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acknowledgements

Any faults and omissions in this book are, of course, my own responsibility. However, although the physical act of writing required a mere two years, the process of research took much longer. Whether facilitating safe sex groups, lecturing to my students, collecting conference papers and articles about lesbian and gay health, videoing yet another television documentary on the gay rights movement or, on one magical occasion, running a health workshop with young lesbians in a South African township, it seems as if much of my life over the past decade has been leading up to this textbook!

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This book is primarily intended to be useful to students in the health and social care professions; social workers, nurses, midwives, physiotherapists, radiographers, youth workers and those working in occupational health, health visiting, community nursing, mental health, residential care and other sectors of this vast and important professional arena. It also contains much of interest to medical students, as well as to students of less applied subjects such as social policy, sociology or psychology. It is designed to be appropriate for use in both basic and post-basic training, and to be helpful whether used as a classroom text or by the individual reader.

As we shall see, lack of information and understanding about human sexual diversity is widespread in health and social care, and this has potentially serious consequences for the well-being of lesbian, gay or bisexual service users and practitioners. Study after study has found that this topic is seriously neglected in basic and post-basic training, thereby undermining the ability of staff to respond effectively to the growing demand for change.

This textbook is the first of its kind. Because of this, it departs somewhat from the usual textbook formula. Much of the material here is new, and makes innovative links between research findings and practice implications. You will also find that it strays into some unfamiliar areas – the humanities, cultural studies or lesbian and gay studies, for example – simply because much that is taken for granted within these disciplines has not yet percolated through to professional education.

What this book is about

The primary aim is to support improvements in service delivery to lesbians, gay men and bisexuals by offering a foundation of sound information to be laid down during training. Crucially, as well as offering information about lesbian, gay and bisexual lives, it takes a more critical perspective on sexuality generally. In other words, rather than assuming
heterosexuality as the norm, all sexualities are seen as being in need of explanation. This approach, although fairly time-worn in many disciplines, is a new one in the health and social care literature. It offers uniquely important insights into questions of health and well-being, since it enables us to pin-point the significance of heterosexuality (as well as homosexuality), something which is obscured by treating it as the norm.

The approach throughout is based on a model of professionalism and ethical practice that is concerned with human rights and human need, and this is underpinned by the recognition that what is good for lesbian, gay or bisexual service users is good for all.

What this book is not about

This book does not follow the model of ‘sexuality’ commonly used in nursing handbooks. It will not tell you how to counsel patients eager to resume sexual activity after heart surgery, nor how to reduce the rate of teenage pregnancies. It may, however, enable you to carry out such tasks in a more sensitive and appropriate manner. There is little here about the biology of human sexuality, about reproductive technologies or the clinical manifestations of various disorders of sexual function. In this book, ‘sexuality’ refers to sexual identity or orientation, and its consequences for health and social care practice, although sexual behaviours are also discussed.

The exercises

Each chapter is followed by a relevant exercise. These are intended to reinforce what you have learned by offering an opportunity to strengthen your understanding by making use of new knowledge. However, some of them are also designed to help you reach a clearer understanding of yourself, your own attitudes and beliefs, and the extent to which these may impact on your ability to do your job effectively. This is because sexuality is a very emotive topic, and one where personal feeling and prejudice is at least as important as rational thinking. As Carol Vance puts it, ‘When we come to sex, our minds grind to a halt: normal distinctions become incomprehensible, and ordinary logic flies out the window’ (Vance 1988: 17). If an exercise can help you to recognise the point at which your ordinary logic ‘flies out the window’, you then have the opportunity to reflect on the consequences of this and to develop strategies for dealing with it, in line with the requirements of reflexive practice.

The exercises can all be successfully carried out by the lone reader, but their outcomes may be enriched if they are done with small groups of people – about five or six for preference. None of them requires any equipment beyond scrap paper and something to write with, and they do not have ‘right’ or ‘wrong’ answers.
The sexual orientation of the reader

As a lesbian myself, I know how irritating it is when books like this one assume that all their readers will be heterosexual. However, not all heterosexuals are ignorant about lesbian and gay issues, any more than all lesbians, gay men and bisexuals are necessarily well-informed. Whatever your sexuality, I hope that you will find much here that is new to you. Some of the exercises will have a very different impact depending on the sexuality of the person engaged in them, and where I believe this to be the case I have suggested alternative approaches. It can be fun, as well as informative, to try both approaches! A word of caution. If a colleague ‘comes out’ to you whilst doing these exercises, do not assume that you have the right to ‘out’ them to anyone else. This is privileged information that still has the potential to harm, and you must check with your colleague how far they want that information to go.

A note on terminology

One reason why it is so difficult to write about sexuality is that the available language is always inadequate and often offensive. In order to write this book at all I have had to make choices about which words to use, and these need to be explained.

The word ‘homosexual’ is one that many gay people dislike. With its origins in nineteenth-century sexology, it carries strong overtones of pathology and medicalisation. I have therefore generally avoided using it except in those circumstances where the alternatives are too clumsy. On the other hand, despite grumbles from those who think a lovely word was ‘spoilt’ when homosexuals adopted it, the word gay has been in the lexicon of sexual slang since the seventeenth century (Grahn 1984; Stewart 1995). Lesbian derives from ‘Lesbos’, the Greek island where Sappho lived. One of the most important writers of ancient Greece (Plato called her ‘the tenth Muse’), Sappho wrote love poems addressed to women, giving rise to a long tradition of referring to love between women as ‘Sapphic’ or ‘Lesbian’ love (Balmer 1984; Wilton 1995).

Members of the lesbian and gay community are often highly sensitised to the significance of naming, and there are literally dozens of self-chosen labels. I use ‘lesbian’ and ‘gay man’ for preference, since these are the terms currently in wide use in and by the community itself.

Bisexuality is not often specifically mentioned in this book. This is not out of any desire to exclude bisexuals. However, the marginalisation of bisexuals within the dominant culture is determined by the ‘homosexual’ rather than the ‘heterosexual’ component of their sexualities. Moreover, the concept of bisexuality is often used by those who wish to reinforce the idea that there is something ‘real’ about dividing people up into homosexual or heterosexual. In this strategy, ‘bisexual’ becomes what is called a ‘residual category’, a kind of theoretical rag bag into which you simply toss anything that does not neatly fit your schema. There are,
therefore, compelling theoretical reasons for not falling back on the ‘lesbian, gay and bisexual’ formula, so I have referred to bisexuals only where the context demands it.

Similarly, although some transgendered people have successfully argued a case for inclusion in lesbian, gay and bisexual communities (Califa 1997), an identity constructed around deeply felt unhappiness with one’s biological sex is different in kind from one constructed around same-sex desire. There is not enough space here to pay adequate attention to the complex and rapidly changing issues of transsexualism and transgender. Readers who wish to find out more about these questions are referred to the growing body of literature (see, for example, Ekins and King 1996; Califa 1997; Ekins 1997; Griggs 1998; Halberstam and Volcano 1999).

As will become clear in the discussions that follow, sexual identity is not a fixed or static concept. People may change sexual identity, the same behaviour may have different significance at different historical times or in different cultures, and the boundaries between ‘gay’ and ‘straight’ are in any case blurred and unstable. It is really only possible to use ‘gay’, ‘lesbian’ or ‘bisexual’ to refer to people who have adopted those names for themselves, and that is how such terms are used here. Also used regularly is one gay subcultural term that has moved into the mainstream, ‘coming out’. This, together with its opposite, ‘closeted’, which refers to someone who has not ‘come out of the closet’, is now widely understood to mean acknowledging one’s sexual orientation openly. Of course, this is not a once-in-a-lifetime event; lesbian, gay and bisexual people must choose where, when and to whom they entrust this information on a daily basis (Farquhar 1999).

Although names and concepts may shift, discrimination against individuals whose erotic interactions are with members of their own sex is real, and has ‘real life’ consequences. Laying claim to a sexual identity is also profoundly significant to individuals and to groups. It is important in any discussion of sexuality to hold on to both perceptions; that the hetero/homo divide is a social, political and cultural artefact and yet has real power to shape the lives of millions. This is somewhat similar to other notions, such as class, for example; we no longer believe that working-class people are biologically inferior to middle-class people, yet we recognise that massive differences in lifestyle and life chances result from the class system (Giddens 1997).

The literature

It is because ‘homosexuality’ has been the subject of such powerful sanctions, and because it still tends to be contaminating by association (Plummer 1981), that the task of writing a book such as this demands rather special skills of the author. A glance at the bibliography reveals that it is not only multidisciplinary, but that it includes many sources which are not formal academic texts. This is because the formal literature ‘on homosexuality’ was, until recently, based on the very ideas that
sociologists of sexuality now criticise. In order to understand the social construction of sexualities, you need to study the dialogue of inclusion and exclusion between the sexual mainstream and those it marginalises. My source materials therefore encompass everything from learned scientific papers on genetics to VD posters aimed at the British army, from sociology textbooks to gay magazines. Each chapter has a Further Reading section. If you want to find out more about a particular topic than I could squeeze between these covers (and I hope you will), these sections should help.
The challenge of change

Social and cultural attitudes towards sexuality underwent a dramatic process of liberalisation during the course of the twentieth century, at least in the industrialised West. Lesbian, gay or bisexual people have benefited greatly from this process, and no longer experience the extremes of social exclusion that were the norm until a few decades ago. However, social change is seldom straightforward, indeed it generally involves extended periods of uncertainty and inconsistency. This is most certainly the case for sexuality, with tolerance existing side by side with the extremes of prejudice.

Such inconsistencies are demonstrated in the July 1999 edition of the newsletter published by Stonewall, a British group that campaigns for
Lesbian and gay equality. Alongside a paragraph reporting the award of an OBE to its director, Angela Mason, 'for services to homosexual rights', is an article describing events following the explosion of a nail-bomb outside a gay bar in London. The public response to the bomb speaks for itself:

As the debris was being cleared and the families and friends began to weep and the wave of shock turned to despair and loss, the calls started to come in [to Stonewall]. 'We're so very sorry.' 'Is there anything we can do?' Tears on the switchboard . . . But then 'I've got a box of nails here, shall I send it to you?' 'They should have bombed every pub in the street.' 'Fuck off nancies.' 'Gas the queers.' They go on and on. Twenty five calls by lunchtime. These words are the second cousin of the bomb.

(Fanshaw 1999: 2)

This is what confronts lesbian and gay people in the UK today; a deeply contradictory world where the Queen honours those who work for 'homo-sexual rights' whilst others speak and act with the most savage hatred. It does not take much imagination to recognise the damage that this unpredictable situation may cause to individual health and well-being, and this is why an informed understanding of such issues is an increasingly necessary element of good practice in health and social care.

Sexuality has long been a particularly challenging issue for health and social care workers. This is, at least in part, because it has for so long been a neglected topic in education and training. As a result, concerned individuals have been left to their own devices in dealing with the range of situations where sexuality can suddenly become pertinent. This neglect has resulted in great variations in understanding, skill and competence, as research is starting to demonstrate (Cossis Brown 1992; Stevens 1993; Farquhar 1999; Mugglestone 1999). To this must be added the fact that practitioners, just as much as their clients, must cope with the often conflicting messages that accompany social transformation.

**Sexuality and professional practice**

Why do health and social care professionals need to know anything about the sexuality of those for whom they care? Practitioners tend to ask this question either because they are uneasy about sexuality themselves, or because they wish to protect the privacy of those they care for, or because they believe that if they treat everyone the same, regardless of gender, age, ethnicity or sexual orientation, then there will be no problem. Looking at each of these reasons in turn, it soon becomes clear that things are not that simple.
Personal unease

Working with vulnerable people requires professionalism. This involves, among other things, dealing with inappropriate personal feelings in such a way that the care of individual patients, clients or service users is not compromised. For example, it is a normal reaction to feel fear or disgust at the sight of a living person's internal organs, and fears of this kind are perfectly reasonable. Yet it is accepted that those who deal with such injuries have a professional duty to overcome their anxiety or squeamishness effectively enough to carry out their work well.

Other kinds of fearful or disgusted reactions may be less rational; for example, negative feelings about fat people, people who are disabled or disfigured, or the very elderly. However strong such feelings may be, professionalism demands that health and social care practitioners respect the human rights of service users and endeavour to meet their needs for care to the highest possible standard. Personal anxiety, unease or disgust about some aspects of human sexuality are not acceptable reasons to remain ill-informed about something which may have implications for professional practice. We would expect someone who routinely faints at the sight of blood to choose a career other than midwifery; it is equally reasonable to expect that anyone unwilling to provide respectful care to lesbian, gay or bisexual service users should not work in health and social care. However, providing care to a high standard requires a sound knowledge-base.

Protecting privacy

In the often invasive context of health and social care environments, it is important to protect the privacy of patients and clients as much as possible. However, respect for privacy is not the same as ignoring people's needs, and if service users need support in dealing with issues of sexuality there is a clear professional responsibility to respond.

For example, a gay man recovering from major surgery may be very anxious about the implications for his sex life, but may be too embarrassed to ask directly for detailed advice. Who is the better nurse in this kind of situation, the one who tactfully offers the opportunity to discuss sex and is well-informed enough to give good advice, or the one whose concern for the patient's privacy prevents any discussion about sexual matters at all? Respect for privacy is not a good reason for the health or social care professional failing to develop a sound knowledge-base about the range of human sexualities and the skills to put this into practice with sensitivity.

Equal care

Finally, there is the argument that treating everyone in the same way guarantees equality. Here it is important to recognise the difference between treating everyone the same, by offering the same high standard of
care to everyone, and treating everyone as if they were the same, which is very different. It should go without saying that everyone is entitled to the same standard of care. However, it is impossible to give good quality care by treating everyone as if they were the same. For example, it is increasingly recognised that members of different ethnic groups have different needs, and that treating them all as if they were the same (which generally means treating everyone as if they were a member of the majority ethnic group), results in a poor standard of care.

We may be more accustomed to thinking about the importance of issues such as ethnicity in this context than we are to considering sexuality. Yet sexuality is a very significant part of our lives, our closest relationships, and our sense of who we are. People receiving professional care may well be in physical or emotional pain and are likely to feel isolated, disorientated, insecure or depressed. Such feelings are stressful enough without the added pressure of having to keep a key part of your identity and your life hidden, or having the disconcerting experience of being treated as if you were someone else. Most heterosexuals would probably feel confused, disorientated or offended, if everyone around them behaved as if they were gay. Yet most lesbians and gay men constantly have to deal with the assumption that they are heterosexual, and have the added stress of knowing that their loving relationships may not be respected by those who are caring for them. It is just as important to acknowledge differences of sexual orientation as it is to acknowledge differences of culture. It is also important to understand that homophobia is likely to impact on the well-being of lesbian or gay service users, just as racism affects the well-being of other groups.

Starting to think about homophobia

It is a fairly common error to assume that the ‘homo’ in words such as ‘homosexual’ and ‘homophobic’ comes from the Latin word for man, as in ‘Homo sapiens’. In fact, it comes from the Greek root meaning ‘the same’, as in ‘homogenous’. Similarly ‘heterosexual’ includes the Greek root for ‘different’, as in ‘heterogenous’. So ‘homosexual’ means a sexuality of same-ness, and ‘homophobia’ (which literally means ‘fear of the same’) is used to mean an irrational fear or disgust towards lesbians and/or gay men.

Research evidence demonstrates that homophobia is common among those involved in health and social care, just as it is in the wider society (see, for example, Marshall 1983; Hepburn and Gutierrez 1988; Pharr 1988; Shernoff and Scott 1988; Gomez and Smith 1990; Stern 1993; Wilton 1997a, 1997b). Although such evidence is useful, it often lacks any sense of the emotional impact that homophobic incidents may have. I would like to share an anecdote from personal experience, which illustrates some of the most characteristic elements of homophobia and its potential impact in one area of practice.

After I had presented a paper on the care of lesbian mothers at a midwifery study day, an experienced community midwife came up to me,
greatly agitated, and asked what should be done with the boy babies. She explained that, since all lesbians were ‘truly homophobic’, they would want to ‘get rid’ of any boy babies they gave birth to. By ‘truly homophobic’ she meant ‘truly man-hating’.

Her convictions remained unshaken by rational argument, and she returned to practice still believing in the infanticidal tendencies of man-hating lesbians. There is nowadays no shortage of research evidence to show that lesbian mothers are remarkably similar to non-lesbian mothers, that they love and care for their children whatever sex they might be, and that the greatest problem faced by their children is not the sexuality of their mum but the homophobia of the wider society (Alpert 1988; Rafkin 1990; Kenney and Tash 1993; Saffron 1994; Gartrell et al. 1996; Griffin and Mulholland 1997; Dunne 1998; Wilton 1999b). In this age of evidence-based practice, this particular midwife gave more credence to the homophobic myths circulating in popular culture than she did to four decades of research findings within the scientific community.

This incident, whilst extreme, flags up some of the important characteristics of homophobia. In common with other prejudices, such as anti-Semitism or racism, it is irrational. However, scholars who have studied prejudice note that homophobia is not only not felt to be irrational – nor are racism or anti-Semitism – but is actually felt to be morally praiseworthy and socially sanctioned (Pharr 1988; Comstock 1991). In order to understand homophobia then, we need to think of it not simply in psychological terms, as an expression of personal fear or disturbance, but in social, cultural and political terms as well.

It is important to recognise the socio-cultural sources of homophobic stereotypes – whether pub humour or newspaper editorials – and to take seriously the consequences of political debates around such issues as equalising the age of consent or permitting lesbians and gay men to serve in the armed forces. It is not difficult to see how many factors, from Acts of Parliament to the banter of canteen culture, may contribute to the ‘sense of virtue’ that one researcher found amongst violently homophobic individuals (Comstock 1991).

Another key issue reflected by this incident is that homophobia is generally not taken seriously as a professional issue. If, for example, staff express extreme racist beliefs, formal structures and procedures exist to ensure that the matter could be dealt with. Equal opportunities policies, disciplinary procedures, legislation and a national race-relations policy might all be drawn on to protect the interests of vulnerable clients. Clearly such strategies have not succeeded in eradicating racism from British society or professional practice. However, the existence of formal sanctions means that racism is at least acknowledged as the social evil that it is. Because there is, as yet, no formal means to protect those who are lesbian or gay from discrimination, there is no equivalent acknowledgement of the wrongness of homophobia.

The continuing invisibility of homophobia as a serious professional issue may itself have indirect consequences for well-being, as one lesbian interviewed recently in Bolton indicates: ‘I feel very isolated, very isolated,
yeah I do. Even I end up dismissing my own needs because I'm in an environment that dismisses my needs' (Mugglestone 1999: 67).

Such statements suggest that a wider acknowledgement of the needs of lesbian and gay service users may in itself have positive benefits in terms of general confidence, self-esteem and well-being for many individuals, whether or not they come directly to the attention of service providers.

The extreme level of misinformation demonstrated by my troubled community midwife is rare. Studies have shown that many lesbian mothers receive excellent and sensitive midwifery care, although this is not yet the norm (Stevens 1993; Stewart 1997). Nor should it be assumed that lesbian or gay service users inevitably have bad experiences. Only a few weeks after my conversation with the community midwife, a friend of mine spent many weeks in hospital with serious injuries. She was visited on a regular basis by her female partner and an assortment of cheerfully 'out' lesbians. The nurses were friendly and respectful, the other patients were openly intrigued without being offensive, and her partner was treated as next of kin with no fuss at all. The entire episode was a model of good practice from start to finish and offered encouraging evidence of a positive shift in attitude.

This brings us back to the point that opened this chapter: the contradictory nature of change. There are no hard and fast rules about homophobia. One of the hardest things for lesbians and gay men to live with is its unpredictability. There is no way of knowing when you get up in the morning whether today will be one of those days when everyone you meet returns your smile, or whether you and your partner will be spat at in the street. This element of contradiction and conflict is found at every level, from the individual to the political.

When, in the summer of 1998, a bill to equalise the age of consent for gay men finally passed its first reading in the House of Commons, this sign of general acceptance was contradicted by the hostile response of many peers. Baroness Young, for example, said on ITN that night: 'I think it signals a paedophiles' charter. I think all 16-year-old boys will be at risk.' The House of Lords promptly returned the bill to the Commons, with the age of consent amendment defeated.

When those in power do not yet know the difference between a gay man and a paedophile, when sexuality is not adequately addressed in basic training, and when it is still not safe for most lesbians and gay men to be out at work, it is not surprising that many HSC practitioners – even some of those who are themselves lesbian or gay – are ill-equipped to deal with the issue of sexuality. Faced with the quite reasonable demands of lesbian and gay service users for better and more sensitive treatment, it is now a matter of some urgency to remedy the neglect of sexuality as an issue in training.

### Beginning to understand sexual diversity

There is one very significant difference between sexual orientation and characteristics such as ethnicity or age. It is usually possible to tell the
difference between the very young and the very old, and attributes such as skin colour, accent or dress offer clues to culture and ethnicity. Sexual orientation is not an easily perceptible set of characteristics, and it is generally only possible to know an individual’s sexuality if they want you to know. This is just as true of heterosexual women and men as it is of lesbians and gay men, although heterosexuals seldom have to think about whether or not to let people know that they are heterosexual.

This characteristic, often referred to in the literature as ‘invisibility’, is partly because sexual orientation is not a physical characteristic like age or skin colour, but it is also reinforced by the very real need for concealment caused by heterosexism (see below) and homophobia. Not being able to read clear signals is one simple reason why many heterosexual women and men believe that they have never come into contact with a lesbian or gay man, and this may have implications for quality of care. For example, it is not uncommon for clinicians to claim that they have never treated lesbian or gay patients, even when this assertion is statistically highly unlikely (Robertson 1993). Of course, if you genuinely believe that you have no lesbian or gay service users, you are unlikely to perceive the issue as serious or relevant to your own practice, and this in turn contributes to a wider perception of sexual orientation as a marginal issue.

Heterosexism

It may be easy to understand why it might be offensive to treat heterosexuals as if they were gay, but less easy to recognise why it might be equally offensive to treat lesbians and gay men as if they were heterosexual. This in itself is a sign that heterosexuality is, often unthinkingly, valued more highly than homosexuality. To regard heterosexuality as being better, more normal, more natural or more morally right than homosexuality is called heterosexism. Although different from homophobia, heterosexism also has an important impact on the delivery of health and social care. It tends to result in errors of omission – for example, designing admissions forms that assume heterosexuality by using terminology such as ‘marital status’ – rather than direct or indirect hostility.

Attitudes have improved in many Western societies in recent years, and it may appear that the lesbian and gay members of these societies are now fully accepted. However, although these changes have made a very real difference to the lives of many millions of people, they are still relatively superficial. For example, gay soap operas on television probably bear the same relation to general homophobia as the Cosby Show does to general racism.

The professional context

Researchers have found substantial evidence that lesbian and gay users of the health and social care services commonly meet with ignorance,
hostility, rude and offensive behaviour and even aggression if they are open about their sexual orientation (Shernoff and Scott 1988; Stevens 1993; Dockery 1996; Sheffield Health 1996). Even where heterosexual staff are well-meaning they may be ill-informed, and this often means that service users are left with the responsibility of educating them about relevant issues or are obliged to put up with voyeuristic and intrusive questioning (Stevens 1993; Wilton 1997b).

This is a catch-22 situation. Although staff clearly need information, it is hardly surprising that their lack of information causes many lesbians and gay men to conceal their sexuality. Well-meaning individuals may find this frustrating, failing to understand that such concealment is often necessary for personal safety. Lesbians and gay men must constantly decide whether or not it is safe to ‘come out’, what the likely consequences will be, and whether or not they can trust the judgement of the other people involved. It is a question not only of predicting the responses of the person you are about to tell, but also of whether or not they are likely to tell others, and what the reaction of those unknown people may be. In the context of a hospital, a care team, a general practice, or a local authority social services unit, it can become very difficult for individuals to retain control over who knows and who does not. Since homophobia is so widespread, this lack of control can be very stressful, and has been identified as the reason why many continue to conceal their sexuality even from their general practitioners (GPs) (Somerset Health Authority 1998; Mugglestone 1999; Wilton 1999b).

Both openness and concealment carry risks for the individual concerned. If they choose to come out, they risk having to deal with negative reactions. If they choose not to, they will have to deal with the emotional costs of secrecy, and with being treated as if they are something that they are not. Both scenarios carry personal costs in terms of stress, anxiety, fear and insecurity. In the context of illness, injury or personal crisis, such an additional burden is likely to have a negative impact on an individual’s ability to heal, to recover or to surmount crisis and regain strength and stability.

Religious beliefs and moral dilemmas

One important distinction between homophobia and other forms of discrimination is that many people believe that love between individuals of the same biological sex is morally wrong. It is not generally thought, even by the most disturbed racist, that to be black is an immoral act – although many racists do claim that black people are more likely to behave in an immoral way than non-black people. In contrast, many insist that simply to be gay, lesbian or bisexual is to be immoral.

Moreover, many believe that their religion condemns homosexuality. This moral/religious aspect of the issue may cause painful conflicts for the HSC professional who genuinely wants to offer the very best standard of care to all users of their service, but who feels that their religious or moral
beliefs prohibit them from offering good care to lesbian, gay or bisexual people. There is no easy way out of this dilemma. It is an absolute requirement of professionalism that personal beliefs be set aside when they conflict with professional duty. The sole exception to this rule is that nurses are permitted to refuse to assist at the termination of pregnancies on religious grounds. This acceptance of duty may demand a thoughtful and open-minded re-evaluation of one's religious or moral standpoint, and it may help to seek advice from one of the lesbian and gay religious groups (for a useful directory of such groups, see Green et al. 1996).

Religion

Researchers have repeatedly found a clear association between homophobic attitudes and strong religious belief (Pharr 1988; Comstock 1991; Haldeman 1991; Sears 1991; Griffen et al. 1998), and this is as true of clinicians and health and social care professionals as it is of any other group (Stevens 1993). Sometimes, homophobic individuals opportunistically make use of what they assume to be religious doctrine in order to justify their own prejudices (Haldeman 1991). In other cases however, individuals with deeply held religious beliefs quite genuinely believe that homosexuality is forbidden by their religion.

There is a more substantial discussion of religious attitudes in later chapters. Here, it is useful to recognise that the holy writings of the world's great religions - Judaism, Christianity, Sikhism, Hinduism, Islam and Buddhism - barely mention homosexuality. The Gospels, for example, contain not a single reference to it. This is not surprising since, as one theologian points out, 'The terms homosexual and heterosexual were not developed in any language until the 1890s...Therefore the use of the word homosexuality by certain English Bible translators is an example of the extreme bias that endangers the human and civil rights of homosexual persons' (Mollenkott, cited in Pharr 1988: 3, emphasis in original). Many contemporary scholars agree that the Bible has nothing to say about homosexuality per se. Indeed, Helminiak concludes (1994: 108), 'the Bible takes no direct stand on the morality of... gay and lesbian relationships'. Where homosexual acts are mentioned, it is usually something other than the gender of the participants which is the issue (Helminiak 1994).

The same is true for other religious traditions; it is the legislative apparatus created by the administrative infrastructure of the world's religions that forbids same-sex relationships. In other words, human authority, not divine law, appears to be the issue. This interpretation remains contentious, but it is clear that religious condemnation of homosexuality is by no means as unequivocal as many assume, and that theologians have found at least as much acceptance of same-sex love in the world's great religious texts as rejection.

It is, therefore, no easy solution to call on religion to justify a personal belief in the immorality or unnaturalness of homosexuality. Concluding an exhaustive study into the morality of homosexuality, philosopher
Michael Ruse writes that: ‘the argument that homosexuality is biologically unnatural and hence immoral, fails’, and recommends that ‘one ought to persuade people not to confuse their disgust . . . with moral indignation’ (Ruse 1988: 196 and 291).

Implications for practice

The homophobia and heterosexism that researchers have identified within health and social care are morally and professionally indefensible. This does not mean that it is easy to shed homophobic prejudices, but it does mean that there is a clear moral as well as professional obligation to recognise them for what they are. As one psychologist recommends to clergymen, ‘Even if you are unable to see the beauty and dignity of Gay people, even if you continue to believe that Gay is sinful and immoral, be good enough to tell the trusting Gay person who consults you that it is your opinion and your interpretation of your religion’ (Clark 1987: 224).

For many working in the field of health and social care, religious belief offers both a source of comfort in an often stressful career and a primary motivation to care for others in this way. In other words, faith often supports the professional ethos. However, in cases where it comes into conflict with a practitioner’s ability to deliver respectful and appropriate care, there is a clear obligation to prioritise professional standards over personal belief or morality. Such professional skills are best supported by developing an informed understanding of the social and cultural roots of homophobia, and by exploring both sides of the relevant religious debates.

exercise

Working alone or with a partner, write down the names of as many well-known gay men as you can think of. Give yourself ten minutes. Now do the same for well-known lesbians.

Points to think about:

- Which list is longer, and which was easier to collect? What does this tell you?
- What did it feel like writing down the names? Were you unwilling to write down any names of people you were not absolutely sure about? What does this tell you?
- If you yourself are lesbian or gay, how did it make you feel doing this exercise? Do you feel that your ‘insider knowledge’ is a useful professional resource, or that it may expose you to homophobia from your colleagues?
Further reading