PSYCHIATRY, SOCIAL CONTROL, AND HOMOSEXUALITY:
CLIENTS’ PERCEPTIONS OF THERAPEUTIC CARE
IN THE DECADES FOLLOWING DEMEDICALIZATION

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by
Randa Richelle Palfy
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Head of the Department of Sociology
University of Saskatchewan
Saskatoon, Saskatchewan S7N 0W0
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DEDICATION

In memory of Georgie
ABSTRACT

In 1973, homosexuality was officially demedicalized. However, the effects of this change on the therapeutic relationship between psychiatrists and their gay or lesbian clients has been largely unexplored. Using clients' perspectives obtained through in-depth interviews, this study examines how psychiatric control was perceived to operate in the therapeutic relationship between six gay men and three lesbians and their psychiatrists.

Employing Michel Foucault's concept of objectification, the findings of this thesis indicate that, as perceived by the clients, the primary means that psychiatrists used to police them was medicalization. Clients perceived psychiatrists as attempting to impose their definitions of 'normal' sexual behavior through the following strategies of policing: defining homosexuality as a problem, normalization (conversion), denial, avoidance, hostility, lack of support, and sexualization of the homosexual.

Although some psychiatrists appear to be becoming more accepting of a homosexual lifestyle, the findings of this study indicate that the clients perceived their psychiatrists as continuing to treat homosexuality as a form of deviance in spite of official demedicalization. This perceived stance is partly attributable to the psychiatrists' apparent lack of knowledge about homosexual-related matters. Nevertheless, the psychiatrists' approach did not foster a therapeutic atmosphere perceived as safe by the clients. Hence, most clients were unable to get their needs as gay men and lesbians met.

In response to the perceived homophobic or heterosexist attitudes of their psychiatrists, some clients were silenced. Most of the clients, however, responded with various strategies of resistance, including: formulating their own definitions of their problems, self-educating, withholding relevant personal information, educating psychiatrists about homosexual-related matters, refusing treatment, terminating therapy, and speaking out about negative therapeutic experiences. Overall, clients' resistance operated in a dialectical manner. Clients' acts of resistance emerged out of their needs to retain a sense of themselves when confronting psychiatric definitions of homosexuality which they perceived as challenging their very identities as gay men or lesbians. The knowledge gained from their resistances came to inform and ultimately strengthen the clients' sense of themselves.
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1.0 Introduction to Research Problem

Over the centuries, the meaning of homosexuality has varied considerably, ranging from an accepted stage of human sexual development to a religious transgression, a sin. By the end of the medieval period, same-sex conduct became a matter for state control, a crime, and more recently, since the 19th century, homosexuality has been defined as a medical problem requiring medical treatment and intervention (Conrad & Schneider, 1980). In particular, psychiatry has played a leading role in defining homosexuality as a 'deviant' activity or lifestyle which needs to be cured, i.e., the goal of psychiatry has been to persuade homosexuals that heterosexual is both normal and natural.

The psychiatric definition of homosexuality as deviance persisted until 1973 when, through agitation from within the American Psychiatric Association (APA) and pressure from Gay Liberation activists, homosexuality was officially removed from the DSM-II; however, in its place the category "ego-dystonic homosexuality" was substituted (Conrad & Schneider, 1980). Implemented as a compromise between the APA's administrative forces and Gay Liberation activists, this
category allowed psychiatrists to diagnose lesbians and gay men who appeared dissatisfied or distressed about their sexual orientation (Silverstein, 1984). Gay and lesbian advocates protested the category "ego-dystonic homosexuality", arguing that if it was a legitimate category, it was an arbitrary decision to include it without simultaneously including "ego-dystonic heterosexuality", indicating that individuals may have problems with their heterosexual orientation (Suppe, 1984). Protestors argued that the addition of the category "ego-dystonic homosexuality" to the DSM-III was yet another demonstration of prejudice on the part of the APA (Begelman, 1977; Davison, 1977; Silverstein, 1977). Eventually, in 1987 as a result of these protests, the APA removed "ego-dystonic homosexuality" from the revised edition of the DSM-III (Harris, 1988). However, the diagnosis of "sexual disorder not otherwise specified...which can be applied in cases where there is persistent and marked distress about one's sexual orientation" remains (American Psychiatric Association, 1987: 168). Despite the official demedicalization of homosexuality, the question now stands, is psychiatry still homophobic?

1.1 Research Questions

This thesis is a critical study of the social control of gay or lesbian clients through psychiatry. I examine how,
from the clients’ perspectives, the structures of knowledge/power in established psychiatric practice are connected with therapeutic interactions between psychiatrists and their gay or lesbian clients. I explore how gay or lesbian clients’ perceptions of the attitudes and practices of psychiatrists toward them in therapy sessions affect the clients’ self-perceptions and empowerment as gay men or lesbians. These perceptions are based on clients’ retrospective accounts as reported in interviews. In the aftermath of the official demedicalization of homosexuality in the DSM-II, I investigate specifically whether the disease or deviant model of homosexuality was still operating in these clients’ perceptions of the therapeutic interactions with their psychiatrists. In this context, the following two questions are examined. First, how do clients come to see themselves as either willing or unwilling patients of these medical professionals? Second, when they do not accept the psychiatrist’s definition of the situation, how do clients respond?

1.2 Theoretical Framework

This thesis uses Michel Foucault’s theories to study the social control of gay men and lesbians through the medicalization of homosexuality. In Foucault’s view, psychiatry functions as an institution of social control in that psychiatric professionals contribute to the construction
of particular patient identities which may alter, or be resisted by the client. Foucault's notions of objectification and subjectification help us to understand clients' perceptions of how they were treated by psychiatrists. Objectification occurs when the body is approached as an object to be manipulated and analyzed for the purposes of rendering it docile (Dreyfus & Rabinow, 1982). Subjectification occurs when individuals internalize knowledge which objectifies them (e.g., scientific classifications or established behavioral norms) and, as a result, actively turn themselves into subjects. Subjectification entails a process of self-understanding and often subsequently, self-formation, both of which are mediated by an external authority figure (Rabinow, 1984). Finally, clients may exercise human agency or resistance to respond to the objectification and subjectification processes imposed through psychiatry. For Foucault, resistance to power occurs when new discourses are introduced which, in turn, produce new truths. These discourses, which oppose hegemonic truths are known as 'reverse discourses' (Ramazanoglu, 1993). However, taking into account Kate Soper's (cited in Ramazanoglu, 1993) argument that the fate of oppressed groups is not simply decided at the level of competing discourses, I argue that resistance occurs at the level of gay men and lesbians' interactions with psychiatrists.
1.3 Methodology

For this research I interviewed six gay men and three lesbians. Using posted notices seeking interviews, I asked those who consider themselves to be gay or lesbian to contact me if they wish to participate in my study. Thus, self-definition was my working definition of 'gay' or 'lesbian'. Besides considering themselves to be gay or lesbian, respondents not only must have seen one or more psychiatrists, they must have disclosed their sexual orientation to the psychiatrist(s). This research used a series of semi-structured interviews, giving the respondents full freedom of expression.

1.4 Overview of Thesis

This thesis examines the social control of gay men and lesbians through psychiatry. Using clients' perceptions, I focus on whether the official demedicalization of homosexuality in the DSM-II has changed the ways that gay men and lesbians are treated by psychiatrists when they engage in therapy. Chapter One provides a background to the topic including the research questions to be examined. Chapter Two discusses how traditional theorists have approached the topic of medicine as an institution of social control. While they provide insights into the power and influence that the medical enterprise has over society, their analyses which are based on the juridico-discursive model of power are limited
in significant ways. Most importantly, they cannot account for the apparent demedicalization of homosexuality as a psychiatric classification. In Chapter Three I discuss how Foucaultian analysis addresses the shortcomings of traditional theorists' analyses as well as the utility and applicability of Foucault's theory to an examination of the social control of those considered 'sexually deviant'. Having outlined the theoretical perspective employed to study this topic, I shift to methodological issues in Chapter Four. Chapter Five consists of an analysis of the therapeutic experiences of six gay men and three lesbians. I discuss the various ways in which clients perceived their psychiatrists attempted to police them by measuring their homosexual orientations against a heterosexual norm. I conclude by arguing that while there is notable evidence that some of the psychiatrists involved with this sample were somewhat accepting of a homosexual lifestyle, the dominant stance among the psychiatrists, as perceived by the clients, still appeared to be to view homosexuality as a form of deviance in spite of official demedicalization. As a result, many of the gay or lesbian clients' therapeutic needs as gay men and lesbians were not met. Lastly, Chapter Six integrates the major findings of this thesis, focussing on how they confirm or disconfirm Foucault's theories. A presentation of my findings reveals that these gay or lesbian clients' therapeutic experiences of objectification are
similar to some degree with those of other patients of medical professionals. Moreover, the gay or lesbian clients' strategies of resistance can also be contextualized within the wider social movements against professionals typified by such terms as 'demedicalization', 'deprofessionalization', 'delegalization', and 'anti-psychiatry'. At the end of this chapter, I outline the advantages and limitations of this study as well as some recommendations for future research endeavors. Finally, Chapter Six concludes with a discussion of how the findings of this thesis are useful to both psychiatrists and gay or lesbian clients alike. These findings may be used by psychiatrists to improve the therapeutic care that they currently provide to gay or lesbian clients. In addition, these findings have the potential to validate the concerns of current or past clients of psychiatric professionals which may have been understood as personal troubles as opposed to more public issues (Mills, 1959).

Overall, this topic is important to study because psychiatrists are seen as authority figures in Western society particularly with regard to norms surrounding sexuality. A study such as this is useful for understanding the ways in which these norms inform the therapeutic relationship from the point of view of the clients.
CHAPTER TWO - MEDICINE AS AN INSTITUTION OF SOCIAL CONTROL: TRADITIONAL APPROACHES

2.1 Introduction to the Social Constructionist Approach to Deviance

The diagnosis of homosexuality as a "disorder" is a contributing factor to the pathology of those homosexuals who do become mentally ill.... Nothing is more likely to make you sick than being constantly told that you are sick.

Ronald Gold, Former Publicity Director for the National Gay Task Force (Rutledge, 1988: 171)

The social constructionist approach holds that dominant individuals or groups in society create designations of deviance based on their own particular interests, values, and views of the world. These designations are then imposed on the less powerful. In this context, deviance is socially constructed in that it is not inherent in a given act, behaviour, or status. Rather, the label of deviance tends to be applied when individuals pose a social problem to dominant groups in society by breaching their norms and conventions. Thus, deviance arises only as a result of the application, either directly or indirectly, of the latter's rules (Conrad & Schneider, 1980).

In Western society, deviance has been most effectively controlled through major institutions--such as religion, law, and medicine. Over specific historical periods in the last
two centuries, deviance has ranged from being designated as a sin, a crime, and most recently, a sickness. When deviance is socially constructed as a sickness, we refer to it as having been 'medicalized'. Homosexuality is a primary example of deviance that has been medicalized. In the late nineteenth century, homosexuality shifted from being overwhelmingly classified as a crime to being viewed as a mental illness or psychiatric disorder (Conrad & Schneider, 1980).

Proponents of medicalization argue that medical involvement results in the removal of social problems or deviance from religious and legal scrutiny and thus from moral and punitive consequences. These problems are treated in an objective and therapeutic manner (Zola, 1994). Indeed, those arguing from the liberal medical perspective hold that the historical shift from classifying deviance as crime to classifying deviance as illness constitutes a more humane approach. (Individuals who come from a liberal medical perspective generally have some close association with the medical enterprise, be it professionally or otherwise, and see medicine as providing a valuable, even altruistic service to society).

In contrast, critics of the medicalization process such as Conrad & Schneider (1980) do not see medical designations as morally neutral, but instead as profoundly political in nature. Highlighting the fact that illness/deviance
designations are based on the social values of dominant groups, they argue that diagnoses and intervention provided to the 'sick' have significant implications in terms of social control over the less powerful in society. Irving Zola (1977; 1994) and Ivan Illich (1976) outline the negative implications of medicalization against the more publicized benefits. Responding to the notion that the shift from badness to sickness in deviance designations would remove deviants from punishment and diminish the responsibility imputed to them, Zola argues that this has not occurred. Instead, he contends that the ways in which punishment and moral responsibility are administered to deviant individuals has merely shifted now that deviance has been medicalized (Zola, 1994). According to Illich (1976), medical intervention has produced an epidemic of disabling-dependence in the population, which he refers to as 'iatrogenesis'. Applying Illich's insight to the topic at hand, the medicalization of homosexuality is an example of the invention of a new category of illness to be treated which produces dependency on professional expertise (Illich, 1976).

Overall, Zola (1977; 1994), Illich (1976), and other theorists such as Conrad and Schneider (1980), Eliot Freidson (1986), Irving Goffman (1961), and Andrew Scull (1984) argue that one of the primary functions of the medical establishment is to socially control the population, or at least certain factions within it. Each of the aforementioned
theorists utilizes a juridico-discursive notion of power which holds that power is repressive in both its nature and consequences; hence these analyses are said to be based on a 'repressive hypothesis' (Foucault, 1978). With the emphasis on the overwhelming medical control over individuals' lives, these analyses do not open up the conceptual space to account for two factors of relevance to this thesis. First, they are unable to account for the fact that many individuals willingly participate in their own oppression. Second, with the exception of Goffman's analysis, they are unable to account for the fact that many individuals utilize resistance in their interactions with dominant institutions such as medicine.

This chapter opens with an overview of Conrad and Schneider's historical social constructionist approach to deviance which holds that our dominant deviant designations tend to be integrated into our major institutions of social control, namely religion, law, and medicine. I note the two great historical transitions in dominant definitions of deviance--from religious to state-legal, with deviance seen as a crime; and from state-legal to medical-scientific, the state we are currently in, with deviance seen as a sickness. Section 2.2 provides a historical background to and definition of the medicalization of deviance. While proponents of medicalization would have us believe that disease designations are morally neutral, Zola and Illich
argue that diagnoses and proposed interventions are embedded with the social values and prejudices of the dominant groups in society and therefore these designations are inherently political. Their notions on the negative implications of medicalization for the general population are outlined (in section 2.3). Section 2.4 explores the analyses of various traditional theorists of medicine as an institution of social control, including those of Parsons, Freidson, Goffman, and Scull. These theorists provide insight into the mechanisms of professional/medical control, but in the end, they too rely on repressive notions of power and are unable to account for demedicalization in general, and gay men’s and lesbians’ resistance to psychiatric control more particularly.

2.2 The Medicalization of Deviance

Medical science’s rise to prominence occurred after 1870 when the germ theory of disease became the dominant model. This theory provided physicians with an explanation for the mysterious forces behind the spread of infectious diseases with its postulation that each disease has a single, specific, external, and objectively identifiable cause that could not only be detected, but treated. Essentially, the germ theory of disease enabled medicine to successfully control some infectious diseases. As a consequence, medicine began to be called upon to perform its ‘miracles’ on more and more human problems. In addition, medicine came to dominate
certain potentially profitable human experiences (e.g., the birthing process) through explicit medical crusading (Conrad & Schneider, 1980). In this context, Freidson warns,

the reputations of the medical profession should not be seen only as a result of actual achievement, but also as the product of negotiation, persuasion, and impression-management by power interests involved in health care. (1970a: 83)

Hence, medicine was able to expand its jurisdiction and eventually consolidate and monopolize medical practice both through its expertise in certain areas and through its own desire to do so.

By the mid-twentieth century, the domain of medicine had expanded to encompass many human experiences not formerly considered medical entities (e.g., childbirth, sexuality, death, old age, obesity, anxiety, and child development). In particular, deviant behaviours once defined as immoral, sinful, or criminal began to be labeled as medical problems or illnesses. While this process, known as the medicalization of deviance, has frequently taken medicine beyond its proven technical competence (Freidson, 1970b) with regard to issues such as alcoholism, madness, and homosexuality, it nevertheless has been relatively successful to the point that the medical paradigm has become the ascending paradigm for deviance designations in postindustrial society.

The medicalization of deviance holds that deviance/disease is caused by differences located within the
body. Hence, intervention by medical personnel is mandated to cure the 'illness'. For example, homosexuality was believed to be the product of a congenital or hereditary weakness for which aversion therapy was widely prescribed from the mid 1930s to the early 1970s (Katz, 1976). Also inherent in the medical model is the notion that diseases can be successfully treated or even prevented. With the process of medicalization being used widely on deviant behaviour, it is important to consider the implications associated with notions of cure and prevention; these are discussed in the following section (Conrad & Schneider, 1980).

2.3 The Implications of Medicalization

A primary assumption underlying medicalization is that medical involvement leads to the removal of social problems from religious and legal scrutiny and hence from moral and punitive consequences. Instead, the problems become part of medical-scientific jurisdiction and thus are treated in an objective and therapeutic manner (Zola, 1994). Indeed many official agents, major spokespersons, and members of the general public have become caught up in the Enlightenment notion that the historical shift from deviance as crime to deviance as illness constitutes an evolutionary step toward progress, i.e., not only are we moving closer to having a cure for society's 'evils', we are doing so by more humane means than in the past.
Critics of medicalization such as Conrad & Schneider (1980), Zola (1977; 1994), and Illich (1976), however, do not see this shift as quite so progressive. They argue that although the medicalization removes social problems from formal religious and legal realms, this does not necessarily mean that the problems have escaped moralizing judgement. For, while Western society's conceptions of illness are grounded partly in biophysiological phenomena, they are still based largely on social evaluative processes. And just as consequences followed from the recognition of microorganisms as 'agents of disease', so there are implications to recognizing illness as a social construction (Conrad & Schneider, 1980). Using Zola's (1994) analysis, the implications of medicalization may be grouped into three areas: condemnation, moral responsibility, and the depoliticization of social problems. Like Zola, Illich (1976) also assesses the seamy side of medical progress against its more publicized benefits, examining how medicine as a dominant profession functions to disempower and disable the general population. At the end of this section, Illich's insight is used as a basis for understanding how medicine, through the medicalization of homosexuality, has attempted to define the reality of gay men and lesbians.

The medical perspective holds that the medical model has had its greatest impact in the lifting of moral condemnation from the individual. Zola, however, points out that while
whipping, torture, chains, and other physical restraints seem to have largely disappeared in North America, our ability, if not willingness, to condemn and inflict anguish on one another does not seem similarly on the wane. To appreciate this, Zola (1994) argues, we need to adjust our notions of punishment and condemnation. More to the point, Conrad and Schneider (1980) note that the change in designations from 'badness' to 'sickness' characterizing the medicalization of deviance has simply involved a shift from explicit moral judgements to the subtle morality of 'sickness'. While it is probably true that individuals are no longer directly condemned for being sick, it does seem that much of the condemnation has been merely displaced; in other words, it is now being applied to individuals indirectly. For example, though an individual's immoral character is not demonstrated in his/her having a disease, it is thought to be evident in his/her response to the disease. Individuals who break medical appointments, fail to follow treatment regimes, or who delay in seeking medical aid tend to be seen as 'personally flawed'. These people are seen as ignorant of the consequences of certain diseases, unable to manage their time properly so as to make or keep medical appointments, or be burdened with shame, guilt, or neurotic tendencies with regard to their ailment (Zola, 1994).

The indirect condemnation of deviancy stems from the social control embedded in medical intervention. While
deviant individuals are not generally punished directly for their 'condition', those who are deviant, are not seen as being acceptable the way they are and thus are encouraged in varying degrees, through medical means, to change. For Zola, [m]edical intervention as social control seeks to limit, modify, regulate, isolate, or eliminate deviant behaviour in the name of health. (cited in Conrad & Schneider, 1980: 29)

Building on Zola's notion of social control through medical intervention, Conrad and Schneider (1980) note that conditions defined as illness tend to reflect the social values of society. More specifically, the social inequality, prejudice, and discrimination persisting in capitalist American society are embedded right into both the diagnoses and intervention provided to the 'sick'. Hence, the medicalization of deviance serves as a powerful tool of social control over the less powerful in society. For instance, one of the most extreme examples of medical social control in the United States/Canada involved those blacks and mentally handicapped who were subjected to eugenics measures, i.e., forced sterilization.

Besides the removal of moral condemnation, Zola notes that the second area in which the medical model is assumed to have had a large impact is in the lifting of moral responsibility from the deviant individual; however, the replacement has not always been beneficial. While the shift in deviance designations from 'badness' to 'sickness' may have diminished the responsibility formally imputed to
deviants, the issue of 'personal responsibility' has re-emerged in medicine in new and different ways. For instance, in so far as illness assumes something undesirable, it is seen as something that can and should be eliminated. More to the point, illness is, by definition, to be eliminated, regardless of the wishes of the individual (Zola, 1977).

The word 'regardless' highlights the tremendous significance of the power imbalance inherent in the process of labeling. For in Western society, illness is only to be diagnosed and treated by certain mandated and licensed officials--namely doctors. The potential patient has little right of appeal to the label-diagnosis. In fact, when a patient does object to the diagnosis put forth, social rhetoric obscures the issue of whether the label-diagnosis is warranted, i.e., since the individual is sick, s/he is seen as not knowing what is good for him/her, or furthermore, what is a worthwhile activity. The treater-diagnosticians, of course, think that they know what is best because it is presumed that they have no vested interest. Indeed, their very expertise, being socially legitimated, makes their judgements seem morally neutral. For Zola, such reasoning holds the greatest deception. He states that even if the illness diagnostician and his/her tools were morally neutral, and he doubts that they are, the medical establishment's decision that a particular social problem is relevant to their province is not without moral consequences. For
instance, with the acceptance of a specific behaviour as an 'illness' and the definition of illness as an undesirable state, certain moral issues may not be raised or faced directly, i.e., the question becomes not whether to deal with a particular problem, but how and when. The debate over homosexuality, for example, becomes focused on the degree of sickness attached to the phenomenon, at the expense of the moral issue of what freedom an individual should have over his or her body (Zola, 1977).

Finally, by presenting one definition as inherently preferential (i.e. medical designations of deviance), medicalization depoliticizes and diminishes a recognition of the moral choices involved in social problems (Zola, 1977). For example, by pathologizing homosexuality, heterosexuality was institutionalized as the norm. Through depoliticization, attention is diverted away from a critical analysis of how the social structures are not set up to meet all people's needs (e.g., the housewife who drinks to numb her feelings of devaluation associated with her traditional role is seen as an 'alcoholic'; while the black man who abuses drugs to avoid the pain of his poverty-stricken lifestyle is seen as a 'drug addict'). Instead, the responsibility for social problems is attributed to the individual and consequently the solution is thought to involve individual treatments. The therapeutic interaction between physician and patient becomes the model for how to contend with the problem. While in many cases
individuals run the risks of serious side-effects to treatments, probably the biggest flaw in the psychologizing of social problems is that it leads us further away from actual solutions (Zola, 1977).

Not only does Zola’s analysis diffuse some of the social rhetoric supporting medicalization, it also provides a good overview of how the growing medical involvement in human and social problems has simply resulted in subtle shifts in the ways that condemnation and moral responsibility are imposed upon deviant individuals. Zola presents a strong case for the idea that rather than destigmatizing human and social problems, and subsequently providing deviant individuals with more freedom from condemnation and moralizing judgement, medical involvement has continued the legacy of social control over these individuals.

In presenting such a strong case for social control through medicine, however, Zola’s approach appears somewhat one-sided in that he does not offer any discussion on how some patients resist medical labeling and intervention. While it may be argued that Zola’s intention was only to discuss medicine as an institution of social control, his work would have been more comprehensive, and indeed would have better informed this analysis had it considered how some individuals use human agency in their dealings with the medical profession. Granted, the medical profession does exert a considerable influence over the population. However,
by not addressing the fact that some individuals respond to this force with human agency, the reader is left thinking that Zola sees all individuals/potential-patients as a homogeneous group who blame themselves at least somewhat for the illnesses that they contract. While this may have described Western society in the early 1970s when this article was first written, the mid 1990s, when this article was updated, are witnessing somewhat of a backlash against this 'blaming the victim' trend. Currently, many groups are protesting the sickness-causing agents that large corporations have injected into our environment and cultures, (e.g., advertisements featuring too-skinny or unnaturally beautiful models, silicon breast implants, toxic chemicals that pollute our air, food, and water). Hence, many people seem to be moving in a direction where they want some control over factors that influence their health.

While Zola outlines the general implications of medicalization, Illich (1976) argues more specifically that the medical establishment has become a major threat to health. In fact, for Illich, "[t]he disabling impact of professional control over medicine has reached the proportions of an epidemic" (1976: 11). **Iatrogenesis**, the name for this epidemic and Illich's central topic of concern, is essentially "disease caused by medical intervention" (Illich cited in Cohen, 1985: 169). For Illich (1976), iatrogenesis occurs on three levels: clinical, social, and
Cultural.

Clinical iatrogenesis occurs when patients become ill or are harmed as a result of the treatment measures provided by their practitioners. Examples of this include unwanted side-effects from prescription drugs or accidents in hospitals (e.g., unnecessary surgery) due to professional callousness, negligence, or even sheer incompetence (Illich, 1976).

Medicine undermines health not only through direct aggression against individuals, but also through the impact of its social organization on the population. Social iatrogenesis occurs when medical damage to health is produced by a socio-political mode of transmission. Through technological advances and specialization, medical services have been overproduced. The concept of industrial overproduction, in so far as it is a value-judgement, is applied when society is invaded by instruments of production designed for financial efficiency rather than local effectiveness and, due to their complex nature, for professional rather than lay control. In order to create a demand for these services, Illich argues that medicine engages in diagnostic imperialism. Physicians have been known to 'invent' new categories of illness and 'discover' new disorders which they attribute to certain individuals. Moreover, as physicians specify who is likely to become sick, the spheres of 'prevention' and 'at risk' are extended (Illich, 1976).
Social iatrogenesis leads to a situation where "[h]ealth has ceased to be a native endowment each human being is presumed to possess until proven ill, and has become an ever-receding goal..." (Illich, 1976: 129). In this way, the conglomerate health profession has rendered the patient role infinitely expandable. The doctor's previous role as certifier of the sick has been replaced by that of the bureaucratic health manager who arranges people according to degrees and categories of therapeutic need, and medical authority now extends to supervised health care, early detection, preventative therapies, and increasingly, treatment of the incurable (Illich, 1976: 129).

Whereas previously medicine controlled only a limited market, now the market seems endless (Illich, 1976). The result, as Illich reports "is a morbid society that demands universal medication and a medical establishment that certifies universal morbidity"--a self-reinforcing cycle (1976: 129).

Finally, in creating a market for its surplus services, medicine extended itself so intensively into people's lives that it has undermined those traditional means of health-production which do not show up in the Gross National Product, e.g., folk remedies or culturally-mediated coping strategies for pain and suffering. Cultural iatrogenesis occurs when the medical profession destroys people's natural potential to respond to pain, suffering, death, and grief in their everyday lives. Traditional culture equips the individual with "the means for making pain tolerable,
sickness and impairment understandable, and the shadow of
death meaningful" through a configuration of language,
symbols, and myths (Illich, 1976: 136) Ideology espoused by
the contemporary medical establishment, however, runs counter
to these cultural functions (Idn Khaldun cited in Illich,
1976: 137). Not only does medical ideology undermine the
continuation of old cultural programs that offer a pattern
for self-care and suffering, it also prevents the emergence
of new ones (Illich, 1976).

The undermining of existing and potential cultural
practices is accomplished through medicalization, which
Illich views as a bureaucratic program based on the denial of
each man's (sic) need to deal with pain, sickness, and death.
Instead, pain, suffering, and untimely death (i.e., death
outside of hospital care) are claimed as new areas of policy-
making by the medical enterprise, and are turned into demands
to be made by individuals on the economy and problems to be
managed at an institutional level. Illich argues that the
modern medical enterprise tends to do for people, through
complex technological measures, what their genetic and
cultural heritage formerly equipped them to do for
themselves. Thus, rather than becoming self-reliant, which
Illich sees as an indicator of health, entire populations
learn to depend on the expertise of health professionals for
their technological 'fix' (Illich, 1976).

Just as the medical enterprise has produced dependency
on professional expertise by constructing pain and suffering as malfunctions, so it has attempted to produce the same result through the medicalization of homosexuality. When homosexuality was medicalized in the late nineteenth-century, medicine began to define the reality of gay men and lesbians. Ronald Bayer (1981) notes that for much of the first half of this century many homosexuals welcomed the psychiatric effort to wrest control of the social definition of their lives from moral and religious authorities. It was considered better to be thought sick than criminal and better to be the centre of therapeutic concern than the target of malevolent law. (Bayer, 1981).

By the late 1960s, however, homosexual activists had discarded whatever lingering gratitude remained toward their former protectors and in a mood of militancy rose up to challenge what they considered the unwarranted, burdensome, and humiliating domination of psychiatry. (Bayer, 1981: 9)

From this point on, gay activists focused on how medicalization disempowered gay men and lesbians through its postulation that they have a mental disorder. Being labeled as mentally ill is disempowering for gay men and lesbians because it takes away their dignity by conditioning the milieu to see them in pejorative terms. Moreover, because many gay men and lesbians are unhappy, generally for reasons related to the homophobic environment in which they live, they are more apt to accept the philosophy underlying medicalization, that there is something organically wrong with them. For those who come to believe that they have a
mental illness because they are gay or lesbian, the label takes away their self-respect. Ultimately, as a result of both their own negative circumstances and the various claims to proficiency made by the health profession, many gay men and lesbians have come to rely on health professionals to 'fix' them.

Serious implications arise, both at the individual and societal levels, when gay men and lesbians rely on health professionals for therapy. Individually, gay men and lesbians may experience serious side-effects, including addiction from drugs that they are prescribed, which could ultimately lead to further dependency on professionals. At the societal level, treating gay men's and lesbians' symptoms through a client/practitioner dyad, which generally involves the prescribing of drugs, takes the focus off a critical analysis of larger social problems. For instance, two main symptoms for which gay men and lesbians seek therapy in the first place are depression and suicidal tendencies and these are likely to stem from societal arrangements which reject significant aspects of their identities. While people who take antidepressants may not be so naive that they see their unhappiness as an individual problem, they are choosing an individualized solution. Consequently, they are less likely, particularly after their senses have been numbed, to work together with others in attempts to produce social change. Ironically, it is just such attempts at producing necessary
social change that might lead gay men and lesbians closer to empowerment and self-reliance, i.e., health. Instead, gay men and lesbians simply learn to rely on treatment from health professionals. And deviants shift from being a threat to a support of the prevailing social order. Dominant institutions, with their primarily conservative ideologies, become more entrenched, while individuals seen as deviant become increasingly dependent upon them.

Recognizing that the medicalization of homosexuality has been a disservice to gay men and lesbians, gay activists campaigned the APA to have homosexuality demedicalized. Gay activists argue that the designation of homosexuality as pathological is not only unwarranted, it is scientifically untenable. For instance, researchers, such as Bell and Weinberg (1979), Hooker (1957), and Rosen (1974) determined that nonpatient homosexuals do not differ from nonpatient heterosexuals in their adjustment. Moreover, Friedman (1975) and Hopkins (1969) argue that homosexuals may be even more adjusted than heterosexuals. Gay activists also view the designation of homosexuality as a mental disorder as burdensome, for as a tool of public policy it can be used to segregate and oppress gay men and lesbians. Finally, gay activists see the medicalization of homosexuality as humiliating for it has become recognized as a symbol of moral degeneracy.

Hence, both gay activists and some of the general public
believed that the demedicalization of homosexuality would allow gay men and lesbians to have more control over their lives because medicine would be defining their realities less. Eventually, in 1973, gay activists were successful in their attempts and homosexuality was demedicalized. Significantly, the demedicalization of homosexuality occurred as a result of both external challenge and the APA's internal theoretical confusion regarding same-sex conduct; i.e., despite the fact that homosexuality was considered a mental illness, psychiatry still had not found a way to 'cure' it (Bayer, 1981). Currently, many people wonder whether the removal of homosexuality from the list of psychiatric disorders has had any effect on the lives of gay men and lesbians.

Unfortunately, Illich cannot offer any insight into the implications of the demedicalization process for, due to the repressive nature of his hypothesis, i.e., that medical progress produces disabling-dependency in the population, he cannot account for two of its primary features. First, he cannot account for the resistance demonstrated by those who struggled to get homosexuality removed from psychiatric nosology. Indeed, his analysis does not open up the conceptual space to recognize human agency exhibited in any form by individuals in their interactions with the medical enterprise. Second, because Illich's analysis is based primarily on a documentation of the prominent influence that
medicine exerts over society, he cannot account for medical enterprise relinquishing its power, at least formally, over a faction of the population. Despite these criticisms, Illich provides a detailed and provocative account of how the medical industry's 'progress' has resulted in large factions of the population becoming increasingly dependent on health professionals. Moreover, his book, *The Limits to Medicine*, introduced a new perspective to research on the impact of medicine on society, showing how the medical establishment has played a far more intimate role in our lives than many of us would have imagined (J. Bishop, 1976). In this context, Illich's belief that medical intervention generates disabling-dependency in the population is similar to Foucault's notion that disciplinary power produces docile bodies (the latter to be discussed in Chapter Three), in that both constitute the deeper effects of professionals' work. In his analysis of the deeper effects of professionals' work, however, it could be argued that Illich sees individuals as somewhat of an homogeneous group (i.e., they are either dependent or in the process of becoming dependent on the medical profession for their health). Or, similarly, he does not consider that individuals differ in their dealings with the health profession (e.g., some people actually benefit from their interactions with medical professionals). In defence of Illich, I believe that his analysis, with its highly polemical approach of criticising the medical
profession, was not meant to be taken literally. Rather, the themes within it are useful as a starting point for social action. The same holds true in response to the criticism that while Illich discusses medicine's health-denying effects with riveting clarity, the remedies he offers to decrease individuals' dependence on the medical profession are not nearly as well-formulated. For example, he argues that an optimal health care system would involve an integrated combination of both autonomous and heteronomous medicine, but he does not say how this should come about. Indeed, as critic C. Curtis (1976) points out, at the time that Illich was writing it was the questions that mattered more than the answers. Needless to say, we need more than just questions now. It is conceivable that the issues and questions that Illich poses in his examination of the workings of modern medicine could, if confronted, lead to the necessary social change.

So far in Chapter Two I have considered the basis for medicalization, when it began and how, from a historical social constructionist perspective, it involves the imputation of one version of reality for another. In discussing the medical transformation of previously non-medical entities into its jurisdiction, it is important to realize that medicalization and its effects are on-going
processes. In the following section I present a series of theorists, each with a slightly different perspective on medicine as an institution of social control, whose analyses, as a collective, span the time period beginning in the early 1940s and ending in the mid 1980s. Of all of the accounts presented, Talcott Parsons' is the most unique with his conservative, even altruistic, viewpoint on the role of the medical profession in society. Although his perspective stands in contrast to the other more critical analyses presented, his work is better appreciated if one understands two of its characterizing features. To begin, of all the theorists presented, Parsons was writing at the earliest part of this century, before most of the problems with our contemporary medical-bureaucratic complex had been exposed. His account is still useful today, however, because it represents the medical profession's own view of itself. Overall, Parsons' work provides a comparison between the services medicine sees itself providing for society and, through the accounts of the other theorists, the services which medicine actually renders and the damage which tends to ensue in the process.

Other, more critical theorists, who challenge Parsons' benevolent view of the medical institution include Eliot Freidson, who argues that the medical profession has a monopoly over its services and the power to define who is and is not ill. From his perspective, the medical profession is
not a disinterested party, but rather has enormous power over individuals' lives. Erving Goffman, who is concerned about the impact of labeling someone as mentally ill, examines the processes which individuals undergo as they move from a position of self-hood to patient status after entering an asylum. Goffman's analysis chronicles how life in an asylum dramatically transforms an individual's sense of self; a process that begins when the usual structures which support and maintain an individual's sense of self are eradicated. Finally, Andrew Scull argues that the power of the medical profession and the means by which we regulate deviant behaviour are determined by the needs of capitalist society. He contends that the move toward institutionalization of the deviant can be linked to the growth of the capitalist market system and to its impact on economic and social relationships.

A final point worth noting is that the analyses of each of the following theorists, as well as Illich's, Zola's, and Conrad & Schneider's presented previously, are based on the juridico-discursive model of power. The juridico-discursive model of power is built upon three assumptions: that power is possessed (e.g., by individuals, by a class, or by the populace); that power flows from a centralized source from the top on down (e.g., through the law, the economy, or the state); and that power is generally repressive (e.g., a prohibition supported by negative sanctions) (Sawicki, 1991).
The assumption that power is repressive refers to both the nature and the consequences of power. All of the analyses of the theorists presented in this chapter are based on repressive hypotheses. Consequently, they do not open much conceptual space to account for resistance by individuals and collectivities.

2.4 Traditional Theories of the Medical Establishment as an Institution of Social Control

Many theorists argue that the medical profession is a major institution of social control because it has the power to define illness. This power has significant implications for individuals because medical diagnoses determine who can collect social benefits, who can work, who can access services, and what will be one's general quality of life. Although many theorists agree that medicine is an institution of social control, each approaches this problem differently. In this section, I outline various theorists' approaches, their concept of medicine as an institution of social control, and their understanding of the sources of medicine's power, the medicalization process and its implications for patients. I begin with the work of Parsons who, as a sociologist writing in the 1940s and 1950s, emphasizes the benefits of professional knowledge, particularly the knowledge of the medical establishment.

Taking a structural functionalist approach, Parsons focuses on the positive functions that institutions such as
medicine perform for society. Although an asymmetric relationship exists between patient and physician, Parsons (1951) argues that physicians would not exploit patients because they had been granted a monopoly, power, and status in exchange for protecting patients. Parsons (1939) argues that professionals, in this instance physicians, approach their work from an altruistic perspective, performing their services for the good of society, rather than for profit-making. He concludes that the extensive power that physicians have is legitimate because they are the only people with the technical competence to care for the sick, and because they perform one of the more difficult jobs in society (Parsons, 1951).

Parsons conceptualized being sick as a social role, not merely as a state or condition. To assume the social role of a patient, one must agree that the state of being sick is undesirable and be motivated to get well. In short, the patient is responsible for seeking technically competent help and for co-operating when that help is provided. The most appropriate source of help would, of course, be the physician (Parsons, 1951).

While Parsons attends to the positive aspects of the medical professions' power, other theorists are more sceptical about the benign nature of medical influence. Writing from a neo-Weberian perspective, Eliot Freidson--one of the leading theorists on medical dominance--argues that
medical power is based on a monopoly granted by the state, which functions as an exclusionary shelter against competing occupations in the market place. With state sponsorship, the medical profession has widened its control over the public through processes of medicalization (Freidson, 1986).

Freidson (1970a) contends that in Western society, health is a primary value which is heavily promoted by the medical profession. The medical profession thus has a monopoly "over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively" and, not surprisingly, an increasing range of human behaviour is labeled and defined as 'healthy' or as an 'illness' (Freidson, 1970a: 251). These labels result in more medical intervention in human behaviour and therefore more medical control over people's lives (Freidson, 1970a). Finally, labels are constructions of the medical profession's formal knowledge, which when applied, colour our perspectives and approaches to certain types of behaviour.

Freidson (1986) distinguishes between formal knowledge and common sense knowledge. Formal knowledge is rationalized knowledge, based on reason and the application of objective measures and practices to control people more efficiently. Freidson contends that the essential spirit of formal knowledge is technique. Technique is grounded in one principle--efficient ordering, which structures the possibilities for choice and action on the part of ordinary
people. As a result, free choice is prevented. Discipline, in terms of shaping the way we conceptualize and thus approach certain types of behaviour, is a consequence of the application of formal knowledge or labels and thus represents a powerful and influential force (Freidson, 1986).

Most of Freidson’s work is directed at a macro-level of analysis and, consequently, he pays little attention to the experience of being ill. Other theorists have studied the ways in which macro-politics are embedded in everyday life. Using a dramaturgical approach, Erving Goffman (1961) examines how medicine’s macro-level politics are embedded in face-to-face confrontations between the deviant and the normal as the former is integrated into an asylum. For Goffman, the very process of being caught and publicly labeled as ‘deviant’ triggers a self-fulfilling prophecy (Scull, 1984). Upon entering an asylum, the individual is stripped of the usual social arrangements which support and maintain his/her sense of self (Goffman, 1961). Then

the neophyte deviant passes through a public degradation ceremony. This ceremony, by imposing a grossly stigmatizing ‘master status’—that is, a status with a generalized symbolic value—ushers him firmly into his new role. (Scull, 1984: 6)

Goffman shows how the crucial factor in forming the master status of a mental patient is not his/her ‘illness’, but the institutional response. In this context, the inmate’s reactions "...were the products of the ill effects of his environment rather than of intrapsychic forces..." (Scull,
1984: 96). Thus, the asylum, instead of providing solace to the disturbed or helping to restore their sanity, performed a disabling function. With Goffman's assertion that deviance is largely a consequence of the reactions of others and his discussion of how society both creates and aggravates deviance while trying to control it, attention was once again directed back to an examination of the agencies comprising our formal social control apparatus.

Continuing this macro-sociological focus, Andrew Scull (1984) who writes from a neo-Marxist perspective, argues that institutions such as the asylum emerged and took the forms they did in response to the growth of the capitalist market system. The development of capitalism transformed the way people related to one another in the public sphere. With secular political authority increasing at the expense of the church's role in society, the upper classes no longer felt as strong a need to give to the poor in order to ensure their own salvation. As a result, a sizable segment of the population was in permanent receipt of poor relief (Scull, 1984).

The newly emergent bourgeoisie felt that the traditional non-institutional, localized manner of responding to the indigent was inadequate. The former were increasingly attracted to an institution-based response which would permit close scrutiny of who received aid, and, by establishing a regime sufficiently harsh, would deter all but the truly
needy from applying. Institutions could also instill the virtues of bourgeoisie rationality, (e.g., discipline through regulation of behaviour), into those factions of the population least amenable to them (Scull, 1984).

The emergence of a labour market and the movement toward institutionalization made it necessary to distinguish between the different categories of deviance. Initially, all deviant groups were housed together in the workhouse, but an unintended consequence of housing deviants in an institutional setting was that it intensified problems in handling them. In order to avoid providing aid to those able to work--which would undermine the very notion of a capitalist labour market--it was necessary to distinguish the able-bodied from the non-able-bodied poor (Scull, 1984).

The differentiation of deviance provided a precondition for the establishment and emergence of a number of professions claiming to possess specific expertise in the management of each type of deviance. Not only would state-supported institutions provide a market for these experts' services, the institutions would provide a structure, isolated from the community at large, where the budding professions could develop their skills in dealing with specific types of deviance. These skills could then serve as the basis for claims to monopolize particular lines of work. In addition, bureaucratically organized specialists would uphold bourgeois interests by providing a buffer between the
upper classes and those requiring control thus obscuring the links between social control and class domination (Scull, 1984).

Psychiatry was one of the professions which forged a niche for itself and became the organization of experts on the management and rehabilitation of the mad. Through this process, the paradigm of insanity, and consequently the treatment of the mentally ill, underwent a radical shift—away from notions of insanity’s demonological, nonhuman, animalistic properties and underpinnings—toward a view that mad persons were exhibiting a defective human mechanism which could be cured (Scull, 1984). Scull shows how various specialists in deviancy control were able to exploit a favourable cultural environment to secure recognition as ‘experts’. Moreover, the emergence of ‘experts’ in the control of deviance, and the elaborate ideological accounts of their work these groups produced, helped to rigidify the various subcategories of deviance, thus resulting in a self-reinforcing system (Scull, 1984).

2.5 Summary

While each of the theorist’s analysis examined in this chapter has presented a different perspective on medicine as an institution of social control, a common denominator among their analyses is that they are all based on a juridico-discursive model of power. As a result, the majority of the
theorists' analyses presented in this chapter have two fundamental limitations for the topic at hand. First, the juridico-discursive model of power holds that power represses individuals to such a degree that they have little or no opportunities for resistance. Thus, analyses which employ this model do not open up much conceptual space to account for individuals who utilize resistance in their interactions with the medical enterprise. Since resistance, along with the APA's own theoretical confusion regarding homosexuality, is what eventually led to the demedicalization of homosexuality in 1973, it is necessary to employ an analytical perspective that can account for human agency. With the exception of Goffman, none of the theorists whose analyses have been presented could account for human agency. In his book, *The Presentation of Self in Everyday Life*, Goffman (1959) illustrates how individuals utilize human agency by presenting various versions of themselves as they interact with different people. Since his insight has important implications for the methodology of this thesis, it is discussed in more detail in Chapter Four. Second, the juridico-discursive model of power which holds that power operates from a centralized source outside of individuals cannot account for the fact that sometimes individuals willingly participate in their own oppression. Such an account would enable us to understand why gay men and lesbians choose to engage in therapy with psychiatrists when
psychiatrists represent an enterprise that has labeled them 'sick'.

Overall, the focus of traditional theorists of medical control is on the ways in which psychiatry restrains and represses individuals, and most notably gay men and lesbians. These theorists would applaud the move to demedicalize homosexuality since it represents an important step in the recognition of homosexuality as a legitimate expression of sexual desire. Michel Foucault’s work, however, would discourage any pronouncements in this direction. In the following chapter I discuss why Foucault would be suspicious of the move to demedicalize homosexuality; and how his work addresses the shortcomings arising out of the analyses of the traditional theorists mentioned above; and finally, how his analysis is useful for examining the control that gay or lesbian clients perceived their psychiatrists to have imposed upon them.
3.1 Introduction: The Usefulness of Foucaultian Analysis for this Research

Homosexual men and women are best understood when they are seen as whole human beings, not just in terms of what they do sexually, and that surely is the most important point about any class of human beings....

Ashley Montagu, Anthropologist (Rutledge, 1988: 117)

The greatest obstacle that gay people have is their fear of rejection on account of homosexuality.

Harry Britt, Gay San Francisco City Supervisor (Rutledge, 1988: 109)

While the analyses of the theorists presented so far are based on the traditional or juridico-discursive model of power, Michel Foucault’s work extends beyond this model, thus representing a new theoretical tradition or paradigm shift in our conceptions of power. Although not denying that the juridico-discursive model of power constitutes one form of power with its primary consequence being repression, Foucault emphasizes the productive nature of power. Foucault contends that power produces discourses that become embedded in the thoughts of individuals. Such a notion enables us to understand how individuals seem to participate willingly in their own oppression, thus eliminating the need for control.
from an outside source. Herein lies the first reason Foucault’s genealogical method was chosen to inform this analysis. But, it is also necessary to account for the fact that individuals may sometimes challenge systems of power which dominate them. How does this happen? Foucault’s genealogical method opens up the conceptual space to account for such resistance, which provides the second reason his work was chosen for this analysis.

Overall, Foucault’s extensive writing on marginalized people and the changing nature of social control makes his theory very applicable to research on the social control of gay men and lesbians through psychiatry. His series of researches documenting the ways that the criminal, the mad, and the sexually ‘abnormal’ have been treated through the penal system and the psychiatric enterprise respectively illustrate a historical and paradigmatic shift in the mechanisms of social control. Although many view the new methods of treating the criminal, the insane, and the sexually deviant as enlightened, more humane, and scientific, "...from Foucault’s perspective, the ideology of rationality that characterized the Enlightenment simply represented a different and more insidious form of social control..." (Deutschmann, 1994: 290). For Foucault (1978), these more subtle forms of social control operate through processes of subjectification.

A classic example of processes of subjectification is
the creation of the homosexual subject. 'The homosexual' as an identity is a discursive formation which only emerged in the mid-nineteenth century after being informed by religious, policing, and finally, medical discourses in society. In the late nineteenth century, sex was primarily being discussed at the formal level through medical discourses. Through medicine, sex began to be seen as an instinct, and this instinct was thought to reflect an individual's nature or identity. At this time, acts began to be replaced by 'identities', and pleasures by 'orientations'. Prior to this, those who were inclined to, simply engaged in homosexual acts or practices; these inclinations were not seen as constructing their identity. With sex seen as informing an individual's identity, however, all sexual behaviour and hence, sexual identities could be scientifically classified as either normal or pathological (Dreyfus & Rabinow, 1982). Around this time an increasing level of hostility toward homosexuality emerged (Weeks, 1977). Arguably, this hostility may be reflected in the classificatory schemes, for instance in the construction of homosexuality as a mental illness.

The creation of the homosexual as an identity has had several implications on the population. First, when it is actively internalized, this discourse results in the potential for greater social control from within homosexuals themselves. For instance, identification with Western
society’s widely stigmatized conceptions of ‘the homosexual’ tends to trigger internal policing mechanisms in gay men and lesbians which reduces the need for control from an outside source. As well, the creation of the homosexual subject serves to keep the wider straight population in check by designating what is permissible and impermissible behaviour in Western society and thus containing and limiting the latter. Finally, in what was likely an unintended consequence, the construction of the homosexual as an identity provides gay men and lesbians with a greater capacity for resistance to unwanted ‘treatment’ by enabling them to identify with a subculture of like-minded others.

This resistance has been significant, for it along with the American Psychiatric Association’s own internal theoretical confusion on homosexuality, is what eventually led to the demedicalization of homosexuality in 1973. Now that the lobbying of activists and some psychiatrists has been successful in formally demedicalizing homosexuality, it is important to consider how the medical establishment, which was previously seen as homophobic, presently regards homosexuality. Significantly, although homosexuality has indeed been removed formally as an illness designation from the APA’s nomenclature, this still does not guarantee that individual psychiatrists’ current attitudes and practices reflect these changes.

I open this chapter by contrasting Foucaultian analysis
with those of traditional theorists of medicine as an institution of social control (in section 3.1), arguing that Foucault's notion that power comes from below and his ability to account for individuals' resistance to professional intervention makes his work more useful for this analysis. After this, Foucault's notions of power, objectification, and subjectification are discussed (in section 3.2) with a focus on showing how individuals are constituted both as objects and subjects through specific technologies of the body operating through human sciences such as psychiatry. Foucault's notion of genealogy is also developed as it opens up the conceptual space to account for individuals who resist the objectifying and subjectifying processes imposed through the historical grid of bio-power.

Section 3.4 discusses how religious, policing, demographic, and medical discourses came together to constitute the homosexual as an identity. In turn, this identity could be internalized and used to subjectify individuals. Conversely, Foucault also shows that one of the unintended consequences of creating the homosexual subject was that it enabled a group of individuals to come together in the struggle to socially legitimate homosexuality. Recognizing that such resistance was largely responsible for the move to demedicalize homosexuality, this chapter concludes with a historical overview of the demedicalization of homosexuality (in section 3.5).
3.2 Discursive Practices

Foucault’s belief that mechanisms of social control have become more insidious in recent years draws our attention to his conceptions of power. If power has indeed become more subtle, what are the ways he sees it as being manifest? Most importantly, Foucault sees power as manifest through discourses. Discourses are "...historically variable ways of specifying knowledge and truth...." (Ramazanoglu, 1993: 19). Discourses, particularly scientific discourses, function as sets of rules that specify what is or is not the case at a given time. For instance, they determine who can or cannot be constituted as insane (Ramazanoglu, 1993). As Linda Deutschmann notes, "[t]o know something is to delimit it, to place a value on it, and to displace other ways of knowing" (1994: 289). Foucault (1978) sees power as being exercised from the micro-level through a process known as 'subjectification' (to be discussed shortly). In brief, power produces its effects through the ways that individuals come to understand themselves. Closely associated with this last notion is Foucault’s belief that power is primarily productive rather than repressive. In other words, power is exercised through the production of discourses, rather than through prohibitive sanctioning. Overall, Foucault’s main ideas about power can be summarized as follows: the exercise of power produces knowledge (through discourses), while
conversely, knowledge produces the effects of power (Ramazanoglu, 1993).

Foucault (1978) uses the term ‘bio-power’ to refer to the new regime of power which took hold beginning in the seventeenth century when the fostering of life and the growth and care of the population became a main concern for the state. This power was constituted through two poles of development bound together by an intermediary set of relations. In the first pole, political attention focuses on the 'species body' and the 'population'. Human beings are seen as resources. Hence, biological processes such as propagation, level of health and life expectancy were studied in order to gain a knowledge of human regeneration. Supervision of this first pole occurs through an entire series of interventions and regulatory controls. As a result, mortality and the birth rate became objects of knowledge. Using the knowledge obtained from studying the birth rate, the state began to intervene in the affairs of the population in ways that it had not before (Foucault, 1978).

The second pole, which Foucault labeled 'disciplinary power', centres on the body as an object to be manipulated and controlled, a process which Foucault called 'objectification'. Around this time, a new set of operations and procedures emerged, combining knowledge with power, to bring about the objectification of the body (Foucault, 1978).
Foucault refers to these operations and procedures as 'disciplinary technologies' (Rabinow, 1984), the goal of which is to produce docile bodies "that may be subjected, used, transformed, and improved" (Foucault, 1977: 136). Docile bodies are "...limited human beings who are disciplined into conformity with the political economy of their time" (Deutschmann, 1994: 289).

Disciplinary technologies utilize three strategies to bring about the objectification of individuals: discipline, surveillance, and normalizing judgement. Foucault emphasizes that discipline is a technique, not an institution. As a technique, it does not replace traditional forms of power (e.g., houses of detention and armies).

Rather, it "invests" or colonizes them, linking them together, extending their hold, honing their efficiency, and "above all making it possible to bring the effects of power to the most minute and distant elements." (Foucault cited in Dreyfus & Rabinow, 1982: 153)

Foucault states further that discipline operates primarily on the body, at least in its initial deployment. While Foucault notes that some form of social control is imposed over the body in all societies, he states that the control imposed through disciplinary societies differs by approaching the body as an 'object' to be analyzed (Dreyfus & Rabinow, 1982).

In its initial deployment, discipline operates primarily on the body. First, the body is divided into its constituent parts. Then, these parts are subjected to precise and calculated training. "The aim is control and efficiency of
operation both for the part and the whole" (Dreyfus & Rabinow, 1982: 153). Second, any signifying dimension that the parts previously had is obscured. Instead, the focus is on the formal organization and response of the constituent parts (e.g., the reflexes of the knees, eyes, hands). Overall, the principle operating here might read

[t]ake small units, strip them of all signifying dimensions, formalize the operations which relate these units, apply them on a large scale. (Dreyfus & Rabinow, 1982: 154)

Third, disciplinary power is imposed through the use of time. For disciplinary power to render bodies docile, it must operate on the body as continuously as possible, rather than being inflicted sporadically or even at regular intervals. Fourth, discipline proceeds through the organization of individuals in a specific space. This space is converted into an orderly grid (e.g., as in a school, a hospital, or a military base) which is partitioned into regular units. Each unit is assigned a value based on whether or not it is occupied by an individual. Once established, this grid facilitates discipline and supervision, thus reducing the danger that individuals or groups could revolt against the system. In addition to inhibiting the propensity for revolution, the structure of disciplinary technologies also encourages the obedience and usefulness of individuals (Dreyfus & Rabinow, 1982).

With this emphasis on dividing practices and efficiency, it follows that disciplinary technology would also be
concerned with normalization. By 'normalization', Foucault refers to

...a system of finely gradated and measurable intervals in which individuals can be distributed around a norm—a norm which both organizes and is the result of this controlled distribution. (Rabinow, 1984: 20)

Through normalization, all behaviour could be seen as subsisting between two poles—the good and the bad. Between these two poles, a precise series of petty offenses could be identified. In this way, a particular offence could be quantified and ranked. As a consequence of these analytic methods, the possibility of penal accounting emerges. Moreover, upon tallying up individuals' offenses, it is necessary to record the summations. Hence, an objective dossier is kept on each individual. After the acts committed are precisely assessed, the penalty deemed necessary becomes part of the knowledge compiled on individuals (Dreyfus & Rabinow, 1982).

Normalizing judgement and surveillance are used to isolate and classify potentially dangerous social deviations. Once the process is set in motion, individuals tend to be objectively ranked, separated, and individualized (Dreyfus & Rabinow, 1982). It is noteworthy that

[t]he child, the patient, and the criminal are known in infinitely more detail than are the adult, the healthy individual, and the law-abiding citizen. (Dreyfus & Rabinow, 1982: 159)

Surveillance is the final means through which individuals are objectified. The disciplinary technique that
uses surveillance most intensively is the examination: "The act of looking over and being looked over will be a central means by which individuals are linked together in a disciplinary space" (Dreyfus & Rabinow, 1982: 156). The examination derives its power from the way it manipulates the visibility of both the authorities and the objects of power. Through the examination, power becomes less visible, while objects of power are made more visible. In this context, Foucault refers to the examination as 'the ceremony of objectification'. The continuous observation of those individuals subject to control culminates in their individualization. Hence, the examination brings individualization and observation together in a structured space (Dreyfus & Rabinow, 1982).

As with normalizing judgment, the examination also involves individualization through the compilation of objective dossiers. Each individual becomes 'a case to be known'. The dossiers allow the authorities to codify and classify individuals as objects. The compiled knowledge leads to increasing specification in the coding procedures. Furthermore, the systematic accumulation of individual documentation enables authorities to measure phenomenon, describe groups and calculate the distribution of individuals in the population. Finally, through this vast, meticulously prepared documentary apparatus, authorities are not only able to continuously expand into new jurisdictions, they can also
refine disciplinary techniques for observing and analysing
the body--all for the purposes of rendering it more available
for manipulation and control. Ultimately, the historic
object-effect of this specific and complex intersection of
power and knowledge is individuated, knowable wo/man (Dreyfus
& Rabinow, 1982).

The processes whereby individuals internalize knowledge
that objectifies them (e.g., scientific classifications or
established behavioral norms) and, as a result, turn
themselves into subjects, Foucault calls 'subjectification'
(Rabinow, 1984). "These operations characteristically entail
a process of self-understanding but one which is mediated by
an external authority figure, be he [sic] confessor or
psychoanalyst" (Rabinow, 1984: 11). Despite such mediation,
Foucault emphasizes the relatively active role individuals
play in their own self-formation. Through objectification
processes (e.g., putting individuals in cells and compiling
their objective dossiers), individuals are seen to be in
relatively passive, constrained positions. However, Foucault
sees subjectification as a process whereby individuals
actively turn themselves into subjects (Rabinow, 1984).

Although individuals actively participate in their own
self-formation, this does not mean that they have control
over the results. Subjectification produces individuals who
tend to understand themselves in certain ways and not in
others. In turn, these self-understandings may, to varying
degrees, affect how individuals act. Hence, subjectification tends to turn individuals into self-acting subjects. From the state's perspective, the production of self-acting subjects is an efficient means of social control for it eliminates the need to police individuals from an outside source—they are self-controlled. (These techniques are discussed in section 3.4).

Individual self-formation occurs through a long and complicated 'genealogy', with genealogy being the analysis of the descent of a trait or concept (Rabinow, 1984). The trait of concern to this thesis is the deviant subjectivity formation of gay men and lesbians. The deviant subjectivity formation of gay men and lesbians is charted in relation to the medical-scientific discourses pathologizing homosexuality, or more specifically, to overlapping processes of objectification and subjectification imposed by psychiatrists. Individual self-formation occurs over an individual's lifetime and reflects both the specific discursive formations that the individual is born into, as well as those that emerge during the individual's lifetime. These discourses may influence individuals in a variety of ways. For example, discourses operate on "...[people's] own bodies, on their own souls, on their own thoughts, on their own conduct" (Foucault cited in Rabinow, 1984: 11).

The genealogy of an individual's self-formation is complicated because it involves the possibility of
individuals resisting the ways in which their self-understandings are mediated. In turn, this resistance comes to inform the individual's self-formation. When individuals resist, however, the self-understandings that result tend to diverge from those imposed through the dominant discourses of the humanist tradition.

For Foucault, resistance to power occurs through new discourses producing new truths. These discourses, which oppose hegemonic truths, are known as 'reverse discourses' (Ramazanoglu, 1993). Foucault offers homosexuality as an example of a 'reverse discourse'.

The idea or "truth" of homosexuality appeared as a discourse which did not counter the prevailing medical discourse. It claimed homosexuality as natural, in the terms of the dominant discourse. (Foucault cited in Ramazanoglu, 1993: 20)

- The notion of homosexuality as natural provided individuals with a means to resist disciplinary practices regulating homosexuality. For Foucault, individuals are never completely constrained by power; they can always modify its hold. In addition, Foucault (1978) contends where there is power, there is resistance.

Foucault's notions on resistance and the position of the subject are reflected in his views on the social field. For Foucault, the social field consists of a multitude of unstable and heterogeneous relations of power. It is an open system where both domination and resistance may occur. Foucault states that the social and historical field is a
field of struggle. Power is diffused throughout this field and is exercised on and by individuals through the internalization of discourses. Foucault is interested in the patterns of power; he refuses to identify the subjects of a struggle. He maintains that all individuals fight against one another. One's interests and allegiances are shifting and unstable because they depend on where one is situated and what role one is assuming at a given time (Foucault cited in Sawicki, 1991).

Foucault's genealogical method opens up the possibility for more than simply a history of victimizations. It opens up a conceptual space for a "historical knowledge of struggles" (Sawicki, 1991: 26). More specifically, Foucault's genealogical method paves the way for an "insurrection of subjugated knowledges" (Sawicki, 1991: 26).

These are forms of knowledge, experience, and understanding that have been disqualified as inadequate to their task, or insufficiently elaborated: naive, knowledges, located low down in the hierarchy, beneath the required level of cognition or scientificity. (Foucault cited in Sawicki, 1991: 26)

Such awareness is not shared by all, but rather constitutes a particular, local, and regional knowledge (Sawicki, 1991). Examples of this include the discredited knowledge of the psychiatric patient, the convicted criminal, and indigent people who become colonized. Most relevant to this thesis topic, however, are the subjugated knowledges of the many gay men and lesbians who, after disagreeing with psychiatric characterizations of homosexuality, struggle against these
professionally imposed identities. Gay men's and lesbians' claims to attention, brought forth both collectively and individually, centre around the notion that their chosen mode of existence in the world is valid and not pathological.

Overall, genealogy as resistance involves using history to give voice to the marginalized and disempowered groups whose voices lie beneath the dominant narrative of history. By providing these voices with an opportunity to be heard, Foucault's method locates the multitudes of regional struggles both in the past and the present (Sawicki, 1991). These are the voices of the "creative subjects of history" and, for Foucault, they constitute the basis of resistance in society (cited in Sawicki, 1991: 28).

3.3 Limitations of Foucaultian Analysis for this Thesis

While Foucault's genealogical method does open up a conceptual space to account for individuals' resistance to processes of objectification, his work, like all theories, has some limitations. Feminist critics argue that Foucault does not acknowledge the gendered nature of subjectivity and that his analysis of the power relations administering sex and bodies does not specify who oppresses. While he draws attention to the capitalist, bourgeois, and scientific/medical institutional interests being served, he neglects to mention that these interests are all primarily masculinist in nature (Bailey, 1993). Moreover, in
Foucault's mapping out of techniques of subjectivity (to be discussed shortly), his subject is a desexualized, general 'human' (Braidotti, 1991). Thus, he does not consider that men and women relate differently to societal institutions (McNay, 1993). Nor does he consider that women's bodily experiences are different from men's due to the former's subordinate status (Ramazanoglu, 1993).

A direct implication of Foucault's failure to account for women's oppression is his inadequate formulation of resistance for feminists. Feminists argue that contrary to Foucault's notion of power as unstable and shifting, patriarchal power is relatively stable and enduring. In critically analysing Foucault's work on sexuality, many feminists conclude that men indeed possess power over women and children.

In terms of resistance, Kate Soper (1993) argues that Foucault's belief that power can only be resisted through 'reverse discourses' obscures the fact that the fate of oppressed groups is not decided simply at the level of competing discourses. Foucault's perspective takes the focus off structural determinants in subordinated persons' lives. Moreover, a critical factor in the advancement of subordinated persons is the specific economic and political climate in which they express resistance.

Foucault's theory is not perfect by any means. However, in being aware of the limitations of his theories I attempt
to remedy them through the following two measures. Given that Foucault does not consider the gendered nature of subjectivity in his work, I attempt to draw out the distinctions between the genders whenever possible (e.g., the ways that gay men and women are approached differently by their psychiatrists as well as the gendered nature in the ways that gay men and women respond to their psychiatrists). In response to the charge that Foucault's notions of resistance are inadequately formulated, I merely note that his theory does open up a conceptual space to account for resistance, then I discuss in the analysis how such resistance is empirically demonstrated by the gay or lesbian clients. Despite the shortcomings of Foucault's work, I chose to use his theories based on the comprehensiveness of his notions of power, the fact that he opens up a conceptual space to account for clients' resistance to the professions, and finally, because of his relatively unique belief that individuals play an active role in turning themselves into subjects.

3.4 The Creation of the Homosexual Subject

Foucault notes that during the eighteenth and nineteenth centuries sexuality shifted from being a relatively free and undifferentiated aspect of everyday life to being controlled and hidden. The new discourse held that sex was

...a drive so powerful and so irrational that dramatic forms of individual self-examination and collective-
control were imperative in order to keep these forces leashed. (Dreyfus & Rabinow, 1982: 169)

These controls were accompanied by an unprecedented rise in discussing, writing, and thinking about sex (Dreyfus & Rabinow, 1982). Foucault argues that the historical construction of sexuality began at the opening of the eighteenth century. Discussions and scientific classifications of sexual activity were carried out under the guise of an administrative concern over the welfare of the population. At this time, sex was still very much embedded in religious discourses involving the notions of flesh, sin, and morality. Gradually certain issues began to emerge which involved the police and demographers, namely prostitution, population statistics, and early forms of venereal disease. Sex was transformed from being something one judged, to something one administered. It was necessary to manage sex for the public's own good. Hence, as the eighteenth century progressed, sex became a police matter (Foucault in Dreyfus & Rabinow, 1982).

At the beginning of the nineteenth century, the discourse on sex underwent a major shift, from articulating sex in terms of the religious and legal obligations of marriage, transmission of property, and kinship ties, to discussing sexuality in medical terms (Dreyfus & Rabinow, 1982). Foucault (1978) notes that sex began to be constructed as an instinct, which registered at both biological and psychic levels. With sex seen as an instinct,
all sexual behaviour could be classified as either normal or pathological. Whether perverted or healthy, the sexual instinct was thought to reflect the individual's nature (Dreyfus & Rabinow, 1982). Physicians, reformers, and social scientists began to argue that sexuality provided the key to individual health, pathology, and identity (Dreyfus & Rabinow, 1982).

In the classificatory scheme, acts were replaced by 'identities' and pleasures were replaced by 'orientations'. Foucault comments that whereas "[t]he sodomite had been a temporary aberration; the homosexual was now a species" (1978: 43). In conjunction with the emergence of the homosexual as an identity, the late nineteenth century witnessed an increasing hostility toward homosexuality (Weeks, 1977). This hostility was likely reflected in the "...vast schema of anomalies, of perversions, of species of deformed sexualities" constructed through the sciences concerned with sex (i.e., psychiatry) at this time (Dreyfus & Rabinow, 1982: 172). In sum, rather than repressing unproductive extramarital sex, the disciplinary power which operated around sex in the last century acted by producing a multiplicity of sexualities. "It did not set boundaries for sexuality; it extended the various forms of sexuality.... It did not exclude sexuality, but included it in the body as a mode of specification of individuals" (Foucault, 1978: 47).

By internalizing such prevailing discourses on
sexuality, individuals turn themselves into subjects. As Bell states, individuals come to "...take on sexuality as part of their identity and become attached to it as a truth, a key to the self" (1991: 86). Since the label of 'homosexual' is stigmatized, it affects the individuals' self-definitions which, in turn, affects their self-expression. When individuals come to recognize they are stigmatized, they are much less likely to express themselves freely in Western society. This highlights Foucault's belief that as disciplinary power is exercised on the body and soul of individuals, it increases the individuals' self-knowledge while simultaneously rendering them more docile (Sawicki, 1991).

The creation of the 'homosexual role' functions to keep the straight population in check as well.

The creation of a specialised, despised, and punished role of homosexual keeps the bulk of society pure in rather the same way that the similar treatment of some kinds of criminals helps keep the rest of society law-abiding. (McIntosh cited in Weeks, 1977: 3)

This occurs in a two-fold manner: by illuminating what is permissible and impermissible behaviour; and by segregating the 'deviants' and thus restricting and limiting their behaviour patterns (McIntosh cited in Weeks, 1977: 3-4).

Producing subjects with sexualities is, however, only part of the process of enmeshing the body in contemporary power/knowledge relationships (Foucault, 1978). Through the deployment of sexuality, the effect of bio-power is most
greatly enhanced in controlling the body and soul through the construction of a specific technology used in both religious and secular settings: the confession of the individual subject. The medical examination—requiring the patient’s confession—was the medium for putting articulations about sex into medical terminology (Dreyfus & Rabinow, 1982).

In order to learn truths about oneself, one had to confess, allowing a doctor or psychiatrist to interpret one’s private thoughts and practices. The conjecture of the confessional and psychiatric diagnoses defining homosexuality as a perversion, provided a space in which psychiatric control could permeate the lives of gay men and lesbians, resulting simultaneously in forms of self-policing and collective control (Dreyfus & Rabinow, 1982).

3.5 The Demedicalization of Homosexuality

Since the move to demedicalize homosexuality was based largely on the efforts of an number of gay activists and even some psychiatrists, it is imperative that the theoretical framework used for this thesis be able to account for individual’s and collectivities’ resistance. As mentioned previously, traditional theorists of medicine as an institution of social control cannot account for the resistance of opponents to the official designation of homosexuality as a mental disorder. Foucault, however, is able to show that one of the unintended consequences of
creating the homosexual subject was that it enabled a group of individuals to come together in the struggle toward a common goal—the social legitimation of homosexuality.

In the century leading up to 1973, throughout psychiatric research on sexuality, the main conception of homosexuality was that it was a mental illness. The status of homosexuality as a pathology can be charted through four editions of the Diagnostic and Statistical Manual of Mental Disorders, manuals which represent the professionally approved diagnostic classifications of mental disorders with which the American Psychiatric Association (APA) is concerned (Conrad & Schneider, 1980).

In 1973, as a result of internal theoretical confusion within the APA and through external pressure from Gay Liberation groups, homosexuality was officially removed from the DSM-II (Bayer, 1981); however, the category 'ego-dystonic homosexuality' was substituted for it (Conrad & Schneider, 1980). Implemented as a compromise, this category allowed psychiatrists to diagnose lesbians and gay men who, in the clinical judgement of their psychiatrists, appeared dissatisfied or distressed about their sexual orientation (Silverstein, 1984). Reorientation therapy in the form of aversive conditioning techniques was used in attempts to produce the shift to heterosexuality (Council on Scientific Affairs, 1987).

Many psychiatrists as well as members of gay and lesbian
communities protested the category of 'ego-dystonic homosexuality' on moral and ethical principles, pointing out that the label amounted to yet another demonstration of prejudice on the part of the APA (Begelman, 1977; Davison, 1977; Silverstein, 1977). Frederick Suppe (1984) notes that the inclusion of the category in the DSM-III was problematic, citing the diagnostic criteria of 'ego-dystonic homosexuality' to make his point:

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. (American Psychiatric Association, 1980: 282)

Paul Gebhard and John Money state that if this was a legitimate category, the DSM-III would also include 'ego-dystonic heterosexuality' (cited in Suppe, 1984). As it appeared, the addition of the category 'ego-dystonic homosexuality' to the DSM-III seemed to have further promoted the notion of homosexual conduct as an illness (Smith cited in Schwanberg, 1985).

In 1987, the APA removed 'ego-dystonic homosexuality' from the revised edition of the DSM-III (Harris, 1988). However, the diagnosis of 'sexual disorder not otherwise specified' remains, and it "can be applied in cases where there is persistent and marked distress about one's sexual orientation" (American Psychiatric Association, 1987: 168). Presently, there is speculation as to whether this change in
nomenclature has had any effect on the social and medical practices of many North American psychiatrists. Given the high rates of alcoholism, depression, suicide, and AIDS among the gay and lesbian population, it is important to examine the social and medical practices of psychiatrists toward their gay and lesbian clients because psychiatrists may well be the primary 'experts' to whom many of these people turn for help (Kus, 1990).

Indeed there are clues which suggest that the APA still has a tendency to medicalize homosexuality. Currently, with the advent of the AIDS crisis, particularly in the gay men's community, gay and lesbian activists are once again resisting a new round of attempts by dominant social agencies and the mass media to construct homosexuality as an illness, and gays and lesbians as 'sick' or 'diseased' (Kinsman, 1987). While today the AIDS crisis may be fuelling the urge to medicalize homosexuality, twenty-five years ago the demedicalization of homosexuality was heavily resisted by the majority of the APA membership, a sentiment that is likely shared by much of the general population. Finally, Schwanberg's (1985) content analysis of the images of gay men and lesbians in health sciences literature between 1974 and 1983 revealed that the term 'homosexuality' was used more frequently than the terms 'gay' or 'lesbian'. From the labeling perspective, her finding is significant because the term that designated the illness classification continues to be used long after
demedicalization. While this theme may be apparent in the structures of knowledge/power associated with established psychiatric practice, it is not at all clear whether it is present in the therapeutic interactions between psychiatrists and their gay or lesbian clients.

3.6 Summary

This chapter shows that through the medical discourses beginning in the late nineteenth century, it became possible to construct the homosexual as an identity. Moreover, with sex seen as an instinct, it also became possible to label that instinct as either normal or pathological, perverted or healthy. Until 1987 in North America, the APA was intent on continuing to consider homosexuality as pathological. The DSM-III Revised Edition's diagnosis of 'sexual disorder not otherwise specified' seems to indicate, however, that the APA's prior homophobia has become less blatant. Nevertheless, with homosexuality now demedicalized at the formal level, at least, I query a number of gay men and lesbians who have been treated by a psychiatrist(s) in the last twenty-five years to gauge their perceptions of how psychiatrists are now viewing homosexuality.
4.1 Introduction to an Uncovering of the Subjugated Knowledges of Gay Men and Lesbians

...when I grew up we had no positive images if we were gay. I was totally lost--I was just this fat faggot living in Brooklyn. All I knew about gays was that they always got beaten up in some Philip Marlowe movie.

Harvey Fierstein, Actor (Rutledge, 1988: 55)

There is no denying that psychiatric definitions of homosexuality both reflect and reproduce society’s views on homosexuality. Designating homosexuality as a sick or deviant lifestyle involves a normative judgement about what is and what is not appropriate sexual behavior. By definition, psychiatric diagnostic categories do not involve consultations with gay men and lesbians to find out their views on their sexual identities. Instead, the imposition of psychiatric designations of homosexuality has resulted in gay men’s and lesbian’s views of themselves becoming buried, or at least disguised.

Using Foucault’s genealogical method, this thesis traces the deviant subjectivity formation of several gay men and lesbians in relation to the pathologizing discourses of psychiatry. The term ‘deviant subjectivity’ refers to the processes by which an identity-space is discursively
constructed by the objects of study who, in their processes of self-inquiry, are at times compliant with and at other times resistant to pejorative, pathologizing characterizations of themselves by medical professionals (Terry, 1991).

The decision to interview gay men and lesbians about their therapeutic experiences with psychiatrists is an act of uncovering subjugated knowledges—"the memory of hostile encounters" (Foucault, 1980: 83). It affords the opportunity for gay men and lesbian to articulate what it means to be a homosexual in a homophobic culture. In addition, interviews with former/present gay or lesbian psychiatric clients provide a commentary on the role of psychiatrists in mediating society's decidedly homophobic and heterosexist views on homosexuality. While the latter is the focus of this study, the former question has significant currency for this research because it highlights the level of sensitivity and empathy needed to study gay men and lesbians who are, as a group, both marginalized and highly politicized at the same time. This issue is addressed in some detail in section 4.2.

Since the goal of this research is to examine the psychiatric relationship from the perspective of the gay or lesbian client, the views of the psychiatrists are not represented at all. One of the dangers in having one perspective is the tendency to stereotype and demonize individual psychiatrists. In section 4.3, I discuss this
challenge, making it clear that a distinction needs to be made between the institution of psychiatry and individual practising psychiatrists. Thus, psychiatrists do not always respond by objectifying their clients (although many of them did), but they bring to the psychiatric relationship a complex set of attitudes mediated through official psychiatric discourses.

In order to uncover the subjugated knowledges of gay and lesbian clients, I conducted in depth interviews lasting approximately 50 minutes each with six gay men and three lesbians. These interviews gave me the opportunity to explore clients' reasons for seeking therapy (and the role that their sexual orientation played in this endeavor), whether psychiatrists met their therapeutic needs as gay men and lesbians, and finally, the level of knowledge that psychiatrists appeared to have about gay- or lesbian-related matters. The sample and the methods of this study are discussed in greater detail in section 4.4.

Conducting this research engendered a number of ethical issues, most significantly my relationship as a heterosexual, female researcher with homosexual informants. These, and other limitations are discussed in the final section of this chapter.

4.2 Being Homosexual in a Homophobic Culture

Homophobia refers to an "irrational fear on the part of
heterosexuals of being in close proximity to people they believe to be homosexual" (George Weinberg cited in Kus, 1990: 92). Societal manifestations of this include 'queer bashing', the removal of children from gay or lesbian parents, discrimination in housing, employment, taxes and pensions based on sexual orientation, and finally, the use of language, usually slang, that is offensive to gay men and lesbians (Stewart, 1995). Homophobia also exists among gays themselves, although the dynamics differ slightly. As Weinberg (cited in Kus, 1990: 92) points out, this phenomenon is characterized by "a self-hatred which results from the internalization of others' irrational fears". Different people react differently to homophobia. Some gay men and lesbians experience both inward and outward reactions (such as engaging in some of the above activities), while others only experience negative feelings. In many cases, these negative feelings escalate to the point that gay men and lesbians attempt to destroy themselves through drug and alcohol abuse and/or suicide (Kus, 1990).

Closely associated with homophobia is the concept of heterosexism, which is a term for prejudice against gay men and lesbians similar to the terms racism and sexism. Heterosexism is distinguishable from homophobia only by a matter of degree. For instance, heterosexism is to homophobia what sexism is to misogyny. Heterosexism and homophobia are essentially two dimensions along the same
continuum of anti-gay sentiment and are built on the notion that the heterosexual lifestyle is normal and superior to any other lifestyle (e.g., gay/lesbian/bisexual). Unlike homophobia, however, heterosexism can often be careless or unthinking. Heterosexism is generally exhibited in the automatic assumption that everyone is straight unless clearly demarcated otherwise, and in the exclusion of any acknowledgement of lesbians and gays as a fundamental part of society. For instance, application forms which only provide boxes to describe oneself as single, married, or divorced are heterosexist (Stewart, 1995). Adding categories such as 'living with a same-sex partner' or even 'other' would show a recognition of more than simply heterosexual institutions in society. Other examples of heterosexism include media portrayals of only heterosexual couples, underreporting of gay/lesbian events, and the refusal to acknowledge a gay man's or lesbian's partner in his or her obituary (Neisen, 1990). Though not as violent or extreme as homophobia, heterosexism is still significant in that it is likely to foster homophobic individuals. Moreover, the term heterosexism, like the concept of homophobia developed shortly before it, is also important in showing that lesbians and gays have developed the pride to declare that their voices form a fundamental part of society and that their exclusion is an ideological position (Stewart, 1995).

Depending upon the personal biography and socio-cultural
context, gay men and lesbians may adopt a number of survival strategies as they negotiate their way through a straight world. From an early age, children are given the message that they must pursue a 'normal' (read heterosexual) lifestyle and are made to feel guilty if they do not. Children are taught myths about gay men or lesbians: that gay men and lesbians are necessarily depressed and lead unsatisfying lives, that gay men are child molesters and transvestites, and that gay men are effeminate while lesbians are masculine. No wonder many gay men and lesbians feel isolated and alienated due to their 'deep, dark secret'. Such individuals may even grow to hate their sexual orientations (Kus, 1990).

At least initially, most gay men and lesbians attempt to keep their sexual orientations 'in the closet'. Even while acting straight or 'passing', however, these individuals are still exploring what it means to be gay or lesbian (Kus, 1990). "'Passing' is done out of fear--fear of rejection, fear of violence, fear of loss" (Kus, 1990: 35). 'Passing' may be carried to the point of dating or even marrying the opposite sex. Ultimately, the phenomenon of 'closeting' creates an invisible population which is facilitated and maintained through a conspiracy of silence. Our culture rewards those who deny or hide their same-sex orientation by leaving them alone. It encourages both gay and straight people to deny the existence of same-sex orientations. The
pressure to remain silent or face prejudice and discrimination is immense (Dana Finnegan & Emily Bush McNally in Kus, 1990: 2-3).

Despite such pressure, there are still those who 'come out'. 'Coming out' refers to the process by which a gay or lesbian individual identifies self as gay or lesbian, changes any previously-held negative notions of gays, lesbians, or homosexuality, accepts being gay or lesbian as a positive stage of being, and acts on the assumption that being gay or lesbian is a positive stage of being. (Kus, 1990: 31)

While indeed there are positive aspects to 'coming out', those people who do tend to feel quite angry that they have to experience such a process. Moreover, unlike racial and ethnic minorities who have many years in childhood to find out what being a minority means, gay men and lesbians tend not to have such an anticipatory socialization process. Initially, gay men and lesbians would even lack role models, since it is unlikely that they would have parents, friends, or relatives who are gay (Kus, 1990).

All of this is not to say that individuals who are gay or lesbian will necessarily lead unhappy lives. Indeed, as Robert Kus states, if gay men and lesbians are able to reach a stage of acceptance with regard to their sexual orientation, they will tend to enjoy a type of freedom not experienced by heterosexuals. After triumphing over an initial war with the self, a certain peacefulness descends (Kus, 1990). As this section shows, however, the odds against gay men and lesbians reaching such a stage of
acceptance are great in a homophobic culture.

Although society is still largely homophobic, actually defining gayness is somewhat problematic because the label homosexual means different things to different people. For instance, how is one to conceptualize those individuals who have sexual relationships with same-sex others but do not label themselves gay or, conversely, the self-proclaimed homosexual who periodically sleeps with members of the opposite sex? In these contexts, the label homosexual appears somewhat arbitrary.

For the purposes of this study I have chosen to interview individuals who label themselves as gay men and lesbians. While I admit that my choice to interview self-identified homosexuals is not unproblematic, it was necessary to have some way of identifying gay men and lesbians and this seemed the least intrusive because the label is constituted through their own self-conceptions rather than being imposed from above. Of course, the wording of my advertisements for potential interviewees (e.g., I was looking for gay men or lesbians who had seen one or more psychiatrist(s) and who had disclosed their sexual orientation to their psychiatrist(s)) would affect who responded to my study. For instance, I would tend to get responses from those individuals who considered themselves to be gay rather than those who simply had sex with same-sex others but did not consider themselves to be gay.
4.3 The Difficulties of Understanding the Dynamics of Identity Formation

A distinction needs to be made between the institutions that produce discourses, namely the APA, and individual practising psychiatrists. While the two are related, they are not synonymous. The APA and its affiliates provide the official accounts of definitions of psychiatric illness as articulated in the DSM. The practice of individual psychiatrists, who are trained in psychiatric theories and methods, will vary according to age, gender, race, and sexual orientation. The degree, then, to which individual psychiatrists objectify their homosexual clients will depend upon a complex interaction between their own beliefs, attitudes, and experiences, and the official discourses set out by the APA--often leading to competing or contradictory sets of beliefs and attitudes. A case in point is the female psychiatrist who treated Carmen, whom Carmen believed was a 'closeted' lesbian afraid to disclose her sexual orientation because they resided in a small town where such a disclosure might have cost her her career. Just as the identity of this psychiatrist was contradictory (i.e., she was lesbian but attempted to pass for straight in matters relating to her career), so was the therapy this woman offered. On the one hand, she suggested that her lesbian client "try dating some nice young men" which seems to indicate that she was attempting to discourage her client from being 'out', while on the other hand, she offered her client a magazine for
lesbians. The contradictory identity of the 'closeted' lesbian psychiatrist, with her contradictory therapeutic techniques, highlights just some of the difficulties in understanding how psychiatrists contribute to the identity formation of gay men and lesbians. Psychiatrists, clients, and myself as researcher each have a relationship to the dominant discourses on homosexuality as well as our own personal feelings about gay men and lesbians. Larger views inform all of us—they are played out, mediated, and subverted. In the case of the 'closeted' lesbian psychiatrist, it appeared that her professional and personal views on homosexuality were in conflict.

Similar to the various factors affecting how psychiatrists objectify their clients are the numerous factors which influence how, or even if, the gay or lesbian clients will comply in their own objectification. For instance, as Terry states, "[t]here are irreducible differences in the experiences of lesbians and gay men that raise problems for theorizing them as a unity" (1991: 68).

The emergence of lesbian subjectivity differs from that of gay male subjectivity not only because of the different gender norms for each sex, but because in Western society these norms are more strictly enforced for males. While the experiences of gay men and lesbians have both largely been hidden from history, lesbian and male homosexuality have been subject to different kinds of historical erasure, different
conditions of visibility, and consequently different strategies of resistance. For instance, when heterosexuals think of homosexuality, they tend to think of gay men. The homosexuality of men is more explicitly documented in everything from novels to police reports of arrests for public sex. Historians of lesbianism tend to have difficulties finding evidence of its very existence, particularly of its sexually explicit forms. Moreover, the policing of lesbianism by dominating factions, like female sexuality in general, has tended to occur in the private sphere (e.g., through the enforcement of proper gender norms). In this context, lesbians have been seen as more of a threat to the family than a menace in the streets because of their rejection of the role of wife and their refusal to reproduce in conventional ways. Women are much less likely to be arrested for engaging in same-sex sexual activity. Basically, the phallocentric police do not appear to believe that sex between women could really be possible. Even legal definitions concerning the 'unnaturalness of homosexuality' generally treat lesbianism like a "misunderstood stepsister" (Terry, 1991: 69). There is no legal definition of homosexuality in the law books of the United States which is not based on male same-sex conduct. More to the point, there is nothing which women do together sexually which has been defined as illegal. All of these points beg the question: how has female homosexuality escaped the social forces which
have rendered male homosexuality so visible? (Terry, 1991).

Gender is not the only system which differentiates homosexual subjects. As Terry notes, "[r]ace, ethnicity, age, and class also structure understandings of homosexuality..." (1991: 69). Historiographers of deviance are now faced with significant questions concerning the various ways that pathological discourses have tended to create different homosexualities in relation to systems of race, gender, class, and age. Two questions arise immediately that are worth noting. First, what are the hazards of assuming that the label of pathology is reflected in all groups of homosexualities? Second, do different homosexual subjects exhibit resistance to pathologizing discourses differently? (Terry, 1991). I include these important questions formulated by Terry to draw the reader's attention to them. However, due to the fact that I do not have the data to analyze them, I leave them for future researchers.

4.4 Research Sample and Methods

For this research I interviewed six gay men and three lesbians in Saskatchewan. Using posted notices seeking interviews I asked individuals who consider themselves to be gay or lesbian to contact me if they wished to participate in my study. In order to participate, each respondent, besides considering her/himself to be lesbian or gay, had to have seen one or more psychiatrist(s) to whom s/he had disclosed
her/his sexual orientation. Respondent confidentiality is the reason I deemed it necessary that willing participants needed to come to me on their own accord.

Interviewees were obtained from three sources. Three of the nine interviewees were recruited through a notice posted at Gay and Lesbian Health Services (GLHS) in downtown Saskatoon. Another respondent from Regina contacted me after reading an ad I had taken out in Perceptions, a monthly magazine for gays and lesbians in Western Canada, obtained at GLHS. The last five, or the majority of the interviewees, were obtained through word of mouth from friends and acquaintances. It should be noted that, except for my first interview, I only attempted to obtain interviews through word of mouth after responses to the posters/ad had dwindled to nothing.

When a friend told me that s/he knew a gay man or lesbian who had seen a psychiatrist and who might be willing to participate, without getting that person's name, I had that friend contact the person s/he knew and explain my study to him/her, providing my phone number. Then, if the gay man or lesbian felt that s/he would like to participate or find out more, s/he could contact me. Knowing that many gay men and lesbians have a distrust of professionals, this procedure was followed to avoid making the gay man or lesbian feel threatened or pressured. Due to the underground nature of the gay community in Saskatoon, I hoped that a snowball
effect would occur by interviewees telling other potential interviewees both about my study and that the procedure followed did not violate their integrity in any way. Only one respondent was obtained in this manner.

Due to the sensitive nature of my topic (i.e., I was dealing with a doubly stigmatized population—potential respondents were gay or lesbian and had been psychiatric patients), it was very difficult obtaining interviews. Although the director of GLHS assisted me in framing certain interview questions so that they might better gauge clients’ therapeutic experiences, it would have been unethical for such a professional to provide me with names of people I might talk to. Difficulty in obtaining interviews affected both the size and the representativeness of this sample.

Initially I intended to interview fifteen respondents. However, when they were not forthcoming, I decided to proceed with nine. All in all, each interview opportunity was very important. Only one woman declined to participate after meeting with me and finding out information about my study. Also, due to the underground nature of the gay community, it was impossible to obtain a random sample. Despite the small sample size and its lack of representativeness, however, the stories presented through this research are valid as long as one recognizes that they constitute one small microcosm of the gay community in Saskatchewan.

In terms of the actual data collection method, this
research used a series of standardized interviews (see Appendix II for the interview schedule). The conversational style of standardized interviews was chosen because it allowed me to establish the rapport needed in order to acquire sensitive information from the respondents. At the outset of each interview, several socio-demographic questions were asked. This phase of the interview was used to 'break the ice' as respondents were asked information which was very familiar to them. Due to the exploratory nature of this research, most of each interview consisted of open-ended questions, thus giving respondents full freedom of expression. Open-ended questions were also chosen in order to avoid guiding the interviewees' responses.

Interviews with the six gay men and three lesbians were conducted in several different locations. Two were done in my office. One was done in an interviewee's office at his place of employment. Another was done in the psychiatric ward of a hospital. Five were done in the confidentiality of the interviewees' homes.

Whenever interviewees consented interviews were taped to avoid the biasing effect of summarized results. Since longer answers were expected, taping was thought to free my attention to monitor interviewees' reactions to the sensitive questions being asked. Four respondents consented to having their interviews taped.

Throughout this thesis I refer to the individuals who
relayed their therapeutic experiences to me as 'interviewees' when discussing them in the context of the interview I had with them, and 'clients' when discussing their experiences during therapy. Although some authors, such as Stein (1988), refer to gay men or lesbians who were treated by psychiatric professionals as 'patients', I deliberately avoided using that word, preferring instead the term 'client'. To me, the term 'patient' has too many victimizing connotations associated with it, while the term 'client' conveys the degree of human agency I heard in these clients' accounts of their therapeutic experiences with psychiatric professionals.

4.5 Socio-demographic Profile of the Interviewees

In this section I provide some general demographic information about the nine clients I interviewed, while still maintaining their confidentiality. Fictitious names have been given to protect the interviewees' identities and to provide the reader with the opportunity to distinguish between the clients' accounts. Upon reading the profiles, it becomes evident that I do not provide standardized information about the interviewees' employment situations. This is because I did not query them directly on this matter, due to both the confidential nature of this study (I did not want them to feel threatened in any way), and because I did not deem this information to be relevant. When an interviewee's employment status was available (i.e., in one
instance, I interviewed a client in his office at his place of employment), I simply note that the client's employment status is confidential. Moreover, to aid the reader in contextualizing the data provided in these profiles, I note the time-frame in which these interviews were conducted: I began interviewing in late 1991 and completed the last of these interviews in the summer of 1994. Finally, at the end of this section, after describing the interviewees individually, I provide some additional information on the clients as a group to show how they are likely to compare with the wider gay and lesbian population.

Terence is a gay male in his early forties. He has a Bachelor's degree and has completed one year toward a Master's degree. His employment status is confidential. Terence has seen two psychiatrists approximately eight years before our interview.

Philip is a gay male in his late teens. He has a Grade Nine education. His employment status is unknown. He has seen four psychiatrists: two in a standard therapeutic context and two in emergency situations, all within a year of this interview. Philip was interviewed in the psychiatric ward of a hospital where he was being monitored and undergoing therapy.

Boyd is a gay male in his mid to late twenties. He has one Bachelor's degree and is three years into another. Boyd has seen one psychiatrist and his therapy ended approximately
six months before our interview.

Rena is a lesbian and bisexual in her early thirties. She has a Bachelor's degree and is the mother of one child. Her employment status is confidential. Rena has seen two psychiatrists; therapy with the first occurred a few years before our interview, and, at the time of our interview she was undergoing therapy with the second.

Jim is a gay male in his late thirties. He has one year of university education and one year of training from a community college. His employment status is unknown. Jim has seen three psychiatrists in the decade between the early 1980s and the early 1990s.

Beth is a lesbian in her mid thirties. She has a Grade Twelve through G.E.D. and a couple of certificates. Her employment status is unknown. Beth has seen three psychiatrists in the twenty year period between the mid 1970s and the early 1990s. Therapy with the third psychiatrist ended approximately a year before our interview.

Carmen is a lesbian in her late twenties. She has completed some first and second year university classes. Her employment status is unknown. She has undergone therapy with two psychiatrists in the early to mid 1980s. As a teenager, she was sent to her first psychiatrist by force. Carmen is the client mentioned earlier who was treated by a female psychiatrist whom she believed was a 'closeted' lesbian.

Don is a gay male in his mid forties. He has two
Bachelor's degrees and an additional year of university education. His employment status is confidential. He had seen one psychiatrist in the early 1970s.

Paulo is a gay male in his early forties. He has a Master's degree. His employment status is confidential. He has seen two psychiatrists: the first in the early 1970s, and the second a couple of months before our interview.

A total of twenty psychiatrists had been visited by the nine interviewees: the six gay men had seen thirteen psychiatrists in total, while the three lesbians had seen seven psychiatrists in total. Seventeen out of twenty therapeutic dyads involved respondents meeting with psychiatrists of the same sex as themselves; in one instance a gay man met with a female psychiatrist, and two lesbians reported meeting with male psychiatrists.

Age, education level, political activeness, though the latter was not measured, seemed to vary among the interviewees. Interviewees also varied in the degrees to which they were 'out of the closet', most likely based on the calculated degree of risk each presumed in being 'out'. Obviously, a university student has less to lose in 'coming out', due to the relatively permissive atmosphere characterizing most North American campuses, than someone who holds a more traditional, professional career. All interviewees must have been 'out of the closet' at least to some degree, however, to have agreed to speak with me.
Overall, I argue that the respondents are likely not typical of the general gay and lesbian population by virtue of the fact that they opted to participate in this study, while many others did not. They are, most likely, more extroverted, more vocal about their grievances with established systems and are thus more political.

4.6 My Role as a Researcher

While undertaking sensitive research such as this, it is necessary to consider the role that I as a researcher play in the nature of the data gathered. For this thesis, the primary factor that needs to be taken into account when considering my interaction with the gay or lesbian interviewees is my straightness. Another factor worth considering is the location in which I chose to undertake this study. Data gathered from interviewing gay men and lesbians at the University of Saskatchewan in Saskatoon, Saskatchewan (where there is a relatively high degree of homophobia) would differ substantially from that gathered in the same manner from, for example, University of California at Berkeley (where homosexuality is more visible and widely accepted).

How did the respondents relate to me as a researcher? All respondents were open and did not seem to mind communicating their experiences to me. Obviously, in doing a study which critically analyzes how gay men and lesbians
have been objectified and subjectified by the medical enterprise in Western society, I did not intend to perpetuate these processes. However, in exploring how the interviewees related to me as a researcher, it appears, from the following two examples, that I may have done just that. Boyd insisted that I be clear on the fact that he did not go to a psychiatrist because he was having difficulty accepting his sexual orientation; rather, he went for another mental health problem. He was very clear on this when I asked him directly, then he mentioned it one more time, unprompted, during our interview. He seemed to be either resisting dominant discourses which objectify the homosexual (i.e., if he was gay he must be unhappy enough about it that he would go to a psychiatrist) or he was resisting what he perceived as objectification processes coming from me as a researcher. Most likely, his need to clarify was based on a complex combination of both factors. Similarly, Rena confided to me during our interview that although she had not told her psychiatrist, she was exploring the possibility that she was bisexual. In this way, our interview interaction seemed to take on the qualities of a confessional, which suggests she was complying with processes of subjectification she perceived as emerging from me as a researcher (i.e., that she should tell me intimate aspects about herself).

In spite of my desire to avoid objectifying gay men and lesbians, aspects of my research demanded it. For instance,
I needed a method of data collection. Given that I was situated in a relatively homophobic environment and did not have direct access to the gay community, which is fairly underground in Saskatoon, I found it necessary to place ads requesting potential interviewees to approach me. However, in placing ads requesting gay men or lesbians who had seen a psychiatrist and who had disclosed their sexual orientation to the psychiatrist, I was, in essence, objectifying the respondents.

As I embarked on this research, two thorny issues emerged stemming from the homophobic climate in which we live: the first involves the question of whether I, as a heterosexual, have any business doing research about gay men and lesbians; the second, which is related to the first, concerns the issue of trust among gay men and lesbians.

It has been suggested to me on a couple of occasions that, as a heterosexual, I have no business writing about the experiences of gay men and lesbians. The first time, I was explicitly told this in a personal interaction with a lesbian friend; the second time, I was given strong feedback of this nature by several lesbians at a conference I attended on 'Homophobia in the Workplace'. These experiences gave me pause for thought as I reflected on the question which Shulamith Reinharz raises, "Do members of different groups speak only for themselves"? (Reinharz, 1992: 258). Approaching this topic with a background of many years of
feminist sensitivity and understanding I can appreciate these women's positions. Open any feminist book published in the last twenty years and you will find a legacy of carnage and abuse produced by dominating factions who have colonized marginalized groups. In support of the idea that members of different groups should speak only for themselves is bell hook's (1988) point that given the politics of race, sex, and class discrimination in our society, there is a tendency to place more value and emphasis, for example, on what white people are writing about black people, rather than on what black people are writing about themselves. Still, at a deep level I do not believe that this line of thinking is conducive to 'bridge building', if you will, across different groups. Thus, I was not content to leave this topic for another 'more suitable' researcher. It was not until I stumbled across another quote by hooks, however, that I felt reassured that I had made the right choice. As hooks contends, I do not wish for a situation where only black women are encouraged to write about issues related to black female experience. Problems arise not when white women choose to write about the experiences of non-white people, but when such material is presented as 'authoritative'. (1988:48,50)[emphasis my own]

Although hooks is discussing relations between caucasians and blacks, I believe her words can be extrapolated to fit relations between gay men, lesbians, and the straight population. Her words provide the right mix of both connectedness with groups who are different from ourselves,
as well as sensitivity to the fact that I, as a heterosexual, represent to gay men and lesbians a faction of the population that has perpetuated a legacy of hatred and repression against them. In this vein, this thesis research constitutes my interpretation of the interviewees' stories. Moreover, as Linda Lemoncheck states, when "inquiring a subject one must assume a perspective from which to launch the inquiry" (cited in Reinharz, 1992: 261). The standpoint from which I interpret and define reality, which I made known to my respondents at the point of interview, is as a white, middle-class, female, and feminist heterosexual.

Implicit in the discussion of thorny issues so far has been the notion of trust; indeed, the issue of trust played a major role in this research endeavour. It could be argued that my respondents were gaining very little in return for granting me, a complete stranger and someone to whom they owed nothing, an interview. While afterward, given the homophobic climate of the society in which we live, I had information that could wreck havoc in their lives. Nevertheless, six gay men and three lesbians agreed to be interviewed, showing that each was not only trusting, but open-minded enough to feel comfortable discussing intimate aspects of their personal histories with a researcher.

A final point relative to the issue of trust involves my position as a professional researcher. I found myself in a contradictory position regarding gay men's and lesbians'
distrust of professionals. On the one hand, I could downplay my professional status as researcher and hope to win the trust of potential interviewees. On the other hand, I was told by someone from the gay community that if I wanted more people to volunteer to be interviewed I might try adding the line--"not just a curiosity seeker"--to my posters, which I did. I include all of this to show that in a context where gay men and lesbians are extremely distrusting of both heterosexuals and professionals, as a heterosexual researcher with no direct link with the gay community in Saskatoon, I found myself in quite a tenuous position when proceeding with the data collection for this thesis.

4.7 The Limitations of this Study

As with any research endeavour, this study has some limitations. The limitations centre around how my position as a female, heterosexual researcher as well as the data collection method itself affected the nature of the data gathered. In addition, I discuss two oversights on my part that occurred during the data collection process which only became apparent in hindsight as I attempted to analyze the data.

As a female, heterosexual researcher who was not a fellow psychiatric patient, I elicited different information than I might have if I had been male, or gay/lesbian, or a psychiatric patient. For instance, it is less likely that
Rena, the lesbian who confided to me that she was exploring the possibility that she was actually bisexual, would have offered the same unsolicited information to a male researcher, or to a researcher who was gay or lesbian (the latter being due to the prevailing notion around gay communities that bisexuals are 'fence-sitters' or unwilling to take a political stand with their sexual orientations). It is also possible that the clients would have been less concerned with presenting themselves in such a positive light (e.g., as victims of a system) if I had been a fellow psychiatric patient instead of a professional researcher. Nevertheless, the point is that my particular configuration of traits drew forth certain information from the interviewees, while discouraging the presentation of other information.

This phenomenon is largely reflected in the idea that the interviewees exhibited some human agency, both in their interactions with me as a researcher and in their therapy sessions with psychiatrists. Goffman's book, *The Presentation of the Self in Everyday Life* is useful for illuminating how individuals present different versions of themselves in different situations. For Goffman (1959), the version of the self presented embodies and reflects the qualities and characteristics that the individual perceives would be most useful to the situation. His insight is worth considering whenever interviews are analyzed, particularly
those that involve individuals who have historically been marginalized. Since marginalized persons have had to become attentive to the desires of their oppressors as a means of survival, this could influence their interview responses. Such human agency is difficult to trace since it is manifest both in what the clients say as well as in what they do not—their silences. Nevertheless, this limitation is necessary to consider, given that each of the clients was likely exhibiting resistance by virtue of the fact that they approached me to be interviewed.

Furthermore, in approaching me to be interviewed, clients were probably exhibiting another feature which would affect the nature of the data obtained: the need for validation and confirmation both as former psychiatric patients (in some cases current patients) and as gay men or lesbians; or, conversely, the fear of disconfirmation of both, or either, of these aspects of their identities. For instance, given that I was offering to listen to them speak about their therapeutic experiences, they might have been more likely to complain about their psychiatrists.

The fact that I was soliciting retrospective accounts of the clients' therapeutic experiences would also affect the type of information offered. The clients gave me their present interpretations of what occurred in the past (sometimes more than twenty years ago), not necessarily what actually occurred. It is neither possible to recover what
psychiatrists actually said, nor it is relevant to the focus of this study.

Finally, as I worked on the analysis of this thesis, sorting the pertinent data from the not-so-pertinent data, I became aware of two areas where the data gathered might have been more useful if I had probed the clients more. The first area that was apparent was when clients claimed that they sought therapy because they were depressed. While in some instances clients indicated why they were depressed, in others, they simply stated that they were depressed and at the time of the interviews this seemed a satisfactory response. In hindsight, however, I recognize that it might have been useful had I been able to include the clients' reasons for depression as part of my analysis, specifically how much the homophobic nature of Western society had contributed to their depression. This information might have enabled me to better understand the clients' therapeutic needs. In addition, it might have been useful for me to probe clients further when they offered general responses to my interview questions. For instance, when I asked Beth "How were you treated by your psychiatrists"?, she answered, "The first two are not even worth speaking about." Obviously, she was treated badly by them, however, it is difficult to discern from her response what forms of social control processes were operating in these dyads. Overall, these limitations are due to general nervousness on my part while
conducting the interviews and to the fact that the theoretical applications to this empirical data emerged as the thesis progressed. In other words, I only realized how relevant certain pieces of data were going to be once I had my analysis formulated thematically. At that point, recontacting the interviewees to obtain further information did not seem to be an option due to the confidential nature of the data involved and the way that the data had been obtained (i.e., potential interviewees contacted me to arrange to be interviewed). Thus, I proceeded to analyze the data in its current form.

4.8 Summary

This chapter discusses the methodological issues involved with uncovering the subjugated knowledges arising from the therapeutic experiences of six gay men and three lesbians with psychiatric professionals. The knowledges gained from these interviews are now employed in Chapter Five to examine, from the perspectives of the clients, the processes of objectification, subjectification, and clients’ resistances operating in the therapeutic interactions.
CHAPTER FIVE - THE THERAPEUTIC INTERACTIONS BETWEEN GAY OR LESBIAN CLIENTS AND THEIR PSYCHIATRISTS

What we have to acknowledge is that our own passivity has given the opposition a free rein to be the loudest voices.... We are the last acceptable prejudice, and we've got to say that intolerance is intolerable.

Virginia Apuzzo, Former Director of the National Gay Task Force (Rutledge, 1988: 109)

5.1 Introduction to the Dynamics of the Therapeutic Interactions

The removal of homosexuality as a diagnostic category in 1973 was hailed by many gay activists as a watershed in gay history because it signalled the end of the APA's exclusive right to define what is and what is not 'normal' sexual behaviour. Or did it? Following Foucault, one might expect to find that new, more insidious forms of social control have developed to control definitions of homosexuality.

In this chapter, I explore clients' perceptions of the psychiatrists' therapeutic practice. To better gauge the nature of clients' perceptions of their therapeutic interactions with psychiatrists, this chapter opens with a discussion of clients' reasons for seeking therapy (in section 5.2), paying attention to the role that their sexual orientations played in these endeavors. After this, I consider how techniques of medical social control were
employed, or more specifically, how the clients perceived that they were objectified by their psychiatrists (in section 5.3). From the clients' accounts, I found that some psychiatrists continue to treat homosexuality as a mental disorder; others, while less openly homophobic, continue to use heterosexuality as the norm against which clients' attitudes and behaviours are measured. Clients interpreted that their psychiatrists used a number of strategies to police their sexual orientations; these strategies are discussed in subsection 5.3.1. While a couple of psychiatrists were able to support clients with their sexual orientations, clients perceived that the dominant stance of the psychiatrists was to reinforce the notion that homosexuality is deviance. This perceived stance fostered a therapeutic context where gay or lesbian clients' needs for therapy as gay men and lesbians went unmet. The failure of the psychiatrists to meet most of these gay or lesbian clients' needs is partly attributable to the psychiatrists' apparent lack of knowledge about homosexual-related matters; this issue is explored in section 5.4. Strategies of policing produced specific effects on the clients, namely subjectification, immobilization, and resistance; these effects are discussed in section 5.5. Due to the nature of the data collection method employed for this thesis, I obtained a sample of gay men and lesbians who were empowered enough to recount their therapeutic experiences to a complete
the data collection method employed for this thesis, I obtained a sample of gay men and lesbians who were empowered enough to recount their therapeutic experiences to a complete stranger. With such strength of character, most of them were also empowered enough to resist definitions of homosexuality that their psychiatrist(s) attempted to impose on them and they did so in various ways; these various strategies of resistance are discussed (in subsection 5.5.1). Finally, before introducing the various strategies of resistance that the clients employed, I discuss how resistance emerged out of the clients' needs to retain a sense of themselves when confronted by psychiatrists whose definitions of homosexuality challenged their personal identities as gay men and lesbians. This chapter closes with the recognition that the experience of resistance increases clients' awareness of the personal resources that they embody, which in turn functions as a source of empowerment.

5.2 Interviewees' Reasons for Going to a Psychiatrist (including the Degree to which Sexual Orientation was a Factor in their Seeking Therapy)

Before discussing clients' reasons for engaging in therapy, I provide some demographic data on the therapeutic interactions so that the reader can better understand the contexts in which the clients were treated. As mentioned previously, across the nine interviewees, a total of 20 psychiatrists had been visited. While six of the
interviewees (four males, two females) noted that they were treated for one primary problem, three of the clients (two males, one female) indicated that they were treated for two or more problems. Except for Philip, who engaged in therapy with four psychiatrists after an apparent suicide attempt, and Carmen, who was forced to undergo therapy as a teenager, all of the clients visited psychiatrists voluntarily. Lastly, all of the psychiatrists, with the exception of two psychiatrists seen by Philip through emergency, were seen in a standard therapeutic context (i.e., an office setting).

Depression was the primary reason clients gave for seeking therapy: seven clients (five males, two females) were treated by a total of twelve psychiatrists for depressive disorders. One male was depressed to the point of attempting suicide. Among those who were depressed, four clients (two males, two females) noted that their depression was due to—and they were seeking help in dealing with—situational factors, including: the death of a family member (for two interviewees), the death of a close friend, difficulties in love relationships, and the fear of having become HIV positive (for two male clients). Reasons for the other three clients' depressions are unknown. Significantly, with the exception of Philip, who was eighteen, all clients who sought therapy for depression did so when they were twenty-five-years-old or older. Moreover, each of the clients who sought therapy for depression did so
approximately a decade or more after the official demedicalization of homosexuality. Consistent with the overwhelming sentiment about homosexuality among gays and lesbians at this time, none of these clients seemed to feel that they needed to change their sexual orientation. Indeed, Boyd was quite adamant about this point, stating twice during our interview that sexual orientation was not the primary reason for his seeking therapy, then adding for emphasis "I didn't go there because I was trying to be made straight."

Though these clients did not seem to feel that they needed to change their sexual orientation, three of them (two males, one female) indicated that they felt their sexual orientation should be considered as a factor relating to their depression. Given that these three clients were among those who cited situational factors as the reasons for their depression, it appeared that besides prescriptions for antidepressants, these clients were primarily seeking assistance from their therapists in living as gay men or lesbians.

Difficulty in accepting sexual orientation was the second major reason these interviewees gave for seeking therapy: four clients (three males, one female) visited six psychiatrists for this reason. All clients who sought psychiatric help for difficulties in accepting their sexual orientation did so when they were relatively young, ranging in ages from fifteen-years-old to their early twenties. This
is not surprising given that younger people tend to feel relatively less secure in their identities due to such factors as inadequate peer support systems and lack of life experience. Moreover, three out of four of the clients who sought therapy for difficulties in accepting their sexual orientation did so in the early 1970s when homosexuality was still considered a mental disorder. Undoubtedly, it would be difficult to accept one’s sexual orientation when it is believed by the majority to be a form of deviance.

There was a difference in accepting their sexual orientations between the clients who sought therapy as young people in the early 1970s and Philip, who engaged in therapy as a teenager in the 1990s for this same reason (along with a depressive disorder). The difference concerns what C.W. Mills (1959) refers to as ‘the dichotomy of personal problems versus public issues’. Clients in the 1970s defined their concerns as a personal problem; their sexual orientations were problematic. They appeared to want not to be gay because of the pejorative meanings associated with homosexuality at the time. There was no mention in their accounts that they had a right to be gay or lesbian. Hence, they appeared to be more vulnerable to psychiatric pressure for conversion. In contrast, Philip saw access to treatment as a rights issue. He seemed to recognize that he had a right to expect from his psychiatrists affirmation, validation, and acceptance as a gay man. This recognition
was reflected in comments that Philip made in reference to his psychiatrists: "...it does not matter whether you are black, white, or pink, or whether you are gay or heterosexual, you are still a person and you should be treated as such." While he engaged in therapy, a personal solution, he appeared to believe that the problem lay with society. Thus, Philip seemed to use therapy as a support mechanism to ward off the negative consequences of homophobia, a public issue.

Besides those clients who sought therapy for depressive disorders and difficulties in accepting their sexual orientation, one female client stated that she was forced into therapy for drug intervention as a teenager. Likewise, two males indicated that as part of their treatment for depression, they were referred to Alcoholics Anonymous and/or Narcotics Anonymous. In the cases of the female client and one of the male clients treated for drug/alcohol intervention, their substance abuse did not appear to be related to problems with their sexual orientation (i.e., they indicated that they were comfortable being lesbian or gay). With the second male client treated for drug/alcohol abuse, however, the relationship between his substance abuse and problems accepting his sexual orientation was less clear since he was also being treated for a depressive disorder and appeared to be looking for support in living as a gay man.

To summarize, depression was the primary reason clients
gave for seeking therapy. Almost all of the clients who sought therapy for depression did so when they were twenty-five-years-old or older and when it was approximately a decade or more after the official demedicalization of homosexuality. For many of the clients, depression was due to situational factors both related and unrelated to their sexual orientation. Hence, in addition to prescriptions for antidepressants, clients appeared to be seeking assistance from their therapists in living as gay men or lesbians. Difficulties in accepting their sexual orientation emerged as the second major reason for clients seeking therapy. In most cases, clients who sought therapy due to difficulties in accepting their sexual orientation did so when they were still relatively young (e.g., in their mid to late teens) and when homosexuality was still considered a mental disorder. Both circumstances would tend to render gay men or lesbians relatively vulnerable to peer pressure away from living in accordance with their sexual orientations.

5.3 Objectification of the Clients

As discussed previously, the Foucaultian concept of objectification involves approaching the body as an object to be manipulated and controlled (Dreyfus & Rabinow, 1982). Processes of scientific classification begin when those exercising power, in this case the APA, construct categories of behaviours (e.g., the DSM) which extend down to the most
mundane aspects of life. During medical examinations, psychiatrists employ these categories which allow them to see all of their clients' behaviours as subsisting on a continuum between two poles, the good and the bad. Between these two poles, a precise series of petty offenses can be identified and ranked, enabling individuals' offenses to be assessed and tabulated. The end result of these analytic procedures is a system whereby individuals can be scientifically classified, which in turn, allows for appropriate treatments to be implemented. At the aggregate level, dividing practices and scientific classification produce an "implantation of perversions" in the population, which refers to the isolation, intensification, and consolidation of sexualities peripheral to those capable of reproducing labour power and the form of the family (Rabinow, 1984: 21). The implantation of perversions in the population enables the powers which socially control sexual relations in the social body to branch out and multiply (Rabinow, 1984).

From the clients' accounts, I perceived that the primary way that the psychiatrists objectified the clients was by medicalizing their sexual orientations. Medicalization occurs when 'deviant' behaviour comes to be defined as an illness. In this study, medicalization occurred when clients perceived their psychiatrists as attempting to impose their definitions of same-sex conduct upon them. Clients viewed these definitions as problematic because they stood in
contrast to how clients defined themselves. Even though homosexuality has been deleted formally from the DSM-II, clients perceived that the majority of the psychiatrists still seemed to conceptualize homosexuality as a mental disorder; homosexuality was still considered a 'problem.' Unlike the aversion therapy used in previous decades to 'cure' homosexuality, contemporary psychiatrists used talk therapy.

In addition to talk therapy, seven out of the nine clients were treated with pharmacotherapy as well: six clients (four males, two females) were prescribed an antidepressant for depressive disorders, while two clients (both male) were prescribed tranquilizers for insomnia. Clients' experiences with these prescriptions were not seen as problematic because the prescriptions appear to have been used primarily to normalize the clients' "biological platforms" in order to facilitate psychotherapy (Maxmen, 1985: 113). For instance, it is difficult for a severely depressed individual to participate effectively in talk therapy if they are confused or speechless, two symptoms which often accompany depression.

At any rate, through talk therapy, clients interpreted that a variety of strategies to police homosexuality were deployed. They included: defining homosexuality as a problem, normalization (conversion), denial, avoidance, hostility, lack of support, and sexualization of the
homosexual. The effect of these policing strategies was to silence the clients. Although the dominant stance of the psychiatrists reflected in the clients' accounts was to reinforce the notion that homosexuality was deviant, there were a few moments (under particular circumstances) when the psychiatrists acted in gay affirming ways.

5.3.1 Strategies of Policing

Although a number of clients had come to terms and were comfortable with being homosexual, they found that some psychiatrists insisted that homosexuality itself was the problem. These psychiatrists attempted to define homosexuality as a mental disorder requiring some form of intervention. Implicitly, heterosexuality was used as the norm by which gay men's and lesbian's sexual orientations were judged. Four of the clients (three males, one female) perceived their sexual orientations to be problematized by their psychiatrists. Each of these clients stated that they perceived their psychiatrist(s) did not accept their sexual orientation or that their psychiatrist(s) appeared to believe that conversion was necessary in order for therapy to be considered successfully complete. For instance, Rena noted that when she disclosed her sexual orientation, her first psychiatrist made comments about her sexual orientation being the real issue for her depression, even though she herself did not see it as the primary issue. Similarly, Jim stated
that when he disclosed his sexual orientation to his first psychiatrist "[He] seemed to think that the reason for my depression was my way of life." Jim believed that his psychiatrist did not accept his way of life. In Jim's words "He [the psychiatrist] tried to turn it around." Boyd indicated that his psychiatrist appeared to consider him dysfunctional because of his sexual orientation; the psychiatrist seemed to believe that if Boyd lived as a gay man, he was not conducting his life in a rational, ethical, or moral manner. For Boyd to be considered healthy by his psychiatrist, he would have to forego his 'perverted' sexual orientation. In the final case, Philip, the only client of these four who may have still been coming to terms with his sexual orientation, noted that his first two psychiatrists appeared to view homosexuality as a mental illness, as not normal and therefore wrong.

Once their sexual orientations became known, clients interpreted that other aspects of their behaviour were subject to scrutiny. For instance, Philip indicated that while being treated for his suicide attempt (which appeared to involve an overdose of alcohol and drugs), his first two psychiatrists asked him how many people he had slept with. Such a question has the potential to produce shame, humiliation, and/or guilt in Philip who was already in a vulnerable state. In a similar vein, Philip's other two psychiatrists took it upon themselves to tell all the nurses
on the psychiatric ward where he was staying that he was gay. This was done without the permission of Philip, who was against the idea when the psychiatrists broached it with him.

Philip's case deserves closer examination because despite their having disclosed his sexual orientation publicly, these psychiatrists also attempted to meet his needs as a gay man at an interpersonal level. For instance, they referred him to Gay and Lesbian Health Services (GLHS) so that he could meet other gays his own age. Such a referral was likely very timely and helpful to a young man in the process of 'coming out'. Indeed Philip indicated that he was grateful for this referral.

The contradictory messages that these psychiatrists appeared to be sending to Philip about his sexual orientation are likely explained by taking into account the settings which can facilitate or constrain gay affirmative responses by psychiatrists. It may have been more difficult for the psychiatrists to support a gay client’s sexual orientation in the generally conservative environment of a hospital. Hence, they committed the seemingly homophobic act of disclosing Philip's sexual orientation to the nurses on the ward. In contrast, perhaps the referral to GLHS was easier for them because it involved a community agency outside the hospital.

Besides problematizing clients' sexual orientations, clients perceived that some psychiatrists responded in a hostile manner when they revealed their sexual orientations.
These psychiatrists made negative comments about being gay or lesbian and/or communicated in a non-verbal way that they disapproved of homosexuality. For instance, Philip indicated that when he disclosed his sexual orientation to his first two psychiatrists at the time he was being admitted into the emergency ward for his suicide attempt, one of them responded with "Well, you probably got AIDS", thus linking homosexuality directly to disease. Philip continued "They made their point that it [homosexuality] was wrong but they did not have to say it. You could just tell from the way they acted that homosexuality was wrong." Jim noted that when he disclosed his sexual orientation to his first psychiatrist, the psychiatrist appeared reluctant to deal with him. Moreover, the psychiatrist appeared disgusted and angry. Finally, Rena indicated that upon disclosing her sexual orientation to her first psychiatrist, the psychiatrist looked at her for quite a while, then gave her a 'once over' look, before proceeding to tell her that her sexual orientation was the reason for her depression. Could it be that this psychiatrist had accepted the stereotype that only unattractive women whom no man would ever want become lesbians, thus she was examining Rena from head to toe to see if she would be considered appealing to men? At any rate, Rena indicated that her first psychiatrist’s reactions were "just about enough to make me want to run away." And run away she did, for Rena never returned to therapy with this
psychiatrist following this interaction.

In addition to reacting in a hostile manner to clients' sexual orientations, clients also viewed psychiatrists as employing normalizing strategies through which they attempted to convert clients from a homosexual to a heterosexual orientation. Processes of normalization were found in the accounts of three of the clients. For instance, Paulo, whose therapy occurred in 1970, noted that his first psychiatrist

...attempted to meet my needs by telling me that I was not gay. He explained how I would work my way out of it. He said that I would go to university and start meeting women that I was attracted to, who were easier to get along with. He thought that the problem was being sensitive in a high school that was rough basically.

Similarly, Carmen reported that her second psychiatrist told her "...that if I dated men my life would be better and she seemed to think I was too young to make an informed choice about my sexuality." Carmen added that eventually after two years her psychiatrist accepted that she was in fact lesbian. Since this psychiatrist was probably a lesbian (as surmised by Carmen), it could be argued that the psychiatrist was only attempting to save her client from the pain and hardship that she, herself had endured by being a lesbian. Nevertheless, she was negating her client’s rights to make her own decisions by attempting to impose her own views. Finally, Beth noted that two of her psychiatrists (one in 1974-75 and the other in 1993), acknowledged her sexual orientation but suggested that she keep it ‘in the closet’ because they felt
that she was dealing with enough problems already. Overall, these three clients' treatment experiences seem to indicate that the psychiatrists believe that heterosexuality is the norm and that homosexual clients can and should adopt a heterosexual orientation. In cases where the psychiatrists were unable to convince their clients, the psychiatrists preferred that they remain 'in the closet'.

Clients also interpreted that their psychiatrists used strategies of denial through which they refused to acknowledge the clients' sexual orientations. For instance, Don reported,

*When I told him I was gay, he told me I was not. He basically ignored the issue altogether. He talked about himself a lot and his clocks.*

When psychiatrists invalidate their clients' sexual orientations, they reinforce negative feelings that clients may already have about themselves. Furthermore, dismissal of sexual orientation is devastating because, as Paulo and Don pointed out, it took a great deal of courage for them to come to a psychiatrist in the first place and to speak about these kinds of issues.

Besides denying that their clients were gay, clients also perceived that some psychiatrists avoided discussing sexual orientation during therapy; this I refer to as strategies of avoidance. Boyd noted that despite the fact that he and his psychiatrist established a contract at the beginning of his therapy which outlined a list of his goals
for therapy--one of them being a discussion of his sexual orientation--his sexual orientation was never really discussed in the thirty sessions that he had with his psychiatrist. Similarly, Rena indicated that after a series of attempts at discussing her lesbianism during therapy: "I [did] not get the feedback I want or I need, so I [felt] like I [was] operating in a vacuum." It reinforces the stigma of homosexuality if clients encounter silence when they attempt to talk about issues of importance to themselves.

A strategy which appeared to operate in much the same manner as denial of clients' sexual orientations was psychiatrists' lack of support for these orientations, as perceived by the clients. One question I asked was: "Did your psychiatrist(s) appear comfortable talking with you about your sexual orientation"? The underlying idea was that if psychiatrists did not seem comfortable discussing homosexuality with their clients, then they would be unlikely to offer clients support or validation for being gay or lesbian. Seven out of nine clients had at least one psychiatrist (three clients had two) whom they felt was uncomfortable discussing their sexual orientation with them. In total, ten psychiatrists (or half the number of psychiatrists who treated this sample) did not appear comfortable discussing homosexuality with their clients. One client commented more explicitly on the lack of support he received for being gay. Boyd noted that his psychiatrist
merely "tolerated" his sexual orientation. During therapy, this psychiatrist's religious beliefs were made known, and these beliefs precluded acceptance of a homosexual lifestyle. Consequently, Boyd surmised that his psychiatrist avoided discussing homosexuality so that he would not inadvertently offer his true views on the matter. All in all, psychiatrists' failure to support or validate their gay or lesbian clients' sexual orientations seemed to be a passive way in which they imposed their dominant definitions of homosexuality on the clients.

If psychiatrists wanted to support and validate their clients' sexual orientations, they could have done so through various measures, for example: by sharing literature about homosexuality (academic or otherwise), by referring clients to various gay affirmative community agencies, by facilitating group work on the homophobic thoughts and feelings of the members, and by providing intensive individual psychotherapy to promote awareness of the sources of clients' thoughts and feelings (Kus, 1990). Only two of the clients (one male, one female) received such support from their psychiatrists (their experiences are discussed shortly).

Finally, the last strategy that clients perceived their psychiatrists as using to police their sexual orientations was the sexualization of the homosexual, meaning that clients' homosexuality was viewed in terms of sexuality only.
Rena discussed how this occurred when she disclosed her sexual orientation to her second psychiatrist.

When I told the second [psychiatrist] she stopped, she sort of just sat back and was more reflective.... "What, what are you talking about"? she said [sic]. "What do you mean you are a lesbian"? I said "Well, I seek my primary relationships with women." She looked at me kind of funny and she said "Don't you mean you have sex with women"? And I said "Well, yes, that too." But to her it was a 'sex issue'. To me that was only a fraction of it.

In the psychiatrist's approach, who Rena fucked was seen as the defining feature of her life--all other aspects of her existence were ignored or denied. Rena indicated that it took a number of attempts to convince her psychiatrist that lesbianism involved more than just having sex with women. In essence then, clients whose homosexuality is sexualized have their humanity erased; they are turned into one-dimensional caricatures of themselves.

Having discussed seven strategies that clients interpreted their psychiatrists employed to police their sexual orientations, I must note that it is not my intention to demonize psychiatrists. In certain circumstances, psychiatrists did attempt to support their clients with their sexual orientations. This support came primarily when the psychiatrists acknowledged other sources more competent than themselves for dealing with clients' problems in living and then referred clients to these sources. For instance, although Carmen's second psychiatrist did not feel that she could speak in an open and accepting manner with regard to
her client's sexual orientation, the lesbian magazine she offered was likely validating to Carmen, a teenage girl attempting to negotiate a 'deviant' sexual orientation in a small, conservative town. Furthermore, the fact that this psychiatrist started a support group for gays and lesbians indicates that she was sympathetic to the plight of gay men and lesbians in her area. Similarly, as noted earlier, Philip's third and fourth psychiatrists were helpful to him when they referred him to GLHS. This referral came after Philip had just attempted suicide and while he was in the process of 'coming out', which Thomas Roesler & Robert Deisher (1972) argue is a period fraught with emotional upheaval. Given that both Carmen and Philip were at critical points when they were offered assistance in living as a lesbian and a gay man respectively, should it be inferred that psychiatrists only offer such support in extreme circumstances? Further research needs to be done in order to respond adequately to this question. What these therapeutic experiences demonstrate is that it is possible to have psychiatrists be agents of positive change for the clients. Hence, when engaging in research such as this, it is imperative that one not have a unidimensional conception of psychiatrists (i.e., that by their very definition as psychiatric professionals they will in some way or another harm their gay or lesbian clients) because, as was pointed out earlier, psychiatrists' own backgrounds and personal
While three psychiatrists were able to support their clients with their sexual orientations, this does not negate the fact that the dominant stance of the psychiatrists, as revealed in the clients' accounts, was to reinforce the notion that homosexuality is deviance. Even though the APA no longer designates homosexuality as a mental disorder through its formal nosology, clients perceived that many of the psychiatrists continued to classify it according to DSM-II standards at an informal level. This shift appears to reflect the relation between heterosexism and homophobia, which, as Stewart (1995) states, is simply a question of degree of anti-gay sentiment. Homophobia is a more overt, violently expressed form of prejudice against gay men and lesbians which could be said to characterize the APA's attempts to 'cure' homosexuality (e.g., by subjecting individuals to electric shocks or inducing vomiting). Currently, heterosexism, a more subtle form of anti-gay bias could be said to characterize many of these psychiatrists informal classifications of homosexuality as a mental disorder. Such informal classifications reinforce the stigma of homosexuality which, in turn, divides gay men and lesbians from the larger heterosexual population. For instance, refusal to socially legitimate gay or lesbian lifestyles functions as a precondition for the denial of basic human rights and freedoms to gay men and lesbians (e.g., the
freedom to decide how they should be medically treated, or the right to raise children). Moreover, if clients internalize definitions of homosexuality that they perceived their psychiatrists were imposing, they would then disavow their own sexual orientations, becoming divided from a significant aspect of themselves. (The extent to which clients internalized these definitions is discussed in the following section).

Returning to the clients' reasons for entering therapy, namely depression due to factors both related and unrelated to their sexual orientation, difficulties in accepting their sexual orientation, and intervention for substance abuse, it appears that the most important factor that the clients were seeking from their therapy was a supportive atmosphere where they could be as comfortable as possible exploring and discussing their thoughts and feelings about their own homosexuality. Unfortunately, the perceived psychiatric stance that homosexuality is deviance was not conducive to such an atmosphere. Thus, in most instances, clients' expectations and needs for therapy went unmet; only four out of twenty psychiatrists were reported to have met clients' needs, while an additional two psychiatrists were reported to have met some of the clients' needs (e.g., alcohol or drug abuse), except those related to being gay or lesbian. The failure of psychiatry to meet the needs of most of these gay or lesbian clients can in part be attributed to the
psychiatrists' apparent lack of knowledge about homosexuality. In the following section, I examine this apparent lack of knowledge about homosexuality and local gay communities.

5.4 Psychiatrists' Lack of Knowledge about Homosexuality and Local Gay Communities as Perceived by the Clients: A Contributing Factor to Strategies of Policing

The majority of psychiatrists who counselled the clients of this sample were not educated about matters related to homosexuality. Each client reported engaging in therapy with at least one psychiatrist who was not knowledgable about homosexuality or the gay community in his/her area (five clients had two psychiatrists who were not knowledgable, one client had three) for a total of sixteen out of twenty psychiatrists. Rena noted that her second psychiatrist asked her about safe-sex practices for lesbians. Rena told her about the practices as well as the devices and services available in the hopes that the psychiatrist would be better equipped to assist her future lesbian clients. Another interesting anecdote concerned Paulo who, when asked about the level of knowledge his second psychiatrist appeared to have about homosexuality stated simply that "[He] probably knew enough about what his attitude should be." In other words, this psychiatrist did not know much about homosexual-related matters except that it was necessary to appear to accept gay or lesbian sexual orientations.
Perhaps it is understandable that the majority of the psychiatrists who treated this sample did not appear to have much knowledge about matters related to homosexuality. After all, most of the clients whom they were treating would have been heterosexual. However, if this were the case, one would expect to hear of psychiatrists admitting their lack of knowledge of homosexuality to clients and then asking them, "How can I help you anyway"? or "What do you need from me as your psychiatrist"? None of the clients reported receiving therapy of this nature.

Interestingly, the clients did not appear to have unrealistically high expectations with regard to their psychiatrists' levels of knowledge about homosexual-related matters. Indeed, several of the clients (three males, one female) made comments to the effect that they were prepared to offer their psychiatrists the benefit of the doubt, recognizing that their psychiatrist(s)' heterosexuality could impede their opportunities to learn more about gay- or lesbian-related matters. The clients seemed to be primarily looking to be treated in a humanitarian manner by their psychiatrists.

A few psychiatrists did appear to be knowledgeable: three clients (two males, one female) indicated that they were treated by psychiatrists (four in total) who were knowledgeable about homosexuality and their local gay communities. When these psychiatrists put their knowledge
about homosexuality and the needs and problems faced by gay men and lesbians to good use, the liberatory potential of their interventions became evident. Their knowledge was manifest in a number of ways. For instance, Jim noted that his third psychiatrist was knowledgeable about the obstacles his client was likely to face as a gay man. Moreover, he recognized that a gay man does not require conversion to heterosexuality in order to be considered healthy. Although Philip's third and fourth psychiatrists disclosed Philip's sexual orientation to hospital staff without his consent, Philip stated that they seemed to understand homosexuality and that they provided him with helpful referrals in the gay community. Similarly, while Carmen's second psychiatrist (whom Carmen believed was lesbian) attempted to discourage Carmen from maintaining her sexual orientation, Carmen noted that the psychiatrist seemed to know more about homosexuality and local gay communities than she let on. For instance, how would this psychiatrist come to possess the lesbian magazine she offered while living in a small, conservative town which Carmen reported did not even have a gay community? Obviously, the psychiatrist had access to gay affirmative services in a larger centre. Furthermore, the fact that this psychiatrist set up a support group for gay men and lesbians also speaks to her knowledge on the subject.

Although three of the psychiatrists were able to put their knowledge of homosexuality and local gay communities to
good use in assisting clients, the fact remains that most of the psychiatrists whom the clients dealt with did not appear to have much knowledge about homosexual-related matters. Psychiatrists in Western cultures are thought to be experts on, among other things, individuals' problems in living. If psychiatrists do not have knowledge about an area of concern to their clients, there may be a tendency for the psychiatrists to impose their own views on the subject in order to maintain their legitimacy as experts. Given that North American society tends to be homophobic, it may be difficult for many psychiatrists to divorce themselves from this perspective. Furthermore, not having much knowledge or understanding about homosexuality, psychiatrists are less likely to be empathetic with gay men and lesbians and more apt to treat them as objects. Unable to identify with gay men and lesbians as human beings, psychiatrists are more likely to view them as perverted or 'queer' in the pejorative sense. Finally, when psychiatrists see their gay or lesbian clients as objects, they tend to introduce intervention measures that they would not normally consider with heterosexual clients (i.e., trying to persuade clients away from their sexual orientations). I discuss the effects of these objectification practices on the clients in the following section.

5.5 The Effects of Strategies of Policing on the Clients: Subjectification, Immobilization, and Resistance

Strategies of policing appear to have been used to
silence the clients on matters involving their sexual orientations. Rather than being provided with opportunities to explore what their sexual orientations mean to themselves through therapy, these gay or lesbian clients perceived that were generally treated in ways that could restrict their freedom of expression in terms of their sexual orientations. Some clients were silenced relatively effectively as evidenced by their feeling badly about being gay.

For the purposes of this analysis, I argue that subjectification occurred when the clients internalized their perceptions of their psychiatrist(s)' definitions of homosexuality as deviance. Through subjectification, clients would come to feel bad by recognizing that their way of being in the world as gay men or lesbians was unacceptable by societal standards. In this sample, three clients had become subjectified. Philip, an eighteen-year-old client who appeared very concerned about others perceptions of him, reported "Basically I felt very useless and not worth anything by the psychiatrists at [the emergency ward of the hospital where he was treated for his suicide attempt]." Similarly, Don discussed that when he began therapy as a twenty-year-old, he was already having difficulties contending with narrow societal norms involving sexuality. Don's subsequent internalization of his psychiatrist's definition of homosexuality only served to perpetuate his distress. Don offered the following comments about his
When I was there [the psychiatrist] invalidated my sexuality. Orientation was not enough to talk about. This was already an issue of mine and he reinforced it. He reinforced my negative feelings about myself.

Finally, Paulo, who was sixteen-years-old at the time of his therapy, alluded to the fact that initially subjectification made him happy; however, that was short-lived. As Paulo explains "[W]ith the first [psychiatrist], I was elated afterwards." Surprised by his remark, I queried "You were elated"? Paulo responded "Yeah, I thought 'Great, I'm not gay. It's going to work itself out.' I added "For one or two days...." And he replied "Yeah, or maybe a little longer. But then those doubts started creeping back in."

Following his brief period of elation, Paulo was forced to contend with his internalization of both society's and his psychiatrist's definitions of homosexuality, which were essentially one in the same. This led to his feeling bad because although he felt dissonance between his desires and the expectations that society and his psychiatrist appeared to have for him, he recognized that he could only be what he is--a gay man.

Significantly, all of the clients who allowed themselves to become subjectified were male, relatively young when it occurred, and seeking therapy for difficulties in accepting their sexual orientation (among other things for Philip). Given this combination of factors, these three clients' vulnerability to subjectification appeared to be attributed
primarily to their lack of experience in disclosing their sexual orientation. In turn, perhaps this lack of experience reflects the relatively shaky self-esteem that many people have at a young age and the strong peer pressure influence during adolescence. At any rate, this hypothesis is supported by comments made by Don: "It was pretty much the first time I had disclosed my sexual orientation to anyone..." and by Paulo who stated that, "It took a lot for me to go to a doctor that I did not know and [then] go to a psychiatrist that I did not know at the age of sixteen and talk about these kinds of things."

In addition to feeling bad because they had internalized their psychiatrist(s)' definitions of homosexuality as deviance, several clients felt bad because their needs for therapy had not been met. Although these clients rejected the medical view of homosexuality, they did not know how to challenge established psychiatric practice at the time of their therapy. Unable to act in a means that would empower them, they became despondent, resolving into a state of passive-acceptance. By 'passive-acceptance' I mean that while the clients rejected the psychiatric definitions of homosexuality they perceived were being imposed upon them, they did not attempt to resist these discourses directly. However, by agreeing to be interviewed and telling their stories, these clients may have experienced a form of empowerment not possible during their therapeutic encounters.
Overall, six clients (five males, one female) appeared to have settled into a state of passive-acceptance with regard to their therapeutic interactions (with a total of nine psychiatrists). Clients' despondency after completing their therapy is typified by the following comments. Don, whose therapy lasted six months, reported: "...I left there feeling awful. I felt that nothing had been accomplished or resolved." Similarly, Paulo noted: "I consider [his first psychiatrist's] intervention to be an unsuccessful intervention. I think he caused me a lot of grief in the end...." Likewise, Beth remarked: "My reaction after seeing the psychiatrists was that I felt even more messed up." Finally, Philip added: "I came away [from his first two psychiatrists' therapies] with a sour taste in my mouth."

5.6.1 Strategies of Resistance

Strategies of policing did not silence all of the clients, however. Some of them actively resisted the definitions of homosexuality that they perceived their psychiatrists as attempting to impose. When clients used their individual resources of intuition, knowledge, and empowerment to affirm that their psychiatrist(s) definitions of their sexual orientations were wrong for them as gay men and lesbians and consequently rejected these definitions, I argue that they were resisting. Assuming that the mode of treatment that psychiatrists offered would be based on their
views on the clients' mental health (including their views on the clients' sexual orientation), my primary concern in searching for instances of clients' resistance was that the clients define what was an acceptable outcome of their therapeutic interaction.

With this sample, resistance was manifest in various ways, including: clients formulating their own definitions of their problems, self-educating, withholding relevant personal information, educating psychiatrists about homosexual-related matters, refusing treatment, terminating therapy, and speaking out about negative therapeutic experiences. It is noteworthy that each of these strategies of resistance is predicated on the clients' needs to retain a sense of themselves. Clients who resisted had developed a solid sense of themselves before entering therapy and were unwilling to have these self-understandings undermined by their psychiatrists. In the following subsection I explore the various strategies of resistance that the clients utilized to retain a sense of themselves.

In examining the various ways that the clients of this sample exercised resistance, it becomes evident that a number of them did resist the definitions of homosexuality that they perceived their psychiatrist(s) were attempting to impose. While this is significant, it is not surprising given the sample. The notices I posted requesting interviews would tend to attract those individuals who were empowered enough
to tell strangers about therapeutic experiences which involved intimate details about themselves. Hence, it follows that the clients would also be empowered enough to resist other’s conceptions of them.

One of the more effective strategies of resistance that clients utilized was to formulate their own definitions of their problems. Clients equipped with such knowledge upon entering therapy were less likely to become subjectified. More specifically, clients appeared to increase their chances of receiving therapy that was satisfying to themselves if they had awareness of each of the following three areas before engaging in therapy: awareness of the nature of the problems for which they were seeking therapy; awareness of the relation of their sexual orientation to the problems for which they were seeking therapy; and finally, awareness of what type of intervention measures would be necessary and appropriate for their problems. Overall, four clients (three males, one female) had awareness in these areas. And, when engaging in therapy with this awareness, these clients did not become subjectified. An example of this was Rena who, recognizing that she had come to terms with her own sexual orientation, tried on several occasions to clarify with her second psychiatrist that her lesbianism was not the reason for her depression.

Significantly, clients who were aware of the nature of their problems (particularly if the problem involved their
having difficulties accepting their sexual orientation) but **not** aware of the types of intervention that would help them, seemed particularly vulnerable to processes of subjectification arising through treatment (this was the case for each of the three males who became subjectified). A classic example of this is Don, who sought therapy because he was having difficulties accepting his sexual orientation. Despite the fact that his psychiatrist would not even admit that Don was gay, Don ended up staying in therapy for six months with this psychiatrist. If Don had had a clear idea of the type of intervention he expected (in addition to awareness about the nature of his problems), Don would not have interacted so long with a psychiatrist who was doing so little to meet his needs.

Like client-formulated definitions of their problems, self-education was another strategy of resistance that began operating before clients entered therapy. Not surprisingly, of all the self-education that these clients appeared to have, the area that seemed to help them the most was knowledge of psychiatry's historical relationship with homosexuality. With this knowledge, clients were able to anticipate how they might be treated by psychiatrists and to formulate alternate plans if they were not provided with therapy they felt was appropriate. Only three clients (one male, two females) appeared to have knowledge in this area at the time of their therapy.
Another area of self-education that appeared to be useful for clients was knowledge about human rights, particularly the rights of gay men or lesbians undertaking psychiatric therapy. Both Carmen and Beth indicated that they were aware of their psychiatrists' obligations to be confidential about therapeutic matters outside of their places of employment. Rena indicated that she was aware that psychiatric definitions of homosexuality as perversion obstructed gay rights from becoming enshrined in the human rights code. Philip, however, was the most vocal about his rights to objective, unbiased medical treatment as a gay man, making direct statements to that effect.

Such knowledge enabled Carmen to proceed with therapy while living in a small town that was hostile, or at the very least, unaccepting of gay or lesbian sexual orientations. For instance, Carmen indicated that if her psychiatrist would have disclosed her own lesbian sexual orientation while living/working in this small town, it would have likely "cost her her career." Recognizing the potential perils of being true to her lesbian desires, she felt assured that she could discuss them with her psychiatrist (once she began interacting with a psychiatrist whom she felt reasonably comfortable with) due to the psychiatrist's obligation to be confidential. Moreover, knowledge about human rights was a factor that led Rena, in an attempt to change discourses on homosexuality, to argue against definitions of homosexuality
put forth by her second psychiatrist that she felt were inaccurate and biased. Finally, knowledge of his rights as a gay client enabled Philip to refuse psychiatric treatment that he found to be inappropriate.

Refusal to accept psychiatric treatment offered was another strategy of resistance evident in the clients' accounts. Although psychiatrists have authority in Western cultures to decide what individuals need in order to make them healthy, sometimes clients did not agree with their psychiatrists' definitions of homosexuality and consequently did not want the treatment proposed. For instance, the psychiatrist that Philip saw following his suicide attempt angered him by keeping him waiting for thirteen and a half hours and then entered to talk with him wearing latex gloves. Philip discussed how he refused treatment at this point.

[The psychiatrist] wanted to admit me and I basically told him where to go and how to get there. Because I said, if you have to wear latex gloves to talk to me, then how do you plan on treating me?

It is difficult to determine why the latex gloves were used without having been there. Certainly, there is the fear of HIV contamination, however, as Philip indicated he and his psychiatrist were only going to talk, thus there should not have been any danger. At any rate, for the purposes of this discussion it is only important that Philip was not satisfied with his psychiatrist's manner and hence refused treatment.

While refusing treatment enables clients to resist definitions of homosexuality which psychiatrists were
attempting to impose, a strategy more likely to change these discourses are clients' efforts to educate their psychiatrists about homosexual-related matters. Rena was the only client who utilized this strategy of resistance. When her second psychiatrist asked her about safe-sex practices for lesbians, Rena described them and gave her opinions about them. Sensing her psychiatrist's interest, Rena then went on to discuss some of the services available for gay men and lesbians. Since this was the psychiatrist who saw lesbianism as a "sex issue" and who indicated that she could not understand how two women could "be together", it appeared that Rena was attempting to add a humanizing dimension to her psychiatrist's knowledge about homosexuality. Indeed, as Rena indicated, such knowledge may assist the psychiatrist treating her future lesbian clients.

Withholding information was probably one of the more subversive strategies of resistance employed. Indeed, it was also used under rather unusual circumstances. This strategy of resistance has to be contextualized in order to be properly appreciated. Generally, when individuals seek therapy, they do so because they have issues of significance to themselves that they require assistance in working through. Thus, they arrive at therapy prepared to discuss these issues. Not so with Carmen, however. As a teenager, she was sent to her first psychiatrist by force. Because she was forced into therapy, Carmen was not necessarily ready to
discuss her concerns when she arrived. This situation was exacerbated by the fact that she was treated by a male psychiatrist whom she did not like or trust. Not liking the therapeutic definitions of her situation that this psychiatrist was attempting to impose upon her, Carmen’s goal became to get the whole ordeal over with as quickly as possible (most likely to please whomever had sent her). After carefully assessing her psychiatrist’s approach, Carmen proceeded to impart the kinds of information about herself that she perceived he wanted to hear so that he would think that she was working through her problems at a fast rate and consequently allow her to end their sessions together. Conversely, Carmen withheld information about what was really happening for herself, information which she perceived would not have been pleasing to this psychiatrist. Indeed, the psychiatrist’s approach seemed to facilitate this type of response for, as Carmen noted: "[He] seemed preoccupied and would 'buy' whatever I said...." In total, Carmen spent four months telling this psychiatrist non- or partial truths.

In addition to withholding information, termination of therapy was another strategy of resistance utilized by clients: four clients (two males, two females) terminated therapy with four psychiatrists. Sometimes clients terminated therapy after one or two sessions because they recognized that the psychiatrist they were seeing would be completely unable to meet their needs as gay or lesbian
clients. This was the case for Terence who stopped seeing his first psychiatrist after one appointment because he recognized that the psychiatrist was ignorant of issues relating to homosexuality. Likewise, Rena halted her therapy with her first psychiatrist after two sessions because the psychiatrist’s approach to homosexuality made Rena uncomfortable. In other instances, clients broke off therapy after attempting to get their needs met over a longer period. For example, Boyd stopped seeing his psychiatrist after thirty appointments because his goals for therapy (i.e., discussing his sexual orientation) were not being met. Similarly, Beth ended therapy with her third psychiatrist after sixteen sessions because she did not feel she could tell him the things that were on her mind.

A final strategy of resistance employed was when clients spoke out about their bad therapeutic experiences to warn others about how psychiatry has traditionally treated homosexuality and to alert potential gay or lesbian clients about what they could expect to encounter when entering therapy in the 1990s. Don’s comments provide a good example of this:

I would like to tell young gay people that they should be critical when looking for a counsellor and shop around. Psychiatrists are in such a power position over their clients in our culture. That is so unhealthy. We need more equality between the psychiatrist and his [sic] client. It’s an unstated power position and it needs to be addressed. The client needs to be more aware of their [sic] rights.

Speaking out provided clients with the opportunity to vent
their frustrations with the objectification processes that they experienced. Essentially, each of the clients of this sample spoke out about their negative experiences by agreeing to tell their accounts to me. I then integrated their words into a written format to be read by others who have an interest in this subject. Former clients who read this thesis will become more aware that they are not alone in their struggles with psychiatrists during therapeutic interactions; there are patterns perceptible. In turn, this awareness has the potential lead to greater acts of resistance.

In closing, strategies of policing challenged the clients' very identities as gay men and lesbians. By choosing to resist definitions of homosexuality clients perceived their psychiatrists were imposing, clients were acting on their own behalf (and on behalf of gay men or lesbians entering therapy after them). They were also teaching themselves that they can rely upon themselves to manoeuvre through situations that are difficult and personally threatening. In turn, clients' knowledge that they can protect their own sense of self becomes a part of their self-understandings. Hence, strategies of resistance operate in a dialectical manner. While resistance emerged out of clients' needs to retain a sense of themselves when confronting definitions of homosexuality they perceived their psychiatrists were imposing, ultimately, this sense of self
emerges stronger and more empowered as a result of these acts of resistance.

5.7 Summary

This chapter examined the impact of the declassification of homosexuality as a mental disorder in the DSM-II on contemporary gay or lesbian clients, using clients' perceptions of their therapeutic experiences. Through the clients' accounts I interpreted that the primary way that psychiatrists objectified the clients of this sample was by medicalizing their sexual orientations. Unlike in previous decades when aversion therapy was used to 'cure' homosexuality, contemporary psychiatrists used talk therapy, which allowed them to impose their definitions of homosexuality through a variety of strategies of policing. They included: defining homosexuality as a problem, normalization (conversion), denial, avoidance, hostility, lack of support, and sexualization of the homosexual. As a result, the needs of only a few clients were actually met by the psychiatrists.

Basically, the primary effect of strategies of policing was to silence the clients on matters related to their sexual orientations. Silencing occurred when clients became subjectified or when they resolved into a state of passive-acceptance after their needs for therapy were not met. Only a few clients from this sample allowed themselves to become
subjectified. Although a larger minority passively rejected the medical view of homosexuality, their attempts to resist or change these discourses were minimal. Finally, clients exhibited various forms of resistance which included: formulating their own definitions of their problems, educating themselves, withholding relevant personal information, educating psychiatrists about homosexual-related matters, refusing treatment, terminating therapy, and speaking out about negative therapeutic experiences. Resistance emerged out of clients' needs to retain a sense of themselves when they were challenged by psychiatrists whom they perceived as viewing their sexual orientations as deviance. In turn, the sense of self that the clients attempted to retain through resistance became stronger and more empowered as a result of engaging in acts of resistance.
CHAPTER SIX - CONCLUSION

Although the APA no longer designates homosexuality as a mental disorder through its formal nosology, the accounts of these clients suggest that at least some elements found in the DSM-II continue to operate in the therapeutic interaction as perceived by the clients. Some elements of medicalization are reflected in the clients' resistance to their perceptions of their psychiatrists' efforts to impose their definitions of homosexuality upon them. As revealed in the interviewees' accounts, these efforts took the form of strategies of policing, including: defining homosexuality as a problem, normalization (conversion), denial, avoidance, hostility, lack of support, and sexualization of the homosexual.

A review of the strategies of policing reported from the clients' perspectives revealed that the dominant stance of the psychiatrists was to treat homosexuality as deviance. According to the interviewees, a factor contributing to psychiatrists' tendency to treat homosexuality as deviance was their apparent lack of knowledge about homosexual-related matters. For the most part, psychiatrists reported in this study apparently did not understand homosexuality.

In fairness to the psychiatric enterprise, however, these reported psychiatrists' attitudes are largely
reflective and typical of wider society's homophobic and heterosexist attitudes. The APA's formal demedicalization of homosexuality, could hardly be expected to eliminate homophobia and heterosexism either in psychiatry or in society. Like other persons, psychiatrists are not immune to these cultural attitudes.

Whether psychiatrists, as reported by the interviewees, had been able to confront their own biases relative to gay or lesbian clients is not clear. What is clear is that the interviewees were not able to get their needs as gay men or lesbians met by their psychiatrists. This analysis revealed that the most important feature that the clients were seeking from their therapeutic relationships was a supportive atmosphere where they could comfortably explore and discuss their own thoughts and feelings about their homosexuality. Clients' perceptions that psychiatrists tend to treat homosexuality as deviance made the former feel unwelcome as gay men or lesbians. Hence, most of the clients experienced their therapeutic needs as gay men or lesbians as not being met.

The gay or lesbian clients responded in several different ways--sometimes simultaneously--to their perceptions of psychiatrists treating homosexuality as deviance. Some clients were silenced by the strategies of policing that were employed in their therapeutic interactions. Through processes of subjectification, some
clients had their already negative feelings about their sexual orientations reinforced by the psychiatrists. Other clients resolved into a state of passive-acceptance or despondency after recognizing that their needs for therapy as gay men and lesbians were not going to be met or had gone unmet by therapy.

The majority of the clients, however, were not silenced by the strategies of policing that they perceived psychiatrists attempted to deploy. Instead, these clients resisted the definitions of homosexuality which they perceived their psychiatrists attempted to impose. Significantly, the fact that most of the nine respondents I interviewed were 'resisters' is a function of the way that this sample was obtained. By placing ads for gay or lesbian individuals who were willing to share the stories of their therapeutic experiences, I drew forth, in my opinion, a sample that was probably more empowered than the general population of gay men and lesbians. These clients would seem to be more empowered because they volunteered to share their accounts with me, while many others did not. By this, I am referring to the difficulties I had obtaining interviews for this study. At any rate, clients' empowerment enabled them to resist what they perceived to be their psychiatrists' policing strategies. It follows then that those clients who did not come forward are likely to have been less open to talking with strangers about their experiences or less
willing to discuss their experiences in general (e.g., because they are ashamed about some aspects of their interactions).

Clients' resistance was manifest in various ways, including: formulating their own definitions of their problems, self-educating, withholding relevant personal information, educating psychiatrists about homosexual-related matters, refusing treatment, terminating therapy, and speaking out about their negative therapeutic experiences. Clients who resisted had developed a solid sense of themselves before undergoing therapy and were unwilling to have these self-understandings undermined by their psychiatrists. Clients' acts of resistance emerged out of their needs to retain a sense of themselves.

In accord with Foucault's dictum that where there is power, there is resistance, but as specific to this particular study, where there is perceived power, there is resistance, the clash between the clients' perceptions of psychiatrists' views of homosexuality and their own understandings led to an affirmation of gay identity for many of the clients. By confronting and ultimately rejecting the moral authority of the psychiatrists, clients were forced to consider and clarify how they actually defined themselves. When the clients resisted processes of objectification, they were demonstrating that they did not view themselves nor did they want others to conceptualize them strictly in terms of
their sexual orientations. Rather, clients wanted to be seen as human beings, with all the complexities that that entails. Both clients' self-reflection and their subsequent demonstration to themselves that they could act on their own behalf contributed to the enhancement of their identities. Thus, resistance operated in a dialectical fashion. While clients' acts of resistance emerged out of their needs to retain a sense of themselves, their sense of self was ultimately strengthened and empowered through their acts of resistance.

It is noteworthy that the gay or lesbian clients' therapeutic experiences were not dissimilar to those of other patients of medical professionals (e.g., the individual with pancreatic problems becomes the 'pancreatic case' instead of being seen as the embodiment of all of his/her other characteristics). And, just as the gay or lesbian clients therapeutic experiences were similar to those of other patients, so were their reactions to these experiences--particularly their acts of resistance. These clients' strategies of resistance reflect the wider movements against professionals in society which are brought to the public's attention through such terms as 'demedicalization', 'deprofessionalization', 'delegalization', and 'anti-psychiatry'. All of these movements emerged from "a distrust of professionals and experts and a [need for a] demystification of their monopolistic claims of competence in
classifying and treating various forms of deviance" (Cohen, 1985: 31). The results of this study support previous findings that some clients perceived psychiatrists to be acting as agents of social control, however, some patients do not accept psychiatrists' claim to exercise legitimate social control--they resist.

However, utilizing the insights of Foucault, my research also goes beyond the traditional social control literature to show how social control is perceived to be mediated in the therapeutic encounter, rather than simply asserting, as do for example the medicalization theorists, that it has happened. My research confirms Foucault's view that the medical examination is experienced as a 'ceremony of objectification'. Through the medical examination, clients found that power becomes less visible while objects of power are made more visible. During initial therapeutic encounters, clients experienced that their psychiatrists' conceptions of the clients' homosexuality as deviance set the overall tone for the therapeutic relationship. As a result, the clients perceived one of their features (i.e., their homosexuality) to be magnified and then subjected to scrutiny and judgment by the psychiatrists. Hereafter, as a function of the patient/professional therapeutic dyad, the gay or lesbian clients experienced themselves as expected, indeed obliged, to accept psychiatric definitions of homosexuality imposed through strategies of policing.
Clients did not feel that they had any opportunity to question directly the authority of the mental health professionals or the ways in which the psychiatrists conceptualized homosexuality. Moreover, the clients experienced their sexual orientations as being the objects of knowledge, while the sexual orientations of the psychiatrists were invisible.

Through the medical examination, Foucault notes, the continuous observation of those individuals subject to control culminates in their individualization. By the highlighting of their sexual orientations (e.g., through the sexualization of the homosexual), clients experienced themselves as becoming 'known' to professionals as objects of knowledge. Through this practice, homosexuals become separated and individuated from the 'normal' population. For the clients, the construction of themselves as homosexuals made them 'different' or Other, thereby legitimating various forms of intervention—the most significant in this case was normalization (i.e., the adoption of heterosexuality as the ideal and normal sexual orientation).

One of the critiques of Foucault's work, drawn from a feminist perspective, is that he is gender blind; he does not see power as having a gendered face. My findings confirm that gender is indeed an important variable to take into account. For instance, when I explored how the clients experienced their psychiatrists as attempting to normalize
them, I found that power operated on the clients in gender-specific ways (i.e., Paulo reported that he was encouraged to behave in a traditionally masculine way and to date a female, while Carmen indicated that she was encouraged to uphold the norms of femininity and to go out with a male).

Foucault’s belief that power is primarily productive as opposed to being repressive is not confirmed. One reason why I rejected the analyses of traditional theorists of medicine as an institution of social control was that they relied upon repressive notions of power. I chose Foucault’s theories because he sees power as operating primarily in a productive manner. Through my analysis, however, I found evidence of clients’ perceptions of both repressive and productive types of power operating. Clients experienced power as operating in a repressive manner when they found psychiatrists attempting to medicalize their sexual orientations. But, clients also found that power was exercised simultaneously in a productive manner through the production of discourses that become embedded in their own thought processes. Clients’ accounts reflect that they confronted a complex matrix of power mechanisms, imposed both from outside and from within themselves. Using the insights gained from my findings, future researchers on social control, particularly social control as it is applied through the medical establishment, should attempt to reconcile the two models of power to gain a richer understanding of how power operates.
While Foucault's belief that power is primarily productive in nature was not confirmed, his corollary notion—that power has become more insidious in recent years—was supported by my findings. Although the APA no longer formally designates homosexuality as a mental disorder, my interpretation of these clients’ accounts suggests that they perceive their psychiatrists to be using this definition during their therapeutic interactions with themselves as gay or lesbian clients. Instead of being treated with aversion therapy techniques when they disclosed their gay or lesbian sexual orientations to psychiatrists (a practice akin to physical punishment), these gay or lesbian clients experienced themselves as being policed by psychiatrists through talk therapy focussed on their sexual orientations. This subtle shift in psychiatrists' treatment of gay or lesbian clients draws our attention to the relationship between homophobia and heterosexism. Rather than seeing heterosexism as a less coercive form of social control, homophobia and heterosexism should be understood as concepts falling along a continuum of anti-gay sentiment (Stewart, 1995). While homophobia may be more overt and physically violent, heterosexism is equally violent because its very insidiousness undermines gay men's and lesbian's sense of self and identity.

The above encompasses the major findings of this thesis. Like any piece of research, however, this study has its
limitations. One major limitation is that it only offers a one-sided perspective on the clients’ therapy sessions based on accounts and interviews. I do not examine the psychiatrists’ perspectives in terms of their thoughts and feelings about the clients, what they intended to do for these clients, or how they actually understood homosexuality. A question that would be worth exploring is how the psychiatrists integrated their personal values and beliefs with their professional perspectives. A second question is, whether the psychiatrists were able to recognize their clients’ resistances. If so, how did they respond? At any rate, to achieve a more complete picture, in addition to speaking with the clients themselves, future researchers should speak with psychiatrists about their perspectives on treating gay or lesbian clients. The ideal study would be to observe the therapeutic encounter between a psychiatrist and his/her gay or lesbian client.

In spite of these limitations, however, the findings of this study may be useful for psychiatrists and gay or lesbian clients alike. Psychiatrists wanting to increase the quality of the therapeutic care they offer to gay or lesbian clients may recognize from my findings that they need to ensure that they provide a therapeutic climate which gay men and lesbians perceive as a place where they can feel safe. When exploring their sexual orientations and/or other issues of vulnerability (both related and unrelated to their sexual
orientations), gay or lesbian clients need to feel secure. However, in order to foster a therapeutic environment perceived as safe by gay men and lesbians, psychiatrists need to interrogate their own values and examine the impact that these values might have on the therapeutic relationship. Moreover, in order to achieve an approach perceived as affirmative by gay men and lesbians, psychiatrists must be prepared to do the work of learning about gay cultures, communities, and values. Knowledge of the strategies of policing which I identified can help current or past gay or lesbian clients of psychiatrists to evaluate critically the quality of care that they are receiving or have already received. Finally, my findings may be helpful to current and past gay or lesbian clients of psychiatrists who may be comforted in knowing that they are not alone in their struggles in psychiatric therapy sessions.
APPENDIX A

INTERVIEWEE CONSENT FORM

Study: An exploration of psychiatrists' treatment of gay or lesbian clients.

Investigator: Randa Palfy B.A. 
Master of Arts Student 
College of Graduate Studies 
University of Saskatchewan 
Phone: 652-0532 (home)

Supervisor: Lesley Biggs Ph.D. 
Associate Professor 
Department of Sociology 
University of Saskatchewan 
Phone: 966-6931 (office)

The purpose of this study is to explore the attitudes of psychiatrists toward their gay or lesbian clients in order to investigate two issues: first, what kind of impact, if any, the official demedicalization of homosexuality in the Diagnostic and Statistical Manual of Mental Disorders II has had on the social and medical practices of psychiatrists; second and consequently, the quality of care that gay or lesbian clients receive through therapy with such professionals. Interview time will last approximately one hour. During this interview the attached questions will be asked regarding your treatment experiences with a psychiatrist(s) who was aware of your sexual orientation.

Outside of having the opportunity to tell of their experiences, there may not be any direct benefits to the participants of this study. However, the information gained will contribute to a better understanding of whether gay men's or lesbian's needs are being met when they seek health care services through psychiatrists.

I hereby agree to be interviewed and for these interviews to be tape-recorded (preferable but optional). I understand that my identity will be kept confidential and thus will not be disclosed in any published information. I also understand that the information will be presented in a manner that prohibits anyone from identifying subjects.

I understand that I am free to skip any questions I would prefer not to answer. I also understand that participation in this study is voluntary and that I am free to withdraw from the study at any time and that withdrawal will not affect me in any way.

I have been given the opportunity to ask any questions about the study that I wish and all questions have been answered to my satisfaction.
AUTHORIZATION:

I, _____________________, hereby consent to participate as a volunteer in the thesis research described above.

_________________________  _______________________________________
(Signature of participant) (Signature of investigator)

_________________________
(Date)

Please print your name and address below if you would like a summary of the study results and/or have a further discussion of the results once the study is complete.
NOTE: Please keep in mind that due to the sensitive nature of this topic, if any of the questions listed below make you uncomfortable so that you do not wish to respond I am prepared to respect your wishes. It is also not expected that you divulge the name of your psychiatrist(s).

Having noted that, any information you can provide on this topic will be useful. As an investigator, I am interested in finding out whether your treatment experiences confirm, deny, or transcend my initial perceptions.

1. Sex of interviewee -
   Male ______ Female ______

2. Age of the interviewee -

3. Sexual orientation of the interviewee -
   Gay ______ Lesbian ______ Bisexual ______

4. Education level of the interviewee -

5. In the interests of finding a psychiatrist who is knowledgeable and understanding of your needs as a gay or lesbian client it may have been necessary to "shop around" (if this was an option for you) in order to find a psychiatrist who was acceptable. How many psychiatrists have you seen? ______

6. Sex of the psychiatrist(s) - Check as many as apply
   Male ______ Female ______

7. Sexual orientation of the psychiatrist(s) - If not known check this space ______ and proceed to question 8, otherwise, continue with question 7. Again, check as many times as apply.
   Gay ___ Lesbian ___ Heterosexual ___ Bisexual ___
   Suspected ___ Known ___ Made Known ___

8. Approximately how old was the psychiatrist(s) that you saw?
9. Did you go to see a psychiatrist because you were personally having difficulty accepting your sexual orientation?

10. Did you trust your psychiatrist(s)?

11. During therapy, did your psychiatrist(s) meet your needs (or at least attempt to meet your needs) as a gay man or lesbian? Could you elaborate on this?

12. If your psychiatrist turned out to be "gay positive", were you aware of this before you contacted him or her?

13. What type of intervention was offered?

14. How were you treated by the psychiatrist(s)?

15. Did you feel that your psychiatrist(s) accepted your sexual orientation?

16. Did the psychiatrist(s) appear comfortable talking with you about your sexual orientation?

17. Did your psychiatrist ever ask you if you were happy being gay/lesbian/bisexual?

18. Was your psychiatrist(s) knowledgeable about the gay and lesbian community in your area?

19. Did your psychiatrist(s) bring up AIDS issues? If so, how were these issues dealt with?

20. Describe your psychiatrist(s) level of knowledge and understanding of the needs and problems faced by gay men or lesbians.

21. Would you say that your psychiatrist had a preoccupation with either your sexual orientation or the sexual acts you perform beyond what was necessary for the circumstances?

22. Did you receive a lecture on morality?

23. When did you begin therapy and when did you end?

24. How many appointments did you have? (with each psychiatrist if applicable)

25. What reactions do you remember having after your appointments? If your reactions were positive, why were they positive? If your reactions were negative, why were they negative? Finally, did your reactions change over time?
26. Did you sense that your psychiatrist(s) would consider your therapy successfully complete if you remained a gay man or lesbian?

27. Additional comments:
Bibliography


