Aims and scope

The Gay and Lesbian Issues and Psychology Review (‘the Review’) is a peer-reviewed publication that is available online through the Australian Psychological Society. Its remit is to encourage research that challenges the stereotypes and assumptions of pathology that have often inhered to research on lesbians, gay men, bisexual, trans and queer (LGBTQ) people. The aim of the Review is thus to facilitate discussion over the direction of LGBTQ psychology both within Australia and abroad, and to provide a forum within which academics, practitioners and lay people may publish.

The Review is open to a broad range of material, and especially welcomes research, commentary and reviews that critically evaluate the status quo in regards to LGBTQ issues. The Review also seeks papers that redress the imbalance that has thus far focused on the issues facing white lesbians and gay men, to the exclusion of other sexual, gender and racial groups. The Review encourages the elaboration of an expansive approach to psychological research on people of a diverse range of sexual and non-gender normative groups, and publishes articles from across a range of disciplines including (but not limited to) psychology, social work, cultural studies, sociology, gender studies, politics, history and legal studies.

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EDITORIAL: HEALTH IN DIFFERENCE: DOING DIVERSITY

GABI ROENSTREICH AND DAMIEN W. RIGGS

Doing Diversity means acknowledging both differences and commonalities between lesbian, gay, bisexual, trans, intersex, sistergirl, two-spirit, takatāpui, queer and other sexual identity, sex and gender diverse people. It also means acting in such a way that all people are able to thrive, and to live healthy, happy lives, participating fully in the various communities with which they identify.

But ‘diversity’ is more than a collection of categories of difference. It is a paradigm that acknowledges the multidimensional complexity of our identities and the interplay of social factors that determine so much of our lives. Each of us has multiple identities, belongings and positions, many of which change over time and context. We live and act in a society structured along contested categories: sex, gender and sexual orientation interrelate with indigeneity, ethnicity, age, socioeconomic status, location, religion, (dis)ability. Sexual orientation, sex and gender identity are parts of the matrix of difference and power that are seldom addressed in broader discussions of health and wellbeing, and if they are, they are often seen in isolation and as though these categories form a homogenous, stable and self-contained unit (see Rosenstreich, 2007).

The National LGBTI Health Alliance was established in 2009 as the not-for-profit Australian national peak body for organisations and individuals working to improve the health and wellbeing of lesbian, gay, bisexual, trans/transgender, intersex and other sexuality, sex and gender diverse (LGBTI) people. It aims to advocate with a national voice on the health needs of LGBTI people and to build the capacity of its members and others to work with and for LGBTI people and communities. It does this because there is strong evidence of significant differences in the health and wellbeing of Australians according to their sexual orientation, sex identities and gender identities. Across all population groups, LGBTI people tend to have disproportionately negative health outcomes, largely as a result of social determinants, such as experience of discrimination, which is also related to reduced access to appropriate health care. There has been an indifference to the issues of LGBTI people in national policy, programs or research, and indeed, until the formation of the Alliance, there were no mechanisms in place by which the federal government or the health sector could engage with the LGBTI community sector and draw on its expertise in a coherent way.

Given how little acknowledgement there is in the government, health and community sectors of issues relating to LGBTI people, much of the work of the Alliance to date has involved raising awareness of the fact that there are differences in health outcomes, and advocating that they are addressed. This often requires a reduction of the real diversity and complexity of LGBTI issues in an effort to get those in positions of power to listen at all. As a result, we seldom have spaces in which we can address issues with the depth of attention that they really require, to share experiences, learnings and resources. Yet to really improve the health and wellbeing of LGBTI people, we need to address the real complexity of people’s identities and experiences and issues of social justice.

In part as a response to this need to foster spaces in which more complex conversations can take place, the National LGBTI Health Alliance agreed to convene Health in Difference, the 7th National LGBTI Health Conference.
This was a significant commitment of capacity at a time when this newly formed organisation still has much to do and very few resources. The papers included in this special issue of the *Gay and Lesbian Issues and Psychology Review* stem from the 58 presentations, 5 panel discussions, and 11 networking sessions held at Health in Difference 2010. They provide a glimpse of some of the issues addressed at the conference.

The issue begins with a paper from Mary Heath, who considers the inclusion – or rather the exclusion – of bisexuality in the papers presented at *Health in Difference*, and by implication, in the broader LGBTI health policy, practice and research context. Three presentations specifically focused on the health issues of bisexual people, but despite efforts to promote the inclusion of diversity, the majority of papers reproduced the limitations of existing research, for example in relation to sampling, accuracy of defining the target group, aggregation or even the explicit exclusion of bisexual respondents, and interpretation of findings. Given that where research does consider the specific experiences and outcomes of bisexual people, it indicates that they have worse health outcomes than gay and lesbian people and may experience higher levels of social marginalisation (Corboz et al., 2008), Mary argues that it is essential that we conduct distinct analyses of this group.

The second paper focuses on the complexity of violence. Senthorun Raj addresses a further dimension of diversity by considering violence within lesbian sadomasochism, and que(e)ring whether violence is indeed always the antithesis to physical and emotional wellbeing. Senthorun argues that people experience violence and intimacy in culturally specific and historically located ways and that we need to address the complexities of pleasure, resistance and emotion in the differing positions of violence if we are to adequately address the diversity of experiences and the impact that violence can have as both a productive and oppressive factor in overall wellbeing.

The third paper, written by Jude Comfort, shares the outcomes of discussions between LGBTI health researchers in one of the conference’s networking sessions with a wider audience. Jude outlines some of the challenges of working within LGBTI health research, in particular marginalisation within the research sector, funding (or lack of it) and the catch-22 of calls for better evidence given marginalisation, lack of funding and methodological challenges faced when researching sexuality, sex and gender diversity. Connections to LGBTI community also pose a challenge, not least because of the diversity within that ‘community’, with associated diversity of experiences and interests. Jude shows how these and other barriers make it difficult to address the diverse health issues of LGBTI people in health research. However, Jude also notes a number of achievements to celebrate and considers what steps could/should be taken to build on them by assisting LGBTI researchers operate in a more supportive, collaborative and productive environment.

Two dimensions of diversity that were a focus of *Health in Difference 2010* are not represented in articles submitted for this special issue: Indigeneity and Sex and Gender Diversity. This absence is of particular note because a particular highlight of the conference was the number and strength of voices of sexuality, gender and gender diverse Aboriginal people and Torres Strait Islanders, and other trans and intersex people. They not only shared their expertise and passion with audiences that may not have known much about their specific issues and their perspectives on broader issues, but they spoke with each other in a space that allowed diversity within the respective group to be acknowledged, shared learnings and built connections and strategies for moving forward collaboratively.

To address this gap, Gabi Rosenstreich has worked with Sally Goldner to provide a closing commentary to this issue that reflects on the lack of articulation of these issues in articles by sexuality, sex and gender diverse Aboriginal people and Torres Strait Islanders, and
other trans and intersex people. In it Gabi and Sally touch on some of the key issues raised by speakers from these groups during the conference, but specifically they focus on strategies for inclusion and exclusion and the argument that the absence of these (overlapping) groups reflects some of the very barriers that still must be addressed and indeed some of the core challenges of ‘doing diversity’.

Excitement about Health in Difference 2010 as a space to do diversity was palpable during the conference. As one participant put it on their evaluation form “When intersex exclusion is still the default for so many things, intersex inclusion was incredible to experience.” It is clear that doing diversity is not what we are necessarily used to, and for all its achievements, Health in Difference certainly didn’t do it perfectly. Indeed, how could it given that no event is independent of the context around it. However, as Mary Heath notes “the continuing imperfection of our attempts [to do diversity] does not make them less crucial”.

Common themes raised throughout the conference were the experience of marginalisation not only within the mainstream sector but also within the LGBTI health sector, the fundamental significance of people speaking for themselves, defining their own issues, needs and solutions – and others listening and engaging with respect, and calls for a human rights and strengths-based approach. Encouraging were the many examples of practice and research contributing to LGBTI health and wellbeing. As a sector, we are making progress, for example addressing the issues of ageing and young LGBTI people in a range of research projects and other initiatives; Indigenous LGBTI groups such as the Moolagoo Mob, Indigilez and Out Black are not only providing peer support, but also sharing their stories with others in various ways; the Parliamentary Secretary for Social Inclusion announced at the conference that a federal working group would be formed to address issues of sex on identity documentation. There is much happening on many levels, and many windows of opportunity. But continuing evidence of significantly poorer health than the rest of the population, widespread experience of discrimination and exclusion, and the ongoing indifference to LGBTI issues in national health policy and programs make it clear that there is still also much to do.

We need to draw on and further develop issues relating to ‘doing diversity’ that were raised during Health in Difference 2010, in particular the health and wellbeing of sexual identity, sex and gender diverse Aboriginal people and Torres Strait Islander people, trans and intersex people and other populations whose issues are too often invisible within LGBTI discussions, such as multicultural LGBTI people, LGBTI asylum seekers, people with disabilities, people living in rural and remote communities, people in prisons, sex workers, etc.

The Alliance strives to ‘do diversity’ not only in the Health in Difference conference, but in its very core as a membership based national peak body. It is a coalition of very diverse and disparate groups, organisations and individuals, learning by doing as we work collaboratively across our differences to share resources, ideas and energy in order to build a strong voice promoting the health and wellbeing of LGBTI people on a national level. We can only achieve this as an organisation, and as a community, if we not only acknowledge but actively address the differences and commonalities between us and draw on our diversity as a strength. However, these efforts do not exist in isolation. The ongoing structural exclusion of LGBTI health issues is also evident in the failure of government to provide funding to the National LGBTI Health Alliance in a similar way to its support of NGO peak bodies for other equity groups. Instead, yet again, the LGBTI community uses its limited resources and relies on donations to fund its work. Until the LGBTI health sector is adequately resourced, it will remain immensely challenging to ‘do diversity’ in a meaningful way.
Author Note

Gabi Rosenstreich is the Executive Director of the National LGBTI Health Alliance, and was convener of Health in Difference 2010: Doing Diversity. Gabi’s background spans the government, community and research sectors. Diversity, empowerment and discrimination generally and intercultural, gender and queer inclusion specifically are a particular focus of her work as a researcher, policy analyst, manager, consultant and educator. Contact: GRosenstreich@yahoo.de

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To find out more about the National LGBTI Health Alliance, see: www.lgbthealth.org.au

To find out more about the Health in Difference conference see: www.lgbthealth.org.au/health-in-difference
WHO’S AFRAID OF BISEXUALITY?

MARY HEATH

Abstract

‘Doing diversity’—the wonderful title of the 2010 Health in Difference Conference—is a complex and perhaps unavoidably messy process. However, experiences of moving toward greater inclusion in the past suggest that doing diversity generates better knowledge as well as more interesting conversations. Currently, the low levels of sampling of bisexual people, partial acknowledgement of bisexual existence and limited analysis of data specific to bisexual people in GLBTI health research, including much of that presented at Health in Difference, represent a failure of inclusion. This, in turn, limits the quality of our knowledge about queer health and impoverishes our analyses.

Keywords: Bisexual, health, methodology, queer, mental health

Overview

‘Doing diversity’ — the wonderful title of the 2010 Health in Difference Conference (HiD) — is a complex and perhaps unavoidably messy process. But maintaining the goal of doing diversity is extremely important even if the achievement of this goal will be deferred over and over again. The progress we make in doing diversity makes a difference to people’s lives and to the quality of what we know. The continuing imperfection of our attempts does not make them less crucial.

The significant and creative ways in which transgender and intersex experiences have been included at HiD as well as in health research in recent times offer some clues to what inclusion can enable. Transgender and genderqueer inclusion has enriched people’s understanding not only of transgender and genderqueer lives but also of cisgendered lives, gender, identity and sexuality. The achievements of all who have contributed to these constructive changes are to be celebrated and built upon, even as we remember how painful some of the stages in the process have been. The evidence is there that doing diversity generates better knowledge as well as more interesting conversations.

It is in this context—and with the confidence that more is possible for us all—that I want to offer some commentary on the inclusion of bisexuality at Health in Difference (HiD) 2010. In doing so, I am not suggesting that something especially egregious happened at HiD. Rather, I am pointing out that, in general, the papers I heard at HiD did not manage to go beyond some of the limitations of existing research in this respect, despite the organisers’ obvious concern with diversity and the diversity achievements of the conference.

Sampling

At HiD 2010 I listened to reports on several research studies in which bisexual people made up a tiny proportion of the total sample.

1 Examples of inclusion in policy and trans-specific research include: (Ministerial Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Intersex Health and Wellbeing, 2009) and (Pitts et al, 2009).
2 In this context, ‘genderqueer’ refers to people and practises which challenge normative concepts, representations and/or performances of gender. ‘Cisgender’ refers to people whose gender identity is consonant with the biological sex assigned to them at birth.
However, in none of them was the under sampling of bisexual people mentioned as prejudicing the representativeness of the sample or limiting the knowledge that might be generated (about gay men or lesbians, let alone bisexual people) from the resulting data.

A large, population based study in Australia (Smith, 2003), and every large study in the US since Kinsey (Yoshino, 2000), show that self-identifying bisexuals are as numerous, or more numerous than, homosexually identifying people. However, convenience samples, such as those generated through queer/GLBTI (gay, lesbian, bisexual, transgender and intersex) events, consistently attract very few bisexual participants. Perhaps it is this kind of data that generates the ‘common sense’ perception, particularly within queer community contexts, that there are few bisexual people.

If we accept the data about the general population, low sampling rates for bisexuals in studies which claim to include bisexual people and generate knowledge about their health are failing to access one of the very populations they are supposed to be studying in anything like the proportions of the population they actually comprise. A moderate degree of curiosity about the differences between population and community sample based studies on the one hand, and convenience sample based studies on the other, should suggest that bisexual participants cannot dependably be recruited by using a strategy designed to attract lesbian and gay participants. However, I have yet to hear of a bisexual-specific recruitment strategy for such a study.

**What is Being Studied?**

In other sessions I listened to reports of studies which investigated the lives of ‘same sex attracted people’, but then excluded from analysis any participant who stated they were currently involved in a relationship with someone of a different sex. These decisions might well be defensible in some contexts. However, once they are made, the study is no longer a study of same sex attracted people. Rather, it is a study of people currently in same sex relationships, which does not attempt to grasp the experiences of same sex attracted people who are currently in different sex relationships. Similarly, studies which claim to investigate ‘GLBTI’ lives but do not actually include bisexual (or for that matter, intersex) people’s experiences should consider whether they have described the population being studied accurately.

The complete elision of bisexual lives also occurs in papers which consider social patterns in gay and lesbian lives. To be completely clear, gay and lesbian lives are entirely appropriate subjects of inquiry. However, at HiD I heard the social contexts in which gay men and lesbians participate divided into two categories: gay/lesbian or heterosexual. When this is done, the possibility of a lesbian or a gay man having a bisexual friend, carer, or for that matter, partner, vanishes completely. Relationships involving bisexual people must either be excluded from the research or the people involved in those relationships treated as if they hold an identity they have not chosen and might not accept. Again, this does damage to our understanding of the lives of the very people under inquiry.

**Analysis**

Having attracted very few bisexual people, many studies continue not to analyse data about bisexual people as distinct from data from lesbian and gay participants. As Pitts and Crouch have observed, ‘One forms the impression that bisexuals are there to make up the team, to ensure no-one is left off the bus.’ (Pitts & Crouch, 2006, p. 272) Sometimes (and I heard this again at HiD), data on bisexual people is not separated out specifically because so few bisexual people have been recruited. The sample is too small for statistical analysis to be meaningful. Data from bisexual participants must either be excluded or aggregated with that from other participants.

However, there is now enough evidence to
suggest that failure to differentiate leads to the construction of inadequate or misleading ‘knowledge’ not only about bisexual people, but about lesbians and gay men. Mental health studies are a case in point. Jorm and his co-authors (2002) pointed out that, based on their analysis, the inclusion of bisexual people may have skewed the data about poor mental health in lesbian and gay populations in previous studies. In a review of the Australian literature, the authors of Feeling Queer and Blue concluded that not only did bisexual people have poorer mental health than gays and lesbians in all of the key Australian studies reviewed, ‘in some cases these differences in mental health between heterosexual and non-heterosexual populations were accounted for completely by the bisexual subsample’ (Corboz et al., 2008, p. 41). Research in the UK has also found sufficient differences between bisexual and homosexual participants to conclude that data about bisexual people should be analysed separately in health research, despite the authors’ scepticism about the prevalence of ‘true bisexuality’ (Warner et al., 2004, p. 483).

If research suggesting bisexual people have worse health outcomes than gay and lesbian people is not sufficient to justify distinct analysis, a review of the literature on factors which support wellbeing in Feeling Queer and Blue, which reported that ‘bisexual people may experience higher levels of social marginalisation’ (Corboz et al., 2008, p. 51), should suffice to justify such analysis.

**Conclusion**

The low levels of sampling of bisexual people, partial acknowledgement of bisexual existence, and limited analysis of data specific to bisexual people in current GLBTI health research, including much of that presented at Health in Difference, represent a failure of inclusion within that research. Health and health research dollars do not straightforwardly follow demonstrated need or an evidence base, in relation to the GLBTI sector in general or in relation to any of its constituent parts, and this reality was the subject of much discussion as well as frustration at HiD.

The continuing invisibility of bisexual people in much queer health research constitutes also represents a failure of inclusion. That this remains an issue of invisibility seems especially clear in relation to HiD, where the conference organisers’ efforts at inclusion were visible, prominent and thorough and their expectations of participants were clearly communicated. At this conference, unlike some, bisexual participants and bisexual content were clearly welcome. There was a session of three papers focusing on bisexuality and health, and overt inclusion of bisexual participants in some plenary sessions. This suggests to me that the issues I have raised are not noticed by some of the researchers who participate in them.

It is entirely possible to argue that bisexual people could do more to argue stridently for inclusion in health research as well as in other contexts. However, I hope I will eventually cease to hear bisexual exclusion defended on the grounds that there are few bisexuals, that bisexual people do not have distinct experiences of health and ill health, or that bisexual people’s privileges mean that they do not encounter social marginalisation. I also hope that in future there will be greater recognition that failures in ‘doing diversity’ in relation to bisexual people represent failures of methodology that jeopardise the creation of dependable knowledge, as do all failures to ‘do diversity’.

The greater inclusion of transgender and genderqueer lives has contributed to a revitalisation of thinking about sex, gender and sexuality. If this is an indication of what doing diversity can make possible, I look forward to discovering what differences increased attention to bisexuality and bisexual lives might make to what we know and the ways in which we think about our fields.
Author note

Assoc Prof Mary Heath teaches law at Flinders University. She is a member of BiAdelaide and a long time community activist. She is currently engaged in a project which investigates bisexual and lesbian women’s strategies for achieving thriving lives with Dr Ea Mulligan. Needless to say, her own work contains plenty of flaws.

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QUE(E)RYING VIOLENCE: RETHINKING PLEASURE, HARM AND INTIMACY IN LESBIAN SADOMASOCHISM

SENTHORUN RAJ

Abstract
Intimacy and violence, often seen as antithetical concepts, have been increasingly intertwined concepts in the diverse sexual practices of lesbian women. In thinking through this relationship, it is important to ask how policy and legal approaches conceptualise ‘violence’. Distinguishing between the embodied qualities of violence, in a socio-cultural context, relies on a consideration of power, pleasure and ethics. However, none of these terms are universal or self-evident. Bodies experience violence, sex and sexuality in culturally specific and historically located ways. Understanding the diversity of lesbian relationships requires more nuanced approaches and greater vocabularies for understanding the affects and effects of intimacy that are often characterised as violent. While violence may be injurious, it can also be linked to the production of pleasure and erotics. Working with this paradox, and using Michel Foucault’s work on subjectivity, pleasure and ethics in combination with Jessica Benjamin’s psychoanalytic work on intersubjectivity and recognition, my paper will tease out the ways in which physical and emotional ‘wellbeing’ is affected by experiences of lesbian sadomasochism (or s/m). Comparing divergent personal accounts of s/m through a discursive analysis of desire, gender, sexuality, psychology and the law, I will argue that ‘violence’ must be located with respect to its embodied specificity and conditions of production rather than defined by particular acts: Violence can be both productive and oppressive. Thinking through the differing positions of violence in lesbian sadomasochist relationships, I offer a revision of pleasure, resistance and desire that problematises pathological and moral narratives of harm.

Keywords: sadomasochism, violence, intimacy, lesbian, sex

I speak not about condemnation but about recognising what is happening and questioning what it means. Audre Lorde (1984).

Introduction
Intimacy and violence, often seen as antithetical concepts, have been increasingly intertwined concepts in the diverse sexual practices of lesbian women. In thinking through this relationship, it is important to ask how policy, legal, and psychological approaches conceptualise the relationship between violence and sexual practices. Distinguishing between the embodied qualities of violence, in a socio-legal context, relies on a consideration of power, pleasure and subjectivity. Bodies experience violence and intimacy in culturally specific and historically located ways. Extending these considerations, my discourse analysis combines concepts from the work of Michel Foucault and Jessica Benjamin, two distinct theoretical positions, to render the erotics of sadomasochist (s/m) intimacy intelligible. Using these positions, I critique the masculine legal and psychological discourses which emerge to define the moralities which govern s/m. Starting with Foucault’s work on power, bodies and pleasures, I argue that understanding the sustainability of lesbian sadomasochism requires greater vocabularies for understanding the different affects of ‘violence’. While violence can have injurious effects, it may also be linked to the production of pleasures and intimate subjectivities. Extending this through Benjamin’s psychoanalytic concepts of recognition and intersubjectivity, my paper will tease out the temporalities of role-playing and desire in experiences.
of lesbian sadomasochism. What is at stake in such analysis is to offer new analytic tools for reading consent, pleasure and power that are not overdetermined by the idea that pain is always harmful or oppressive.

My use of the term ‘lesbian sadomasochism’ or ‘s/m’ encompasses a diverse range of practices and experiences. With such differences between practices, I consider a few examples where s/m practitioners (at the time) self-identified as lesbian and referred to their practices as ‘sadomasochism’ or ‘s/m’. Noting the diversity of lesbian s/m communities and sensibilities, I do not claim the existence of an authentic lesbian sadomasochist subject or create a representative (political) position for people who identify with this practice. My relationship to this discourse is not experiential. Instead, I position myself as an observer, attempting to use theory as a way of negotiating an understanding of complex sexual practices. By examining personal accounts of s/m through an analysis of desire, performativity and pleasure rather than a question of pathology, I will argue that normative biopolitical claims that imply violence is an act of harm (of perpetrator/victim) is dislodged when you take into account the way pleasure and consent is mobilised in these practices. Differentiating what is meant by ‘violence’ in intimate lesbian sexual situations, this paper que(e)ries the assumption that physically intrusive acts or verbal taunts are always counterproductive to having intimate relationships. While acknowledging that violent acts in sexual play can be problematic and harmful, this paper contributes to a revision of how implications of pleasure, desire and agency are understood in specific encounters of lesbian sadomasochist play and problematises the assumption that this practice necessarily induces harmful relationships.

The Socio-Legal Context of Lesbian Sadomasochism

Sadomasochism, within a normative (hetero) sexual public, remains a marginalised practice understood in most contexts as a crime of assault. As a culturally ‘transgressive’ practice, sadomasochism emerged as a politically contested area and term in the ‘sex wars’ of the 1980s (Hart, 1998, p. 56). The practice inspired much debate: those in favour of the practice emphasised its consensual nature, whilst those opposed to it claimed it was a problematic internalisation of patriarchal heterosexist violence. These polarised discursive strategies, which define s/m, articulate a ‘double bind’ for the sexual agency and desire of queer women.

In theoretical terms, Gilles Deleuze posits a distinction between sadism and masochism and finds the blurring of the terminology problematic (Merck, 1993, p. 240). Whilst this is an important distinction, Deleuze’s argument is premised in terms of heterosexual encounters. In the context of lesbian practices, the slippage between the terms is increasingly visible and the distinction blurs, which is why I use the term ‘sadomasochism’ to frame the practices that will be discussed. Lesbian sadomasochism challenges the organisation of sexual pleasure within a cultural imaginary of genital (read: penile) penetration. That is, forms of eroticism between women are marked as ‘unacceptable’ or ‘deviant’ because they do not exclusively privilege genital penetration. Such rhetorical characterisations provide a moralising framework for particular desires by shaming those who fantasise about such same-sex practices (Califia, 2000, p. 169).

In a legal context, sadomasochism remains prohibited in circumstances which result in physical wounding. Commonwealth jurisprudence connects ‘deviance’ or ‘transgression’ (decided in the context of gay male sexual behaviour) to practices which cause bodily harm. The British case of Brown (1993), where five men were charged with assault occasioning actual bodily harm, remains the legal precedent by which sadomasochism is characterised as a type of assault. Lord Templeman summarises:

The violence of sadomasochistic encounters involves the indulgence of cruelty by sadists and the degradation of victims... Pleasure de-
rived from the infliction of pain is an evil thing.

Cruelty is uncivilised.

Using a public policy approach, the absence of the participants’ intentions in Lord Templeman’s characterisation of the act suggests that consent is not relevant to sexual activities that promote cruelty and threaten the ‘civility’ of society. The legal rationalisations distinguish between ‘acceptable’ activities (such as violent sports) and deviant sexual activities. In this delineation, the ‘evil’ queer body must not be allowed to ‘indulge’ in its violent sexual tendencies.

In the case of Brown, ‘actual harm’ is understood in terms of public interest, focussing on the exchange of bodily fluids. While Lord Jauncey of Tullichettle added that the actual injuries in this case did not warrant medical treatment, he went on to note:

Wounds can easily become septic if not properly treated, the free flow of blood from a person who is HIV positive or who has AIDS can infect another and an inflictor who is carried away by sexual excitement or by drink or drugs could very easily inflict pain and injury beyond the level to which the receiver had consented.

Connecting the practices of gay men with HIV, substance use and subsequently the transmission of fluids, the practice becomes potentially infectious, a ‘danger’ that one cannot possibly consent to. These sexual practices become accountable to intoxicants or substance use, either by drugs or alcohol, which is the only lens by which the law can imagine the reasons for consent or engagement with such behaviour. Sadomasochism is not isolated to the material facts, but becomes a broader biopolitical problem that threatens the health (read: social and civil wellbeing) of the population.

Extending the moral rhetoric offered in Brown (1993) through a radical feminist lens, conduct amounting to humiliation, degradation and ‘oppression’ to the female body has also been repudiated as essentially dangerous. During the 1980s in the US, a tension between radical feminist discourse on sex and lesbian sadomasochism emerged in what was popularly termed the ‘sex wars’. Radical feminist debates were largely characterised by conflating sadomasochism with acts of patriarchal violence against women (Hart, 1998, p. 53). Additionally, in a ‘vanilla’ lesbian imaginary, assuming a dominant/submissive position is seen to reproduce heterosexual roles (Ardill & O’Sullivan, 2005, p. 14). Contrastingly, within a hegemonic heterosexual matrix, non-reproductive acts or sex acts in which women are dominant are seen (within the context of the 1980s ‘sex wars’) as ‘wasteful’ and ‘reprehensible’. Connecting these two separate (though not mutually exclusive) structures of knowledge, feminism and (patriarchal) heterosexuality, women are conceptualised as simultaneous victims and perpetrators of violence. By using words such as ‘violence’ and ‘waste’ to characterise this practice, alternative desires and behaviours are marginalised and rendered offensive (Califia, 2000, p. 170).

Perverse Pathologies

In understanding the relationship between sex, violence and sexual identity, it is necessary to examine how s/m practices are organised within a psychological framework of abnormality. Heterosexual matrimonial/reproductive sexual publics define sex through notions of romance, genital pleasure, bodily aesthetics and orgasmic acts. Violence, within a matrimonial conjugal relationship, is seen as divorced from intimacy. Non-reproductive sexual practices involving pain undermine the legitimacy or benefits of sex rather than enhance it. Sadomasochism remains classed as a psychopathology from the *ICD-10* and the *DSM IV*, an index of psychiatric or mental illnesses, as “an obsession with unusual sexual practices” (Bauer, 2008, p. 237).

Historically, psychoanalytic approaches to sadomasochism, akin to the reasoning in Brown (1993), reinforced pathologies of sexual deviance. For example, using a psychological imaginary, influential sexologist Robert Stoller
Acknowledges the variety of sadomasochistic ‘perversions’ and the limits of homogenising imaginaries. However, by labelling it as a mode of ‘perversion’, he reinforces normative notions of sexual propriety and ‘non-violence’ in intimate relationships (Stoller, 1991, p. 28). Stoller’s approach, as but one example, illustrates how the varied medical, sexual and psychological agencies normalise and insidiously coerce individuals who engage in this practice to remain ‘silent’ as to its affects and effects (Califia, 2000, p. 171). That is, s/m practices of queer and non-reproductive sexual relations are produced as an abnormal fetish. These fetishes become self-regulating, as bodies attempt to avoid the punitive or pejorative consequences of a heteronormative gaze.

However, such heteronormative discourses of sex are problematic because they can fracture, circulating between individual expectations, collective practices and counterpublics (Berlant & Warner 2000). As Berlant and Warner note, the sexualisation of non-heterosexual intimate relations transforms resistant queer sexual practices into counterpublics that are not reducible to domesticity, reproduction or the nation. These practices produce intense and differentiated personal affects that are not easily organised within a simple trajectory of romance and conjugal intimacy. In relation to s/m, as Califia (2000, p. 169) notes, “terms like roles, masochism, bondage, dominance and submission have become buzzwords” with competing meanings for those who engage in sadomasochism and those who oppose (or do not understand) it. Practices such as sadomasochism limit the intelligibility of discourses to make sense of experiences where the ‘self’ or individual is no longer fixed by a particular identity or no longer conform to a particular normative public. Instead, these counter-cultural practices are disruptive, generating differing modalities of intimacy that combine pleasures with pain, and physical aggression and verbal ‘abuse’.

Responding to these pathological characterisations, a counterpublic queer approach broadens the scope of psychoanalytic frameworks to resist accounting for dynamic bodily experiences in terms of (perverse) pathologies. Normalising discourses, as Foucault (1977) would contend, emphasise the deviancy and abjectness of the act. Within a constellation of discourses (legal, cultural, family, medical, psychological) lesbian sadomasochism is imagined as violent, degrading, repulsive and negative. Pat Califia (2000) notes that s/m experiences are not necessarily antithetical to romance:

a good top builds sensation slowly, alternates pain with pleasure, rewards endurance with more pleasure, and teaches the bottom to transcend her own limits (p. 175).

Pleasure is a production rather than a fixed experience (Foucault, 1977). Califia’s experiences highlight the ways in which pathologising lesbian sadomasochism as a ‘deviance’ or form of internal political oppression reinforce a process of normalising desires. This process recuperates sexual shame by objectifying the practice and discursively marking out those who identify and engage in the practice. ‘Harm’ becomes engendered in the processes of shaming the individual body. By naming the act as deviant, sexual shame emerges from the operation of the pathology rather than any intrinsic quality of the practice itself.

Discourses that seek to pathologise lesbian sadomasochist desires recuperate a biopolitical investment in reproductive/pleasurable understandings of ‘healthy’ sex. Physically or verbally intrusive acts in sexual relations are rendered antithetical to intimacy. Extending this further, lesbian sadomasochist eroticism is not reducible solely to a structure of pleasure, it has political implications. As Pat Califia notes, the practice is diverse, involving: “leathersex, bondage, erotic torture, flagellation, verbal humiliation, fist-fucking, and watersports” (2000, p. 171). Particular significations of ‘violence’ and ‘abjection’ are connected to the ‘destructive’ bodily acts of bloodletting during menstruation, fisting, whipping and biting. Instead of assuming the autonomy of each individual, we are asked to question the voluntariness of the s/m practi-
tioners in their subjection or complicity in these networks of different power relations. Responding to this, it is important to ask how can strategies of resistance or agency within these discourses mobilise corporeally specific pleasures and sexual practices?

**Erotics and Intersubjectivity of ‘Violence’**

Marking the body in violent ways in sadomasochism is characterised as an affective process for generating erotic intimacy. In some ways, this resonates with Foucault’s position on sadomasochism, which favours a more creative reading of the liberatory potential of ‘violence’. These practices create new possibilities of pleasure with “strange parts of the body” (Foucault, 1984, p. 165). It is a “deseualisation of pleasure” by eroticising strategic relations of power (McClintock, 1993, p. 108). Rather than reify rigid codes of identity, some positions and erotic roles in sadomasochism are fluid. It is not a logic of aggression, but a mode of sexual pleasure which utilises differing parts of the body. As Tony (a female s/m practitioner) describes,

> I’ve been able to kind of get on terms with parts of me that I may have rejected or splintered off. I feel role-play’s been one of the most integrating things I’ve done (Bauer, 2008, p. 243).

As the above account illustrates, the practice is about relaying pleasure across parts of the body that have often been ‘rejected’ or not conceived of in terms of sexual pleasure. Even where particular sexual roles are maintained, it is framed as a ‘play’, one which can transgress limits of genital pleasure but also makes participants aware of certain boundaries. The terms ‘splintered’ or ‘rejected’ are used by Tony to delineate between parts of the body. Yet the practice is also described as an ‘integrating’ process. This suggests that while these practices are fragmentated, the connection of pleasure with different parts of the body produces new (unified) sexual experiences. This becomes a logic of cultivation or subjectivation of the ‘self’ (making subjects) using parts of the body that have been ‘splintered off’. In this scenario, affects of pain and pleasure are negotiated through self-reflexive and innovative strategies that produce different sexual subjectivities (cf. Foucault, 1984; 2000).

While the rhetoric of bodies and pleasures is useful for moving beyond a politics of sexual normalisation, the intersection of violence and sex is a point at which politics and the law often intervene. Practitioners and policy makers in health agencies are required to engage in interventions to prevent (non-consensual) ‘harm’ to the body. However, it is difficult (although important) to distinguish between the different kinds of affects generated when intimacy intersects with physical or verbal intrusions. In order to work within an interventionist narrative that must promote intimate health by defining boundaries, feminist approaches to psychoanalysis provide a framework in thinking about the diversity of identities and outcomes implicated in s/m practices.

Audre Lorde challenges the idea that lesbian s/m is either a pursuit of ‘sexual freedom’ or a practice of ‘objectification’ and reformulates lesbian s/m as an experience of ‘communion’ (Chinn, 2003). That is, sexual play in s/m relies on an embodied negotiation with the ‘Other’, which is not necessarily about violence or mastery of the ‘Other’. Extending this further, Jessica Benjamin (1988) argues that erotic domination in sadomasochism is not a coercive act. Rather, it involves a desire for independence and a desire for recognition. However, such recognition is always elusive. As a practice of desire, sadomasochism embodies a paradox: freedom through practices of submission. For example, each partner in the scenario of whipping negotiates what is involved and the ‘submissive’ partner is given a ‘safe word’ which ends the act:

> The safe word allows the bottom to fantasise that the scene is not consensual and to protest verbally or resist physically without halting stimulation (Califia, 2000, p. 172).
The erotic subjectivities of the participants become mutually constitutive in negotiating pleasure and resistance in the role-play. In this encounter, the fantasy relies on physical or verbal protest that produces 'stimulation', while the 'safe word' acts as the performative statement to dissolve the role-play. Submission and domination are only possible in this scenario because it can be disarticulated with a single word. Extending this further, Benjamin articulates a new problem, inviting us to consider whether physical and verbal submission in sex is synonymous with being weak or losing identity. Focussing on the erotic affects and effects of s/m play allows a more nuanced consideration of the conditions under which submission occurs.

Sadomasochism disrupts the moralising action/submission and pleasure/pain dichotomies that underpin legal and psychological understandings of 'normal' intimacy or sexuality (Lotringer, 1988). Women are no longer implicated in what Simone de Beauvoir refers to as the "female masochistic fantasy", which eroticises the fantasy of violence for the purpose of desiring a penis (1949, p. 398). Moving beyond Beauvoir’s argument on masochism, participants in s/m are no longer struggling over phallic power or masculine humiliation, but are utilising codes of sexual domination/submission as a means of asserting sexual(ity) differences. It is about exploring the limits of individual corporeality through acts which do not rely on a heterosexual model of vaginal/penile penetration. As Califia notes,

The roles, dialogue, fetish costumes, and sexual activity are part of a drama or ritual. The participants are enhancing their sexual pleasure not damaging or imprisoning one another (2000, p. 172).

In this context of lesbian sadomasochism, the organisation of penetrative sexual desires shifts, with men absent from the sexual encounter. Much of the practice involves fantasy and theatricality, rather than delineating a gendered role of each participant. This resonates with Foucault’s pedagogical arguments on ‘care of the self’. ‘Care of the self’ is an ethical practice which involves a self-reflexive engagement with a particular activity, in order to become qualitatively better or more productive (Foucault, 1984, p. 284). In this instance, the subject becomes produced through an intimate sexual relation with another body. Additionally, as Teresa de Lauretis reminds us, the act of penetrating the body, whipping or cutting it, is redeployed against a phallocentric organisation of pleasure around the norm of penile penetration (1994, p. 53). That is, the emphasis is on negotiating fluids, differences and theatrical performances rather than a desire for penetration necessarily.

Moreover, scenarios of sadomasochism must be carefully planned and require immense skill. These scenarios challenge the notions of routine sexual scripting by using pain as a vehicle for new pleasures and bodily challenges. As Lorde reminds us, the erotic is no longer understood in terms of the visual (what we see), it takes shape through the skin (how we touch) (1984, p. 54). Fist-fucking, for example, can be a long and time-consuming process, taking hours. Such a practice is not simply a question of one subject dominating another, as the fisting subject’s pleasure is reliant upon the willingness of the ‘bottom’ to ‘play’ (Califa, 2000, p. 172). As McWhorter notes, the practice is not determined by a goal or function of orgasm. Rather, it involves a tactile combination of caressing, force and gentleness in order for the bottom to experience bodily sensations which are not necessarily recognised as sexual in a reproductive sense due to the absence of a (biological) penis (1999, p. 185). Such a practice challenges politics of sexual normalisation which values phallic penetration and orgasm as necessary for a ‘genuine’ sexual encounter.

Agency, Dialogue and Performativity

In exploring the problematic constructions of submission and coercion, it is important to situate what is meant by ‘violence’ in a socio-historical setting. Foucault (1977) distinguishes sadomasochism from the question of
harmful violence, which he sees as a juridical action to destroy subjects. However, Gail Mason finds Foucault’s distinction between violence and power problematic because it reduces violence to its juridical sense (sovereign seeking to destroy another). Violence is not simply a corporeal injury, but a discursive statement that infiltrates the subjectifying process that constitutes bodies and identities (Mason, 2002, p. 130). Mason’s analysis problematises Foucault’s approach to the body by que(e)rying the ability of the body to engage in practices of pleasure and new ‘games’ outside regimes of intelligibility. Mason notes that bodies are situated discursively, and female bodies are subjected through disciplinary norms surrounding domesticity and sexual passivity. Thus, the ability to use ‘violence’ as a form of sexual expression for women raises questions over agency and capacity. Califia expresses that,

What looks painful to an observer is probably being experienced as pleasure, heat, pressure or a mixture of all these. A good top builds sensation slowly, alternates pain with pleasure, rewards endurance with more pleasure, and teaches the bottom to transcend her own limits. With enough preparation, care and encouragement, people are capable of doing wonderful things…the sadomasochist has a passion for making use of the entire body, every nerve fiber, and every wayward thought (2000, p. 177).

Califia’s account que(e)ries the assumption that if female bodies have historically been denied the capacity for agency in sex, then they are unable to create new forms of pleasure (O’Sullivan, 1999). As the scene above demonstrates, women use pain as a sexual pedagogy to realise new erotic sensations that push their personal ‘limits’. There is a moral code to the practice: being able to teach and ‘mix’ pain and pleasure is valued as ‘wonderful’. Using Foucault, it is important to note how new ethical relations are forged through erotic play, where a ‘good top’ is produced by their capacity to shape ‘sensation’ and ‘endurance’ using their ‘entire body’. Such a statement also implies that it is not fruitful to then engage in a discourse of victimhood which perpetuates the construction of women as objects within a system of violence rather than agents of it (or interruptions to it). The description Califia offers evinces the problematic use of ‘violence’ to characterise the types of enjoyment that emerge amongst participants in s/m.

In exploring the ambiguity of agency, the practice of sadomasochism can be understood as a process of ‘desubjugation’, a theoretical concept that suggests individuals no longer fit within a normative framework of identity. Such a theoretical position is troubling, in that it eschews notions of consent and the importance of differentiating between the kinds of bodies engaged in the practice. S/M pushes the limits of the categories that define sex, sexuality, gender, erotics and the body. Using a Foucauldian approach, flagellation, for example, has a political ‘desubjugating’ capacity. In a similar vein, Lorde connects the erotic experience as irreducible to a ‘function’ of sexuality (1984; pp. 56-7). That is, bodies are not reducible to a singular subject or object position in the act of whipping or biting. As Tersea de Lauretis argues, the attempt to engage the ‘Other’ in visceral (cutting/biting) ways seeks to reproduce a new conception of a lesbian subject through a tactile and aural imaginary of physical and verbal humiliation as erotic (De Lauretis, 1994, p. 57). Biting the body or cutting flesh is a means of forging new identities through a narcissistic identification with erotics. That is, it is a form of ‘rebellion’ (resisting the idea that the body is ‘sacred’) and ‘excess’. Or, as Lorde would suggest, it creates a new space of the ‘sacred’ for lesbian sexuality, one which does not rely on a reproductive imaginary. Taken together, these arguments imply that s/m practices involve an intersubjective ethics of solidarity and bonding (Merck, 1993, p. 251).

Moving against a Foucauldian ‘bodies and pleasures’ approach to understanding sadomasochism, feminist approaches to psychoanalysis invite us to consider the ways in which certain forms of ‘violence’ create alter-
native desires that resist shaming bodies. Califia notes that 'shame' is a corrosive affect which limits one's mobility in space (2000, p. 140). However, and as Elspeth Probyn suggests, shame can also be productive, and this is reflected in the way shame is managed in sadomasochism (Probyn, 2005, p. 130). Shame in s/m is articulated through the theatricality of the role, which itself is fluid. As one participant notes, S/M relationships are usually egalitarian. Very few bottoms want full-time mistresses. In fact, masochists are known within the S/M community to be stubborn and aggressive. Tops often make nervous jokes about being slaves to the whims of their bottoms. After all, the top’s pleasure is dependant on the bottom’s willingness to play. This gives most sadists a mild to severe case of performance anxiety (Quoted in Califia, 2000, p. 172).

The costume choice, the role the participant identifies with, the kind of act produced and the bodily fluids that are involved are contextually specific. Pain and aggressive physical stimulation on the body is a practice of ‘freedom’ engaged through negotiating performative roles. Anxiety and humour penetrate the sadist or ‘top’ subjectivity. Sexual dominance is no longer fixed to the ‘top’ and the act does not shame, but seeks to pleasure the ‘bottom’. Sadomasochism, therefore, becomes a specific ‘fantasy ritual’ where individuals perform sexual roles in a theatrical or performative sense (Califia, 2000, p. 172).

Benjamin’s (1988) analysis of recognition as an intersubjective exchange implies that the ‘Other’ is not opposed to the ‘Self’, but rather is a means through which communication and relation are enabled. In the context of sadomasochist encounters, Benjamin suggests that these conflicts between self/other may include a fear of loss or absence which transposes itself onto the infliction of pain and desire to be dominated. In a Foucauldian sense, the way sexual subjectivity is produced in this moment involves a literal “listening to the lessons of the master” (Foucault, 2000, p. 287). In the case of submitting to the verbal or physical taunts, the act designates a sexual parody of submission,

Not everyone who has a pair of handcuffs on his belt is a cop, not everyone who wears a nun’s habit is a Catholic. S/M is more of the hidden sexual nature of fascism than it is a worship or acquiescence to it. How many real Nazis, cops, priests, or teachers would be involved in a kinky sexual scene? It is also a mistake to assume that this historical oppressor is always the top in an S/M encounter (Califia, 2000; 174).

This account alludes to how lesbian sadomasochism is a performative encounter. Sadomasochism brings female participants into a pedagogic scenario, imbricated in networks of power relations where they are both objects and subjects. No one role, however, has a fixed historical meaning. Rather the act produces identities (cop/prisoner or teacher/student) in particular sexual narratives which parody public forms of power imbalances or social relations. Shifting positions of being a subject/object or a dominated/submissive participant produces simultaneous experiences of pleasure and danger (Ardill & O’Sullivan, 2005, p. 120).

Desires in the previously discussed s/m scenario also produce different, often contradictory, experiences of pleasure. While Hart and Benjamin’s psychoanalytic argument provides an insight into the possibilities of violence in producing subjectivity, it does not account for forms of ‘violence’ and pleasure that exceed our intentionality. Erin Manning extends this critique, to imply that violence exceeds the language which articulates it (2007, p. 66). Erotic violence cannot be reducible to a perpetrator or conduit; it is an event of potentialities and movements that produce pleasures. It challenges the Freudian psychoanalytic elision between pleasure (as the life drive) and pain (as the death drive) (Quoted in Moore, 1999, p. 69). Benjamin’s argument seems sympathetic to Foucault’s critique of the politics of desire, challenging the assumption that aggressive sexual play should be understood in
the form of violent or victimised subjects.

Conclusion

Forms of intimacy which utilise physically or verbally aggressive acts remain a point of intense cultural and political anxiety. In thinking about how lesbian sadomasochism is practiced in a range of contexts, it is important to distinguish between criminal behaviour and consensual play within sexual relationships. Resistance to normative sexual publics is also central to the production of creative forms of pleasure. Using Foucault’s approach, new corporeal erotics are possible in the negotiation of bodies and communities. By connecting Foucault’s position on pleasure with psychoanalytic accounts of intersubjectivity, it is possible to reframe a pathological or legal understanding of sadomasochism as a practice that is necessarily counterproductive to intimate and emotional wellbeing. Instead, it should be considered as a disparate set of culturally and materially contingent erotic practices. This is not to suggest that sadomasochism is always ethical. In some circumstances it can be harmful when overdetermined by abusive relations of power. In fact, it is crucial to distinguish between the different kinds of bodies and subjectivities implicated in these practices. Abuse and consent must not be eschewed from the academic and policy debates.

However, rather than saturating analyses of s/m in further binary logics, greater attention must be paid to how resistance, pleasure and subjectivity are implicated in these sexually diverse practices. By rethinking socio-legal and psychological frameworks for understanding lesbian sadomasochism, queer intimacies become intelligible without a pathologising or moralising narrative that reduces these practices of intimacy to a crime or abnormal fetish.

Author Note

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References


LGBTI HEALTH RESEARCH: CHALLENGES AND WAYS FORWARD

JUDE COMFORT

Abstract

Research in the area of lesbian, gay, bisexual, trans and intersex (LGBTI) health, whether as an LGBTI researcher or as someone working in the field, presents unique challenges. The recent Health in Difference Conference provided a networking session to explore some of these issues. Identified challenges could be grouped around four themes, namely 1) marginalisation, 2) funding, 3) the need for better evidence and 4) the relationship between research and LGBT communities. In this article these themes are explored in detail before presenting some practical steps that could be taken to better support LGBTI health research. In particular, collaboration and targeted networking are suggested. It is hoped that the adoption of some of these steps will lead to a more inclusive and supportive LGBTI health research culture.

Keywords: LGBT health research, marginalisation, evidence base

Overview

The 2010 Health in Difference conference held in Sydney and organised by the National LGBT Health Alliance provided the opportunity for networking amongst LGBTI¹ researchers and/or those researching in the LGBTI health area. Approximately 25 participants contributed to a robust discussion which I facilitated as a part of one session within the conference. I proposed this as a networking session, principally because I have faced challenges as a lesbian researcher in a university environment. I was keen to explore the experiences of others in a similar situation. An initial ‘round robin’ introduction demonstrated a breadth of experience of the participants both in terms of research areas and length of involvement in LGBTI research. The session discussion centred around two core questions:

- What are the challenges of working in the LGBTI health research area?
- What steps can be taken to support LGBTI research in the future?

A summary of the main discussion points is presented below with a view to contributing to the debate on how to support researchers in this area and to assist in reducing the isolation many workshop participants reported.

Challenges of Working in LGBTI Health Research

The challenges of working in LGBTI health research identified by workshop participants can be grouped under the four inter-related themes: marginalisation, funding, evidence and working with the community.

Marginalisation

LGBTI research is generally marginalised within university departments. In Australia there are few institutions that have built their reputation as specialist LGBTI health research facilities. The few that exist include the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, The National Centre in HIV Epidemiology and Clini-

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¹ LGBTI (lesbian, gay, bisexual, trans and intersex) is used throughout this paper to mean any non-heterosexual person and/or any person who identifies outside commonly accepted male and female gender norms. It is accepted that other acronyms are also in wide use.
There are several challenges that arise from researching in a fringe or non-mainstream area, including a lack of funding, the difficulties of establishing multi and cross-disciplinary interest, and the lack of access to expertise in other areas. Health research is competitive in seeking funding, gaining academic publications and in presenting stories to a non-academic audience. There is a need to recognise this and work towards mechanisms that help to build a LGBTI research voice. There are many other issues that have strong communities of support, political influence and a more saleable public message which regularly overshadow LGBTI health issues (even though they could have an angle that includes LGBTI issues). For example obesity or binge drinking – two public health issues that have received a great deal of recent coverage (National Preventative Health Taskforce, 2008) with little or no mention of unique issues for LGBTI communities. Many LGBTI health studies have found higher levels of obesity and licit and illicit drug use within these communities when compared with the broader population (Boehmer, Bowen, & Bauer, 2007; Case et al., 2004; Hyde, Comfort, McManus, Brown, & Howat, 2009), yet little attention has been paid to health interventions for the GLBTI community.2

HIV based research has dominated the LGBTI health research agenda and is often seen synonymously as being ‘gay’ health by many outside the area. This can be very limiting for those working outside the HIV area (and in particular those working in lesbian, bisexual or trans health) and shows a lack of understanding of the complexities faced by all people of diverse sexualities and genders. It has also perpetuated a research agenda which tends to concentrate on problem areas within LGBTI health (i.e., working from a health deficit model and not a resilience model).

There is, of course, an ongoing challenge in regards to gaining publication in mainstream journals. Many researchers in the field therefore find that publication success lies in LGBTI specific journals such as the Journal of Homosexuality. Publishing in such journals can be problematic as they are typically not widely accessed by those outside the field and generally have much lower impact factors, which means researchers in the area are poorly rewarded. Exceptions to this occur when more prominent journals devote special issues to LGBTI health-related topics as did the American Journal of Public Health in 2001 (although as noted by the editor this decision was not met with universal endorsement, see Northridge, 2001).

Many researchers who work in the LGBTI area find themselves quickly pigeon holed as a ‘gay’ researcher and are suddenly considered to be an expert on all things LGBTI. Again this fails to recognise our individual research backgrounds and the complexity of LGBTI health issues. This can also result in a lack of critical discourse or challenge from other university colleagues because they do not feel they understand the area or do not want to risk showing ignorance or political incorrectness through this. Most of us would be open to working collaboratively outside the LGBTI area and many do not want to be pigeon holed exclusively into the LGBTI area.

Finally, many LGBTI researchers work alone and may feel they are the only ‘gay in the village’ within their university department. It takes time to build an infrastructure of support

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2 There is evidence that minority sexuality and gendered status results in poorer overall health and Meyer and others argue for sexual identity/orientation to be considered as a social determinant of health (McNair, Gietzman, & Hillier, 2006; Meyer & Northridge, 2007)
both within respective institutions and also with each other which crosses state borders, discipline lines and philosophical approaches. Some universities have attempted to address the isolation of both LGBTI staff and students through their diversity agendas with programs such as the Ally network which offers training to both LGBTI and non LGBTI campus members who support inclusive practice (deVries & Goody, 2003).

**Funding**

The call for increased funding and attention to LGBTI research is not new (Cochran, 2001; Diamant, 2000). Nonetheless, participants in the networking session emphasised the fact that researching in a marginalised area means that LGBTI health struggles to attract adequate funding. Again, those working in the HIV/AIDS area have had more success and more recognition than most LGBTI areas, as have projects dealing with youth who are seen as a vulnerable group. The lack of access to large funding options has also meant a reliance on smaller, often community based, funding and a reliance on volunteer input. Most people who work in LGBTI research are committed to the area and therefore often contribute many hours of unpaid work to see research projects through. It is not uncommon to use volunteers for data input, for example.

**Better Evidence**

There is a continuing call from outside the sector for better evidence around LGBTI health issues. Yet due to the marginalisation of LGBTI populations and a lack of adequate research funding, this can be difficult to deliver. There are also some specific methodological challenges such as lack of random sampling, and a reliance on convenience samples, small sample size, and confusion over sexual orientation, sex and gender definitions (Binson, Blair, Huebner, & Woods, 2007; Meyer & Wilson, 2009; Pega, Gray, & Veale, 2010). These issues are compounded by the great diversity within LGBTI communities, as well as the impact of how ‘out’ or connected to LGBTI communities a potential participant is. These issues impact significantly on sampling design, representativeness and response rates, especially in attempting to work with the hidden element of this population (Morris, 2006). Although the situation is slowly changing, most large epidemiological surveys do not include questions on sexual orientation, gender identity or intersex status (McNair et al., 2006), and hence there is a reliance on purposive sampling techniques which may be open to criticism (Ryan, Wortley, Easton, Pederson, & Greenwood, 2001). It is likely that all researchers in the area are acutely aware of the need to produce high quality research, but as has been discussed there are often constraints to achieving this.

Sexuality and gender identity issues often arise in adolescence and situations where ethics clearance has demanded adult consent can illustrate a lack of understanding of this situation. There have been successes in research projects which have full ethics approval to enrol 16 year olds without adult consent and hence allow for valuable research with this group. This shows that youth research and the vulnerability of having to obtain parent/guardian consent when researching LGBTI issues has been understood and that this important research can be undertaken sensitively, ethically and with duty of care considerations and with the potential for more insightful research results.

**Relationship to LGBTI Communities**

Research can be a powerful tool for social change, and for most researchers in the LGBTI area there is a commitment to, and a concern that, research needs to work with and for the community of interest. However this is not without challenge. For example, the evolving nature of LGBTI communities means that there is no such thing as a single community. Yet despite this, sections of the community may have very firm ideas of what ‘a’ LGBTI research agenda should be. There is generally perceived to be a lack of collaboration between LGBTI social activists and researchers.
and a tension between presenting a united and cohesive front but at the same time working within a diverse community. Some network session participants recognised that social action research may be a way forward; however this is not always easily constructed, respected or funded. As a minority group there may be suspicion from the community on how research data is to be used and issues of confidentiality. This was demonstrated recently during recruitment of lesbian and bisexual women as part of a gay periodic health surveys undertaken by WACHPR, where several recruiters reported questions such as “who is going to see this?”, “why should I answer this survey?”, “you only ever ask about sex”, “what happens with all of this data – we never see the results”.

There have, of course, been demonstrated partnerships between sectors of LGBTI communities and researchers which have led to the translation of research outcomes into policy and legislative changes (e.g., parenting reform).

Supporting LGBTI Research in the Future

The workshop session ended with a brief discussion on what steps could be taken to support LGBTI researchers operate in a more supportive, collaborative and productive environment. It was recognised that the first step was to more formally organise a network for those working in the area. The host organisation of the Health in Difference Conference, the National LGBT Health Alliance, was seen as an ideal organisation to facilitate this; no other identifiable peak body exists and the Alliance membership bridges the community and research sectors. However, it was also recognised that this organisation currently does not have ongoing funding, and efforts to secure government funding in line with other minority groups (e.g., seniors, culturally and linguistically diverse groups, disabled groups) was vital (LGBT Health Alliance, nd).

Due to the geographic and organisational diversity of LGBTI researchers, in the first instance electronic networking opportunity with ongoing coordination and support to ensure sustainability was identified as the most appropriate mechanism to achieve this. Such a network would allow for a sharing of expertise, collaborative opportunities, peer research support, review options and sharing of research findings.

Secondly, proactive use of existing network opportunities, for example at mainstream conferences, would also build the capacity of a LGBTI research community. Such gatherings can provide an opportunity for LGBTI researchers to meet and network and not remain hidden from each other. This may be as simple as organising an LGBTI informal lunchtime session (which happened shortly after the Health in Difference conference when, at the Sixth Australian Women's Health Conference in Hobart in May 2010, a lunchtime gathering of interested lesbian and bisexual women was convened).

The importance of ensuring that research results are fed back to the community of interest was also acknowledged. Such action both informs the community and builds support and trust for future research. It therefore enables better researcher access to the community. WACHPR has built good relationships with the gay media in Perth and has used this to feedback research results. For example a full page advertisement was taken out in the local paper Out in Perth to report on the gay periodic survey (WACHPR, 2007).

The continuing use of on-line research participation is seen as a way of increasing access opportunities for ‘hidden’ LGBTI community group members who are often missed in research. The success of this recruitment methodology can be seen in some important Australian research (Dane, Masser, MacDonald, &

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3 Recruiter feedback to the author following Perth Fair Day recruitment for gay periodic surveys, 9 October 2010.
Those people who have little or no connection to LGBTI communities (whether that be face to face or electronically) are likely to remain outside a researcher's recruitment regardless of strategy and yet they may be the most marginalised and vulnerable in our community. This was recognised as a continuing challenge to be addressed by researchers.

The positives to be gained by the inclusion of research questions relating to sexual orientation and gender identity in large population based surveys was acknowledged. Continued advocacy in this area is required with the proviso that consultation must occur with LGBTI research communities in order to gain assistance in how to frame these questions. For example, having a binary of 'heterosexual' or 'non heterosexual' will miss many subtleties and adding a third sex/gender category of 'other', while a step forward, will not necessarily provide the data sought. Funding bodies need to be lobbied to ensure that LGBTI research opportunities are considered and taken seriously. This may require personal representations to funding bodies and for advocacy groups such as the National LGBT Health Alliance to actively put this on their agenda.

**Conclusion**

This article has considered some of the challenges that exist for both LGBTI researchers and those undertaking research in the area. While research challenges were easily identified and discussed, the network session also provided an opportunity to consider the many research achievements in the area. There has been a moving forward from a time where LGBTI research was greeted with silence by the mainstream research community, to one where it is now appearing and even occasionally celebrated.

There was also recognition that there are increasing numbers of LGBTI-identified researchers and research areas, some with good cross-discipline practices, being undertaken. There is also an increasing number of researchers who have published their LGBT work; a huge achievement in the face of working in a marginalised research area. The supportive role of non government and community groups in research endeavours was acknowledged by network session participants.

Some university departments have led the way in implementing curriculum changes that see LGBTI issues being taught, usually the result of the hard work of concerned LGBTI academic staff. Curtin University, for example, has a sexology department within the School of Public Health and provides units both at a post graduate and undergraduate level providing critical analysis, teaching and research opportunities in the LGBTI area. Session participants saw this as vitally important as a means of promoting more acceptance of LGBTI people and issues at both practitioner and academic levels. It assists in ensuring the next generation of professionals and academics have at least been exposed to LGBTI issues (and some may be inspired to follow this into further research.) It also affirms and supports LGBTI students who may themselves be struggling with their own sexual orientation, sex or gender identity.

**Health in Difference** provided a valuable forum for discussing LGBTI health issues and a forum for LGBTI researchers to meet in an environment where they make up the majority of attendees – an affirming situation in itself. The research networking session at **Health in Difference**, reported here, demonstrated a vibrant LGBTI research culture in Australia but one that would benefit from more support, collaboration and understanding from the broader research community. This is likely to lead to a higher profiling of LGBTI health research in the future attracting increased funding, new researchers and reward for those

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researchers who have already been working in the area for some time. Universities and other research institutions are urged to work towards supporting LGBTI research to ensure that the health of this minority group is improved.

**Author Note**

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**References**


INCLUSION AND EXCLUSION: ABORIGINAL, TORRES STRAIT ISLANDER, TRANS AND INTERSEX VOICES AT THE HEALTH IN DIFFERENCE CONFERENCE 2010

GABI ROSENSTREICH AND SALLY GOLDNER

Two common themes raised throughout the Health in Difference 2010 conference were the marginalisation of some groups within LGBTI1 communities and the LGBTI health sector, and the fundamental significance of people speaking for themselves, defining their own issues, needs and solutions – and others listening.

Some (overlapping) groups that addressed these themes and spoke clearly and strongly for themselves at Health in Difference 2010 were ‘Aboriginal and Torres Strait Islander people’2 and ‘trans and intersex people’.3 However, these voices were not articulated in papers received for this special issue. In response to this gap, in this paper we outline some of the key issues documented by these groups during the conference in an effort to share them with readers of this journal. We also reflect on the absence of submissions from members of these groups and on some of the strategies implemented in the conference to support participation. These reflections may shed some light on both inclusion and exclusion processes and indeed on some of the core challenges of ‘doing diversity’.

Gabi writes from the position of a cisgendered, non-indigenous conference convenor, and Sally from the position of a non-indigenous transwoman on the conference organising committee. We do not seek to speak on behalf of others, but rather to share here what has been captured in conference documentation and our own reflections. This is far from ideal. However, it appears preferable to the alternative of reproducing the invisibility of the voices of Aboriginal/Torres Strait Islander/trans/intersex people in the broader LGBTI sector in this journal issue. We acknowledge the intersex/trans/Torres Strait Islander/Aboriginal participants at the conference and thank them for their willingness to share some of their wealth of knowledge.

1 All conference materials included a statement about the use of LGBTI as an acronym to refer to a diverse group of identities that includes but is not limited to lesbian, gay, bisexual, trans/transgender and intersex people. It included a specific invitation to think across identity labels and consider sexualit y, sex and gender diversity in all their facets and communities, including queer, sistergirl, transsexual, and other people. This is the sense in which the acronym is used in this paper.

2 While many people are comfortable with the term ‘Indigenous’ as a term encompassing ‘Aboriginal’ and ‘Torres Strait Islander’ people in the Australian context, it is also contested by some of those people these terms supposedly label. At Health in Difference, both terminologies were used, in addition to other local/regional terms. Where possible, we have attempted to use the terms that presenters themselves used, resulting in a diversity of terms throughout the paper. As a default, we have tended to use ‘Aboriginal and Torres Strait Islander’ in line with what appeared to be a general preference among conference participants.

3 ‘Trans’ is used in this paper as an umbrella term for people whose internal sense of gender differs from the sex assigned at birth (eg transsexual, transgender, genderqueer, sistergirl) and ‘intersex’ as an umbrella term for people born with variations in their sex development that differ from common expectations of male or female bodies (eg hormones, gonads, genitals, chromosomes). While the two groups share some issues and have formed coalitions in advocacy and community groups, grouping them together should not be taken as implying a homogeneity. Indeed, Health in Difference 2010 provided a number of opportunities to address their significantly different experiences.
Inclusion

The inclusion of lesbian, gay and/or trans/sistergirl\(^4\) Aboriginal people, and to some extent Torres Strait Islanders, other trans people and intersex people,\(^5\) and their visible and active participation in the conference was repeatedly commended by members of these groups and others.

As organisers our committee of 14 utilised a number of strategies to ‘do diversity’ and proactively foster participation of these (and other) groups. We recognised that, among others, Aboriginal and Torres Strait Islander LGBTI people, and other trans and intersex people, tend to be marginalised from and within conferences and the LGBTI community sector.\(^6\) Just as the National LGBTI Health Alliance argues for proactive inclusion of LGBTI people by generic service providers, we acknowledged that members of marginalised groups were unlikely to assume that the Health in Difference conference was a space for them unless this was proactively demonstrated. Crucial for the Alliance was ensuring that members of these groups were part of the organising committee and that the committee consulted broadly at various stages of conference planning. Thus one of the organisers was Aboriginal, working with 13 other members who were neither Aboriginal nor Torres Strait Islanders; two members of the committee were trans and 12 cisgendered. And of course we all identified according to various sexual orientations, genders, cultural belongings and other aspects of our identities.

\(^4\) The term ‘sistergirl’ is used by some, but by no means all, Aboriginal and Torres Strait Islander people for an identity which approximates what non-Aboriginal people might term ‘transwoman’. Kooncha Brown notes that “western definitions of transgender or gay do not reflect the lived reality of Aboriginal and Torres Strait Islander transgendered people” (2004: 25). At Health in Difference 2010 Laimena Wilo Muwadda addressed the transience of sexuality and gender identities among some Aboriginal and Torres Strait Islander people and noted that these identities have not yet been explored and discussed by Aboriginal and Torres Strait Islander LGBTI communities at a national level to determine a national Aboriginal and Torres Strait Islander LGBTI position. The differences and commonalities between the understandings and concepts of gender identity of Aboriginal peoples, Torres Strait Islander people and others is an area warranting further exploration by members of these groups as they seek to develop coalitions around gender identity related issues. The term is often spelt ‘sistagirl’, however presenters at Health in Difference who identify with this label used ‘sistergirl’ so that spelling has been retained in this paper.

\(^5\) While we did not capture robust demographic data on the 212 participants, on the basis of the information available we estimate that approximately 25% of participants were Aboriginal or Torres Strait Islanders, with 15-20% trans, intersex or genderqueer. Of the total 111 presenters at Health in Difference 2010, so far as we know 29 identified as Aboriginal, two as Torres Strait Islander or having Torres Islander decent, 17 as trans, three as Intersex (including four who identified as both Aboriginal and trans, and one who identified as both Torres Strait Islander and Aboriginal).

\(^6\) Mary Heath’s article in this issue addresses some of the marginalisation experienced by bisexual people. While we implemented a number of the strategies discussed in this paper in relation to bisexual people too, most notably this group was not prioritised in the form of one of the ‘key conference themes’ and in part as a result did not visibly participate in Health in Difference 2010 in the same way or to the same extent as Aboriginal and Torres Strait Islander people/trans and intersex people.
ing planning, and worked with them in various ways, for example, by recruiting three Aboriginal and three trans reviewers for the paper selection process.

Some of the other mechanisms we used included:

- having explicit themes STREAMS in the conference;
- networking sessions for specific groups early in the conference, facilitated by peers (ensuring that the ‘Aboriginal People and Torres Strait Islander People’ session was not concurrent with the ‘Sex and Gender Diverse/Trans and Intersex People’ session), and the opportunity to self-initiate further or other networking sessions;
- targeting dissemination of information;
- identifying and encouraging potential presenters and assisting them with proposal submission where necessary;
- ensuring that we had members of these groups speaking in each plenary session in the conference and, where possible, presenting in the various streams, rather than exclusively the ones pertaining specifically to ‘First Australians’ and ‘Sex and Gender Diversity’; and
- securing scholarship funding and including membership of one of these groups as a factor in selection;
- collaboration with the Closing the Gap Indigenous leadership program;
- putting harassment procedures in place;
- including acknowledgement of the local people (Gadigal) in materials, including in speakers’ notes;
- having dedicated networking opportunities;
- striving for appropriate language use (while acknowledging different positions on what that entails); and
- avoiding sex-specific structures where possible (the availability of unisex toilets was particularly appreciated on both a practical and symbolic level not only by trans and intersex people, but by some other participants, and posed a productive challenge for some cisgendered participants).

Of particular note is perhaps the strategy of having specific themes STREAMS in the conference on “Indigenous Health and Wellbeing: Culture, Context and Colonisation” and on “Sex and Gender Diversity: The Health and Wellbeing of Trans and Intersex People”. As organisers we had some reservations that this would silo and thus marginalise the issues, and also that it rendered the overlaps between these population groups invisible. However, feedback from most members of these groups was that the invisibility and exclusion of their issues is so pervasive that potential presenters and participants were unlikely to engage unless we are very explicit that this is a priority, with its own space. Structuring them as core conference streams was suggested as the most appropriate mechanism, at least this time.

We asked those submitting proposals to indicate all streams which their presentation addressed, and included overlaps/intersections between streams as a favourable factor in selection. While respecting presenters own ‘first’ choice of stream where possible, we also sought to incorporate presentations address-

7 The term “sex and gender diversity” has become a commonly used umbrella term among trans and intersex people and in the Australian LGBTI sector generally, following its use by the Australian Human Rights Commission in its work on the legal documentation of sex. Like so many other terms it is contested. Like the (also contested) term ‘Culturally and Linguistically Diverse’, it positions ‘diversity’ as that which is outside the dominant norm. Normative and programmatic aspects of the concept of ‘diversity’ in a European context are discussed in Rosenstreich 2005 and Rosenstreich & Mecheril 2005. The term ‘sex and gender diversity’ is used by the National LGBTI Health Alliance together with the specific terms trans/transgender and intersex, in recognition of the wide diversity of further terms people use to describe their sex and/or gender identity.
ing issues of Indigeneity and/or sex identity and/or gender identity in various streams. We had a plenary session for each theme, with a presenter and panel discussion, to ensure that key issues were being raised for all participants, and not just for those with a specific interest in the area. As one evaluation respondent said “The plenaries were valuable from the perspective that they exposed participants to areas they may not normally have contact with and thoroughly demonstrated (or in some cases CELEBRATED) diversity”. In addition to a presentation and panel discussion, these plenary sessions included ‘report backs’ from the concurrent sessions.

This mechanism did appear effective in this instance, with a large number of proposals to present submitted in these (and other) areas and very positive feedback from many participants: “As an Aboriginal man it was great to see us on the agenda” (participant evaluation form). However, some participants expressed concern in the evaluation survey that having specific streams did in fact ‘silo’ or separate those who identified as Aboriginal, Torres Strait Islander, trans and/or intersex, with many attending primarily or solely concurrent sessions within ‘their’ stream, e.g. “wonder if it was necessary to have an entire stream devoted to indigenous Australians. I also wonder if this made them feel excluded from others in the conference”. However, this concern appears to have been voiced mainly by people not themselves members of these groups. Although feedback on this issue was not systematically sought, a number of Aboriginal/Torres Strait Islander/trans/intersex participants specifically noted their appreciation of a focussed space to engage with each other and with their issues, while also engaging more broadly via the plenary sessions. As one participant said in response to the evaluation question ‘what did you like most about the conference’: “It was my first time attending the conference: For me it was building strong networks and links with our mob - Aboriginal & Torres Strait Islander working together and supporting each needs. I felt so good to see all of our mob in one place and made me feel strong and proud.”

A similar dichotomy of views was expressed to us verbally during the conference in relation to the networking sessions, some of which were specifically defined as being by and for members of particular groups. Some participants were disappointed to not be ‘allowed’ to participate in some networking sessions. They expressed their motivation in terms of interest in learning more about the experiences of marginalised groups of which they were not members and/or wishing to get to know people within them. Members of marginalised groups on the other hand emphasised how empowering it was to have the opportunity to network in a ‘safe space’ with others from around the country who shared that part of their identity. In fact, the desire to establish ongoing national networks by and for Aboriginal and Torres Strait Islander LGBTI people, and by and for trans people, was formulated by participants. Given that all but 1.5 hours of the conference, including the concurrent sessions and plenaries, was open to all and offered opportunities for others to learn about the experiences of members of marginalised groups, we remain confident that this networking mechanism was valuable. However, we acknowledge that more communication of the significance of ‘closed’ spaces for marginalised groups to participants would be helpful as would further interactive opportunities for participants to get to know each other.

Trans/intersex/Aboriginal/Torres Strait Islander participants (by which we mean both those whose names appear in the program as speakers as well as the other participants) thus not only shared their expertise and passion with audiences that may not have known much about their specific issues and their perspectives on broader issues, but they spoke with each other in an empowering space that

8 The tensions and the opportunities for empowerment afforded by ‘closed’ spaces are discussed in Rosenstreich 2006.
allowed diversity within the respective group to be acknowledged, shared learnings and built connections and strategies for moving forward collaboratively.

This is partly expressed in a closing comment made by an Aboriginal participant on their evaluation form “thank you for the opportunity to share our information with everyone. I was able to make positive networks with a couple of Indigenous groups in South Australia & Northern Territory. I had a lot of positive feedback from various people & groups. I also had the opportunity to network and assist other States. ... Thank you for this amazing experience, not only did I learn about myself, I also learnt from others.”

The active participation of Torres Strait Islander/Aboriginal/trans/intersex and other sex and gender diverse people was so frequently commented on that it highlighted their absence in most other spaces in the wider LGBTI community sector. While there is certainly much room for improvement, the Health in Difference 2010 conference organisers and participants can, we think, be proud of this ‘diversity in action’.

**Some Key Messages at Health in Difference 2010**

So, what were some of the key messages that members of these (overlapping) groups conveyed during Health in Difference? Some presenters used powerpoint slides or had typed up speeches, which they have made available via the Alliance’s website, and the chairs captured two or three core messages from most sessions, so we can collate the echoes of the voices of at least some participants to share with readers a glimpse of what was discussed at Health in Difference 2010 in relation to Indigeneity and sex and gender diversity. Please note, however, that our brief synopsis cannot do justice to the voices or the breadth of knowledge and experiences presented by Aboriginal and Torres Strait Islander LGBT people and other trans and intersex people at the conference.

As already noted, common themes throughout the conference, and in particular in relation to Aboriginal and Torres Strait Islander LGBT people and other trans and intersex people, were the experience of marginalisation within the LGBTI sector and the fundamental need for people to speak for themselves, define their own issues, needs and solutions – and for others to listen, communicate and not assume. In various ways, participants asked ‘what are we doing to reduce discriminating behaviours within our communities?’

**Aboriginal and Torres Strait Islander LGBT® Voices**

In the first plenary presentation of the conference James Ward, an Aboriginal man of Nurrunga and Western Arrente descent from Central and South Australia, discussed the ongoing health crisis facing Indigenous Australia, reporting that Aboriginal and Torres Strait Islander people have the worst health status of any identifiable group in Australia. Exacerbating this for Aboriginal and Torres Strait Islander lesbian, gay, bisexual and sistergirl people is that this agenda is rarely articulated in the Indigenous health agenda. Furthermore, the LGBTI community health sector often struggles to find the right responses for the community. In terms of identity having both an Aboriginal and/or Torres Strait Islander lesbian, gay, bisexual or sistergirl identity can be fluid and interchangeable. It is not necessarily straightforward and a tension can be created in terms of both the “double whammy” of experiences of discrimination and marginalisation within both communities and a pressure to privilege one identity over another. This can lead to detrimental effects on

9 We are not aware of issues for Aboriginal or Torres Strait Islander intersex and/or brotherboy/transmen being addressed at the Health in Difference 2010 conference. This does not mean they were not present, just that we did not hear them or read documentation of such voices and thus cannot comment on them.
social and emotional wellbeing. James noted that Aboriginal and/or Torres Strait Islander and LGBTI identities both bring pride and strength and sometimes internalised and externalised anguish. He argued that it is crucial to strengthen identities to enable people to be more in control of their own circumstances, and strengthen resilience to adversity, and by doing this decrease the attention related to shame, stigma and illness (Ward, 2010).

These themes resonated in other presentations and discussions by Aboriginal and Torres Strait Islander people. Dameyon Bonson discussed how colonisation and missionary zeal have worked together to suppress and oppress Indigenous sexuality within Australia, and presentations from three LGBT community groups by and for Aboriginal and Torres Strait Islander people – Indigilez Women’s Leadership and Support Group (Queensland), OutBlack (Victoria) and Moolagoo Mob (South Australia) – demonstrated the importance of grassroots action to build community. With essentially no funding, these groups are building links and alliances. One outcome of Health in Difference was the decision by Moolagoo Mob to form a specific group for women in acknowledgement of some of the barriers to their involvement in a mixed group.

The strength of the voices of sistergirls at the conference was inspiring and empowering for many participants. Rusty Nannup, from the West Coast of Australia, introduced herself as a panel discussant in the ‘Sex and Gender Diversity’ plenary session by saying “I have never allowed my sexuality or identity to be a handicap because it’s my personal strength. Being able to maintain oneself in both worlds is something special and I’ve done it. I believe we can make it if we take the time to look and listen to each other. I left my home many years ago but I never left my country. Remember who you are. I am a proud Wajarri-Nyungar woman” However, sistergirls also made clear that achieving this strength can be challenging and some spoke of isolation in many remote communities, and the negative impact of exclusion from men’s and women’s business on wellbeing. Presenters Crystal Johnson and Bertram Tipungwuti from Nguiu, Tiwi Islands, noted that violence and stigma in community drives some Northern Territory sistergirls to relocate to cities. As a number of participants noted, this can result in isolation from culture and family and experiences of racism, including within the LGBTI community. Crystal and Bertram argued that it is necessary to develop connections between remote communities and support networks to better support sistergirls to live in their traditional lands. Laimena Wilo Muwadda spoke of some of the ways that the 2 Spirits program in Queensland is striving to do this, but also questioned the meaning and use of identity labels for transient sexualities and genders in Aboriginal and Torres Strait Islander societies, and the implications for health interventions.

Some inspiring examples of LGBTI Aboriginal and Torres Strait Islander community groups working in partnership with mainstream Indigenous, LGBT and HIV organisations were shared, such as the cooperation between Feast - Adelaide’s LGBTQ festival - and gay, lesbian and queer Indigenous performers in ‘Queer Gifted and Blak’ (“a great way to communicate”, session feedback sheet). However, it was clear that there is still much to learn about partnership and inclusion. Other practice explored was work of ‘mainstream’ LGB(T) organisations to provide targeted services for Aboriginal and Torres Strait Islander people, such as ACON’s health retreat for Aboriginal gay men living with HIV, NTAHC’s sistergirl retreat and the work of QAHC’s two-spirit program to empower Aboriginal and Torres Strait Islander gay men and sistergirls. Learning that participants documented from that session 10:

10 The chair of each session was asked to provide the organisers with up to three key messages to document that session. Conference participants were informed that this feedback would be both shared verbally in the plenary sessions and in published form. This was one strategy to share knowledge beyond the specific circle of those able to attend sessions.
• “Cultural appropriateness is not hard. It is a matter of having program participants determine their needs. The term "two spirit" can be a useful one for Indigenous programs
• Increased reliance on technology presents some dangers for Indigenous folk - where face to face communication is very important
• Retreats are an important space for grieving and healing and the opportunity to undertake this should be supported by LGBTIQ organisations. Recognising that it is difficult for Indigenous folk to fit into mainstream service formats such as appointment times and opening hours”.

As discussed above, the conference included networking sessions – loosely structured gatherings in which members of a number of groups could come together, discuss issues important to them and generate and build ideas. These groups were also asked to document key messages from their sessions to share with others. The network gathering of Aboriginal people & Torres Strait Islander people noted:

• Value in “setting up a national network for Aboriginal & Torres Strait Islander LGBTIQ”;
• Need to “approach AFAO, NACCHO & AIDS Councils to commit to AETSI LGBTIQ”; and
• Want to “explore the development of safe spaces nationally for Aboriginal and Torres Strait Islander LGBTIQ focusing on youth and elders”.

Trans and Intersex Peoples’ Voices

The voices of sistergirls have been included above as most indicated that their presentation was primarily located within the “Indigenous Health and Wellbeing” stream. They could, however, be repeated under the heading ‘Trans and Intersex Peoples’ Voices’ too.

There was also resonance between the themes addressed by Aboriginal and Torres Strait Islander LGBT people and non-indigenous trans and intersex participants. An example of this appeared in the clear articulation that health rights are human rights. James Ward touched on this in his presentation and it was echoed by other participants in the “First Australians” panel. Several of the trans presenters, including Peter Hyndal, Jack Byrne, Aram Hosie, Crystal Johnson, Bertram Tipungwuti, Sally Goldner, Katherine Cummins, Robyn Graffin and intersex presenters Gina Wilson and Mani Bruce Mitchell addressed how human rights are currently being denied to many sex and gender diverse people. Specific issues raised in a number of presentations included the fundamental impact on health and wellbeing of a legislative and policy environment that structures access to resources such as medical treatment, overseas travel, marriage, etc on the basis of binary sex identity on documentation that does not or only inadequately reflects the reality of many trans, intersex and other sex and gender diverse people.

The conference was provided with an update on the Australian Human Rights Commissions efforts to advocate on identity documentation issues (the ‘sex files report’) on a state/territory and federal level and the Parliamentary Secretary for Social Inclusion, Senator Ursula Stephens, announced in a speech to the conference that the Federal Attorney General was setting up a working group to address this issue. So, some progress is being made. However numerous participants made it clear that the denial of self determination for sex and gender diverse people is widespread from infancy (non consensual surgical/hormonal interventions on intersex children)
through to old age (e.g. aged care service providers forcing people to wear inappropriate gender specific clothing).

In a plenary presentation, Mani Bruce Mitchell, intersex advocate, said "I do not know of any other medical intervention where the purpose is to create 'normality'. The very essence is at its core homophobic. Nothing will change until that fact is addressed and parents are supported to deal with the complexity that intersex issues bring. To hold as precious the idea that preserving choice and receiving unconditional love, valuing diversity and difference is what their children need. As adults to find safe supportive spaces to deal with our own anger, shame, and fear so that we can live wonderful productive lives as the person we are (whatever that is!) not as the person the world, our parents, society wants us to be" (Mitchell, 2010).

A number of participants drew attention to transphobia and the exclusion of intersex people (as well as biphobia) within organisations attempting to work for LGB and TI people and among gay and lesbian people more generally. As trans (and bi) advocate Sally Goldner put it “We've put the sledgehammer into seemingly granite-like bastions of queerphobia. But there seems to be a granite elephant in our own pink lounge room that barely seems to have any hairline cracks.” Sally suggests that many seemingly identity-related tensions may in fact be based on assimilationist attempts to lessen the stigma of homosexuality by rejecting the stigma of "inappropriate" gendered behaviour/ gender ambiguity and thus reject those who are more visible. She argues that valuing difference and communicating are key to working together as an LGBTI community to achieve shared goals (Goldner, 2010).

Lack of self determination is evident in relation to terminology too – for example, intersex advocates, such as Mani Bruce Mitchell and members of Organisation Intersex International Australia clearly rejected the term ‘disorders of sex development’ being used in current medical discourse. On the other hand, the inherently contested nature of identity labels was also clear, with differing perspectives on terms such as 'sex and gender diversity’, trans/transgender, etc. Tracie O'Keefe argued for the death of transgender as an umbrella term in her presentation, while other participants argued for moving away from terminology discussions altogether and focussing on shared issues. And indeed, differences and marginalisation within groups that share identities were also addressed, for example in Gabby Skelsey’s presentation on the experiences of trans sex workers. Various presentations illustrated the increasing hybridity of gender identity and participants discussed its implications for service providers. Key messages from that session:

- “It's really about embracing diversity of lived experience and realising the limitations of our traditional LGBT framework
- The need to positively challenge ourselves around gender identity. From our professional and personal assumptions, through to creating safe spaces and gender appropriate programs, through to organisational and institutional structural change. The resilience of our gender diverse community!”

Across differences, trans and intersex participants voiced the desire to work together for the benefit of all, and undertook to put in place processes to continue the conversation across the community, nationally in partnership with the Alliance.

Key messages formulated in the networking session of sex & gender diverse/trans & intersex people:

- “Intersex and gender/sex diverse people need their own funded/resourced support services (sometimes, but not always, GLB organisations might be suitable homes for these services);
- Intersex and gender/sex diverse people/groups need to work in partnership with GLB organisations and vice versa;
- Need to ensure that the intersex and gen-
der/sex diverse community is a sustainable one - that we look after each other, nurture/share what infrastructure/knowledge we have and encourage new leadership. Sustainable networking is key (possible role for the Alliance)"

We recommend that interested readers take a look at the documentation of the conference on the Alliance website, including the abstracts provided by presenters. Most have also provided contact details.

Exclusion

So, why are we passing on these words rather than them being articulated in depth by Aboriginal people, Torres Strait Islanders, trans and/or intersex people in this journal? We don't have a clear answer, but we do have some thoughts and suggestions.

We suggest that it reflects some of the very barriers that have been outlined and indeed some of the core challenges of ‘doing diversity’. While the conference did a good job of providing a space for the voices of members of these (overlapping) groups, this has not been reflected in this special issue. The dissemination of knowledge such as that presented at Health in Difference 2010 is significant, because it provides visibility and a foundation for others to build upon. It is not only empowering for people seeking to promote LGBTI health and wellbeing to learn from their peers, but it also serves to build power by providing citable ‘evidence’ to support cases presented to policy makers and others. For all critique of what counts as ‘real’ knowledge among decision makers, we acknowledge the power of print, and in particular the power of academic journals such as Gay & Lesbian Issues in Psychology Review, and the leverage they potentially provide in promoting the health and wellbeing of LGBTI people. It is therefore worth considering the barriers that have resulted in there not being articles specifically on trans, intersex, Aboriginal and/or Torres Strait Islander issues in this journal special issue.

On a practical level, some speakers suggested that Aboriginal and Torres Strait Islander people tend to prefer to talk rather than read or write. This has implications for programs targeting these groups, but also means that written documentation may be inappropriate for some presenters and audiences. Video and audio recordings might be better ways to disseminate the knowledge conveyed in some conference presentations to those not fortunate enough to be able to attend.

In a similar vein, even where we have text, an academic journal such as Gay & Lesbian Issues in Psychology Review is simply not the appropriate medium for all. Just as reading aloud an academic article makes for a very poor oral presentation, oral presentations require reworking to effectively communicate knowledge in the form of a journal article. This doesn't necessarily need to adhere to traditional academic rules — Kooncha Brown's excellent article on sistergirls, for example, breaks with such norms by addressing readers directly and 'speaking' in a first person, conversational tone (Brown, 2004). However, it does need to translate to the linearity of text, and, for example, provide structured information and analysis.

Although we acknowledge that many in the research and policy sectors would perhaps see it otherwise, we suggest that an academic journal does not convey 'truer' or more 'legitimate' knowledge than other media. Nor, however, do we regard it as a less valid form of sharing knowledge than others. It is simply a specific medium, a fragment of a specific discursive context, powerful within a particular context and targeted to a particular audience, and like all targeted media, less accessible to other audiences.

Without wishing to detract from the significance of issues such as culturally specific forms of communication, experiences of discrimination and marginalisation among these communities are not only barriers to health and wellbeing but also to education and employment for many. These are structural barri-
ers that hinder many Aboriginal and Torres Strait Islander people (and in particular LGBTI people within these communities) as well as many non-indigenous sex and gender diverse people from being part of the academic discourse within which a journal such as this exists. Add to this the particular marginalisation of intersex/trans/Aboriginal/Torres Strait Islander issues within the LGBTI research sector for some of the very reasons that Jude Comfort’s article in this issue addresses, so there is neither a lot of research to draw upon nor a lot of researchers there to present on their work.

A related factor is that most of the intersex, trans, Aboriginal and/or Torres Strait Islander presenters at Health in Difference were not participating in the conference within a substantive – paid – role, but rather participating in their ‘free time’, just as in the vast majority of cases their advocacy, peer support, etc is done on a voluntary basis. Finding the capacity to write up a presentation in a form suitable for publication poses a significant hurdle for many people even in those rare cases where they could do so within a paid role or as part of their studies.

All presenters and participants were invited to submit to the journal both in announcements at the conference and in calls for papers in the handbook and disseminated via email after the conference (and it was noted that articles not suitable for publication in the journal could be published on the Alliance website). Some presenters were specifically followed up and encouraged to submit. The lack of resourcing for the Alliance and the voluntary work of putting together this journal, however, meant that there was a lack of capacity to intensively follow up with presenters and/or to support them to produce articles suitable for publication in this form. Nor indeed the capacity to critically reflect on these thoughts and suggestions as we would have wished to with others.

Two further structural barriers are the current lack of general awareness in the population of issues for trans/intersex/Aboriginal/Torres Strait Islander Australians and the lack of opportunities for members of these groups to engage with each other. It means that people seldom get any further than explaining that there is in fact an issue – raising the awareness of ‘others’. Specific strategies employed to reduce this barrier in the context of the conference included raising some issues in information provided to presenters in advance and in publicity materials, striving to establish groundwork when facilitating the plenary sessions and of course providing networking spaces, etc. These could be built on and further strategies developed.

Doing diversity requires us to move beyond pointing out that there is an issue, to share the power we respectively have and to empower marginalised groups to network and strategise, to build issue-based coalitions, develop strategies and act to address the complex needs of a fundamentally, multidimensionally diverse community. The National LGBTI Health Alliance strives to facilitate these processes, for example through networks and the Health in Difference conference, and we are collectively learning as we go.

Although we know that learning from Health in Difference 2010 will spread with the stories that participants are telling across the country and in the networks that were formed, as advocates and committed allies/partners (and a former academic – Gabi), we acknowledge the power of publication and would have liked to see more of these stories in print.

The under-resourced LGBTI health and wellbeing sector currently has limited capacity to establish mechanisms to support marginalised groups to overcome the numerous barriers to participation. However, we suggest that we actually have extensive knowledge of how to empower ourselves and others, work inclusively and ‘do diversity’ on which we can build. Doing diversity is not something ‘extra’ but core to achieving our collective goals of improved health and wellbeing for LGBTI people. We demonstrated the positive impact of a range of inclusion and coalition building
strategies in the Health in Difference 2010 conference, and many of these could be implemented well in other contexts too. We need to be exploring and implementing further strategies in relation to the dissemination of knowledge arising from events such as this to 'do diversity' better and amplify the impact of our learnings.

Author Notes

Gabi Rosenstreich is the Executive Director of the National LGBTI Health Alliance, and was convener of Health in Difference 2010: Doing Diversity. Empowerment, discrimination and diversity generally and intercultural, gender and queer inclusion specifically have always been a particular focus of her work as a researcher, policy analyst, manager, consultant and educator. Gabi has presented and advised widely on inclusive practice and multidimensional difference and continues to learn how to 'do diversity'. Contact: GRosenstreich@yahoo.de

Sally Goldner has been out of the gender closet for over 15 years and an active participant in Melbourne’s queer community for the last 12. This includes ongoing involvement with TransGender Victoria, especially participation in achieving trans EO law in Victoria, 3CRs Out of the Pan, VGLRL and the Zoe Belle Gender Centre. Sally is a member of the National LGBTI Health Alliance and was part of the organising committee for the Health in Difference 2010: Doing Diversity conference, at which she also presented. In her ‘day job’, she is an accountant specialising in the not-for-profit sector. Contact: enquiries@transgendervictoria.com

References


BOOK REVIEW

GIPSY HOSKING


Becoming Parent is an enticing read about what it means to be a lesbian or gay parent in Western society. This book highlights how the very category of 'parent' is used as a tool of oppression. For lesbian and gay parents their experience of parenting is influenced and shaped by a complex intersection of disadvantage and privilege depend on their particular circumstances.

One of the strengths of the book is that Riggs avoids homogenising the experience of all gay and lesbian parents. Rather, he draws out differing experiences based around gender, race and other factors. Most of the claims that lesbian and gay parents are, or can be, 'good' parents are made by, and for, white middle class couples at the detriment of non-white, working class and single parents regardless of their sexuality.

Drawing on his knowledge of psychology and using his experience as a gay foster parent Riggs is able to deconstruct the process in which we 'become parent' in relation to the children which we care for.

The main premise of the book is that by using parent as a verb rather than a noun, and exploring the ways in which we 'become parent', we can circumnavigate the privileging of biological bonds and the traditional construction of the family though heterosexual relations. In this way society is able to recognise more diverse family structures.

Riggs takes the reader on a challenging jour-
HOSKING: BOOK REVIEW

critiques this argument in *Becoming Parent* and forces myself and others to question what language and arguments we use to justify our families. Riggs summarises the persistent tension arising when your family status is subject to the recognition of others when he say “I feel like I am both always and never a parent”.

It would have been an interesting extension of the work in *Becoming Parent* to explore the experiences of children with lesbian or gay parents (as the author does elsewhere). This would further disrupt the assumptions of parental ownership over children and also fully acknowledge children’s active role in creating and shaping the families they form part of.

*Becoming Parent* addresses an important gap in the literature on lesbian and gay parenting which up until now has largely ignored both the experience of lesbian and gay foster parents and parenting in the specific Australian context.

Not only does Riggs make an important contribution to the academic field, but he does so by employing a writing style that is accessible to those outside of academia. Riggs describes his work as “part autobiographical, part pedagogical, part political” which makes for an interesting and engaging read. His work is refreshingly honest, revealing the conflicting emotions of pain, loss, joy and love, which accompany the parenting process.

**Authors Note**

Gipsy Hosking is a recent graduate of the University of Adelaide. She has same-sex parents and has recently been doing research into the experiences of children with lesbian or gay parents. She can be contacted at ghosking@internode.on.net
CALL FOR PAPERS

TRANS BODIES, LIVES & REPRESENTATIONS

Special Issue of GLIP Review, April 2011
Editor: Damien W. Riggs

To date, research on the experiences of trans people within the social and health sciences has largely focused upon either describing the lives of trans people or reflecting upon gender categories through the lens of trans embodiment. New avenues of critical research, however, have increasingly called for the extension of research on, with and by trans people to encompass other aspects of trans identities, and importantly, to consider the role of non-trans researchers in the field and to reflect upon the functioning of gender norms more broadly in the production of trans experience. This special issue seeks to contribute to this agenda by gathering together a collection of cutting-edge research on gender, trans issues, and social norms in relation to embodiment and identity.

We welcome full length empirical and theoretical papers (6000 words) as well as shorter commentary papers (2000 words) that address (though are not limited to) the following issues:

- Attitudes towards trans people amongst non-trans communities
- Media representations of trans people
- Critical examinations of previous literature on trans people
- Writing by trans people as well as writing by non-trans people that critically examines the location of the latter in this field
- Research on the specific health needs of trans people
- Research exploring the intersections of sexuality and gender in the lives of trans people

Papers should be submitted to the special issue editor via email by January 15th 2011: Damien W. Riggs [damien.riggs@adelaide.edu.au] Reviews will be returned to authors by early February 2011 with final revisions to papers due mid March 2011. Early submissions are very much welcome. If you have any questions about a potential submission, please direct these to the special issue editor.
CALL FOR PAPERS

ACCESSING QUEER DATA IN A MULTIDISCIPLINARY WORLD

Special Issue of GLIP Review, August 2011
Editors: Gareth Treharne & Chris Brickell

What are the current challenges in accessing queer data that are faced by researchers and members of the communities with whom we carry out our research? How do we define queer data? And how do we define queer communities/stakeholders? Who has power in these definitions and who sets the research agenda for research on queer issues? What are the implications of disciplinary boundaries for research on queer issues? These are some of the questions that we want to raise in a special issue of Gay and Lesbian Issues in Psychology Review: ‘Accessing queer data in a multidisciplinary world’. We hope to open up debate about the ongoing need for interrogation of epistemological, methodological and personal reflexivity, and question the divide between researcher and the researched.

We welcome full length empirical and theoretical papers (6000 words) as well as shorter commentary papers (2000 words) that address the following issues:

- The value and caveats of a range of different research methods, including: reviews of literature and policy documents, archival research, visual methods, interviewing, ethnography, practitioner reflection, surveying and experimental manipulation.
- Theoretical and pragmatic insights from the multitude of critical social science disciplines (e.g., anthropology, ethnomusicology, historiography, social work, sociology) that will help to enliven psychological research on queer issues.
- The ethical issues involved in identifying queer participants/data in a range of settings, and the potential solutions that promote inclusive consideration of queer communities/stakeholders.
- Experiences of research participants as well as researchers.

Papers should be submitted to the special issue editors via email by 15th February 2011: Gareth J. Treharne [gtreharne@psy.otago.ac.nz] and Chris Brickell [chris.brickell@otago.ac.nz]. Reviews will be returned to authors by late March 2011 with final revisions to papers due mid May 2011. If you have any questions about a potential submission, please direct these to the special issue editors.
Preparation, submission and publication guidelines

Types of articles that we typically consider:

A)  
Empirical articles (7000 word max)  
Theoretical pieces  
Commentary on LGBTI issues and psychology

Research in brief: Reviews of a favourite or trouble-some article/book chapter that you have read

B)  
Conference reports/conference abstracts
Practitioner's reports/field notes  
Political/media style reports of relevant issues

Book reviews (please contact the Editor for a list of books available & review guidelines)

The Review also welcomes proposals for special issues and guest Editors.

Each submission in section A should be prepared for blind peer-review if the author wishes. If not, submissions will still be reviewed, but the identity of the author may be known to the reviewer. Submissions for blind review should contain a title page that has all of the author(s) information, along with the title of the submission, a short author note (50 words or less), a word count and up to 5 key words. The remainder of the submission should not identify the author in any way, and should start on a new page with the submission title followed by an abstract and then the body of the text. Authors who do not require blind review should submit papers as per the above instructions, the difference being that the body text may start directly after the key words.

Each submission in section B should contain the author(s) information, title of submission (if relevant), a short author note (50 words or less) and a word count, but need not be prepared for blind review.

All submissions must adhere to the rules set out in the Publication Manual of the American Psychological Association (fifth edition), and contributors are encouraged to contact the Editor should they have any concerns with this format as it relates to their submission. Spelling should be Australian (e.g., 'ise') rather than American ('ize'), and submissions should be accompanied with a letter stating any conflicts of interest in regards to publication or competing interests. Footnotes should be kept to a minimum. References should be listed alphabetically by author at the end of the paper. For example:


References within the text should be listed in alphabetical order separated by a semi-colon, page numbers following year. For example:

(Clarke, 2001; Peel, 2001; Riggs & Walker, 2004)
(Clarke, 2002a; b) (MacBride-Stewart, 2004, p. 398)

Authors should avoid the use of sexist, racist and heterosexist language. Authors should follow the guidelines for the use of non-sexist language provided by the American Psychological Society.

Papers should be submitted in Word format: title bold 14 points all caps left aligned, author 12 points all caps left aligned, abstract 10 points italics justified, article text 10 points justified, footnotes 9 points justified.

All submissions should be sent to the Editor, either via email (preferred): damien.riggs@adelaide.edu.au, or via post: School of Psychology, The University of Adelaide, South Australia, 5005.