asking (Agar, Read, & Bush, 2002; Read & Fraser, 1998).

There are, however, some queer considerations regarding encouraging all staff to ask clients about sexuality. As discussed earlier, much mental health research has used essentialist notions of identity. This has likely excluded some queer participants. Therefore, it is important the staff do not ask questions which reify particular sexual identities such as ‘Are you gay or straight?’ Rather questions which open up possibilities for discussion are more likely to be useful. For example, ‘Have you ever had any concerns about sexuality?’ Further, when starting such conversations, clinicians need to know how to continue with them. For example, when I ask this question of my new clients various responses include ‘Why are you asking me that?’ or ‘What do you mean?’

Although the above considerations are not meant to be exhaustive; they show how a queer perspective can usefully inform clinical practice within PMHS. This also has implications for mental health policy and the training of mental health clinicians. Queer theory helps us understand the ways in which heteronormativity and the homo/hetero binary constructs same-sex attracted identities, mental health services and the relationships between clients and staff in these services. Failure to acknowledge the complexity of these relationships risks research which unintentionally continues to essentialise and marginalise the very people it purports to liberate.

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Notes

1. Here I am using 'queer' to denote same-sex attracted people in the broadest sense and to signify that many do not identify with the common terms of lesbian, gay or bisexual. For a discussion of various limitations and strategic possibilities of 'queer' as a term, see Halperin (1995) and Hegarty (2005).
2. My own research focussed on men who have sex with men (MSM), but it is possible that the queer theoretical considerations outlined in this article may be relevant to research and practice with other same-sex attracted sexualities.
3. In exploring universalising strategies, I agree with Sedgwick (1990), and others (Chambers, 2002; Nairn & Smith, 2003), who argue that the marginalising/universalising dichotomy is a useful analytical tool, but need not represent mutually exclusive approaches. Rather, I contend that it is important to use both approaches strategically and ethically to support queer-affirmative goals.
4. When designing the research I chose to focus on MSM as it seemed likely that being a man would significantly impair my ability to access women clients within PMHS.
5. As with the universalising/minoritising dichotomy discussed earlier I am not implying a good/bad dichotomy between constructionist and positivist research in LGB psychology. Both have their strengths and limitations and positivist LGB psychology has achieved much for the cause of LGB rights (Bohan & Russell, 1999; Kitzinger, 1995, 1997). 'The oppression of lesbians and gay men can be effected by both essentialism and social constructionism alike: and equally, the struggle against that oppression can make use of both (albeit logically incompatible) perspectives' (Kitzinger & Coyle, 2002, p. 21). Thus, I agree with Clarke and Peel (2007) who argue that critical psychology can add to rather than 'replace other approaches to this area of psychology' (p. 5).
6. For further examples, see Meyer (2001) who poses various heteronormative restraints to researching LGBT public health issues.
7. It is relevant to note here that throughout the literature, the terms 'sexual orientation', 'sexual identity' and 'sexuality' are used interchangeably. There seems to be little pattern to how they are used and I follow this multiple usage.
8. This observation does not negate the significant research done within the field of LGB psychology on the effects of marginalisation and homonegative experiences on the lives of LGB people (see Balsam & D'Augelli, 2006; D'Augelli & Grossman, 2001; D'Augelli & Hershberger, 1993; D'Augelli, Grossman, & Starks, 2006; Espelage, Aragon, Birkett, & Koenig, 2008; Meyer, 1995, 2003a, 2003b; Rivers, 2001; Rivers & D'Augelli, 2001; Ryan & Rivers, 2003; Wright & Perry, 2006).
9. For more examples of this style of questioning, see 'Appendix 2 – Interview Guidelines Clients' in Semp (2006, pp. 329–331).
10. The 'Gender and Critical Psychology Group' is in the Psychology Department, University of Auckland. Key staff involved are Associate Professor Nicola Gavey and Senior Lecturer Dr. Virginia Braun.
11. Furthermore, I did not want to exclude men who experienced same-sex attraction but had not acted upon it. So in the recruitment brochures I additionally stated that 'the study also includes

- men who are sexually attracted to men but who have not had or do not have sex with men' (Semp, 2006, p. 335).
12. In an article on issues regarding lesbians and gay men doing research with lesbian and gay communities, LaSala (2003, p. 23) discusses the notions of lesbian and gay researchers being 'both insiders and outsiders' in relation to the communities and participants they study. However, I include this comment to acknowledge that LaSala does not use a social constructionist perspective to theorise this. Nevertheless, his article is useful for considering some of the advantages and disadvantages of a partial 'insider' status as a researcher.
 13. Consistent with a queer perspective on identity, my use of a 'gay' identity for the purposes of the research does not presuppose that I use this identity consistently across contexts or time.
 14. These discourses are explicated in Semp (2006).
 15. Semp (2006) critiques the research on 'gaydar' as being limited by which lesbian and gay people get represented by it. 'Gaydar' research tends to focus on 'out' 'lesbian' and 'gay'-identified people who are involved in lesbian and gay communities. There is also little attention paid to ethnicity in such research.
 16. Māori are the indigenous people of Aotearoa/New Zealand.
 17. At this point I use the term LGBT (lesbian, gay, bisexual and transgender) as it is the terminology most commonly used in the literature regarding separate services for sexual minority groups. This term (while still contested) represents a broader shift towards increasing inclusivity within what was previously called 'Lesbian and Gay Psychology' (Clarke & Peel, 2007).
 18. CMHC stands for Community Mental Health Centre. This is the term commonly used to describe adult outpatient public mental health services in the United States, the United Kingdom and New Zealand.
 19. This study focussed on LGB, and did not use the terminology of LGBT.
 20. I asked eight of the men about this issue. Of those eight, all said that they would prefer it if mainstream services were able to meet the needs of MSM clients. One said he thought both should be available.

Notes on contributor

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