Acknowledgements

To L. J., thank you for being there.

D. R. T.

'It makes far better sense to rely on a fence
Than an ambulance down in the valley.'

Anonymous

Promotion of Mental Health
Volume 2, 1992

Published 1993

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Avebury
Aldershot · Brookfield USA · Hong Kong · Singapore · Sydney
### Appendix 1

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### 15 Psychological well-being and gay identity: Some suggestions for promoting mental health among gay men

A. Coyle and M. Daniels

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**Introduction**

Many studies have been undertaken which examine the prevalence of psychopathology among gay men, mostly prompted by the adoption of a medical model of homosexuality. The results of these studies have been decidedly mixed. Some have reported that, compared with heterosexual men, gay men are lower in psychological well-being on such dimensions as neuroticism (Van den Aardweg, 1985), self-esteem (Jacobs & Tedford, 1980), hostility (Rizzo et al., 1981) and emotional vulnerability (Williams, 1981). Other studies that have examined factors such as general psychiatric disorder, depression, extraversion-introversion, ego development, sex guilt and - once again - neuroticism and self-esteem have found no significant differences between heterosexuals and homosexuals (Carlson & Baxter, 1984; Harry, 1983; Hooberman, 1979; Pillard, 1988; Weis & Dain, 1979). Others still have reported higher levels of psychological well-being among gay men than among heterosexual men (Skracek & MacKenzie, 1981). In reviews of studies of psychological well-being among gay men, Gonsiorek (1991) and Hart et al. (1978) criticised them on conceptual and methodological grounds. They concluded that there is no empirical basis for the belief that homosexuals are inherently any less psychologically adjusted than heterosexuals.

The following examination of psychological well-being among gay men takes as its starting point a study which used a self-completion questionnaire to investigate the gay identity formation experiences of a non-clinical group of 140 gay men from the Greater London area (Coyle, 1991,
The questionnaire addressed a broad range of experiences that - in a pilot study and in previous work on the topic - have been described as instrumental in the formation of a gay identity (Cass, 1979; Coleman, 1982; Hencken & O'Dowd, 1977; Hetrick & Martin, 1987; Lee, 1977; Minton & McDonald, 1974; Plummer, 1975; Troiden, 1979, 1988; Weinberg, 1983). As part of this study, respondents' levels of psychological well-being were ascertained by having them complete the 30-item General Health Questionnaire (GHQ-30) (Goldberg, 1978). The scores obtained by the gay men were compared with the scores obtained in a study by Cox et al. (1987) which applied the GHQ-30 to men from the general population (Coyle, in press).

Bearing in mind that the lower the score a person obtains on the GHQ-30, the higher is their level of psychological well-being, the mean score obtained by the gay men who participated in the gay identity formation study was 4.56, while the mean score obtained by single men in Cox et al.'s study was 3.67. The difference between these scores was statistically significant (z = 2.08, p < .05). This difference persisted when the married men in Cox et al.'s study were considered. Their mean score was 3.35 and the difference between this score and the gay men's mean score was again statistically significant (z = 2.56, p < .05). Divorced/separated men and widowed men in Cox et al.'s study obtained mean scores of 4.61 and 5.19 respectively. The differences between these scores and the gay men's mean scores were not statistically significant. In terms of psychological well-being, the sample of gay men was comparable with groups of men from the general population who have undergone potentially traumatic emotional life events that may have undermined their psychological well-being.

Psychological well-being and gay identity formation

Studies of gay identity formation have described the sorts of potentially traumatic experiences that men may encounter when constructing a gay identity against a background of negative social representations of gay men/homosexuality and that may impact negatively upon their psychological well-being. An indication of the nature and content of these negative social representations was obtained in the gay identity formation study when respondents were asked to report what they first learned about homosexuality and to describe what they thought a stereotypical gay man was like at that time. In addition to learning about the meaning of the gay/homosexual social category, i.e., that there were men who were called 'gay' or 'homosexual' and who were sexually attracted to other men, respondents said they had also learned that being gay was some-

thing to be despised and ridiculed; that it was associated with being effeminate; and that it was sick or abnormal. Respondents reported that at that time they saw a stereotypical gay man as someone who was effeminate; who was sexually attracted to other men; who wanted to have sex with young boys; who was 'a dirty old man in a dirty raincoat'; who wanted to be a woman; and who dressed in women's clothes.

Through the process of what Malyon (1982) called 'biased socialization', most people internalize these negative social representations of homosexuality. The suspicion that one is or might be gay/homosexual and that the socially devalued gay/homosexual category has relevance for the self may therefore be a source of considerable distress. This self-suspicion process has been linked with physical and psychosocial dysfunction, including feelings of alienation, isolation, loneliness and guilt, a diminution of self-esteem and a tendency towards depression and self-blame (Malyon, 1982; Remafedi, 1987a, 1987b; Richardson, 1981). Respondents in the gay identity formation study frequently reported having experienced fear, worry and uncertainty at this point. The self-suspicion stage also had social implications, as respondents thought they would have to be very secretive, felt socially isolated and became very concerned about what other people thought of them. These reactions persisted, although to a lesser extent, even when respondents had decided that they were definitely gay. At this point, however, more positive reactions did emerge, with many respondents feeling glad that all the doubting and questioning was over, and believing that they had been courageous in facing up to their socially stigmatized sexuality.

The process of disguising their homosexuality or of 'passing' as heterosexual (Goffman, 1963) appeared to exert particular strain on respondents. At the time of the study, over half the respondents disguised their homosexuality from at least one person or one group of people, most commonly from friends, family members, and work colleagues. However, some disguised their homosexuality from everyone in their non-gay social world. When asked to describe their feelings when they now passed as heterosexual, many said they felt that those from whom they disguised their homosexuality did not really know them and they wished they had the courage to tell them. They felt they were not being true to themselves, that they were 'letting the side down' and being hypocritical. Such feelings of guilt, dishonesty and estrangement from others and from oneself may prove highly detrimental to psychological well-being.

The fact that these feelings were currently reported by respondents demonstrates that the identity demands an individual faces in constructing a gay identity many continue, albeit in an attenuated form, in the
maintenance of that identity. A further example of this is provided by Lee
(1977), who noted that the disclosure of sexual identity is not a once-and-
for-all task but rather involves continually risking the loss of different
aspects of one’s social world as these become new audiences for disclo-
urse.

Two findings that emerged from multiple regression analyses of the gay
identity formation data (see Coyle, 1991, 1992) and that concerned psychol-
ogical well-being are of particular interest. Respondents’ levels of psychol-
ogical well-being were found to be significantly related to the extent to
which they perceived being gay as holding salient personal advantages for them and to their degree of involvement in the gay subculture. Neither of these results were particularly surprising. If a person perceives being gay as personally advantageous, they are less likely to experience anxiety, stress or depression - the principal dimen-
sions measured by the GHQ-30 - as a result of holding a gay identity. They
may be said to feel positively about their gay identity and by extension
about themselves. Nor was it surprising that a high degree of involvement
in the gay subculture should be associated with a high level of psychologi-
cal well-being. Through conversations with other gay men in the gay
subculture, those who are engaged in identity construction can discover
strategies for coping with the interpersonal problems that a gay identity
may cause. They may be able to hear and internalise legitimating accounts
of what it means to be gay and to normalise through mixing with similar
others what society at large would regard as an aberrant sexual identity.
They can key into what Golan (1981) termed the ‘mutual help system’ of
the gay subculture and can obtain social support, new reference groups,
and a social context in which a positively-evaluated gay identity can
develop. In this way, a high degree of subcultural involvement can
decrease the potential for gay men to experience anxiety, stress and
depression as a result of their sexual identity.

The advent of HIV/AIDS constitutes a further factor that may depress
the psychological well-being of gay men. Media constructions of the
HIV/AIDS pandemic have variously represented it as a ‘gay plague’,
transmitted through the unnatural sexual practices of irresponsible,
immoral, promiscuous gay men (Armstrong, 1985; Watney, 1987). With
the advent of HIV/AIDS, already negative social representations of gay
men have become suffused with notions of physical disease, divine
damnation and death. Although it has been contended that HIV/AIDS
is no longer represented in this way in the media (Berridge, 1992), the
extent to which the original media constructions of HIV/AIDS continue
to inform public ideas about the condition is uncertain. It could be that the
social representation of HIV/AIDS as a ‘gay plague’ has proven durable
and retains a capacity to render the construction of the positive gay
identity even more difficult and to undermine the self-worth of gay men
(Feldman, 1988). Those gay men who have HIV/AIDS may have to cope
with a range of issues that may exert extremely adverse effects upon their
psychological well-being. These include multiple losses (for example,
losses of finance, relationships, self-image, future, sexuality, and control
over one’s life), which may include multiple bereavement if many mem-
bers of the person’s social network have died from AIDS-related con-
tions; issues of dependency; the disguising and disclosure of HIV status;
coming to terms with one’s own mortality and coping with terminal
illness; trying to obtain and co-ordinate services from diverse service
providers; and coping with the social stigma associated with HIV/AIDS
(Coyle and Craig, 1992; Martin, 1988; Morin and Batchelor, 1984; Morin
et al., 1984; Sherr, 1989). The epidemic has also been found to have
detrimentially affected the psychological well-being of gay men who do
not themselves have HIV/AIDS (Hirsch and Enlow, 1984; Noh et al., 1990;
Stulberg & Smith, 1988). In view of these considerations, it is apparent that
the promotion of psychological well-being among gay men in the light of
HIV/AIDS constitutes a separate topic in its own right. When examining
how the mental health of gay men could be promoted, the topic of HIV/
AIDS will therefore be dealt with only in terms of its most basic negative
effects upon gay identity.

Neither will the promotion of mental health among lesbian women be
explicitly addressed. Political differences between gay men and lesbian
women and differences in the ways in which male and female sexuality
are socially constructed mean that the issues faced by gay men and lesbian
women in the establishment and maintenance of their sexual identities are
not equivalent (Kitzinger, 1987). On account of this, the study of gay
identity formation which informs the following discussion of mental
health promotion strategies was not broadened to include the experiences
of lesbian women. That is not to deny that there exists a considerable
degree of cross-gender experiential convergence. In constructing positive
sexual identities, both gay men and lesbian women face similar problems
of disclosure, passing, overcoming the heterosexual socialisation process
and coping with negative social representations of their sexual identity.
Many of the mental health promotion strategies to be outlined could
therefore be usefully adapted and applied to lesbian women.

Strategies for promoting mental health among gay men
The foregoing presentation of findings from the gay identity formation
study may be regarded as a form of mental health needs assessment for gay men. The research offers empirical evidence that, in constructing and maintaining their sexual identities, gay men must negotiate tasks that may exert a detrimental effect on their psychological well-being. It affords insights into the nature of these tasks and allows the identification of factors that may mitigate their deleterious effects. The findings from the gay identity formation study provide an empirical framework within which to locate suggestions for interventions that would promote mental health among gay men.

When planning health promotion interventions, it is important to be aware of the variety of health promotion approaches available and to select those approaches that are most suited to the aims of the interventions. Most of the interventions that follow may be viewed as loosely residing within the community development and educational approaches to health promotion. The community development approach operates when a group or groups of like-minded people, who recognise themselves as having common experiences in health matters, come together to discuss and review their concerns, to take stock of their situations, to identify mutual problems and to share in the process of clarifying options, working out appropriate joint action and setting about the process of trying to change their circumstances (Beattie, 1991, p.176). The educational approach involves presenting people with information and ensuring that they understand it so that they can make informed decisions about health-related behaviours (Tones, 1981). In most, however, difficult to fit health promotion interventions into mutually exclusive theoretical categories and it is often possible to discern characteristics of different approaches within the same intervention.

For health promotion workers who wish to become involved in promoting the mental health of gay men, gay social or political groups or gay contacts within the local community constitute a valuable resource. For example, one such group is Friend, an organisation with branches in many parts of the country which provides information, advice and social activities for gay men and lesbian women. Using a form of co-operative inquiry within a community development model (Daniels & Coyle, 1992), members of these groups may be consulted to help identify the most pressing mental health needs of those with whom they come into contact. At this stage, the findings from the research on gay identity formation may constitute a useful source of ideas. Group members may then be co-opted as voluntary workers in the establishment and maintenance of mental health promotion projects. Their roles could involve publicising the projects and recruiting men to participate in them; co-facilitating projects with health promotion workers; and, after projects have been initiated, assuming the role of project facilitators themselves.

The precise nature of any mental health promotion interventions that are undertaken will depend upon the issues that they seek to address. This in turn will be determined largely by the developmental stage of the gay men at whom the interventions are targeted, i.e., whether the gay men are in their teenage years, young adulthood, middle adulthood, or older adulthood. At each stage of the life course, gay men must deal with issues additional to those faced by heterosexuals (Herdt, 1992). For example, although the multiple, simultaneous transitions of adolescence have been described as potentially stressful for all adolescents (Simmons et. al., 1979), gay adolescents must additionally negotiate the meaning, management and expression of their socially-devalued sexuality (Boxer & Cohler, 1989). As part of this process, they may experience grief and may require time, space and a context in which to mourn the loss of what Herdt and Boxer (1992) have termed 'previously internalized heterosexual life goals' such as marriage and heterosexual parenthood, and to construct new life goals.

**Discussion groups**

One very simple strategy that could constitute a mental health promotion intervention for gay men or that could act as a point of departure for such an intervention would be the establishment of discussion groups. These could be aimed at certain groups of gay men - such as young men, retired men or men who are actively constructing their gay identities - who would be responsible for setting their own agenda of topics for discussion. Alternatively, the groups could address predetermined issues, such as the management of sexual and emotional relationships. The benefits of simply discussing shared problematic concerns and exchanging shared experiences within a group context should not be underestimated.

Within a non-threatening context, the discussion of gay identity formation experiences that may have been traumatic can prove cathartic and can divest these experiences of their negative affective charge. During discussions, the men may find that their gay identity-related experiences overlap with the experiences of other gay men, which may serve to validate and legitimise these experiences. They may come to realise that, although they may have felt socially isolated when they first thought they might be gay, other men experienced similar reactions and felt similarly isolated. By openly sharing these feelings, the men can retrospectively receive the legitimisation and social support they lacked at the time. If some men are experiencing difficulties with certain developmental tasks in gay
identity formation, their range of coping strategies may be broadened by listening to the experiences of other men who have already negotiated these tasks. Moreover, they may feel reassured that others have trodden their path before and have survived. Finally, as Coyle (1991, 1992) has noted, through verbalising and sharing their experiences in a group context, gay men are given the opportunity of creating meaningful, cohesive and self-esteem-enhancing identity narratives. These functions are also partly fulfilled by the gay subculture but gay men may welcome the chance to meet others specifically to air and deal with the psychosocial difficulties of assuming and maintaining a gay identity within a society that devalues that identity. Thus conceived, such discussion groups conform to many of the tenets of the community development approach to health promotion, as outlined by Beattie (1991).

Given that a high degree of involvement in the gay subculture was found to be related to a high level of psychological well-being in the gay identity formation study, one way of promoting psychological well-being among gay men would be to facilitate social involvement with other gay men among those who, for whatever reason, lack such involvement. One reason why some men may not be involved in the gay subculture is that they have only recently reached a stage in the construction of their gay identities where they feel capable of adopting such an identity in a public domain. In the London area, groups exist which offer these men support and the opportunity to discuss shared concerns and to socialise with others who are negotiating similar identity tasks. However, such provision is limited in other parts of the country. In these areas, it might be useful to establish discussion groups for men who are actively constructing their gay identities, with the facilitation of entry into the gay subculture constituting an optional activity within this context. Some of the men may feel apprehensive about entering a gay social context because they are unsure about what they will encounter or about how they should behave and they may feel self-conscious about entering this environment by themselves. Such apprehensions may be mitigated by involving more experienced gay men in the discussion groups firstly to answer participants’ questions about the gay subculture and then to accompany them to a local gay social venue. This strategy may help dispel any fears that the men have and may give them the confidence to attend gay social venues without group facilitators. Progress towards independent functioning in the subculture may be facilitated by suggesting that several of the men arrange to visit gay social venues together. Specific issues related to socialising in a gay context may subsequently be addressed through discussion and role play at future meetings of the discussion group.

**Group exercises**

Although gay men may accrue considerable psychological benefits from the straightforward sharing of experiences, some problematic issues may be dealt with in a more directive way within a group context through the use of group exercises and role play. This strategy is located within a broadly educational model of health promotion, although the exercises that will be outlined owe more to a self-empowerment educational approach than to a didactic one. To take an example of a situation in which group exercises could prove useful health promotion tools, if group members were discussing their experiences of disclosing their sexual identity and if some were considering engaging in initial disclosure or in disclosure to new audiences in the future, the facilitator could construct group exercises that might promote positive disclosure experiences.

Such an exercise might involve having group members choose a particular disclosure audience as their focus (for example, parents) and brainstorming a range of disclosure strategies or settings that might be appropriate for the disclosure of one’s sexual identity to this audience. The group would then be subdivided. Each subgroup would be assigned certain strategies or settings and would be asked to identify the advantages and disadvantages of engaging in disclosure using those strategies or in those settings. Through processing feedback from this exercise, the group could reach general conclusions about the nature of optimal disclosure strategies and settings, allowing of course for variations in the circumstances faced by individuals. The facilitator would then elaborate an imaginary situation in which a gay man is about to disclose his sexual identity to the chosen disclosure audience. The group would divide into subgroups and, using the disclosure strategies that they have identified, participants would role play the disclosure situation and its consequences, with some playing the gay man, some playing the disclosure audience and some acting as process observers. Alternatively, the facilitator could seek volunteers to play the gay man and the disclosure audience; these volunteers could then begin the role play while the rest of the group observed. At various junctures in the role play, other group members could volunteer to assume the roles or else the role play could be repeated in order to enact different outcomes to the scenario.

The purpose of this exercise is to provide gay men with an opportunity to practise and refine disclosure strategies and to help them to cope with alternative outcomes to disclosure situations or at least to be aware of what these outcomes might be. This may then encourage some men to engage in self-disclosure, which may mitigate the strains of passing as heterosexual that respondents described in the gay identity formation study.
Participating in the exercise may help other men to realise that it is not feasible to disclose their sexual identity to certain people in their social world, perhaps because they are particularly unsure about how these people would react and/or because they could not cope with any rejection that might ensue. If, on the basis of the issues raised by the exercise, some men make an informed decision not to disclose their sexual identity to people whom they had previously been considering as potential disclosure audiences, the facilitator can initiate a discussion about strategies for passing as heterosexual and about strategies for coping with any negative feelings experienced when passing. The exercise can easily be adapted and applied to many potentially problematic situations that may be encountered in the establishment and maintenance of a gay identity.

Other group exercises can promote self-esteem by encouraging gay men to examine the negative social representations of gay men and homosexuality with which they were socialised. By portraying gay men as sick and abnormal, these social representations may encourage those gay men who have internalised them to attribute any identity-related difficulties they may have experienced or may be experiencing to personality or psychological defects. Exercises that permit the critical examination of the nature and effects of these social representations may help gay men attribute any identity-related difficulties not to internal factors but to the difficulty of constructing a positive gay identity against a backdrop of negative social representations of gay men and homosexuality. Any tendency towards self-reproach may thereby be diminished. Some training materials that have been designed to raise awareness about HIV/AIDS contain exercises that permit the examination of issues related to sexuality and sexual stereotypes (for example, see Aggleton et al., 1989). Adaptations of these exercises may prove useful tools in helping gay men to explore the nature of negative social representations of gay men and homosexuality and to consider how these have impacted upon their gay identity formation experiences.

The value of HIV/AIDS awareness training in promoting the psychological well-being of gay men should not be overlooked. If gay men carry vestiges of internalised negative social representations of gay men and homosexuality, they may at least partly acquiesce in negative social representations of HIV/AIDS which have portrayed HIV as transmitted through the unnatural sexual practices of irresponsible, immoral, promiscuous gay men. Most HIV/AIDS training packs contain exercises that help those participating in training to examine these representations in a critical way and to identify the illogicalities and prejudices that underpin them (for example, see Aggleton et al., 1989, & Weisner & Grant, 1989). As gay sexuality features so prominently in social representations of HIV/AIDS, the use of such exercises within an HIV/AIDS training context can help gay men to disentangle their sexuality from these social representations and may empower them to see their sexuality — and, by extension, themselves — in a more positive light.

It could be argued that rather than attempting to counteract the effects of the internalisation of negative social representations of gay men and homosexuality, a more proactive approach to promoting mental health among gay men would involve minimising the internalisation of these social representations in the first place and actively challenging them. Such a strategy represents what has been termed the ‘radical’ approach to health promotion (Tones, 1981). In this case, it would entail providing children with factual and positive education about homosexuality that presents being gay as a life choice of equal value to heterosexuality. However, the provision of such education has been forbidden by Section 28 of the 1988 Local Government Act which prohibits the teaching in any maintained school of the acceptability of homosexuality as a ‘pretended family relationship’. The outrage caused by a gay rights group which distributed positive educational leaflets about being gay or lesbian to schoolchildren (O’Neill, 1991) suggests that mental health promotion among gay and lesbian students is not regarded as an important issue within the educational system. Without the co-operation of the educational system in providing positive education about being gay or lesbian, it is difficult to deliver a broadly-based challenge to negative social representations of homosexuality, which will continue to compromise the psychological well-being of gay men and lesbian women. Any mental health promotion interventions with gay men will therefore of necessity be reactive rather than proactive.

**Improving clinical services for gay men**

In considering the ways in which mental health issues among gay men can be addressed effectively, it is useful to examine the approaches adopted by other projects that have sought to address similar concerns. One such project is the Evelyn Hooker Center for Gay and Lesbian Mental Health, established within the Department of Psychiatry at the University of Chicago (Boxer, personal communication). The Center is primarily concerned with promoting mental health among gay men and lesbian women who have encountered mental health problems rather than proactively trying to prevent such problems arising. The clinical services that it offers include out-patient counselling and psychotherapy for gay and lesbian individuals as well as for gay and lesbian couples and for
families in which one or more members are gay or lesbian. In-patient psychiatric services for gay and lesbian clients are also offered at a local hospital. Both out-patient and in-patient services are delivered by mental health professionals who are themselves gay or lesbian and/or who receive ongoing, in-depth, specialised training on gay and lesbian mental health issues. In the future, the Center plans to develop more specialised clinical services for gay men and lesbian women, including counselling and support programmes for perpetrators and survivors of domestic violence; family counselling for gay and lesbian youth and their families and for gay and lesbian parents and their children; treatment programmes for alcoholism; substance abuse and sexual dysfunction in gay men and lesbian women; support groups for gay men and lesbian women who have chronic mental illnesses; and specialised services for gay men and lesbian women with HIV/AIDS and for their caregivers. The Center also provides an array of training opportunities in gay and lesbian mental health issues for (mental) health professionals and students, social service providers, criminal justice authorities and other institutions that directly impact on the lives of gay men and lesbian women.

It is unlikely that any UK health authority would prioritise the establishment of a centre for gay and lesbian mental health which delivers specialised mental health services to this client group in a co-ordinated way. However, some of the strategies used at the Evelyn Hooker Center could be usefully promoted for adoption in the UK. Gay men and lesbian women who experience psychological problems may wish to consult a gay or lesbian counsellor or psychotherapist because these practitioners' empathic potential may be greater than that of heterosexual therapists by virtue of the experiences and understandings that clients and therapists may share. Health promotion workers could facilitate this process by devising a directory of gay and lesbian counsellors and psychotherapists in their area, and distributing it to local gay groups, public libraries and citizens' advice bureaux.

The fact that HIV/AIDS training has been provided to health care workers in many health authorities attests to the feasibility of promoting awareness of particular issues among staff in a systematic way. In the same manner, it would be possible to implement training programmes to promote awareness of gay and lesbian issues among mental health staff, possibly within a more general training programme on sexuality-related issues. Such training could increase staff's understanding of the psychosocial pressures faced by gay and lesbian clients and could heighten their empathic potential in their interactions with this client group. If health promotion workers and mental health professionals in a health authority perceived a need for such training on the basis of their experiences or on the basis of health needs assessments conducted with the local gay community, they might then be willing to lobby for funding to be made available for training.

Conclusion

In conclusion, the research on gay identity formation found a level of psychological well-being among the gay men who participated that was comparable to that shown by men from the general population who had undergone potentially traumatic life events. Much of the emotional trauma experienced by gay men can be attributed to any inherent psychological defect but to the difficulties involved in constructing a positive sexual identity within a social context that devalues that identity and having to do so with often limited support from others in their social world. The health promotion interventions that have been outlined may help to increase psychological well-being among gay men by providing them with an opportunity to discuss their experiences and to learn from the experiences of others in a supportive, non-threatening environment; to increase access to social support from other gay men; to examine critically the negative social representations of gay men and homosexuality which may have sabotaged their attempts to develop a positive gay identity; to generate, practise and refine strategies for coping with some of the potentially traumatic tasks of gay identity formation; and to receive understanding and non-judgemental treatment from providers of mental health services, if they should require them.

However, in order for a programme of such interventions to be established, health authorities must recognise that the promotion of mental health among gay men is a legitimate and necessary area of work in which health promotion departments should become involved. It must be admitted that at present the likelihood of this occurring is small. Many health authorities appear reluctant to tailor health promotion projects specifically to the needs of gay men. For example, although gay men constitute the epidemiological group most affected by HIV/AIDS in the UK to date (PHLS AIDS Centre - Communicable Diseases Surveillance Centre and Communicable Diseases (Scotland) Unit, 1992), only ten per cent of health authorities have been adjudged to have conducted adequate HIV/AIDS health promotion work aimed specifically at this group (King, 1992). In such a climate, any health promotion worker may have difficulty firstly in establishing mental health promotion with gay men as health promotion priority in his/her health authority and secondly in securing adequate funding for his/her work.
Health promotion workers who wish to promote mental health among gay men are therefore advised to conduct assessments of the mental health needs of gay men in their local community. When lobbying their departments of public health in order to obtain permission and funding to undertake mental health promotion interventions with this client group, they could use their findings to support their case. Furthermore, the possible interventions that have been outlined are relatively small in scale and involve initiating projects through local gay contacts and social groups, enlisting gay men as co-workers and empowering gay men to promote their own psychological well-being. The adoption of this approach to mental health promotion projects with gay men represents an economical way of promoting mental health, which, at a time when concerns about cost-effectiveness are paramount, may increase the likelihood of such projects receiving official sanction.

References


Boxer, A.M., Personal communication. Department of Psychiatry, University of Chicago.


16 'Health dividends': The use of co-operative inquiry as health promotion intervention with a group of unemployed women

M. Daniels and A. Coyle

Introduction

From the publication in 1938 of Eisenberg and Lazarfeld's classic work on the psychological consequences of unemployment, the adverse effects of unemployment upon psychological well-being have been well documented. With regard to the extent of these negative consequences, Jackson and Warr (1983) stated that twenty per cent of unemployed people experience a deterioration in their mental health as a result of unemployment. In more specific terms, the same authors reported increased anxiety, depression, insomnia, irritability, lack of confidence, listlessness, inability to concentrate, and general nervousness among the unemployed men whom they studied. This list succinctly summarises the biopsychosocial consequences of unemployment that other studies have also identified. Additional characteristics that others have noted include anomic, self-blame, anger, aggression, reduced life satisfaction, decreased motivation to work, and a feeling of helplessness and of not being in control of one's life (Kaufman, 1982); loss of self-esteem (Shamir, 1986); and disturbance in family relationships (Hill, 1977; Jackson & Walsh, 1987; Martin & Wallace, 1984). Some authors have sought to locate psychological reactions to unemployment within a stage framework and have identified stages of shock and disbelief; denial, optimism and the making of concerted efforts to secure re-employment; anxiety, distress, self-doubt, anger and pessimism; and resignation, fatalism, withdrawal and adjustment (Fagin & Little, 1984; Harrison, 1976; Hill, 1977; Kaufman, 1982).


