MENTAL HEALTH SERVICES AND SEXUAL/GENDER MINORITY CLIENTS

IN BANGKOK, THAILAND:

VIEWS BY SERVICE USERS AND SERVICE PROVIDERS

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The purpose of this qualitative study was to explore how professional Thai mental health practitioners and sexual/gender minority clients view sexual/gender minorities and the provision of mental health services for them.

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ABSTRACT

This qualitative study explored how Thai psychologists, psychiatrists and their sexual/gender minority clients view these minorities and professional mental health services in Bangkok, Thailand. 16 Bangkok-based Thai nationals were interviewed (3 gay clients, 3 transgendered client, 1 other client, 5 psychologists, and 4 psychiatrists). Neither clients nor practitioners openly viewed homosexuality as abnormal; views on transgenderism were more diverse. Only 1 psychologist viewed either as changeable, and added that only he offers therapy aimed at sexual orientation change in Thailand. Services openly based on a pathologizing model of homosexuality thus seem rare in the context. Many practitioners viewed service provision to sexual/gender minority clients as little or no different from other service provision, but also expressed views about distinct characteristics of such clients or issues that need to be considered when providing services to them. Parental pressure, sexual/relationship issues, depression, and SRS readiness evaluation were some key issues among these client groups. Key problems in service provision include lack of personnel resources on the public sector (allowing few opportunities for counseling); stigmatization of service use, and low level of practitioner knowledge, especially on community resources. Sufficient budgeting, training, and online/hotline services are ways to address these problems.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

Note on Transcription Method

This thesis uses a modified version of the Royal Thai General System of transcription (RTGS) for writing Thai words in Latin script. While RTGS is a semi-official Thai Romanization system, the resulting script fails to differentiate certain important features of the Thai language. This thesis therefore uses a modified version of the system, similar to that used in Ojanen (2009).

To distinguish between short and long vowels, this modified system represents long vowels by a doubled vowel symbol (e.g., "aa" in "*chaai-rák-chaai* is a long vowel, while the "a" in "rák" is a short vowel). Excepted are Thai vowels that do not have a single-letter symbol in the Latin alphabet, such as [-oei] in *kàthoei*, and would be difficult to distinguish in this way. The two Thai o sounds (ออ and โอ), both of which roughly approximate the English oh but are differentiated sounds in Thai, are differentiated here by underlining the former in transcription (e.g., the underlined <u>ŏo</u> in *m<u>ŏo</u>* refers to the ออ sound; the not underlined oo in *rôok* refers to the โอ sound). The sound represented by the letter จ is distinguished from the sound represented by the letters ช, ฉ and ฌ by using the Latin letter "j" for the former, and "ch" for the latter.

Tones are indicated by tonal marks placed on the vowel in each syllable, as follows: [´], high tone; [`], low tone; [˘], rising tone; [^], falling tone; no tonal mark, middle tone (e.g., the first syllable in the word kàthoei has a low tone and the second syllable has a middle tone).

Exempted from these principles altogether are words borrowed from English, such as *gay, tom, dee,* and *bi,* which have been left in their original or typical form. Direct quotations also have been left in their original form. Names of people or places are referred to in their given or preferred transcription, whenever available.

CHAPTER I: INTRODUCTION

"I would like to apply for your counseling psychology degree course."

"If you're to study in the field of psychology, you'll need to behave

appropriately. If you dress as a woman, who's going to respect you?

Even in the psychological circles they won't accept you."

This interaction took place in 2006 between a Thai student, who was graduating from a Bachelor's Degree course at a Thai university, and a Thai psychologist, who interviewed her to consider her suitability to study for a Master's Degree course in Counseling Psychology, at a Thai state university. The student seemed well adjusted and had good grades from her first degree. However, a comparison between her appearance and her name, as it was given in her identification documents, revealed to the interviewer that the student was not living according to the gender she had been assigned at birth. She had what was considered a masculine name, yet her gender expression was feminine. The interviewer considered this to be proof of her inability to work with people and persuaded her to drop the application. She told the story to the author in person.

This interaction illustrates that those inhabitants of Thailand, who differ from the gender-normative, heterosexual norm (referred to as *sexual/gender minorities* in this thesis) still face discrimination in their lives. This might increase their need for various kinds of support, including counseling. However, as the account shows, psychologists' views may still reflect society's biases. Thus, if counselors also have these kinds of bias, they may be more a part of the problem (discrimination) than the

solution (assisting sexual/gender minority people to lead meaningful and fulfilling lives on an equal footing with those belonging to the sexual/gender mainstream).

One major debate in the field of counseling has been whether a single approach can equip a counselor to work with all kinds of clients, or if knowledge of specific client groups is necessary for a counselor to effectively work with a client from specific populations. The poles of this debate are what have been called divergent (i.e., context-specific) and convergent (i.e., universalistic) approaches (see Patterson & Watkins, 1996, for an account of the debate).

Those who hold a universalistic view believe that some core competences can equip a counselor to work efficiently in all contexts and with all clients. Carl Rogers (1961), for example, strongly tended towards this view:

> The process of psychotherapy, as we have come to know it from a client-centered orientation, is … exhibiting a lawfulness and order which is astonishing in its generality. As I have become increasingly impressed by the inevitability of many aspects of this process, I likewise grow increasingly annoyed at the type of questions which are so commonly raised in regard to it: "Will it cure a compulsion neurosis?" "Surely you don't claim it will erase a basic psychotic condition?" "Is it suitable for dealing with marital problems?" "Does it apply to stutterers or homosexuals?" (p. 74)

In contrast, context-specific approaches, such as counseling influenced by the *multicultural movement in psychology,* hold that some knowledge of a given group or the issues its members typically face is necessary to design and provide optimally helpful counseling to members of that group (e.g., Sue & Sue, 1999):

> In order to be culturally competent, mental health professionals must be able

to free themselves from the cultural conditioning of their personal and

professional training, to understand and accept the legitimacy of alternative

worldviews, and to begin the process of developing culturally appropriate

intervention strategies in working with a diverse clientele. (p. ix).

Failing this, "forms of treatment may represent cultural oppression …that may do

great harm to culturally[1] different clients" (Sue & Sue, 1999, p. ix.). Thus, Sue and

Sue, for example, have not only focused on *ethnic* minorities within the United States,

but also on "four other groups who have experienced *systematic marginalization and*

oppression by the dominant culture ... *gay men and lesbian women*, elderly persons,

women, and individuals with disabilities" (p. 304, emphases added).

Prior to the declassification of homosexuality as a mental illness by the

American Psychiatric Association in 1973 (followed later by other associations and

much later by many Asian countries; see Martin, 2003) it was standard practice for

psychologists and psychiatrists to consider a homosexual sexual orientation as an

illness to be cured (Neal & Davies, 1996).

The methods used to bring about such a cure have included, among others,

"neurosurgery, peripheral hormone injections, psychoanalysis, aversion therapy using

electric shocks and nausea-inducing drugs, social learning and heterosexual

assertiveness training, religious exorcism and prayer" (Davies & Neal, 1996, pp. 17-

18). All these cures share the pathologizing stance that unless the so-called patient

can change, (s)he will remain less of a fully functioning person than heterosexuals

are. Some psychologists and psychiatrists continue to provide such treatments to this

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[1] The word *culture* here refers to the actually existing cultures of different ethnic, religious, sexual and

other subcultures, rather than any state-sanctioned idealized national culture, because it is the *de facto*

cultures that most guide the lives of clients.

day, while the outcomes of such treatments remain questionable (American Psychological Association/APA, 2010).

While such treatments are an extreme case in point, the APA (2000) has also recognized that "*heterosexism* pervades the language, theories, and psychotherapeutic interventions of psychology" (p. 1441, emphasis added) in general. Heterosexism is defined as "the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community" (Herek, 1995, as cited in APA, 2000, p. 1441).

The multicultural view on counseling asserts that, against this backdrop of a history of marginalization and oppression of minority groups such as sexual or gender minorities, psychology needs to develop new context-sensitive approaches that actively pursue to reverse these harmful practices and replace them with working methods. APA's (2000) *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients* and related statements, such as the recent *Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts* (APA, 2010) provide recommendations for such methods, based on relevant research.

However, as the APA (2010) has stated, "age, gender, gender identity, race, ethnicity, culture, national origin, religion, disability, language, and socioeconomic status may interact with sexual stigma, and contribute to variations in sexual orientation identity development, expression, and experience" (no page number). Therefore, in line with the logic of the multicultural movement, optimal helping of the members of specific subcultural groups is also likely to depend on various cultural factors as well. It is thus hardly surprising that "the APA encourages mental health professionals to provide assistance to those who seek sexual orientation change by utilizing affirmative multiculturally competent ... and client-centered approaches"

(APA, 2010, no page number). The APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) has noted such approaches are generally known as "affirmative, gay affirmative, or lesbian, gay, and bisexual (LGB) affirmative" (p. 11).

Thailand is a context that differs considerably in terms of culture from the Western, English-speaking countries where most research on providing appropriate therapy to sexual minority individuals originates. While differences are evident on the level of mainstream culture (e.g. language, religion, traditions), they are also considerable on the level of sexual/gender minority subcultures (Ojanen, 2009). Due to such differences, counselors working in this context need to be aware that findings related to given minorities abroad may not directly translate to the Thai context.

What Thailand does share with the West is marginalization of sexual/gender minorities. Research on these minorities in Thailand suggests that while the most violent forms of homophobia are rare, heterosexism is pervasive in Thai mainstream culture, and *transprejudice* or *transphobia*[2] may play an even more harmful role in Thai society (Ojanen, 2009). Consequently, many sexual/gender minority individuals face discrimination in the Thai context, feeling "that their lives are miserable, if not a living hell, where they are threatened by public denunciation, job discrimination, malicious gossip and indirect interference in both private and working spaces" (Rattachumpoth, 1999, p. viii). Some serious concerns may to some extent be specific to sexual/gender minorities in Thailand. The author has summarized the pertinent group-specific challenges from existing literature elsewhere (Ojanen, 2009).

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[2] These terms have been defined as "feelings of fear, disgust and/or hatred towards transpeople … often expressed as discriminatory behaviour towards transpeople" (Winter, 2007, p. 1)

Like in the West, Thai sexual/gender minorities have also been pathologized by the psycho-sciences (psychology and psychiatry). Jackson (1997) has argued that the pathologizing perspective was imported from the West in the latter part of the 20th century, with little attention paid to sexuality issues within Thai psycho-sciences prior to that. While Thai society has put little emphasis on attempts to change the sexual orientation of those considered outside of its sexual norms, mainstream academic discourses have left no doubt that non-conformity with the local gender and sexuality norms have been perceived as a problem to be solved, as in the following excerpt:

> … the number of those who had homosexual behavior and those who had a high risk of being homosexual was very high. Therefore, their parents, guardians, instructors, mass media, and those who are involved in the Ministry of Education should realize this important problem and hurry to find the prevention. That is, they should be careful not to let the adolescent students- the adults-to-be who are going to be the national resources in the future have homosexual behavior so that Thailand will lack both real men and women for the future (Khunakorn, 1989, as translated and cited by Jackson, p.37).

This excerpt suggests that the pathologizing approach on minority sexualities has been a mainstream view in Thailand at a much later point in time than it was, for example, in the United States. However, studies on sexual/gender minorities completed within the last 10 years seem mostly sympathetic to them (Ojanen, 2009).

In Thailand, the Department of Mental Health (DMH; under the Ministry of Public Health) made its first public affirmation of the non-pathology of homosexuality as recently as 2002 (Martin, 2003), in a one-page document that referred to the ICD-10, issued because Anjaree, a lesbian organization, had requested

it (Martin, 2003)[3]. This affirmation of non-pathology was made later than in Japan (1995) or China (2001), as Martin (2003) has noted, and much later than the American Psychiatric Association position shift (1973). Older Thai psychiatric or sexological textbooks still portray homosexuality as a mental illness and continue to be reprinted (Chonwilai, 2007; Romjumpa, 2003) without editing the contents.

Transsexualism, on the other hand, remains a disease category in Thailand under the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Thai Modification (ICD-10-TM)* (Ministry of Public Health, 2007) as it does in other countries, except France (France Delists, 2010).

It seems likely that sexual/gender minorities' perception of the psycho-sciences (and counseling as a part of them) is affected negatively by the fact that homosexuality and bisexuality were until quite recently considered mental illnesses, and that transgenderism is still viewed as pathological. Furthermore, many existing Thai service providers are likely to have been trained under a paradigm that viewed homosexuality as pathological. These service providers might now be left confused about how to deal with homosexual and bisexual clients, if no comprehensive framework of counseling with these client groups has replaced the outdated one. The status of transgenderism is also contested.

Although there are many similarities between the concerns of sexual/gender minorities in Thailand and those living in predominantly Anglo-Saxon countries, models of helping such clients are based on what has been found best to work in those countries. They are thus not directly applicable to the Thai context due to cultural differences. Using such models without any modification might constitute yet another form of cultural insensitivity. Therefore, trust between sexual/gender minorities and

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[3] Martin's (2003) thesis contains a photocopy of the original document by the DMH as an appendix.

psychology should be built within the Thai context through creating shared understandings that are relevant within the context, together with locally based models of best practice.

If understandings regarding Thai sexual/gender minority groups, the challenges they face, or the ways in which counselors should help them, are not shared between the service providers and clients, barriers to treatment may be erected. This can happen either because such discrepancies make sexual/gender minority individuals perceive counselors as not understanding and consequently do not seek counseling, or because these discrepancies create lack of understanding or agreement during the counseling process that can reduce or completely undermine its therapeutic efficacy. To understand and dismantle such barriers, it is important to study how Thai sexual/gender minorities and Thai service providers view and treat each other.

The present research study makes an exploratory first attempt at elucidating this interface by presenting views from both mental health professionals (psychologists and psychiatrists) and from sexual/gender minority individuals who have at one point been mental health service users. Presenting these views will hopefully help to demonstrate what kinds of presenting concerns may be encountered, what are thought of as appropriate ways of helping such clients, and which characteristics of the present context are seen as barriers to effective helping.

The author self-identifies as a sexual minority individual. Prior to embarking on this research project, he had some experience in Europe (the UK and his native Finland) on the typical concerns of sexual minorities in these societies, for example through working as a volunteer telephone counselor in a Finnish sexual minority organization (Seksuaalinen tasavertaisuus ry.).

Since coming to Thailand, the author has met many Thai sexual/gender minority individuals and got to know the challenges they face, based both on personal exchanges of experiences as well as participation in public meetings on related topics, for example at the Thai National Human Rights Commission. The author also completed a counseling internship in 2006 (and has volunteered ever since) at Rainbow Sky Association of Thailand (RSAT; www.rsat.info), a Thai sexual diversity organization that serves sexual/gender minorities in Thailand and is run by them. Besides volunteering as a telephone counselor in the organization, the author has documented the organization's counseling service as a part of an article on sexual/gender minorities in Thailand (Ojanen, 2009). The author speaks, reads, and writes Thai. He believes that the characteristics outlined above have put him at a good vantage point from which to comment on the issues of sexual/gender minority individuals in Thailand. Since the author was also a post-graduate student in the field of Counseling Psychology while conducting this study, the themes mentioned above came together in this thesis.

The author has a firm belief that counseling can be helpful to sexual/gender minority individuals in Thai society, just as it can for heterosexual, gender-normative individuals. However, the author also believes that in order to be effective, counseling must be practiced in ways that compromise between what is acceptable for a culture (Thai mainstream culture), a sub-culture (local sexual/gender minority cultures), a professional approach (the practice of counseling or psychotherapy), and the idiosyncratic needs of individuals. Serious study seems to be called for in order to tease out the details of this synthesis.

Although this great synthesis may not be reached by a single research study, the process leading to it can be initiated by studying the existing constructions that the

clients and the counselors hold. Therefore, a study is reported below that explores the

constructions related to counseling, gender/sexuality related concerns, or their

intersection, both in the service provider community and in sexual/gender minority

individuals that have been counseling clients.

Statement of the Problem

Prior to the study, it was not well known how counselors and sexual/gender

minorities in Thailand construct issues related to gender/sexuality, counseling, and

their intersection. It was unclear whether there were discrepancies among these

constructions that might constitute barriers to effective counseling. If applicable

context-specific models for counseling with sexual/gender minority clients existed in

some professional contexts in Bangkok, they were not well known or publicized. If

counselors lack access to such models, the quality of their work with sexual/gender

minority clients may suffer, and sexual/gender minority clients may lack trust in

service providers.

Purpose of the Study

This study elucidates the current state of counseling with sexual/gender

minority clients in Bangkok, Thailand. The study examines the views and experiences

of counselors and sexual/gender minority clients on topics related to counseling with

sexual/gender minorities, in order to provide counselors a way to reflect on their own

views and practices and compare these with the views of their colleagues and their

clients. By doing so, the study aims to facilitate counselors to improve the quality of their work with sexual/gender minority clients in Thailand.

Significance of the Study

This study specifically examines professional counseling with sexual/gender minority clients in Thailand, which apparently had not been done before. The findings may help counselors, psychotherapists, social workers, and practitioners in related fields to understand their sexual/gender minority clients and consequently help them better in the Thai context. This increased understanding might lead to the creation of context-specific counseling models. Educators, clerics, administrators, other professionals and volunteer helpers may also be able to use the findings to make their work more sensitive for sexual/gender minority issues. The findings might also be useful for furthering self-understanding among sexual/gender minority individuals in Thailand on how the societal context influences their lives and how counseling can be used for coping with such influences. Sexual/gender minority organizations might use the findings in order to organize or reorganize their counseling services. All of these improvements may in turn result in an improvement in the mental health and the quality of life of sexual/gender minority individuals in Thailand.

Questions Guiding the Study

1) How do Thai sexual/gender minority individuals view themselves and counseling in light of their own experiences with it? How do they view it could be made more responsive to their needs?

2) How do Thai counselors view sexual/gender minority individuals and the practice of counseling with them? What do they view are main presenting concerns and appropriate responses to them? What do they think are barriers to effective treatment and how these barriers might be dismantled?

3) Do the views of Thai counselors and clients on these issues differ to the extent of constituting barriers to mutual understanding and trust?

Basic Assumptions

In the author's view, the question of whether (and to what extent) a given society can permit sexual and gender diversity or whether it should attempt to impose universal, compulsory, gender-normative heterosexuality, is a *value judgment*, not a scientific question. This research study itself operates on the assumption that Thai society, among others, should permit maximal sexual/gender diversity to accommodate the actually persisting diversity, forbidding and attempting to curb only such forms of sexual or gender expression as clearly and directly harm other people (e.g., rape), because repressing harmless aspects of gender identities and sexualities is likely to cause unnecessary suffering to those for whom they form an important part of personal identity.

From the different possible answers to this value question, distinct psychological paradigms arise; the task of their effective formulation, on the other hand, results in a variety of scientific questions. If a society allows maximal sexual diversity, then the task of the psycho-sciences is to assist and empower members of

sexual/gender minorities to live as meaningful and fulfilling lives as possible, without having to repress their self-asserted gender, gender identity or sexual orientation.

On the level of epistemology of the present study, the author views the universe *as we know it* as (multiply) socially constructed. This means that the experiential world of each human being is the result of active attempts at making sense of our sensory perceptions, and that this process is also intricately social, since social practices, including language, are ways through which we construct our meanings and therefore influence the shape of the resulting constructions. However, the author deems that it is not necessary to specifically assume or deny the existence of an underlying objective reality for the purposes of this study. The author simply assumes that human beings currently do not have any direct access to such a realm.

As for the methodology of the present study, the researcher set out with a qualitative approach that attempted to minimize theoretical assumptions. However, the study was guided by a central assumption that especially when existing research on a given topic within the human sciences is scarce, the field may best benefit from an open-ended and loosely structured exploratory approach. It was the contention of the author that fixing questions and possible responses at such a time would necessarily bias the inquiry to an undesirable extent. A flexible schedule for semi-structured interviews was thus considered the most appropriate research tool.

Limitations

Since this study is exploratory, it cannot confirm whether any particular counseling maneuver is more effective than another. It has a small sample size due to practical limitations and is thus unlikely to accurately represent the whole populations

of practitioners and sexual/gender minority clients. However, the findings may be useful in creating a first impression on problems and methods of solving them.

Because the mother tongue of the researcher is not Thai, some nuances of the participants' accounts may have been overlooked (see pages 8 to 9).

A more serious limitation is that the author was unable to find any lesbian informants with experience of having been a client of mental health services. Their experiences are thus represented in this study only through a few second-hand accounts by some practitioner participants.

Delimitations

This is an exploratory qualitative study that focuses on the discourses that can be found among professional counselors (psychologists and psychiatrists) and sexual/gender minority individuals, who have been a client of mental health services at least once. All data was collected in the Bangkok metropolitan area. The findings are thus most representative of the context of Bangkok and its suburbs.

Definition of Terms

In this thesis, the terms *counselor* and *practitioner* are used in a broad sense covering psychologists, psychotherapists and psychiatrists. The word *counseling* is used interchangeably with *psychotherapy,* unless otherwise stated.

The expression *sexual/gender minorities* is used throughout this thesis as a collective term for Thai gays, lesbians, transgender, bisexual, and intersex people, as well as other similar minorities (see pp. 28-36 for details of these groups). Use of the

term is based on the author's previous review article (Ojanen, 2009), which

introduced the term to reflect the fact that most of the identified Thai minorities are

minorities both in terms of sexual orientation and gender – in Jackson's (2003, ¶86)

words, "while having distinctive erotic interests and objects of sexual fascination,

each of the modern Thai identities is a gender more than it is a sexuality." However,

this usage is not extended to Western sexual minorities which are still seen

internationally more exclusively in terms of sexual orientation.

CHAPTER II: REVIEW OF RELATED LITERATURE

Scope of the Review

This chapter first reviews two sets of current guidelines outlining psychological best practices in providing assistance to homosexuals and bisexuals on one hand (APA, 2000) and to transgendered people on the other (by the World Professional Association for Transgender Health, formerly known as the Harry Benjamin Gender Dysphoria Association; Meyer et al., 2001), together with related literature, in order to chart the levels of acceptance and understanding that Western psycho-sciences have on sexual/gender minorities.

This is followed by a brief comparison about Thai and Western sexual/gender systems. The purpose of this comparison is to familiarize the reader with how sexual diversity is conceptualized in Thailand, and how this conceptualization differs from the Western world. This is crucial for understanding the need for locally developed models on counseling with sexual/gender minority clients in a context like Thailand.

After this, estimates of sexual/gender minority prevalence in Thailand are considered to provide an indication of the size of the potential client population.

Finally, the scant already existing information about the state of counseling with sexual/gender minorities in Thailand is reviewed.

As this information is fragmentary, the review concludes that currently very little is known about how mental health professionals are or should be helping their sexual/gender minority clients in Thailand. Through identifying this gap within the existing literature, the review concludes by arguing for the need for a comparative

study on service provider and sexual/gender minority individuals' constructions on counseling with sexual/gender minority clients, which is described in Chapters 3 to 5.

Western Psychological Perspectives on Homosexuality and Bisexuality in Counseling

Whenever homosexuality has been a topic of public debate, it seems that there has always been some kind of hegemony in the discourses that explain it, together with dissenting voices that question that hegemony (Narrain & Chandran, 2005). For example, Havelock Ellis, Magnus Hirschfeld and Karl Ulrichs saw homosexuality a natural variant of sexual behavior at a time when the hegemonic view saw it as an illness (Narrain & Chandran). Today, the hegemonic view within the psycho-sciences is, as the APA has held since 1975, that "homosexuality per se implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" (Conger, 1975, as cited in APA, 2000, p. 1440), but some psychiatrists and psychologists still disagree (e.g., Nicolosi, 1993).

The APA guidelines now recommend that all psychologists "understand that homosexuality and bisexuality are not indicative of mental illness" (APA, 2000, p. 1441). This view followed historically the decision by the American Psychiatric Association in 1973 to remove homosexuality as a disease category from the Diagnostic and Statistical Manual, 3rd edition (DSM-III), and was subsequently followed by numerous other professional associations, as well as the World Health Organization's (WHO) International Classification of Diseases (Martin, 2003).

The DSM-III had a category of *ego-dystonic homosexuality* that was used for providing a diagnosis for those homosexuals and bisexuals who were dissatisfied with their sexual orientation. However, following criticism that practically all homosexuals

are dissatisfied with their sexual orientation at one point or other due to societal pressures, this category was removed (see Narrain & Chandran, 2005, for a historical account). While ego-dystonic homosexuality is not listed in later editions of the DSM (such as the DSM-IV-TR; American Psychiatric Association, 2000a), *ego-dystonic sexual orientation* remains in the ICD-10, published by the World Health Organization (WHO, 2003), and its Thai version *ICD-10-TM* (Ministry of Public Health, 2007). According to Narrain and Chandran, in India this category still forms the basis of treating homosexuality as an illness. Since Thailand also uses the ICD-10, this category might be used for the same purpose in Thailand.

Due to the long-lived beliefs in the pathology of minority sexualities in Europe and North America (held by both counselors and lay people), the relationship between counselors and their sexual minority clients has been for a long time ridden by clients' mistrust and service providers' misunderstandings (Davies, 1996a).

When counselors view minority sexualities as pathological, they may apply a variety of methods to convert a client into heterosexuality (e.g., Nicolosi, 1993). However, even a controversial study (Spitzer, 2003) that used a highly religious and change-motivated sample, and self-report as the sole means of data collection, had to conclude that reports of a complete change in sexual orientation were uncommon. Based on this and other pieces of evidence, the APA thus has concluded that "there is insufficient evidence to support the use of psychological interventions to change sexual orientation" (APA, 2010, no page number).

Thus, improving the client's quality of life is probably a more meaningful focus of therapy than attempting to change the client's sexual orientation. The APA (2010) now

advises parents, guardians, young people, and their families to avoid sexual

orientation change efforts that portray homosexuality as a mental illness or

developmental disorder and to seek psychotherapy, social support and

educational services that provide accurate information on sexual orientation

and sexuality, increase family and school support, and reduce rejection of

sexual minority youth. (no page number)

However, it remains that counselors who believe that a client's homosexual or

bisexual orientation is indicative of mental illness are likely to view that sexual

orientation as a major source of the client's psychological difficulties (Garnets et al.,

1991; Liddle, 1996; Nystrom, 1997, as cited in APA, 2000), which can compromise

the effectiveness of the interaction (APA).

Furthermore, there exists "now a large group of professionals who feel sure

same sex sexuality is not pathological but who lack the information they need to

contradict prejudicial learning from their culture and their own psychological and

therapeutic training" (Neal & Davies, 1996, p. 1). To help counselors with this task,

several theoretical concepts have been developed.

The concept of *homophobia* is probably the most widespread among these

theoretical constructs. According to Davies (1996a), this concept was first coined by

Smith (1971, as cited in Davies), but made popular through Weinberg's (1972, as

cited in Davies, p. 41) definition, "the dread of being in close quarters with

homosexuals – and in the case of homosexuals themselves, self-loathing." Originally,

this concept was thought to be a form of individual psychopathology, similar to other

phobias (Davies). In the case of self-loathing by homosexuals (or bisexuals), it would

be referred to as *internalized homophobia.* When referring to discriminatory societal

practices, the term *institutionalized homophobia* is used (Davies).

Although often used, there seems to be no consensus as to the actual meaning or range of applicability of the concept of *homophobia* (Davies, 1996a). It is debated if homophobia can be thought of as one individual phobia among others, or if it inaccurately labels a societal problem as an individual pathology (Herek, 1991, as cited in Davies, 1996b). Herek has argued for the latter and the discontinuation of the use of the term, whereas Davies has viewed that the term should be kept in use in its narrower meaning of situations when an actual "fear response to homosexuality" (p.42) takes place in an individual.

Davies (1996a) has used the term *anti-gay prejudice*, which may be laden with less theoretical baggage than the word homophobia, as it simply refers to one prejudice among others, traceable to societal mechanisms like others (Davies).

A more precise, related concept is *heterosexism* (Davies). As the word implies, the concept is built on the model of *sexism* — discriminatory beliefs and practices that oppress women for the supposed advantage of men (Davies). Likewise, heterosexism refers to beliefs and practices that oppress sexual minorities for the advantage of heterosexuals (Davies). Herek (1995, as cited in APA, 2000, p. 1441), has defined it as "the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community."

The concept of heterosexism is broader than that of homophobia and can tap at mechanisms that are not adequately referred to by the word homophobia. Both homophobia and heterosexism are useful concepts when evaluating what specific concerns sexual minority clients might bring to counseling, and also useful in evaluating whether particular aspects of counseling are fair or discriminatory.

To counter the effects of heterosexism, APA guidelines urge psychologists to "recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues

may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated" (APA, p. 1441). The guidelines further caution that when "psychologists are unaware of their negative attitudes, the effectiveness of psychotherapy can be compromised by heterosexist bias" (APA, p. 1441), since when "heterosexual norms for identity, behavior and relationships are applied to lesbian, gay or bisexual clients, their thoughts, feelings, and behaviors may be misinterpreted as abnormal, deviant, and undesirable" (APA, p. 1441).

The APA (2000) guidelines also explicitly state that simply ignoring the related issues "denies the culturally unique experiences of a population … [and] is also likely to pervade that work in a manner that is unhelpful to clients" (APA, p. 1442), or in other words, when "psychologists are uninformed about the unique issues of lesbian, gay, and bisexual people, they may not understand the effects of stigmatization on individuals and their intimate relationships" (APA, p. 1442).

The APA guidelines therefore strongly encourage psychologists to "seek training, experience, consultation and/or supervision to ensure competent practice with these populations when necessary" (APA, 2000, p. 1442), and further specified certain key issues (APA, p. 1442):

> …an understanding of human sexuality; the "coming out" process and how variables such as age, gender, ethnicity, race, disability; and religion may influence this process; same-sex relationship dynamics, family of origin relationships, struggles with spirituality and religious group membership; career issues and workplace discrimination; and coping strategies for successful functioning.

In conclusion, the APA currently has a comprehensive set of guidelines for counseling with certain sexual minority groups in the US. The guidelines are practical

in nature and synthesize an extensive body of research into a single framework. They also constitute a challenge, particularly for those counselors for whom LGB clients are not the only minority they work with, in calling for extensive understanding in various sectors of their LGB clients' lives. While the guidelines might offer new perspectives also for the Thai context, their applicability should be directly evaluated within this context, or similar guidelines built on locally applicable research evidence.

International Psychological Perspectives on Transgenderism

The APA (2000) guidelines on homosexuality and bisexuality reviewed above represent a relatively solid understanding and a sense of consensus within the psycho-sciences in the US. For transgenderism, a similar set of guidelines is issued by The World Professional Organization for Transgender Health (http://www.wpath.org/). In full, the latest guidelines are known as *The Harry Benjamin Gender Dysphoria Association's standards of care for gender identity disorders, Sixth version* (Meyer et al., 2001), preserving the earlier name of their issuing organization. These guidelines are below referred to as the SOC (standards of care).

The current official status of transgender issues within the psycho-sciences differs from that of homosexuality or bisexuality, because transgenderism is still considered a mental disorder – Gender Identity Disorder in the DSM-IV-TR (American Psychiatric Association, 2000a), and Transsexualism in the ICD-10 (World Health Organization, 2003) as well as in the ICD-10-TM (Ministry of Public Health, 2007). Both systems also provide other related diagnostic categories. The main justifications for having diagnostic categories for transgender identities are that

these are frequently associated with mental suffering, and that a diagnosis is often necessary for obtaining transitioning treatments (Meyer et al., 2001).

The SOC have been issued since 1979, in order to articulate professional consensus (to an extent) on the best known practice to create "lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment" for "persons with gender identity disorders" (Meyer et al., 2001, p. 1). These guidelines, unlike the APA guidelines reviewed in above subchapter, are provided for a larger group of professionals (for example, psychologists, psychiatrists, counselors, surgeons) and this is reflected in their content. Although all of the contents are relevant for those professionals dealing with a transgendered individual undergoing physical transformations, only a part refers explicitly to psychotherapy or counseling. This is explainable by the broad role the SOC suggest for mental health professionals (Meyer et al.):

1. To accurately diagnose the individual's gender disorder;

2. To accurately diagnose any co-morbid psychiatric conditions and see to their appropriate treatment;

3. To counsel the individual about the range of treatment options and their implications;

4. To engage in psychotherapy;

5. To ascertain eligibility and readiness for hormone and surgical therapy;

6. To make formal recommendations to medical and surgical colleagues;

7. To document their patient's relevant history in a letter of recommendation;

8. To be a colleague on a team of professionals with an interest in the gender identity disorders;

9. To educate family members, employers, and institutions about gender

identity disorders;

10. To be available for follow-up of previously seen gender patients. (p. 6)

In other words, psychotherapy/counseling is seen as simply one component of the

mental health professional's work with transgendered individuals.

However, these SOC refer to the treatment of gender identity disorders, which

is not the same as the psychological treatment of transgender individuals. A person

diagnosed as "having Transsexualism" is more than their so called disorder. They are

persons whose mental health needs may be as broad as anyone's. Thus, by extension

from the case of LGB clients, counselors should be wary of broad interpretations that

construe any problems that a transgendered client has, as reflections of their gender

concerns. However, the SOC target specifically the treatment of the gender concern

(or helping an individual who is dealing with gender issues).

The combination of hormonal and surgical treatments (particularly sex

reassignment surgery/SRS) and a real-life experience of living in society as a member

of the self-assigned gender is called *triadic therapy* (Meyer et al., 2001). The SOC

state that "psychotherapy is not an absolute requirement for triadic therapy" (Meyer et

al., p. 11), and that there is no minimum number of psychotherapy sessions that need

to be conducted in order to start triadic therapy. No minimum number is stated so that

psychotherapy/counseling can be perceived as a real opportunity for personal growth,

instead of being "construed as a hurdle" (Meyer et al.., p. 11).

Since being transgendered often involves stressful experiences, psychotherapy

is, however, often indicated. It should emphasize "the need to set realistic life goals

for work and relationships, and it seeks to define and alleviate the patient's conflicts

that may have undermined a stable lifestyle" (Meyer et al., 2001, p. 11), and facilitate the following kinds of processes (Meyer et al.):

1. Acceptance of personal homosexual or bisexual fantasies and behaviors (orientation) as distinct from gender identity and gender role aspirations;

2. Acceptance of the need to maintain a job, provide for the emotional needs of children, honor a spousal commitment, or not to distress a family member as currently having a higher priority than the personal wish for constant cross-gender expression;

3. Integration of male and female gender awareness into daily living;

4. Identification of the triggers for increased cross-gender yearnings and effectively attending to them; for instance, developing better self-protective, self-assertive, and vocational skills to advance at work and resolve inter-personal struggles to strengthen key relationships. (p. 13)

Besides identifying these processes, the SOC recommendations for psychotherapy state common characteristics of effective therapy, such as duration, creating a trusting relationship between the counselor and the client, the patient's right to make their own choices, and so on (Meyer et al.). The only specific recommendation is that non-judgmental exploration of gender concerns should be covered first in counseling, in order to create an appreciation in the client that the counselor has an interest in and understanding of the client's gender issues (Meyer et al.) The SOC further specify differences between treating children and adults, processes and activities of physical and social transformation, and state that mental health professionals dealing with gender identity disorders need specialized training and continued further professional development.

The SOC do not seem to be unequivocally accepted within either the professional or the transgender communities. And the SOC also state, there are limitations to current knowledge that may limit the value of the current paradigm. One of the issues of longstanding debate is whether male-to-female transgendered people are an etiologically and phenomenologically homogenous group or whether there are two main types of them (Meyer et al., 2001).

Another, even more profound issue is whether transgenderism constitutes mental illness. The representation of transgender as pathological has received criticism (e.g., Winter, 2007), as has the guidelines' emphasis on rigorous testing of the genuineness of the wish for physical transformation, which is seen by many transgendered people as a demeaning process of having to prove their sanity in order to gain access to essential medical treatment (Platine, 1997). However, WPATH has earlier responded to these criticisms through qualifying statements in the guidelines (Meyer et al., 2001) as to the possibility of carefully justified departures from the provided protocol. More recently, WPATH (2010, no page number) has published a more paradigm-shifting position statement, urging

> ... the de-psychopathologisation of gender variance worldwide. The expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative.

Winter (2007) and colleagues recently studied *transphobia* and *transprejudice* (concepts parallel to *homophobia* and *heterosexism*) in an international, seven-country study (China, Malaysia, Singapore, Thailand, the Philippines, the United Kingdom and the United States). They identified five factors in these phenomena:

1) the belief that transwomen suffer from a mental sickness

2) the belief that transwomen are not women, should not be treated as such, and should not be afforded rights as women

3) rejection of contact with transwomen in a variety of social situations, including among family members and teachers

4) rejection of contact with transwomen within one's peer group

5) the belief that transwomen engage in sexually deviant behavior

While these factors offer a good summary of the social difficulties transgendered people face, Winter has also pointed at the role that the continued pathologization of transgender plays in creating these difficulties, since there were strong correlations between factors 1, 2, and 3. In other words, those who believed transgenderism was a mental disorder, also tended to refuse the right for "transwomen" (defined as "natal males living female lives") to be seen as women, and had difficulty accepting any personal contact with them (Winter). Winter (2007, p. 3) has thus drawn the conclusion that "a mental-disorder model of transgenderism may support and encourage key transphobic attitudes" and argued for a model that reconstructs the issues as somatic complaints.

Sam Winter (personal communication, 10 March 2010) has also expressed concern about the new term, *Gender Incongruence,* proposed for the DSM 5, since the proposed criteria as of 2010 do not include distress in the person being diagnosed:

Those transpeople worldwide who are comfortable with their bodies, whose bodies do not in any way undermine their sense of being female (or indeed male), and who do not have any need for medical support at all, are therefore at risk of being regarded as mentally disordered and (if they get into the hands of a doctor) being diagnosed as such.

This criticism is also included in a formal commentary made by WPATH (DeCuypere, Knudson, & Bockting, 2010) on the proposed new category.

In conclusion, there is considerable debate as to whether transgenderism should be viewed as a mental disorder or not. The SOC reviewed above considered that "use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments" (Meyer et al., 2001, p. 6). Some, such as Winter (2007), have argued that these advantages could be maintained by reconstructing the issues as a somatic diagnosis, which would have the further benefit of helping to gradually reduce and eventually eliminate *transphobia* and *transprejudice* from society.

If the latter position should take precedence in the academic community, guidelines of best practice with transgendered clients might one day look quite similar to those used by the APA (2000) for gay, lesbian and bisexual clients today[4]. If one takes this line, using the APA guidelines by simply replacing the words homosexual or bisexual with the word transgendered may be more helpful for counselors dealing with transgendered clients than an immersion in the mental-disorder view of transgenderism. However, there are some distinct transgender concerns that are not covered by the APA guidelines, such as those dealing with the challenges of physical and social transformations, and specific societal challenges that result from the non-acknowledgement of the rights of transgendered people to be seen as full members of their self-assigned gender. These are already covered to some extent by the SOC, which implies that a combination of the two models might be most helpful at present.

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[4] The APA's Task Force on Gender Identity and Gender Variance (2009) has published a thoughtful and comprehensive review of related research. It contains numerous recommendations, but it is not formulated as a set of guidelines. Nevertheless, it is a good source of information on the subject, and contains a number of references for proposed guidelines not yet endorsed by professional associations.

Comparing the Thai and Western Sexual/Gender Systems

The current Western academic understanding of sexual matters utilizes concepts like sex, gender, sexual orientation, and gender identity. Western lay people often see these in terms of binary oppositions (male-female; man-woman; heterosexual-homosexual; gender normative-gender deviant) without intermediate positions. Many Western researchers, on the other hand, have seen them as axial. For example, Kinsey, Pomeroy and Martin (1948, p. 639) stated in their classical study that "[m]ales do not represent two discrete populations, heterosexual and homosexual … The living world is a continuum in each and every one of its aspects."

However, Kinsey and his colleagues still discussed the sexual behavior of men and women in separate volumes, which suggests that they did not view anatomical sex as axial, in contrast to how they viewed sexual orientation. Later researchers, particularly anthropologists (e.g., Herdt, 1994), have argued for a non-binary conception of sex and gender, in order to be accurately account for all the data which exist for these categories. *Intersex* persons (persons born with genitalia that can not be considered either clearly male or female) are a case in point as regards sex, and *transgendered* persons are a key example in the case of gender.

In the Thai indigenous understanding on sexual/gender diversity, there is no distinction between sex, gender, sexual orientation, and gender identity; all these concepts are represented by a single word: *phêet* (Cook & Jackson, 1999). These *phêet* might be thought of as *sexual/gender categories*. According to Jackson (2003), "while having distinctive erotic interests and objects of sexual fascination, each of the modern Thai identities is a gender more than it is a sexuality" (¶ 86). They are mutually exclusive and draw on different aspects of sex, gender and sexual

orientation for differentiating between the different types (Jackson). Such categories are psychologically significant self-definitions and group identity referents for Thai sexual/gender minority persons and thus need to be taken seriously.

Thai scholars also use the Western-derived concepts of sex, gender, sexuality and gender identity, increasingly in Thai translations (e.g., Thammarongwith, 2005, has provided Thai-language explanations of these concepts). Furthermore, Thai academic writings increasingly emphasize continuity and fluidity between different sexualities (e.g. Chonwilai, 2007; Danthamrongkul & Posayajinda, 2004). While many academia-derived concepts (e.g., gender, sexual orientation) seem to have been adopted as lay concepts in Western countries, they are not much used in Thai lay discourses. English words have been borrowed to label certain phêet, but often so that the original meaning of the word is not the same as that used in Thai.

Arguably, the three traditional Thai *phêet* are man (*chaai*), woman (*yǐng*) and *kàthoei* (Jackson & Sullivan, 1999). In contemporary Thailand, men are viewed as anatomically male individuals with masculine behavior and primary sexual interest in women; women are seen as anatomically female individuals with feminine behavior and primary sexual interest in men (Maneesrikum, 2002). How long a distinct kàthoei phêet has been a part of the system is debated (Jackson, 2003). Previously applied to non-gender-normative females and males, and also intersex individuals, today the term usually denotes only people born in a male body but have more or less feminine behavior and dress, as well as sexual interest in men (Chonwilai, 2009a).

In contrast to the three-phêet model, some authors (e.g., Chonwilai & Boonmongkon, 2009) view that only man and woman are truly acknowledged as phêet in Thai society. It seems that while Jackson and Sullivan (1999) wrote about how people view these matters in non-official contexts, Chonwilai and Boonmongkon

addressed how official contexts view things "ought to be" – and how practices in such contexts are thus modeled.

In any case, the term kàthoei is universally known in Thailand. However, it often has a negative connotation (e.g., Cameron, 2006) and it can be used to derogate those who self-identify as gays, apparently because it compromises their privileged masculinity (Naksing, 2004). An even more derogatory word is *tút*, used to ridicule both kàthoeis and gays (Naksing; Sripanich, 1998). The terms *săao-pràphêet-sǒong* (Cameron; second-category girl) or *phûu-yǐng-pràphêet-sǒong* (Winter, 2006a; second-category woman) are often considered more polite terms than *kàthoei*, as is the more technical *khon-khâam-phêet* (person-crossing-phêet), a Thai translation of the word *transgender* (Bunprasert, 2007), often abbreviated as *TG* (Chonwilai, 2007). Ojanen (2009) and Winter (2002) have listed more terminology.

Thai use of the term *gay* emerged around 1965, used as the self-assigned label of masculine, male homosexuals (Jackson & Sullivan, 1999). Gays in Thai society are not defined as a binary opposite to straights (Jackson & Sullivan, 1999), and the term *heterosexual* is largely unintelligible to many Thais outside of the academic domain, its meaning already contained in the heteronormative connotations of the words *man* and *woman.* Hence, concepts like *gay man* might be considered as contradictions in terms in Thailand.

The gendered nature of *phêet* is still evident in the subcategories of gay that are commonly encountered in Thai contexts. The term *gay king* denotes a degree of masculinity and an insertive role in anal and oral sex, whereas the term *gay queen* specifies a more feminine gender expression, together with a receptive role in anal and oral sex (Danthamrongkul & Posayajinda, 2004). Gay kings are now often called *fàai rúk* (aggressor side) and gay queens are referred to as *fàai ráp* (receiving side)

(Martin, 2003). However, there are also sexually versatile Thai gays who might simply call themselves simply gay (De Lind van Wijngarden, 1999), *gay quing* (Jackson & Sullivan, 1999), or *both* (one who can do *both* in anal sex; Martin, 2003). Maneesrikum (2002) has emphasized that sexual roles of gays are by no means stable and can vary based on the experiences and preferences of both sexual partners.

In contemporary academic Thai, homosexual males are often referred to as chaai-rák-chaai (Martin, 2003), a term sometimes used interchangeably with *MSM* ("men who have sex with men"; used primarily in health promotion concerns). According to Cameron (2006), most Thai MSM do not identify as gay, and MSM is thus a more useful grouping for reaching them. MSM is an analytic category rather than an identity—although the author has encountered Thais who referred to themselves as MSM or *em* (an abbreviation of MSM). According to Cameron, NGOs sometimes use the term *MSM* to refer to male sex workers (MSWs) rather than to all men who have sex with men; the term sometimes does and sometimes does not cover săao-pràphêet-sŏong (Cameron). Because săao-pràphêet-sŏong do not identify as men, *MSM* is a problematic label for them (Cameron).

A recent large-scale study (Danthamrongkul & Posayajinda, 2004) that combined qualitative and quantitative methods and had health-promotion aims used the phrase *men who like men* (MLM) instead of MSM because MLM was what most participants called themselves.

Sinnott (1999) has pointed out that "female homosexual behavior has been part of Thai life throughout history, evidenced by representations in Buddhist temple murals, and court poetry describing sexual activity between women in royal harems" (p.95). According to Sinnott, a large segment of female homosexuality is now divided into the gendered types of masculine *tom* (from English *tom*boy) and feminine *dee*

(from English la*dy*). These terms seem to have emerged in the 1980's; Sinnott's older informants remembered having been called kàthoei in their childhood due to their non-normative gender expression.

Sinnott (1999) considered toms are transgendered and stated that the tom "identity is a fluid concept structured by class, ethnic, and educational background, but the idiom of masculinity, or 'maleness' is a consistent feature of being a *tom*" (p. 105). This masculinity shows in toms' attire, hairstyle, and behavior, as well as in being sexually interested in feminine women, or dee. Toms are stereotyped in Thai society as engaging in the traditionally masculine pursuits of "excessive drinking, smoking, gambling, and promiscuity" (Sinnott, p. 106). They are expected to take care of their partners as a man would (Sinnott). At the same time, some idealized feminine qualities, such as understanding their partners better than men could, are also supposed characteristics of toms (Sinnott). Like gays, toms are sometimes divided into subtypes. *Tom one way* refers to a tom who does not allow her dee partner to take an active role in sex, whereas a *tom two way* would allow this (Chonwilai, 2009b). According to Chonwilai, these terms have emerged within Internet communities during the last 4-5 years and are known only in limited circles.

Dees, who are more gender normative than tom in their appearance and behavior, are characterized predominantly by their sexual interest in toms (Sinnott, 1999). They attract less societal attention and criticism than toms because they are less differentiated from heterosexual women (Sinnott). The dee identity label is not universally accepted or even recognized by all partners of toms, which makes characterizations difficult (Chanchai, 2003). Sinnott (2004) emphasized that seeing tom and dee as facing the same concerns due to their homosexuality would imply ignoring the importance gender has in shaping Thai sexual identities. She also pointed

out that considerable differences can be found within both *tom* and *dee* categories.

The term *lesbian* is often seen as negatively loaded in Thailand, because it connotes female-on-female pornography produced for straight men (Chetami, 1996). However, the shortened version, *les,* is a common term for female individuals who prefer same-sex partners but who, unlike tom and dee, do not engage in strict division between masculine and feminine types (Martin, 2003). Like dee, les typically have a feminine appearance, but unlike dee, they are not predominantly sexually interested in tom. Some les state their sexual role preference with specifiers borrowed from the Thai gay culture (*les queen:* passive; *les king:* active; Chonwilai, 2009b).

The term *yĭng-rák-yĭng* was deliberately created to introduce a label for female homosexuals that would move beyond the gender-role-bound identities tom and dee; it is also used as a collective term for all female individuals who prefer same-sex partners (Sinnott, 2004).

The word bi (or *sŭea bai*) in Thai refers exclusively to males who are sexually interested in various genders (Pramoj na Ayutthaya, 2008). This exclusively male definition may result from local discourses linking bisexuality to promiscuity, which in Thai society is more acceptable for males than for females (Pramoj na Ayutthaya).

Behavioral bisexuality seems common in Thailand: Beyrer et al. (as cited in Cameron, 2006) reported that half of their sample of central Thai MSM also had casual female sex partners. However, many bisexual individuals in Thai society do not adopt a bisexual identity, and society generally does not recognize them as bisexual (Pramoj na Ayutthaya). Many bisexual male individuals define themselves as men (Pramoj na Ayutthaya). Similarly, many dees are behaviorally bisexual and perceived as such by toms, but the label bi is not used for them (Sinnott, 2004).

Indeed, some partners of toms self-identify as women (Chanchai, 2003), just as many behaviorally bisexual males identify as men.

Furthermore, in Danthamrongkul and Posayajinda's (2004) study, not only a majority of those identifying as bi, but also a considerable minority of those identifying as one of the subtypes of gay, contemplated having a female partner in the future (bi, 66.7%; king: 43.1%; both, 16.4%; queen, 3.1%). The high proportion of those with a king, both, or queen identity contemplating this is surprising in the sense that these are by definition exclusively homosexual identities. The gradual decline in the percentage contemplating having a female partner and a corresponding increase in the percentage contemplating having a male partner (bi, 36.0%; king, 34.0%; both, 44.4%; queen, 62.3%) when moving toward the more feminine types, seems to demonstrate in practice the gradual nature of sexual orientation (quite like it was conceptualized by Kinsey, Pomeroy & Martin, 1948) also in the Thai context, even though the identity labels used are constructed with reference to aspects of sexual orientation, sexual preferences, and the masculinity/femininity continuum. Danthamrongkul and Posayajinda also noted there was a continuum, and plotted the nonnormative male phêet on a continuum ranging from kàthoei to bi.

In recent studies, the newer term for both male and female homosexuals, *khon-rák-phêet-diao-kan* (person who loves the same phêet; e.g., Thanaphong, n.d.) seems to have mostly replaced the earlier *rák-rûam-phêet* (homosexual), a term that can be mistranslated as *loving intercourse* (Sinnott, 2004) and has been used in a pathologizing way (Sinnott). The even more negatively loaded *bukhon-bìeng-been-thaang-phêet* (person deviant in terms of phêet) and *lákkàphêet* (stolen phêet, or transvestite; Sinnott) seem now rare in academic writing. Newspapers and academic articles often refer to both gay and sǎao-pràphêet-sǒong as *phêet-thîi-sǎam* (third sex);

the term is sometimes also used as a self-referent (Sinnott, 2004). Transgenderism and homosexuality are sometimes confused even in academia; for example, Sripanich (1998) has referred to postoperative transgendered people as *rák-rûam-phêet*.

Thai NGOs have lobbied the term *khon-thîi-mii-khwaam-làak-lăai-thaang-phêet* (people who have sexual diversity) for a few years as a politically correct composite term for sexual/gender minorities (National Human Rights Commission [NHRC] & Rainbow Sky Association of Thailand [RSAT], 2007), but the term has not been universally accepted (NHRC & RSAT). This author views that the main weakness of the term is its incorrect implication that gender-normative heterosexuals have no sexual diversity.

Although Thai researchers and NGO activists often use English loanwords to describe sexual and gender issues, several Thai translations have also been suggested for such terms as *sex, gender, sexuality, sexual orientation,* and *gender identity.* The lack of consensus on the terminology used for these concepts may cause confusion in the field. See Ojanen (2009) for Thai translations used in the literature.

Arguably, practitioners in the context should have basic knowledge about the concepts sex, gender, sexual orientation, and gender identity, and how they are manifested in specific Thai identities, not in order to stereotype their clients but to be conversant with the terminology and its related complexities to demonstrate to their clients they are capable of understanding the issues the client is dealing with.

Prevalence of Sexual/Gender Minority Groups in Thailand and Abroad

Jackson (1999) reviewed a large number of studies evaluating the prevalence of homosexual experiences in Thailand. In a 1992 nationwide survey using stratified

random sampling, 3.3 per cent of Thai males and 1.2 per cent of Thai females interviewed reported having sexual experiences with a member of their own sex (Werasit, Phanuphak, Barry and Brown, 1992, as cited in Jackson, p. 40). Rates of any self-reported homosexual experience found among Thai Royal Army recruits ranged (by province) from 9 to 31 per cent in 1996 (Kitsiriphornchai, as cited in Jackson, p. 48). The studies reviewed show the prevalences studied vary largely by factors such as sex, age, class, education and type of locale (urban versus rural).

A recent survey (Kittisuksadit, 2008) among 411 school pupils and university students aged 12 to 24 living in various parts of Thailand found that 3.4% of the youth studied identified as homosexual and 5.2% identified as bisexual. In contrast to earlier studies, only 1.5% of the male respondents considered themselves homosexual and 5.2% as bisexual, but of the female respondents, 5.4% considered themselves homosexual and 8.4% stated they were bisexual.

Since socially stigmatized activities (such as sexual behavior with a member of one's own sex) tend to be under-reported in interview studies, actual rates are likely to be higher (Beyrer, Eiumtrakul, Celentano, Nelson, Ruckphaphunt et al., 1995, as cited in Jackson, 1999).

Male-to-female (MtF) transgender persons may see themselves as women (Luhmann & Laohasiriwong, 2006); hence they may not see themselves as engaging in homosexual behavior when having sex with a man. This might be a further source of under-reporting of so called homosexual behavior. Winter (2002, p.1) has considered an earlier estimate of 10,000 MtF's in Thailand to be "almost certainly an underestimate" and that informal estimates are as high as 300,000; this figure would comprise approximately 0.5% of Thailand's population.

The true extent of homosexual behavior in Thailand is probably found between the extremes given above. The Thai population, counting legal and illegal residents, has been estimated to be at least 65.5 million people (Cameron, 2006). Extrapolating from this figure and the lowest and highest percentile estimates given above, there would be between 786 000 and 20 305 000 people in Thailand who have some behavioral non-conformity with the heterosexual norm, plus 10 000 to 300,000 MtF's (and an unknown number of FtM's) that the above estimates do not yet cover.

Jackson (1999, p. 56) has concluded about the relevance of the studies evaluating the prevalence of homosexual behavior in Thailand:

> …rates of same-sex experience among Thai males and females fall within the range found in Western studies conducted since the end of World War II. This means that the data should not be used to argue that same-sex experience is more common in Thailand than the West. At the same time, however, the Thai results indicate that significant minorities of Thai men and women engage in same-sex eroticism, and that the interests of these people should not be dismissed by unsympathetic service providers and social policy makers with spurious claims that homosexually active people represent an insignificant section of the population whose welfare needs can or should be ignored.

This conclusion is also applicable for the purposes of this present study.

Sexual/Gender Minorities and Mental Health Services in Thailand

Unlike sometimes inferred from the tolerant veneer of Thai society, existing research suggests that sexual/gender minority people have to face a number of serious problems in their lives. For example, Rattachumpoth (1999) has referred to problems

such as the non-acknowledgement of these groups in the constitution or common law,

non-existence of legal marriage-like agreements; differential treatment of same-sex

couples in financial issues such as tax benefits, social welfare and insurance benefits;

legal non-recognition of sex change operations, persistence of negative stereotypes in

the general public, media, and academia, family ostracism, discrimination in the fields

of education and sports, negligence in provision of health services relevant to this

group, and negligence of the needs of this group as research topics. The present

author has published a review of these concerns based on recent research (Ojanen,

2009), suggesting that Rattachumpoth's (1999) account is still up-to-date in many

respects, but not exhaustive. For example, Rattachumpoth did not mention specific

problems with the military, employment discrimination or religious intolerance,

which also seem to complicate the lives of some minorities (Ojanen).

Understanding these issues helps may help counselors see their clients as parts

of their societal context, devise strategies to facilitate clients' attempts to deal with

such issues, and understand how such issues affect their clients' mental health.

Bualombai (1992) compared the mental health, measured by a validated Thai

version of the Symptom Checklist 90 (SCL-90), of homosexual and heterosexual

sample groups of 90 persons each. The homosexual group had significantly higher

scores, indicating more pathology on each of the nine areas measured by the

instrument (somatization, obsessive-compulsiveness, interpersonal sensitivity,

depression, anxiety, hostility, phobias, paranoia, and psychoticism). However, the

only sub-score in either group in the pathological range was depression in the

homosexual group. The findings seem to suggest that homosexuals have more mental

health problems than heterosexuals. However, the generalizability of the findings is

limited by three factors: 1) the findings relate to the societal context of 18 years ago,

when Thai society seems to have been less tolerant than today (which would have caused more minority stress); 2) both sample groups consisted of beauticians, entertainers and students only; and 3) the homosexual group was identified by 17 aspects of their appearance or behavior, such as "wearing tight trousers, pulling trousers high up and tightening the belt very tight so one's waist looks slender, bending knees when walking, having sissy [*krà-tûng-krà-tîng*] behavior, wearing make-up" (ibid., p.17) and so on. The identification criteria may have limited the sample to more feminine homosexuals (or indeed, transgender people). Thus, the study more accurately describes the mental health of these groups. Nevertheless, the findings do seem to suggest that at least some subgroups of sexual/gender minorities may have a less optimal mental health than members of the general population.

One reason for this has been provided by Uckaradejdumrong (1996), who investigated the psychological significance of *coming out* among Thai male homosexuals, also using the Thai SCL-90. He found that those "overt" about their sexuality had lower distress levels than did their "covert" counterparts (the difference was statistically significant in the Depression and Hostility subscales). Chooprasert (2001) reported a similar trend for Thai lesbian participants, but with no statistically significant results. These studies suggest that facilitation of the coming out process may be beneficial for at least male homosexuals' mental health in the Thai context.

However, when Nithiubat (2003) investigated coming out among male homosexuals in the Thai context, less than half of his participants' families completely accepted their son's communication; reactions in the majority of families ranged from grudging acceptance to physical violence or expelling their son from home. Winter (2006b) reported comparable parental acceptance rates for male-to-female transgender youth. Thus, coming out might be a valuable transition event at

least for Thai gay and male-to-female transgender people, but would have to be pursued carefully to avoid negative social consequences. It is also an example of a group-specific issue that homosexual clients may struggle with and whereby a counselor would do well to understand the relevant social and psychological context.

While the realization of such group-specific concerns and their consequences has led to the creation of group-specific counseling models in the US, such as the APA (2000) model reviewed above, in Thailand, such models are only beginning to emerge: as of August 2010, The Thai Royal College of Psychiatrists was preparing a set of guidelines for dealing with TG clients, but their set of guidelines was still at a draft stage with a note forbidding citation. The website of the Thai Psychological Association (www.thaipsy.or.th) and the Thai Psychiatric Association (www.psychiatry.or.th) contained no publicly accessible information on sexuality at all, when accessed in January 2008.

The DMH run websites (www.dmh.gov.th and www.thaimental.com) did contain some information. There was an account about homosexuality and transgenderism on www.thaimental.com, signed in the name of the DMH (2003). It still saw these sexualities as somewhat problematic, discussing them as abnormalities and addressing their prevention and treatment in childhood. However, it also stated that their treatment in adulthood typically does not yield any results. It saw both homosexuals and transsexuals as abnormal, albeit somewhat different (DMH):

> It can be seen that the problem of homosexuality and the problem of transsex (sic) have similar characteristics, for example, there might similarly be wrong-sexed clothing, an abnormality seen from childhood, and sexual pleasure with the same sex, but the differences between the two problems can be concluded as follows… (no page number)

This account also used the old English-language diagnosis title "Homosexualism" that was previously used as a diagnostic category for homosexuality in earlier versions of the ICD that viewed homosexuality as pathological. On www.dmh.gov.th, there were short postings that were also available as recorded messages on the automated mental health hotline 1667. The following example viewed homosexuality and bisexuality as non-problematic:

> In the current era, with more scientific studies, we find that people who are homosexual are normal people, only with sexual characteristics differing from other persons. Homosexuals can live their lives in a valuable manner no less than other people in society. There are only a few cases that have difficulty with this feeling and need to see an expert counselor (Khuankhong, n.d., no page number).

However, no information could be found on what could make a psychologist an "expert counselor" in helping homosexuals or other sexual/gender minority individuals in the Thai context. It seems that an accepting perspective is gaining force, but is not yet joined by understandings about specific counseling needs of sexual/gender minority individuals. In the absence of clear policy, guidelines and training for giving counseling to transgendered persons, homosexuals and bisexuals, counseling with them may not be as helpful as it could.

Romjumpa (2002) reviewed a number of widely used Thai psychiatric textbooks and manuals. The general image these books portrayed was that there was grudging acceptance that homosexuality needed not be treated if the patient does not request it, but at the same time, these materials portrayed a variety of methods for treating it (notably psychoanalysis and aversion therapy). Romjumpa analyzed that psychiatrists are generally divided into two groups, supporting either of these

positions, but the voice of those who support the pathologizing perspective was still heard clearer in Thai society than the voice of those who didn't.

An earlier review by Jackson (1997) contained more details about the attitudes toward sexual/gender minorities within Thai academia. Jackson reviewed 206 pieces of Thai articles, theses, books and other materials printed. His conclusion was that the mainstream academic paradigm was homophobic and psycho-scientists favored psychoanalytical and behaviorist explanations for homosexuality, which was seen as an abnormality. More research attention had been given to male than for female homosexuals. The perspectives about transgendered people, however, were less condemning than those about gays, since the supposed abnormality was usually seen as bodily rather than mental. Jackson also stated that by the early 1980's, the main concern had shifted from trying to cure homosexuals (which had not worked) to preventing more people from becoming homosexual. He also identified a *tolerant but unaccepting* perspective toward individual homosexuals.
Maneesrikum (2002) Thammarongwith (2005) have described interactions between a gay client and psychologist or psychiatrist. They also suggest that some counselors in Thailand continue to view homosexuality as undesirable, and that on the level of practice, such counselors also view it as treatable, which may lead to unhelpful and possibly traumatizing (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009) sexual orientation change efforts.

However, it is not clear if these views and practices constitute the main paradigm within Thai psychology today. The paradigm on these matters in Thai academia seems to be shifting and it is not so clear if it still is as described by Jackson in 1997. The present author's recent review of these topics (Ojanen, 2009) suggests that attitudes in new Thai research have significantly shifted from those described by

Jackson. However, it is unknown to which extent this change has influenced the clinical practices of psychology and psychiatry. Thus, empirical research is needed to study the attitudes and current practices of Thai psychologists and psychiatrists, along with the experiences that sexual/gender minority clients have of it.

Conclusion on Existing Information

The above review leads to three general conclusions: 1) context-specific models or guidelines of counseling are now widely considered helpful for providing efficacious counseling to sexual/gender minority clients; 2) such models or guidelines for the Thai context are at a rudimentary stage; 3) no systematic knowledge exists about the practices of Thai counselors with sexual/gender minority clients.

As long as sexual/gender minority people cannot trust that they will receive understanding services from counselors, they are less likely to seek counseling, even though they might have elevated support needs that counseling could (in theory if not in practice) address. It is thus necessary to evaluate the current practices and views of Thai counselors in this context.

The present author has already evaluated the practices of Thai voluntary sector, nonprofessional counselors working in this area (Ojanen, 2009). This thesis, on the other hand, explores the attitudes and practices found among practitioners and clients in various professional counseling settings.

At the time of the study, there was no specific instrument that could reliably and validly measure the quality of counseling interactions between Thai counselors and their sexual/gender minority clients. Therefore, an exploratory approach was adopted. Chapter 3 delineates the adopted methodology and its underpinnings.

CHAPTER III: METHOD

Type of Research

This study was conducted as a *generic qualitative inquiry*, drawing on the epistemological and technical considerations of McLeod (2001), whose account specifically focused on qualitative counseling research.

The choice of research methodology must fit both the topic to be studied, as well as the epistemology chosen to guide the study. McLeod (2001) has summarized that the primary aim of all qualitative research is "to develop an understanding of how the world is constructed" (p. 2), and that:

> the notion of the world being "constructed" implies that we inhabit a social, personal and a relational world that is complex, layered, and can be viewed from different perspectives. This social reality can be seen as multiply constructed. (p. 2)

This is consistent with the epistemological standpoint taken in this study (see Chapter 1) – that is, working under a minimalist agenda that assumes neither the presence nor the absence of an ultimate objective reality, and chooses to work on a level that at least is accessible to human inquiry: the level of multiple subjective realities.

This further corresponds with McLeod's (2001) notion that "there is someone doing the constructing: the world is constructed through the collective activities of people" (p. 5). Those influential in constructing meanings in the subject of the current study are mainly psychiatrists, psychologists and sexual/gender minorities themselves (although their constructions are influenced by other societal groups). Hence, in this study, it was these two groups' constructions that were mapped. In Denzin's (1970, as

cited in Bryman, work in progress) terms, the use of client and practitioner data on the same topic constitutes *data triangulation.*

The words of McLeod (2001) also well summarize the purpose of mapping the views of practitioners and clients:

> Those of us working in the broad area of human services … have to be able to find our way around this constructed world of common-sense understandings. Specifically, we need to be able to claim some kind of understanding of what is going on that is somehow better or more insightful than ordinary, everyday understanding. … Qualitative research is a process of careful, rigorous inquiry into aspects of the social world. It produces formal statements or conceptual frameworks that provide new ways of understanding that world, and therefore comprises knowledge that is practically useful for those who work with issues around learning and adjustment to the pressures of the social world. (p. 3)

In this study, it was expected that this kind of inquiry would produce practical understandings of sexual/gender minority clients and the process of helping them through counseling. Such understandings could then be utilized by service providers in Thailand to ensure their assumptions and their approaches are compatible with those considered useful or at least acceptable by their sexual/gender minority clients.

Although using qualitative methodology constitutes a rigorous procedure of mapping knowledge, it does not imply dogmatic adherence to any particular method. McLeod (2001) has argued for a generic qualitative method that can be flexibly utilized according to the demands of the context. This fits the minimalist agenda assumed in this study: no so called *brand name approach* to qualitative methodology is seen as a royal road to more objective research findings. Mapping subjectivities is seen as a task that should be specifically designed to meet the demands of the context.

McLeod (2001) has explained that there are typically three areas in which qualitative research can produce new forms of knowing: "knowledge of the other", "knowledge of phenomena", and "reflexive knowing". The first of these, knowledge of the other, regards a "category of person … who is of interest to members of a professional group, and seeks to describe, analyze and interpret the world-view, experiences and language of a sample of people who represent that category" (McLeod, p.3). This kind of knowledge is "enormously useful to practitioners" since "practitioners are socialized into somewhat stereotyped views of clients or service users, and may have little time to explore in depth how their clients feel about things" (McLeod., p.3). McLeod has further specified that:

> there may be barriers of gender, class, ethnicity and power that inhibit professionals gaining a rich understanding of the world of their clients. Qualitative research which gives clients a "voice", which allows their experiences and life stories to be documented, is therefore invaluable to the smooth, efficient and humane running of human service agencies. (p. 4)

By adding sexual orientation and gender identity to the above list of issues that may constitute barriers to counselor-client understanding, the above excerpt becomes a concise summary of the key problem that has impeded the efficiency of counseling with sexual minority clients in the Western world for decades and may still be impeding it with the same process in Thailand. Hence, developing a better understanding of the selected groups of sexual/gender minorities, both as clients and as persons in the everyday fabric of Thai society, should help create services that are more "smooth, efficient and humane" to members of this group in the Thai context.

However, the other two types of knowing are also, to a degree, relevant to the present inquiry. "Knowledge of phenomena … is directed toward categories of event

that are of interest to professional groups", for example, "change events, or the use of figurative language in therapy" (McLeod, 2001, p. 4). In this study, a good example of this kind of knowledge is what practitioners do when parents demand that the practitioner try to make their child "normal" (i.e. heterosexual and gender-normative).

The third type of knowledge, reflective knowing, "occurs when researchers deliberately turn their attention to their own process of constructing a world with the goal of saying something fresh and new about that personal (or shared professional) world" (McLeod, 2001, p. 4). While the author does not reflect on his professional practice in this thesis, he is, however, a practitioner/researcher updating his personal world view. The practitioners interviewed in this study also reflected quite a lot on both their own views and about their colleagues' views and ways of practicing, which might also be taken as a form of reflective knowing, since they constitute knowledge of the ways of *us* (service providers), rather than the ways of *them* (client groups).

Research Design

McLeod (2001) has listed stages of research procedure common to most qualitative methodologies. This list constitutes a practical index of what qualitative researchers *do* when they conduct research on counseling and psychotherapy. It was used as a guideline for conducting this study. The model has the following stages:

1. Choosing the topic

2. Identifying the audience

3. Developing a greater awareness of the topic

4. Formulating a research question

5. Keeping a personal research journal

6. Developing awareness of method

7. Choosing an approach

8. Deciding on techniques of data collection and analysis

9. Finalizing the research plan

10. A period of immersion in the phenomenon.

11. Compiling the research text

12. Refining the method of analysis

13. 'Condensing' the research text

14. Analysing: comprehensive and exhaustive analysis of the research text

15. Checking

16. Writing

17. Theorizing

By the time of the thesis proposal, the researcher had completed stages 1 to 9. Stages 10 to 17 were completed after it.

In the case of this study, the researcher had gained initial interest in sexual/gender minority issues through his own identity, Bachelor's degree level studies in psychology, volunteering experiences and reading literature on the topic (stage 1). It was clear that to bring about positive change in the field of counseling, counselors and policy-makers would need to be the primary audience (stage 2). Reading Western guidelines on therapy with sexual minority clients, as well as Thai and non-Thai research on these groups in Thai society helped create creater awareness on the topic (stage 3) as well as formulate a research question that was clearly counseling-related, as this was a field that the literature did not much address in the Thai context (stage 4). A research journal was not kept in a formal sense; rather, notes were kept in numerous text files on the resarcher's laptop computer

(stage 5). Participating in seminars on qualitative methods, organized by the Graduate School of Psychology, reading literature on qualitative methodology, particularly the work of McLeod (2001), and submitting initial assignments for Statistics II and Multicultural Psychology course modules helped develop greater awareness of method (stage 6), choose an approach (stage 7), decide on techniques of data collection and analysis (stage 8), and finalize the research plan (stage 9).

After the thesis proposal hearing, the period of immersion in the phenomenon (stage 10) consisted not only of conducting interviews, but also of the preparatory work for them, such as identifying and contacting participants and creating further proposals for the two internal review boards (IRBs), and reading more related literature. Compiling the research text (stage 11) meant in this case transcribing all the interviews. Refining the method of analysis (stage 12) meant deciding on the technicalities of how to select, summarize, compile, and categorize the meaning units. Condensing the research text (stage 13) meant in this case summarizing the contents of meaning units in English. Analyzing (stage 14) meant categorizing the meaning units, which was done twice (see Data Analysis below, p. 62). Checking (stage 15) and writing (stage 16) were mostly simultaneous during the write-up of Chapter 4. Finally, most theorizing (stage 17) was done while writing Chapter 5 that analyzed the findings and comparing them to existing research.

Participants and Sampling

Altogether 16 participants – Thai native speakers and Thai nationals (some with Chinese ancestry), living or working in Bangkok or neighboring provinces – were interviewed for this study. Nine were "practitioners" and seven were "clients."

As stated above, the terms "counselor" or "practitioner" in this study refer to professional psychologists and psychiatrists providing counseling (and other mental health services) in one form or another. This study set upon to recruit at least eight practitioners. Eventually, nine counselors including five psychologists and four psychiatrists were interviewed.

The term "client" refers to persons who had sought help for some issue in their lives from counselors prior to their involvement in this study – or, as it turned out, were in many cases "dragged" to see a provider either by parents or friends. This study sought to find clients from three groups: chaai-rák-chaai (heretofore referred to as "gay"), yĭng-rák-yĭng (heretofore referred to as "lesbian") and săao-pràphêet-sŏong (heretofore referred to as TG, short for "transgendered" when used as an adjective, and "transgendered person" when used as a noun, usually referring to male-to-female individuals)[5] since these are the three broad groupings that are typically encountered in Thai contexts. The study attempted to find at least four persons with experience of having been a counseling client from each of these groups.

Eventually, three gays and three TGs were interviewed, plus one participant who indicated he was between these categories and preferred the term MSM as a self-referent. No lesbians with experience of having been a counseling client could be identified; thus, none were interviewed. However, an informal interview was

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[5] While the selected English terms are acceptable when used in English, they do not correspond directly to Thai phêet: the word chaai-rák-chaai covers in many cases not only gays but also male bisexuals (no participants in this study stated they were bisexual). The English word lesbian is not well received if used as a loan word in Thai (Chetami, 1996). It is used here as a shorthand collective term, with the understanding that distinct subgroups like toms, dees and les are included, and that concerns faced by different subgroups, are distinct (Sinnott, 2004). The abbreviation TG is used instead of săao-pràphêet-sŏong because it is shorter yet often used as a self-referent within transgender communities.

conducted with a feminist activist, Klairung Sonklin, of the Women's Health Advocacy Foundation (www.whaf.org), to gain background information on the situation of Thai lesbians and their utilization of mental health services. The information from this interview is referred to in Chapter 5.

Since finding client participants was quite difficult, the researcher had to include any sexual/gender minority individuals with counseling experience, without further theoretical consideration. Clients were sought through the researcher's existing network of acquaintances (including activists in NGOs specifically serving each of these groups in Thailand) and their acquaintances, online on Thai gay, transgender and lesbian webboards[6], in the activities RSAT arranged for each group, and by posting small flyers on notice boards in gay-frequented cafés and bars (see Appendix I for a sample flyer). All the TG participants (and the one participant who preferred the term MSM) were either the researcher's existing acquaintances or their acquaintances; however, all gay participants themselves contacted the researcher through various avenues. Table 1 below provides client participant details.

Unlike the client participants who were quite difficult to find, with counselors the researcher was able to use more purposive sampling, aimed at maximal diversity of viewpoints. The researcher chose participants that were known to have certain views on the topic, as well as participants of whose views the researcher had no prior knowledge. Counselor participants were all contacted directly. Some were suggested as interviewees by other participants and yet others by acquaintances of the researcher. Diversity maximization also meant that the counselor participants

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[6] Gay participants were sought on www.xq28.org and www.thailandout.com; TG participants on www.thailadyboyz.net and lesbian ones on www.baantomdy.narak.com and www.lesla.com (now defunct) – when no lesbians could be found through these and off-line contexts, advertisements were also posted on www.pantip.com specifically to recruit lesbian participants, but still to no avail.

1) Worked in the private, public or voluntary sectors.

2) Had diverse work contexts; many worked in more than one context.

3) Had a broad variety of theoretical orientations.

4) Had a wide age range (from 32 to 62).

5) Were either male or female.

6) Were either heterosexual or homosexual.

7) Were either public figures or not so well-known.

While some practitioners would have agreed to be named, the researcher decided to keep all participants and their employing organizations anonymous to minimize the possibility of any of them being recognizable. Due to the risk of participants being identified, given the small number of practitioners in Bangkok, individualized information is not systematically given about practitioner participants. Like client participants, they're identified by a code name consisting of either the abbreviation PA (psychiatrist) or PL (psychiatrist), and a number (e.g., PA1 or PL5).

In the case of counselor participants, the researcher considered it too intrusive to ask their sexual orientation or phêet, as some might have thought that leaks of this kind of information could jeopardize their careers. Only their legal sex was thus recorded; there were two female and seven male practitioners. However, some practitioners were identified by the researcher's acquaintances as gay, and one was open about it off-record. In contrast, some emphasized that they were heterosexual, adding that the public tends to think otherwise due to their known interest in the topic.

Most practitioners implied they used an eclectic or integrative theoretical orientation, but one cited reality therapy as a primary theoretical affiliation. Main components of eclectic/integrative approaches cited included psychodynamic therapy, brief psychotherapy of Virginia Satir's type, Gestalt, and behavior therapy.

Based on many practitioners' accounts, the psychiatrists interviewed may have been unusual in the context because all of them also gave counseling instead of limiting their role to diagnosing and prescribing medication to their patients, which they identified as common practice in Thai public sector hospitals.

Work contexts cited by the practitioners comprised two state university counseling clinics, one private university counseling clinic, one private and one public psychiatric hospital, one private and one public general hospital, one medical school hospital, one private counseling clinic, one private school, and one NGO.

Besides the participants and organizations that agreed to participate in the study, one individual practitioner at a state general hospital, one medical school hospital, one state university counseling center and one private university counseling center were contacted to recruit participants. Of these, the individual practitioner did not contact the researcher after the initial request by the researcher. The medical school hospital was dropped as their representative indicated their IRB procedure would be "prohibitively difficult" to pass. A representative of the private university denied the university had a counseling center, in spite that the university website had information about the center. The state university counseling center representative stated when telephoned that they did not have any homosexual clients. These claims were shown positively false because coincidentally, one participant in this study was working part-time in both centers and stated that both universities did have counseling centers and that these had some homosexual clients.

Interview permission requirements by participating institutions ranged from simple informal agreement (in three cases) through submitting an official letter from the Graduate School of Psychology (in three cases) to full-scale in-house IRB assessment coupled with written permission from the hospital director (in two cases).

Table 1. Background information of client participants. # indicates participant code number.

Code Name	Phêet	Age	Occupation/ employment	Reason(s) for becoming a client (if several sets of appointments, indicated with numbers)	Place of interview	Way of establishing contact
G1	gay	25-30	private entrepreneur	1) A psychiatrist visited G1 in an emergency room after a failed suicide attempt. 2) G1's mother took him to visit a psychiatrist after he came out as gay to her.	Online on MSN (G1 refused to come for a face-to-face interview but was happy to do it on-line).	G1 saw a recruitment advertisement for the study on a gay web board and contacted the researcher.
G2	gay	35-40	fashion designer	G2's concerned friends took him to see a psychiatrist, seeing he was very depressed. Numerous treatment contacts.	RSAT meeting room.	G2 saw a recruitment advertisement on a gay web board and contacted the researcher.
G3	gay	40-45	business consultant and analyst	1) When still a pupil, G3's mother took him to a psychiatrist, first concerned about him staying alone a lot, then talking to himself. 2) G3 was stressed about his studies around end of high school.	RSAT meeting room.	G3 saw a recruitment advertisement on the notice board of a coffee shop and contacted the researcher.

				3) G3 was depressed in adulthood.		
M1	MSM	30-35	project manager in an INGO	M1's mother found out that he was taking female sex hormones through changes in his body, and forced him to see a psychiatrist.	Meeting room at the participant's workplace (his preference).	M1 was an existing acquaintance of the researcher.
T1	TG	25-30	various kinds of freelance work	1) T1 was first sent to see a psychiatrist when her chronic physical health problems started affecting her mental health, causing depression. 2) Later, the participant got to see a psychiatrist and psychologist for pre-SRS evaluation.	RSAT meeting room.	T1 was an existing acquaintance of the researcher.
T2	TG	20-25	project assistant, research institute	T2's mother, concerned about her transgenderism, took her to a psychiatrist.	RSAT meeting room.	T2 was an existing acquaintance of the researcher.
T3	TG	20-25	helps family business	T3 was sent to a psychiatrist to assess her eligibility for SRS.	T3's condominium apartment (her preference).	T3 was contacted by another participant.

Note: participant age is given in 5-year brackets to reduce the risk of participants being identified.

Instrumentation

Interview schedules were based on whether each participant was a client or a practitioner, as well as based on any existing knowledge of the practitioner's viewpoints. These schedules were specifically written for the purpose of this study. They were written in Thai, and their wordings were checked by a native speaker prior to their utilization. Appendix III shows a sample list of interview questions in the format it was introduced to some counselor participants prior to the interview, when their employing organizations demanded this.

Besides provisional interview schedules, a consent form (see Appendix IV) was created, and due to IRB regulations in one of the participating organizations, a client information sheet was also created and given to those participants that were interviewed after it was created (slightly variant versions were used based on the participant's type and work context; see Appendix V for a sample form). Besides this, several letters requesting permission were sent by mail or taken to the participating organizations in person in the process of contacting counselor participants. Due to the anoymization of participants and their organizations, only an anonymized sample letter is shown in Appendix VI (unlike this letter implies, no client participants were finally recruited through institutions, because this could have complicated the IRB procedure or made it impossible to gain approval for the study from these boards).

A laptop computer with a microphone and audio editing software was used to record, edit (amplify, reduce noise, or hard limit the signal, as appropriate), and store the interviews as MP3 audio files. This computer was password protected to ensure confidentiality of the interview material. The same computer was utilized for transcription and further processing of the interviews with word processing software.

One electronic backup copy was made of all material and kept on a USB storage device stored in a safe cabinet with a combination lock, at the researcher's apartment.

In the process of analysis, interview transcripts and categories collating certain types of information were created, along with English-language summaries of each meaning unit; these were printed and cut into strips for manual analysis of each main category, then glued on A4 sheets to form completed categories.

Data Collection and Compilation

As seen above, to gain the participants' cooperation, the researcher had to obtain their own initial agreement, and also in many cases institutional approval. Beyond this, factors that may have helped establish sufficient rapport with the participants included the resarcher's Thai language skills and awareness of Thai cultural conventions, non-threatening personality style, having proper documentation of the research for the participants (request letters, consent forms, information sheets), interviewing skills gained through counseling training, and in many (but not all) cases a personal acquaintance with the participant or with someone they knew. It may also have been helpful that the researcher positioned himself more as a sexual/gender minority community member with the client participants, and more as a graduate student in the field of psychology with the practitioners, implying a more formal way of approaching the practitioner participants than the client participants.

The data collection took place from March 2008 to January 2010. The researcher conducted all the interviews in Thai (but many participants used a lot of English words when interviewed in Thai). The interview schedules were used as a guideline, but the wording or the order of the questions was adapted in the interview

situation. Items were made redundant by answers already given were omitted. Likewise, new issues brought up by answers to already asked questions could be traced further with the aid of improvised questions.

All except one practitioner interviews were conducted in the participant's office (one was conducted in a nearby coffee shop at the participant's request); most client interviews were conducted in the meeting room of RSAT, which permitted the researcher to use their premises for free (see Table 1 for locations).

The shortest interview took approximately 20 minutes and the longest one took about 75 minutes, reflecting the extent of material that each participant came up with. Resulting transcripts were six to 20 pages long (single spaced, Tahoma 12 points) and together made up 209 pages of interview transcripts.

Each interview recording was typed up in Thai script either by the interviewer or a research assistant, paid per piece. Two research assistants were used for the transcription of interviews; they signed documents stating they understood the confidentiality of the data and would be held responsible for maintaining such confidentiality (see Appendix VII for a sample form). Research assistants were used only for transcribing interviews of participants they were not acquainted with. All transcripts created by research assistants were checked and corrected by the researcher to ensure they corresponded with the audio recording. Four participants personally checked their transcripts for accuracy; one added remarks in the text body.

Data Analysis

The interview transcripts constituted raw data in this study. They were split into *meaning units* representing various types of information. Attempt was made to

limit each meaning unit to one meaningful statement. These units were then summarized in English. The meaning units were color coded in the electronic document file, based on various criteria, and punctuated by comment bubbles that contained the English summary of each item (one bubble per item) and in some cases also further coding reflecting differences between meaning units.

The summarized units were grouped into emergent categories of phenomena. Categories were labeled, further categorized into subcategories (described in Chapter 4), and interspersed with quotes from the meaning units. The category structure developed throughout the process. Meaning units were summarized and added to emerging categories after each interview. However, the category structure underwent changes even after all interviews had been conducted; the sub-categorization and explication of each category were done only after all interviews had been collected, transcribed, and split into summarized meaning units.

The researcher began with nine initial tentative categories. It was soon clear that there were two higher order categories – one with material related to sexual/gender minorities and the other with material related to the psycho-sciences, practitioners, or counseling in general. There was also a "recycle bin" category for off-topic material that related to neither of the two or was too indiscriminate to be categorized or reported. The lower-order categories changed even during the writing stage (stage 16 in McLeod's, 2001, scheme), as the author realized that redundancy could be reduced in this way. For example, a category for problems sexual/gender minorities face was eliminated as it could more concisely be reported under other lower order categories. The final main categories reported in Chapter 4 are thus:

1a) Treatment of Sexual/Gender Minorities in Thailand

1b) Acceptance of Sexual/Gender Minorities in Thailand

1c) Characteristics of Sexual/Gender Minority Individuals and Communities in Thailand

2) Experiences and Views on Mental Health Services in Thailand.

Ethical Considerations

The APA's (2002) *Ethical principles of psychologists and code of conduct* was followed as a guideline in this study.

As the study involved enquiring into sensitive and controversial matters and experiences from the participants' personal or professional lives, it was important that each interview be conducted in a non-judgmental and respectful manner. Any resulting information was kept safe and care was taken to ensure it could not be linked by outsiders to the participant who contributed it.

All participants were ensured they could stop their participation at any point or withdraw their data afterwards, but no participants chose to do so.

Participants were provided an opportunity to check their interview transcripts. Besides those who wished to check their interview transcripts, one practitioner requested an audio file copy of their interview, which was given to him.

All participants were asked to give written consent for participation. This was done using a printed copy of the consent form created for the study in all cases except that of G1, who was interviewed through an online messaging service and sent his consent form back by email (his true identity is not known even to the researcher).

The researcher also had the contact information of a few existing counseling services ready in case the participants needed to be referred for further counseling as a result of re-experiencing stressful emotions as a result of participating in the study.

While a few of the client participants expressed that their internal conflicts or problems remained unsolved, they either had an existing treatment contact, did not believe the matter was serious enough to contact a counselor, or did not believe any organization or individual could provide counseling service appropriate for them. This highlights ongoing problems in the field.

Institutional affirmation of this study's ethicality was provided by approval of the thesis proposal by the thesis proposal committee at Graduate School of Psychology, Assumption University, as is customary for the School.

In two of the participating hospitals (one medical school hospital and one public sector psychiatric hospital), the research proposal also had to pass the IRBs of these hospitals. In the medical school hospital, this meant submitting 6 printed copies of the thesis proposal to the hospital's IRB for an "expedited review," together with all forms used in the study, application and funding source declaration forms, the researcher's CV, and all these materials also on a CD-R disc. In the psychiatric hospital, no printed copies were needed, but the researcher had to send the thesis proposal file and a Thai-language digest of it to the IRB by email, modify them, and give a PowerPoint presentation and defend the study at their IRB hearing. Both of these hospitals issued official documentation as proof of passing their IRBs, but since these documents are practically impossible to anonymize, they are not included in the Appendices; however, the researcher will keep these documents for eventual checks.

Participants were not given incentives in return for participation, but they will receive an abstract in English and Thai. Two participating hospitals requested a full bound thesis in return for permitting its employees to participate; these will be supplied to them after the study is completed. One of the participating hospitals also

demanded a 1000 baht donation to the hospital foundation in return for permitting its employees to participate; this was paid in cash from the researcher's private funds.

Besides this compulsory donation, the study incurred direct costs for printing, scanning and mailing materials, transportation within Bangkok, and remuneration of research assistants who helped transcribe some of the interviews. These costs were altogether around 5000 baht and were paid from the researcher's private funds. No funder involvement was thus necessary. However, the researcher received a living allowance (a student grant) from the Social Insurance Institution of Finland for a part of the duration of the Master's degree course of which this thesis forms a part.

CHAPTER IV: RESULTS

This chapter reports the findings of the generic qualitative inquiry, as described in Chapter 3.

Reporting Conventions Used in This Chapter

In quotes, when an English word is in *italics,* it denotes that the participant used an English word instead of a Thai word; when a Thai word is in italics, it emphasizes that the word is a Thai word transcribed into Roman script. Thai words are used particularly when no obvious equivalent translation is available in English, or given in brackets when a Thai word is ambiguous or communicates connotations beyond those an English equivalent would. Ellipsis (…) indicates an omission of some words, and a slash (/) indicates boundary of a meaning unit. Words in ordinary brackets "( )" indicate the interspersed voice of the researcher or interviewee, whereas words in square brackets "[ ]" indicate additions made by the researcher for clarity.

In this chapter, accounts on sexual/gender minorities in Thailand are presented first, beginning with accounts on how they are treated by other people and fellow minority members, followed by views and experiences on what they are like. Accounts about the psycho-sciences and how they are serving these client groups form the latter part of the chapter.

Treatment of Sexual/Gender Minorities in Thailand

This category consists of answers to the question "how are sexual/gender minority individuals treated in Thai society?" Issues reported in this section refer to actions, regulations, laws and practices that affect the lives of sexual/gender minority people. Actions by counselors are not covered in this section but in sections dealing with the psycho-sciences. Mere views are reported in the next category.

Actions by Parents

Actions by parents were the kinds of action most frequently talked about, both by clients and practitioners. The following types were mentioned.

Taking One's Child to a Psycho-Scientist

Both client and practitioner participants talked about parents taking their child to see a practitioner, hoping for a cure for their child's supposed abnormality.

G1, M1, and T2 had been taken to a psycho-scientist by their parents after the parents had realized the sexuality or gender identity of their child wasn't what they had expected. G1 said that after deciding "to tell mother that I was [gay]; the next morning she took me to see a doctor, a psychiatrist." M1's mother had noticed bodily changes in him after he had been taking female hormones and "dragged" him to a psychologist. T2's mother had taken her to see a child psychiatrist upon having suspicions about her behavior that was showing signs of transgenderism.

Of the practitioners, five (PA1, PA2, PA4, PL2 & PL3) referred to parents taking their child to see a practitioner to change their child "back to normal" which

"in their thoughts means reverting to liking the opposite sex" (PA2). PA2 noted that this "still happens continuously, a person or two per month. Maybe [the parents] come alone first, or maybe they drag their child along straight away." PA1 gave an extreme example of a father that "forced the 38-year son that had already done [augmented] breasts to come [see me], saying: 'Doctor, [you] can inject whatever, [you] can use electric shocks, just make him a man.'" PL2, who provides therapy aimed at sexual orientation change, estimated that perhaps only 5% come to treat their homosexuality on their own initiative; the rest are forced to do so by their parents. PA1, PA2 and PA4 said parents often contact other practitioners after one has told them sexual orientation can't be changed.

Violence against One's Child

The second most talked about type of action was the use of violence by parents, albeit only by two participants. M1 stated his mother would forcibly shave his hair (after he'd worn it long), slap and hit him, as well as tear his (feminine) clothes off him when he was a child, but when he got older "[she] didn't have the strength to hit" him anymore. PL1, working at a domestic violence center, also noted that sexual/gender minority people are sometimes physically attacked by people in their families (second most after their partners) due to non-acceptance.

Forbidding a Type of Gender Identity or Expression

T3 said her friend had been told by her parents that being transgendered is not permitted. PA1 recounted a more specific case: "[the father] forced [his] son who was a *kàthoei*, who'd had a breast augmentation [to] take (*tàt*) the breasts out … and forbade him to have a sex change."

Expression of Denial

G1 referred to her mother's denial of his sexuality as follows: "Sometimes she speaks with me as if I wasn't [gay] / but one thing is *sure,* namely, the *subject* of gay issues is an issue that is still silenced…"

Control

M1 talked about parental control, both in relation to his own parents and those of her cousin (also transgendered): "since she [started] dressing as a *kàthoei*, she finished her Bachelor's, her family, they'd keep her at home, not let her go out … imprison [her]," whereas he himself had been able to move around more freely.

Acting Out

T2 recounted her father asking her at a child psychiatrist's appointment: "have you never really thought of liking women" and when she replied "never even thought of liking women," the father stormed out [of the psychiatrist's room].

Giving Consent for SRS

In contrast to more prohibitive reactions, T3 said her mother gave her consent to have SRS when she was 19 by signing a consent form "because my mother, she's been with me all the time since I was a kid and she knows that I really am [transgendered] – not following a trend or … [my] friends' example."

Actions by Employers

Two client participants (G2 and G3) and one practitioner participant (PL1) talked about actions by employers.

Controlling Employees' Gender Expression

G3 explained "the supervisor … said … err, act a bit [more] manly, don't give an impression of gayness / …like, dress, like, make it look respectable" because "they feel that'd be *professional,* see … there are problems with [gaining a] promotion." Similarly, PL1 noted that in her hospital, transgendered nurses "due to the regulations of civil servants – they can't come wearing a [female] nurse outfit" but "there are several people" who might express their identity through gestures. However, "those who are much [feminine], their rights are quite limited (umm), in taking care of the patients" (PL1) She mentioned there are some handsome, probably gay doctors in her hospital, who must "have quite a bit of a frame in being a doctor."

Sacking an Employee Because For Being Gay

G2 recounted that some callers to a gay helpline 7-8 years ago "were fired from work because they were gay … they didn't pass the [trial period of] 4 months."

Actions by Partners

Actions by sexual/gender minority individuals' partners were talked about by four practitioners (PA1, PA4, PL1 & PL3).

Violence between Partners

PL1 explained that "some, but not that many" "*chaai-rák-chaai* or *yĭng-rák-yĭng* come to use the services" at the domestic violence help center because "these groups also have, have violent victimization like other groups." Likewise, PA4 noted "there is violent behavior, attacking [one's] partner..."

Abandonment

PL2 noted that gay clients who come to treat their homosexuality generally "suffer from having been repeatedly abandoned." Likewise, PL3, working at a DMH hospital, viewed that "if you're a *queen*, like this, *kings* won't stay long; you've got to try to understand…"

Staying Married for Appearances

PA1, in private practice, noted that some heterosexual partners stay married even after finding out their partner is really homosexual, in an *empty love* relationship characterized by commitment only, "just creating an image, maintaining an image that this person is the husband."

Actions by Healthcare Staff

Although actions by psycho-scientists are not included in this category, actions by other healthcare staff are. T1 said that when she had to go to hospital, she came across "the problem of medical services … once [they] knew I wasn't a woman [they] treated me differently." PL1 added that even MtF's who have had breast augmentation surgery still "still can't go sleep in the women's *ward*" but have to

"sleep in men's *ward*" where they may face all sorts of problems. PL1 also noted that sometimes doctors refuse to see a transgendered patient if they are excessively attention seeking, exclaiming: "Ooh, I'm not seeing them anymore!"

PA2 explained that surgeons might refuse to do SRS on an HIV positive client because they'd be afraid of being infected themselves, and because they would not view the surgery as unavoidable as surgery necessitated by life-threatening illness.

Actions by Schoolmates

G1 and PA2 talked of phêet-specific bullying in schools. G1 recounted that throughout primary school, "friends called [me] *tút*, friends teased [me] … it wasn't just words, there were both [physical] attacks and humiliation." PA2 also "saw at school how male friends would tease *kàthoeis*, tease, tease, tease *kàthoeis,* [who] because of being a bit *feminine* were on the weak side."

Actions by Staff in Educational Institutions

One client participant (G3) explained that 30 years ago when he was at school, those teachers who didn't like gays might have special measures, such as "catching us to go on camps, like, boot camps … seeing [gayness] as a problem," whereas a practitioner participant, PL2, described the singling out gay or transgender students by teachers with quite a different kind of reasoning behind it: "let's make [them] a comedy figure for stage shows, or make them head of class, a cheerleader, activity arrangers … / Suppose there's a school fair, take them to a [beauty] competition."

PA1 referred to a TG who had been accepted to study psychiatry by using her connections, but "she knew that … the professor would not let her graduate" and quit.

Actions by Others

This residual sub-category contains accounts of actions by people not represented in any of the subcategories above.

Treated as Abnormal

T1, a transgendered participant, stated she "sometimes was teased for the issue of [her deep] voice." She added that besides problems "men" and "women" also face, all sexual/gender minority people may face "stigmatization, violations, discrimination." PL1 said that "they'd be criticized … why are you like this, abnormal like this?"

Sexual Violence

Three client participants commented on the sexual violence transgender people may face. T1 "faced physical violence (umm); I encountered a person trying to rape me." So did M1: "The first time I had sex I was raped. I was raped at … [*gay sauna[7] in Bangkok*] … it was the first time. … it hurt, it was torture." T2 viewed that "most people who are *kàthoeis* face … sexual violations, quite a lot." G2 noted that when he received helpline calls, some gay callers had been raped.

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[7] *Gay saunas* are men-only venues with hot and steam rooms, typically coupled with fitness facilities, bars, dining rooms, and private cubicles or dark rooms, enabling customers to have sex with each other (see Danthamrongkul & Posayajinda, 2004, for more information).

Malicious Gossip

M1 told of a "kid [I] met at an *orgy,* to [whom] I gave a condom" who then came to his office, "pointed at my face …and went to tell the [colleagues] – [he] took this issue to complain to senior people," even though the participant had been there in his free time. PA1 referred to a politician who "was outed[8] by the PAD as gay … nobody knew he was gay, until his own lot, people in the same circles stated it."

Other Relatives' Reactions

Besides parental actions, only two items referred to actions by other relatives, both by M1, who stated that "big brother hates *kàthoeis* [and] kicks" such people and that "my mother hates [my *kàthoei* cousin], hates a lot … berates [her] every time they meet."

Discrimination by Social Workers

PL1 stated that transgender clients asking for financial assistance from social workers "might be refused, because [the social worker] … might be inclined to think that … they might not use it on what we wish them to use it on… they might give it to a man, or go buy something."

The Legal Context

G2 noted that single people in Thailand "pay very high taxes" and have less access to welfare benefits than families with children, and that gays are always

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[8] *Outing* means exposing a person's sexual orientation or gender identity to others against their will.

considered single because they don't have the right to get married with a partner of their choice.

PL4 noted that although Thai society is more liberal than other Asian countries on sexuality matters, legal processes haven't developed at the same pace, with no same-sex marriage law or legal recognition of the new gender of TGs. PL5 also noted the absence of a same-sex partnership law. PL1 noted from her experience at the domestic violence assistance center that while heterosexual victims of domestic violence have organizations providing legal assistance, sexual/gender minority people don't. She also lamented that sex-specific state shelter homes do not have reasonable placement options for transgender clients, and that TGs do not have the right to adopt a child, even if they have the financial means to take care of an adopted child.

Acceptance of Sexual/Gender Minorities in Thailand

While the above section referred to specific actions, regulations, and practices affecting the lives of sexual/gender minority persons, the following section focuses on client and practitioner views about sexual/gender minorities.

Views by Client Participants

General Views by Gay Participants

G2 noted that "about 7-8 years ago", when he was a gay helpline volunteer, "gays were not yet that accepted … / some people had had to endure a lot." G3 said that "in this era, there might not be that much trouble … there is to an extent … but only a little." Both seem to view that problems with the societal context were rather a

thing of the past, although G3 said that even when he was in school 30 years ago, he didn't notice gays having much trouble with society.

General Views by TG participants

T1 analyzed that she has gained more social space because she looks very much like a woman, and society values TGs who are beautiful and "pass" as women. However, T1 acknowledged, "in others' eyes I'm [still] a *kàthoei*." T2 stated that TGs who wear feminine clothing cannot live in mainstream society, as in "Thai society, negative attitudes are quite common" and "they tend to stereotype … that if [one] is a *kàthoei*, [one] has to become a *cabaret show* performer [or] a beautician." She added that information on the health effects of hormones and other transitioning technologies on TGs is scarce, because their safety is only studied in females. In contrast, T3, the youngest participant in the study, stated she'd "never had any obstacles" or problems related to being a TG – she'd never even been called a *tút*. She mused that boys at her school did not dare bully TGs, because they would have fought back as a group, and added that kids of all *phêet* could be friends.

Client Views on Parental Acceptance

As seen above, G1, M1, and T2 had all been taken to see a practitioner by their parents upon being confronted with their real sexual orientation or gender identity. G1 thought that when he told his mother he was gay, she "must've been shocked, probably wanted the doctor to check where the abnormality lay [and] if it could be corrected." M1 noted that his mother "didn't want me to be a *kàthoei* … she thought I'm mad" or "dirty." So did T2's mother, who also had believed transgenderism could be cured by psychiatry. Her mother even negotiated with her,

stating she'd prefer her to be gay instead of TG, because that way she "could live in society." T2 analyzed that finding out one's son is transgendered contradicts parental expectations, and not just in her family. However, T3's mother has fully accepted that T3 is a TG.

Views by Practitioner Participants

Acceptance within Society at Large

PA2, PA3, PA4, PL2, and PL4 viewed that Thai society is quite tolerant of homosexuality and transgenderism. PL2 said: "Thailand is very fortunate, it opposes gays the least" in the world. He also spoke about the presence of sexual/gender minority people on Thai television, which he viewed would not be possible in many other countries. Both PL2 and PL4 viewed that Thailand's level of acceptance is reflected in the influx of foreign gay tourists to Thailand. PA2 said: "it seems like the atmosphere [on acceptance of sexual/gender minorities] has improved." PA3 said that "*homosexual, transsexual* groups are quite well accepted" in Thailand. And like PA2 and PL4, PA4 also noted that "homosexuals … lately have received more acceptance due to having had the chance to show their abilities more than before."

However, PA1, PA3, PA4, PL1, PL2 and PL4 also spoke of the bounds of such acceptance. PA1 noted that while school visits by sexual/gender minority individuals might be useful to increase understanding about these minorities, they might be opposed by those who view that such visits incite children to have such sexualities, just like sex education used to be seen as inciting children to have sex. PL1 analyzed that gays tend to be accepted only if they are skillful and have power and influence. PL2 viewed that Thai society does not really accept gays, but since

most Thais engage in some kind of sexual misconduct, they generally don't dare to criticize gays, fearing they themselves will be criticized in turn. PL4 noted that non-acceptance of gays was common some 20 years ago (in the beginning of his career), but kàthoeis were better accepted, because Thai society was more familiar with them; bisexuals were even more incomprehensible for society at large. PA3 analyzed that in Thai society, "if it's not my child, anything goes." PA4 acknowledged that "there is now quite a lot of acceptance, but … not 100% yet …/ Thailand will probably still have to spend some time." He added that gays may be accepted when their work contribution is appreciated, or as comic figures providing stress relief, but not unconditionally.

Parental Acceptance

PA1, PA2, PA3, PA4, PL1, PL2 and PL3 all spoke of parental non-acceptance of their child's homosexuality or transgenderism. PA1 gave some examples of concerned parents, who had contacted him for help, such as a mother in her 50's or 60's, who had found out her son had contacted men through the internet for sex; she had cried a lot in the session and called her son a pervert (*wípàrít, wítthăan*). PL1 noted she's only met one family that was accepting of their child's phêet. PL2 viewed it's the parents who most oppose gays in Thailand.

In explaining familial reactions, PA1 noted that parents are typically upset not by their children's sexuality, which is a private matter, but by their conspicuous cross-gender expressions. He also noted that sons in families with only one son tend to face more pressure to perpetuate the family. When asked if ethnic Thais and Chinese Thais differ on this matter, he viewed that there is not so much difference in the level of acceptance *per se*, but Chinese Thai families may put a greater emphasis on having a

son perpetuate the family line, which may make sons in Chinese Thai families face more pressure to marry and have children. PA1 also emphasized that Thai society puts great emphasis on preserving face; if one's only son is a TG, it can constitute a loss of face. PA4's observations were similar; he noted that the eldest son may be most likely to face expectations for marriage and perpetuating the family line. He added that parents also have fears that nobody will care for their child when old, or hold the misconception that being gay or TG is by definition disgraceful, shameful.

Acceptance within Religions

PL2 noted that all religions oppose homosexuality, even Buddhism, which calls them *pandakas* (*bandó* in Thai pronunciation). PL4 stated that certain religious groups may not accept homosexuals. PA2, PA3 and PL2 noted that certain groups of Christians, (including some Christian psychiatrists), might have more negative views on homosexuality than Buddhists do. PA2 noted that some Buddhists view being born as gay is a punishment for actions in past lives, whereas some fundamentalist Christians view it as resisting God's will. PA1, PA2 and PL2, also viewed that Muslims may be stricter on these matters than Buddhists are.

Acceptance by Other Named Groups

Women and men. PL2 noted that women tend to accept gays more easily than men do, viewing they are adorable, cute, make good friends, and won't pose a risk of sexual violence. PA4 stated that many women even like to have gay partners or "have *sex* with a person who's gay." In case of women who find out their husband is gay after marriage, PA1 viewed that most can accept it provided that the husband still bears his responsibility for the family, and the woman herself is not so interested in

sex. However, many "feel disgusted … that … the penis that's coming to have sex with me, where it has been…" PL3 was more ambivalent about women's and men's views: "you go have men as friends: some men are not so good-hearted … you go have women as friends: some women will be your friends, some won't."

Teachers. PL2, working at a university counseling center, said Thai teachers view gay students as "lively" or "good humored." PA4 also said that "educational institutions … are quite accepting." But PA2, also working at two university counseling clinics, said that sexual/gender minority students sometimes have problems with their professors.

Friends. PA2 said sexual/gender minority students' friends may view them as having problems.

Hospital staff and patients. PL3 noted that sometimes hospital patients ask if sexual/gender minority staff members are in fact patients. PL1 also said that patients don't seem to accept such staff members as well as other staff members do.

Government. PA2 analyzed that gays and TGs are often seen as comic figures in Thailand, which has the negative consequence that people "can't take it seriously." Thus, "supposing a parliamentarian raised his hand and said, 'let's start helping this group now,' it would [appear] silly (*khǎm*)" and would not be taken seriously.

Characteristics of Sexual/Gender Minority Individuals and Communities

The above sections reported views on the societal context in which Thai sexual/gender minorities live their lives. In this section, views will be presented about sexual/gender minority individuals and their communities themselves.

Views and Experiences by Client Participants

Experiences Related to Identity Development

Some client participants' experiences of what it has meant to them to be themselves in different periods in their lives represent the below types of experience.

Lack of awareness of one's phêet. In their childhood, G1, T1 and T2 initially didn't either know what identity labels assigned on them meant or did not believe they were as described by those labels. For example, G1 said that when called tút in school, he didn't "even know what *tút* means, and when [I] did know what *tút* means, I believed I wasn't a *tút* … I didn't know I liked men…" T1 felt "I wasn't a *kàthoei* ... I was a woman."

Embarrassment, hiding one's phêet. G1, G3 and T1 talked about feeling embarrassed about being the way they were, and/or having to hide it. G1 hid that he'd been labeled as tút and bullied for it, feeling he couldn't tell anybody. T1 felt she'd suffered for being a TG. G3 said his parents probably still don't know he's gay.

Coming to terms with one's phêet. G3, T1 and T2 talked about how they came to terms with their sexual orientation or gender identity. T1 accepted herself while "working with NGO matters." G3 accepted his gayness in high school, facilitated by the presence of many other gay pupils in the male-only school, and T2, upon "growing up and receiving more information," she realized that she "wasn't the problem. It was me. It was what I chose. Outsiders, instead … didn't understand and turned it into a problem."

Identity confidence. G2, G3, T1, T2 and T3 all reflected their current identity confidence. T1 expressed that her skills, combined with her beauty, highly valued by society, has given her "some opportunities in life." G2 believed he was "*born to be,*

born to be gay." G3 said "I am out of the closet." T2 told a doctor who suggested she should be gay instead of a TG that that wasn't what she'd chosen. T3 noted she'd been a TG "since the age of 5 years, since my first memories."

Client Views on Etiology of Homosexuality and Transgenderism

Participants were not asked about their views on the etiology of homosexuality or transgenderism, but T1 and G2 stated they had been born the way they were, and T3 said she'd been transgendered as long as she could remember.

Gay Participants' Views and Experiences

Sexual and relationship problems. G1, when asked to clarify what he meant by "gays who have problems," replied: "The type that excessively engages [*mòk-mûn*] in *sex*, perhaps … those that are *pedophiles*, too" but when asked if being gay was related to being a pedophile, he retracted: "[no, it's] not related. Women, men, gays, all can be [pedophiles]." Likewise, G2 viewed that "gays in Thailand, they emphasize *sex* ... [it]'s a *sex game.*" He believed he had no chances of finding a partner in Thailand. G2 also noted that when he was a helpline volunteer, many clients were in sex-based relationships where lack of financial planning led to problems; some gay callers had had a female partner who had gotten pregnant but neither one had wanted the child. He said he himself suffers from an incurable kind of impotence. M1 stated he may appear emotionally hard on the surface but really longs for love and feels "lonely all the time" because his family never loved him; he added he cannot find a partner, only sex that is "not refreshing." G3 talked about disappointments in love life.

Specificity of gay people. G2 and G3 viewed that gays differ in many ways from heterosexuals. G2 viewed that "[our] way of life is not like men's and women's,

and thinking, thinking and actions, like, they're not alike, there is likely to be a group specific psychology." G3 noted that most people who live in a world of imagination, sadness and loneliness "like [in] the films of Wong Kar Wai" tend to be gay.

Involvement in gay specific groups and a need for a sense of belonging. G3 felt a group of gay youths in his school some 30 years ago "was a very conspicuous *gay community"* and "I felt I could belong to [this] group … While living in [that] society I didn't feel isolated …" Belonging to this group also gave G3 confidence to come out as gay. M1, in turn, told of his involvement in gay communities, such as leading a virtual gay community as a Camfrog[9] DJ, going to various events ("I go to *grand openings* in [entertainment] venues that invite [me]") or helping a sexual diversity NGO, with which he, however, felt quite disillusioned due to what he perceived a lack of real volunteer spirit among the volunteers, creating an impression that some key activities "aren't sacred [*sàk-sìt*] [anymore]… it has to feel connected [*phùuk phan*]." Likewise, G2 had been a gay hotline volunteer in the past.

Drug use. Drug use was commented upon only by M1: "*poppers*[10]*,* some friends inhale [them], but it's like so-so, doesn't feel at all. Some people say they inhale [poppers] and it's arousing. I say I don't need to inhale anything." Besides poppers, M1 also stated that "when [I was] a kid I used to shoot up [i.e. inject drugs]

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[9] Camfrog is an on-line group chat program favored by gays and TGs for chat and webcam shows with sexually explicit content (Ronnapoom, Chonwilai, and Boonmongkon, submitted for publication).

[10] *Poppers* are inhalants, typically amyl nitrate. Its recreational use "is common for its pleasant euphoric effects and the breakdown of normal inhibitions. It is especially popular among homosexual men because it relaxes involuntary muscles, including the anal sphincter" (Gahlinger, 2004, p. 179)

sometimes … But having grown up, I don't do it anymore … nowadays, *ice*[11] is common, I do *ice* sometimes."

Reactions to problems. Of the gay participants, G1 and G2 stated they had attempted suicide. Having been bullied throughout primary school, G1 had tried to hide the problem from everyone, but by sixth grade felt he couldn't take it any longer, and "secretly poured insecticide into a small bottle and hid it by the bedside" and would look at it now and then, until one day he "really drank it," because he felt it would be "better to die, to begin anew" in the next incarnation. G2, who has long suffered from depression, said his suicide attempt with "Phenobarbital, 1000 tablets" was because "[I] felt *sad* – nobody in my life."

At another occasion, however, G2 went to see a psychiatrist at the insistence of concerned friends. He also said he's seen various doctors in relation to his problems. G3 had gone to "see a psychiatrist because [he] was stressed about his studies" around the time he entered university, and again after having started working, due to depression. M1 noted that while he'd been taken to a psychologist due to his mother's dismay about him showing signs of transgenderism, the visits rather addressed the problem that "back then I ... couldn't control my emotions and so didn't obey my mum; I'd hit people ... I wasn't interested in studying ... [and] was selfish."

M1 noted he wards off loneliness by hiring a sex worker for 5 to 10 days to stay with him full time, or hook up with people who "even though I know cheat me, let them cheat me, I'll give [money to them]" and that his wild sex life is due to his lack of a partner. M1 also noted that as a child, if he "wanted something, I'd take my

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[11] *Ice* refers to "a base version of dextromethamphetamine" that "gives off vapors when heated, which can produce a rapid and intense intoxication lasting up to 14 hours" and is "usually smoked" (Gahlinger, 2004, p. 208).

hand down [my] throat ... vomit ... and mum and dad would give me things," which he viewed still makes him vomit whenever he feels upset, even now as an adult. As a young adult, when he had given in to his mother's insistence on masculine gender expression, he "would never call anyone … disappear from this world, and stay with a feeling that's, that's finished … like there's nothing there anymore."

T3 said her friend who had been told not to be a TG had "fled from home and … like, went to ruin."

TG Participants' Views and Experiences

 Sexual diversity and fluidity. T1 held the view that "sexual diversity probably means masculinity and femininity in all their forms … gays have masculinity, *transgender* [people] have femininity" rather than anything more specific. T2 said she "believes in sexual fluidity" – she herself, for example, "might also change to be gay, but that change has to come from my own consent, not from being forced to change my behavior by others; it'll have to come from our own needs." She also noted that "many *kràthoeis*[12] choose their own way without attachment to masculinity, femininity" and that "it's not that people who have the same identity would understand each other, because many times, [I]'ve come across that … people who are *kàthoeis* like [myself] also judge, evaluate each other."

 Medical versus social model of transgenderism. T3 agreed with the medical model of transgenderism as a mental disorder, because "that we want to have a sex change, it's like we're patients" as "we people probably won't run to the doctor, go to the hospital, right, if there's nothing wrong with us, so I think, it's correct, like, that we have to see a psychiatrist" before obtaining SRS. T1 wondered: "how could a

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[12] Alternative form of the word kàthoei.

psychiatric process be the thing that confirms our *phêet*?" However, she went through psychological testing prior to SRS, with great curiosity as to how it would be conducted. T2 was most critical of the medical model: "I think it's not always to the point, because if [they] only take the medical point of view, they'll *focus* on illnesses, and when you're ill, you have to be treated, without a societal perspective."

Transitioning.[13] M1, T1, T2 and T3 all stated they'd taken hormones at some point, and all except M1 were still taking them – he had decided to stop transitioning and revert to an MSM identity due to his mother's fierce opposition. M1 also said he had an allergic reaction to hormones, "vomiting, lots and lots, and I couldn't bear to take them … I didn't know you have to take them and [then] go to bed" – however, he did try several ones before giving up. T2 reminisced she'd learnt about hormone use as a part of her identity development from older friends rather than from media, because "there are lots of publications stating what men must be like, what women must be like, but … no publications stating what *kàthoeis* must be like." She acknowledged the community "bias" that the more hormones one takes, the faster one will become beautiful. T2 herself had also "wanted to be a woman, and [so] I had to be beautiful like a woman … without consideration for side effects." Her use had, however, been moderate at only a tablet a day, with no injections. T3 mentioned she'd started using hormones at age 13.

T1 and T3 had undergone SRS. T1 had used the internet to gain information about SRS, and in the process come across the website www.thailadyboyz.net. Similarly with how some of the gay participants had been community volunteers, T1 shared her knowledge on hormone use with members of this website, while herself

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[13] *Transitioning* refers to a transformation from a person of one gender to another, covering aspects such as hormone use, SRS, and the social aspects of living in one gender rather than in another.

gaining more information on SRS. Later, she'd accompanied a younger friend to the hospital to consult on SRS and gained the opportunity to start her own process, too. T3 viewed that it needs to be considered whether TGs generally do the operation for themselves or for their partners. She herself didn't have a partner at the time. Instead, she felt that "if I didn't do it today, I'd have to do it some other day." T3 had asked the doctor if she could preserve some sperm for later artificial insemination in case she wanted to have a child, but the doctor had told her that the sperm would be too weak to be usable since she'd already taken female hormones for several years.

T2 had a critical view on both hormone use and SRS, noting that information of either desired or undesired health consequences of either procedure was scarce in Thailand, SRS generally being done on a commercial basis, with even SRS tourist packages arranged for foreign SRS candidates. Therefore, she viewed, "we should rather give importance to the societal perspective that you can develop your identity, even without changing your body at all" to provide an opportunity for young transgender people to develop their identities "without being stuck with [the idea] that *kàthoeis* have to be beauty queens, beauticians, show girls, and beautiful like angels."

Reactions to social pressure. T1 noted that "*kàthoeis* by nature ... we've got *ego* … we've been through a lot in life, before reaching this point" and so "sometimes when we enter society, begin working, we've got [our] biases to start off with." In contrast, T2 viewed that "regardless of whether [people] are *straight* or *homo,* there are always expectations from society, and pressure, [so it's] not different."

Reactions to other problems. T1 noted her chronic psychological and physical problems were interlinked, and had resulted at different times in suicide attempts (using psychiatric drugs as the method), help-seeking from psychiatrists and herbal medicine prepared by a relative, religious practices (counting beads, prayers), and

"trying to enter society." She also noted she had long tried to hide being transgendered, as she had felt she could not identify with the label in the past, and said she had survived a financially austere period through finding various temporary jobs.

Specific Demands, Recommendations to Society by Sexual/Gender Minority Groups

G2 viewed that gay people should be compensated by other types of social security benefits because they currently lose out on child-related benefits. He also viewed there should be a same-sex marriage law, but acknowledged this might require a long campaign. T2 simply noted that young people, whether straight or otherwise, should be allowed to decide about their sexual behavior. She also said the government should pay more attention to the dangers of commercially based SRS.

Views and Experiences by Practitioner Participants

Etiology of Homosexuality/Transgenderism

Like client participants, practitioners were not asked about their etiological views, either, but many (particularly PA1, PA4, PL2 & PL3) volunteered them. PA1 tended to favor a biological explanation, "it might be a matter of *biological factors ... chromosomes, hormones* or the brain, whatever" since "many doctors that are gay or *lesbian* – their upbringing by their parents wasn't different in any way from others, not in the slightest. Hence, this is an old theory ... it's history, not a fact." Similarly, PA4 stated the cause might be "*genetic, chromosomes, genes,* many things, that are passed on from relatives are involved … or there is a change in the structure of the brain that makes … *sexual orientation* change, right?" PL1 mused in passing that "it's something... in the inside."

PL2 and PL3, both older practitioners, held the opposite view. PL2 said: "there's not a single cause. Generally [people] tend to pretend they know [*mûa*] that it's *organic* or genetic" but instead "there are no less than 50-60 causes, and some have … five, six causes concurrently that make them [homosexual]" plus which "it's become, er, a matter of taste … a fashion" caused by the positive attention those acting effeminately can gain, or by sexual addiction. PL3 viewed some are "*born to be* [gay]... but some people might be because of their occupation, or some fashion … some people are [gay] because they might've been cheated [into it] since childhood."

Normality of Sexual/Gender Minorities

Many practitioners referred to the declassification of homosexuality as a mental illness by international bodies, such as the WHO, the change it has constituted in Thailand, and their own views.

PA1 and PA2 asserted they have many gay (or TG) friends. PA1 said he has no negative views about people in these groups: "it's just difference, diversity," and PA2 said about TGs: "[I] feel it's not a problem at all … they live their lives in their way … [I] don't feel negative about them in any way," and furthermore, "[I] *almost* don't view it as an illness or a psychiatric *disorder* at all / … I view that it'll be cured if they have SRS and live their lives like *Nong Poy*.[14]"

PL1 said she sometimes has to tell clients that "it's not abnormal; it's what you choose." So does PL3 with patients who suspect that sexual/gender minority staff are in fact patients: "Oh, so how are they ill then? Are [they] taking care of you? Yes, [they] take good care of you. There you go, so why do you think they're ill?"

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[14] "Nong Poy" is the nickname of a Thai TG noted for her beauty; she won the Miss International Queen and Miss Tiffany's Universe beauty competitions in 2004 (Nong Poy, n.d.).

PL2 believes sexual orientation can be changed by psychotherapy, but nevertheless qualified his statement by adding he's "not saying gays are abnormal."

Two practitioners noted that gays themselves tend to view homosexuality as normal. PL2 said: "if they're gays, they won't treat it, because they don't think it needs to be treated …/ *anxiety*, or *OCD*, or *depressive,* they're suffering, they'd like to cure it, but gays or *túts* think it's happiness, because *sex,* it's *addict[ing]*." PL5 also noted: "[clients] that walk in and say, oh, I don't want to be gay … I've never met one. Err, it's like everyone can accept themselves." Similarly, PA3 said that some university students come to consult when they feel confused about themselves, but few consult explicitly because they are homosexual.

Non-Specificity of Sexual/Gender Minority People

PA2, PA4 and PL2 emphasized that sexual/gender minority people are not that different from other people. PA2 noted that "people view that those who are, err, *homo,* get into relationships quickly" but since "men and women also do … it doesn't differ … they've got characteristics, personality, or problems of some kinds, which, I [think] really don't differ from *heterosexuals*." Other practitioners (PA1, PA3 & PL4) also viewed their problems are not distinct. PA1 noted that problems *between* different sexual/gender minorities don't differ from each other. PL2 took issue with the alleged special abilities of gays, asserting that "they are still men, it's just that they tend to have … sexual feelings toward other men." PA4 acknowledged that "society itself views that these people are a group that have quite violent emotions, but I view that they don't differ that much … in my view, all *phêet* are similar, don't differ from each other all that much."

Specificity of Sexual/Gender Minority People

In contrast to views emphasizing the similarity of all phêet, some practitioners spoke of the various differences they feel gays and other sexual/gender minority people have with those in the sexual/gender mainstream. PL1 said she'd "learnt that their ways are not like normal, normal people … that they've got their own ways of thinking" and "will accept and endure a lot …they're, *o-ho*, really patient," plus sometimes very generous toward their partners, as well as have "strange ways of thinking … some things they do, oh, *surprise* me."

Creativity of sexual/gender minority individuals. One concrete example of viewing sexual/gender minority individuals as having specific characteristics is viewing them as very creative. PA1 said "many of them have a lot of *creative thinking*" and PA4, likewise, viewed "it's like God created them with a special ability, that is, their *creative thinking* is good." PL2 held the opposite view: "always remember that they are good men … men who have abilities, not that they don't and [then] suddenly start to like the same sex and turn into good gays or skilled gays."

Specific relationship and sexual characteristics and problems of sexual/gender minority people. Many of the views on gays and other sexual/gender minority people as somehow distinct from others dealt with their sexual and relationship patterns.

PL1 remarked: "these groups, their sexual ways, they might have something that's odd … might be violent, or one couple were *sadists* ..." and that some might have difficulty accepting their partners' sexual preferences. As one example of odd sexual practices, PL1 mentioned a hospital patient who "went to take a youngster to sleep with them." PL1 also noted that "they've got *families* as well, [it's] not that they don't; therefore, they might have *families* that are different from, err, real men and women, but they're still a part of society."

PL2 viewed that upon seeing a man, gays will "be really excited, joyous …

more excited than a woman who sees a man" and "feel averse to women / sometimes

so averse they can't touch a woman's body." PL2 also said that gays who come to

request treatment for their homosexuality feel they suffer, for example due to

abandonment, loneliness or one-sided love, adding that "in Thailand, gays, *túts* are

most afraid of having no money … and getting old, see, gays and *túts* have to … pay

the men" they have sex with, especially when older and unattractive. PL3, likewise,

noted that some clients come for counseling because they can not find a partner or are

about to be abandoned by a partner who is going to marry a heterosexual partner.

PL5 said his gay clients have typically consulted on relationship problems,

such as being "heartbroken," "not knowing whom to choose" or wondering if "one is

being taken advantage of." Both PA3 and PA4 said that in private practice, gays come

both alone and as couples to consult on relationship issues. PA4 gave examples of

such problems: arguments, overuse of emotion, feeling one is not loved or given

importance, and self-destructive or abusive behaviors. He also stated that often,

psychiatric illnesses rather than personality disorders (i.e. Axis I rather than Axis II

conditions in the DSM) are behind the problems, without anyone being aware of it.

PA4 reported feeling shocked by youngsters explicitly soliciting on the web

that they "need some income; happy to provide services off-site" plus "strip and

show, without any shame or embarrassment" in spite that "the kids, sometimes they're

good-looking kids, have a father and mother, have education…" making PA4 view

that "these kids must have some hidden pathology because I think their *judgment* that

is very *poor* might not be due to their *personality* – it's probably an illness …"

PA4 also remarked that in the "*chaai-rák-chaai* group, we see that sexual

promiscuity is quite common … / … infidelity has become matter of course for them," causing various relationship problems.

Finally, PA4 also noted the *gaydar* ability of gays and lesbians to spot other homosexuals: "sometimes [they] look each other in the eyes and already know it."

Gay social life. PL2 extensively shared his perceptions of gay social life, whether of "gay clubs, clubs of … *violet people … purple people* … homosexuals … or gays [on the internet]" or "gay bars [and] gay stage shows, like Tiffany, Alcazar, or *cabarets* – these are all gay", as well as gay hotels and "covert gay spas" especially in tourist areas," so that "in Thailand, we, we don't need *gay parades* but we do have them … in Pattaya, Phuket, they do it but really, not very successfully … because Thais are used [to gays] so [they] feel indifferent about this issue …"

Closeted vs. out[15] sexual/gender minority people. Like client participants, practitioners also talked about sexual/gender minority people in and out of the closet. PA1, PL1 and PL4 emphasized that sexual/gender minority people exist in all communities and even among politicians, teachers, and married couples, but not all are open about their identities. PA1, PA4 and PL1 noted that some, however, are open about their identities, PA1 stating that some even have come out on TV, and PA2 quoting a gay he overheard say "even in next life, let me still be gay." PA4 noted that in contrast to the past, when gay clients acted sissy, there are now more gender-normative, masculine gays as clients, confused about their identity.

PA2 gave a long explanation of how those who are open about their identities may be better adjusted than those who are in the closet, based on his experiences of providing counseling to students at two university counseling centers. He noted that

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[15] The word "out" (of the closet) when used as an adjective means that others know about one's identity as a sexual/gender minority individual. The word "closeted" means the opposite.

those who are out of the closet may be considered more entertaining by their friends, whereas those in the closet might act in a stiff way and be seen as disingenuous by their friends. Closeted persons will also be afraid of gossip.

Similarly, PL3 noted that "If you don't really dare [to be yourself], you'll be like this – *wishy washy,*" but also those who dare to be themselves would have to prepare themselves for a lonely life, since "not many people walk this way."

Reactions to societal pressure. PL1, who works at a suburban domestic violence center in a state hospital, noted that since outsiders in Thai society "still accept" sexual/gender minority individuals "to a low extent" and sexual/gender minority individuals might be blamed or stigmatized as abnormal, some sexual/gender minority individuals internalize these messages and "even agree to be [physically] hurt, thinking it's their lot, because they're not normal." Some, she said, "are very lonely… when in the hospital – very *depressed* as if they didn't know how to speak anything with anyone." PL1 viewed sexual/gender minority individuals have more "unstable emotions," tend to be long vengeful toward partners who have wronged against them, think in a more fixed way, wish they were really either full-fledged men or women – "not half-way like this", and added that boys who are discovering themselves in school "begin to have an inferiority complex straight away." PL4, likewise, noted about adjustment difficulties among these groups, and PA2 stated "they feel sensitive, wondering if it's because they're like this or not."

PL1 also noted that sexual/gender minority people may not be able to rely on their families if they have faced violence from partners, and that they may not want to talk about their issues with anyone (wishing the issue came to a close and afraid of being reported on by newspapers). She found that this also holds for their trust on health service providers and the legal system as well, as they might not think they'll

gain anything: "[They'll think] I'll have to endure yet a bit more …" Even when using the services of the domestic violence center, PL1 said sexual/gender minority clients are unwilling to follow advice given on reducing domestic violence and "having an appointment, they'll not come regularly; they'll drop out of the assistance system.

Likewise, PL3 noted the DMH hospital she works in has few clients from these groups, and even some of those come for drug abuse treatment rather than other reasons. Those few that do consult on sexuality related issues may "feel constricted … unhappy, and sometimes feel pressure from their families … to change some things." PA4 made a similar observation about masculine-looking gays who feel confused about themselves and face pressure from their families, and added that many only come when their problems have resulted in depression. PA4 also noted many *chaai-rák-chaai* and *yĭng-rák- yĭng* are over-acting and very attention-seeking.

PL3, however, viewed adjustment as ultimately an individual responsibility: "Sometimes you will just ... feel *upset* with other people … it's not important what whoever thinks about you. [It's] about you: what do you think about them?"

STIs and HIV. PL2 and PL4 noted some sexual/gender minority clients are HIV positive. PL2 said such clients may be concerned they will infect others, whereas PL4 also referred to STDs and the issue of "living together with AIDS patients." PL5 said he has never come across the issue in a client, but it's "an *issue* that people talk about a lot … [and] are increasingly afraid of."

Gay Social Influence

PL2 noted that gay groups are trying to lobby "educational circles to view gays as natural" and that Thai media are controlled by powerful gay people who try to

influence people in general. He also viewed that gays creating and using "strange names" for themselves "makes society very confused."

Practitioner Views Specifically on TGs

    SRS and psychological adjustment. PA2 and PA4 spoke at length about SRS and adjustment following it. PA2 noted that while Thai people know they can get good quality service in medical school hospitals, some TGs prefer to avoid the lengthy testing procedure and expense and thus choose to go to lesser-known clinics (where the surgeon's skills might be questionable) or choose to do breast augmentation surgery before SRS, for the same reasons. PA2 also noted that both the cost and time spent might provide a psychological screening tool:

> I've not really seen anyone have problems after the operation, because generally [they've] got to be very determined, because the cost of the operation is high and the process of [them] calming their minds before coming here takes long. It helps show that their mental health is probably *OK*; otherwise they wouldn't have been able to live their lives like this.

PA4's experience, in contrast, suggested that "many people who've had the operation have had lots of problems with unstable emotions" which he viewed might in part be due to hormonal changes, but also "we don't know whether before that, really, they had [psychiatric] illness or not, so when that's not treated, they'll be all the worse if operated," and if the operation isn't fully successful and the resulting genitals "can't be used", that also contributes to psychological disturbance. Nevertheless, PA4 noted, some TG clients (or their relatives) are angry if denied permission for SRS following a single session, without awareness of their own lack of readiness for the operation.

Reactions to harassment. PA2 said that when he was in school, "some male friends would bully *kàthoeis* … the *kàthoeis*, due to being a bit *feminine*, they'd be somewhat weak; they'd play the role of a victim … [and] cry." However, "some *kàthoeis* were *masculine* and retaliated strongly, ran after and slapped [them]…"

Relationship issues. PA4 noted that sometimes TG clients have partners much older than themselves and have arguments with them.

Involvement in sex work. PL2 viewed that unlike gays who in his experience usually have to pay their partners, "*kàthoeis* … those who've had a sex change … and then go show at Alcazar … get money from men" or "if the person who's had a sex change is somewhat beautiful, they can sell themselves [*khǎai tua*] and get money."

Beauty. PA1 and PA2 noted that some TGs are very beautiful, to the extent that "[you] look [at her] and forget altogether that it's a man who's had a sex change" (PA2) or "*kàthoeis* are more beautiful than women; the fake is prettier than the real thing / and Westerners will not know the difference … I've met a Thai *kàthoei* who cheated a Westerner [who] didn't know his wife was a *kàthoei*." (PA1)

In-between beings. In contrast to views about some TGs' beauty, PL1 and PL3 noted that TG's are neither men nor women and thus "can't be women, not women who look good … it's still something, half-half, middle-middle, always" (PL1).

Likeness with God. PA1 mentioned that he likes to view God as incorporating aspects of femininity and masculinity – therefore God must be transgendered.

Practitioner Views and Experiences on Lesbians

Practitioners said surprisingly little about lesbians, even when specifically asked. This seems to be because fewer lesbian clients use counseling. PA4 and PL1

both noted that they see fewer lesbians than gays or TGs, both as clients and in society in general. PL5 estimated he'd had ten gay clients but only one lesbian client.

PL1 viewed that toms have more fluid identities than do feminine males (gay queens or TGs). PA1 recounted information he attributed to the website www.lesla.com (now offline) that only about 10% of toms are FtM's ("have a man's heart, want to have a penis"). PA4 told of his experience with a tom, his junior, who had amazed him by spotting a fully ordinary-looking woman, known straight away she must be lesbian and tried to woo her. He also mentioned a case of a woman who had felt confused about her sexual feelings toward other women, wondering if she was a dee. PA4 also recounted that

> in the past … there were lots of upbringing-related issues, like … a daughter didn't have much importance [in the family], so she felt she had an inferiority complex, or had bad experiences with Dad, like Dad who likes to abuse Mom … so she'd [the daughter would then] feel she's to be strong, protect [Mom].

Practitioner Views on What Sexual/Gender Minority People Should Do

The practitioners expressed a number of views on what they viewed sexual/gender minority people should do in their lives.

Ordain. PL2 noted that for those gay individuals who do not want to be "gays in society," ordination is an option characterized by pure, non-sexual love, since many gay people find they can love the Buddha as they would a man. On the other hand, PL3 noted certain monks in Chiang Mai who "wore their robes like a kimono" definitely did wrong as they broke society's rules.

Work. PL3 emphasized the importance of sexual/gender minority people finding work and being able to support themselves, because "you might be alone, you

might not have children … nobody might stay with you." PA1 said TGs might not be suited for highly esteemed professions, but should rather go for "dance, whatever that's creative work … rather, stay in the entertainment circles, will be really good [because] society … they accept this group, and these people, many of them have a lot of *creative thinking.*" PA4 noted that homosexual people tend to have special abilities, so it would be good if they could utilize them.

Stick to society's frame. PL3 noted sexual/gender minority people should model their lives along ordinary people's example. PA4 also noted they should control their expressions and stay within an appropriate frame.

Create good publicity. PA4 noted that since there is a lot of societal interest toward homosexuals, they should utilize this interest to create good publicity. PA4 also noted they should help society, and that he feels campaigning for acceptance is useless – rather, if one feels pride in what one does, one should keep on doing that.

Find a way to be happy. PL3 noted many times that those born homosexual should find their own way to be happy. PA4 also said they should see their own value.

Dare to be yourself. PL3 noted that people who are different have to dare to be themselves. PA2 noted that one person coming out may help others to do so, too.

Understand relationship realities. PL1 noted that sexual/gender minority people should assess whether they gain anything by giving (money, things) to other people, and if not, change their strategy. PL3 noted: "If you're *queen, kings* won't stay long – you've got to try to understand nature."

Clients' Experiences and Views on Mental Health Services

The presenting issues or reasons why the client participants received mental health services have already been summarized in Table 1 (pp. 52-53). Below subsections present various aspects of these clients' experiences and views related to psychological and psychiatric services.

Clinical Roles of Various Kinds of Practitioners

Psychiatrists

All the client participants had seen psychiatrists. G2, G3 and T1 had received medications from their psychiatrists. T1 said "a psychiatrist has the responsibility to medicate; a psychologist has the responsibility to rehabilitate."

The psychiatrists of all client participants also had engaged in some counseling-like interactions, but G2, G3 and T1 identified limitations in this role of the psychiatrist, with G2 stating Thai psychiatrists tend to "see [the patient's] face and give drugs" straight away. Likewise, T1, upon "becoming the doctor's patient for real… they would just give drugs," and at another point stated that "psychiatrists … tend to … give drugs or various processes … but it's not counseling; it emphasizes treatment, rather." G3 said he'd met three psychiatrists, but "a psychiatrist skilled in discussing – really skilled, never met one." In contrast, M1 found his psychiatrist had listened to him very patiently (but she was not working at a state hospital).

All participants had also received advice from their psychiatrists, and diagnosing and permitting SRS were likewise a part of psychiatrists' roles.

Psychologists

Only G2, G3, M1 and T1 had seen psychologists. Of these, M1 had earlier received treatment at a famous psychologist's clinic based in a private hospital, but the psychologist was always only seen signing documents, selling audio tapes and giving instructions, while M1 received counseling from a psychiatrist in the team.

T1 viewed that psychologists were those who "gave counseling … [were] more to the point, more understanding, or sometimes, providing an opportunity for me to talk, recount my problems, vent [my frustrations] and point at options, but not point at the answer" – rather, "let us go find the answer for our problems, without having to speak much, without having to give various suggestions" but "try to make me … open my heart, pull out the feelings, sufferings to see them as concrete … and they'd help me deal with those problems." Likewise, G3 found that "psychologists were more skilled … in analyzing … in my view … [they] would understand better."

In contrast, G2 viewed Thai psychologists generally "consult, teach, and blame" their clients, unlike one US-educated Thai psychologist he regularly consults.

G2, G3 and T1 had received psychological testing from their psychologists, which seemed to be a major part of their role. G2 said that during his initial treatment contact, "I only met the psychologist to do the *psychotest*."

Other Clinical Staff

G2 noted his case history was first taken by a social worker, who then sent him on to a psychiatrist. T2 was seen by two other members of hospital staff (one of them a nurse) to take her case history before seeing a psychiatrist. M1 had seen some sexual health clinic counselors, who apparently were not full-fledged psychologists, and addressed the utilization of volunteers in various clinic and NGO based services.

Confusion of Roles and Lack of Professionalism

M1 was vocal about practitioner role confusion and professionalism. In his organization, for example, most counselors were nurses with short psychological training, and in his view, full-fledged psychologists generally seemed a rarity in the counseling circles. At one point, his organization had considered hiring people with just senior high school certificates as counselors – a plan he had successfully defeated. He also viewed that the excessive use of volunteers is likely to reduce the quality of counseling. M1 considered that since nurses' training emphasizes physical matters, it is inappropriate they become counselors, and so is the practice encountered on some sexual health clinics that the counselor also provides physical treatments. Even a counselor with a Master's degree in psychology, M1 viewed, without a Bachelor's degree in the same field, would not have "pure" expertise. He noted there is no clear division of labor between social workers, nurses, psychologists and psychiatrists, which is confusing.

Helping Processes Other than Counseling

Below, counseling is not addressed in a specific section, because it constitutes a non-specific element of the services, addressed in other subsections.

Psychological Testing

G2, G3 and T1 had received testing by psychologists to guide treatment; T1 and T3 had also received specific testing before obtaining SRS (T1 by a psychologist, T3 by a psychiatrist). Each reported the use of projective tests, such as a drawing task, an inkblot test, a sentence completion task, and a picture interpretation test (such as

TAT). T1 also reported having completed an intelligence test and a visuo-spatial reasoning test as a part of her pre-SRS assessment. Likewise, G2 had completed an intelligence test as a part of his clinical assessment.

Both T1 and T3 had gone through the pre-SRS testing process within a single day, but while T1's test had taken some three hours at a general state hospital, T3 had passed it after a 30-minute discussion and testing with a general hospital psychiatrist. T1 had heard that a medical school hospital had higher standards, and so the process would take longer. T3 was aware that new regulations[16] had recently been issued, making certification by two psychiatrists a condition for obtaining SRS, and that abroad, the process would be even more difficult as it involved a 1-year trial period.

While T1 wondered how a test could validate a person's phêet, she acknowledged the procedure must have been validated because it has been around for a long time. T3 viewed the psychiatrist's questions were "to the point, as if he knew already" what to ask, and justified "so that having done it [SRS], it won't be a mistake toward myself." She felt the process was "really easy," whereas T1 reported hers had left her very tired. T1 felt that the pre-SRS test had helped her recognize her intellect, personality characteristics, life experiences and imagination. She recounted her personality had so well matched a personality type that the psychologist had insisted on phoning a colleague to tell the colleague they'd encountered such a clear-cut type.

G3 and T1 had a generally positive experience with testing. T1 said testing the first time was done to assess her personality and her psychological resources that could facilitate her return to normal life, and she found out she was in fact quite talented. G3 said the inkblot test "was a really good *test* … having interpreted the result, err, how could they know?"

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[16] The regulations T3 referred to are those specified in Lolekha (2009).

G2, on the other hand, interpreted that having some cards in the inkblot test set come up more than once meant that the psychologist *"looked down"* on the "patient" and that the psychologist felt "the patient is stupid (*ngôo*)." The final card in the test was blank and G2 had felt annoyed when the psychologist had asked what it looked like, since it was a blank card. The negative experience had turned even worse when he had "secretly read what [the psychologist had] recorded … very negatively … 'this patient is … temperamental, angry, aggressive, vulgar … uncooperative,'" which G2 felt was unjustified since he had completed the test set as requested.

Diagnosis & Certificate Writing

T1 noted that both as a child when she had health trouble, and as an adult seeking SRS (both times at a state hospital), the psychiatrist would make the diagnosis based on psychological testing by a psychologist. A psychiatrist would also be the person issuing a certificate for permitting SRS. However, during her pre-SRS test (which passed very clearly), "the psychiatrist would not issue [the document] – she didn't know how to do this; she sent me back to the psychologist … to discuss what a *psychotest* is …" because the psychiatrist herself did not know what it meant and how to issue a certificate. In contrast, T3 obtained her certificate following a 30-minute interview and a drawing test interpreted straight away by the psychiatrist, and wondered afterwards how it could be so easy.

G3 pondered why three psychiatrists each had given him a different diagnosis:

The first one … tried to think I've got *bipolar* … and after some discussion, "oh, no, you've got another disease … *borderline disorder* ..." and when I went to discuss at … [they'd say] "you're not *borderline,* I can guarantee that. You've got one kind of *dysthymia*."

Advice

G1 noted his psychiatrist had told his mother after his suicide attempt that he watched too much TV. After he had come out to his mother as gay, the psychiatrist he'd been taken to see saw his parents alone during the third session, but he didn't know what they were told, because he wasn't in the session.

T1 was instructed by a psychiatrist to "enter society" which at the time did not make sense for her – she didn't know why that would have been helpful and also did not feel ready for that. Similarly, the psychiatrist "told [me] that we can't change others, we can only change ourselves … without explaining why I'd have to change myself, and how much," so this constituted another unhelpful piece of advice.

T1's psychiatrist had instructed her to relieve stress by tearing paper and throwing it at a wall. T1 did not say if this had been useful. When M1 was a child who had difficulty in controlling his emotions, he was likewise trained in progressive muscle relaxation, which he didn't know was beneficial "in which way, but when I'm angry I might be able to use it sometimes, even today," as it would "allow me to control … some emotions."

G2 had become infatuated with another (male) doctor at the hospital; his psychiatrist warned this doctor was a real "square," not a good partner candidate.

Medication

As stated above, G2, G3 and T1 had received some psychiatric drugs. G3 had the most positive experience of medication: "the drugs the doctor gave were quite OK," helping to stabilize his emotions, as he put it. G3 added he "doesn't believe [in] psychiatrists much / but I'd go to get medications ... because I felt so sad I had to go

and get some." G2 seemed to have improved somewhat due to medications; whereas for T1, "drugs didn't help me to get better at all."

Both G2 and T1 had experienced drug dependency, drug allergy and severe side effects. Both had also used their medication for suicide attempts. T1 said that initially, the psychiatrist had had to experiment to find out which drugs would have desired effects, making her feel "like I was a laboratory rat." In her case, the adverse effects of the drugs had been so severe she had quit taking them. G2 stated some psychiatrists would insist on prescribing drugs he had already had an allergic reaction to, while others would be willing to listen to him and adjust the medications.

Referrals

G2, G3, T1 and T2 all reported their practitioners did quite a lot of referrals.

G3's and T1's practitioners referred them on to more experienced or skilled practitioners. G2 reminisced that a neurologist and a psychiatrist would keep on referring him to each other, viewing his problem was the other doctor's specialty.

T1, G2 and T2 also encountered referrals that were an integral part of the state hospital system. For example, G2 noted that at the state psychiatric hospital, a social worker would first take his case history, send him on to a psychiatrist, who would send him for testing for a psychologist, who would then refer him back to the psychiatrist. Likewise at a state psychiatric hospital, T2 reported that

> If we don't have a case history in the hospital, we'll have to go and report our name first; they'll ask about the symptoms ... and after that [we'll] have to go see a nurse or talk about our problem on a basic level, before we can see the doctor ... [I] felt, why do I have to divulge my issue to two more people before getting to see the doctor – why can't I see the doctor straight away?

T2 added this kind of system probably endangers confidentiality in state hospitals, and wondered how a rape victim, for example, would feel about having to divulge their issue to two officials before even seeing the doctor.

Practitioner Stance toward Sexuality and Gender Issues

Both G1 and T2 had been taken to a psychiatrist by their parents – G1 because he'd come out to his mother as gay, and T2 because she had exhibited cross-gender behavior (both around 10 years ago). M1's mother had taken him to a psychologist due to signs of transgenderism, but the treatment did not focus on gender identity or sexual matters because he "was still a kid" and had no sexual experience at that point.

G1 confirmed the psychiatrist in a private hospital his mother had taken him to had not tried to change his sexuality, but had asked questions like "when you wake up in the morning, is your [sexual] organ stiff" that G1 had felt were irrelevant and much too personal for a first appointment.

T2 thought state sector services in general lack gender sensitivity. During her own visit to a child psychiatrist at a state psychiatric hospital, the psychiatrist had already been briefed about her cross-gender behavior, and in the meeting drew a line ranging from 0 to 10, with "zero being a man and 10 being a woman," inviting her to quantify the level of femininity. When T2 indicated she was at number eight, the psychiatrist said "in that case, with [your] family's expectations toward their son, could you come [down] to number 5?" This meant "just being gay." The psychiatrist, by suggesting T2 should just be gay (not TG) in her view "did not consider the real needs [of the client] – what the child really has chosen." The psychiatrist also asked her if she wanted to be "like this because [you] want to dress as a woman, because

you ... like to make up, would [you] like to go dance at a *cabaret show* or not – would

you like to go to Alcazar?" T2's psychiatrist had also told her parents her behavior

was changeable by having her do a lot of masculine activities with her father, or

attending a special clinic, and exerted more pressure on her to change during their

second meeting.

M1 noted that unlike his mother, his psychiatrist did not seem to think he was

crazy because he was transgendered.

Later, M1 had had a four-hour discussion with a sexual health clinic

counselor, who had been astounded at the intensity of his sexual behavior and asked if

he wouldn't consider "quitting" it. After M1's HIV test result came back negative, the

counselor had said "wouldn't have believed [you'd] survive [i.e. not be infected],"

which M1 had felt was so shocking he could have sued the counselor if he'd have

audio recorded the interaction as evidence.

G3 and T1 had not gone for counseling due to gender or sexuality issues, but

they had eventually surfaced. G3 said one practitioner a long time ago had been

"taken by surprise, would not believe" he was gay and felt it was strange; but it was

seen as a problem only when he was a child – after reaching university, he was told he

could not change. Practitioners did ask him some related questions, and he felt they

didn't "divide [*bàeng-yâek*]" between straight and gay clients.

T1 said the psychiatrists she'd seen as a teenager simply would not talk about

sexual matters, the hospital being a military hospital: "I felt they were not open – even

ordinary matters in my life they would not listen to … [they'd] just say 'take the

medicine and [you'll] be better.'" One psychiatrist had wondered if T1 "was a relative

of the patient" as her appearance did not match the male sex stated in her documents,

and she had had to correct that she was indeed the patient herself. T1 had liked the

practitioner's reply: "it doesn't matter what we're born as, what's important is that we know what we are."

G2 noted he must have seen at least 20 practitioners, so he has seen all kinds – those "that understand gays, and then [those who] don't know gays and look down on gays" or psychologists that "don't even know how gays and *kàthoeis* differ … [or] how many types of gays there are" and added that those who did look down on gays were never open about it, but their nonverbal behavior clearly communicated it. He viewed that those practitioners who have knowledge about gays are a small minority.

G2 also mentioned a TG who had called the helpline he was volunteering on and been upset because all practitioners she had consulted had just told her not to do SRS. In contrast, T3 viewed the attitudes of the psychiatrist she'd seen at a private hospital about half a year earlier for pre-SRS evaluation were "OK, all of them."

Positively and Negatively Perceived Practitioners and Practices

Negatively Perceived Practitioners and Practices

Psychiatrists. G2, G3 and T1 were particularly dissatisfied with psychiatrists. T1 said that "going to see psychiatrists did not help me feel more valuable / … or find solutions in my life, not in the least." G2 said about two of the 20 psychiatrists he'd seen had been good. G3 said he doesn't believe in psychiatrists and feels that "the science of … psychiatry, it's not developed enough to treat people." While M1 and T3 were quite satisfied with their psychiatrists (both seen in the private sector), M1 noted the treatment didn't seem to change him much.

Lack of confidentiality. When G1 had to see a psychiatrist after a failed suicide attempt, he could not confide in the psychiatrist because he knew the psychiatrist

would have to report back to his mother. T2 was also concerned about confidentiality she viewed was endangered by the screening system used in the state hospital.

Lack of responsiveness and respect toward the client. The main shortcoming that G2 and T1 identified was psychiatrists' tendency to just prescribe drugs (even ones the client had reacted badly to), not listening or showing an interest in the client. G2 also felt they tended to view their patients as "stupid" and unaware of their rights, sometimes not telling the clients even the name of the medications they prescribe.

Lack of diagnostic and counseling skills. For G3, dissatisfaction with psychiatrists stemmed from their inability to give him a consistent diagnosis; G3 also noted the talking cure he received from a psychiatrist made him "wonder if this was therapy," since the way the psychiatrist discussed with him was little different from what a friend could have done, saying things like "this is an ordinary kind of thing … don't think [too] much."

Too narrowly focused or inappropriate advice. As seen above, the advice the parents of G1 and T2 were given about G1 watching too much television or the need for T2 to be involved in many masculine activities were felt by these participants as highly inappropriate.

M1 noted that sexual health clinic counselors do give advice on condom use, "but they don't give advice on way of life" that should target both how to be safe from HIV and live one's life happily. Similarly, T2 noted her psychiatrist had not addressed sexual pleasure, sexual acts, safe sex, or preventing sexual violence at all, which T2 now felt would have been be important topics even with a teenage client, as transgender youth are often sexually violated, and at high risk of STIs and HIV/AIDS.

Insincerity. As seen above, G2 felt that many practitioners' nonverbal expressions gave away their lack of interest in (or outright dislike of) the client. M1

said that though he considered himself a service provider (in addition to having been a client) due to his work, "service providers … don't have sincerity: everyone says they've got ethics but [I] don't believe them." He demonstrated this with examples of clinic staff and counseling line volunteers gossiping about clients, calling them with disrespectful names (e.g. *dòok-thoong*, "a slut") when out of session.

Something missing. M1 felt that counselors "do listen ... do encourage, but it ... it lacks *something* ... I don't know what it is."

Lack of knowledge about sexuality matters. G2 asked: If practitioners don't know about *"tops and bottoms,"* or the difference between gays and kàthoeis, or when clients "have problems in life, and sometimes speak about their problems in life and you don't know them, don't know the world, so how could you give counseling to them?" He then analyzed this would be like "a doctor who doesn't know drugs."

G3 viewed that psychiatrists may need less group-specific information than psychologists due to their different work role, and that basic knowledge is enough for hospital-based psychologists (no specialization needed), provided they know someone with specialist knowledge on gay issues, for eventual referrals.

Positively Perceived Practitioners and Practices

Establishing therapeutic relationship. G1 noted that when forced to see a psychiatrist, he hadn't known why he had to be there, and viewed that "if the doctor could *lead* [and explain the] purpose of the meeting, [that] would be good," as would ensuring the client they have full confidentiality. G2 and T1, in turn, viewed that good psychiatrists establish contact through simple questions. T2 said hers had done so.

Listening. Generally, practitioner willingness to listen to their clients was seen as important by G2, M1, and T1: "she listened to me, she asked [questions] in great

detail, letting me recount about the problems in my life, all my sufferings … all my anxieties" (T1). Correspondingly, practitioners who didn't listen to their clients were not liked. T1 stated psychologists should "attend to us more" and listen with an open mind, as difficult as it is when there are so many patients.

Analyzing. G3 and T1 found psychologists were helpful because they were skilled in helping clients analyze their problems and strengths.

Influencing emotions and thinking. G2 noted his regular psychologist has got the rare ability of being able to control clients' emotions. One of the ways the psychologist did this was concretizing his daily schedule and encouraging him to focus on the present rather than the past or the future.

Familiar and truly caring. G2 and T1 talked about good practitioners as those who were truly caring. G2 noted his trusted psychologist was "endearing, like, chatting, getting familiar … speaking briefly, informally." G2 noted good psychiatrists remember all their patients in spite that they are so numerous. G2 viewed one psychiatrist he had seen was "really good, not like a doctor, [rather] like a big brother," and could remember the kind of problems he had and enquire on them every time, or even let him borrow money if he had been laid off. G2 knew that "according to principles, he [the psychiatrist] violated the rules" and was reproached in the hospital for crossing relationship boundaries with patients, but for G2, he was an exceptional psychiatrist. M1 noted practitioners must be committed to their work.

Resting any decisions with the clients. T1 viewed clients rather than practitioners have the responsibility to find out how to adjust, and therefore practitioners do not "need to speak much or provide copious advice." T2 also viewed that doctors should only provide information, not make decisions for clients.

Tackling sexual matters. T2 noted that sexual matters may constitute taboos in Thai society, but practitioners should nevertheless find a way to address them (though possibly not in the first session) to prevent problems like sexual violence or HIV.

Addressing physical and emotional health together. M1 noted briefly that physical and emotional health should be addressed hand in hand.

Specific follow-up on medication outcomes. G2 noted that only those psychiatrists who really care would ask how the drugs they had prescribed were working, ask about specific side effects, change medication if necessary, and welcome patients for a new appointment even before the one agreed on (in case medication was not working as intended). T1 viewed psychiatrists should invite the patient to tell how they felt while on medication, instead of just asking if they felt "better" or not, as patients would not necessarily know what "better" in the doctor's sense means.

Relevance of Practitioner Phêet and Age

All but one (G1) client participants had views on the relevance of practitioner phêet. G3 had a clear preference for male psychiatrists, because he would not feel comfortable disclosing private matters to a female practitioner. T1 felt that "if looking at [it] deeply," practitioner's sex "is irrelevant, but personally, I feel comfortable when talking with a woman, but sometimes, women can also be mean" and on the other hand, "if a man opens his heart for me to talk [to him], I'll feel even better … it's like *gender* matters might be involved as I'd get a good feeling from a man … which in my real life I haven't, ever."

G2 noted he'd met both straight male psychiatrists and gay ones, and the straight ones "don't really know … what kind of lifestyle we have / and having

arrived [there], would not look [at my] face, just prescribe drugs." Similarly, M1 viewed that when both client and counselor are MSM, "I feel no division into them and us," especially because "if we recount stories about having sex," there would not be a single straight man in a group of thousand who could really accept the contents. M1 questioned the sincerity of the numerous straight men and women now working with MSM. Yet, on the other hand, a practitioner "mustn't just be gay or what, the word trust … a psychologist or whosoever must have more than that – trust, the thing called, 'yes, this person is it, I can tell everything … here's the real thing.'" Likewise, T2 viewed that similarity in identities and experiences between client and practitioner helps to establish trust, but nevertheless practitioners of any phêet could do the job.

Of the TG client participants, only T2 didn't have reservations about the abilities of transgendered practitioners. T1 had only met a TG general practitioner who had been very normal and good to her, but never a TG psycho-scientist, and "didn't know either" what one would be like, as "*kàthoeis* by nature … have [big] egos … we've been through a lot in life … [when] we start working, we start out harboring prejudices." Likewise, T3 felt that if a practitioner "was a *săao-pràphêet-sŏong* herself … I think [we'd] understand each other more … more than [if the practitioner was] a man, because men probably doesn't know how we live our lives" but nevertheless, "I think it'd be weird." She also wondered that as TGs generally have to meet psychiatrists, how could they themselves become psychiatrists, and acknowledged that neutrality might be an issue when seeing TG clients.

Only T1 addressed practitioner age, viewing that if the practitioner "is old, they've studied with the methods … of that era," then "it's not contemporary knowledge. If they haven't *updated* themselves they won't know, and they can't

practice with us; they'll use the methods of the era when they studied … traditional style, using beliefs of that era on us" and "so it might not be appropriate for us."

Role of the Clients' Actions

G1 said that when he was visited by a psychiatrist after a suicide attempt, he was "frightened of having to talk with a psychiatrist" and since he believed that "if he knew, mum would also know, because everyone wanted to know what had happened, and I didn't want anyone to know." G1 thus "just tried to smile, make a face like there wasn't anything, everything all right" and "whichever [question I] didn't want to answer, [I'd] lie." He hadn't wanted to see a psychiatrist and thus didn't cooperate.

T1 had seen the first psychiatrist "with the general suffering of a teenager, but really, they didn't know what I suffered about … being *transgender"* and initially "didn't want to tell how I was, that I was like this," and even denied being transgendered, because her mother was also in the session. Only when she felt she "couldn't take it any longer", did she start telling the psychiatrist she "wasn't a man" or address the rape attempt she'd faced. Even later, T1 requested to see a female psychologist, because she felt her issues would be awkward to address with a man.

At one point, T1 had asked her psychiatrist if she could stop taking psychiatric drugs when they did not seem to help, but the psychiatrist said no. When the psychiatrist just kept on asking if she was better and dispensing more drugs, she "felt tired and stopped seeing this doctor and everyone, who was a psychiatrist."

M1 and T2 confided in their psychiatrists that they felt constricted about their families not being able to accept what they were. However, when T2's doctor tried to persuade her to revert to a gay identity, she felt "it wasn't right, but at the time, being

a kid, I didn't want to argue, it's, there was no negotiation power," especially since "Thai society and culture teach to obey ... not to argue," which limited the usefulness of her discussion with the doctor, and "while we spoke I cried and ... felt terrible."

G2 saw numerous practitioners for various problems. He played an active role in obtaining medications he felt were useful, because "doctors [in] all systems, they view patients as stupid … [think that] patients don't know … they view that patients don't know their own rights" such as the right to know which drug they are prescribed, and thus patients have to "secretly read [their] … *OPD card*" to obtain that information, like he himself has done. Besides vehemently refusing to take drugs he had previously had bad reactions to, G2 had even convinced his psychiatrist to give him a 6-month supply of certain tranquilizers to prevent a shortage in case the doctor went abroad, by demonstrating to the psychiatrist he knew a more effective suicide method than psychiatric drugs to kill himself.

Outcomes

G1 replied that the first meeting with a psychiatrist hadn't benefited him; he "hadn't asked to [or] wanted to see a psychiatrist" and therefore hadn't cooperated. The second time, "the only benefit was: it was like an official affirmation, at last, that I am [gay], really."

As seen above, T1 had had very negative experiences with psychiatric medication, and didn't feel she'd gotten anything from psychiatrists, or as she summarized it, they had "no *methodology* ... none that would have come to my aid ... why are they psychiatrists?" However, "the psychologist made me feel really good … like they paid attention to me, they tried to look for my real self … tried to pull out the

good things, things that were attitudes on my good side," which "made me see I was valuable." As also seen, she gained insight to her nature from psychological tests, and a psychologist was also instrumental in the pre-SRS testing.

G2 noted that compared to his mental state around his "*breakdown*" some 10 years earlier, his current state was "worlds apart" from that, and even his friends were surprised he had survived at all. However, he said he was still depressed and suffered from impotence despite numerous clinical consultations.

M1 remarked that his mother had wondered why treatment did not seem to change him at all. For himself, having a psychiatrist who was "quite good" because they would "listen to all I would say – I could say anything" meant he had someone who would listen to him as he vented his anger toward his mother, and as seen above, he kept on using the progressive muscle relaxation technique even now.

G3 felt that treatment "wasn't that useful ... / the doctor … couldn't even diagnose ... / but the drugs the doctor gave were quite OK" in stabilizing his emotions.

T2 analyzed that "one good side of the doctor's provision of counseling was [that the doctor] tried to *tune* between [me] and [my] family, to get us to talk…" but in practice, "atmosphere [at home] was even more constricting than before … because [my] family [now] knew my [real] identity, what I wanted and how I felt, right?"

T3 was quite satisfied at having received a psychiatrist's permission for SRS after a single, short session.

Willingness to Use Services in the Future and Finding Good Services

G1 noted he still had (non-gay related) issues he'd like to consult on, but thought "they're not important problems, and since not, the doctor might view it silly

[*ráai- săará*]" to consult on them. He doesn't know where he would go, but would probably choose somewhere "that had skilled personnel in this field."

T1, who has earlier been satisfied by the services of psychologists, said she would recommend a depressed or otherwise suffering friend to "go speak with a psychologist. A psychologist can help them … if the psychologist sees [the client has] heavy symptoms, they'll have to refer [the client] on to a psychiatrist anyway." T1 said she would recommend the state hospital where she received satisfactory services.

G2 viewed that good psychologists and psychiatrists are hard to find in Thailand, "unless [you're] a bit lucky, like I [who] met [a good psychologist because I] had a friend who recommended: 'come see this psychologist.'" Thus, knowing a social worker or a nurse might be helpful in identifying a good practitioner.

M1 said he would not meet a psychiatrist now. He wondered "just how many people are there [I] could tell everything … I haven't met [a single] one" and "is there [such a thing] – a psychologist that would sit and listen to me for about three hours?" He also wondered who or which institution could help him with loneliness and thought that there were generally no hospitals where decent people with a professional standing like himself could go for counseling, and he'd have to "wait to go crazy before going" to a certain state psychiatric hospital he knew by name.

T3 noted that TGs tend to exchange information about good hospitals for SRS, and she also chose her hospital based on a friend's recommendation. She viewed that in the future, if she was faced with a lot of stress, she could probably cope with it, but if it was something that made her very confused, she might see a psychiatrist again. If she did, she'd like to talk to a psychiatrist who "would open their heart to speak about all issues."

Socio-Economic Context of Service Provision

Lack of Resources and Limited Governmental Commitment

G2, M1 and T2 addressed limited state resourcing of mental health services.

G2 estimated that there are only about 200 psychiatrists in Thailand and thought that psychologists are mostly found on the public sector. G2 added Thailand lacks mob control psychology, psychological services on sexual issues, those for preschool children and senior citizens, or a law that would allow patients to sue their practitioner in case of malpractice.

T2 viewed the physical spaces in state hospitals "are inappropriate spaces, due to state budgeting issues, too, that they don't divide between spaces where patients have mental abnormality and cannot control themselves and [those with] people who can control themselves but feel they'd like to come consult" the practitioners, which makes the atmosphere unfavorable for counseling if "supposing we sit next door, and the other room has loud noises" made by a severely disturbed patient, as was the case when she saw the psychiatrist.

M1, who besides working was also a graduate student when interviewed, noted the "Thai government does not give importance to mental issues," and his university provides counseling services just "to make it look like the organization has" such services, while in fact there isn't much to them. His employing organization provides sexual health services staffed by a nurse, because it's cheaper than hiring a doctor, and because a nurse can also handle the physical aspects of the job, such as taking a blood sample, which a psychologist could not do.

Stigmatization of Clients

The popular perception of mental health service users as abnormal or disturbed was a consistently attested theme in all client participants' accounts.

G2, G3, M1, T1, T2 and T3 all acknowledged that others generally see service users as "crazy" (*bâa*) or "psychotic" (*rôok-jìt*), and G3, M1 and T2 viewed worry about stigmatization deters people from using the services or wonder if they indeed are crazy when they do use the services. T2 even noted that outside Bangkok, "there are many *cases* that don't dare to receive services in their own area, and travel cross-province to receive services elsewhere because they're afraid of [a lack of] confidentiality, safety" or don't feel confident in doing so in their own area.

G1 and T3 viewed that psycho-scientists are only to be visited if one has serious problems. T3 thought that if she decided to see a psychiatrist for a reason other than obtaining SRS permission, she "probably would think I'm like, neurotic [*rôok-pràsàat*]" as people who see psychiatrists generally "have to have mental symptoms … or [something] weird, or not like normal people." Even today, she would not feel good if someone suggested to her she should see a psychiatrist. M1 and T2 had both felt bad about being forced to see a psychiatrist in their childhood, as both had associated it as something only for crazy people. G1 had felt "frightened."

Nevertheless, at least G2, G3, T1 and T2 had told others about seeing practitioners. T1 said her family had opposed her visits to a psychiatrist, feeling concerned she would divulge family secrets. G2 and G3 had told their colleagues. G3 said a colleague had replied with a warning: "don't go tell anyone, otherwise you can't get employed elsewhere" and when G3 had showed a psychiatrist's assessment about himself, a colleague told had him to hide the document. T2 had told friends at school; they had felt excited and curious about the visits since they also had issues

with their parents and had toyed with the idea of going to see a practitioner with their parents like T2 had done, but hadn't dared to. T3 said that if she saw a psychiatrist again, she would tell a family member to obtain a second opinion about whether she really seemed to have mental problems or not.

M1 linked stigmatization to the atmosphere of existing services, which he viewed rather negatively. One state psychiatric hospital in his view was a "place to keep the crazy" and "really a frightening place to go" or even pass by. Inside, he believed, there was an "atmosphere like a slaughterhouse, with electric shocks … having to wear green straightjackets" and so on. M1 further linked this negative image to lack of management commitment, because as long as "people on the top … don't give orders … they'll just keep on treating crazy people."

Other Barriers to Access

Lack of awareness and outreach. M1 noted that people in general don't know which issues a psychologist, psychiatrist or a counselor could help with, and it is not helpful that "psychologists in Thailand like to stay still and wait for people to come in" instead of doing outreach, like social workers or community leaders do.

Costs in the private sector. G2 and T1 viewed private sector services are expensive. G2 had once visited a private psychiatric hospital that charged a 2500 baht consultation charge per hour, plus medication costs – his single visit had cost him around 5000 baht. M1 thought psychiatric services in general are expensive. T3 viewed the 1150 baht she'd paid for half an hour at a private hospital was reasonable.

Hotlines, NGO Services, Specific Service Units

Of the client participants interviewed, M1, T1 and T2 viewed the state should operate a counseling hotline, and M1, T1 and T2 emphasized callers should get through to a counselor directly, rather than having to first listen to an answerphone. T2 added the service should be open 24 hours and have a mobile crisis team. These participants would be satisfied with a generic hotline, not necessarily a sexual/gender minority specific one.

Only G2 unambiguously viewed the state should provide a specific service center for sexual/gender minority clients (perhaps starting from one hospital), viewing that sexual/gender minority individuals' "way of life is not like men's and women's, and [our] thinking ... or actions won't be alike, so there should be group specific psychology." T2 acknowledged it was still debated if a specific clinic be opened, or specific spaces created for homosexual people, and viewed the matter would best be assessed by researching it first, and the state should pay for the research. T3 viewed a private hospital could establish a department for TGs, both for counseling and researching TG lifespan development, which is currently not well known. She viewed having just one such center in Thailand would be enough.

Of the client participants, four had had some kind of NGO involvement in various groups. G2 had previously been a gay hotline volunteer, and viewed the system had been quite good as it had had a team consisting of a nurse, a psychiatric nurse, and a social worker, as well as a referral network. However, it had received no financial support and had to close down after two years in operation.

T1 wondered "why NGOs have had to pave the way" for establishing hotlines instead of the state taking responsibility. She viewed that while volunteers may

understand sexual diversity better due to having friends in the communities, a short counseling training wasn't comparable with a 4-year degree level training, and therefore professional psychologists should become involved. Similarly, M1 viewed volunteers should pass training, and T2 was "quite concerned whether people who are to practice as *counselors* have any standards or guarantees" about their ability.

M1 viewed that NGOs like RSAT or Bangkok Rainbow[17] offer a health-related service funded from HIV/AIDS funds, which limits the scope of the work; they're not really services for psychological issues.

Furthermore, M1 also viewed some volunteers seem to have forgotten the pride of being a volunteer and provide services without real commitment or even confidentiality. M1 also noted volunteers tend to interpret a call focused on sexual matters as a "sex phone" call and hang up, instead of taking the opportunity to discuss the matter with the client and refer them on.

Finally, M1 was highly critical of the current practice of two-way anonymity, where counselors don't tell their name to the client; he viewed that this does not build trust, and that volunteer counselors should be able to keep private life and work separate by having ethical standards, without having to resort to practitioner anonymity. He viewed that if a hotline counselor and a client would meet in real life, it would only be good as it would bring more people into the hosting NGO. Furthermore, M1 also viewed there should be a way to provide regular hotline counselor contacts, because "is there anyone who wants to go tell [about their issues to] other [counselors]? … No, there isn't; [there] has to be a regular [counselor]."

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[17] Bangkok Rainbow (www.bangkokrainbow.com) is similar to RSAT but smaller in scope and target group (emphasizing activities for gay people).

Miscellaneous Recommendations by Clients for the Psycho-Sciences

Many views on what constitute good mental health practices, or how they could be improved, have already been presented above. However, a few more issues need to be addressed separately.

Firstly, G3 and T2 addressed the need for gay- and TG-related research. G3 viewed that "gays have a mental health of another type" warranting specific research. T2 viewed medical doctors should "study the context of *kàthoeis*, in Thai society, with possible comparison … with foreign societies that have different kinds of study contexts," in a non-judgmental manner and "more comprehensively without having stereotyping attitudes of *kàthoeis* as having to be women or *cabaret show* [artists]," but rather focus on the study of "the identities of Thai *kàthoeis*."

Secondly, in line with M1's views about professionalism, he recommended that psychologists and social workers should be mandated to have (at least) a Bachelor's degree in their fields and their work roles clearly demarcated. He also viewed that an act (*phrárâatchábanyát*) regulating each profession might be helpful, and that "professionals in the field of psychology should rise to revolutionize" counseling by claiming it as their own territory, not because "they desire more work space … but to uphold consumer rights."

Thirdly, M1 also viewed that psychologists should inform the public what they can offer to it, and how their role differs from that of social workers.

Fourthly, M1 noted a need for improvements in the public image of state psychiatric hospitals: They should emphasize specific clinics and counseling so that ordinary, "decent" people would dare to enter them.

Finally, T2 noted that public health insurance schemes like the National Health Security one should "cover all services, throughout the country." In her view, providing access to services even outside locations where service users are registered is especially important so that those who dare not use mental health services in their own area could use the services, and so that registration problems would not impede internal (Thai national) migrant workers' access to services in locations like Bangkok.

Practitioners' Experiences and Views on the Provision of Mental Health Services

Point of Entry to Sexual/Gender Minority Work and Level of Involvement in It

Of the practitioners interviewed, PA1 and PL2 had plenty of experience and specific interest in sexual/gender minority issues. PA1 said he hadn't originally been interested in these topics, but while working on relationship issues and sexual dysfunction, he started getting clients from these minorities to the point he is now often invited to speak about these issues, both during lectures and on television, and many even think he is gay himself, in spite that he has a wife and children.

Other practitioners saw sexual/gender minority clients as a part of their work in general; PL5 noted that his one lesbian and 10 gay clients had all been friends or friends of friends who knew he did counseling. PL3 noted she might only see one or two homosexual clients face-to-face per year in the hospital, but the hospital's hotline gets more such contacts. PA3 stated he sees sexual/gender minority clients all the time. PA4 said he has some, but not extensive experience with these client groups.

General Socio-Economic Context: Insufficient Quantity and Quality of

Mental Health Resources in Thailand

Too Few Practitioners

PA1, PA2, PA4, PL1 and PL3 all addressed the insufficiency of Thailand's mental health resources in terms of quantity. PA1 estimated the number of practicing psychiatrists in Thailand at 300; PL4's estimate was 400. PL4 noted this meant roughly one psychiatrist for around 200,000 Thai citizens, and added that some smaller provinces might not have any at all, having to rely on general practitioners. In state hospitals that do have psychiatrists, a single psychiatrist might see 50-60 patients during the morning hours (PL3) or "throughout the day … more than a hundred clients" (PA1), while a psychiatrist at a private hospital can see as few as three clients during a morning (PA1 & PL2). PA1 gave an example of a state hospital in Southern Thailand that was so insufficiently staffed and neglected by the bureaucracy that practitioners started leaving the hospital first, and finally even the director resigned.

PA1 and PA2 viewed that this shortage of psychiatrists and consequently insufficient time allocation per patient are manifestations of similar shortages in all fields of medicine in Thailand, whereas PA4 viewed physical medicine in Thailand is already competitive with foreign countries, while psychiatry remains underdeveloped. However, PA1 noted that there are roughly 2000 ophthalmologists in Thailand in contrast to just 300 psychiatrists, and added that Thai doctors generally haven't felt interested in specializing in psychiatry. PL4 made the same observation, adding the training of psychiatrists is lengthy and the work stressful and "not particularly joyful."

PA1, PA2 and PA4 noted that psychiatrists' lack of client time leads to an emphasis on medication; PL2 also noted psychiatrists emphasize medication but

thought it is rather due to their training that involves a belief in an exclusively biochemical model of mental illness, and PL3 noted younger psychiatrists haven't had much psychotherapeutic training to begin with. PA4 said "state hospitals emphasize quantity quite a lot, and have but little time. Therefore, psychotherapy has to be really short and isn't that effective. [They] emphasize the use of medication … and … use of the [clinical] *team*." Likewise, PL3 noted that if "a patient wants to speak, [psychiatrists will] send [the client] to speak with a psychologist."

While no practitioner gave an estimate of the number of psychologists in Thailand, PL1, PL3, and PL4 (all psychologists themselves) indicated that also psychologists are in short supply. PL3 noted that psychologists doing psychological testing "sometimes, in one morning, do three people," which she viewed "nobody's crazy [enough] to do, but we've got to do it … which isn't doing it the correct way anymore, but we do it and interpret [the tests] correctly, but we might be a bit concise," adding that foreign visitors tend to be "astounded" at the speed.

This lack of resources means fewer opportunities for psychotherapy or really speaking with clients, necessitates a greater emphasis on medication, but also means that officials are too busy to follow up clients and have to refer them on to network partners for long term management, as PL1 noted. PA1, PA2 and PL4 also noted it leads to a need for psychiatrists to prioritize more severe cases (especially those with psychoses), which PA1 and PL4 analyzed was the root cause of the Thai perception of psychiatrists as "psychosis doctors" ("*mǒo rôok jìt*") and stigmatization of mental health service users as "crazy" ("*bâa*"), with wide ranging consequences for the acceptability of the services (see below).

Quality Issues with Practitioners in Thailand

PL1 noted that the lack of professional counselors or counseling psychologists in Thailand means that nurses with short counseling training (e.g., 3 months) or social workers (sometimes with no counseling training whatsoever) are used instead, and even psychologists can start working holding just a Bachelor's degree. However, "some work tasks are more difficult than a person with a Bachelor's degree [can] do; really, it should be a Master's degree or higher" and "therefore, psychologists in our country don't have that much quality – some people, even the counseling [they do] really sucks (*hùai tàek*), can tell [you] that."

PL2 and PL4 focused on the shortcomings of Thai psychology training programs. PL2 viewed that psychological resources in Thailand "are plentiful but have low quality" because psychiatrists only rely on medicating their patients, and psychologists "are told by the psychiatrists to just do *tests*, so they lack the ability to … give *counseling* or various clinical [procedures], err, do *therapy*." Thus, "even the teachers haven't ever done it … [they] only know theories and come to teach, and then teach only half correctly." PL2 viewed this lack of skilled personnel to be so extreme that "if I quit, the word 'real *psychotherapist'* [or] the word 'real *counseling*' won't exist in Thailand" any more. PL2 also noted Thai psychological training programs have their respective weaknesses and operate without collaborating with each other, as do the various professional associations in the field of mental health.

As for cultural issues, PL2 said Western counseling methods "have to be adapted … *counseling*, all of it, using *fàràngs'* [methods] can't be done … doesn't produce results" in Thailand. For example, PL2 mentioned clients are encouraged in a client-centered spirit to be themselves, but given that they've been brought up to be

passive and obey their parents, they come to psychologists expecting to receive advice, and when they don't receive it, they won't come to a second appointment.

PL4 sounded almost as critical of psychological training programs as did PL2: "these days, the world of psychological education in educational institutions, it's another world [which]… doesn't coexist with the real world … [so psychologists] graduate and aren't able to do any work." The main shortcoming PL4 identified was that the training programs "don't teach about Thai culture, and try to be *Western style* – *westernize* too much … refusing to study the personalities of Thai people" and "sometimes questionnaires are … American; if it's an American form, it was born in America, [we] shouldn't use them just for the sake of using them." Students are taught to hug their clients though it is an inappropriate thing to do in Thailand. The "syllabi weren't developed for Thai society." There is also an inappropriate emphasis on research skills: "Thai communities don't need people skilled in statistics [but] if you [want to] develop researchers, it's a different matter altogether." Yet, if practicing psychologists "are to be skilled in psychology, [they] have to be skilled in the issues of Thai culture … values and beliefs of Thai people." At present, "educational institutions teaching psychology … are not accepted / because people feel they're not a part of life."

In contrast to PL2 and PL4, PL5 viewed that cultural issues are not a big obstacle, because especially in Bangkok, culture is hardly different from the West at all. However, PL5 acknowledged his clients had all been highly educated, many with degrees from outside Thailand, so this may have had a bearing on the issue.

Other Systemic Inadequacies

PA1 and PL4 both lamented the stiffness and slowness of the state bureaucracy, which PL4 commented is "a *monster* – it cannot adapt itself quickly," adding that the state sector lacks innovation – new services might be thought of, but not implemented. PA1 noted he had left the civil service due to these shortcomings.

PL5 remarked that private "*insurance* doesn't yet cover coming to do *therapy,*" making it not only less accessible but also less culturally accepted – if therapy expenses could be claimed from an insurance company, it would constitute "accepting it's a normal thing" to do.

PL2 lamented the fragmented state of Thai professional mental health associations that each wish to be famous but don't communicate with each other, "and whenever there's no *sharing,* [things will] go to ruin."

Stigmatization of Clients and Client Unwillingness to Use Mental Health Services

Almost all the practitioners acknowledged that members of the Thai general public are still unwilling to use mental health services. PA4 noted that "even to come here, some people are afraid; even a private [hospital with] luxurious premises [like this – people still] view it's a psychiatric hospital all the same." However, PL5 noted that "Thai people are now better, knowing that really, [they] don't have to be crazy to come to speak with a psychiatrist or a psychologist" but nevertheless, "it's the last *option* … if they came to have a chat earlier, [they] might get better without having to [develop] heavy symptoms and [go through] not being able to figure anything out."

PL2 noted patients may be unwilling to see his assistant instead of himself, whereas PL3 noted patients may insist on seeing a psychiatrist even though a psychologist might be more helpful in terms of psychotherapeutic help.

As seen above, PA1 and PL4 thought stigmatization and the consequent unwillingness to use services derives from the (earlier) prioritization of psychiatric services for those with the most severe symptoms.

PL3, working at a DMH psychiatric hospital, viewed clients' unwillingness to use services is their own thinking: "you think this is a psychiatric hospital, so you don't come – but who forbids you? If you yourself don't come, you don't dare to come, so how can you know what it's like here?"

PL1, on the other hand, noted that clients sometimes cooperate inconsistently and drop out of the system, viewing they may have earlier received biased services.

PA2 noted Thai people have a silly tendency to avoid seeing doctors, not wanting to know if something's wrong with them, as if hearing the diagnosis from the doctor was the cause of the disease. Therefore, it tends to be the relatives who bring people to psychiatrists when something is clearly wrong with them.

PA4 remembered seeing a poll result showing that no more than 10% of the Thai population had a good understanding of mental health issues, causing them to view such problems more in terms of character faults, which contributes to low willingness to receive treatment.

While practitioners in general felt that stigmatization can be a problem for all groups, PA2 and PL1 viewed that sexual/gender minority clients may feel particularly sensitive to judgmental attitudes, impacting their willingness to use services. Yet, PA3 and PL3 said clients from these groups seemed even over-represented in the services, suggesting they may have a lower threshold for using the services than others do.

PA4 had earlier been involved with a state mental health destigmatization campaign, but it was not very successful due to inconsistent commitment from the staff involved. His current hospital now operated a network of patients' relatives,

which had been more successful. He viewed that while many people are working on destigmatization in Thailand, it remains a very difficult task in this context.

Impact of the General Context on Work with Sexual/Gender Minority Clients

The interviewed practitioners also noted on the impact the general context has on work done with sexual/gender minority clients. PA1, when asked about the possibilities of a psychiatrist in a busy state hospital to help on these issues, replied "it's simply impossible, can't be done – and they also only do psychiatric illnesses … they're not experts in this issue."

PL2, who believed sexual orientation can be changed through psychotherapy, noted psychiatrists can't do it as they only know about medication, adding that mental health resources in Thailand are inadequate "even for providing information" about homosexuality.

PL1 and PL4 noted that client databases (whether those managed by the state or the NGO where PL4 works) only record clients as male or female, and PL1 noted this means such databases cannot be used to gain information about sexual/gender minority clients, unless each case is manually checked for such information.

PL4 viewed that the inability of the state sector to adapt itself quickly means the state cannot quickly provide new services to minority groups that need them: "even services for the youth – in the past there weren't specific services for the youth, but with … bigger problems [these have emerged.] …We have to accept that the civil servant system adapts slowly," and even sympathetic civil servants willing to help sexual/gender minority people may be hurdled by the state system, may not be willing to "come out," or still harbor inappropriate attitudes.

Working with Sexual/Gender Minority Clients: Distinct vs. Generic

Views seeing sexual/gender minority client work as having distinct characteristics and views seeing it as little different from mental health work in general were both common among the interviewed practitioners.

Universality

Almost all practitioners interviewed expressed some views that reflect their belief in the applicability of universal principles in sexual/gender minority client work, at least within bounds.

PA1 noted that helping heartbroken sexual/gender minority individuals "does not differ from cases of men loving women or women loving men … when someone changes their mind and doesn't love us anymore, that's a time when we have to return to loving ourselves." PA1 also noted that "sometimes we don't need to address (*kâe*) them being *kàthoeis,* or address them being gays, but address [their] way of thinking."

PL1, who works at a domestic violence center, viewed that the work processes used with sexual/gender minority clients and other client groups "probably don't differ from each other, but establishing contact does" since sexual/gender minority clients may not trust the service provider as easily. She also noted that although sexual/gender minorities have been provided services since the establishment of her center, "we don't have a body of knowledge specifically about these groups," and thus apply feminist principles as with other clients.

PL3, working at a DMH psychiatric hospital, stated that when a distressed client comes to the hospital, "we don't need to look at what they are or have …

human feelings, whichever *phêet*, it doesn't matter … [I] thus view everything as humanity, rather."

PL4 noted that when his employing organization (an NGO) provides services to what he called "sexually diverse clients," the format of service provision "doesn't differ from providing services to women, men or young people in general," because "in each family or each community, there will always be groups that are sexually diverse." PL4 also viewed that mental health professionals are likely to be helpful for minority clients due to their inherent tendency towards liberalism, emphasizing that no particular "sexual taste" (*phêet-rót,* probably meaning sexual orientation) is necessary for working with such clients, but rather, the necessary characteristics are

> knowing how to look for information, and, importantly, developing [one's]
> personality … making oneself into a real professional and not getting
> emotionally involved with the clients … having neutral attitudes, not judging,
> not having bias and viewing that … all problems can emerge in all groups,

as well as upholding the principle of nondiscrimination.

PL5, a counselor at a private clinic, when asked if specific knowledge was needed when providing services to sexual/gender minority clients, replied that it "isn't necessary … with all the *theories* … if we understand humanity, all people, regardless of *phêet,* have the same needs – acceptance, love, all kinds of *approval* – that is, the needs are the same. … just the actors change." He also viewed that "if [one] really is a psychologist, one should be able to receive every *case*" since the job of psychologists is to help distressed people, and helping in these cases is "hardly different at all."

PA2, working at a medical school hospital and a university counseling center, stated: "Specific principles? Definitely none. They're still human – same *species*" and went on to explain that while the content of therapy sessions might be different,

themes are still the same – even the non-acceptance of people who are different in some respect is something that many groups have to encounter, whether on the basis of their physical characteristics, gender, disability, ethnicity, looks or other issues.

PA3, also practicing at a medical school hospital, held a similar view as did PA2: there's "nothing specific – we *treat* them as [people] in general" and therefore the psychiatric treatment of sexual/gender minority clients "is not an issue."

PA4, working at a private hospital, also said that "in my view, psychological principles, we can apply universally."

Distinctness

Despite the belief of the interviewed practitioners in universal principles, they all also held views that reflected distinct characteristics of working with sexual/gender minority clients.

PA1 had developed his own categorization of sexual/gender minority clients that could be explained using the ten fingers of two hands, one for males and the other for females. He noted that when a heartbroken client is gay, "I'll advice him to enter gay societies, because he'll get to meet many people, and I think that gays [speaking with] gays will understand each other well … *Social support* I think is more powerful than *therapeutic support*" and besides that, they might also gain a new partner there. PA1's way of dealing with upset parents is also based on a distinct model (see below).

PL1 held several views on the distinctness of sexual/gender minority work: "the distinctness is accepting them, accepting them before anything," because this will make such clients willing to interact in the first place. However, sometimes even practitioners who try to understand "can't help judging them." PL1 admitted this has happened to her, but working with such clients and learning from them helped her

understand that "they're special," sometimes have a layer upon layer of complexes due to their negative life experiences, and need to be given "*empowerment … it's like they've often been told they're not normal.*" PL1 also noted that "we ourselves have to know the principles of *gender* quite a lot, the frames of femininity, masculinity – [that] these are things assumed into existence by society."

PL2 explained at length about the conditions that must be fulfilled if homosexuality is to be "corrected" through psychotherapy: the client must be 100% willing for change, a flexible combination of theories is needed ("even a single person that's a *tút* cannot be treated with a fixed regime"), the therapist must have great expertise, be truly client centered, sensitive and understand gays well; treatment requires both "art and science." PL2 also held that "women just don't understand gays," in particular their aversion to women or the excitement they feel upon seeing a man, and lamented other practitioners saying homosexuality is untreatable just because *they* can't treat it.

PL3's advice for those working with sexual/gender minority clients was as follows: "Oh, you must know about sexology to begin with, know about shifting emotions, know about *hormones*, many things… and what's important is – have you got *bias* or not?" adding that some people who "were forced to work on … *AIDS counseling* ...* think these people are looking for trouble" and shouldn't really work with such issues because they already feel negative about the clients and the work.

PL4, while emphasizing the applicability of universal principles, noted that "when talking about *sex,* real mean and women like *vaginal sex ...* but they like *anal sex,* they like *oral sex* … it's just a small detail, to understand this." He also viewed practitioners should understand "what belongs to the nature of sexually diverse

groups," know their identities, what they want and what kinds of problems they encounter, how they adjust to those problems, and what their communities are like.

Similarly, PL5 emphasized universal principles, but viewed psychologists should know how "the societal context is involved … such as *yĭng-rák-yĭng* … or *chaai-rák-chaai*, they might not be able to disclose [their identities to others]" or that "the *commitment* they have might not be registering a marriage … it might be other kinds of *commitment* that are not particularly *legal*." PL5 also noted that "what's scary is *bias* … in case [you] have *homophobia* … you might better not do that *case* … [psychologists] must be *aware* if they have *countertransference*" toward clients.

PA2 and PA3 also viewed that while the principles of helping are the same, practitioner attitudes have to be paid attention. PA2 viewed that practitioners with negative attitudes are very unlikely to be helpful as they cannot help judging the client. PA3 explained about the importance of practitioner neutrality as follows:

> If we're *too positive* we might *encourage* them to *commit* to certain things or *accept* their *identity,* especially in youth that aren't ready yet – or if we're *negative*, we might *pro[mote]* an *average* societal *sexuality* as a guideline for them. … That's what I view is an issue … but if our *attitudes* are neutral, [I] think there won't be trouble.

PA3 also thought confidentiality and stages of the coming out process may have to be paid particular attention to when providing services to young homosexual clients.

PA4 noted that while universal principles are applicable to sexual/gender minority client work, practitioners should follow trends of the changing society. He also viewed that to reach really good outcomes with gay people struggling with familial nonacceptance, continuous therapy of three months to a year may be needed.

Issues related to TGs and SRS. One clearly distinct element of working with sexual/gender minority clients is dealing with clients that come for a psychiatric readiness evaluation for SRS. PA2, PA3, PA4 and PL3 commented on the matter. PA2 and PA3 noted that in their hospital, SRS candidates first contact the surgeon, who then sends them to a psychiatrist for evaluation.

PA2 said that in the past, "medicine wasn't developed yet – we tried to change … their minds to match [their] bodies. Later we found that it didn't work so we have to change their bodies to match their minds. Easier. Much easier." However, as PA2 acknowledged, Gender Identity Disorder remains officially a disorder. PA2, when asked if the category should be retained, analyzed the issue:

> I don't *care* about principles, I view what the result is. For example, if [we]
>
> make a *diagnosis* and it's followed with assistance, I think it's *OK,*
>
> appropriate, but if *diagnosis* is followed with *stigma …* threats … ridicule …
>
> negative attitudes, I [don't] know why to look for trouble by blaming them.

In other words, in PA2's view, the issue is not so much whether there should be this disease category or not, but rather how people view it.

PA4 noted that in the more recent past, SRS was easier to obtain, with just an interview enquiring if the client had lived as a woman for the last two years, but "lately, what we tend to be afraid of … is that many people after the operation tend to have lots of problems with unstable emotions … thus, our consideration about who should be operated … it has to be more detailed." However, PA4 said many SRS candidates that don't receive permission immediately (or their relatives) tend to react angrily, lacking an appreciation it is their well-being that is being safeguarded.

In contrast, PA2 said he'd never met TGs with problems after the operation, but added he wasn't sure if this is the case because there are hardly any such cases, or

because they are screened out by the process. Like PA2, PA3 viewed that SRS candidates in "Thailand are mostly very *obvious cases* – they've lived their lives [as women] for a long time, and when they come [for the evaluation] you wouldn't know, they're beautiful already," and thus less structured testing procedures are sufficient for Thailand. PA2 said he had only had one case in which he did not give the permission, adding he wanted to help such clients rather than act as a gatekeeper.

PA2 and PA3, both working at a medical school hospital well-known among the TG communities for its relatively detailed pre-SRS evaluation procedure, noted that besides assessing the "inner *phêet*" of the SRS candidate and their understanding of patterns in their lives, the evaluation screens out major psychiatric illnesses such as borderline personality disorder, schizophrenia and other psychoses, since these cloud the decision making capacity of the candidate and thereby reduce the SRS candidate's ability to give informed consent.

Psychotic individuals in particular may think they are gay or kàthoei, when in fact they are not, PA2 noted, adding that a patient with schizophrenia might also not be able to comply with post-SRS self-care, which would put them at risk of physical complications after the operation. PA2 said persons who have both schizophrenia and gender identity disorder are truly unfortunate, since their chances of obtaining the surgery are very low. However, when asked if someone who has had a transient psychosis (e.g. as a result of amphetamine use) could obtain SRS, PA2 thought this was probably possible. PA2 mused that in an extreme case, perhaps a criminal might be ready to have SRS to mask their identity – but the testing would prevent this.

PA2 explained that while the final decision lies with the psychiatrist, a clinical psychologist is needed to run the actual "psychotest," because clinical psychologists study such testing, unlike psychiatrists. A psychiatrist, PA2 said, would not even

understand the raw test data. One part of the test, PA2 said, is a person drawing task, since men tend to draw a man, but both women and kàthoeis tend to draw a woman.

PA4 said that in the private hospital where he works, psychiatric pre-SRS evaluation takes around 1-2 weeks, depending on the doctor. PA3 said the interview itself takes only half an hour. PA2 estimated that in the medical school hospital, the testing process should take no more than one month, or at worst two, if their psychologist happens to be on leave. PL3 and PA2 noted that the delay itself provided by psychiatric examination may help prevent the operation taking place in individuals that would later regret it by measuring the client's determination, although PA2 mused that this might just be "an excuse."

PA2 pointed out that SRS candidates with schizophrenia are unlikely to be able to work and thus unlikely to have the funds for the operation, which also tends to screen them out.

Both PA2 and PA3 noted that having a testing process also protects surgeons against malpractice lawsuits, and PA3 said "the person at risk is probably the doctor [rather than the patient], because the patient [is the one who] wants to do it." PA4 was also aware of this, but affirmed that "the issue of being sued – [I'm] not particularly afraid of, but [rather of] … the problems the patient may encounter."

PA3 remarked that minors are unable to give consent for SRS and should therefore not be operated. PL3 noted she tells clients seeking SRS to first tell their parents and social circle "so that at least they won't be shocked dead."

Dealing with upset parents. As seen above, another clearly distinct aspect of sexual/gender minority client work is dealing with upset parents of both TGs and gay individuals, who may not give up the hope of changing their child even if a practitioner tells them that sexual orientation or gender identity are not changeable

(PA1, PA2 & PA4), or as PA1 noted, sometimes "I'm the fourth or fifth psychiatrist they've taken their child to." Both PA1 and PA4 emphasized the need to be sensitive toward the parents.

PA1 explained that he will need to ascertain who the client really is: "Who is the person who's suffering? If the kid's not suffering, he doesn't have problems – the mother, instead, [is the person] who suffers, has problems; the mother is my *client* ... the persons receiving therapy are the parents" but however, "speaking like this – the parents can not accept it … in the beginning, I'll need to [do] … *empathic listening*" because if he would just tell them (like others do) that homosexuality is neither an illness nor treatable, it would "end – for the psychiatrist … but the mother would not be able to accept it … and she would take [her child] to a psychiatrist elsewhere."

PA1 continued he will "speak with the parents first, assess [their] attitudes / and then speak with their child, that having been brought here for this reason, what (s)he thinks about it," check the child's gender identity and sexual orientation "to make [the matter] clear" and then look for the thing that "makes the parents suffer."

PA1 noted that in fact, "a liking for … the same sex is a private matter, but what the parents can't accept are the sissy mannerisms (*thâa-thaang krà-tûng-krà-tîng wîit-wáai krà-tûu-wúu*) or [how they] dress or walk," so he'll ask the child if the child could "reduce these a bit, so the parents could suffer less," whereas "issues in the future, whether you like the opposite sex, the same sex, how often you want to have *sex,* with whom, [in] which … *sexual position,* these are private matters."

PA1 went on to explain that with gay individuals he sometimes also needs to address the "next issue," namely

> You're single. Meaning [this is what] you tell them. … We don't need to say
>
> we like men, but we shouldn't marry a woman to cover [things] up. … You

just live your life as single – nobody will suspect a single man, because there are many men who are not gay but want to be single, enjoy a life of freedom … having finished work, they stay at home, have a partner (*faen*), want to have *sex* with their partner, but don't want a couple life, without being gay. Therefore, if you're single, nobody will find out you're gay.

PA1 viewed this strategy can ease family tensions. Finally, PA1 said, he will refer parents to a well-known gay activist, who can give them further advice.

PL1 said that usually, domestic violence center staff won't take action on parents, as such issues are very difficult to deal with in Thai society. However, if a client manages to bring their parents in, the practitioner can explain to them that their child's phêet isn't anything strange, and help them focus on what's good about their child and how the child can grow within society.

Like PL1, PA2 said he will explain to parents their child's sexuality isn't anything strange or automatically imply problems, console the parents and try to initiate "a process of *identity* acceptance" in them. He might say to them that "real men and women" also cause trouble – thus their child's value doesn't lie in their phêet. However, PA2 noted that some parents leave immediately upon hearing their child's sexuality cannot be changed.

PA4 noted that some doctors and counselors are likely to be more understanding toward the sexual/gender minority child than toward the parents, which creates an unhelpful impression that the counselor and parents belong to opposite camps. PA4 explained that if the parents already have seen other psychiatrists, he will first ask them what they were told, and

mostly the parents will answer that, err, some doctors advise to wait and see a bit longer, which makes the parents feel anxious, such as: "how much longer

will I need to wait", or some doctors will tell them: "oh, there's no way it can

be changed anymore" … so parents feel opposed and have to come to me.

PA4 continued that parents need to be educated on the causes of homosexuality,

because many parents feel guilty, blaming themselves, [wondering] if one

oneself is the cause or not … "Was my upbringing not good?" Or maybe the

mother blames the father that because the father didn't behave well, had minor

wives, didn't give warmth to the child … taking turns blaming each other.

PA4 will tell parents that although it hasn't yet been clearly confirmed what leads to

the "*biological*, anatomical" changes involved, genes, chromosomes, and so on "are

involved and can make it to be that way, or there are changes in the structure of some

parts of the brain that lead to … *sexual orientation* change." PA4 said that

explaining [it] in scientific terms makes parents accept it better … and they

will feel more sympathy for their child, as if the child's ill and can't choose,

just as the child couldn't choose whether to be born or not. Not that the kid is

misbehaving or imitating their friends and … going to ruin … not obeying.

But acceptance, PA4 noted, "probably will take time / and the thing we'll need to do

next is we have to give psychological *support* to the parents" and

gradually point at their fears … / gradually changing the parents' *attitude,* how

they view these groups, [giving] them another viewpoint, that if their child is

like this but … can take responsibility, doesn't lose *function* at workplace, is

committed to studying, is a good kid, doesn't cause trouble in society, "would

you be okay [with that]?" / And I might also give examples that many real

men and women can also cause a lot of trouble in society … / sometimes …

giving *education* might not be enough, [but we] might need to do *family*

therapy / and we might see that really, that they can't accept, it's not about the

child being or not being gay … but it's about other issues, such as the mother

having inner *conflict,* such as an inferiority complex in life, and wants her

child to compensate for that complex … and when she has a child … she can't

take to *show* to anyone, she'll feel awful – really, it's not about the child, it's

in the parents. / … and so the problem is even more complicated, and here we

must use *psychotherapy.* Mere generic *education* or *support* aren't effective.

PA4 added that he doesn't use any particular theory, but rather would "look for the

problem or *conflict* in each person, what causes them, and gradually correct them, one

at a time, one complex at a time."

Issues on referrals. A third distinct aspect of sexual/gender minority client

work concerns the referrals that can be made.

As seen above, PA1 will recommend heartbroken gays and lesbians to enter

relevant sexuality-specific groups, and will also give them the phone number of a gay

activist willing to give counseling by phone.

PL1 noted that problems emerge when a transgendered client at the domestic

violence center needs temporary shelter, because state shelters are sex-specific,

female shelters don't accept transgendered clients, and placement at a male shelter

would probably cause problems. Community resources may also be unavailable

because community leaders may likewise be prejudiced against transgendered people,

despite the attempts of center staff to brief them and instill appropriate attitudes.

Sometimes, PL1 noted, they need to admit a TG client into the hospital itself

as a temporary measure, but even then, to place a TG client into a female ward

requires several layers of permission, though it is easier if the client is very feminine

or has had SRS. If they sent a TG client to a DMH hospital, PL1 said

they would ask why [the client] was sent … Sent in to treat this issue [their gender identity]? … To correct their behavior? … Nobody does that … [They] think it's to correct [the client's abnormality], not in order to enable you to live the way you are. … Psychiatric hospitals … aren't yet 100% open about this issue.

Practitioner Attitudes toward Sexual/Gender Minorities

As seen above, many practitioners viewed that having appropriate attitudes is necessary for providing appropriate services to sexual/gender minority individuals. This subsection focuses on what practitioner accounts said about attitudes in the field (rather than their own attitudes, represented in the first parts of this chapter).

PA2, PL1 and PL2 talked of changes in the field, particularly the declassification of homosexuality as a mental illness and changes in terminology. PA2 noted that while being a kàthoei still has its own diagnostic category,

[being] *homosexual* isn't in the diagnosis [manual]. In the past it was. In the past it was really awful, [homosexuality] was classified in the group of illnesses called *paraphilias*. The Thai term was even worse because the term used was really weird … *kaamwítthăan* ... which sounds like [someone who] should be arrested and thrown into prison (*laughs*) … but these days [psychiatry] doesn't care [about homosexuality] any more.

PL2 likewise acknowledged the WHO declassification of homosexuality as an illness:

[Now] there's nobody in Thailand treating gays. They go by the *WHO* or international psychiatry, because now [being] *homosexual* isn't an illness anymore. In the past it was classified as a *sexual deviation* … but the *WHO list*

… resulted … from saying this is a *human rights issue,* so it was classified as

a *sexual preference* ...[and] became a fashion, all around (*tem pai mòt loei*).

PL1 also reflected on the shifting terminology and its consequences: "In the past, even

when writing doctor's certificates, they viewed it as constituting abnormality, which

was very harmful. But these days they don't write [so] anymore. They [now] use the

word … sexual deviance."

Due to the historical shift, PA2, PA3 and PL1 viewed that older psychiatrists

may accept homosexuality with difficulty even now. PA2 viewed that psychiatrists

aged 30-40 "generally can accept [homosexuality] already and have really good

attitudes, but if [they're] older, [it's] not certain, because they might've been *trained*,

like old *school* that still judged [being] *homosexual* as an illness." PA2 estimated 90%

of Thai psychiatrists probably have appropriate attitudes on this issue.

PA3 said he'd heard of religiously strict Christian (either Catholic or

Protestant) psychiatrists and noted they may "feel quite awkward with" sexual/gender

minority issues. However, PA3 believed that "there is no way [a psychiatrist] would

go *discriminate* against them [sexual/gender minority clients] because it's *against*

what we've studied."

PA2 and PL1 noted that some practitioners are outright homophobic, disliking

sexual/gender minority people for no apparent reason, and when seeing a

sexual/gender minority client their "facial expression, gestures immediately change."

PA2 and PL1 both viewed that nurses and other hospital staff may have less

understanding for sexual/gender minority people than psychologists and psychiatrists,

due to having less training and perhaps less understanding for psychological rather

than physical suffering, as PA2 noted.

Nevertheless, PL1 viewed that even psychologists and social workers are not fully "*OK*" with sexual/gender minority clients due to their lack of specific knowledge. They might openly label sexual/gender minority clients as abnormal and criticize them for that, or view them as people "looking for trouble" or "already having a lot of risk in and of themselves." PL1 viewed that only people with heavy involvement or direct training have fully appropriate attitudes; nonjudgmental attitudes are difficult to instill in staff.

Similarly, PA2 noted that some of the Thai psychiatrists who have appropriate attitudes do so because they themselves are homosexual, while the rest probably have friends who belong to these groups, so they are used to such people. PL2 likewise viewed that the lack of willingness among Thai psychologists and psychiatrists to interfere with homosexuality is in part due to the fact that many of them are homosexual themselves. PL2 also noted that "most men don't understand [homosexuals], thinking that … gays, *túts* – [if they] go to a female sex worker (*thîao phûu-yǐng*), [they'll] be cured … or *toms, dees,* passing a man [(i.e., having sex with a man), they'll] be cured." But because this doesn't really work, PL2 viewed Thai "treatment circles" mostly accept homosexuality, not knowing what to do about it.

PL3 said it's difficult to say anything about societal attitudes when she can't even know what the psychologists in her own team think of the matter.

Level of Knowledge about Sexual/Gender Minorities and Other Sexual Matters

Another key element of appropriate services identified by practitioner participants was practitioner knowledge of their client groups. This subsection focuses on what practitioner participants said about the level of knowledge in the field.

PA1 was particularly vocal about the lack of sexological knowledge in Thailand: "In Thailand, there are only a few doctors that do sexual issues … / [we] don't know which department should teach [them] … we doctors study *anatomy, physiology* ... but nobody studies *orgasms,* foreplay, sex," and similar matters – thus, "even doctors themselves don't know [about these issues]" or if they do, "they don't know for real." Nevertheless, in his view, the situation seems to have improved since there is now a sexological society in Thailand, psychologists and social workers also study sexual matters, there are more books about them, they can be talked about on television, and consequently people understand them better.

PL1 noted that psychiatrists might have some understanding of gender and sexuality, but doctors in other fields are simply not interested. She also viewed policy is unclear even on equality between men and women in state bodies, let alone on sexual/gender minority issues, the importance of which isn't yet appreciated. PL4 also viewed that state bodies do not have clear information about these issues.

PL2 viewed there are only a couple of people with a good understanding of homosexuality in Thailand (he himself being one of them).

Sexual/Gender Minority Individuals as Practitioners

Many practitioners (PA1, PA2, PL2, PL3 & PL4) acknowledged that there are some or even numerous homosexual psychologists and psychiatrists in Thailand, and PA2 said that "in the psychiatric circles themselves, there are lots of doctors that are *homo*; even doctors that are outright kàthoei also exist." This subsection deals with practitioner views on such fellow practitioners.

Both PA1 and PA2 said that when applying to train or work as a psychiatrist, applicants won't be asked if they are gay or not, but if a male applicant is very effeminate, he won't be accepted. In contrast, PA2 noted that masculine toms do tend to be accepted, as do males who are just "a bit sissy (*tûng-tîng*)."

PA1 viewed psychiatry, alongside other professions that have to be respected to the point that "people raise their hands in a *wâai*" to the professional, is not really suited for TGs, but for gay people this is not a problem since nobody has to know they're gay. PA2 held a similar view regarding applicants to training programs: "if they don't burst out (*tàek-sànít*) with *'khà khăa'* ... in front of the committee members, we'll say yes, OK, they know to *hold* [it back]" but if not "it's like they don't know propriety rules (*kaalá-thêetsà*) … their mental state isn't developed yet."

PA2 didn't know what would happen if a TG living fully as a woman after SRS applied for a psychiatry course, but assumed senior professors would not accept such an applicant. PA2 added some very conservative doctors view psychiatrists shouldn't even be gay. PA2 himself held an almost opposite view, noting that "men who are feminine – they're detailed, interested in people, very *psychologically minded* people, and can understand people. That is, I think they can help other people."

Similarly, PL3 said she's seen a lot of sexual/gender minority staff members who "often make a fuss (*wiin*), aren't able to control themselves, and then blame themselves, 'it's because … I'm like that, I'm like this'" and wondered that if "they can't take care of themselves, when coming to work with others, can they really manage [it]?" She viewed sexual/gender minority individuals' suitability for the work depends on their goals in life – if they are genuinely motivated to work and ready not to care about what others think of them.

PL4 noted that homosexual counselors "might have a tendency to" develop emotional attachment to clients, but added then that this also happens with straight men and women in the same fashion, even to the point of marrying their client.

PA1 viewed that social support or counseling given by a member of one's own group (e.g. a gay person with a gay person, a lesbian with a lesbian) may be more powerful than formal therapeutic support, but in case of family nonacceptance, the family might not consider a counselor belonging to a sexual/gender minority as neutral. PL3 and PL4 had a different view. PL3 said she'd questioned homosexual counselors claiming to understand other homosexuals better whether those working on AIDS also need to have AIDS themselves, and PL4 viewed no particular "sexual taste" (i.e., orientation) is necessary for working with sexual/gender minority groups.

PA2 used this same idea from another angle, noting that "being a psychiatrist really doesn't depend on [our] *phêet* – it depends on … skills and … *self development*," and therefore, a person that "is a *kàthoei* … [but has] *cleared* her complexes a lot, is very OK with herself… has little internal *conflict* – she'll be ready to help others, regardless of her *phêet*."

Existing Resources and Views on Further Development

The DMH

The role of the DMH as a resource center and service provider was discussed with many of the practitioners interviewed.

PL1 stated the DMH operates roughly 20 psychiatric hospitals in Thailand, "simply speaking, where people are either crazy or neurotic," and "the emphasis of their work is still on … not working much with normal people … if you refer

[someone] there, you've got to have a hunch (*săai*) that it [the problem] is definitely

psychiatric." PL1 also noted that in domestic violence cases, clients themselves

emphasize treating physical rather than psychological trauma:

> People don't go there if they've been injured, for example, supposing [you]
>
> are *rák-rûam-phêet, tom, dee, tút ...* when you've been subjected to violence,
>
> you won't go to a DMH hospital … you go to an ordinary hospital, because
>
> you've been injured, it goes mostly by the physical injury.

As seen above, PL3 noted that homosexual clients tend to contact the DMH hospital

where she works through the hospital's hotline, rather than walk into the hospital.

PA2, PA3, PA4 and PL1 all acknowledged the academic role of the DMH.

However, PA2, PA3 and PA4 thought the DMH (in line with other state bodies)

prioritizes socially hot topics, which sexual diversity issues in their view aren't, and

thus the DMH probably cannot provide practitioners with useful information on

homosexuality or transgenderism. For example, PA2, asked about the DMH, replied:

> Speaking like this, I [feel] *desperate* because … I've got no hope for the Thai
>
> government in many issues, it doesn't *work* at all – problems like this … will
>
> be seen as not *urgent* … the DMH also has problems; suppose that I suggested
>
> [to them] that *gender* issues, that these people have it rough, I think it would
>
> be prioritized lower after drug problems … or stress from political instability.

Similarly, PL1 noted that while the DMH can research specific topics, there are many

such topics, and especially in ordinary (non-DMH) hospitals little implementation

may take place following such research. PL1 also viewed that the DMH hasn't yet

clearly understood sexual diversity as normal variation in sexuality.

Specific Services and NGOs

Practitioners were asked if they viewed that specific services for sexual/gender minority clients are necessary or not. While some supported the idea, many viewed such services already exist, and/or that they are not necessary because generic services already serve these groups adequately.

PA2, PL1, PL4 and PL5 viewed that a specific service unit would be a good thing. PL1 said: "if it could be done, it would be very good – it should be done because nowadays there are lots of these people" and if they have problems and "don't receive assistance, therapy, it'll burst out elsewhere, or might cause more problems elsewhere" and thus "if there was a specific body that could *train* people to understand [them], problems could be reduced." PL4 viewed such a unit might be a useful resource center for adolescents. PL5 also viewed having a "really group-specific" center might be good because clients would not have to be afraid of bias or judgmental attitudes, for example enabling gay clients to say that their partner is male instead of waiting for a session or two before divulging the information. PA2 had a similar view – a specific service would increase readiness to access services, especially if it was an anonymous online service, with links to gay websites.

At the same time, PA1, PA3, PA4, PL3 and PL5 viewed that such services are already provided by NGOs. PA1 said: "lesbians – they probably have their own *counselors*, whether [for] individual or group [counseling]," and NGOs such as "*chomrom fáa sǐi rúng*[18], all the lesbian groups, societies like Anjaree … are much more skilled and also give more correct information" than state sector services that are

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[18] The full Thai name of RSAT is สมาคมฟ้าสีรุ้งแห่งประเทศไทย (*sàmǎakhom fáa sǐi rung hàeng pràthêet thai*); *chomrom* means a society or club, while *sàmǎakhom* means "an association" (a legal entity distinct from a foundation, *muunláníthí*).

"really slow and not much interested." PL3 also noted that "they already exist …
chomrom phûean rák ... lots of them, and a big society called *chomrom sǎai rung,* [I]
think it's around Red Cross, and on Patpong[19]," viewing that "they are foundations,
they receive foreign funds." Asked about specific services, PL5 asked back: "Really,
RSAT already does it, doesn't it?" PA3 said "there probably is [one] because I have a
friend who has a *clinic* dealing with these things … but I can't remember because I've
never been involved … haven't seen it, just heard of. [It's] around this area." PA3
added it might be a *"self help group* [or] *support group."* PA4 stated "it's probably an
NGO … what's its name, *sǐi rúng* something … I don't know much about the details."

PL4 himself worked in an NGO that had been established some 25 years ago,
first targeted at women but soon broadened to provide counseling for all groups, upon
finding out the narrow focus didn't work. He said the organization provides a wide
range of services and prioritizes service provision to the underprivileged.

Many practitioners were aware of the potential limitations of existing NGOs.
PL1 noted that while academic institutions and NGOs provide information on
sexual/gender minorities, they haven't managed to bring about major policy changes.
PL4 noted that NGO services suffer from lack of coordination:

> [They're] sexually diverse but also diverse [as] groups. … this might be
> because the groups don't get along well. Each person would like to be a
> leader, each person might have their own way of thinking … So maybe
> cooperation or coordination aren't as close as they should.

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[19] RSAT began in 1999 as a group called ชมรมเส้นทางสีรุ้ง (*chomrom sên-thaang sǐi rung*). It was
founded by Kamolset Kanggarnrua, then a counselor at the Thai Red Cross anonymous clinic in
Bangkok. In the beginning, the group used to gather in the nearby Lumpini Park, until it established a
main office on Patpong Road in 2003. Patpong Road still has an office of the Service Workers In
Group (SWING) that assists male sex workers. RSAT moved to Ratchadaphisek Road in 2006.

PL5 acknowledged NGOs might not have funds to hire a doctor, making the

volunteers "tired." He himself had offered to volunteer in one organization, but the

organization's requirement that he do an extra training course of three to five days (in

spite that he was already a practicing psychologist) was too high a time demand for

him, making PL5 view the organization wasn't flexible enough. PA3 wondered if the

support group he'd heard of might push coming out or pride in being gay too strongly.

PA2, PA3, PL3 and PL4 viewed that specific services are not strictly

necessary, as existing generic services already cater for sexual/gender minority

people. For example, PA3 said: "I don't think there needs to be [one], because they're

like ordinary people anyway – why would there have to be [one]? … They already

receive services through ordinary routes." However, PA3 made a qualifying

statement: "unless we do it for *academic* [purposes] like we want to study these

groups in particular … [or] their *health* in particular, or *study* with *action research."*

Both PA2 and PL3 viewed the state would probably not fund such a service.

PL3 said that "a specific clinic like this, they've got to say, 'and will there be many

patients?' [But] there aren't many, not many per year, it's not worth it, a clinic like

this in a hospital." PA2 held a similar view, but added that NGOs could do it, or

> the private sector might see it as an opportunity to gain income ... some
>
> hospitals say they only treat the elderly, some hospitals only receive kids –
>
> suppose a hospital opened: this hospital's *homo*, building painted in rainbow
>
> colors ... the doctors [would also be] *homo* ... understand each other well.

PL4 held the opposite view: "really, the budget's not the problem, but it's a problem

of *attitude* and *management* in the Thai state sector." As a matter of principle, PL4

viewed the state is responsible for the provision of mental health services, and that the

state should assess which groups are not provided for by current services, and then establish services for them.

PA2, PA3, PA4, PL2 and PL4 also talked of the potential shortcomings of specific services. PL2, viewing such a center would be set up to treat homosexuality as an illness, said it would be useless since "gay groups would oppose it immediately." PL4 viewed it would have to be made clear if such a center was volunteer or professional run, and professionalism paid attention to, because if it "turned out to be [for] grabbing company … to go out at night or the like … it could destroy the profession of other people as well." PA2 and PA4 noted having a specific clinic or "gay day" at an ordinary clinic might in fact deter clients who would be concerned for being seen entering and thus identified as gay. Thus, online or mixed services would be better than physically-based, specific ones. PA3 said having specific services "might be a double-edged blade, causing them to discriminate."

Professional Development

As seen above, many of the practitioners viewed that additional training is either helpful or necessary when working with sexual/gender minority clients, since existing training programs say little about these issues. For example, PL1 noted that when she did her Master's Degree about 10 years ago, it only covered "what kinds of behavior are sexually abnormal." Yet, she noted that just as providing domestic violence assistance services requires specific training, so does assisting sexual/gender minority people.

PL1 also noted that mainstream gender training is still limited to issues of heterosexual men and women, while broader sexuality training is available in a few places (such as Mahidol University). PL3 viewed the 10-day sexology course she had

taken at Chulalongkorn University had been excellent, since teaching was full-on, homework reading was a requirement, and "mostly the teachers [had] direct experience of working with *homosexual* [people], so they were experts; some were experts in physical matters, some were experts in psychological matters."

PA1 felt information for professional development was best found in pocketbooks written by sexual/gender minority people or by participating in seminars with community members, rather than in textbooks. He said he had helped arrange such seminars, as well as discussion sessions with community members in medical schools. PA1 added seminars arranged by the DMH on related topics should adopt this approach, and organizations like RSAT should have an active role in educating the public, as "academics usually just recite the textbooks." PA2 favored a similar approach, feeling that direct experience of community members was much more effective than a medical school teacher giving a lecture. Both noted that it was good if students could pass on questions on pieces of paper, to be answered by the community members in attendance. PA4 felt practitioners probably learn by asking around rather than consulting any particular organization.

PL4 noted that the fields of psychology and medicine in Thailand had produced little information on "sexually diverse groups" in the Thai context – more information has been produced by anthropology and sociology. PL4 viewed that

> Foreign studies can also be read, it's just that they need to be used with
> modification with Thai people … It has to be understood what the habits of
> Thai people are like, how is [their] personality, how do Thai people express
> themselves, and understand Thai culture, because the sexual diversity [i.e.
> sexual/gender minority] culture of Thailand differs from many countries.

Changing Attitudes through Schools and the Media

Three practitioners recommended that practitioners should also have a role in preventing problems, rather than just addressing them after they've emerged.

PA1 and PA3 recommended working through schools. PA3 said that while he doesn't believe psychiatrists need to provide specific treatment services to sexual/gender minority individuals, he does believe that

> problems don't emerge overnight when they come to see a psychiatrist –
> mostly it begins in childhood, and when *sexual identity forms* from the age of
> 3, 4 years, or even before, the issue is that there should be *health promotion*
> that *concerns* [itself with] *minority* groups, and not just issues of *sex*, ever
> since school [age]… at least *sexual prejudice* has to be reduced … you can
> like whatever, up to you, but you have to be able to get along with others.

PA3 viewed that such education has to be started "from the earliest, and not begin at *homosexual* [issues] but at *gender, prejudice,* that being prejudiced is not good." He added that due to the shortage of psychiatrists in Thailand, practitioners arranging this kind of education "could be psychologists, social workers, whatever, because in ... *health promotion* it's not necessary to use psychiatrists, just [someone] who understands the issues. PA3 viewed that "changing the *attitudes* of society, of families, we do it in schools." He thought such contents should be a part of generic prejudice reduction or sexual health instruction, which could be integrated in homeroom subjects or covered in social studies or health education, for example through a technique whereby the discussion begins with general matters like heterosexual boys or girls having partners, if they are teased for that, and how they feel about it, and is then gradually guided to sexual/gender minority subjects, inviting the children to imagine how they would feel in place of others subjected to prejudice.

PA1 also viewed that sexual education is important, but noted it may be opposed by school directors and teachers viewing it as inciting the children to have sex. However, PA1 made the comparison that sexual education is not "pointing a cone to a squirrel" – it might sometimes rather be a case of "erecting a fence when the cow's gone," because teenagers are already having problems related to sexual matters. PA1 viewed that nurses and doctors are better suited for the task than school teachers, being more likely to be accepting of such matters.

PA2 noted that many changes in Thailand begin from the mass media, as shown by the success of anti-smoking and certain anti-alcohol campaigns. And while beliefs about sexual/gender minorities may be difficult to change, when Thai people see someone suffering on a personal level, they have a tendency to feel compassion, PA2 thought. Therefore, television commercials that showed, for example, parents mistreating their sexual/gender minority child might bring about compassion and thereby also acceptance, he viewed.

Other Recommendations

Given the insufficient scope of current mental health resources in Thailand, it is unsurprising that practitioners advocated scaling up service provision. PL4 was particularly vocal, demanding that the Thai state should bring the number of psychiatrists and other mental health professionals (psychologists, psychotherapists, mental health social workers, and even volunteers) onto a level appropriate for the Thai population. A part of this would be increasing the desirability of mental health professions as occupational choices. PL4 also said every province and even every district should have a mental health center for mental health problems on all levels, which would increase the acceptability of using services, reducing stigmatization.

PA1 viewed that ideally, all service provision should follow the one client per hour model he is able to stick to in his private practice.

PA1 also called for psychiatrists to use media channels to increase public awareness of the fact that psychiatrists not only exist to treat psychoses.

PL2 called for a more inclusive professional association than current ones, to enable mutual learning in the practitioner community.

PL4 viewed that changes are also needed in universities: the training of psychologists has to be changed a lot, to emphasize cultural issues more, and psychology faculties also need to become a part of their surrounding communities. PL2 similarly felt that at least clinical examples and case conferences have to be introduced into the training of psychologists.

PL5 said advocacy will be needed for two developments: getting insurance cover for psychotherapy and a same-sex partnership law.

PL4 stated that there has been very little qualitative counseling research in Thailand, yet it would in his view be much more useful for practitioners than quantitative research. PA4 would like to see research on how homosexual people know someone is sexually or romantically interested in them.

CHAPTER V: DISCUSSION

In writing this thesis, the researcher made a conscious choice to represent participants' views at length – not only because they provide a wealth of information about the context, but also to provide a voice for the participants themselves. This discussion section, on the other hand, picks up major themes represented by the participants, compares practitioner and client views with each other and with existing research, assesses the appropriateness of the attitudes and practices represented, and identifies problems as well as ways how these could be addressed in the Thai context.

The reader is invited to keep in mind that the accounts analyzed in this study are provided by a clinical sample of sexual/gender minority individuals and mental health practitioners; therefore, they may present a more problem-ridden view of the situation than would be the case in a sexual/gender minority community sample.

Practitioner and Client Views and Experiences on Homosexuality and Transgenderism

Etiology of Homosexuality and Transgenderism

While the participants in this study were not asked about their etiological views, some volunteered them: G2 and T1 stated they'd been born the way they were. PA1 and PA4 seemed convinced of the biological origins of homosexuality. This etiological view roughly matches the current Western mainstream view, as stated by the Royal College of Psychiatrists, (2007):

Despite almost a century of psychoanalytic and psychological speculation, there is no substantive evidence to support the suggestion that the nature of parenting or early childhood experiences play any role in the formation of a person's fundamental heterosexual or homosexual orientation. It would appear that sexual orientation is biological in nature, determined by a complex interplay of genetic factors and the early uterine environment. Sexual orientation is therefore not a choice, though sexual behaviour clearly is. (p. 2)

In contrast, two older practitioners (PL2 & PL3) still held the view that homosexuality can also be caused by a number of causes separately or together, such as parental factors, occupational factors, following a fashion, voluntary choice, or even having been cheated into it.

Given that neither practitioners nor clients distinguished between homosexuality and transgenderism in their etiological views, they seem to largely conflate the two in this regard (as in many others), mirroring the way these matters are understood by many Thai lay people (as discussed in Chapter 2).

Malleability versus Fixedness of Sexual Orientation and Gender Identity

It seems that those who hold the view that homosexuality can result from non-biological factors, such as the ones suggested by PL2 and PL3, might be more likely to question the genuineness of a client's sexual orientation, and propose changing it. PL2 explicitly stated that sexual orientation can be changed, provided that a number of conditions are fulfilled, such as high and broad practitioner expertise and full client willingness to change, and was willing to try it if the client requested it. He claimed to

have brought "cure" for homosexuality in numerous individuals, but also that he is the only practitioner offering such treatment in Thailand.

However, T2 reported that such treatment was offered as an option to her parents some ten years ago in a large provincial city, suggesting perhaps that such treatments have been more broadly offered in the past. Jackson (1997) has noted that by the early 1980's, the failure of such treatments had already largely shifted the emphasis from "cure" to "prevention" of homosexuality in Thailand.

If PL2's account of himself as the only practitioner offering such treatments in Thailand today is accurate, it means that therapies aimed at sexual orientation change have now almost disappeared from the Thai mental health scene, while in the US and UK they are still offered by a small minority of practitioners (APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009; Royal College of Psychiatrists, 2007).

As suggested above, it seems that Thai practitioners conflate aspects of homosexuality and transgenderism or view them as parts of a masculinity-femininity continuum. In view of the research reported by Danthamrongkul and Posayajinda (2004), such views may be a fair reflection of the context. However, it seems that these views may be accompanied with the view that a client's position can be shifted on the continuum, for example, to appease their parents.

T2, whose psychiatrist had negotiated with her to reduce her femininity along this continuum, said she had felt terrible about the pressure exerted on her to change. M1, who had earlier underwent a shift from a TG identity to a non-TG MSM gender presentation due to pressure from his mother, said it made him feel emotionally empty. These client accounts suggest that while it may be possible to negotiate gender expression with a client, such negotiation should not lightly be used, as it means

asking the client to give up a crucial aspect of their identity, and seems to have negative consequences.

Related to this issue is the question of choice over sexuality and gender identity: T2, PL1 and PL3 expressed a belief that the sexuality of a person was their own choice and the two practitioners indicated they would communicate this to clients as a part of their approach. While this view might seem empowering, it goes against current mainstream psychiatric understanding about sexual orientation (e.g., Royal College of Psychiatrists, 2007) being unchangeable. One of the possible consequences of communicating the view to clients is that clients willing but unable to change their sexuality might blame themselves for this inability to change.

Normality versus Abnormality of Sexual/Gender Minority People

Homosexuality

In this study, not a single client or practitioner stated they viewed homosexuality as abnormal, and many acknowledged the international change that had taken place, including the WHO declassification of homosexuality as a mental illness in 1992. Even PL2, who continued to provide therapy aimed at sexual orientation change, explicitly stated he did not claim gays are abnormal (though he did seem to view that living one's life as a gay person was a recipe for a less than optimally happy life). PL2 noted gays themselves didn't view themselves as abnormal due to being addicted to sex, suggesting he held an indirectly pathologizing stance. PL3 made a distinction between those "born to be" gay or kàthoei and those who were so for other reasons, viewing the former just had to find a way to be happy with how they were, but didn't state what should be done about the latter.

While Jackson (1997) has stated that most Thai researchers have generally ignored the changes in how Western academia view homosexuality, or noted them but determined to continue pathologizing homosexuality, the situation seen in this study appears different, perhaps matching a general shift toward more positive views on homosexuality in Thai academia, earlier noted by the author on the basis of a review of Thai research conducted in the past 10 years (Ojanen, 2009).

PA2 estimated that around 90% of Thai psychiatrists now hold attitudes appropriate enough to work with homosexual clients.

Transgenderism

As regards transgenderism, the situation is more complicated than with homosexuality, as "Transsexualism" and "Gender Identity Disorder" remain disorders in the ICD-10 and DSM-IV, respectively, and Thailand follows its own version of the former, ICD-10-TM (Ministry of Public Health, 2007).

Of the TG participants, one (T3) agreed with the pathological/medical model, while another (T1) was more ambivalent, and the third (T2) criticized the medical model as "not always being to the point." The only practitioner (PA2) who commented on the issue said he "almost" didn't view it as a disorder, that it would be cured following SRS (a view similar to that proposed for the upcoming DSM-5 on www.dsm5.org) and that retaining it as a medical category should depend on the consequences (e.g., assistance or stigmatization) rather than principles. However, Winter (2007) has provided evidence that pathologizing views tend to go together with discriminatory views, and one unavoidable consequence of sticking to the medical model may thus be perpetuating discrimination within society at large.

Thailand's transgender communities are debating the issue and there are advocates for both depathologization and the status quo (Nada Chaiyajit, personal communication, 20 May 2010). It would thus be misleading to refer to clear-cut "practitioner" and "community" standpoints in this case. However, many transgender advocacy bodies, like the recently established Asia Pacific Transgender Network, have taken a stance to advocate for the delisting of Transsexualism as a mental illness (Boonyapisomparn, 2010).

Internationally, The Task Force on Gender Identity and Gender Variance of the American Psychological Association (2009) likewise noted that numerous transgender individuals and organizations had contacted the working group in writing, asking them to advocate for depathologization, but the APA Task Force did not come to a conclusion on the issue. France has already delisted Transsexualism as a mental illness before any international bodies (France Delists, 2010).

However, neither practitioner nor client accounts in this study contained anything suggesting that Thailand would follow the lead taken by France. This matter is thus probably not solved on the practitioner level, or even on a national level, but depends mostly on the decisions of the APA and consequently WHO, which will determine the stance the DSM-5 and ICD-11 take on the issue.

Distinctness versus Generality of Sexual/Gender Minority People

Both client and practitioner participants expressed views on whether there were some qualitative differences (beyond sexual preferences and gender role) between sexual/gender minority individuals and those with normative phêet.

The gay participants G2 and G3 viewed gays are likely to have specific personality characteristics. T2 noted that many kàthoeis choose their own way without strict adherence to standards of femininity and masculinity. The quantitative research of Winter and Udomsak (2002) among Thai transgender women suggests that T2 held an accurate view about TG identities.

Similarly, in the US, the APA Task Force on Gender Identity and Gender Variance (2007) has noted that there is a rising trend of transgender people asserting a distinct transgender identity instead of trying to pass as members of the gender opposite to their natal sex. In contrast, T1 viewed sexual diversity means just a male-female continuum (as Danthamrongkul & Posayajinda, 2004, did).

Most practitioners seemed to favor a universalistic view, especially PA2, PA4, PL2 and PL5. In contrast, PL1 seemed to hold the strongest views for specificity of sexual/gender minority individuals, talking about their different ways of thinking, relationship and family characteristics, sexual practices, and the instability of their emotions. PL2 also talked of specific reactions gays have when encountering a man or a woman, and the entertainment venues either staffed by them or providing services to them. PA3 noted the need to understand stages of coming out, and other practitioners also talked of closeted versus out sexual/gender minority persons.

PA1 and PA4 viewed sexual/gender minority people as particularly creative, whereas PL2 explicitly stated he opposed the view – that creative sexual/gender minority individuals are not creative because of their sexual preferences – it is coincidental. This issue seems to have been long debated, but after an early article by Ellis (1959), very little research seems to exist on the matter. Domino (1977) compared four groups of homosexuals and heterosexual controls with 36 measures,

and did not find homosexuals more creative in any of those measures – indeed, nine measures indicated heterosexuals were more creative.

TGs in particular were noted for specific characteristics by practitioners, such as beauty (PA1 & PA2), being in an in-between state between men and women (PL1 & PL3), and even as having a likeness with God (PA1).

Practitioners not only expressed views about whether sexual/gender minority individuals were distinct from the general population – they also commented on the desirability of this. Several views expressed by the practitioners seemed to reveal heterosexist bias, showing that they still found sexual/gender minority lifestyles less desirable or worthy than gender-normative heterosexual ones, such as the view that gays should consider ordaining as monks so that they could love the Buddha instead of loving a man (PL2), the view that they should model their lives along those of "ordinary people" (PL3), or the view they should try to stay within society's frame (PA4), which, of course, has been designed for gender-normative heterosexuals. In contrast, PL3 also noted that sexual/gender minority individuals should try to find a way to be happy with how they are, which is a more affirmative take on their lives.

Overall, both practitioners and clients held a combination of views about the distinctness and non-distinctness of sexual/gender minority people; often the same person held a general conviction in their non-distinctness, but also spoke of some specific characteristics (e.g., PA3, PA4, PL2 & T1). Therefore, a general belief in the non-distinctness of sexual/gender minority individuals does not always preclude an understanding of specific characteristics.

The APA guidelines (2000) have warned that "when psychologists deny the culture-specific experiences in the lives of lesbian, gay, and bisexual people, heterosexist bias is also likely to pervade that work in a manner that is unhelpful to

clients" (p. 1442), because heterosexual norms would in this case be used for assessing minority clients. In these terms, what is crucial is probably not a general philosophical stance for or against human universals, but an appreciation and acceptance of the role of relevant subcultural characteristics.

In this study, the distinctness of sexual/gender minority individuals can be seen in descriptions of specific identity development, specific relationship and sexual behavior types, gay social life, and so on (see below). On the other hand, many if not all of these characteristics can be argued to be products of the social status of these minorities, and subject to change as society changes. The next section discusses this.

Group-Specific Problems of Sexual/Gender Minority People

As seen in Chapter 4, all participants in this study had an appreciation that sexual/gender minority groups are still not fully accepted in Thai society. There were marked within-groups differences in the views on these matters. For example, both G2 and PL1 viewed the situation in general in more pessimistic terms than, say, either PA3 or T3, suggesting that practitioners as a group did not have markedly different views on societal acceptance from those of their sexual/gender minority clients.

However, there were differences in emphasis, and in specific matters, some practitioners seemed to lack appreciation of the possibility of negative treatment based on prejudiced views. For example, PL2 viewed Thai television as fully gay dominated and therefore outright encouraging of homosexuality, and school teachers also being generally encouraging of sexual/gender minority identity, and possibly not appreciating those media outlets or teachers who behave otherwise. Likewise, PA3 viewed that psychiatrists could possibly not discriminate against minority clients.

Many client (G2 & G3) and practitioner (PA2, PA4 & PL4) participants viewed that acceptance of sexual/gender minorities is increasing in Thailand, but problems still persist. This corresponds with the author's earlier analysis of the situation (Ojanen, 2009) and may also be supported by the finding that the youngest client participant in the study (T3) seemed to have had the least negative experiences of all participants, while the oldest practitioner participants (PL2 & PL3) seemed to hold the view that the lives of (especially older) sexual/gender minority individuals are characterized by loneliness and/or unhappiness. While possibly coincidental, this may also reflect that younger people have overall had more positive experiences of the societal context.

Nevertheless, the accounts clearly reflect the bounds of acceptance of sexual/gender minorities in Thai society. As seen above, PL1 viewed gays need to be skillful and influential to be accepted. PA4 emphasized they may be accepted only when their work contribution is needed. PA2 and PA4 noted they may be seen as comic stress relief figures and not taken seriously. PL1 and T1 noted TGs are better accepted if they are very feminine. T2 lamented the stereotyped roles ascribed for TGs. A couple of such stereotyped role expectations seemed to be held by two practitioners: PA1 said it would be good if TGs could be employed within entertainment or other creative occupations because they would then be better accepted, but should not attempt entry to esteemed professions; PL2 noted that more beautiful TGs can support themselves by selling sex.

Parental Non-Acceptance

Clients and practitioners generally seemed to agree that most problems of non-acceptance of sexual/gender minority individuals originate in their parents.

Client accounts also showed that some parents (e.g., T3's mother) perceive the reality early on and don't have a problem with it. However, many react more negatively, resorting to violence against their child (M1), expressing anger (T2) or denial (G1), attempting to forbid their child's gender identity or sexuality (M1 and T3), taking various control measures (M1), trying to convert their child's gender identity through sex-typical activities (T2), and importantly, taking their child to a practitioner in the hope their child could be cured of their sexuality or gender identity (G1, M1 & T2). Practitioners (PA1, PA2, PA3, PA4 & PL3) had gained first hand experience of parents seeking their help and thus had an appreciation of these reactions; some recognized violence (PL1), anger and forbidding (PA1) as reactions.

These reactions somewhat match those reported by Nithiubat (2003), who studied coming out in 35 "male homosexuals."[20] In Nithiubat's study, less than half of the families fully accepted their child's direct or indirect communication of their sexuality, whereas Winter (2006b) found that among 195 "transgendered females," "62.9% of mothers and 40.6% of fathers accepted or encouraged their child's transgender from its first expression" (p. 47), others viewing it more negatively.

Many parents described in this study seemed to have had negative emotional reactions to their child's sexuality or gender identity, such as G1's mother, who "must've been shocked," M1's mother who called him "crazy" and "dirty," M1's relatives who "imprisoned" his transgendered cousin, or the highly upset parents afraid of losing face described by PA1. Since these reactions seem to be characterized by inordinately negative emotions, the labels "homophobic" or "transphobic" might

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[20] Some of Nithiubat's (2003) participants seem to have been TGs rather than gays because Nithiubat referred to reactions of partners upon some of the participants "coming out" to them – had they been gays, it would probably have been obvious to their partners from the beginning of the relationship.

be appropriate even in the narrow sense used by Davies (1996b, p. 42): one marking the presence of a "fear response to homosexuality" (or transgenderism, by extension).

The label "transphobic" may be particularly appropriate in many situations because as PA1 noted, the matter provoking negative parental reactions is often not who the person has sex with (which the parents generally don't know), but rather their cross-gender expressions, clothing, and other visible actions. However, as homosexuality and transgenderism have blurred boundaries in the Thai context, and parents are not always familiar with these academic concepts, in practice the demarcation may be quite irrelevant. In any case, Nithiubat (2003) reported such cross-gender expressions were important ways to indirectly communicate one's sexuality to one's parents without risking as harsh reactions as if explicitly telling them. Clearly, some parents do get the message but just cannot accept it.

Besides the emotionality of negative parental reactions, they also seem to have a cognitive component, being apparently rooted in biased views of sexual/gender minority individuals as inherently disgraceful, shameful, necessarily spending their old age alone and lonely, cared for by nobody, as PA4 noted. This cognitive component is more accurately described as transprejudice (cf., Winter, 2007).

Implicated in spreading biased views (or failing to correct them) have been Thai media[21], schools[22] and psycho-scientists themselves[23] (incidentally, all of them

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[21] RSAT (2010a) noted that one of the reasons the group was originally formed was negative media portrayal of these groups; Thammarongwith (2005) has also analyzed negative media portrayals of sexual/gender minority individuals.

[22] Martin (2003) analyzed school sexual education syllabi and noted that the ones then used first mentioned homosexuality on *mathayom* (high school) grade 5, when it would be noted as a cause in the increased spread of STIs and homosexuals as a risk group for AIDS. Homosexuality would be lumped

groups that PL2 viewed won't bother opposing homosexuality). Prior to about 10 years ago, the role played by Thai academia in general wasn't very helpful, as there used to be scarce Thai research on homosexuality that didn't problematize it (Ojanen, 2009). Even today, hardly any research exists on elderly Thai sexual/gender minority individuals (Ojanen), who, as seen, are often viewed with a combination of pity and contempt. The absence of systematic, factual evidence exacerbates the problem, as such evidence would be crucial to counter negative stereotypes. Psychologists and psychiatrists could address these issues through conducting appropriate research and making related statements in the mass media and education-related forums.

Non-Acknowledgement in Official Contexts

In official contexts, homophobia and transphobia are sometimes expressed openly (as in PL1's account of clients being criticized as "abnormal" or practitioners refusing to see them) or indirectly (as many psychiatrists G2 saw did). However, in this study, these seemed relatively rare reactions in official contexts of any kind.

Both practitioner and client accounts suggest that non-acknowledgement (rather than non-acceptance) of the existence of non-normative phêet (other than "men" and "women") seems a more accurate analysis of the situation in official contexts. It is reflected in the lack of flexibility in the placement of TG clients in state shelter homes or hospital wards (T1 & PL1); the lack of sensitivity toward TGs in healthcare (PL1, T1 & T2) lack of research on the safety of SRS and feminizing hormone use (T2) or the lifespan development of TGs (T3); the lack of legal recognition of the self-assigned gender of even post-operative TGs (PL4); the lack of

together with other "sexual abnormalities" together with pedophilia and cross-dressing. On mathayom 6, pupils would be warned that sex-segregated schools may lead to a "gay and lesbian problem."

[23] At least historically, and to some extent still today, as analyzed in Chapter II.

legal same-sex marriage or partnership provisions (G2 & PL5); even wealthy TGs being forbidden to adopt a child (PL1); pressure on gay professionals and those aspiring to esteemed professions to act in accordance with masculine sex stereotypes (G3, PA1, PA2 & PL1); lack of state interest in the appropriateness of mental health services for sexual/gender minority individuals (PA2, PA3, PL1 & T1); and the feeling within government that sexual/gender minority issues are little but a laughing stock (PA2). Yet another telling example is the state university counseling center representative, who denied the center has any *chaai-rák-chaai, yĭng-rák-yĭng* or *săao-pràphêet-sŏong* clients, when the author contacted the center by telephone to recruit participants.

These issues match Thammarongwith's (2005) analysis of Thailand as a heterosexist society – even though official contexts in Thailand don't exude open homophobia, it is clear such contexts don't acknowledge non-normative phêet such as gays or *săao-pràphêet-sŏong* as legitimate alternatives to the normative phêet "man" and "woman," leading to double standards in human rights: one set for those with normative phêet, and another for those with non-normative phêet.

Sanders (submitted for publication) has described the situation as follows: "Thailand's commitment to human rights is weak. … It has no overtly anti-homosexual laws, but it has made absolutely no legal accommodation for *kathoeys*" (p. 35). However, it seems no legal accommodation whatsoever has been made for homosexual people, either (Suwanpradit, 2000). The Thai NHRC (2009) has also analyzed issues like violations of dignity, lack of access to healthcare or lack of right to establish a family, in its general report for the years 2008–2009.

Thus, while in everyday life Thai people generally acknowledge the existence of identities such as kàthoei, gay, tom or dee, any expression of these identities in

official contexts is generally seen as "not knowing propriety rules (*kaalá-thêetsà*)" (PA2), "not professional" (G3), or as comical stress relief (PA2 & PA4). Such views constitute both stigmatization and marginalization of the identities in question.

The examples provided by M1 and PA1 demonstrate that gossip intended to result in a public "outing" and consequent stigmatization of a sexual/gender minority individual can also be used in the Thai context in a malicious attempt to ruin a high standing individual's reputation. On the other hand, Sanders (submitted to publication) has noted that even a former Thai prime minister has been rumored to be gay, without anyone seeing this as a problem. Perhaps this would only be problematic if the politician in question explicitly confirmed the rumor.

Some practitioners, like PA2, PL1, PL4 and PL5 seemed to appreciate the problem of non-acknowledgement in its various forms, others less so. Nevertheless, it would be important for practitioners to appreciate this official marginalization to understand what their sexual/gender minority clients are dealing with.

Romantic/Sexual Relationship Issues

G1, G2, G3 and M1 (the client participants with comparatively masculine identities) all reported some difficulties with intimate relationships: G2 talked of gay relationships as a "sex game" in which he could find no lasting partner, and of various other relationship problems helpline callers had consulted him on. M1's own life involved many of sex partners and group sex, coupled with loneliness due to his inability to find a long-term partner. G1's relationship had recently terminated prior to the interview. The TG participants in this study, however, did not seem to view their relationship lives as a problem in the same way.

All practitioners mentioned relationship problems among these groups, either as presenting issues, or as more general views of the lives of sexual/gender minority people: PL2 and PL3, both older practitioners, seemed to view that gays simply do not have long-lasting intimate relationships (with PL2 emphasizing how "gays" may repeatedly be abandoned by "men" and PL3 noting that "kings won't stay long," which "queens" should just accept). PA3, PA4 and PL5 said gay or TG people sometimes come to consult on relationship issues, alone or in couples, and PA4 noted the greater "promiscuity" of gay people when compared to heterosexuals, which in his experience leads to relationship problems.

Male relationship patterns in the non-normative Thai phêet have been charted in large-scale quantitative/qualitative research: Danthamrongkul and Posayajinda (2004), who studied 289 MLM (242 with a gay identity, 39 with a bi identity, and 8 with a kàthoei identity), painstakingly recorded the sexual and relationship practices and preferences of their sample group. Roughly one fourth of all their contacts were "sexual encounters" defined as having sex within one week of first encounter, and only 3.5% of those met through encounters of this type remained a part of the sample group's network at two years' follow up. This suggests that casual sexual contacts are indeed quite common male Thai non-normative phêet. Such contacts are seen as a male prerogative in Thailand (Sinnott, 2004), apparently for both heterosexual men and male Thais with non-normative phêet. Unless viewed from a traditional-moralist view, such contacts are not a problem as such, but if safe sex practices are neglected or sexual encounters have an abusive/exploitative nature, problems ensue (see below about HIV/AIDS and sexual and domestic violence).

At the same time, as Costa and Matzner (2004) have noted, many TGs view that while gays are promiscuous, they themselves try to follow the sexual ideal of

monogamy prescribed for women in Thai society. In fact, Danthamrongkul and Posayajinda (2004) found that four out of six kàthoeis and 62.3% of gay queens said they wanted a male long-term partner, as opposed to just 44.4% of "gay both", 34.0% of "gay kings" and 36.0% of those with a "bi" identity. These figures suggest that among people with Thai non-normative male phêet, the more feminine one's identity, the more likely one is to intend to have a male long-term partner. A higher percentage of those with the more masculine identities (not only bi) were also found to contemplate having a female partner in the future. These findings show that there is a grain of truth to the pattern described by PL2 and PL3 (the more masculine male partner leaving the more feminine male partner, often in order to marry a female partner) while also showing that viewing this as an absolute rule is an exaggeration.

Relationship ideals don't always manifest themselves in the actual behavior of either party – for example, Boonyapisomparn, Samakkeekarom and Boonmongkon (2008) have noted that many TGs uphold the principle of monogamy and sex following love, but lack of opportunities may lead them to opt for short-term relationships instead.

Different relationship ideals do seem likely to constitute a specific source of relationship tension in Thai male-male relationships where one party has a more feminine identity than the other (which is not always the case). However, although toms (who are more masculine) are perceived as womanizers, they themselves are often afraid of their dee (more feminine) partner leaving them for a male partner, and dees seem to face more family pressure to marry a man than toms do (Sinnott, 2004).

M1's account of how he at times hires a male sex worker for a period of five to ten days, PL1's emphasis on the "generosity" of sexual/gender minority individuals, PL2's firm view that male partners of gays generally stay with them for

money, and PA4's upset realization that young, educated gay people openly sell sex on the internet all reflect that some sexual encounters or even relationships take place due to economic considerations on the side of the party that receives money or goods. The gay-oriented sex industry and male sex workers in Thailand have been described for example by Herder (2006).

However, to claim (as PL2 seemed to do) that gays generally have to pay the men they have sex with seems not only a sweeping statement – it also seems to imply a perception that gays mostly have sex with men who view themselves as "real men," while to the author's knowledge, they rather tend to have sex with gay or bi oriented males. It is possible that PL2's comment reflected a conflation of homosexual and transgendered people and thus referred to TGs rather than gays. The partners of TGs generally do tend to be perceived as heterosexual men by both parties, and the sex in question as heterosexual (Winter & King, submitted for publication). However, Boonyapisomparn, Samakkeekarom and Boonmongkon (2008) have noted that while TGs generally wish for a heterosexual man as their life partner, they may have casual sex with the more masculine gays, or even have a (female) wife and children.

Any sexual encounters and relationships may or may not contain an economic element, but little conclusive evidence seems to exist on the level of such elements in gay and TG relationships. TGs in Thailand have been noted as providers rather than consumers in sex work; for example, Cameron (2006) has stated most of them are employed in "service professions, including but not limited to sex work" (p. 31) due to discrimination in other fields. However, Boonyapisomparn, Samakkeekarom and Boonmongkon (2008) have noted that TGs both sell and buy sex, and that many agree to be the party covering all expenses in a relationship with a man, because they believe it is the best available arrangement they will be able to attain.

In the UK, the Royal College of Psychiatrists (2007) has acknowledged the possibility of relationship instability among same-sex couples, but suggested it depends on the societal context:

> There appears to be considerable variability in the quality and durability of same-sex, cohabiting relationships. A large part of the instability in gay and lesbian partnerships arises from lack of support within society, the church or the family for such relationships. … Legal recognition of civil partnerships seems likely to stabilise same-sex relationships…" (p. 2-3).

In Thailand, Purin (2004) has given a similar explanation for males having anonymous sex instead of sex within relationships, and Boonyapisomparn, Samakkeekarom and Boonmongkon (2008) have lamented how Thai society blames TGs for promiscuity while denying them legitimate options for lasting relationships. In this study, G2 and PL5 called for a same-sex partnership law. For TGs, the equivalent would be the legal acknowledgement of their de facto gender, which would enable them to marry a man – in this study, PL4 noted the need for this.

Overall, it seems many practitioners interviewed for this study had an understanding of some aspects of typical gay or TG relationship problems, but not necessarily a balanced or comprehensive view on the matter. While practitioners developing an understanding of particular relationship dynamics seems helpful in terms of understanding their clients better, they risk doing so by forming inflexible stereotypes, which may be do more harm than good.

Sexual and Domestic Violence

Of the client participants interviewed, M1 and T1 said that they'd been subjected to a rape attempt. T2 considered that "most people who are *kàthoeis*" face

sexual violence, and G2 recounted some gays called the helpline he volunteered on, saying they had been raped. Sitthiphan Boonyapisomparn (personal communication, 27 April 2010) has stated that over 50% of the participants in her research on săao-pràphêet-sŏong (Booyaphisomparn, Samakkeekarom & Boonmongkon, 2008) had faced sexual violence, corroborating T2's view.

Of the practitioners, PL1 and PA4 noted violence between sexual/gender minority couples, but no practitioners talked of a particular risk of being a rape victim in any of the groups studied, suggesting they lack an appreciation of the significance of this issue. This matches the analysis of Sankatiprapa (2007), who has studied sexual violence against kàthoeis and argued the matter tends to be trivialized in a society that hardly acknowledges the existence of kàthoeis and denies them a voice.

While T2 wondered how a rape victim would feel when having to explain their problem to three officials in a state hospital, PL1 said sexual/gender minority victims of domestic violence use services in an inconsistent manner, seemingly expecting to have insult added to injury, demonstrating that these two participants had a similar understanding of the issue, while others were silent on the matter. It seems more awareness needs to be built about this issue.

HIV and STIs

Issues related to HIV and STDs were curiously rare in the accounts collected in this study. No client participants confessed to being HIV positive, and at least one practitioner (PL5) said he'd never encountered a client concerned with the ramifications of a confirmed HIV infection, while acknowledging that people are now increasingly afraid of HIV. PL2 noted some gay clients are HIV positive and afraid of

transmitting the virus to others. PL3 and PL4 briefly noted HIV as an issue among the groups concerned. M1 recounted a story of a less than sensitive HIV test counselor.

Phliphat, Klatsawat, van Griensven and Wimonset (2008) have reported that in 2007, HIV prevalence among MSM in Bangkok was 30.7%; among TGs in Bangkok it was also several times higher (11.5%; 2005 data) than the national overall HIV prevalence of 1.5% (Cameron, 2006). This is understandable when considering the combination of opportunities gays and TGs have for sex in Bangkok on one hand, and Danthamrongkul & Posayajinda's (2004) findings on the other: Only 54.5% of gays in their sample reported using a condom when having anal sex with their partner (and a mere 11.1% reported using it while having oral sex); with casual partners and strangers, the condom use rate was 80.6% and 86.4% for anal sex, respectively.

Hence, at first sight, it seems surprising that no more HIV related issues were encountered in this study. There are many possible explanations. Firstly, the HIV prevalence rate among urban Thai MSM and TGs has risen so sharply (Phliphat, Klatsawat, van Griensven & Wimonset, 2008) over the past few years that many of those living with HIV may still be asymptomatic, or not even know they carry the virus. Secondly, just as in domestic violence cases, in which people tend to go to hospitals to treat their physical injuries but may not think of treating psychological trauma (PL1), those who know they are HIV positive may only seek medical care to control the physical aspects of the infection. Thirdly, HIV and sexual health issues are the one field in which group- and issue-specific (thus probably more sensitive) counseling services already exist in Thailand (see Ojanen, 2009, for an assessment); specific support groups for HIV positive MSM also exist in Bangkok (e.g. The Poz Home Center; www.thepoz.org), probably leaving little motivation to utilize generic mental health services, in which staff may have little understanding of the involved

issues and hold biased views on both HIV and non-normative phêet. However, these services may not have the capacity to deal with severe depression or obsessions related to HIV (Ojanen, 2009), and thus at least referral avenues to mental health services proper should be made available where they do not yet exist.

Harassment within Schools

In this study, G1, PA2 and PA3 referred to selective harassment of children perceived to be tút or kàthoei (and who could thus grow up as either gay or TG) by their peers in school. G1's account of his consequent suicide attempt shows how devastating this can be. In contrast, T3 said that when she was in school, a peer group of TGs ready to fight back helped to deter harassment. Of the practitioners, PA2 observed that more masculine TGs may be motivated to fight back more readily than their more feminine counterparts, reflecting the gendered nature of the harassment.

Harassment of TGs in schools is also highly common and pernicious in the US, where according to "Sausa's (2005) research, 96% of participants reported being verbally harassed, 83% being physically harassed, and 75% not feeling safe in schools and eventually dropping out" (APA Task Force on Gender Identity and Gender Variance, 2008, p. 54). In comparison, the presence of peer groups of young TGs in Thai schools, and the greater cultural familiarity with TG identities in Thailand may mean that the situation is not quite as bad as this in Thailand, although this should be specifically evaluated in quantitative terms.

PA3 noted that children should be thought that prejudice is not good, not just as regards homosexuality, but in general. School counselors and teachers might be better positioned than practitioners in medical settings to deal with this issue, and as PA3 noted, prevention of problems like this should be of primary interest.

Alcohol and Drug Use

In this study, M1 mentioned using "ice," poppers and intravenous drugs. Since the substances mentioned by M1 are all illicit in Thailand, their use could lead to both health and legal problems. PL3 noted some sexual/gender minority individuals enter her hospital for drug abuse treatment.

The APA Task Force on Gender Identity and Gender Variance (2007) have noted in their review that in studies done in North America, "alcohol and drug use are common among transgender people," but also that these studies have limited generalizability. Kowszun and Malley (1996) have noted the same about gays and lesbians in the Western world in general, and reviewed reasons for this, such as the bar and alcohol centered social lives of gay people, less reduction in alcohol use with advancing age, or the use of alcohol and drugs to cope with homophobia and heterosexism. Kowszun and Malley have also noted that while gays and lesbiasns seem to have more substance related problems than heterosexuals, they seem to utilize substance abuse services less, perhaps due to fears of being faced with homophobic or otherwise not understanding reactions.

While the author is not aware of any published research on drug use among Thai sexual/gender minorities, RSAT has collected some data through outreach work. Of over 30,000 MSM contacted in gathering places of MSM (e.g., parks, entertainment venues, beauty parlors) in 14 provinces including Bangkok, 3284 were verbally asked between November 2009 and June 2010 about their alcohol and drug use in the past month. Of those asked, 2182 stated they had drunk alcohol, 84 said they had used poppers, 52 said they had used ice, and fewer than this reported having used other illicit substances (RSAT, 2010b).

These figures from RSAT are high for alcohol and low for illicit substance use. However, stigmatized and illegal activities like illicit drug use may not be readily admitted in interviews. Moreover, experience from RSAT suggests there are concentrated pockets of illicit drug use in contexts like gay sex parties and some entertainment venue areas in Bangkok (Danai Linjongrut, personal communication, 25 August 2010). Likewise, Natchanon Aonket, working with TGs in Pattaya, stated the abuse of amphetamines and sleeping pills was widespread among the group she works with, and often results in depression (Ojanen, 2009). The role of alcohol and other substances among Thai sexual/gender minority communities and individuals would merit specific research to guide service provision in the field.

Identity Development and Reactions to Problems

Given that issues like stigmatization, marginalization, non-acknowledgement and non-acceptance of sexual/gender minority identities are still present in Thai society, and may have been even a greater problem earlier, it is likely they also have a bearing on the identity development and mental health of individuals belonging to these minorities.

In this study, the client participants' experiences could be categorized into four stages of identity development:

1) Lack of awareness of one's phêet;

2) Embarrassment, hiding one's phêet;

3) Coming to terms with one's phêet; and

4) Identity confidence.

Based on such a small sample (7 client participants), this is just a tentative categorization, and the stages probably overlap depending on the situation.

It also seems that not all individuals go through all the stages. T3, for example, reported having known she was transgendered as long as she could remember, and thus did not have to pass the first stage. All the client participants (M1 possibly excepted) in this study now had relatively firm identity confidence, which some individuals in less accepting contexts might never reach. On the other hand, if one grew up in very accepting surroundings and had many friends of a similar identity (both G3 and T3 noted this had been helpful), possibly one would not have to go through the second stage.

In comparison, Naksing (2004) has proposed a similar, three-stage model for gay identity development in Thailand:

1) A feeling of difference from others arises;

2) Doubt or thoughts about oneself "possibly" being a homosexual;

3) Acceptance of a gay identity.

Comparing these models, the first stage identified in the present study seems to be the state prior to Naksing's first stage, which Naksing wrote is characterized as not feeling one is a kàthoei or tút (as one is labeled by outsiders) but rather, a boy (like G1 felt as a child). Naksing's second and third stages roughly correspond to the second and third stages identified in this study; and the final stage identified in this study seems to be the state following the third stage in both models.

In both Naksing's (2003) model and in two similar models for TG identity development in Southern Thai Muslim society (Sanguankaew, 2003) and in Central Thailand (Sripanich, 1998), both TG and gay individuals are labeled by others as kàthoei or tút; those who accept the kàthoei label (or an equivalent one) go on to

develop as transgendered, and those who reject the label will identify as gay instead. However, in this study, it was seen that a transgendered individual like T1 may (at least initially) reject the kàthoei label, rather seeing herself as a woman.

In Sanguankaew's (2003) model the final stage is the reduction of femininity to conform with the societal pressure of Southern Thai Muslim society, whereas in the model of Sripanich (1998), the final stage is increased identity confidence due to obtaining SRS. In this study, both pathways were observed: T1 and T3 proceeded to SRS, whereas intense opposition from M1's mother resulted in M1 reverting to a more masculine identity that M1 prefers to call simply MSM, demonstrating that external pressure may result in a compromised identity also outside of Southern Thai Muslim society (in M1's case, a Thai Chinese family), and at least in M1's case the emotional consequences seemed quite harsh.

Yet, such a compromised identity is what T2 reported her psychiatrist tried to negotiate with her, and what PA1 implied he would attempt with clients whose parents are upset about their identity. Thus, it seems that the model proposed in this study only applies if the individual is able to deal with non-acceptance without succumbing to familial or societal pressure, in which case identity development might follow Sanguankaew's model.

Winter (2006a) has studied identity development in a group of 195 Thai MtF TGs, noting that "many were developing a transgendered identity in middle childhood, were actively presenting themselves as transgendered by their early to mid teens, and were pursuing surgery by their late teens and early twenties" (p.15).

Similarly, in Danthamrongkul and Posayajinda's (2004) findings there seems to be a clear pattern that the more feminine one's identity category is (from kàthoei, through gay queen, both, and king to bi), the earlier one will also realize

one likes other males (mean age of realizing one liked other males for members of the bi group was 17.5, whereas for those who identified as gay, it was 15.6; of the 8 kàthoeis studied, 5 said they knew it before the age of 10); mean age of first sexual encounter with another male was also lower in the more feminine identity groups (16.0 for kàthoeis, 17.5 for gays[24], 18.7 for bi individuals).

Three Western identity development or coming out models reviewed by Davies (1996c) appear to be more detailed than any of the Thai models; the closest match seems to be a six-stage model by Cass (1979, as cited in Davies, 1996c), charting an individual's progress from "identity confusion" to "identity synthesis." However, the Thai-produced models seem to match the type of identity development seen in this study quite more closely than any reviewed by Davies, corroborating the argument that identities need to be studied in the cultural context.

The only participant in this study who explicitly referred to "stages of" identity development was PA3, who said knowledge of the "stages of coming out" might possibly be necessary for practitioners to know. While it is possible some practitioners did have experience of such models but did not feel like sharing it, it seems more likely they simply were not aware of these models, suggesting that the practitioner's involvement with these topics was not intensive enough to warrant this level of studying of the topic.

In terms of the identity development stages proposed in the present study, specific negative psychological consequences can occur during the first stage, if others note an individual's difference from sexual/gender norms and consequently harass him/her for it, as happened to G1. However, the second stage seems most risky

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[24] This implies that many gays and kàthoeis begin their sexual lives while still below the Thai legal age of consent (18 years); thus, their partners would risk legal repercussions if found out by the authorities.

in terms of negative behavioral reactions because the individual is now aware of their difference from such norms, but cannot yet accept it.

Depression

One reaction that seems possible during the second stage is depression. Of the client participants in this study, at least G1, G2, G3 and T1, have suffered from depression. It was directly related to stigma and having to hide one's identity in G1's case; but in the case of G2, G3 and T1, it may rather have been indirectly linked to their sexuality or gender identity, through relationship problems, for example. G3 viewed depression as a common personality characteristic among gays.

Of the practitioners, PL1 said some sexual/gender minority patients in the hospital suffer from depression due to their isolation and loneliness. PA4 viewed that relationship problems often conceal an underlying psychiatric illness. PA4 and PL5 both noted that often clients (whether with relationship or family issues) wait too long before coming to see them, meaning they'll be depressed when they do come.

As seen in Chapter 2, previous research has already established that at least some Thai male homosexuals (and possibly by extension, TGs who are still in the closet) suffer depression related to the stress of hiding their identity (Uckaradejdumrong, 1996). In the author's earlier research, Natchanon Aonket of Sisters, an organization serving TGs in Pattaya, noted that depression in this group tends to result from disappointing relationships, abuse of illicit drugs, getting bad results from surgeries, or being criticized for not looking as beautiful as expected, reflecting the specific stressors TGs face (Ojanen, 2009).

Suicidality and Suicide Attempts

The most extreme kind of reaction to problems in this study were suicide attempts, such as those made by G1, G2 and T1. G1's case was directly linked to gay-themed harassment in school; T1's involved both physical and psychological health problems, and G2's was due to depression and loneliness.

The author could not find published quantitative data on the prevalence of suicide attempts among Thai gay, lesbian or bi individuals, but Winter and Vink (2005) found that 22% of the 224 Thai transgender women they surveyed had attempted suicide. In a large-scale survey (Bunditchate, Saosarn, Phanomsri, Kitiruksanon & Chutha, 2002), lifetime prevalence of suicide attempt was only 1.0% in the general Thai population. If both figures are accurate, it means Thai transgender women are over 20 times more likely to attempt suicide than the general population.

The prevalence of suicide attempts reported by Winter and Vink (2005) is at a level comparable to that reported among transsexuals prior to transition in other countries (19% to 25%; Dixen, Maddever, Van Maasdam, & Edwards, 1984, as cited in APA Task Force on Gender Identity and Gender Variance, 2007). It is also close to the ratio of female homosexual or bisexual adolescents who had ever attempted suicide (20.5%), but lower than the ratio observed among their male bisexual or homosexual counterparts (28.1%), both reported in a population-based study in the US (Remafedi, French, Story, Resnick & Blum, 1998).

In the US context, "antigay verbal and physical harassment has been found to be significantly more common among gay and bisexual male adolescents who had attempted suicide compared with those who had not" (Rotheram-Borus et al., 1994, as cited in APA, 2000). Rutter (1996) found out that scores on the Beck Hopelessness Scale were related to a suicide attempt in the past six months among lesbian, gay, and

bisexual youth, whereas social support was related to lower levels of hopelessness. Research assessing the importance of these factors in the suicide attempt risk of each Thai sexual/gender minority group might be warranted.

The view G1 held as a child, namely that suicide means a fresh start in a new incarnation, is intriguing as it suggests that a Buddhist worldview including a belief in reincarnation might deter suicide less than other religious views do. And indeed, Vijayakumar, Pirkis, Huong, Yip, De A. Seneviratne and Hendin (2008) have noted that predominantly Buddhist countries have relatively high suicide rates. However, "the exception is Thailand, where the rate is 6.3 per 100,000, and where taking one's own life is believed to lead to condemnation to hell for 500 lifetimes" (p. 25), demonstrating that not all Thai Buddhists share G1's view. Nevertheless, the same authors noted that suicide rate among Thai Muslims was lower still than among Thai Buddhists, which suggests that religious views do have a bearing on the matter. Thus, there might be merit for practitioners to explore clients' religious views on suicide.

In general terms, if Winter and Vink's 2005 estimate is accurate, this level of group-specific suicide risk certainly warrants specific consideration by practitioners, as well as by the suicide prevention program currently run by the DMH (www.suicidethai.com). The author contacted the program by email to enquire if they already do, but did not receive a reply. Nevertheless, suicide risk among sexual/gender minority groups was hardly mentioned by the interviewed practitioners, suggesting more awareness on these matters should be raised among practitioners.

Other Behavioral and Psychological Reactions

The interviewed practitioners also described many other psychological and behavioral ways sexual/gender minority individuals react to their minority status:

PA2 noted that those still in the closet feel sensitive to how others view them, act in a stiff way and are afraid of gossip, which creates a disingenuous public image. PL3 called those who don't really dare to be themselves "wishy washy," or feel constricted and unhappy. PL1 noted that some sexual/gender minority individuals internalize societal stigmatization and agree to be victimized, have unstable emotions, think in an inflexible way, have inferiority complexes, lack trust in their families and state institutions, and/or wish they were gender-normative. PA4 noted gays and lesbians may be attention seeking and over-acting.

Overall, it seems many interviewed practitioners did have an understanding of the ways in which minority status affects sexual/gender minority individuals' psychological functioning, but this understanding may not be comprehensive, and may also risk viewing the groups as too pessimistically (as might be the case in PL1's case) while yet overlooking serious risks such as suicidal tendencies.

Distinctness versus Specificity of Providing Services to Sexual/Gender Minority Clients

Above, practitioner and client views on the distinctness or non-distinctness of sexual/gender minority people (beyond the obvious differences) were already analyzed. This section comments on views about the work done with them as clients – do practitioners view it as markedly distinct kind of work with specific requirements? Do client perceptions of good service implicate specific adjustments to the work?

Almost all interviewed practitioners espoused a belief in the universality of psychological principles. Underlying motivations might include a belief in the need for professionalism, as reflected by practitioners' ability to receive all cases (PL4 &

PL5), or a humanistic view of all humankind as essentially similar (PL3, PL5 & PA2). PL5 and PA2 commented that while "actors" change, "themes" are the same. PA2 noted that many kinds of people are familiar with being in a minority on various grounds; thus, it is a common rather than distinct experience. And PL4 quite explicitly backed the case he made for universalism by noting that "people with sexual diversity" (his preferred term for sexual/gender minorities) exist in all communities.

The intention behind beliefs in humankind as essentially alike and practitioners as obliged to receive all cases is positive, as it condones providing humane treatment for all clients. However, as the APA (2000) guidelines argue, such a perspective might still mean that heterosexual norms will be used on a population they are not appropriate for, which may lead aspects of clients' lives be seen as pathological or undesirable (PA4's concern for their promiscuity might be an example). Therefore, the result of such views might be contrary to the intention. This kind of reaction also occurs when practitioners are obliged to work with clients they have biased views of, as PL3 noted.

Yet, it seems that while believing in a universalist ideology, the interviewed practitioners also appreciated the need for special adjustments when working with sexual/gender minority clients, such as the need to understand the taxonomy of distinct identities (PA1), do community referrals for social support (PA1), emphasize trust building (PL1), neutrality (PA3) or confidentiality (PA3) more than with mainstream clients, do empowerment to counter negative societal conditioning (PL1), understand hormonal phenomena (PL3), have sexological knowledge (PA1 & PL3), knowledge of specific sexual practices, identity development, needs, problems, ways of adjusting to problems, and sexual/gender minority communities (PL4), specific issues related to SRS (PA2, PA3, PA4 & PL3), how the societal context affects

relationships (PL5) or self-disclosure (PA3 & PL5), follow societal trends (PA4) and create strategies for dealing with upset parents (PA1 & PA4; see below).

This all suggests that many practitioners do appreciate specific aspects of working with these client groups, which means that their belief in universalism on one hand and the specific considerations they feel are necessary on the other are in apparent contradiction. It may be that while practitioners hold an ideological affiliation to universalism, in their day-to-day work, they operate within a pragmatic approach, taking into consideration such specific issues as have entered their awareness, without rigid adherence to universalist ideology.

Nevertheless, universalist ideology may play a part in deterring them from approaching service provision to distinct groups with a systematic approach that would chart all the needed adjustments to practices (although time constraints are probably a more important obstacle), rather than just include those they happen to come across in their work.

However, the British Association for Counselling and Psychotherapy (2007) has concluded on the basis of their systematic review on counseling and psychotherapy with LGBT populations that "therapists cannot, and should not, rely on being educated about LGBT cultures by their clients" (p. 3) because doing so might "simply fit in with whichever dominant discourse their clients subscribe to; secondly, it simply wastes the client's time; and thirdly, it may make clients feel odd and misunderstood" (p. 3). This points at the necessity of practitioners having specific and systematic knowledge of minority clients' cultures before handling such clients.

By looking at the practices and characteristics seen as helpful by clients in the present study (establishing a therapeutic relationship, listening, being familiar and truly caring, resting any decisions with the clients, analyzing, influencing emotions

and thinking, tackling sexual matters, addressing physical and emotional health together, specific follow-up on medication outcomes), it is evident that most (but not all) refer to common therapy practices. The first four in the above list are compatible with those mandated by person-centered theory (e.g., Rogers, 1961). Others relate to more directive or interpretive therapy modes, and the last two seem more relevant for psychiatrists than for psychologists.

Some of the seemingly universally desirable characteristics of counseling are indirectly linked to knowledge of and respect for sexual/gender minority identities and lifestyles – for example, establishing a therapeutic relationship and being experienced as truly caring may be difficult if the practitioner in fact does not respect their clients' identities (clients particularly noted insincerity as one of the undesirable characteristics), and it may be difficult to help analyze the client's problems if one does not understand their life situation.

Of the clients in this study, G2 viewed that a practitioner who did not know about sexual/gender minority people was like a doctor who didn't know about medications, whereas G3 viewed the necessity for such knowledge depends on the level of involvement, but at a referral should be available for a practitioner with more specialized knowledge. Yet, some practitioners, like PA1, PL1 and PL2 noted there is considerable lack of knowledge and even interest on these topics in Thailand.

One example of this lack of knowledge, or rather, misunderstanding, is the full-scale (rather than gradual) conflation of homosexuality and transgenderism. It was manifested in G2's lament that some practitioners don't even know the difference between gays and kàthoeis, or between the subtypes of gay. Some of PL2's comments also seemed to demonstrate such confusion – such as his comment that cabaret venues like Tiffany's or Alcazar are "all gay," whereas in fact performers tend to be TGs (see

Pramoj Na Ayutthaya, 2003). Since the identity development of TGs and gays differs from each other, TGs tend to wish to transition whereas gays don't, and relationship patterns and social standing also differ from each other, a practitioner demonstrating confusion between the two might make a client "feel odd and misunderstood" as the British Association for Counselling and Psychotherapy (2007) put it.

Specific knowledge may be particularly important when dealing with sexological problems ("orgasms, foreplay, sex" as PA1 put it) in which specific problems may require specialized knowledge, which PA1 indicated is lamentably rare among practitioners. In the present author's experience, gay clients contacting the counseling service at RSAT quite often ask about issues like premature or delayed orgasms, or lack of confidence in the size of their penis. While helping heterosexual men deal with such issues also benefits if the practitioner operates with sexological knowledge rather than makes educated guesses, with gay clients the issues come with a twist: What does the size of one's penis mean to a gay as opposed to a (straight) man? How can a gay who has a receptive sexual role best be helped to delay an orgasm? And so on. This again points at the importance of specific knowledge, although it may not be easily available.

Another key issue is how to build trust in a client that might come to the appointment laden with suspicion as to the helpfulness and sincerity of the practitioner. PL1 noted that building trust (i.e. therapeutic alliance) may be the most challenging part, and PA3 noted that confidentiality needs to be paid particular attention. This is corroborated by the analysis of the role of the clients' actions in Chapter 4: if therapeutic alliance (which would imply the client knows why he or she is seeing the practitioner, agrees with that purpose, and has trust in the practitioner

and the confidentiality of the interaction) isn't sufficiently built, it might make the client avoid or even lie on sexual/gender minority related matters.

The practices seen as unhelpful by the clients largely mirror the ones seen as helpful: most psychiatrists were not liked because they weren't good at listening, analyzing, or counseling (which were seen as helpful practices); on the other hand, it is hard to be "familiar and truly caring" if one is unresponsive, insincere or lacks respect for the clients (all reported as unhelpful practices). Psychiatrists were also criticized for lack of dependable diagnostic skills (while psychologists' analytic skills were praised). These issues generally show how important it is to get the basics (universal aspects of service provision, largely but not exclusively those mandated by humanistic counseling theory, e.g., Rogers, 1961) right. At the same time, practitioners were blamed for their lack of knowledge about sexuality, which would obviously impair their ability to tackle sexual matters with clients, but might also do so with their ability to analyze or give counseling on other matters in which understanding of the societal position of sexual/gender minorities would be needed.

A discussion by Vasquez (2007) on the importance of the therapeutic alliance for therapy outcome on the other hand, and the threats that "racism, ethnocentrism, sexism, heterosexism and other –isms" (p. 882) pose to it when therapists (commonly but unknowingly) act in accordance with these discriminatory belief systems toward their minority clients, helps clear the apparent contradiction between universalism and context-specific approaches, as well as the finding that common rather than distinct factors in therapy seem to account for much of the variance in therapy outcomes (e.g. Wampold, 2000, as cited in Vasquez) and the fact that therapy often fails to serve minority clients due to cross-cultural issues (Vasquez). Regardless of which stigmatized minority the client belongs to, a major so called common factor of

efficacious therapy, therapeutic alliance (Warwar & Greenberg, 2000, as cited in Vasquez) may fail to be established due to therapist conscious or unconscious bias or lack of understanding.

Four specific issues that merit longer discussion are how to deal with parents who are upset with their child's sexuality or gender identity, dealing with transgender clients requesting permission for SRS, referrals, and relevance of the phêet, age and religion of practitioners. These either relate to the level of trust clients can have in the practitioner, or to specific knowledge needed to deal with specific problems.

Dealing with Upset Parents

Both PA1 and PA4 had thought-out strategies for dealing with parents upset about their child's homosexuality (or cross-gender behavioral expressions), both comprising the provision of information about the etiology of homosexuality emphasizing biological origins (to reduce parental guilt and suspicions whether one has been a bad parent), empathy and support for the parents themselves, and negotiation with either the parents or the child. Both practitioners seemed to use their approach to good effect.

These approaches seem to match the recommendations of the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation (2009) quite well:

> Licensed mental health providers (LMHP) can provide to parents who are concerned or distressed by their child's sexual orientation accurate information about sexual orientation and sexual orientation identity and can offer anticipatory guidance and psychotherapy that support family reconciliation

(e.g., communication, understanding, and empathy) and maintenance of the

child's total health and well-being. (p.5)

One probable difference between the Thai and US contexts is that academic concepts

like sexual orientation might not be emphasized as parents are unlikely to be familiar

with them or construct the matter with reference to them.

Thai parents seem to be upset about their offspring showing signs of

belonging (or disclosing they belong) to a sexual/gender minority phêet because of

their fears and stereotyped notions of sexual/gender minorities as disgraceful,

perverted, and shameful (PA4), concern that their children will be lonely and unhappy

when older (PA4), because they fear a loss of face for themselves or the family (PA1

& PA4), dismay at not having one's only son perpetuate the family line (PA1 &

PA4), or the child's sexual orientation compromises the parents' need to use their

child to compensate for their own inferiority complexes (PA4).

While some parents in the US also seem to seek residential or other coercive

sexual orientation change treatments for their offspring due to fear and stereotypes, it

seems that in the US, the concerned person's own strong religious beliefs are more

commonly implicated in the initiation of sexual orientation change efforts (APA Task

Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009) than in

Thailand. However, they might hold such beliefs because their parents and their

communities also do so. In any case, it seems that the need to deal with dilemmas

between religious beliefs and sexual orientation seems less common in the Thai

context than in the US[25]. On the other hand, a need to negotiate a compromise

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[25] However, PL2, PA2 and PA3 all noted either Christians' or Muslims' stricter stance on

homosexuality. The researcher has come across Thai Muslim (e.g.,

http://www.baanmuslimah.com/dp57/node/342) and Thai Christian (e.g.,

between the parents' and the person's needs (such as the parents' desire to perpetuate the family line or gain respect through their child's marriage vs. the person's desire to transition or have same-sex partners) seems more common in Thailand.

One more reason why parents may be upset is because they feel guilty, doubt the quality of their parenting, or feel it is the other parent who has failed to play their part in properly raising the child, as PA4 pointed out. In the Thai context, these feelings seem understandable in the light of Jackson's (1997) comment about earlier Thai psychological paradigms aimed at the prevention of homosexuality: "In these analyses, it is Thai parents, not their homosexual children, who bear the strongest and most persistent criticism" (p.73). In this sense, Thai psycho-sciences in the past have exacerbated the problem by making parents feel they have failed if their children turn out as sexual/gender minority individuals. As an antidote, addressing feelings of guilt and self-doubt through accurate information is probably now an important part of the therapeutic response in the Thai context.

On the level of details, the approaches of both PA1 and PA4 had some questionable elements. PA1 said he might negotiate with the sexual/gender minority person if they could reduce cross-gender expressions or hide any same-sex relationships from their parents. While these actions may reduce parental negative feelings, they effectively mean asking the person to closet themselves and hide integral aspects of their lives, which at least Uckaradejdumrong (1996) has found to be linked with depression in Thai male homosexuals. In this study, T2 recounted how

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http://www.jaisamarn.org/webboard/question.asp?QID=3349) websites (both operational in May 2010) that reflect these groups' anxieties and reservations about homosexuality. In these minority communities, religious pressure to change or repress a minority sexuality or gender identity might be more common than among Thai Buddhists. Sanguankaew's (2003) research demonstrates the ramifications of this among TGs in Southern Thai Muslim areas quite well.

bad she had felt when a psychiatrist had tried to convince her to be "just gay" instead of a transgendered woman, feeling that wasn't the way she had chosen.

PA4, on the other hand, said he'd negotiate with the parents if they could accept their child's sexuality in case the child "takes responsibility, doesn't lose *function* at workplace, is committed to studying, is a good kid [and] doesn't cause trouble in society," which could be seen as positioning the child's sexuality as a shortcoming that has to be compensated for by complying with stricter standards than other people in other life areas. Nithiubat (2003) has noted many male homosexuals already do so anyway. However, whether practitioners need to encourage or be wary of such overcompensation needs to be considered, because unquestioning encouragement of this strategy in effect colludes with discriminatory societal double standards that expect sexual/gender minority people to do more and better than others to receive the same rewards or acceptance, and might contribute to perfectionism, feelings of inferiority or burn-out in the client if they fail to do better than others.

It also seems quite important that the power inequality between young clients, the practitioner, and the clients' parents is sufficiently taken into account, because otherwise, this could make the client unable to assert their point of view or even acknowledge belonging to a sexual/gender minority (as cases of G1, T1 & T2 show). This means providing the client an opportunity to talk with the practitioner without the parents in session and creating trust in the client that whatever they say, it will not be reported to their parents (as PA3 recommended).

Dealing with Requests for SRS Clearance from TG Clients

Both TG clients' (especially T1 & T3) and some practitioners' accounts (e.g. PA1, PA2, PA3 & PA4) reflect that a major reason why TGs seek practitioners is to get their clearance for proceeding with SRS. T3 even suggested this might make TGs use their services more often than members of the general population do. Due to their gatekeeping role, practitioners need to have a stance on how to deal with these cases.

The accounts presented demonstrate that across hospitals where such clearance can be obtained (which seems to range from general state hospitals via medical school hospitals to private hospitals), the procedure is less complicated than recommended in the WPATH guidelines (Meyer et al., 2001), at most consisting of an interview by two psychiatrists and separate psychological testing, instead of long-term evaluation and therapy. It also seems that such permission is needed only for SRS; other surgeries like breast augmentation can be done without any psychiatric involvement at all (unlike the WPATH guidelines recommend; Meyer et al.). Hormones can be and are commonly bought and used without any medical supervision by Thai TGs (Luhmann & Laohasiriwong, 2006), unlike seems to be the case in many Western contexts (Meyer et al., 2001). PA3 acknowledged this relative ease of procedure, and explained that it makes sense because TGs in Thailand tend to be more incontestably feminine (than in the West) when they come to see the practitioner.

However, there are also clear differences in the ease of procedure between hospitals in Thailand, with evaluation at one medical school hospital taking up to two months, while T3 received her clearance from a private hospital psychiatrist within half an hour. Both PA2 and T1 recognized these varying standards, which mean that

those unwilling or unable to undergo more stringent procedures can seek SRS where permission is most easily obtained – but they might risk lower quality surgery.

Lack of regulation of the context is evident also in the fact that T3's psychiatrist used a projective test in testing T3's readiness for surgery, administering the test and interpreting the results on the spot within the half-an-hour interview, while PA2 stated that psychiatrists are neither licensed nor competent to interpret psychological test raw data. However, the decision to permit or not permit SRS lies with the psychiatrist, and psychologists are simply used by the psychiatrists as technicians assisting them in the decision (as is common in Thai mental health services in general; Tapanya, 2001). Sometimes this is unfortunate, such as in the case of T1's psychiatrist who initially refused to issue the permission letter, as she didn't know how to formulate such a letter, or what the "psychotest" used for readiness evaluation meant, even though the psychologists in the same hospital department had already conducted the "psychotest."

Nevertheless, more regulation is clearly underway. One change already noted by T3 is that since she obtained her SRS clearance, new regulations (Lolekha, 2009) stipulate that at least two psychiatrists need to assess an SRS candidate before surgery can take place. If the clinical practice guidelines in preparation by the Royal College of Psychiatrists in Thailand are issued in a form similar to that proposed in the draft version (read by the present author), they will recommend much more stringent procedure than before.

Whether more or less stringent procedure is desirable is debatable. Two practitioners viewed that there do not tend to be problems after SRS anyway (PA2 and PA3), while one (PA4) thought that the risk of hormone-related emotional instability

post-surgery needs to be carefully assessed. PA2 and PA3 thought the risk lay more in a potential malpractice lawsuit against the psychiatrist.

Internationally, "many studies have shown that the vast majority of transsexuals are satisfied with the outcome of sex reassignment" (APA Task Force on Gender Identity and Gender Variance, 2007, p. 42). Furthermore, "a substantial number of the patients who did not receive SRS were still gender dysphoric at the time of a follow-up assessment that occurred, on average, 4 years later" (Smith et al., 2001, as cited in APA Task Force on Gender Identity and Gender Variance), suggesting that not permitting SRS or using prohibitively stringent procedures may perhaps unnecessarily prolong the dysphoria experienced by SRS candidates.

In Thailand, the cultural visibility and presence of a well-known transgender identity, known as kàthoei (or its alternates), the generally high level of TG integration in Thai society (outside formal or official contexts), the social support and guidance that young TGs receive from older TG peers, and the early age at which transitioning usually begins in Thailand, may all make it easier for Thai TGs to successfully live their lives post-surgery than their Western counterparts, which further suggests that excessive concern about post-surgery adjustment may indeed be misplaced in Thai society.

On the other hand, the post-surgery emotional and hormonal imbalance noted by PA4 may be due to unsupervised hormone use that is common among Thai TGs (Luhmann & Laohasiriwong, 2006; T2), which may mean that excessive doses are taken. It might be that some Thai TGs undergoing SRS are unaware that the level of hormonal supplement intake needed post-surgery is lower than prior to the surgery (Meyer et al., 2001), leading to excessive dosing. This problem could be countered by providing endocrinological consultation as standard procedure for all SRS candidates.

However, this would require knowledge among doctors about hormonal dosages relevant for TGs, which, as T2's account explained, may not always be available because the hormonal preparations have been tested only for use in females.

Therefore, appropriate hormone combinations need to be researched, the findings disseminated, and the involvement of endocrinologists and other practitioners who can provide consultation on hormone use increased. Western dosage guidelines may be inappropriate in Thailand, because in the West, hormones tend to be taken at a more advanced age and for a faster transition than in Thailand; thus, the dosages used tend to be different between these two contexts (Nada Chaiyajit, personal communication, 20 May 2010). There may also be other physical differences that necessitate adjustments on the dosage. Thus, also this issue needs to be studied specifically in the Thai context. Both community and practitioner advocacy and involvement could help such processes to take place and be conducted in a way that would address the questions of both practitioners and TGs themselves.

As argued above, debates about the possible depathologization of Gender Identity Disorder and Transsexualism may also affect clinical practice in the near future in these matters, but presently it seems unlikely that the Thai psychiatric or psychological professions will play an active part in the international debate.

Referrals

Referrals as a clinical practice demonstrated both universal and sexual/gender minority-specific issues.

Universal issues in this case refer to dilemmas faced with all clients. It seems that the Thai public sector mental health system involves an inbuilt mechanism within

which clients will need to first see reception officials, screening nurses, then a psychiatrist, a psychologist for psychological testing or counseling (if the psychiatrist feels these are needed), and then perhaps the psychiatrist again. This system may help conserve client time of that most scarce of personnel resources on the system, psychiatrists, but it may also be felt as awkward and compromising confidentiality by clients (like T2). While having to deal with all these practitioners may be awkward for all types of clients, those belonging to stigmatized groups such as sexual/gender minorities and those whose problem involves considerable shame or embarrassment (such as being a rape victim) may find that anticipated awkwardness and lack of confidentiality an insurmountable barrier for using mental health services of this type.

Increasing the number of practitioners (see below) is one of the conditions of reducing reliance on this in-built referrals system, but not sufficient in itself. Investigation seems to be called for evaluating if Thai public sector mental health services could be reorganized so that clients could directly speak with a psychiatrist or psychologist, and thus feel more comfortable in using the services.

The first type of group-specific issues regards community referrals between mental health professionals and sexual/gender minority organizations and groups. While many practitioners in this study viewed such organizations as doing important work, and had a rudimentary idea of what these organizations (notably RSAT) are called and where they are located, many practitioners did not know the current name or location of these organizations. This shows that they probably have little contact with these groups (as many of them admitted) and may be unable to do on-the-spot referrals, even though some, like PA1, thought such referrals can produce very useful social support (like the APA, 2000, guidelines also state). Some, like PL3, seemed to

overestimate these organizations' capacity to deal with mental health issues, while client accounts, especially by M1, provided a more critical take on their capacity.

At the same time, the author's earlier analysis of the NGO services (Ojanen, 2009) has shown that while they are able to provide sometimes life-saving counseling, they tend to be at loss with more perplexing mental health issues such as clinical-level obsessions or callers who try to gain sexual satisfaction by contacting the services by phone. Yet, counselors in these organizations almost never make referrals to the general mental health system, partially because of stigmatization of service use, but also because networks or even informal linkages between these counselors and professional mental health practitioners are either nonexistent or too weak (Ojanen).

The finding from this study that practitioners don't have sufficient knowledge of NGOs providing counseling and social support further corroborates the importance of the earlier suggestion by the author (Ojanen, 2009) that linkages should be built between professional and volunteer-run services, for example in the shape of practitioner forums and seminars between volunteer and professional counselors. Perhaps this would enable more referrals between the two contexts, as appropriate, and also understanding in both ends of the referral network for what purpose such referrals are made, and how the most can be made of them.

The second type of group-specific referrals issue was taken up by PL1, who noted that community/inter-organization referrals to organizations and groups other than sexual/gender minority NGOs may be hazardous as the latter may lack sympathy and understanding for sexual/gender minority individuals; in the case of state bodies, strict sex-segregation causes problems. PL1 added that staff attempt to educate those for whom referrals are made, but with limited success.

This points at the necessity of having group-specific sexual/gender minority NGOs available in each practitioner's referral network, but also at the need for broad societal awareness building to improve attitudes and level of knowledge in society. Practitioners who are in contact with both sexual/gender minority organizations and other community organizations (providing services unavailable from sexual/gender minority organizations, such as temporary shelter, or operate in geographic areas where sexual/gender minority organizations don't) might also be able to play a part in bringing the two together and enabling them to learn from each other.

Relevance of Practitioner Phêet, Age and Religion

In this study, all but one client expressed views about the relevance of practitioner phêet: G3 had a clear preference for male psychiatrists, while G2 and M1 felt more comfortable with practitioners who themselves were MSM or gay, G2 because he felt it guaranteed they had knowledge of related issues, and M1 so that no division to "them and us" would take place. Of the practitioners, PA2 and PL2 noted gay practitioners are particularly likely to be more sympathetic toward gay people.

In contrast, the TG clients did not express a preference for transgendered psychologists or psychiatrists, suspecting their neutrality or appropriateness for the job, while admitting that having a practitioner of the same phêet might help establish trust and understanding. T1 preferred female practitioners. Besides the explanation given by T1 (that TGs begin their working lives holding biases due to what they've had to endure in life), two more explanations might account for this difference in TG and gay/MSM participants' preferences: firstly, T3 still seemed to view fellow TG individuals as unsuitable due to their supposed abnormality (she supported the

medical model of transgenderism); secondly, at present there are no or hardly any transgendered practitioners in Thailand, which may explain why T3 felt it would be "strange" to talk to one. In contrast, the two gay or MSM participants who had a preference for gay/MSM practitioners already had met such practitioners either as clients or in their working lives, and therefore felt it wasn't strange in any way.

In the US, Liddle (1997) has documented that 38% of the therapists chosen by gay male clients were LGB themselves; among lesbian clients this figure was 43%. Particularly striking was Liddle's finding that 79% of therapists chosen by lesbian clients were female (40% were lesbian or bisexual; 39% were heterosexual women), suggesting relatively strong preferences for female practitioners among them. Klairung Sonklin's account (see below) on Thai lesbians suggests that they also have strong preferences for talking about their problems with other lesbians.

In the present study, most practitioners also acknowledged the presence of gay psychologists and psychiatrists in Thailand, and suggested they are quite numerous. The general consensus among practitioners seemed to be that gay people are acceptable as practitioners if they don't act in a notably effeminate way. Gender expression thus seems to be the dividing line that allows gays entry to these professions, and keeps TGs out of them. Sexual orientation or internally felt phêet seems not to be asked either when applying for employment or relevant training courses – in effect, it's a "don't ask, don't tell" policy.

There are at least three possible perspectives on this matter. The first is to view transgendered individuals as unsuitable for the profession due to having a mental disorder. The second is to view the matter as a human rights issue and discrimination on the basis as phêet as unacceptable. The third is to consider the lack of respect and cooperation that clients might have for transgendered practitioners.

The first point of view is problematic not only because it is contested whether transgender people should be considered mentally ill or not, but also because of the stigmatization that is likely to follow pathologization, as Winter (2007) has argued. While the author feels that pathologization is for these reasons probably undesirable, two accounts showed that this kind of view still influences how the matter is seen: PL3 noted that hospital clients sometimes ask of somewhat effeminate practitioners if they in fact are patients, and T3 viewed TGs have a mental abnormality. In contrast, the American Psychological Association clearly seems to welcome transgendered psychologists (APA Task Force on Gender Identity and Gender Variance, 2009), while analyzing that

> The American Psychiatric Association, however, does not recognize
> transgender psychiatrists as an interest group. Furthermore, transgender
> psychiatrists are not included on committees examining GID as a disorder,
> since, as our key informant explained, it is not policy to have individuals with
> a disorder examining the DSM (p. 20-21).

This suggests that the pathologization of transgenderism still does reduce the respect TGs receive as practitioners, if not barring them from these professions altogether.

The second view, seeing TGs' access to psychological and psychiatric professions as a human rights issue, asserts that it is as unacceptable to discriminate against TGs as it is to discriminate against women or ethnic minority individuals entering these professions. While there are no distinct anti-discrimination laws to back this up (Sanders, submitted for publication), Clause 3 of Article 30 of the *Constitution of the Kingdom of Thailand* specifies that "unjust discrimination against a person on the grounds of the difference in … sex … shall not be permitted" (Foreign Law Bureau, Office of the Council of State, 2007) and the *Intentions of the*

Constitution of the Kingdom of Thailand, 2550 B.E. specifies that "differences in 'phêet,' besides meaning the difference between men and women, also cover the differences between people who have a different Sexual Identity, Gender, or Sexual Diversity from that they were born into" (Committee (Special Task Force) recording intentions and remarks and checking minutes of meetings, Constitution Drafting Assembly, 2007, p. 22-23). The wording of the provision is odd as it seems to consider "sexual diversity" as an individual characteristic rather than a societal phenomenon. However, the provision has already been referred to in one administrative court case in which an order given by a provincial governor that discriminated against TGs was provisionally restrained by the court as "likely to be illegal" (Teerarojjanapongs & Champathong v. The Governor of Chiang Mai Province, 2010) However, not all practitioners agree with this perspective. PL2 explicitly stated his reservations, as follows:

> The weak spot of *human rights* is [that they] make people confused, like, you do whatever you want to do, up to you, you have the right to do whatever that doesn't infringe on others, forgetting that we very much need to have the word religion [and] religion means prohibitions. People will in any case have to have prohibitions.

This is thus an issue that will probably be debated both philosophically and legally.

The third issue is that if clients do not have respect for their practitioners, it may be at least as likely to impair the quality of the interaction as when the practitioners don't respect their clients (PA1 viewed TGs as unsuitable to the profession of psychiatry for this reason). This may be a particularly big challenge in Thailand where esteemed professionals are under a lot of pressure to appear as respectable as possible. If Thai psychiatry and psychology are to open up for

transgendered professionals, they will need to find strategies to enable TGs to gain clients' trust. Maybe experiences from the long struggle of women and ethnic minority individuals to enter previously male-oriented professions (in Thailand and abroad) could provide guidance in gradually opening up such professions for TGs.

Some practitioners also expressed concern that gay psychologists might try to seduce their clients (PL4) or be unable to act professionally when countered with prejudiced reactions from clients and other staff (PL3). However, as PL4 acknowledged, straight practitioners aren't immune for the first problem, either, whereas the second problem is probably rather a matter of identity development than gender identity, as PA2 pointed out – it would seem necessary that the practitioner has reached identity confidence to be able to cope with such reactions. Training and supervision sensitive to this problem, as well as institutional policy making it clear to clients that prejudiced reactions are not acceptable, might be among the solutions.

Three practitioners (PA2, PA3 & PL1) and one client (T1) noted that older practitioners (in the view of PA2, those in their fifties and older) may hold more negative views unless they've updated their knowledge since they received their training. This analysis seems to match the finding that PL2 and PL3, both older practitioners, held some less positive views (such as gays conflicting with culture or religion, living their old age as lonely, or the possibility of becoming gay by being "cheated into" homosexuality) than did younger practitioners. This corresponds with the situation in the US, where the American Psychological Association Task Force on Gender Identity and Gender Variance (2009) has reported is

a conspicuous difference of opinion according to age, with younger and early

career scholars in the area of the psychology of women more likely to be

sympathetic to and embracing of transgender issues, in comparison to members who are more advanced in their careers (p. 19).

PA1 and PA3 noted that some religiously strict Christians hold negative views on homosexuality, but couldn't say how Islamic practitioners would feel about the matter. T1 had felt a Muslim woman practitioner had been very caring for her. Given the small sample of this study, extensive generalizations cannot be drawn from these preferences. Rather, the relevance of practitioner phêet, age, and religion should be evaluated further with quantitative studies. However, what can be concluded based on these findings is that some Thai sexual/gender minority clients do have preferences for male/female practitioners, and some for fellow sexual/gender minority ones, and that older practitioners may be more likely to hold more negative views than younger ones on sexual/gender minority issues.

State Sector Under-Resourcing, Issues with Practitioner Training, Lack of Cultural Appropriateness and Their Consequences

While the practices seen as beneficial by clients were above seen to necessitate specific knowledge, they are also conditional on the practitioner having enough time to fully engage in each kind of practice. Building a therapeutic relationship, listening, and doing follow-up were all activities that clients in this study reported some of their practitioners either skipped or did in a hurried, unconvincing fashion, undermining the client's perception in that practitioner's helpfulness.

Nevertheless, practitioners are not doing this out of laziness. Instead, the interviewed psychiatrists (PA1, PA2, PA3 & PA4), the two psychologists practicing in the public sector (PL1 & PL3), and the one psychologist practicing in an NGO

(PL4), plus the client participants who had experience with state sector mental health services, (especially G2 & T1) all addressed the under-resourcing of state mental health services and the consequent lack of client time in these contexts.

This suggests that clients and practitioners familiar with state mental health services share an understanding of the current limitations of the context. Moreover, they both point at a structural problem that may undermine the effectiveness of most psychological and psychiatric work done in the public sector.

G2, PA1 and PL4 gave estimates of the number of psychiatrists in Thailand, ranging from 200 to 400. These estimates are in line with those cited in the literature; Tapanya (2001) estimated there were roughly 300 psychiatrists and 400 psychologists in Thailand. If these figures are correct, Thailand has more than 200,000 people per psychiatrist, as PL4 noted, and over 150,000 per practicing psychologist.

Consequently, state hospital psychiatrists, in particular, have very little client time. Supposing a psychiatrist sees 60 clients in one morning (as PL3 estimated), from 9 a.m. to noon, this leaves three minutes per client. PA1 said it is "absolutely impossible" to have any discussions about sexual matters in such a time frame. However, client accounts suggested that psychiatrists even in general state hospitals do attempt some discussion, but it may be reduced to rushed and unhelpful advice giving (G1 & T1). In any case, it is unsurprising that clients feel psychiatrists often hand out medication as soon as they see the client's face, as G2 put it. Furthermore, it seems that some psychiatrists are even unwilling to follow up the effects of medication or adjust it (G2 & T1), probably due to lack of client time.

While state hospital psychologists seem more likely to be able to have meaningful discussions with clients than psychiatrists working in the same contexts, they also work under time pressure: PL3 said they might have to test and immediately

interpret the tests within one hour per client, having to cut corners of correct procedure, whereas PL1 noted their multiple responsibilities means activities like following up clients may be impossible. These limitations set the parameters of when counseling or therapy can even begin to address sexuality or gender topics.

NGO and private sector services don't seem to suffer from such matter-of-course under-capacity per client, however, and PA2, who practiced at a medical school hospital, also noted that medical school hospital psychiatrists see considerably fewer clients than those at general state hospitals. However, PL4 noted that NGOs suffer from lack of coordination instead. Moreover, they rarely use psychologists as counselors (see Ojanen, 2009). M1 viewed his private university only had a counseling center so as to be able to claim it had one, suggesting that lack of commitment to truly thought-out services may also be found at universities.

Many practitioners seemed to have little hope for improvement in state sector services; PA1 explicitly stated he'd left state employment for this reason. Most hopeful was perhaps PL4, who viewed that with proven need and advocacy, the state will sooner or later arrange the needed services.

Besides tight timing, psychiatrists' ability to discuss gender and sexuality issues may also be limited by their training that emphasizes biological explanations and medication, as noted by both PL2 and PL3. This also explains why G2, G3 and T1 all felt psychiatrists were not skilled in "discussing." According to Tapanya (2001), behavioral science components have recently been reduced rather than increased in the education of Thai medical students, exacerbating the problem.

While this puts more pressure for psychologists to provide counseling and psychotherapy, psychologists' role has often been limited by psychiatrists to clinical testing, leading to a lack of opportunity to develop counseling and therapy skills, and

a consequent lack of those skills, as PL2 noted. Tapanya (2001) has made the same observation, stating that psychiatrists have been able to dominate the mental health field due to the power they hold in the system. This, at worst, leads to situations in which psychologists test, psychiatrists diagnose and medicate, but nobody provides counseling or psychotherapy.

PL2 and PL4 also criticized the training of psychologists for utilizing inexperienced teachers who only know theory (PL2) and over-emphasizing research skills and Western models (PL4); both lamented that training programs fail to pay attention to the Thai cultural context. These criticisms mirror those of Sue and Sue (1999), who have written extensively of the need for cultural adjustments, and also noted that social science training programs generally prioritize research skills over practice skills, suggesting that this problem not only affects Thailand.

PL4 mentioned the inappropriate use of foreign-produced psychological tests as an example of cultural inappropriateness, but no clients criticized this. Tapanya (2001) has acknowledged that foreign-made tests remain in general use after abortive attempts at creating and using Thai-made scales. However, as both client and practitioner accounts in this study suggest, projective tests are very common in Thailand, and in these ones, at least language probably plays a less important role than in questionnaire-based tests. In this study, reactions to testing among clients were mixed, as G3 and T1, in particular, seemed to be quite impressed with the testing process and its results, whereas G2 interpreted aspects of it as demeaning.

PL4, who works in an NGO that prioritizes services to underprivileged clients, viewed cultural issues as critical, while PL5 who works in private practice with mostly well-off and often foreign-educated Thai clients felt they weren't much of an issue. This suggests that in the Thai context, clients with a higher class background

and closer cultural proximity with Western culture indeed make a better match with mainstream, Western-style services, whereas more cultural adjustment in clinical practice is necessary when providing services to those with lower class backgrounds and less exposure to Western culture, which seems to match experiences from the United States (Sue & Sue, 1999).

However, no client participants in this study criticized mental health services for being excessively westernized. On the contrary, for G2, the fact that his regular psychologist was US-educated seemed to raise rather than reduce her status in his eyes, as it marked her apart from the Thai-style practitioners he was very critical of. G2 seemed overall more impressed by Western countries than Thailand; a Western-style practitioner was thus a good match for his preferences. Nevertheless, this might also reflect the general failure of Thai academia to produce skilled mental health personnel – if other practitioners fail to demonstrate having basic practical skills, even a foreign-style practitioner who at least knows their trade may be preferable.

PL1 also criticized the training of Thai psychologists, but in quantitative rather than qualitative terms – she noted many practice with just a Bachelor's degree while the work would really demand a Master's degree. This overall low level of training of Thai psychologists is, again, reflected by Tapanya (2001), who wrote nine years ago that "over 80% of Thai psychologists have only an undergraduate degree, about 15% have earned the master's degree, and about 5% have a doctorate degree (all from overseas and almost none have completed internship or postdoctoral training)" (p. 69). Tapanya has also provided an explanation for this problem:

Although there are too few psychologists to serve the Thai population, relatively few jobs are available for the existing pool of psychologists. Those jobs that are available usually require only a bachelor's degree, the pay is

minimal, and the potential for career advancement is limited vis-a-vis other health professions. (p. 70).

In other words, if only a limited number of low-qualification, low-pay jobs are made available for psychologists, it is not surprising that few individuals train (sometimes at considerable expense to themselves) to receive higher qualifications and establish themselves in the profession of psychology.

The bleak career prospects of psychologists and the resulting shortage of them may also explain why nurses with short counseling training are used instead of fully qualified psychologists (besides that nurses may be even cheaper to hire). M1 and PL1 noted this practice and were quite critical of it, because nurses may have a better understanding of physical than psychological issues (as M1, PA2 & PL1 observed). M1 viewed practitioner roles were currently blurred and should be clarified, with legislation if necessary, and that practitioners should stick to those roles.

While this might increase practitioner credibility and understanding of each practitioner's role among the public, the trade-off for clearer roles in a situation characterized by scarce resources might be that practitioner availability would become even lower as practitioners would be less able to adopt different roles (as demanded by each situation). It might mean more of a "team work" emphasis as different practitioners would stick to their limited role. The primary problem with this, as T2 noted, is that clients then need to explain sensitive and emotionally painful matters to several practitioners, which may waste time, be awkward to clients, raise concerns about confidentiality, and deter some clients from using the services.

Perceived lack of confidentiality is already a problem within the state sector both because extensive screening procedures and internal referrals mean clients need to talk to several practitioners; this problem is exacerbated by physical spaces that are

not, for example, sound proof, as noted by T2. While the high prevalence of nurse-run screening procedures and inappropriate physical spaces might in part be due to a lack of sensitivity to the problems inherent in them, they are more likely to boil down to a lack of sufficient funds to build a sufficient number of private appointment rooms or to have a single practitioner deal with the client from beginning to end (because one hour of a psychologist's or psychiatrist's work probably costs more than a nurse's).

With private sector mental health facilities probably too expensive for most clients in Thailand, especially in the absence of private (PL5) or public (Tapanya, 2001) health insurance coverage for psychotherapy, and given the prominent role of state universities in producing new psychologists and psychiatrists, it seems quite clear that the lack of lack of meaningful job opportunities, the related shortage of qualified practitioners, and the resulting quick fixes (e.g., utilizing nurses as counselors), are all caused by insufficient budgeting and general lack of commitment to mental health within successive Thai governments.

Thailand has recently been able to establish universal access to relatively expensive medical therapies, such as antiretroviral treatment for HIV (Cameron, 2006), suggesting that public funding for improving the state of Thai mental health services could probably be allocated if there was enough commitment and appreciation of the importance of the field within the government. The comparison with the treatment of HIV is especially pertinent in the case of services for the treatment of depression, as Patel et al. (2007) have noted that primary care interventions for depression in low-income and middle-income countries are as cost effective as antiretroviral HIV treatments.

Stigmatization of Service Use and Its Consequences

Both client and practitioner accounts in this study pointed at the stigmatized image of clients as "crazy" in Thailand, and Thai people's consequent lack of willingness to use such services as a key problem in the Thai mental health circles, which some clients (G2 & T3) and practitioners (PL4 & PL5) contrasted with the greater acceptance of using mental health services in Western countries.

Both PA1 and PL4 linked this problem to the lack of mental health resources; when psychiatrists only have time to provide services to those most in need, they will be seen as existing only for the crazy, which raises the threshold for their use among the people. However, PA1 and PL4 explained that if mental health practitioners had time to deal with all kinds of cases, then perhaps ordinary people would dare to enter as the services demonstrated that they did not only exist for the crazy.

However, as with the level of necessity of cultural adaptation of practices, PL5 noted the situation seemed to have improved considerably from the past (people now dare to use services more than in the past) but acknowledged the clients that dared to come to him did so because they were well-off (implying higher class background), often foreign-educated, and thus culturally closer to Western countries, where using mental health services is somewhat more widely accepted.

In contrast, PA4 (who also practiced in a private setting like PL5) noted that even if the physical hospital environment is luxurious, in the potential clients' view, "it's a psychiatric hospital all the same," making them afraid to enter. Nevertheless, both M1 and T2 viewed that the unattractive (and to some, frightening) state hospital surroundings that lack privacy do exacerbate the problem.

PA4's experience of a public sector mental health destigmatization campaign shows that there are some attempts to solve the problem within the DMH. At the time of writing, the DMH website had a section for a mental illness destigmatization campaign (http://www.dmh.go.th/destigma), but the sections containing the details of the campaign returned an error message when the researcher tried to enter them in early May 2010. Furthermore, as PA4 noted, the campaign he was involved in wasn't very effective because staff could not commit to it wholeheartedly. This corroborates the view that sector-wide under-resourcing of public sector mental health is the key problem that needs to be addressed – not only so that destigmatization campaigns could have sufficient resources, but rather in order for regular services and training programs to have them, which would make them more accessible and acceptable for the general public, as PA1 and PL4 analyzed.

While most practitioners had an acute understanding of the ramifications of stigmatization, including unwillingness to use services (and thus were in touch with the clients' view of the issue), PL3 located the problem in the potential clients instead of the setting, viewing the services are not responsible for how potential clients view them. PL4 noted that practitioners on the state sector may also be unwilling or prevented by the hierarchical nature of their workplaces, or their workload, to take remedial measures like increasing outreach (as suggested by both M1 and PL4).

Ways to Develop Mental Health Services in Thailand

The author perceives two main ways to address gaps in existing mental health service provision in Thailand: improving services within the general service provision context, and developing specific services.

Development within the General Service Provision Context

Ideally, all mental health services should have high quality and readiness to meet the counseling needs of sexual/gender minority individuals. The accounts presented above make it clear that ways to achieve this would include scaling up service provision, actively addressing stigma, and improving the training of practitioners both quantitatively (more practitioners with postgraduate degrees) and qualitatively (more attention to practice-related issues and cultural factors).

One more issue that is specifically relevant for clients belonging to minorities, such as those that are the topic in this study, is how to make practitioners have those skills and attitudes that this study has demonstrated facilitate work with such clients.

PL1 and PL3 praised the sexuality/gender and sexology related training courses arranged by Mahidol and Chulalongkorn universities, respectively. Such training courses may indeed offer a good foundation for working with sexual/gender minority clients, but their obvious shortcoming is that since they are not an integral part of the curriculum of trainee practitioners, they will only address the training needs of a segment of practitioners motivated enough to seek extra training.

T2 and others demanded that these topics should be a mandatory part of practitioner training. This would be a way of ensuring that there is at least exposure to these topics, but whether that exposure would lead to the adoption of knowledge and appropriate attitudes was a concern expressed by some practitioners, such as PA1 and PA2, who both suggested arranging seminars in which community members share their experiences. While this might be a good method, arranging such seminars to all practitioners in training requires readiness and commitment to do so from educational

institutions. The DMH and sexual/gender minority NGOs could step in to help arrange such seminars.

Reading related research from both Thailand and foreign countries (PL4), as well as pocketbooks produced by Thai sexual/gender minority individuals (PA1) might be one component of gaining the needed level of understanding.

And while ensuring that practitioners have a good grasp of the specifics of sexual/gender minority work is important, the suggestions made by M1, PA2, PA3 and PL4 that practitioners should broaden their roles from sitting in their offices and waiting for clients to working within communities, schools and through the media, are also laudable. These would broaden the definition of the word "service provision" itself and in part help make psychologists and psychiatrists better known and more useful to communities and society than at present. Working through schools and media would also have an important preventive function and thus be important tools in reducing the unnecessary suffering caused to sexual/gender minority individuals by lack of understanding and stigmatizing attitudes still prevalent in Thailand.

Specific Services, NGOs and Hotlines

While ensuring that all practitioners in the general service provision context have the readiness to work with sexual/gender minority clients is the long-term ideal espoused by this study, given the low level of resources in the system and the Thai government's lack of commitment to increase them, this ideal seems far away. Thus, specific services could be a useful shortcut to providing such services for at least a segment of the Thai population that might have an elevated need for them, due to their ongoing discrimination and stigmatization, and seemingly higher suicide and

victimization risk. At least two main types were discussed with practitioners and clients: face-to-face services in a physical location, and online/hotline based ones.

Of the client participants, only two indicated they felt a group-specific clinic (either for counseling or for SRS evaluation and research on TGs) as a physical entity was necessary. Some practitioners weren't quite sure whether one would work – on one hand, having specific services would communicate acceptance of sexual/gender minorities, but clients might be afraid to be seen entering. Many said that it wouldn't be a bad idea, but the state wouldn't fund one.

As some practitioners like PA2 noted, online or hotline services could avoid these limitations. Of the clients interviewed (M1, T2 and T1) in this study demanded the state should operate a counseling hotline, which would not necessarily have to be a group-specific one, but callers should get straight through to a counselor rather than an answerphone.

These participants seemed unaware that the DMH already operates such a line (1323), which in turn suggests that the DMH hasn't been very successful in creating correct awareness of their service (participants seemed to confuse it with the DMH's automated information hotline, 1667). Furthermore, if PL1's criticism of DMH hospitals as not understanding the reasons for sexual/gender minority client referrals is correct, and also applies to this hotline, the services the hotline provides may not be appropriate for sexual/gender minority clients. However, the readiness of the service providers on this line to help sexual/gender minority clients could and should be directly evaluated.

Experiences from RSAT, which provides services both by phone and online through MSN messenger, show that the online mode has had roughly four times as many clients as the hotline option (Ojanen, 2009), and in the author's experience in

2009 and 2010, this trend has been even more marked. Thus, an online based service might be the most acceptable and accessible option for a large number of potential clients, and like a hotline, it could provide nationwide coverage with just one center.

All this leaves at least three options for developing specific services that meet the needs of sexual/gender minority individuals. The first is to evaluate the readiness to serve these clients on the DMH live hotline, 1323, provide additional training to make the providers sexual/gender minority friendly and competent, and then market the service among sexual/gender minorities. The strengths of this option would be that the practitioners staffing the line are already mental health professionals; and the DMH might have more continuity as an operator of such a service than NGOs that are always wondering how to keep services running when one project grant is coming to the end of its lifetime. A main weakness would be the fact that the DMH is automatically associated with mental illness, which might deter use; some sexual/gender minority individuals (both as studied by Liddle, 1997, and some of those studied in this study) also will not trust a practitioner unless the practitioner belongs to the same minority as the individual themselves.

The second option is to improve services at one of the existing sexual/gender minority organizations, most likely RSAT, because it is the one furthest in the development a formal system of service provision (Ojanen, 2009). The main strengths of this option would be the existing practitioner knowledge of sexual/gender minority concerns, and high acceptability and accessibility among potential clients. However, RSAT would need 1) more counselors, preferably ones with knowledge in psychology and experience in counseling, 2) further training in psychological matters, 3) more staff resources for publicity work and 4) a workable referral system to deal with cases that exceed the abilities of RSAT counselors. If data was to be collected

for action research, the organization would also need to create an electronic database on which data searches would be possible both in qualitative and quantitative terms.

The third option would be the creation of altogether new services. This is the most challenging option as the work would begin with no existing resources, but would also not suffer from the institutional limitations of existing services, such as the mainly HIV/AIDS based focus of RSAT, or the (possibly excessively) broad target group and stigmatized image of the DMH hotline.

Whether specific services are to be provided under the aegis of the DMH, NGOs like RSAT, or some other institutional context, unless plenty of marketing to the targets group is done, their members may not find the service or dare to use it. Messages on community websites and continuous posting of messages to revolving MSN lists have been found good ways to create publicity at RSAT (Ojanen, 2009). Having a project website with links to community websites, along with presence in social media sites used by the target community have been found useful in a Swedish project similar to the services provided by RSAT (Dennermalm, 2009). However, given that the client participants in this study indicated that services considered worth a try tend to be identified by asking friends, snowball marketing might also be a good adjunct, consisting of asking clients to also tell their friends about the service.

The Lack of Lesbian Participants in this Study and its Implications

The fact that the researcher was unable to find any lesbian (yĭng-rák-yĭng, tom, dee, les) participants for this study is lamentable since it means little new information was gained about members of these groups.

That such participants could not be found is quite striking given the researcher's attempts to find some (see Chapter 3). While some practitioners mentioned having had a few Thai lesbian clients, the Thai lesbians the researcher spoke to said they had never used counseling services and didn't know others who had, either. The only reply to the researcher's posting on www.baantomdy.narak.com recommended the researcher to give up the search as no lesbians would want to divulge experiences of this kind.

Two main explanations for this occurrence seem possible. The first one is that some of the people contacted had had relevant experience, but were unwilling to confide in a non-lesbian (albeit sexual minority), male, foreign researcher. The second possibility is that Thai lesbians use counseling services so rarely that those who have been clients of such services are simply very rare.

Tangential evidence for the first possibility comes from two sources: Firstly, while the researcher was able to find transgendered clients as participants, they all were existing acquaintances of the researcher, or acquaintances of acquaintances, despite the researcher's attempts to recruit strangers through www.thailadyboyz.net (a major transgender website) and RSAT, which suggests that members of this non-gay community also were not so willing to confide in a stranger belonging to a phêet other than theirs. Secondly, Liddle (1997) found that in the US, 89% of a sample of lesbian clients had chosen female therapists, and 40% of the sample had chosen a lesbian or bisexual woman therapist. Participation in this study as a client participant involved recounting personal issues in an interview. If Thai lesbians have preferences similar to those of American lesbians, it would be understandable if they would also be unwilling to disclose personal and sensitive matters to a foreign, male researcher. In

hindsight, recruiting Thai lesbian research assistants to recruit and interview lesbian participants might have been a better strategy.

Evidence that supports the second possibility is that PA4, PL1 and PL5 all noted having had much fewer lesbian than gay clients – notable especially in the case of PL1, a female practitioner working at a domestic violence center.

One reason for the seemingly low level of mental health service utilization among Thai lesbians overall might lie in the reasons why Thai sexual/gender minority individuals usually use the services. In this study, two common reasons for service utilization were being "dragged" to a practitioner by upset parents, or seeking permission for SRS. Very few toms (and no dees or other subgroups of Thai lesbians) will seek SRS (as noted by PA1), and Sinnott (2004) has noted that parents may be less likely to condemn tom-dee relationships than male-male ones (or even premarital heterosexual relationships) because tom-dee relationships are less likely to be condemned as "dirty" than male-male relationships, and also less likely to be taken seriously because the sex involved is seen as non-penetrative and thus not as real sex (which would be seen to impair the woman's purity and marriage prospects). If there is less parental condemnation, there may also be fewer Thai parents taking their lesbian daughter to a psychologist or psychiatrist than parents of gay or TG offspring who do so, and consequently fewer Thai lesbian clients overall.

To gain further understanding about this issue and the situation of Thai lesbians in general, the researcher consulted Klairung Sonklin (who was happy to be identified by name) of the Women's Health Advocacy Foundation, on 26 November 2009. She noted that while many of her lesbian acquaintances and friends suffered from depression or a broken heart, they preferred to consult their friends rather than

mental health practitioners, suspecting the latter may not understand their way of life. Some, she said, feel they have nobody to turn to.

This is hardly surprising: though PA1 assumed lesbians probably have their own counselors, to the researcher's knowledge there are no counseling services explicitly targeted for this group after Anjaree became inactive (although individual practitioners might be known through word of mouth). As noted earlier by the researcher (Ojanen, 2009) RSAT's (whose community includes lesbians) hotline and internet based services also have so far failed to meet the needs of lesbians.

Ms. Sonklin also noted it may be even more difficult to come out as *yĭng-rák-yĭng* in Thai society than as gay, that talking about "family matters" to strangers remains stigmatized, and that the Thai stereotype of lesbian relationships as doomed to failure causes pressure to pretend one's relationship is in good shape even if it's not. These factors may further contribute to the isolation of Thai lesbians, and taken together, suggest that Thai lesbians indeed do use mental health services to a low extent, although the matter should perhaps be investigated by surveys in their communities. Currently, they clearly have unaddressed needs, and the possibility of specific service provision for this group, preferably by lesbian mental health professionals, should be investigated, and such services eventually launched.

Other Groups Not Represented in this Study

Besides lesbians, three other groups of sexual/gender minority individuals were not represented in this study: female and male bisexuals and female-to-male transgendered people. As seen in Chapter 2, these three groups are quite invisible in Thai society, their identities subsumed under the gender normative identities man and

woman, or the minority identities gay, tom and dee. Many of them themselves identify with one of these three labels, and even if they adopt a distinct one (such as bi), they may not be well understood within Thai society.

Sinnott (2004) has defined toms as transgendered by definition, but they rarely cross the line of undergoing physical transformation assisted by hormones or SRS. In this study, PA1 cited information from a Thai lesbian website, stating that just about 10% of "toms" in fact fall into this category. Whether their identities are distinct enough to eventually split from the tom identity and perhaps adopt a new locally based identity label remains to be seen.

In this study, PL4 acknowledged that when he began his career some 20 years ago, kàthoeis might have been better accepted than gays because Thai society was more familiar with them, and that bisexuals were even more incomprehensible than gays for Thai society at large. Even today, both the public and some practitioners conflate homosexuality and transgenderism, but the identities gay, tom and dee seem better understood as distinct from the old, monolithic kàthoei label (signifying transgenderism) than before. Whether there is more understanding of bisexuality or not is not evident. More time and research will be needed before these specific identities and the concerns that come with them are well understood.

Intersex people are one more group that also have specific issues, but are largely invisible within Thai society. One of the transgendered participants in this study was in fact intersex, but she now identified as kàthoei and with a transgender community. However, when younger, she had not identified with transgendered people, feeling she was a woman rather than kàthoei.

In the US, the APA Task Force on Gender Identity and Gender Variance (2007) was initially charged with assessing both transgender and intersex issues, but

came to the decision that the concerns of these two groups were so distinct that it would not have been feasible to comprehensively address both in the same report, underlining the need for specific awareness and research on intersex people. New research specifically on Thai intersex people will soon be published (Sankatiprapa & Wilainut, submitted for publication).

Other Limitations of the Study and Suggestions for Future Research

Besides the lack of representation of many sexual/gender minority groups, this study has the obvious limitations of any qualitative study. It draws conclusions based on a very limited number of people, which limits its generalizability.

Sampling was also limited in the Bangkok area; the situation upcountry might be different. However, as Tapanya (2001) has noted, 80% of all Thai psychiatrists practice in urban areas, and as PL4 stated, some provinces don't have any psychiatrists at all. Bangkok is by far the largest of these, suggesting that quite a large portion of those 80% probably practice in the study area. Due to the way mental health services are organized in Thailand, psychologists tend to be used as assisting testing "technicians" by psychiatrists (Tapanya; PL2), which means that psychologists are probably mostly found in the same clinics and hospitals as psychiatrists. Thailand is still quite centralized and Bangkok-based; there may thus be a trickle-down of practices and policies from Bangkok to the provinces, and the situation described here is thus probably relevant for upcountry provinces as well.

In the future, practitioners could be surveyed on their views and level of awareness on the key issues identified in this study, to establish quantitative estimates of the prevalence of specific points of view and levels of awareness. However, while

such surveys have been created with the assistance of the APA in the US (e.g., Kilgore, Sideman, Amin, Baca & Bohanske, 2005) the fragmentation of professional associations in Thailand would mean that several professional associations would need to be contacted for a sample that was truly representative. Securing their collaboration might be a challenge. Alternatively, practitioners could be surveyed with assistance from the DMH or individual hospitals.

A similar survey-based approach to gain representative quantitative data from sexual/gender minority clients of mental health services may be impossible due to the difficulties in identifying and recruiting sexual/gender minority clients, as seen in the present study. Surveys among non-clinical samples of the general population of sexual/gender minority groups are possible and have been done on other topics, but minority members without experience of having been a client in mental health services may be unaware of the issues that exist within the mental health service context, and thus constitute a not very useful study sample for this purpose.

The observation made by PL1 – that sexual/gender minority issues are invisible in hospitals and clinics because all patients are classified only as male or female – is an important one. If a sensitive and confidential way was found to record sexual/gender minority clients as such (at least in contexts where their status might be related to their health or their need for services), hospital records would more accurately represent who receive services and for which reasons, and form a formidable database for archive-based mental health research.

The characteristics of optimal service provision to Thai sexual/gender minorities could also be investigated by action research that involved both service provision to these groups and monitoring usage levels and outcomes (an option suggested by PA3). Especially if provided through online services accessible

nationwide, this kind of research could both be a shortcut to increasing access to sexual/gender-minority friendly services in the population, and evaluating how they best can meet the needs of these groups. While this study has clearly demonstrated that many improvements are needed in the general context for the benefit of all user groups, such changes may take a long time to materialize, and online-based services might thus be a resource-efficient way to address the counseling needs of sexual/gender minority clients while working for improvement in the general context.

Besides directly service provision related issues, throughout this thesis areas of knowledge have been identified on which further research is warranted and may also be helpful for service provision. These include the lifespan identity development of sexual/gender minority individuals (especially TGs); parameters of safe and effective hormone use in Thai TGs; prevalence and patterns of illicit drug use among sexual/gender minority individuals; and prevalence of phêet-specific harassment.

Conclusion

The findings of this qualitative, interview-based study demonstrate that having a well functioning general mental health service context is a necessary but not always sufficient condition for effective work with sexual/gender minority clients.

In the Thai context, both clients and practitioners viewed that private sector mental health services in Thailand seemed to be managing the generic aspects of mental health service provision reasonably well for their limited client base who can themselves afford to pay for the services.

However, on the public sector, it seems that most psychiatrists are simply too busy to talk with their clients for more than a few minutes, which mostly limits their

role to medication, referrals and certificate writing. Public sector psychologists, while also overburdened, more frequently provide counseling in addition to their main role (psychological testing), and their input is appreciated more than that of psychiatrists by sexual/gender minority clients – although not without criticisms.

Group-specific NGO based services may be friendly but are currently not professional mental health services; rather, they concentrate on health advice. Community members have reservations about some aspects of their operations, too, such as the training of counselors, or their level of confidentiality.

Much more commitment is needed from the Thai state to increase the number of psychiatrists and psychologists in Thailand by providing training opportunities, higher hiring quotas and making these jobs into more meaningful and secure career options. If the quality and quantity of practitioners in Thailand could thus be radically improved, public sector practitioners might finally have enough time to listen to their clients, and the services might constitute a more meaningful and less stigmatized way to help cope with life's slings and arrows.

Among these are the non-acknowledgement and non-acceptance of sexual/gender minorities in Thailand, especially in official contexts and within families, as well as relationship problems, to which minority individuals react with various psychological complications, such as depression and even suicide attempts. Many of these issues mirror problems and reactions caused by them seen in the US, but there are differences on the level of details.

Today, neither Thai psychiatrists nor psychologists seem to openly view homosexuality as pathological (although transgenderism still officially remains pathologized). However, the views many practitioners hold on these groups are quite ambivalent, combining both supportive and heterosexist (and sometimes even

homophobic or transphobic) views. The latter kinds of views include dislike of certain aspects of these minorities, fatalistic pessimism about their chances for a happy life or a lasting romantic relationship, or views that these groups should aspire to be as much like gender-normative heterosexuals as possible.

As a general view, many practitioners and some clients hold that universal principles are sufficient for dealing with all clients – but on the level of practice, they do have an appreciation of the need for specific knowledge, attitudes, or clinical strategies while dealing with sexual/gender minority clients, such as how to gain the trust of such clients, deal with their upset parents, assess their readiness for SRS, or understand the coming out process.

However, there are gaps in practitioner knowledge and appropriateness of attitudes – from the basics, such as communicating respect to their clients, not using disrespectful terms (such as tút or sexual deviant), or knowing the basic differences between distinct minority groups, to more specific ones such as understanding stages of identity development or relationship dynamics in a non-stereotyping way, appreciating the elevated suicide risk among these client groups, or being familiar enough with community resources to be able to make community referrals.

Besides the upgrading needed in the general context, trainee practitioners should study sexual/gender minority issues, preferably through direct interaction with community members, materials written by them, or through research conducted on their lives in the local context, mostly outside of the fields of psychology and psychiatry. Increasing outreach is also on the agenda, as is promotion of wellbeing through providing knowledge about these groups in schools and on the media.

As regards minority individuals as practitioners, both clients and practitioners acknowledged that Thailand has many gay (and some lesbian) psychiatrists and

psychologists, but at least psychiatry seems to operate an implied "don't ask, don't tell" policy when hiring new staff or recruiting students to training programs, whereby homosexuality is tolerated if it is not expressed. Transgender people still have low chances of entering either of these professions. Increasing the openly acknowledged presence of all sexual/gender minority groups within these professions might play a part in making these fields more helpful and appropriate for minority clients, as well as demonstrate the commitment of these fields to human rights principles. However, strategies to make clients respect and trust sexual/gender minority practitioners need to be devised to facilitate their entry to these professions.

Creating specific, professionally operated services for Thai sexual/gender minority individuals would be a shortcut for providing services to these groups. On-line services would be a resource-efficient and accessible way to do so nationwide; such services might be run as action research. However, it needs to be considered whether they should be operated by the DMH or sexual/gender minority NGOs, and by community volunteers or by professional helpers.

REFERENCES

American Psychiatric Association. (2000a) *Diagnostic and statistical manual of mental disorders, (4ᵗʰ Ed.., Text Rev.).* Washington, DC: Author.

American Psychological Association (APA). (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist*, *55*(12), 1440-1451.

American Psychological Association (APA). (2002). *Ethical principles of psychologists and code of conduct*. Retrieved 24 October 2005 from http://www2.apa.org/ethics/code2002.doc

American Psychological Association (APA). (2010). *Resolution on appropriate affirmative responses to sexual orientation distress and change rfforts.* Retrieved 13 March 2010 from http://www.apa.org/about/governance/council/policy/sexual-orientation.aspx

American Psychological Association, Task Force on Gender Identity and Gender Variance. (2009). *Report of the Task Force on Gender Identity and Gender Variance.* Washington, DC: Author.

APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* Washington, DC: Author.

Boonyapisomparn, Sitthiphan. (2010). *Asia Pacific Transgender Network calls for depathologisation of Gender Identity Variance (Transgenderism).* Retrieved 9 May 2010 from http://www.msmasia.org/news_article/items/ APTN_calls_for_depathologisaion_of_gender_identity_variance_tran.html

Boonyapisomparn, Sitthiphan, Samakkeekarom, Ronnapoom & Boonmongkon, Pimpawun [สิทธิพันธ์ บุญญาภิสมภาร, รณภูมิ สามัคคีคารมย์ & พิมพวัลย์ บุญมงคล]. (2008/2551). *ชีวิต ตัวตน และเรื่องเพศของสาวประเภทสอง* [Life, identity and sexual matters of săao-pràphêet-sŏong]. Bangkok, Thailand: Women's Health Advocacy Foundation.

British Association for Counselling and Psychotherapy. (2007). *A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual & transgender people.* Lutterworth, United Kingdom: Author.

Bryman, A. (work in progress). Triangulation. In Sage Reference, M. Lewis-Beck, A. Bryman & T. Futing Liao (Eds.), *Encyclopedia of Social Science Research Methods*. Sage Publications, London. Retrieved 14 October 2010 from http://www.referenceworld.com/sage/socialscience/triangulation.pdf

Bualombaai, Damrongchai [ดำรงชัย บัวล้อมใบ]. (1992/2535). *การศึกษาเปรียบเทียบ ปัญหาสุขภาพจิตของชายรักร่วมเพศกับชายปกติ* [A comparative study of mental health problems between male homosexuals and normal males]. Unpublished master's thesis, Srinakharinwirot University, Bangkok, Thailand.

Bunditchate, Anurak; Saosarn, Phanomsri; Kitiruksanon, Paknapin & Chutha,

    Worawan. (2002). Epidemiology of mental disorders among Thai people.

    Journal of The Psychiatric Association of Thailand, *46*(4): 335-343. Abstract

    retrieved 29 April 2010 from

    http://www.suicidethai.com/abstract/abstract_detail.asp?ntitle=Epidemiology

    %20of%20Mental%20Disorders%20Among%20Thai%20People&id=285

Bunprasert, Janjira [จันทร์จิรา บุญประเสริฐ]. (2007/2550). สิทธิมนุษยชนของคนข้าม

    เพศ (Transgendered people) กรณีการใช้คำนำหน้านาม [The human rights of

    transgendered people, case of using personal titles]. *มุมมองสิทธิ* [Rights

    Viewpoint], *6*(3): 6.

Cameron, L. (2006). *Sexual health and rights. Sex workers, transgender people &*

    men who have sex with men. Thailand. Report for the Open Society

    Institute, Network Public Health Program, Sexual Health and Rights Program.

Chanchai, Manitta (มานิตตา ชาญไชย). (2004/2546). *ความเป็นเอกลักษณ์ทางสังคม*

    ของ "ดี้" และกลยุทธ์ในการใช้ชีวิตประจำวันของผู้หญิงที่มีคนรักเป็นทอม

    [Social identity of "dee" and daily life routine of tom's lady lover].

    Unpublished master's thesis, Thammasat University, Bangkok, Thailand.

Chetami, Mathana (มัทนา เชตมี). (1996/2539). *วิถีชีวิตและชีวิตครอบครัวของหญิงรัก*

    หญิง [Life style and family life of lesbians]. Unpublished master's thesis,

    Thammasat University, Bangkok, Thailand.

Chonwilai, Sulaiporn [สุไลพร ชนวิไล] (Ed.) (2007/2550). *เพศไม่นิ่ง – ตัวตน เพศ ภาวะ เพศวิถี ในมิติสุขภาพ* [Shifting sex – identity, gender and sexual lifestyle within a health dimension]. Salaya, Nakhon Pathom, Thailand: The Southeast Asian Consortium on Gender, Sexuality and Health.

Chonwilai, Sulaiporn [สุไลพร ชนวิไล]. (2009a/2552). กะเทย [Kàthoei]. In Sulaiporn Chonwilai & Pimpawun Boonmongkon [สุไลพร ชนวิไล & พิมพวัลย์ บุญมงคล] (Eds.), *ภาษาเพศในสังคมไทย: อำนาจ สิทธิและ สุขภาวะทางเพศ* [Sexual language in Thai society: Power, rights and sexual well-being] (pp.151–164). Nakhon Pathom, Thailand: The Southeast Asian Consortium on Gender, Sexuality and Health & National Human Rights Commission of Thailand.

Chonwilai, Sulaiporn [สุไลพร ชนวิไล]. (2009b/2552). หญิงรักหญิง [Yĭng-rák-yĭng]. In Sulaiporn Chonwilai & Pimpawun Boonmongkon [สุไลพร ชนวิไล & พิมพวัลย์ บุญมงคล] (Eds.), *ภาษาเพศในสังคมไทย: อำนาจ สิทธิและ สุขภาวะทาง เพศ* [Sexual language in Thai society: Power, rights and sexual well-being] (pp. 165–174). Nakhon Pathom, Thailand: The Southeast Asian Consortium on Gender, Sexuality and Health & National Human Rights Commission of Thailand.

Chonwilai, Sulaiporn & Boonmongkon, Pimpawun [สุไลพร ชนวิไล & พิมพวัลย์ บุญมงคล] (Eds.). (2009/2552). บทส่งท้าย [Conclusion]. In Sulaiporn Chonwilai & Pimpawun Boonmongkon [สุไลพร ชนวิไล & พิมพวัลย์ บุญมงคล] (Eds.),

ภาษาเพศในสังคมไทย: อำนาจ สิทธิและ สุขภาวะทางเพศ [Sexual language in Thai society: Power, rights and sexual well-being] (pp. 241–256). Nakhon Pathom, Thailand: The Southeast Asian Consortium on Gender, Sexuality and Health & National Human Rights Commission of Thailand.

Chooprasert, Nantaya. (2001). *The psychological adjustment of covert and overt lesbians at the Anjaree Group.* Unpublished master's thesis, Assumption University, Bangkok, Thailand.

Committee (Special Task Force) recording intentions and remarks and checking minutes of meetings, Constitution Drafting Assembly [คณะกรรมาธิการวิสามัญ บันทึกเจตนารมณ์ จดหมายเหตุ และตรวจรายงานการประชุม สภาร่าง รัฐธรรมนูญ]. (2007/2550). *เจตนารมณ์รัฐธรรมนูญแห่งราชอาณาจักรไทย พุทธศักราช ๒๕๕๐* [Intentions of the Constitution of the Kingdom of Thailand, 2550 B.E.]. Bangkok, Thailand: Bureau of Committee 3, Secretariat of the House of Representatives [สำนักกรรมาธิการ ๓ สำนักงานเลขาธิการ สภาผู้แทนราษฎร]. Retrieved 11 March 2010 from http://library2. parliament.go.th/giventake/content_cons50/cons50-intention.pdf

Cook, N. M. & Jackson, P. A. (1999). Desiring constructs: Transforming sex/gender orders in twentieth-century Thailand. In P. A. Jackson, & N. M. Cook (Eds.) *Genders and sexualities in modern Thailand* (pp.1-27). Chiang Mai, Thailand: Silkworm Books.

Danthamrongkul, Wipha & Posayajinda, Wichai (วิภา ด่านธำรงกูล วิชัยโปษยะ

จินดา) (Eds.). (2004/2547). *เครือข่ายสังคมและเพศสัมพันธ์กลุ่มชายชอบชาย*
[Social networks and sexual relations of the group of men who like men].
Bangkok, Thailand: Chulalongkorn University, Research Institute of Medical
Science, Department of Research on Drugs of Abuse.

Davies, D. (1996a.) Homophobia and heterosexism, In D. Davies & C. Neal (Eds.).
Pink therapy (pp. 41-65). Maidenhead, UK: Open University Press.

Davies, D. (1996b) Towards a gay affirmative therapy. In D. Davies & C. Neal
(Eds.). *Pink therapy* (pp. 24-40). Maidenhead, UK: Open University Press.

Davies, D. (1996c) Working with people coming out. In D. Davies & C. Neal
(Eds.). *Pink therapy* (pp. 66-85). Maidenhead, UK: Open University Press.

Davies, D. & Neal, C. (1996). An historical overview of homosexuality and
therapy. In D. Davies & C. Neal (Eds.). *Pink therapy* (pp. 11-23).
Maidenhead, UK: Open University Press.

DeCuypere, G., Knudson G., & Bockting, W. (2010). *Response of the World
Professional Association for Transgender Health to the proposed DSM 5
criteria for Gender Incongruence.* Retrieved 29 May 2010 from
http://www.wpath.org/documents/WPATH%20Reaction%20to%20the%20pro
posed%20DSM%20-%20Final.pdf

De Lind van Wijngarden, J. W. (1999). Between money, morality and masculinity:

The dynamics of bar-based male sex work in Chiang Mai, Northern Thailand. In P. Jackson and G. Sullivan (Eds.) *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand* (pp. 187-212). Chiang Mai, Thailand: Silkworm Books.

Dennermalm, N. (Ed.). (2009). *We are the Sexperts! A manual on how to use Internet chatrooms and communities to promote sexual health and condom use.* Stockhom, Sweden: RFSL Stockholm.

Domino, G. (1977). Homosexuality and creativity. *Journal of Homosexuality, 2*(3), 261-267. Abstract retrieved 4 April 2010 from http://www.informaworld.com/smpp/title~db=all~content=t792306897~tab=sample

Ellis, A. (1959). Homosexuality and creativity. *Journal of Clinical Psychology, 15:* 376-379.

France Delists. (2010). France de-lists transgenderism as a mental illness. *PinkNews.co.uk,* retrieved 19 February 2010 from http://www.pinknews. co.uk/2010/02/15/france-de-lists-transgenderism-as-a-mental-illness/

Gahlinger, P. M. (2004). *Illegal drugs: A complete guide to their history, chemistry, use and abuse.* New York: Plume Printing.

Meyer W., III, Bockting, W., Cohen-Kettenis, P., Coleman, E., DiCeglie, D., Devor,

H., et al. M. (2001). *The Harry Benjamin International Gender Dysphoria Association's standards of care for gender identity disorders, sixth version.* Retrieved 3 July 2007 from http://www.wpath.org

Herdt., G. (Ed.). (1994). *Third sex, third gender: Beyond sexual dimorphism in culture and history.* New York: Zone Books.

Jackson, P. A. (1997). Thai research on male homosexuality and transgenderism and the cultural limits of Foucaultian analysis. *Journal of the History of Sexuality,* 8(1): 52-85.

Jackson, P. A. (1999). Studies of rates of same-sex sexual experience in Thailand: A critical survey, In P.A. Jackson and G. Sullivan (Eds.) *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand* (pp. 28-59). Chiang Mai, Thailand: Silkworm Books.

Jackson, P. A. (2003). Performative genders, perverse desires: A bio-history of Thailand's same-sex and transgender cultures. *Intersections: Gender, History and Culture in the Asian Context*, 9. Retrieved 18 January 2007 from http://wwwsshe.murdoch.edu.au/intersections/default.htm .

Jackson, P. A. & Sullivan, G. (1999). A panoply of roles: Sexual and gender diversity in contemporary Thailand. In P. A. Jackson & G. Sullivan (Eds.), *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand* (pp. 1-27). Chiang Mai, Thailand: Silkworm Books.

Khuankhong, Thanapong (ธนพงษ์ ขวัญคง). (n.d.). *อย่างไรจึงเรียกว่าเป็น คนรักเพศเดียวกัน* [Why "person loving the same sex"?]. Retrieved 8 December 2007 from http://www.dmh.go.th/1667/1667view.asp?id=3620

Kilgore, H., Sideman, L. Amin, K., Baca, L., & Bohanske, B. (2005). Psychologists' attitudes and therapeutic approaches toward gay, lesbian and bisexual issues continue to improve: An update. *Psychotherapy: Theory, Research, Practice, Training*, 42(3): 395-400.

Kinsey, A., Pomeroy, W. B., Martin, C. E. (1948). *Sexual behavior in the human male.* Philadelphia: W.B. Saunders Company.

Kittisuksadit, Sirinan (ศิรินันท์ กิตติสุขสดิต). (2007/2551, July). *รสนิยมทางเพศของ วัยรุ่นไทยยุคไซเบอร์* [Sexual orientation in Cyber Age Thai youth]. Paper presented at the Prachakon Lae Sangkhom 2551 conference, Bangkok, Thailand.

Kowszun, G. & Malley, M. (1996) Alcohol and substance misuse. In D. Davies & C. Neal (Eds.). *Pink therapy* (pp. 170-187). Maidenhead, UK: Open University Press.

Liddle, B. J. (1997). Gay and lesbian clients' selection of therapists and utilization of therapy. *Psychotherapy, 34*(1): 11-18.

Lolekha, Somsak [สมศักดิ์ โล่ห์เลขา]. (2009/2552). ข้อบังคับแพทยสภาว่าด้วย การรักษาจริยธรรมแห่งวิชาชีพเวชกรรม เรื่อง เกณฑ์การรักษาเพื่อแปลง เพศ พ.ศ. ๒๕๕๒ [The Medical Council's regulations on maintaining ethicality of the medical profession as regards the conditions of treatment to change sex, B. E. 2552]. *ราชกิจจานุเบกษา* [Royal Gazette], 126, ตอน พิเศษ ๗๗ ง [Special issue, 33 Ngo]: 37-38. Retrieved 15 March 2010 from http://www.tmc.or.th/download/jul09-02.pdf

Luhmann, N. & Laohasiriwong, W. (2006). *The health risk and health care seeking behaviors of male-to-female transgender persons in Khon Kaen, Thailand. First implications for targeted prevention.* Retrieved 29 May 2007 from http://web.hku.hk/~sjwinter/TransgenderASIA/paper_luhmann.htm

Maneesrikum, Totsaworn. [ทศวร มณีศรีขำ]. (2002/2545) *การสร้างความเป็นอื่นให้กับ เกย์* [Designating gay to be the otherness]. Unpublished doctoral dissertation, Srinakharinwirot University, Bangkok, Thailand.

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Martin, Piyarat. [ปิยรัตน์ มาร์แตง]. (2003/2546). *แนวทางการให้การศึกษาเพื่อ ความเข้าใจในวิถีชีวิตของคนรักเพศเดียวกัน* [Educational approach for the understanding of homosexual life]. Unpublished master's thesis, Chulalongkorn University, Bangkok, Thailand.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London: Sage Publications Ltd.

Ministry of Public Health. (2007). *International statistical classification of diseases and related health problems, tenth revision, Thai modification (ICD-10-TM)*. Ministry of Public Health, Bureau of Policy and Strategy, Office of the Permanent Secretary, Thailand. Retrieved 1 March 2010 from http://www.thcc.or.th/ebook1/vol1_chap05.htm

Naksing, Purin [ปุรินทร์ นาคสิงห์]. (2004/2547). *เกย์: กระบวนการพัฒนาเอกลักษณ์และวิถีชีวิตทางเพศ* [Gay: Identity development and sexual lifestyle]. Unpublished master's thesis, Thammasat University, Bangkok, Thailand.

Narrain, A. & Chandran, V. (2005). It's not my job to tell you it's okay to be gay. Medicalization of homosexuality: A queer critique. In Narrain, A, & Bhan, G. (Eds.). *Because I have a voice: Queer politics in India*, (pp. 49-69). New Delhi: Yoda Press.

National Human Rights Commission. (2009/2552). *รายงานประเมินสถานการณ์สิทธิมนุษยชน ปี ๒๕๔๙-๒๕๕๐ ในประเทศไทย* (Evaluative report on the human rights situation in 2008–2009 in Thailand). Bangkok, Thailand: Author.

National Human Rights Commission of Thailand & Rainbow Sky Association of Thailand [คณะกรรมการสิทธิมนุษยชนแห่งชาติ & สมาคมฟ้าสีรุ้งแห่งประเทศไทย] (NHRC & RSAT). (2007/2550). *สิทธิมนุษยชนของบุคคลที่มีความหลากหลายทางเพศ* [Human rights of lesbians, gays, bisexuals, transgender and intersex people]. Bangkok, Thailand: Authors.

Neal, C. & Davies, D. (1996). *Introduction*. In D. Davies & C. Neal (Eds.). *Pink Therapy* (pp. 1-10). Maidenhead, UK: Open University Press.

Nicolosi, J. (1993). Reparative therapy of male homosexuality: A new clinical approach. *Contemporary Psychology. 38*(2): 165-166.

Nithiubat, Chaiyo [ไชโย นิธิอุบัติ]. (2003/2546). **การสื่อสารเพื่อเปิดเผยตนเองของกลุ่มชายรักชาย** [Communication for self disclosure of male homosexuals]. Unpublished master's thesis, Chulalongkorn University, Bangkok, Thailand.

Nong Poy (n.d.) *ประวัติน้องปอย ตรีชฎา* [Nong Poy Trichada's Biography]. Retrieved 27 April 2010 from http://women.kapook.com/star00219/

Office of the Council of State, Foreign Law Bureau. (2007). *Constitution of the Kingdom of Thailand (unofficial translation).* Bangkok, Thailand: Author. Retrieved 15 May 2010 from http://www.asianlii.org/th/legis/const/2007/1.html

Ojanen, T. T. (2009). Sexual/gender minorities in Thailand: Identities, challenges, and voluntary-sector counseling. *Sexuality Research and Social Policy. 6*(2): 4-34.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, et al. (2007, September 15). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet, 370*(9591): 991-1005.

Patterson, C. H. & Watkins, C. E., Jr. (1996). *Theories of psychotherapy*. NY: HarperCollins.

Phliphat, Thanarak; Klatsawat, Kiratikan; van Griensven, Fritz & Wimonset, Wipas [ธนรักษ์ ผลิพัฒน์, กีรติการต์ กลัดสวัสดิ์, ฟริทส วัน กรีนสแวน & วิภาส วิมล เศรษฐ]. (2008/2551). ผลการเฝ้าระวังความชุกของการติดเชื้อเอ็ชไอวี กลุ่มชาย ที่มีเพศสัมพันธ์กับชาย ในกรุงเทพมหนคร เชียงใหม่ และภูเก็ต [Results of prevalence surveillance of HIV infection; men who have sex with men in Bangkok, Chiang Mai and Phuket]. In Thanarak Phliphat & Kiratikan Klatsawat [ธนรักษ์ ผลิพัฒน์ & กีรติการต์ กลัดสวัสดิ์] (Eds.), *การป้องกันและ แก้ไขปัญหาการติดเชื้อเอ็ชไอวีในกลุ่มชายที่มีเพศสัมพันธ์กับชาย* [Prevention and solving the problem of HIV infection among men who have sex with men] (pp. 1–9). Nonthaburi, Thailand: Bureau of Knowledge Management, Department of Disease Control, Ministry of Public Health.

Platine, C. (1997). *The Harry Benjamin International Gender Association and you.* Retrieved 29 May 2007 from http://gallae.com/cathy/essay1.htm

Pramoj na Ayutthaya, Prempreeda [เปรมปรีดา ปราโมช ณ อยุธยา]. (2003/2546). *การช่วงชิงอัต ลักษณ์"กระเทย"ในงานคาบาเรต์โชว์* [Contesting identities of "Kathoei" in cabaret show]. Unpublished master's thesis, Chiang Mai University, Chiang Mai, Thailand.

Pramoj na Ayutthaya, Prempreeda [เปรมปรีดา ปราโมช ณ อยุธยา]. (2008/2551, November). *Sexual fluidity within bisexuality in Thailand* [Draft version; permission to cite obtained from the author]. Paper presented at the Seventh Thai Studies Conference, Bangkok, Thailand.

Rainbow Sky Association of Thailand (RSAT). (2010a). [Promotional material contents]. Manuscript in preparation.

Rainbow Sky Association of Thailand (RSAT). (2010b). [Drug use in the past month among MSM contacted in 14 provinces of Thailand]. Unpublished raw data.

Raksayu, Chantalak [ฉันทลักษณ์ รักษาอยู่]. (2007/2550). *เจตนารมณ์ มาตรา ๓๐ ใน ร่างรัฐธรรมนูญปี ๒๕๕๐ กับการคุ้มครองสิทธิมนุษยชนของบุคคลที่มีความ หลากหลายทางเพศ* [Statement of intention of article 30 in the 2550 constitution draft and the protection of the rights of persons who have sexual diversity]. *มุมมองสิทธิ์* [Rights viewpoint], *6*(2): 15.

Rattachumpoth, Rakkit. (1999), Foreword. In P. A. Jackson & G. Sullivan (Eds.), *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand,* pp. v-xiv. Chiang Mai, Thailand: Silkworm Books.

Remafedi, G., French, S., Story, M., Resnick, M. D. & Plum, R. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health, 88*(1): 57-60.

Rogers, C. (1961). *On becoming a person.* Boston: Houghton Mifflin Company

Romjumpa, Terdsak [เทอดศักดิ์ ร่มจำปา]. (2002/2545). *วาทกรรมเกี่ยวกับ 'เกย์' ใน สังคมไทย พ.ศ. 2508-2542* [Discourses on 'gay' in Thai society between 2508-2542 B.E.]. Unpublished master's thesis, Chulalongkorn University Bangkok, Thailand.

Rutter, P. A. (2006). Young adult suicide and sexual orientation: what should counselors know? *Journal of LGBT Issues in Counseling, 1*(3): 33-48 (59 ref).

Sanders, D. (submitted for publication). *The Rainbow Lobby: The Sexual Diversity Network and the Military-Installed government in Thailand.*

Samakkeekarom, Ronnapoom; Boonmongkon, Pimpawun; Chanthong, Wachira (submitted for publication). *The sexuality of Thai men who have sex with men (MSM) who use Camfrog on-line webcam chatrooms: Cyberspace, power structures and sexual health.*

Sankatiprapa, Kittikorn (กิตติกร สันคติประภา). (2007/2550). *การลวนลามทางเพศ กะเทย : นัยสำคัญภายใต้วาทกรรมรักต่างเพศ* (Kathoey sexual harassment: Its significance in heterosexual discourse). Unpublished doctoral dissertation, Srinakharinwirot University, Bangkok, Thailand.

Sankatiprapa, Kittikorn & Wilainut, Phairot (กิตติกร สันคติประภา & ไพโรจน์ วิไล นุช). (submitted for publication). *Intersexed people: Beyond boundary of*

dimorphic sex.

Sinnott, M. (1999). Masculinity and *tom* identity in Thailand. In P. A. Jackson & G. Sullivan (Eds.), *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand* (pp. 94-116). Chiang Mai, Thailand: Silkworm Books.

Sinnott, M. (2004). *Toms and dees: Transgender identity and female same-sex relationships in Thailand.* Honolulu: University of Hawaii Press.

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? 200 participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*(5): 403-417(15).

Somrudee Sanguankaew [สมฤดี สงวนแก้ว]. (2003/2546). *กระบวนการพัฒนาและธำรงเอกลักษณ์ "กะเทย" ในสังคมมุสลิม* [The development and maintenance process of "transgender"in Muslim society]. Unpublished master's thesis, Thammasat University, Bangkok, Thailand.

Sripanich, U-Sa [อุษา ศรีพานิช]. (1998/2541). *ประวัติชีวิตของชายแปลงเพศ* [Life histories of male transsexuals]. Unpublished master's thesis, Chulalongkorn University, Bangkok, Thailand.

Sue, D. W. and Sue, D. (1999). *Counseling the culturally different: Theory and practice.* New York: John Wiley & Sons.

Tapanya, S. (2001). Psychology in medical settings in Thailand. *Journal of Clinical Psychology in Medical Settings, 8*: 69–72.

Teerarojjanapongs, Natee & Champathong, Suchathinat v. The Governor of Chiang Mai Province [นที ธีระโรจนพงศ์ & สุฌาธฐีณัฏฐ์ จำปาทอง v. ผู้ว่าราชการ จังหวัดเชียงใหม่]. Case number 24/2553 (Chiang Mai Administrative Court, 2010/2553, February 5).

Thammarongwith, Sutham [นายสุธรรม ธรรมรงค์วิทย์] (2005/2548). *อำนาจและการขัด ขืน : ชายรักชายในสังคมที่ความสัมพันธ์ต่างเพศเป็นใหญ่* [Power and resistance: gays in a heterosexist society]. Unpublished master's thesis, Thammasat University, Bangkok, Thailand.

Uckaradejdumrong, Pichai. (1996). *Psychological adjustment of covert and overt Thai male homosexuals.* Unpublished master's thesis, Assumption University, Bangkok, Thailand.

Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8): 878-885.

Vijayakumar, L., Pirkis, J., Huong T. T., Yip, P., De A. Seneviratne, R. & Hendin, H. (2008). Socio-economic, cultural and religious factors affecting suicide prevention in Asia (pp. 19-29). In H. Hendin, M. R. Phillips, L. Vijayakumar,

J. Pirkis, H. Wang et al. (Eds.), *Suicide and suicide prevention in Asia.* Geneva, Switzerland: World Health Organization.

Winter, S. (2002) *Country report: Thailand.* Retrieved 29 May 2007 from http://web.hku.hk/~sjwinter/TransgenderASIA/country_report_thailand.htm

Winter, S. (2006a). Thai transgenders in focus: Demographics, transitions and identities. *International Journal of Transgenderism, 9*(1): 15–27.

Winter, S. (2006b). Thai transgenders in focus: Their beliefs about attitudes towards and origins of transgender. *International Journal of Transgenderism*, 9(2): 47–62.

Winter, S. (2007). *Transphobia, a price worth paying for Gender Identity Disorder?* Paper presented on 17th April 2007 at First World Congress for Sexual Health (18th Congress of the World Association for Sexology), Sydney, Australia. Retrieved 29 May 2007 from http://web.hku.hk/~sjwinter/TransgenderASIA/WAS2007paper.htm

Winter, S. & King, M. (submitted for publication). *Well and truly fucked: Transwomen, stigma, sex work and sexual health in South to East Asia.*

Winter, S. & Vink, L. (2005) [Suicidal ideation and suicide attempts among Thai transgender women]. Unpublished raw data.

Winter, S., & Udomsak, N. (2002). Male, female and transgender: Stereotypes and

  self in Thailand. *International Journal of Transgenderism, 6*(1). Retrieved

  May 11, 2007, from http://www.symposion.com/ijt/ijtvo06no01_04.htm

World Health Organization (WHO). (2003). *International statistical classification of

  diseases and health related problems.* 2nd Ed. Geneva, Switzerland: Author.

World Professional Association for Transgender Health (WPATH). (2010). *WPATH

  news and upcoming events.* Retrieved 29 May, 2010 from www.wpath.org

APPENDIX I: SAMPLE RECRUITMENT COMMUNICATION

งานวิจัย ... จิตวิทยา/จิตเวชศาสตร์กับพวกเรา...

คุณเคยไปปรึกษานักจิตวิทยา/จิตแพทย์ไหม?
หรือรู้จักเพื่อนที่เคยไป?

หากคำตอบของคุณคือ ”เคย” หรือ ”รู้จัก” ประสบการณ์ของคุณหรือของเพื่อนคุณอาจจะนำไปช่วยพัฒนาคุณภาพบริการสำหรับคนอื่นในอนาคตได้
     ผมเป็นนักศึกษาระดับปริญญาโทวิชาจิตวิทยาการปรึกษาในมหาวิทยาลัยอัสสัมชัญ ผมกำลังทำการวิจัยเรื่องคุณภาพบริการด้านจิตวิทยา/จิตเวชศาสตร์ที่ สาวประเภทสอง หญิงรักหญิง และ ชายรักชาย ได้รับ
     จุดเป้าหมายของการวิจัยคือการพัฒนาบริการการปรึกษาสำหรับสามกลุ่มดังกล่าว โดยเปรียบเทียบทัศนคติและประสบการณ์ของผู้รับคำปรึกษาและผู้ให้คำปรึกษา วิธีการวิจัยคือการสัมภาษณ์ทั้งผู้รับคำปรึกษาและผู้รับคำปรึกษา (ผู้รับบริการและผู้ให้บริการ) ผู้ให้ข้อมูลจะไม่ต้องบอกชื่อและข้อมูลจะเป็นความลับทั้งสิ้น ในการรายงานผลการวิจัยผู้วิจัยจะรายงานถึงประสบการณ์และทัศนคติของผู้ให้ข้อมูล แต่ผู้อ่านจะไม่ทราบว่าใครให้ข้อมูลบ้าง การให้ข้อมูลจึงจะไม่กระทบกับความเป็นส่วนตัวของคุณ
     ถ้าคุณคิดว่าคุณสามารถช่วยในการวิจัยได้ กรุณาติดต่อผมทางอีเมล์ timoojanen@hotmail.com หรือทางโทรศัพท์ 089-1648319
     ช่วยบอกเพื่อนด้วยว่ามีการวิจัยแบบนี้กำลังทำอยู่ ช่วยหาผู้ให้ข้อมูลครับ

APPENDIX II: NOTES ON THAI REFERENCES

Author names

All authors (Thai and foreign) are referred to by their surname, to comply with APA style requirements. However, in both English and Thai language academic literature published in Thailand, it is common practice to refer to Thai authors by their first names. To make looking up references possible also in this case, the reference section gives the surname followed by the first name of all Thai authors, whenever both are available. Thai authors cited from Thai-language sources have the author's name in Thai script in brackets, in the form it is given in the original work.

Transcription of Thai names as used by their owners does not consistently follow any given system. Therefore, in this thesis, the transcription used by an author is also used here, or if the name is only available in Thai script, the name has been transliterated by the present researcher following the Royal Thai Institute General System of Transcription (RTGS). Author names need to be given in both scripts since discrepant transliterations sometimes make it difficult to track down names in their original Thai script form, especially because commonly used transcription systems, including the RTGS, provide insufficient information to reliably reconstruct a Thai-script word from the transcribed word.

Publication Year

Publication years are quoted according to the Western calendar (C.E.: Common Era). In Thai-language publications, however, the Buddhist calendar is used (B.E.: Buddhist Era). To help find Thai-language references, their publication years are also given in Buddhist years in the reference section (for example: 2003/2546).

Titles of Publications and Other Cited Works

If an English version of a title of a Thai-language work is offered in the original work, this English title is here reported first in English (regardless of possible grammatical or spelling errors in the original), followed by the Thai title in brackets. If no English title is given in the original work, the Thai title is given first, followed by the present author's English translation of the title in square brackets.

APPENDIX III: SAMPLE INTERVIEW SCHEDULE

โครงการวิจัยหัวข้อ "Counseling with sexual minority clients in Thailand – Voices of Service users and service providers": ประเด็นที่จะถามผู้ปฏิบัติงาน

- ลักษณะของหน่วยงานที่ทำงานอยู่ รูปแบบบริการและลักษณะของผู้รับบริการ

- ประสบการณ์ในการให้บริการกับผู้รับบริการที่เป็นชายรักชาย / หญิงรักหญิง / สาวประเภทสอง (มีมากน้อยแค่ไหนในแต่ละกลุ่ม)

- ประเด็นและปัญหาที่พบว่าผู้รับบริการในกลุ่มที่ศึกษามีบ่อย (มีอะไรบ้าง มีลักษณะอย่างไร)

- แนวทางการให้ความช่วยเหลือที่ใช้ในประเด็นที่พบในกลุ่มที่ศึกษา

- ความสำคัญของความรู้เฉพาะด้านและทัศนคติ ในการให้บริการกับผู้รับบริการในกลุ่มที่ศึกษา (สำคัญแค่ไหน ควรมีความรู้ในเรื่องใดบ้าง ควรมีทัศนคติอย่างไรบ้าง)

- ทรัพยากรในการส่งเสริมการทำงานกับผู้รับบริการในกลุ่มที่ศึกษา (มีอะไรบ้าง เข้าถึงได้อย่างไร)

- หน่วยบริการพิเศษสำหรับผู้รับบริการในกลุ่มที่ศึกษา (ควรมีหรือไม่ เพราะอะไร ถ้าควร ควรมีลักษณะอย่างไร หน่วยงานใดที่ควรรับผิดชอบการก่อตั้งหน่วยบริการพิเศษ)

- การถูกตีตราของผู้รับบริการในด้านจิตวิทยาและจิตเวชศาสตร์ (เป็นปัญหามากน้อยแค่ไหน)

APPENDIX IV: SAMPLE CONSENT FORM

เอกสารฉบับนี้จัดทำขึ้นเพื่อขออนุญาตในการเก็บข้อมูลเพื่อทำวิทยานิพนธ์ในหัวข้อ "COUNSELING WITH SEXUAL MINORITY CLIENTS IN THAILAND – VOICES OF SERVICE USERS AND SERVICE PROVIDERS" โดย นาย Timo Tapani Ojanen ซึ่งเป็นนักศึกษาปริญญาโทคณะจิตวิทยา มหาวิทยาลัยอัสสัมชัญ วิทยาเขตหัวหมาก กรุงเทพ

เอกสารฉบับนี้ ขอรับรองว่าข้าพเจ้ายินยอมที่จะให้ความร่วมมือในการทำวิทยานิพนธ์ โดยมีเงื่อนไขดังต่อไปนี้

1) การวิจัยหัวข้อนี้ประกอบด้วยการสัมภาษณ์ผู้ให้บริการและผู้รับบริการในด้านจิตวิทยา/จิตเวชศาสตร์ และมีวัตถุประสงค์ในการสำรวจประสบการณ์ในการให้และรับบริการดังกล่าวโดยผู้รับบริการเป็นชายรักชาย หญิงรักหญิง หรือสาวประเภทสอง เพื่อเพิ่มความเชื่อมั่นของประชาชนในการใช้บริการที่มีอยู่ในปัจจุบัน และพัฒนาคุณภาพการบริการต่อไป ในการเก็บข้อมูลนี้คาดว่าใช้เวลาหกเดือนถึงหนึ่งปี

2) ผู้ให้สัมภาษณ์หรืออาสาสมัครให้ข้อมูลด้วยความสมัครใจ และมีอิสระที่จะปฏิเสธ หรือถอนตัว (ร่วมถึงข้อมูล) จากโครงการวิจัยเมื่อใดก็ได้ โดยไม่สูญเสียผลประโยชน์ใดๆ (ก่อนการวิจัยจะเสร็จสมบูรณ์)

3) ผู้ทำวิจัยจะไม่ระบุชื่อของผู้ให้สัมภาษณ์ ยกเว้นกรณีผู้ให้สัมภาษณ์ มีความประสงค์ที่จะระบุชื่อของตนเองในรายงานการวิจัย ผู้ทำวิจัยอาจจะขออนุญาติทราบชื่อของผู้ให้ข้อมูลเพื่อใช้ในเอกสารฉบับนี้เท่านั้น ทั้งนี้เพื่อให้สอดคล้องกับข้อบังคับและจรรยาบรรณของสมาคมจิตวิทยาอเมริกา พ.ศ. 2545 ซึ่งไม่มีการเปิดเผยข้อมูลส่วนตัวของผู้ให้สัมภาษณ์ ไม่มีการระบุชื่อหรือสถาบันในรายงานการวิจัย

4) การที่ผู้วิจัยจะตั้งคำถามในประเด็นที่ค่อนข้างส่วนตัว และละเอียดอ่อน อาจทำให้ผู้ให้สัมภาษณ์เกิดความระลึกถึงเหตุการณ์หรือปัญหาในอดีต ซึ่งอาจทำให้เกิดปฏิกิริยาหรืออาการทางจิตได้ ในกรณีเช่นนี้ผู้วิจัยจะแนะนำผู้ให้บริการที่อาจพึ่งพาได้ในการปรึกษาเกี่ยวกับประเด็นที่ทำให้เกิดอาการดังกล่าว

5) ในระหว่างการสัมภาษณ์จะมีการบันทึกเสียงสัมภาษณ์สดและเขียนบทสัมภาษณ์เป็นลายลักษณ์อักษร ก่อนผู้ทำวิจัยจะนำบทสัมภาษณ์ไปวิเคราะห์ ผู้ให้สัมภาษณ์สามารถตรวจสอบบทสัมภาษณ์ได้ การบันทึกเสียงสัมภาษณ์สดและบทสัมภาษณ์จะเก็บในคอมพิวเตอร์โดยใช้รหัสผ่าน ส่วนเครื่องบันทึกข้อมูลจะนำไปเก็บในตู้นิรภัย ผู้ทำวิจัยจะอ้างอิงคำพูดของผู้ให้สัมภาษณ์จากบทสัมภาษณ์โดยไม่ระบุชื่อหรือรายละเอียดตัวบุคคลอื่นๆ

6) ผู้ร่วมการวิจัยสามารถติดต่อ ดร. ฮอลลี่ ดูแกน อาจารย์ที่ปรึกษา หรือ ดร. วรพจน์ รักธรรม คณบดีคณะจิตวิทยาเพื่อสอบถามรายละเอียดเพิ่มเติมหรือร้องเรียนข้อผิดพลาดเกี่ยวกับเรื่องการดำเนินการวิจัยได้

7) ภายหลังจากผลงานวิจัยเสร็จสมบูรณ์ผู้ให้ข้อมูลจะได้รับบทคัดย่อเกี่ยวกับผลการวิจัย

_____ _____ _____
(ลายมือชื่อของผู้ให้ข้อมูล)   (ชื่อ นามสกุลของผู้ให้ข้อมูล)   (ลงวันที่)

_____
(ลายมือชื่อของผู้วิจัย)

APPENDIX V: SAMPLE PARTICIPANT INFORMATION SHEET

เอกสารคำชี้แจงสำหรับอาสาสมัคร/ผู้ให้ข้อมูลในโครงการวิจัยเรื่อง "COUNSELING WITH SEXUAL MINORITY CLIENTS IN THAILAND - VOICES OF SERVICE USERS AND SERVICE PROVIDERS" (ฉบับที่ใช้ในการเก็บข้อมูลจากโรงพยาบาล [name omitted]**)**

โครงการงานวิจัยนี้มีชื่อว่า "Counseling with sexual minority clients in Thailand - Voices of service users and service providers" ซึ่งแปลเป็นภาษาไทยได้ว่า "การปรึกษาในประเทศไทยกับผู้รับบริการที่เป็นคนชนกลุ่มน้อยทางเพศ – เสียงจากผู้รับบริการและผู้ให้บริการ" เนื่องจากโครงการนี้เป็นส่วนหนึ่งของการศึกษาระดับปริญญาโทของนักศึกษามหาวิทยาลัยอัสสัมชัญ ซึ่งในฐานะเป็นมหาวิทยาลัยนานาชาติที่ใช้ภาษาอังกฤษเป็นสื่อกลางจึงมีชื่อโครงการเป็นภาษาอังกฤษ และวิทยานิพนธ์ที่จะรายงานผลการวิจัย จำต้องเขียนเป็นภาษาอังกฤษเช่นเดียวกัน

วัตถุประสงค์งานวิจัย
งานวิจัยชิ้นนี้มีวัตถุประสงค์ที่จะวิจัยประสบการณ์ ทัศนคติ และการประกอบสร้างวิธีคิดเกี่ยวกับประเด็นที่เกี่ยวโยงกับการให้บริการและรับบริการด้านจิตวิทยาและจิตเวชศาสตร์ (ในที่นี้เรียกว่าการปรึกษา) ในประเทศไทย เฉพาะกรณีที่ผู้รับบริการเป็นชายรักชาย หญิงรักหญิง หรือสาวประเภทสอง เพื่อเป็นข้อมูลสำหรับการพัฒนารูปแบบวิธีปฏิบัติด้านจิตวิทยาและจิตเวชศาสตร์ที่ใช้ในประเทศไทย ในกรณีให้บริการกับชายรักชาย หญิงรักหญิง หรือสาวประเภทสอง

รูปแบบการวิจัย
โครงการวิจัยนี้เป็นงานวิจัยเชิงคุณภาพเพื่อรวบรวมประสบการณ์ ทัศนคติ และตัวอย่างการประกอบสร้างวิธีคิดในประเด็นที่ศึกษา โดยเปิดโอกาสให้ทั้งผู้ให้บริการและผู้รับบริการเล่าถึงประสบการณ์และประเด็นที่เกี่ยวข้องจากแง่มุมของตนเอง โดยผ่านการสัมภาษณ์เชิงลึก ซึ่งใช้เวลาประมาณ 1 ชั่วโมงต่อท่าน และมีการบันทึกเสียงด้วยคอมพิวเตอร์โน้ตบุ๊ค
          หลังจากที่ผู้วิจัยถอดบทสัมภาษณ์เป็นลายลักษณ์อักษรเสร็จแล้ว ผู้ให้ข้อมูลมีสิทธิ์ตรวจความถูกต้องของเอกสารถอดบทสัมภาษณ์ (หากต้องการ)

เครื่องมือที่ใช้
เนื่องจากงานวิจัยนี้เป็นงานวิจัยเชิงคุณภาพ จึงมีเครื่องมือเพียงน้อย ได้แก่ รายการคำถาม (ซึ่งจะมีการเลือกประยุกต์ใช้ตามลักษณะของผู้ให้สัมภาษณ์และจังหวะการพูดคุย) และคอมพิวเตอร์ โน้ตบุ๊คสำหรับการบันทึกเสียง และการถอดบทสัมภาษณ์

ขอบเขตงานวิจัย

เนื่องจากโครงการวิจัยนี้เป็นส่วนหนึ่งของการศึกษาระดับปริญญาโทของผู้วิจัย โครงการจึงมี
ทรัพยากรและเวลาอย่างจำกัด คาดว่าจะเก็บข้อมูลเสร็จสมบูรณ์ภายในเดือนมิถุนายน พ.ศ.
2552 และสัมภาษณ์ผู้ให้ข้อมูลไม่เกิน 20 คน (ในเขตกรุงเทพฯ และปริมณฑล) โดยจำนวนผู้ให้
ข้อมูลที่ขอสัมภาษณ์ในโรงพยาบาล [name omitted] คือ นักจิตวิทยา 1 คนและจิตแพทย์ 1 คน
โครงการวิจัยนี้เน้นความหลากหลายของประสบการณ์และวิธีคิดของผู้เกี่ยวข้อง จึงมีการ
สัมภาษณ์ทั้งผู้รับบริการ (ชายรักชาย หญิงรักหญิง สาวประเภทสอง) และผู้ให้บริการ
(นักจิตวิทยาและจิตแพทย์) แต่ในกรณีโรงพยาบาล [name omitted]จะสัมภาษณ์เฉพาะผู้
ให้บริการเท่านั้น

ประเด็นทางจริยธรรม

เนื่องจากประเด็นที่ศึกษามีความละเอียดอ่อน (ทั้งในแง่มุมของการดำเนินชีวิตส่วนตัวและการ
ประกอบอาชีพของผู้ให้สัมภาษณ์) จึงมีความจำเป็นอย่างยิ่งที่การสัมภาษณ์จะอาศัยรูปแบบที่
แสดงความเคารพต่อผู้ให้สัมภาษณ์ และข้อมูลที่ได้รวบรวมมาจะไม่มีการเปิดเผยชื่อหรือสถาบัน
ของผู้ให้ข้อมูล มีการกล่าวถึงลักษณะของผู้ให้ข้อมูลเฉพาะในลักษณะทั่วไปที่ไม่สามารถใช้ใน
การค้นหาชื่อผู้ให้ข้อมูลได้ (เช่น "จิตแพทย์ ชาย อายุ 46 ปี รพ. รัฐ" หรือ "ผู้รับบริการชายรัก
ชาย อายุ 35 ปี")

ผู้วิจัยจะขอลายเซ็นของผู้ให้ข้อมูลเพื่อเป็นหลักฐานที่ผู้ให้ข้อมูลยินยอมที่จะให้ข้อมูล
โดยใช้เอกสารที่ระบุสิทธิของผู้ให้ข้อมูล (ใบยินยอมให้ข้อมูล / informed consent form)

คอมพิวเตอร์ เครื่องบันทึกข้อมูล และเอกสารยินยอมให้ข้อมูล จะถูกเก็บในตู้นิรภัย
หลังจากใช้งานเสร็จแล้วในแต่ละครั้ง

ทั้งนี้ผู้ให้สัมภาษณ์มีสิทธิ์ที่จะยุติการให้สัมภาษณ์และการถอนข้อมูลของตนออกจาก
ฐานข้อมูลในขณะที่งานวิจัยยังไม่เสร็จสมบูรณ์ และผู้ให้สัมภาษณ์มีสิทธิ์ตรวจสอบความถูกต้อง
ของเอกสารบทสัมภาษณ์ เมื่อถอดออกมาเป็นลายลักษณ์อักษรเรียบร้อยแล้ว และผู้ให้
สัมภาษณ์จะได้รับบทคัดย่อของรายงานวิจัยเมื่อโครงการเสร็จสมบูรณ์แล้ว

การที่ผู้วิจัยจะตั้งคำถามในประเด็นที่ค่อนข้างส่วนตัว และละเอียดอ่อน อาจทำให้ผู้ให้
สัมภาษณ์เกิดความระลึกถึงเหตุการณ์หรือปัญหาในอดีต ซึ่งอาจทำให้เกิดปฏิกิริยาหรืออาการ
ทางจิตได้ ในกรณีเช่นนี้ผู้วิจัยจะแนะนำผู้ให้บริการที่อาจพึ่งพาได้ในการปรึกษาเกี่ยวกับประเด็น
ที่ทำให้เกิดอาการดังกล่าว

ในกรณีผู้ให้ข้อมูลต้องการสอบถามรายละเอียดเพิ่มเติมหรือร้องเรียนข้อผิดพลาด
เกี่ยวกับเรื่องการดำเนินการวิจัยได้ ผู้ให้ข้อมูลสามารถติดต่อผู้วิจัย (โทร. 089-1648319)
อาจารณ์ที่ปรึกษาของผู้วิจัย (ดร. ฮอลลี่ ดูแกน โทร. 02-300 4543 ต่อ 3636 หรือคณบดีคณะ
จิตวิทยา ดร. วรพจน์ รักธรรม (02-300 4543 ต่อ 3636) หรือคณะกรรมการพิจารณาจริยธรรม
การวิจัย [name omitted]

ผู้ดำเนินโครงการ

ผู้ดำเนินโครงการชื่อ Timo Tapani Ojanen เป็นนักศึกษาระดับปริญญาโท สาขาจิตวิทยา ใน
มหาวิทยาลัยอัสสัมชัญ กรุงเทพฯ เป็นคนสัญชาติฟินแลนด์ เกิดเมื่อวันที่ 14 พฤษภาคม ค.ศ
1979 ในประเทศฟินแลนด์ จบการศึกษาระดับปริญญาตรีจาก University of East London
ประเทศอังกฤษ ในด้านจิตวิทยาทั่วไป และได้อาศัยอยู่ในประเทศไทยตั้งแต่ปี พ.ศ. 2548 โดย
ได้รับการศึกษาภาษาไทยตั้งแต่ปี พ.ศ. 2546 จนสามารถใช้ภาษาไทยได้อย่างเพียงพอสำหรับ
การดำเนินงานวิจัยในโครงการนี้

      ผู้ดำเนินโครงการได้รับทุนการศึกษาจากองค์กรบำนาญประชาชนแห่งประเทศฟินแลนด์
(Kansaneläkelaitos) เพื่อการศึกษาในมหาวิทยาลัยอัสสัมชัญ แต่ทุนการศึกษาทุนนี้ไม่มีความ
เกี่ยวเนื่องกับงานวิจัยชิ้นนี้โดยตรงเนื่องจากเป็นทุนการศึกษาประเภทเบี้ยเลี้ยงหรือเงินสวัสดิการ
(ไม่ใช่เงินทุนเพื่อทำการวิจัย) โครงการวิจัยชิ้นนี้จึงใช้เพียงเงินทุนส่วนตัวของผู้วิจัยเท่านั้น

APPENDIX VI: SAMPLE PERMISSION REQUEST LETTER

มหาวิทยาลัยอัสสัมชัญ
ASSUMPTION UNIVERSITY

6 สิงหาคม 2551

เรื่อง   ขอความร่วมมือในการเก็บข้อมูลเพื่อทำวิทยานิพนธ์
เรียน   ท่านผู้อำนวยการโรงพยาบาล

เนื่องด้วย Mr. Timo Tapani Ojanen นักศึกษาปริญญาโท สาขาจิตวิทยาการให้คำปรึกษา คณะ จิตวิทยา มหาวิทยาลัยอัสสัมชัญ รหัส 482-9402 ซึ่งในขณะนี้กำลังทำวิทยานิพนธ์ในหัวข้อ "COUNSELING WITH SEXUAL MINORITY CLIENTS IN THAILAND - VOICES OF SERVICE USERS AND SERVICE PROVIDERS" โดยมีวัตถุประสงค์เพื่อศึกษาแนวทางปฏิบัติเกี่ยวกับการให้บริการของนักจิตวิทยา จิตแพทย์ และผู้ เข้ารับบริการของกลุ่มชายรักชาย หญิงรักหญิง และสาวประเภทสอง

ในการเก็บข้อมูลเพื่อศึกษาวิจัยครั้งนี้จะใช้วิธีการสัมภาษณ์กลุ่มตัวอย่างซึ่งมีสัญชาติไทย   อาศัย อยู่ในเขตกรุงเทพมหานครและปริมณฑล ประกอบด้วยนักจิตวิทยา 1 ท่าน จิตแพทย์ 1 ท่าน และผู้เข้ารับบริการ 3 ท่านโดยจะเริ่มการเก็บข้อมูลตั้งแต่เดือนกรกฎาคม พ.ศ. 2551 และสิ้นสุดในเดือนมีนาคม พ.ศ. 2552 ทั้งนี้ข้อมูล ที่ได้รับทั้งหมดจะไม่มีการเปิดเผยหรือเผยแพร่แต่อย่างใด

เพื่อประโยชน์ต่อการศึกษาวิจัยอันจะก่อให้เกิดประโยชน์ต่อผู้เข้ารับบริการด้านจิตวิทยาและจิต เวชศาสตร์ มหาวิทยาลัยอัสสัมชัญ จึงหวังเป็นอย่างยิ่งในความกรุณาของท่านและขอขอบคุณมา ณ โอกาสนี้

ขอแสดงความนับถือ

(ดร. วรพจน์ รักธรรม)
คณบดี
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APPENDIX VII: TRANSCRIBER CONFIDENTIALITY GUARANTEE FORM

เอกสารยืนยันเงื่อนไขของการจดบันทึกเสียงจากแหล่งข้อมูลแบบอิเล็กทรอนิกส์

ด้วยลายมือชื่อของข้าพเจ้า ข้าพเจ้ายืนยันว่า

1) ข้าพเจ้ายินยอมรับไฟล์บันทึกเสียงจากนาย Timo Tapani Ojanen (ผู้วิจัย) เพื่อจดบันทึกเป็นเอกสารลายลักษณ์อักษรตามบทสัมภาษณ์ในไฟล์บันทึกเสียง รหัสผู้ให้สัมภาษณ์ _____

2) ข้าพเจ้าเข้าใจเป็นอย่างดีว่าข้อมูลที่ปรากฏในไฟล์บันทึกเสียงและไฟล์ที่ข้าพเจ้าจดบันทึกตามไฟล์บันทึกเสียงคือข้อมูลที่ห้ามเผยแพร่ต่อบุคคล หน่วยงาน องค์กร หรือนิติบุคคลใดๆ ไม่ว่าในรูปแบบใดๆ

3) ข้าพเจ้าสัญญาว่าจะไม่เผยแพร่ข้อมูลจากการจดบันทึกไฟล์บันทึกเสียงต่อบุคคล หน่วยงาน องค์กร หรือ นิติบุคคลใดๆ ไม่ว่าในรูปแบบใดๆ มิฉะนั้นจะถือว่าข้าพเจ้ากระทำผิดสัญญาที่ระบุในเอกสารฉบับนี้และข้าพเจ้าต้องรับผิดชอบการกระทำของข้าพเจ้าตามที่กฎหมายในประเทศไทยกำหนด

ลายมือชื่อ   วันที่และสถานที่

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