

Experiences of disclosing sexual orientation in healthcare consultations

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

This study focused on experiences of healthcare consultations for lesbian, gay and bisexual (LGB) people, particularly their disclosure of sexual orientation. LGB people are more at risk of certain healthcare conditions than heterosexual people; disclosing sexual orientation allows healthcare professionals to consider the most appropriate approach to treat the concerns of LGB people. Previous literature suggests that lesbians use techniques to assess the safety of a healthcare environment before choosing to disclose their sexual orientation (Hitchcock & Wilson, 1992). No previous study to the author's knowledge has explored British LGB people's experiences of healthcare consultations. Six students between the ages of 18 and 25 from the University of Leeds were interviewed using semi-structured interviews. These were analysed using interpretative phenomenological analysis (IPA). Individual analyses are presented followed by a group analysis detailing master themes occurring across participants. These are: somewhere safe to be free, discomfort defining sexual orientation, searching for acceptance and anticipation and fear of punishment. A process of participants' approach to healthcare consultations and disclosure of sexual orientation is presented. A combination of participants' search for acceptance of self and anticipation and fear of punishment seemed to shape their expectations of professionals and how they approached consultations. The interactions between professionals and participants then appeared to influence the participants' perception of the consultations and their approach future consultations. Clinical implications of this study include: increased training for healthcare professionals around lesbian, gay and bisexual issues, so that they are better able to pick up cues from LGB patients, making it easier for them to disclose sexual orientation if they so choose. By providing the conditions for LGB people to disclose, healthcare professionals are helping to ensure that their LGB patients receive the most appropriate healthcare.

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TERMS, ABBREVIATIONS AND CONVENTIONS

BPS: British Psychological Society

LGB: Lesbian, gay and bisexual

LGBT: Lesbian, gay, bisexual and transgender

Straight: A heterosexual person

Coming out: Disclosing sexual orientation; often used to describe the first time a person tells another that they are lesbian, gay or bisexual, but can be used to refer to disclosing sexual orientation to any person who is unaware of it.

Polari: Dialect often used by gay people when homosexuality was illegal. Many words are commonly used in English now, such as 'camp'.

Camp: From the Polari slang meaning, 'exaggerate or make stand out', used to describe flamboyant gay men.

Butch: From the Polari slang meaning 'masculine'. Often used to describe more masculine looking lesbian women.

IPA: Interpretative Phenomenological Analysis

GP: General Practitioner

MSM: Men who have sex with men, but who do not necessary identify as bisexual or gay.

Background

I felt it was important to explain why I had chosen to pursue this thesis, and why I feel it is a topic that needs exploration. Experiences of healthcare affect us all. Several years ago I believed that although healthcare needs differed, we could all expect similar levels of respect and care from healthcare professionals, even if we had all seen one doctor who we didn't like that much and wouldn't return to. When I came out, I hadn't even considered the impact it might have on my healthcare. So when several years ago I was humiliated by a GP asking about how lesbians have sex, and writing down 'homosexual' across my computerised notes, his diary and on a scan request, as well as refusing to examine me, I was dismayed. When I complained the surgery did not take me seriously. When I kept complaining, they asked if I'd like to sort out my personal differences with the GP. I said no. I suggested that the surgery take part in LGBT awareness training. They responded, saying it was their policy not to action any changes until a complaint was closed. I refused to close my complaint and left the surgery. Initially I understood this experience as an isolated incident with an old-fashioned GP and a surgery with poor LGBT awareness. However, since then I have repeatedly had to justify to doctors why I do not believe I am pregnant and have been laughed at when I took my partner with me to appointments. Equally, both myself and my partner have received excellent healthcare where we have felt respected, included in the discussion, and our relationship has not been an issue. But I don't remember those times before I go to a doctor. When we spoke to friends about these experiences we realised they were not uncommon. We had friends who never reported any instances of discrimination. Then there were those who described professionals being rude and asking intrusive questions. People allowing others to assume they were straight seemed to be the norm. These anecdotes made me more aware of how stressful the day-to-day events sometimes are when you are gay. I began to wonder if other gay people had experiences like mine, and wondered what the differences were between the really good experiences and the really bad ones which make you not want to go back. These were the ideas which sparked this thesis.

CHAPTER 1: INTRODUCTION

Lesbian, gay and bisexual (LGB) people have arguably never been as visible in Britain as today. The Civil Partnership Act (2004) allowed couples to formalise their relationships and enjoy similar rights as married couples and the Equality Act (UK Government Equalities Office, 2010) made it illegal to discriminate against someone on the basis of their sexual orientation. However, homophobic attacks still litter the headlines (BBC News, 2009). In this chapter I will present the context of LGB people in Britain, including a brief history of how LGB people have been viewed in Britain and issues which are specific to the LGB community such as coming out. I will then discuss healthcare consultations, specific healthcare needs of LGB people, how they access healthcare and disclosure of sexual orientation in these consultations.

Section 1: Lesbian, Gay and Bisexual People in Britain: The Context

Epidemiology

There are no accurate statistics showing the number of LGB people in Britain, the national census (Office for National Statistics, 2011) asked about civil partnerships for the first time, but like the previous census (Office for National Statistics, 2001) did not include a question on sexual orientation. Estimates of the numbers of LGB people in the UK do exist. In 2000 the national survey of sexual attitudes and lifestyles estimated that between 2.6 and 8.4 % of men were gay or bisexual in the UK (NATSAL, 2000). For women the estimate was between 2.6 and 9.7%. This study surveyed people between the ages of 16 and 74. For the current research, I was interested in LGB people between the ages of 18 and 25. Unfortunately the NATSAL survey is unable to provide estimates of the numbers of LGB people in this age range, but does estimate the number of LGB young people between the ages of 16 and 24 as between 2.6 and 4.3% for men and between 4.5 and 9.1% for women (NATSAL, 2000).

These estimates are useful as a guide, but are limited by the definition of LGB. Not everyone defines LGB in the same way; some use sexual behaviour as an indicator, some use sexual attraction, others measure by self-identification. How a person identifies may change over time, so the number of people self-identifying as LGB may not be constant. There are also people who do not ascribe to labels as they do not feel they accurately describe their sexuality. Same-sex behaviour can be associated with negative connotations, so is likely to be under-reported due to fear of stigma. Britain has varied in the way it has viewed the LGB community. The remainder of

this section provides highlights of the last fifty years of British history showing how attitudes to the LGBT community have developed.

How the British view LGBT people: Past and present

Before 27th July 1967 homosexuality between males in Britain was illegal, although no mention was made of sex between two females. On this day the law changed for England and Wales; two males over the age of 21 could consent to gay sex in private (UK Government, 1967). The age of consent was higher than for heterosexual couples and the definition of 'in private' meant rooms not publicly accessible, meaning that a locked hotel room still constituted a public space; therefore prosecutions against gay men continued. Sex between females was omitted in the law, although LGBT activities, including sex between women, were sometimes viewed as inappropriate (Jivani, 1997; PCS Proud, 2007).

There was variation across the UK for some time. In 1980, Scotland legalised homosexuality (UK Government, 1980). Northern Ireland followed in 1982, fifteen years after England and Wales, after previous attempts to change the law had been thwarted by public campaigns. These changes did not mean that LGBT people in Britain had equality, merely that they did not risk prosecution in the same way. Sexual behaviour between LGBT people was still kept secret, for fear of prosecution. In 1987 a case occurred where sexual behaviour between gay men led to prosecution. The police found a video during a raid, depicting gay men involved in sadomasochistic activities. Believing the video showed a man being killed, a murder investigation began. The investigation found no murder had occurred and all men had consented to the activities. Despite their consent, all the men were prosecuted on assault charges. They appealed, but their convictions were upheld at both the Court of Appeal and the House of Lords. Although sadomasochistic activities are not solely restricted to gay men, this case highlights the offence it caused to the police and the general public. It is unclear if the same result would have been reached if heterosexual couples had been engaged in similar activities (PCS Proud, 2007).

In 1988 Section 28 of the Local Government Act made it illegal for any government body to "intentionally promote homosexuality or publish material with the intention of promoting homosexuality" (UK Government, 1988). Without clear definition of 'promotion' confusion ensued. Teachers struggled with whether they could teach about gay issues, or use texts written by gay people; councils feared prosecution for funding LGBT helplines. No prosecutions ensued, but section 28 had a huge impact on the LGBT community, leaving them feeling marginalised. The LGBT

community responded by forming the Stonewall charity, which now acts as an advisory body on government policies (Jivani, 1997; PCS Proud, 2007; Stonewall, 2011).

The British public have not always welcomed the LGB community, particularly celebrities. In 1988, Justin Fashanu, considered the world's first professional footballer to come out, took his own life (The Justin Campaign, 2011). Fashanu had played for several UK clubs, and was seen as a rising star. When manager Brian Clough heard of his sexual orientation he allegedly suspended him, escorting him from the football ground. Fashanu moved to the USA to continue his career managing a junior team. During this time a seventeen year old claimed Fashanu had sexually assaulted him. Fashanu was questioned by police and returned to England. He took his life days later. The police reported no intention of arresting him based on the allegations. The British tabloids reacted to Fashanu's coming out and commented on his homosexuality throughout his career; this quote from Justin Fashanu illustrates this.

"I have been greatly criticised for coming out in the tabloid press. Many people thought I just did it for the money, I suppose they have never stopped to consider that my world is based around Sun and Daily Star readers; the football world has that kind of mentality, it doesn't read the Sunday Times. I genuinely thought that if I came out in the worst newspapers and remained strong and positive about being gay, there would be nothing more that they could say. Of course, I was wrong and lost three years of my career." Justin Fashanu-football (Hunt, 2006, p.9).

In 2000 things started to change for British LGB people. The Scottish version of Section 28 was repealed, the ban on LGB people serving in the armed forces was lifted and the age of consent for gay men was reduced to 16. In 2003 the English version of Section 28 was repealed (UK Government, 2003b) and the Employment Equality Regulations prevented discrimination in the workplace, including that based on sexual orientation (UK Government, 2003a). This should have provided LGB people protection in the workplace, but loopholes meant that an employer could refuse to employ someone based on their sexual orientation if they proved they had a legitimate reason to do so. There was fear that religious organisations could use these loopholes to prevent LGB people working for them. This legislation did not cover goods and services, meaning that an LGB person could be refused services due to their sexual orientation, even though this would be illegal if the refusal was based on race or religion. In 2003 the Sexual Offences Act (UK Government, 2003c) was also met with mixed feelings in the LGB community. Although the Act aimed to correct many of the previous injustices to gay men, making many activities only an offence if a third party complained, one clause made sex in public toilets illegal, regardless of gender or sexual orientation. This created a situation where people could have sex outside a public toilet as long as no third parties complained, but once inside the toilet, potentially away from

others, sex was illegal. Whether or not this was the intention, this legislation was understood by the LGB community as an attack on gay men, and what is a common practice between them (PCS Proud).

Despite this legislation, in 2004 the UK made equality for LGB people a little closer with the Civil Partnerships Act (UK Government, 2004). This allows same sex couples to enjoy the same rights in law as married heterosexual couples. This has been followed by the Equality Act 2010 (UK Government Equalities Office, 2010) preventing discrimination on the basis of race, religion, sexual orientation and for people with health conditions and disabilities. It aims to promote a more equal society, providing protection from discrimination for all. Legislation is beginning to recognise the rights of LGB people in Britain, but it is difficult to know how much the attitude behind the legislation has filtered into society, including the health service. The speed and scale of change in legislation in recent years suggests that research around how this works in practice would be relevant, and could help guide implementations of future legislation. In the next section I will discuss existing literature on healthcare consultations.

Section 2: Healthcare Consultations

We all consult healthcare professionals at times. These consultations and the interactions which occur within them affect what care we, as patients, access and how this progresses. In the past the patient has been viewed as taking a passive role in consultations (DoH, 2001; May et al., 2004), however this view has been replaced by an increased focus on patient participation and collaborative working between patient and professional (Ariss, 2009; DoH, 2001).

Doctor-Patient Interactions

Successful interactions in healthcare consultations depend on the balance between patients' needs to explain their difficulties and the professionals' needs to glean information, diagnose or suggest solutions (Perloff, Bonder, Ray, Ray, & Siminoff, 2006). The success of these interactions is important as they are associated with improved patient outcomes and fewer complaints against the professional (Kenny et al., 2010; Stewart, 1995; Street, Howard, & Haidet, 2007; Tamblyn et al., 2007). Doctor-patient consultations have been shown to comprise five aspects: opening and agenda setting, history taking, physical examination, counselling and closing (Weingarten et al., 2010). During these interactions doctors have been shown to dominate the conversations (Weingarten, et al., 2010). This may be due to a need, in their roles, to provide information or ask questions. Although patients value explanations from healthcare professionals (Beiseker &

Beiseker, 1990; Hagihara & Tarumi, 2006), patients have been found to not always understand all the information they are given during these interactions, which may affect how they manage their healthcare condition (Kokanovic & Manderson, 2007).

Shared decision making

Patient participation has been shown to vary across clinical situation and cross-culturally (Schouten, Meeuwesen, Tromp, & Harmsen, 2007; Street, Gordon, Ward, Krupat, & Kravitz, 2005). Patients who actively participate in consultations increase shared decision making about their care and show greater self-efficacy in asking questions; these have been associated with higher patient satisfaction (Carlsen & Aakvik, 2006; Kidd, Marteau, Robinson, Ukoumunne, & Tydeman, 2004). One of the ways patients can begin their participation is by providing cues. Cues are indicators of something the patient wants to discuss, they can include information about symptoms or history of a problem, or any issues of importance for the patient (Zimmerman, Del Piccolo, & Finset, 2007). They are more likely to occur if the patient displays emotional distress (Del Piccolo, Mazzi, Dunn, Sandri, & Zimmermann, 2007). Cues are often not only missed by professionals but discouraged by behaviors displayed by professionals such as information giving or asking questions unrelated to the cue (Zimmerman, et al., 2007). Training can increase the likelihood of professionals responding appropriately to cues, increasing patient satisfaction with the consultation (Fallowfield et al., 2002; Jenkins & Fallowfield, 2002; Zimmerman, et al., 2007). Without training, the professional may miss cues, leaving the patient feeling dismissed, and this could lead to a sense of conflict within the consultation.

Conflicts

Conflicts can occur in doctor-patient interactions. One study of GP consultations found that conflicts occurred in 40 per cent of doctor-patient interactions (Weingarten, et al., 2010), which seems to imply that patient outcomes may be put at risk by these interactions. These conflicts have been found to be most likely to be concerned with differing beliefs about the patients' illness and expectations for treatment (Vanderford, Stein, Sheeler, & Skochelak, 2001).

LGB people's specific healthcare needs are influenced by their identity development, societal values associated with minority sexual orientation and responses from others to their sexual orientation. In the next section I will discuss how people discover their sexual orientation and the potential impact of this period on their developmental trajectory.

Section 3: Identity Development and Emerging Adulthood

People who identify as LGB can experience a different trajectory of psychosocial development to their heterosexual counterparts. Literature on identity development will first be discussed followed by sexual orientation development and emerging adulthood.

How do people realise they are lesbian, gay or bisexual?

Erikson's theory on ego identity development suggested that humans develop through interactions with the environment around them. He identified eight psycho-social stages of development, where individuals would have predictable developmental challenges to negotiate. When challenges are negotiated successfully, the person develops, and is better able to face more complex challenges in life. If the person is not challenged or fails to master a challenge, Erikson believed that this would negatively impact on an individual's cognitions and sense of self-worth and believed that this was from where mental health problems arose (Cote & Levine, 2002). In adolescence, Erikson believed that the main conflict was identity versus role confusion and saw this as the time when identity development was most important. To manage this stage successfully an individual would develop an identity by trying out different possibilities, finding what suited them and making commitments in three areas: personal relationships, work and ideology. This time of trying out possibilities was viewed as a psychosocial moratorium, where adult responsibilities are put on hold until this development is achieved (Arnett, 2004a). Marcia (1966) further investigated Erikson's stages of development and described adolescents as falling into one of four categories of identity status.

- Diffusion – No exploration of identity
- Foreclosed – an identity is assumed without questioning
- Moratorium – exploration of identity has begun, but is not resolved.
- Achieved – exploration is complete and an identity is committed to.

These models have been used as a basis for research into specific areas of identity development such as sexual orientation development.

Identity development for LGB people

Several models of identity development for LGB people have been proposed (Cass, 1979; Coleman, 1981b; Rotheram-Borus & Fernandez, 1995; Rotheram-Borus & Langabeer, 2001; Troiden, 1988). All are in line with Erikson's model of development and comprise periods of awareness, identification, and comparison to others, exploration, confusion resulting in an

integration or commitment to a sexual orientation. A brief summary of all models will now be presented.

Cass (1979). Cass's model is probably the most cited model of sexual orientation development (Arnett, 2004a). It is considered the first to promote homosexuality as a positive part of identity. It suggests that development occurs as a way of maintaining interpersonal congruence; how a person's perception of self affects their behaviour and how these are perceived by others. Six stages of development are described; although these are not necessary linear and an individual may return to one or all stages throughout their lives. The stages are:

- Identity confusion – Questioning sexual orientation
- Identity comparison – Accepts the possibility of being gay and considers the implications
- Identity tolerance – Realises there are other people 'like them' and seeks out supportive society
- Identity acceptance – Individual adopts a positive perspective on their sexual orientation
- Identity pride – 'Coming out' often occurs as the individual finds pride in their orientation and immerses themselves in gay culture
- Identity synthesis – Integration of sexual orientation identity into the individual's sense of self

Cass's model was the first of its kind, but fails to consider factors outside of sexual orientation which may impact on a person's development, such as the impact of society and family perspectives on minority sexual orientation. It also assumes that a person is able to consider being gay as a positive attribute, which may not be possible for some (Davies & Neal, 2003).

Troiden (1988) Troiden's model consisted of four stages described below:

- Sensitisation – the individual has experiences, in the future these will serve as validating their sexual orientation
- Identity confusion – the individual questions their own sexual orientation
- Identity assumption – the individual begins to move towards identifying themselves as having a particular sexual orientation
- Commitment – The individual commits to a certain sexual orientation and discloses this to others.

Coleman (1981) Five stages of development are described by Coleman. He believed that sexual orientation was part of sex-role identity and set by the age of three. Whilst growing up, the individual learns of their family's views on minority sexual orientation and although they may be unaware of their orientation, they may have fears of not fitting in. He postulated that the result of these fears would be behavioural problems or psychosomatic illnesses. The five stages are:

- Pre-coming out – individual unaware of own sexual orientation, but feels 'different'
- Coming out- individual first considers that they might be gay and seeks validation from others
- Exploration- Individual begins mixing with other gay people
- First relationships- Begins to have first same-sex relationships, these are characterised as 'adolescent relationships' and may be short term
- Identity integration- Integration between public and private selves, relationships now take on 'adult' qualities of openness and mutual trust

Coleman's model makes assumptions about the types of relationships held by LGB people and suggests that gay men can become stuck in a cycle of exploration and brief relationships. This perspective may be viewed differently now, with more acceptance for people who choose to have different types of relationship (including short term or one-off encounters), rather than a stereotyped expectation that all people should conform to long-lasting relationships (Davies & Neal, 2003).

Rotheram-Borus and Fernandez (1995). This model described four dimensions of sexual orientation development:

- Recognition (of self as gay)
- Exploration (of sexual orientation through the gay community)
- Disclosure (of sexual orientation to others)
- Comfort (with one's sexual orientation)

Rotheram-Borus and Langabeer (2001) This model of sexual orientation identity development states that adolescents in the process of forming an identity of sexual orientation could be classified into four categories (Rotheram-Borus & Langabeer, 2001).

- Diffuse – there is a lack of focus on sexual orientation.
- Foreclosed – a sexual orientation is assumed without questioning.
- Moratorium – exploration of sexual identity has begun, but is not resolved.

- Achieved – exploration is complete and a sexual orientation is committed to.

Many adolescents fall into the 'foreclosed' category as they never feel the need to explore their sexual orientation. Society assumes heterosexuality and so it has been suggested that only when an adolescent's attractions are not solely heterosexual do they begin to consider other orientations (Glover, et al., 2009; Rotheram-Borus & Langabeer, 2001). This assumption of heterosexuality by society could prove a challenge to those adolescents who try to explore their sexuality (Striepe & Tolman, 2003). It has been suggested that sexual minority youth may experience an identity development process, where they are always aware of themselves being different to the 'norm' (Striepe & Tolman, 2003). Striepe and Tolman (2003) describe the different developmental challenges of being part of a sexual minority in this way:

"Few adolescents worry that they will have to sit down with their parents and confide what they have come to realise about their sexual identity, that is to say "Mom and Dad, I'm straight". In our society, heterosexuality is assumed from birth. It is when adolescents show signs of being different than the heterosexual norm that sexual identity becomes a visible aspect of development (p.523)."

Emerging adulthood

These models all suggest that LGB people go through a process of sexual orientation development, however it has been suggested that within a generation the process of identity development has changed across people of all sexual orientations. Many young people are now delaying traditionally 'adult' tasks of marriage, having children and having a career, instead they are extending the period of exploration, trying new things and testing out 'adult' tasks of independence such as living away from home. This period has come to be termed emerging adulthood (Arnett, 2004b). Five features combine to comprise emerging adulthood: identity exploration, instability, self-focus, feeling in-between and possibilities. These will be discussed in turn.

Identity exploration. Emerging adulthood is characterised by the exploration of possibilities. This exploration could be in love, work and deciding what they want from their lives. It can occur to a greater extent than in adolescence as emerging adults are more likely to be living away from home and have the freedom to explore without having to explain themselves to a parent or guardian (Arnett, 2004b).

Instability. The extent of exploration in this period can lead to rapid changes and great instability. These changes can occur again in all areas of life, but most obviously in their residencies. Emerging adults may move out from home, they may go to university or move repeatedly within a short period of time and may not know where they will be living from year to

year. This instability is often in contrast to their earlier development where they may have been living in the same area for many years. This contrast may make instability more noticeable for the emerging adult (Arnett, 2004b).

Self-focus. Being away from the restrictions associated with adolescence allows emerging adults to be self-focussed in a way they have not been before. This allows them to explore what they need to in order to find their way in life. It is through this self-focus that emerging adults acquire the skills of daily living and ability to face future changes in their lives; becoming more independent and self-sufficient (Arnett, 2004b)

Feeling in-between. The sense of being in-between results from this time of exploration between adolescence and adulthood. They have finished school but do not feel ready for the tasks of adulthood such as forming long-term relationships and having children. In the USA emerging adults were asked about when they would know they were adults, they responded that adulthood would be reached when they could accept responsibility for themselves, make independent decisions and be financially independent. Until these milestones have been reached, those questioned felt they would remain feeling in-between (Arnett, 2004b).

Possibilities. Emerging adults are at a point in life when almost everything can change, although this can result in instability, it offers possibilities and opportunities. Their choices at this time could open up possibilities for careers, travel and meeting new people. This can particularly be beneficial if the individual's adolescence was difficult, as they have the opportunity to distance themselves from those people or places which they found troubling (Arnett, 2004b). This period of development is associated with life changes, exploration and instability as is adolescence. Young LGB people face added pressures of society during this period of development and exploration. Through this exploration they may disclose their sexual orientation for the first time and in turn the issue of disclosure to different people, including healthcare professionals arises for the first time. How these experiences of disclosure are navigated could influence how LGB people approach future disclosures. In the next section I will discuss issues which are specific to young LGB people and how they impact on healthcare.

Section 4: Societal issues specific to young LGB people

Societal issues, including the pressures of being in a minority contribute to young people's sexual orientation identity development and coming out. This section will discuss these in turn and their

impact on LGB people's health and therefore their likelihood of coming into contact with healthcare professionals.

How do LGB people tell other people about their sexual orientation?

Coming out

Once a young person believes that they have a minority sexual orientation they may start to consider how they will tell others about this. Self-disclosure is the "act of revealing personal information about oneself to another" (Collins & Miller, 1994; Griffith & Hebl, 2002) p.457). Griffith and Hebl (2002) state that disclosures often include information which is surprising or stigmatising, citing sexual orientation as a common disclosure. Coming out can be viewed as a central aspect of identity development, the point at which a young person is sure enough of their own identity to disclose it to another. People's experiences of coming out may differ enormously; some may be fearful or anxious of others' reactions to their disclosure (Griffith & Hebl, 2002) or view it as a freeing experience, allowing them to be themselves. There may be positive and negative consequences to disclosure (D'Augelli, Hershberger, & Pilkington, 1998) so that for example, Griffith and Hebl (2002) report disclosure at work and perception of supportive colleagues as being related to higher job satisfaction and lower job anxiety.

Evidence suggests that there are sex differences in the experience of coming out. Savin-Williams and Ream (2003) found that sons feared the reactions of their parents more than did daughters. Parents' reactions tended to be supportive or slightly negative. Young people reported that the relationships with their parents improved or stayed the same after their disclosure. Interestingly, sons and daughters both made choices about who to disclose to first, based on the closeness of their relationship. In this study, more mothers than fathers were disclosed to. Reasons for disclosure to fathers varied; sons were more likely to disclose due to wanting support from their father, daughters were more likely to disclose "to get it over with." (p.436).

Society's impact

There are many aspects of a person's life which will impact on their experience of coming out. The environment in which a young LGB person grows up will have an effect on how they experience sexual orientation development. In Britain, LGB people are beginning to be afforded the same rights as heterosexual people, although as discussed, there is a history of discrimination. The changes in law around LGB issues suggest that attitudes to LGB people are changing; however, much of the research in this area was published before these changes and is now dated. Past

research suggests that some groups of people were more likely to hold negative attitudes towards LGB people than others (Ellis, Kitzinger, & Wilkinson, 2003). These groups were men (Chng & Moore, 1991; D'Augelli, 1989; Klamen, Grossman, & Kopacz, 1999; Seltzer, 1992), people who held religious views (Berkman & Zinberg, 1997; Seltzer, 1992), ethnic minorities and people with few openly LGB acquaintances (Klamen, et al., 1999). In one study, middle adolescents (ages 14-16) were also more likely to exhibit negative attitudes towards LGB peers, than either younger or older adolescents, although holding negative beliefs about homosexuality did not differ dependent on age, suggesting that at an age where young people may be discovering their sexuality, they are most likely to experience negative attitudes from their peers (Horn, 2006).

Minority stress

Although things are changing for the better, Britain's past history of discrimination towards LGB people is ever-present. The term 'insidious trauma' has been used to describe the ongoing traumatic experience of living with oppression (Root, 1992). Belonging to a minority group brings different stresses than belonging to the majority (Meyer, 2003). Some of these 'minority stresses' relevant to a young adult LGB population (in line with the sample for this study) will now be discussed.

Homophobic bullying. According to Stonewall, bullying around sexual orientation is increasing in the UK (Stonewall, 2007). As part of their report on gay and lesbian school pupils, Stonewall asked gay and lesbian people over the age of 50 about their school experiences. 27% reported homophobic bullying when they were at school. In comparison, in 2007, 65% of gay and lesbian pupils reported homophobic bullying and this rose to 75% in faith schools. Section 28, which made it illegal to promote homosexuality, was only repealed in 2003, meaning that many schools were in a quandary about homophobic bullying (Stonewall, 2007). Since the repeal, it appears schools have been slow to combat homophobic bullying, resulting in many young people being educated in an environment where their sexual orientation is not only seen as minority, but as a legitimate target for bullies. Despite contact with Stonewall, the specific authors of this research are unknown and the study are not written in a way which allows for understanding or critique of their method, thus the results from this study must be considered with caution.

Heteronormativity. Heteronormativity is defined as a pervasive bias exhibited by society where individuals and institutions are expected to behave as if everyone were heterosexual (Queer Theory, 2010). LGB people are seen in the British media, with high profile gay men seen

regularly in the newspapers, although lesbians seem to have less of a presence. Additionally, those LGB people in the media have often had to formally come out to the public. Announcing their sexual orientation seems to be a requirement of continuing their career in the public eye. In advertising, almost all adverts are aimed at the heterosexual market. Companies want to appeal to the majority; the lack of an LGB presence in advertising means that young LGB people can grow up without seeing role models who are relevant to them.

LGB individuals' experiences of living within a heteronormative society have been found to resemble racism and sexism (Swim, Pearson, & Johnston, 2008). Swim et al (2008) recruited 69 LGB participants (34 male and 35 female) through university and community organisations, LGB computer listservs and through friends and family of the LGB community. Participants completed daily diaries detailing the most impactful hassles of the day. These were then analysed using grounded theory. They reported that verbally abusive comments, poor service and expressions of stereotypes were experienced by individuals living with racism, sexism and heteronormativity; however the fear of discrimination was only found to be constant in the LGB participants (Swim, et al., 2008). They also noted that the number of heteronormative events experienced by the LGB participants did not differ depending on how open or 'out' they were. The nature of the events did change though, as those who were less 'out' reported fewer experiences of poor service, but higher levels of fear of discrimination (Swim, et al., 2008). Discrimination due to sexual orientation may only account for part of the minority stress experienced by individuals. Lesbians, bisexual women or people with a disability are also at risk from 'dual stigmatising' as they may be discriminated against due to their gender or disability as well as their sexual orientation (Meyer, 1995). If the lesbian or bisexual woman is also from an ethnic minority group this adds to the stigmatisation and increases the impact of any discrimination (Balsam, 2002).

Critique

In the field of issues specific to LGB people and in the following section around access to healthcare, much of the literature originates from the USA (Eliason, Dibble, & DeJoseph, 2010). Although Britain and the USA have much in common, we have different histories and legislation, thus the context of being LGB in each country is different. Evidence from the USA (and other countries) may have similarities with LGB people's experiences in Britain, but similarity should not be assumed. Many of the studies are also small scale, thus limiting their generalisability not only to the population they were selected from, but also to the wider LGB community.

Effects of exposure to bullying on LGB people's health

The constant fear of discrimination felt by LGB people in Swim et al's, (2008) study suggests that this fear will extend into the healthcare setting. Unless LGB people are reassured in some way that they are safe from discrimination (perhaps by gay friendly posters or materials in the waiting areas) then it seems likely that this fear would impact on their use of services and their ability to disclose their sexual orientation, thus making it less likely that they would be able to receive appropriate healthcare. As mentioned, homophobic bullying is prevalent in UK schools; the effects of bullying can result in increased likelihood of contact with healthcare services which will now be discussed.

Literature on the effects of homophobic bullying focuses mainly on young people and adolescents. Evidence suggests high levels of mental health difficulties, maladaptive coping skills, substance use, suicidal ideation and attempts among young LGB people (D'Augelli & Hershberger, 1993; Grennan & Woodhams, 2007; Hampel, Manhal, & Hayer, 2009; Kulkin, Chauvin, & Percle, 2000; Lebson, 1998; McAndrew & Warne, 2004; Nabuoka, Ronning & Handegard, 2009; Rivers, 2004; Taylor, 2008), increasing the likelihood of young LGB people coming into contact with professionals. Homophobic bullying has also been shown to have a negative effect on LGB adults' mental health (Gemzøe Mikkelsen & Einarsen, 2002; Moreno-Jiménez, Rodríguez-Muñoz, Pastor, Sanz-Vergel, & Garrosa, 2009).

Bullying and other stresses associated with belonging to a minority sexual orientation occur through the LGB person's life; stresses specific to minority sexual orientation have been significantly associated with emotional distress, which has been associated with lower self-esteem and further mental health problems (Grossman & Kerner, 1998; T. Hughes, Haas, Razzano, Cassidy, & Matthews, 2000; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Meyer, 2003; Rosario, Rotheram-Borus, & Reid, 1996). By affecting a person's mental health, the exposure to minority stress also increases the likelihood that the individual will come into contact with healthcare professionals. Young LGB people are not only at risk of coming into contact with healthcare professionals through the impact of societal pressures, there are also certain healthcare conditions which are more common in LGB people these will now be discussed.

Section 5: LGB Healthcare: Access and Consultations

Some studies suggest that LGB people may present with different mental health concerns than heterosexual people (Cochran & Mays, 2009; Volpp, 2010; Westefeld, Maples, Buford, & Taylor,

2001). Additionally, LGB people have physical health concerns and risk factors for health conditions which are different to the heterosexual population (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006). In order for healthcare professionals to accurately assess an individual's risk of these conditions, they must know their sexual orientation. These conditions will now be discussed. This will be followed by a discussion of how LGB people are accessing healthcare and their experiences in doing so, as well as the perspectives of the healthcare professionals who treat LGB people.

Healthcare specific to LGB populations

In many areas, LGB people have similar healthcare needs to the general population. However there is literature to suggest that LGB people also have healthcare needs which are specific to them and that they are more at risk of developing certain conditions due a series of risk factors and behaviours (Sandfort, et al., 2006).

Sexual behaviour risk factors

There are healthcare risks related to specific sexual behaviours. For example, men who have sex with men (MSM), even without identifying as gay or bisexual, may be at a higher risk of hepatitis A and B (Cotter et al., 2003; Mackellar, et al., 2001). Since 1996 the Centers for Disease Control and Prevention (CDC) in the United States have recommended immunisation against both Hepatitis A and B as a preventative measure in gay men, with similar recommendations now adopted in the UK (NHS Choices, 2010a).

HIV. HIV has long been associated with gay men even though the major sources of infections are through heterosexual sexual activity and intravenous drug use (WHO, 2010). Gay men are at risk of contracting HIV through sexual behaviour and through sexual risk taking behaviours such as bare-backing. Bare-backing is intentional unsafe anal sex with a person known to be HIV positive (Halkitis, Parsons, & Wilton, 2003). Anal sex also increases the risk of developing anal cancers (Goldstone, 1999). This can occur due to the increase in risk of anal dysplasia resulting from exposure to multiple strains of the human papillomavirus (HPV) (Goldstone, 1999). Evidence also suggests that HIV can be contracted through female to female sexual contact, so that lesbians are still at risk, but they may take fewer precautions (Chu, Conti, Schable, & Diaz, 1994; White, 1997).

Substance use

Several studies suggest that substance use, including smoking and drinking alcohol, is greater in an LGB population than in a population of demographically similar heterosexual people (Boyd,

McCabe, & d'Arcy, 2003; Crothers, Haller, Benton, & Haag, 2008; Koh, 2000; Sandfort, et al., 2006; Tang et al., 2004; Valanis et al., 2000; Welch, Howden-Chapman, & Collings, 1998)¹, although there are also studies which found no difference between LGB people and heterosexual people (Hughes, Johnson, & Matthews, 2008; Sandfort, et al., 2006)² If LGB people are smoking and drinking alcohol to a greater extent than heterosexual people, they are at increased risk of certain cancers, heart and respiratory problems (NHS, 2010), thus increasing the likelihood of contact with healthcare professionals.

Cancer risks

There is some evidence that suggests that LGB people may be at higher risk of developing certain cancers. As mentioned there is evidence to suggest that a higher proportion of LGB people may smoke than the heterosexual population, thus increasing their risk of developing cancers associated with smoking (Hughes, et al., 2008; Ortiz-Hernández, Gómez Tello, & Valdés, 2009; Tang, et al., 2004). Some evidence suggests that lesbians may be at a higher risk of breast cancer than heterosexual women, due to a combination of risk factors including obesity (Aaron et al., 2001; Cochran et al., 2001); higher reported rates of nulliparity (Bradford & Ryan, 1988; Powers, Bowen, & White, 2001) and alcohol intake (Roberts, Tarmina, Grindel, Patsdaughter, & DeMarco, 2005). Smoking, low socio-economic status and HIV have also been identified as increasing the risk of developing cervical cancer (Price, Easton, Telljohann, & Wallace, 1996).

Mental health

There are no figures available for the number of LGB people who access mental health services in the UK. However some studies suggest that LGB people may be more at risk of developing mental health problems (Cochran & Mays, 2009; Volpp, 2010; Westefeld, Maples, Buford, & Taylor, 2001) and so may use services at a higher rate than would be expected from the percentage of LGB people in the population. One systematic review found that LGB people are more at risk of mental disorder, suicidal ideation, substance misuse and deliberate self harm than heterosexual people (King et al., 2008). The evidence also suggests that LGB clients present to mental health services with a higher prevalence of adjustment disorders and lower levels of anxiety disorders than heterosexual clients (Berg, Mimiage, & Safren, 2008; Rogers, Emanuel, & Bradford, 2003) as well as high levels of suicidal ideation (Remafedi, French, Story, Resnick, & Blum, 1998). There is, however, disagreement within the literature, as some studies found that having a minority sexual

¹ Crowthers et. al. 2008 found that lesbians had higher past use than heterosexuals but less current use.

² Sandfort et al. 2006 found that LGB people consumed more alcohol than heterosexual people but found no differences in smoking behaviour.

orientation is associated with an increased risk for anxiety and substance use disorders (Cochran & Mays, 2009). If there is evidence suggesting a high proportion of LGB people use substances, then we must also consider the risk factors associated with substance misuse and its correlates with mental health (Macleod et al., 2004; Moore et al., 2007; Zammit et al., 2008). The evidence base also suggests a higher rate of referral to mental health services among lesbians than heterosexual women (Berg, et al., 2008; Rogers, Emanuel, & Bradford, 2002). The reasons behind this rate of referral are unclear, but it may indicate higher levels of distress in lesbians or a greater desire to seek help (Berg, et al., 2008; Rogers, et al., 2002).

Self-harm and suicide are also thought to be more prevalent in LGB populations. The reported rates of suicide for LGB people vary, although studies tend to agree that they are at greater risk of suicide than heterosexual people (King, et al., 2008; Schneider, Farberow, & Kruks, 1989). Young LGB people may be particularly at risk of self-harming behaviour. Many studies are from the USA, but they report that between 20 and 42% of LGB adolescents attempt suicide (Remafedi, et al., 1998). Suicidal gestures of LGB adolescents have also been found to be more serious and more likely to be fatal than attempts made by heterosexual adolescents (Remafedi, et al., 1998). These findings may be considered alongside the previous discussion on minority stress and the numbers of LGB adolescents reporting homophobic bullying in UK schools.

Accessing healthcare: LGB perspectives

Evidence suggests that LGB people may be at risk of certain health conditions, but they may not be accessing the most appropriate healthcare. I will discuss the evidence regarding LGB people's access to healthcare and their experiences of this. I will then discuss healthcare professionals' experiences of working with LGB people.

Accessing healthcare

There is some evidence which suggests that LGB people may not be accessing services in the same way as heterosexual people. For example, men who have sex with men are recommended to receive vaccinations as they are at greater risk of developing hepatitis B (NHS Choices, 2010). Research from the USA, where gay men are also entitled to this vaccine, suggests that the vaccine is not being taken up at the rates that were expected (MacKellar et al., 2001). Vaccinations against Hepatitis A are also not well utilised by MSM (Cotter et al., 2003). It is unclear whether similar results are found in the UK.

Research into lesbian women's uptake of healthcare suggests similar lower rates of use. For example, lesbians are less likely to undergo mammograms or perform regular breast examination (Koh, 2000; Polena, Gillispie, Lederman, & O'Hara, 1994; Powers, et al., 2001; Price, et al., 1996; Trippett & Bain, 1992). They are also less likely to receive smear tests (Aaron, et al., 2001; Powers, et al., 2001; Price, et al., 1996), although it is unclear whether this is due to lesbians not being offered some forms of screening or lesbian women themselves perceiving they are less at risk and therefore not taking up the offer of screening (Fish & Antony, 2005). Fish and Antony (2005), found similar uptake for smear tests in their UK national survey. Of 1066 lesbian women surveyed, 85% (n= 901) had attended for a smear test and 15% (n = 165) had never had one. 128 of the women surveyed were eligible through age for a smear test but had never been called for screening. In total, 27% of the women surveyed had either never attended for screening or were no longer attending when called for regular tests. When asked about their experiences of smear tests, 44% reported having a bad experience and 46% reported having a good one. Bad experiences included repeated questioning by healthcare professionals about contraception and sex. If the woman chose to disclose her sexual orientation, there were examples of women being told that they were wasting nurses' time by coming for screening when they were not at risk. Good experiences included staff who listened and took time to respond to questions or explain procedures (Fish & Anthony, 2005).

Research which looked at gay men's utilisation of healthcare in the UK showed that 78% of gay men surveyed had visited their GP in the past year. This meant that gay men were slightly more likely to have visited their GP in the past year than heterosexual men (32% compared with 28%). Of those surveyed, 27% reported that their GP was aware of their sexual orientation. When these results were combined with the results about the quality of service they received, it appears that gay men were less likely to disclose their sexual orientation to GP practices where they felt the service was poor and more likely to disclose to practices which were perceived as offering a high quality service (Keogh & Henderson, 2004). These studies are both surveys, and although surveys are able to ask the same questions to a large number of people, they are unlikely to access detailed accounts of the person's experience of a situation and the meaning they ascribe to an event. They are also unlikely to be able to identify the cause of the lack of uptake of healthcare, whether it is on the part of the individual or the healthcare service. Decisions about accessing healthcare appear complex; however, these surveys suggest that variation exists in LGB people's experiences of healthcare.

Healthcare consultations with LGB people

Literature suggests that attitudes of healthcare professionals towards LGB people vary. Healthcare professionals are in a difficult position. They must uphold the NHS constitution and provide high quality healthcare for all whilst responding to the needs of individual patients (NHS Choices, 2010b). Unfortunately if professionals are unaware of a patient's sexual orientation or assume heterosexuality, they may not consider the health conditions that LGB patients may be more vulnerable to, and so may not refer to the most appropriate services (Bonvicini & Perlin, 2002).

Studies that have investigated healthcare professionals position in relation to working with LGB people have found varying results. Much of the evidence base in this area originated from the USA, with a different healthcare system and system of consultations, however this literature can be considered with those caveats in mind, given that there is no equivalent evidence base in the UK.

In a study conducted in the Washington DC area of the United States, East and Rayess (1998) surveyed 60 Paediatricians about working with LGB patients. In the USA paediatricians are a person's family doctor until they reach adulthood. The study found that 22% of paediatricians assumed patients were heterosexual unless otherwise specified and 68% did not include questions about sexual orientation in history taking. 41% of Paediatricians also assumed that all gay men who disclosed their sexual orientation were HIV positive until proven otherwise. When presented with true or false questions, 27% thought that it was false that one third of LGB adolescents attempt suicide (East & Rayess, 1998) despite research which suggested otherwise (Remafedi, et al., 1998). Initially it may appear that the Paediatricians in this study were avoiding discussion of sexual orientation because of their beliefs; 90% had reservations about approaching the subject of sexual orientation, 35% of these did not know how to ask the questions and 33% felt they did not know enough about LGB youths' healthcare needs (East & Rayess, 1998). This was a small study of Paediatricians, conducted 13 years ago in the USA and the results may not be representative of all healthcare professionals, but it does raise questions about the training that healthcare professionals receive and whether they feel prepared to ask the questions in order to be able to address the healthcare needs of LGB people.

As the British public's view of LGB people is changing, perhaps due to recent equality legislations (UK Government, 2004; UK Government Equalities Office, 2010), attitudes of healthcare

professionals towards LGB people are also becoming more positive (Kilgore, Sideman, Amin, Baca, & Bohanske, 2005; Mathews, Booth, Turner, & Kessler, 1986; McDermott & Stadler, 1988; D. M. Smith & Mathews, 2007). There are still mental health professionals who would undertake work to try and change a person's sexual orientation (Bartlett, Smith, & King, 2009), which suggests that training in LGB issues is still needed. Other healthcare professionals have felt that further training would improve their work with LGB people, including psychologists (Jones, 2000; Murphy, Rawlings, & Howe, 2002). Training healthcare professionals about the needs of LGB people has been found to improve students' knowledge and confidence for working with LGB people (McGarry, Clarke, Cyr, & Landau, 2002). It appears that the amount of training on LGB issues varies between training courses for healthcare professionals, with some receiving none at all (Amato & Morton, 2002; lasenza, 1989; McNair, 2003; Peel, 2009; Sherry, Whilde, & Patton, 2005), suggesting that some healthcare professionals may not be able to meet the needs of an LGB population due to lack of training. This is supported by research showing that LGB people are more likely to disclose if they feel that their healthcare professional is 'gay-friendly', comfortable talking about gay issues and respects their confidentiality (Allen, Glicker, Beahc, & Naylor, 1998; Fitzpatrick et al., 1994; Klitzman & Greenberg, 2002). Although healthcare professionals' behaviour will affect whether LGB people disclose sexual orientation, the decision to disclose remains theirs alone. In the next section I will discuss the particular issues around disclosure of sexual orientation in healthcare consultations.

Critique

Much of the research into LGB people and healthcare originates from outside of the UK, mainly in the USA. Therefore the studies relate to different healthcare systems, both public and private where patients may have more or less choice over the healthcare they receive than in the UK. The people who take part in LGB research must also be considered. In order to take part in LGB research, people are likely to identify with one of these groups, which means that anyone who considers themselves label-free, or who are questioning their sexual orientation and so do not identify with these labels, may not be represented in research. This means a bias will exist in research and it may not be generalisable to all people who have a minority sexual orientation. Recruitment for some studies also occurs through LGBT groups, meaning that people who do not attend will not have the chance to take part. These potential biases should be borne in mind when considering all literature reviewed here.

Section 6: Disclosing sexual orientation in healthcare consultations

Much of the literature around disclosure in healthcare consultations is concerned with the disclosure of HIV serostatus. When a person has HIV, they may have to disclose this during healthcare consultations; this can occur alongside disclosure of sexual orientation, although this is not always the case. Studies have found that disclosure of HIV is linked to regret, fear and stigma as well as homophobia (Bairan et al., 2007; Klitzman & Bayer, 2003; Serovich, Grafsky, & Reed, 2010). There are few studies which address disclosure of sexual orientation in healthcare consultations not associated with HIV status. The only one which specifically investigates this area is twenty years old: Hitchcock and Wilson (1992) interviewed 33 lesbians about the conditions in a healthcare consultation where they had made a decision about whether to disclose sexual orientation. This was a qualitative study, using grounded theory to understand the process of disclosure in those situations. They described the decision making process used by the women as personal risking. Personal risking consisted of two phases, anticipatory and interactional. During the anticipatory phase, the women used cognitive strategies to assess whether disclosure was safe, including imagining scenarios and gathering information about the healthcare professional. The interactional phase began with the women gathering more information about the safety of the environment with regards to disclosure, including scanning waiting rooms for posters or other cues which could suggest whether it is safe to disclose. The combination of the anticipatory phase and interaction phase determined whether disclosure occurred (Hitchcock & Wilson, 1992).

Rationale for the study

There appears to be a dearth of literature in the area of LGB people's experiences of healthcare in general (Eliaison, et al., 2010; Harcourt, 2006) and specifically in the UK. There are also no studies to the author's knowledge since Hitchcock and Wilson which use qualitative methods to examine LGB people's experiences of disclosing sexual orientation in healthcare consultations and the sense they make of these experiences. Moreover, equality legislation in Britain has changed dramatically since 1992. As there is a limited evidence base, much of the literature has been published before the effects of these changes have been noticed in the literature. Thus literature may always be a step behind LGB people's current experiences. For example the civil partnership legislation was passed in 2004, this has led to high profile LGB people having civil partnerships and appearing in magazines, increasing the visibility of the LGB community and thus normalising same-sex relationships. Current 18 year olds would have been 11 years old when the legislation changed, meaning that they would go through their adolescence with a more visible LGB

community; although current 25 year olds would have been 18 years old when it was repealed, thus the LGB community may have been less visible during their adolescence.

Emerging adulthood appears to be a period of development where research is still needed, particularly outside of the USA (Arnett, 2004a, 2004b). Exploration is a key element of this developmental stage, suggesting that this may be a time when young LGB people are developing and disclosing their sense of their own sexual orientation. Growing up in a hetero-normative society exposes these young people to stresses associated with their minority sexual orientation and increases their likelihood of contact with healthcare services. As LGB people they may also be more at risk of certain healthcare conditions, which may require disclosure of sexual orientation to a healthcare professional for accurate diagnosis and treatment. Emerging adults are at a time of life where they are just beginning to access healthcare independently from their families; their ability to access appropriate healthcare at this time could affect their future use of services.

In order to provide a more up-to-date examination of LGB people's experiences of healthcare; this study aims to examine the healthcare experiences of LGB people, including disclosing sexual orientation in healthcare consultations by taking a qualitative approach which can incorporate the sense that LGB people make of these experiences. As experiences in emerging adulthood may affect future use of healthcare, this study will recruit emerging adults in order to examine their experiences of healthcare. Findings from this study could then be used to inform future research into LGB people's experiences of healthcare and disclosure of sexual orientation, which may in turn impact on the training of healthcare professionals and provision of healthcare to LGB people. The research questions for this study are listed below.

Research questions

- What are young adult lesbian, gay and bisexual people's experiences of healthcare consultations?
- What are young adult lesbian, gay and bisexual people's experiences of disclosing sexual orientation within healthcare consultations?
- What sense do they make of these experiences?

CHAPTER 2: METHOD

This chapter is divided into three sections. I will consider the theoretical methodology, the ethical considerations and the method.

Section 1: Theoretical Methodology

In this section I will discuss my own theoretical position, followed by the methodology I chose to use, alternative methodological approaches and methods of data generation.

Qualitative or Quantitative Methodology

Traditionally, quantitative research was viewed as the only truly scientific method. In recent years this has changed, with qualitative research becoming popular (Denzin & Lincoln, 1994), particularly in psychology and health sciences (Smith, Flowers, & Larkin, 2009). Quantitative research tends to focus on small numbers of variables, excluding and controlling for other variables which may contribute to the results. This approach can enable detailed understanding of the influence of specific variables, and although rigorous, this method can reduce the generalisability of such research, as people often do not present with only the variables tested. Qualitative research focuses on the more subjective area of people's lived experiences, their understanding of the world around them and the social processes they engage in (Mason, 2002). It allows examination of data in depth, whilst considering the context in which it occurs. It can provide a rich understanding of a concept by examining thoughts, intentions and meanings given to a particular object, event or behaviour. By taking in contextual information it can also illuminate new avenues of scientific enquiry as it allows the researcher to 'discover' phenomena which have not been previously investigated (Denzin & Lincoln, 1994; Mason, 2002). According to Mason (2002) qualitative research should focus on an 'intellectual puzzle' (Mason, 2002, p.13), it should not only produce explanations for the 'puzzle' but these should be generalisable in some way to a wider population than the individuals in the study.

This study's intellectual puzzle is why do young LGB people seem not to be accessing healthcare in the same way as their heterosexual peers? Moreover, how do we help healthcare professionals to offer consultations in a way in which young LGB people perceive as positive, and therefore increases the likelihood of them receiving appropriate care? These questions fit within a qualitative research paradigm, although different qualitative approaches and positions may be appropriate to use, the possibilities for this study will now be discussed.

Ontology and Epistemology

The stance that a researcher takes to knowledge affects the research by affecting what knowledge is sought, how it is gathered and how it is understood (Mason, 2002). There are several positions on knowledge which can be taken in research. These will now be discussed.

My approach to knowledge fits with the constructivist position. Constructivists hold the view that events or experiences are perceived in different ways by individuals and may be understood to have different meanings or significance in their lives. This position fits within a qualitative research paradigm and can allow the researcher to enter the participants' world and consider their reality, constructed through their experiences. Studies using this stance view the interaction between researcher and participants as key to eliciting the participants' constructions and therefore their understanding of the world. This position is quite different to the traditional positivist approaches which assume there is one true reality which is able to be uncovered. In positivist approaches experiments are often used to manipulate variables, confirming or refuting hypotheses (Denzin & Lincoln, 1994; Fossey, Harvey, McDermott, & Davidson, 2002; Harding, 2005). Although positivist approaches can be used in qualitative methodologies such as content analysis, Fossey et al (2002) suggest that they are not suited to understanding people's experiences or the meaning they attribute to them. Post-positivist approaches also consider that a reality exists, but focus on refuting hypotheses rather than understanding experience. Post-positivists also believe that humans are unable to truly understand the complexities of phenomena as our intellect is flawed.

The aims of this study suggest that it is important to consider the participants' lived experience of consultations and the sense they make of them; in order to do this a constructivist approach which assumes that each individual constructs reality for themselves was applied as oppose to a positivist or post-positivist stance which would be considered incompatible with such a research question.

Interpretative Phenomenological Analysis (IPA)

IPA is a qualitative methodology which has been developed for use in research concerned with a person's experience. Much of this research has been in the fields of Psychology, Counselling and other social and health sciences (Smith, et al., 2009). It has been chosen for this study as it offers a means of approaching data which can help understand a person's lived experience of a healthcare consultation and disclosing their sexual orientation. The interpretative element allows depth of understanding, taking the findings from concrete to more abstract concepts. Smith and his peers

developed this method and continue to publish work on the topic, with their most recent text offering the most comprehensive guide to IPA (Smith, et al., 2009). They were heavily influenced by the works of the philosophers Husserl and Heidegger as well as elements of hermeneutics and idiography. In this section I will discuss the origins of IPA, its approach to research, interpretation of data and why it has been chosen for this study. I will then consider other possible methods and discuss why they have not been used.

Origins of IPA

IPA's origins lie in philosophy, hermeneutics and idiography. The philosophical approach of phenomenology is concerned with experience. Although there are different approaches within Phenomenology, most Phenomenologists would agree that they are interested in what human experience is 'like', particularly those experiences that hold significance for us. Hermeneutics is concerned with the meaning that is attributed to an experience or event, and idiography in this context suggests a move from single cases to group analysis.

Phenomenology. Husserl, a philosopher, was particularly interested in how a person could understand their own experience in detail. He wanted to find a way of analysing experience in a way that allowed the essential elements of that experience to be exposed. He felt that if this was possible, those essential elements of an experience could transcend the individual's experience and be applied to others' experiences. He is known for his argument that we should 'go back to the things themselves' (Smith, et al., 2009, p.12). By this he meant the experiences or objects themselves. He believed that humans too readily 'fit' other experiences into that which is already known, categorizing them before they have been examined in their own right. In order to examine objects and experiences afresh, Husserl believed that a phenomenological approach must be taken, looking at our perception of an experience or object, rather than the experience or object in the abstract.

Hermeneutics. This is the theory of interpretation, originally aimed at providing a basis for interpreting biblical texts, but which developed into a philosophical approach for interpreting different types of documents and texts. Hermeneutics takes interest in the methods employed and the reasons behind the interpretation. One of the proponents of hermeneutics was Heidegger, who argued for collaboration with phenomenology. He noted that phenomenology was concerned with the appearance of an object or experience. It also encompassed the discourse about the object or experience, something which the phenomenologist must analyse to help the 'thing itself'

to emerge. Heidegger argued that it was this analysis which made phenomenology hermeneutic. However, Heidegger's perspective on interpretation differed from that of Husserl. He believed that a person's interpretation would always be based upon what he called the 'fore-conception', that their previous experiences would impact on how they interpret the present experience. This fore-conception could be detrimental to interpretation as the new experience should be the primary concern; however an understanding of the fore-conception should enable a greater understanding of the interpretation. Heidegger suggested that this process may sometimes occur from the experience, back to the fore-conception and not the other way around.

Smith et. al., (2009)'s perspective on fore-conceptions centred on the potential for researchers to be unaware of elements within their previous experiences which may be relevant to the interpretation until they notice having a reaction to the text (Smith et al., 2009). For example even if a participant's experiences appear quite different to those of the researcher, and take place in different settings or circumstances, the meaning they attribute to them may be similar to an experience of the researcher.

Features of IPA

IPA draws on these approaches, examining experience by going back to the 'thing itself', but looking for meaning and the discourse around the experience. It is an iterative process where the findings are truly grounded in the data. Part of this iterative process is the use of the hermeneutic circle. This is where the researcher considers the relationship between each part and the whole. Understanding each part depends on understanding the whole, but the whole cannot be understood without understanding the parts. An example would be the understanding of a whole sentence in comparison to the meaning of the individual words (Smith, et al., 2009). In the same way, an extract can be understood in a different way when considered in the context of the whole text and a single case can be understood as part of a group. IPA uses a double hermeneutic, where analysis includes not only the participants' sense making, but the researchers understanding of the participants' sense making. This is one of the features which made IPA seem most beneficial to use in this study, as my own understanding is unavoidably interlinked with the participants.

Interpretations in IPA are influenced by the researcher's own previous experiences and 'fore-conceptions' and considers these unavoidable. By taking a reflexive stance to the research process these 'fore-conceptions' can be identified as they become apparent, allowing the researcher to be aware of times when the 'thing itself' is evoking a fore-conception and equally when a fore-

conception is influencing interpretation. Each case is analysed individually, interpreting the individual's experience by drawing out themes which occur throughout the interview. When individual cases are analysed the researcher may look for themes which are common across participants, allowing them to see if there are similarities between the participants' experiences.

Data generation

Data generation in IPA can occur by using a number of methods such as interviews and focus groups. Focus groups, where participants are given specific questions or topics to discuss, are useful when the aim is to gather a range of opinions on a subject (Kvale & Brinkmann, 2009) but may not feel a safe place for participants to disclose difficult experiences. Interviews are considered a means in which to elicit participants' detailed accounts of experiences and allow questioning by the researcher to enhance the richness of the data (Smith, et al., 2009). An individual approach could also allow participants time and space to tell their story. Given the aims of understanding LGB peoples' experiences of healthcare consultations, interviews would seem to offer greater opportunities for rich, detailed accounts to be collected.

Interviews can take several forms; structured interviews were not considered suitable for this study. They involve each participant being asked the same questions and either choosing from provided responses, or answering freely. These interviews are useful if there is a large amount of research already in the area and there are several themes likely to arise, although by restricting the participants' answers to pre-determined topics, defined by the researcher, they limit the amount of new information that can be gathered and make it unlikely that a rich account of the participants' experiences would be gathered (Smith, et al., 2009). Semi-structured interviews are more often used in qualitative research. The interviews are based on pre-determined topics, however the participant is often able to speak freely, guiding the interview themselves, with little direction from the interviewer if they are talking about the pre-determined topics. The interview may look like a conversation about a particular topic, with the researcher taking their lead from the participant. This allows data to be gathered which may not have been previously considered by the researcher (Rubin & Rubin, 1995; Smith, et al., 2009).

Data analysis

Analysis in IPA can be viewed as a flexible process which encompasses the common processes of moving from the particular to the shared, from description to interpretation and the principle of a commitment to understanding the participant's perspective and meaning they make of their

experience (Smith, et al., 2009). Analysis is iterative and inductive; data is repeatedly returned to until themes emerge and take shape. This can start by line-by line coding, moving on to noticing themes within the codes first in a single case and then as a group. A structure of how themes relate to each other may also be produced (Denzin & Lincoln, 1994; Smith, et al., 2009). It is noted that there is scope for flexibility within this process, providing that all analysis is iterative, inductive and any findings are grounded in the data.

Other possible methods

Other methodologies use interviews and use an iterative process of analysis; other methodologies which may be been appropriate for this study will be detailed briefly and an explanation given as to why they were not chosen.

Grounded Theory. Grounded theory was developed as a way of producing a theory from a set of data. Its developers, sociologists Glaser and Strauss, were interested in how patterns of interaction could uncover underlying social processes. It uses a process called induction where data already collected can influence new ideas in future data collection. Data is analysed throughout the research process, with data collection continuing until saturation is reached. Although a popular method in psychological research (Willig, 2001) which can help understand individuals' experiences, IPA's combination of the phenomenological and hermeneutic approaches was considered better suited to this study.

Narrative Analysis. Narrative analysis is a method examining how an individual constructs their experiences through how they tell their story about it (Webster & Mertova, 2007). A story can capture large amounts of detail about an event whilst exposing thoughts, feelings and beliefs. How the teller positions themselves in the story can allude to power relationships and how they see themselves in relation to others. Narrative analysis seems best able to understand these experiences in relation to other events in an individual's life. This study sought to examine not only the story of an experience, but the meaning attributed to it, therefore IPA was felt more appropriate.

Discourse Analysis. Discourse analysis encompasses a range of methodologies focussed on the language used by participants. These can illuminate how an individual views themselves in relation to others, including elements of power. Some methodologies focus on the discursive resources available to the individual and how this influences their interpersonal style (Willig, 2001). Discourse analysis would allow investigation of the language used in consultations between LGB

people and professionals. However, the purpose of this study was to understand the experiences of individuals, so the meaning that they make of their experiences is more important than the language used to negotiate the consultation. Discourse analysis might be more suited to future research in this area, possibly using live data, although this assumes that the participant would know that their sexual orientation would need to be disclosed prior to a consultation. IPA's combination of the phenomenological and hermeneutic elements made it seem most appropriate for this study, but the different approaches discussed might all have been used to good effect.

Section 2: Ethical Considerations

This section will consider the ethical considerations in relation to this study. Ethical clearance for this study was granted by the University of Leeds joint ethics committee LIHS/LIGHT (appendix, G). The study was designed in adherence with the ethical guidelines provided by the University of Leeds and the British Psychological Society (BPS, 2010; University of Leeds, 2008). Consideration was given to ensure that participants who took part did so of their own free will. The study aimed to fully inform participants prior to consent by not only informing them of what they could expect, but also their right to withdraw at any time without giving a reason. The protection of participants' confidentiality was considered paramount and measures put in place to ensure this occurred. As participants and researcher did not know each other, the measures were taken to minimise risk associated with the personal safety of both parties. Due to the nature of the study, the interview had the potential to touch on sensitive issues for participants. Their well-being was considered of utmost importance and steps taken to manage this as best as possible. The study also included a small payment given to participants to cover their expenses in attending the interview, which had the potential to act as persuasion to participate, even though this was not the intention. The strategies taken to manage these issues will be detailed in the next section.

Section 3: Methodology Used in This Study

Design

This study aimed to explore the experiences of accessing healthcare and disclosing sexual orientation to healthcare professionals for lesbian, gay and bisexual people; therefore this study used a qualitative design, where semi-structured interviews were analysed using IPA as single cases and then as a whole.

Recruitment

Participants were recruited using posters around university (appendix A). These did not include any information about the amount of money which would be offered to cover the participants' expenses. This was hoped to minimise any chance that payment would act as a factor in a decision to participate, therefore participation was more likely to be due to their own volition. This acted as a safeguard for participants' wellbeing, as participation was entirely voluntary it was hoped that those who felt their experiences were too sensitive to discuss, would not volunteer. When a potential participant did contact me, I sent them an information sheet by email telling them more about the study, asking them to contact me if they were still willing to participate.

Materials

Prospective participants were provided with an information sheet detailing the reasons behind the study, their rights and how they would be able to participate and where they could seek support if necessary (appendix B). A brief checklist was used to ensure participants met the minimum criteria for participation (appendix B). These included the participant's number, self-identified sexual orientation, age, and if they were living away from home. If they met these criteria, participants were asked to sign a consent form, saying that they understood the purpose of the study and agreed to take part (appendix C). A topic guide to use during the interviews was developed which included questions about accessing healthcare and experiences of disclosing sexual orientation. Questions were designed to be open-ended, non-judgemental and exploratory, allowing the participant to answer as freely as possible, whilst gaining information about the detail of an experience before moving on to the meaning the participant attributed to it (appendix, D).

Personal safety

The advertisement for the study included a telephone number. This was a telephone provided by the university to ensure that the researcher's number remained unknown to participants. All interviews were arranged in the university, and participants were met by the library and escorted to the interview room. At least one member of staff knew the time, place and expected duration of the interview, and agreed to telephone if they had not heard by a pre-arranged time.

Management of distress

The interviews had the potential to involve recounting distressing experiences for the participants. They were provided with contact details for the Samaritans in the information sheet and reminded of this prior to the interview. During the interview I was aware of managing any potential distress

and used my clinical skills do this; noticing when a participant appeared in distress and helping to navigate them through that part of the interview, gathering rich data without pushing them outside of what they seemed to be able to manage.

Confidentiality

In order to protect their anonymity, participants were assigned a number and pseudonym. Interview recordings were labelled using this number to ensure confidentiality was maintained through the transcription process. Consent forms were kept in a locked filing cabinet separate from interview data. Checklists were filed separately to the consent forms, with the completed transcripts. Transcribers were recruited from the university staff and agreed to keep all data confidential (appendix E). Audio data was transferred using an encrypted memory stick, which was labelled using the number assigned to each participant so they could not be identified by the transcribers.

Participants

Ten participants contacted me for more information. One participant did not meet the criteria as they did not identify as lesbian, gay or bisexual and so was excluded from the study, one contacted me after recruitment had closed; and two contacted me for information, agreed to be interviewed and then did not respond to suggestions for interview dates. Those who agreed to participate were given another copy of the information sheet asked to sign a consent form before the interview began. Participants were interviewed for between 40 and 80 minutes. Interviews were recorded using a digital recording device. At the end of the interview participants were given £10 to cover their expenses.

Inclusion and exclusion criteria

IPA requires a homogenous sample to ensure that the research questions are meaningful to all participants (Smith, et al., 2009). For this study the main criterion was that the participants identified as lesbian, gay or bisexual. Changes in societal attitudes towards LGB people have occurred over time as have changes to the healthcare system in Britain. With this mind the population chosen was students in Leeds between the ages of 18 and 25, ensuring similar levels of education and age in the participants. It was decided that only participants who were living away from where they called home would be included. Although this would mean participants were likely to be from a wide range of places, it offered an opportunity to discuss healthcare that had occurred either in Leeds or somewhere else, giving the participant a choice about whether they

wanted to discuss an experience with a professional with whom they may have to have contact again.

Participants were eligible if they lived away from home to study (this requires registration with new medical services and increases the possibility of recent contact with health services) and if they had disclosed their sexual orientation to a healthcare professional. From a perspective of achieving a largely homogenous sample, there would be an argument for only sampling one gender's experiences. Lesbians, gay men and bisexual people have differing health concerns and potentially different experiences of disclosure. However with the dearth of literature in this area, there was no available evidence to suggest that their experiences of disclosure to healthcare professionals would differ and so men and women were included. People who identified as transgendered or intersex were not included in the study as their experiences of health services may differ from the experiences of LGB people. For example it has been reported that transgendered people are more likely to experience discrimination in general and that some healthcare services are unwilling to work with them (Lombardi, 2001). People known to the researcher were excluded from participation, to avoid them feeling coerced or having concerns about the confidentiality of their information. People who were not fluent in English were also excluded from the study. IPA relies on the language used in the interview to understand the sense that a person makes of their experience (Willig, 2001). Non-fluency in English analysis could have compromised analysis.

Participants: Summary

There were six participants in total. All were students of the University of Leeds and between 18 and 25 years old. They were all living away from where they called home and identified as being lesbian, gay or bisexual. All had seen a healthcare professional in the past year and disclosed their sexual orientation to a healthcare professional. Half the sample comprised foreign students; two originated from countries with less developed health care systems than the UK, the remaining participant originated from a country with a highly developed healthcare system.

Transcription

All transcribers were recruited from the University of Leeds staff and paid to transcribe for this study. All interviews were transcribed, the first by the researcher, the remainder were completed by transcribers. The transcribers signed a confidentiality agreement (appendix E) and agreed to

replace any identifiable data such as personal names or place names which occurred within the data with the words [name/place].

Analysis

IPA was used to analyse all six semi-structured interviews. Smith, Flowers and Larkin (2009) suggest that analysis should involve the researcher immersing themselves in the data; this can be achieved by reading and re-reading the transcripts and is aimed at focussing the researcher onto the participant. They suggest the researcher should then progress to initial noting of language use, descriptive comments and conceptual comments; thus helping the move from descriptive to more abstract ideas. Following this process the comments can be analysed, allowing themes to emerge. Once this has occurred, they recommend searching for links between the themes, allowing the researcher to try and understand how they fit together and allowing super-ordinate themes to develop. They remind the researcher that this stage in particular allows for creativity in the organisation of data. Only once these stages have been completed do they recommend moving to the next case.

As described, IPA allows the researcher freedom in how they approach analysis. Table 1 shows the stages of analysis completed in this study. Initially, each transcript was read whilst listening to the audio recording of the interview and then re-read, whilst initial thoughts were noted down in the margins of the transcript. Phrases or sentences were highlighted, initially coding for experience in general, such as 'worry', before coding specific experiences such as 'concern about getting appropriate treatment' and the participants' meaning making, e.g. 'she's not competent'. The decision about what information to code was taken based on data which included information about visiting healthcare services, disclosing sexual orientation, (whether to a healthcare professional or not), or experiences outside of healthcare which seemed to contribute to the participant's understanding of a healthcare experience. I used different colour sticky notes attached to the transcript so it was clear which were the participant's meaning making comments and which were mine. At this point I returned to listening to the audio recording, noting down my thoughts, in particular any contradictions or differences in the participant's account, making lists of these where they occurred. These notes and lists were then compared to the codes already created and any amendments were made (appendix G). I compiled a list of all codes for a transcript. I then went through the list systematically, grouping similar codes together, removing and re-naming any which seemed to refer to the same phenomena. These groups were then refined, forming larger clusters. Clusters were named to reflect the codes within them which

became the emergent themes. Any themes which appeared to group together were linked, allowing super-ordinate themes to emerge. Each case was analysed before group analysis began. Group analysis looked for shared experiences across participants. Transcripts of all participants were re-read, looking for similar experiences. Shared experiences were noted down and clustered together in a similar manner to the individual analyses. All themes extracted from individual analyses were spread out on paper. Similar themes were clustered and a name befitting them all created, forming the master themes. (appendix E).

Table 1: Stages of analysis, including group analysis

Stage	Description
1	Transcript read whilst listening to audio recording, corrected as required
2	Transcript read whilst noting down initial thoughts in the margins
3	Highlighting specific experiences and 'meaning-making' statements using colour-coding (pens and post-it notes): identifying non-verbal aspects of interview
4	Added comments on my experience of the interview and understanding of participant's account
5	Developed documents for initial clustering
6	Refining themes and sub-themes
11	Super-ordinate and sub-ordinate themes finalised and re-named if required to describe the theme accurately.
12	Repeated for each transcript before moving on to group analysis.
13	All transcripts re-read
14	All existing themes clustered
15	Clusters named to form master themes
16	All transcripts re-read to check whether the themes represent the data.

Conventions used

Quotes from participants are used to illustrate the themes found during analysis. All hesitation and repetitions of words have been removed and will be shown like so, [...]. This symbol will also be used to indicate when any text deemed unnecessary to illustrate the theme has been removed including non-functional words or phrases. This also includes data which may identify the participant e.g. a place name would be replaced by [place]. The following symbol consisting of three 'full-stops' was used to illustrate a continuation of text: ..., this usually occurred at the beginning of a quote.

Quality checks

There are standards which are suggested to improve the quality of qualitative research (Elliot, Fischer, & Rennie, 1999). These will be outlined alongside a description of the quality checks used in this study.

Owning one's perspective

By stating the perspective that a researcher approaches a study with, their theoretical orientation, personal views and assumptions can be presented at the start of the study, and their influence can be tracked through data collection, analysis and understanding. By disclosing their stance on the research topic, researchers allow others to understand why they might have understood their data in the manner they describe. In this study, a preamble has highlighted the reasons behind the research and much of what I bring to it. A statement on reflexivity will follow this section, and reflections on the process will be offered throughout analysis and discussion.

Situating the sample

The sample of participants should be detailed in a way that allows the reader to know some information about them relevant to the study. This could include demographic information but also information specific to the particular study. In the current study, descriptive information about the participants has been provided alongside more detailed pen-portraits which included information about disclosure of sexual orientation and any views the participants expressed which seemed relevant to the study.

Grounding in examples

Providing examples of findings is thought to help present the analytic process which occurred. It can help illustrate links the researcher has made between the data and the findings. In the current study all themes are illustrated with at least one quote from the data.

Providing credibility checks

Credibility checks can be employed by the researcher to help ensure that the analytic process is logical and consistent. These can include, returning to the participants in order to check understanding, use of other qualitative researchers to 'audit' or verify the analytic process, comparison with other qualitative viewpoints and, if relevant, triangulation with quantitative or external factors, such as recovery. In the current study, monthly meetings with my supervisor allowed discussion of the analysis at different stages. She received copies of the anonymised transcripts and we discussed coding as well as clustering codes into themes and super-ordinate

themes, allowing her to be aware of my thinking and challenge it, making me consider when my own perspective was influencing analysis.

I also attended the Qualitative Research Support Group (QRSG), a forum for clinical psychology trainees to discuss research. These were facilitated by staff and used for discussion, e.g. to exchange useful references, or ask others for help in troubleshooting a particular difficulty, such as recruitment. I used the group to help me reflect on my reactions to the interviews, and by talking to others I felt better able to know when my own experiences were affecting how I interpreted data. The topic guide was also piloted with a member of the qualitative research support group; comments about the interview were positive, including the move from general to specific experiences and concrete examples to meaning making.

Coherence

Findings should be presented in a coherent manner, understandable to the reader. Themes should fit together, telling a story. They may be illustrated with a diagram, showing the links between them if necessary and a narrative summary provided to further illustrate how the findings fit together. In the current study, each participant's themes are first presented in a table before being described. Data is illustrated using diagrams where it was felt to aid understanding.

Accomplishing general versus specific research tasks

When the study is suggesting that findings can be generalised outside of the sample, an appropriate number of participants should have been recruited. If the study aimed to understand only a specific experience, this experience should have been examined in as systematic a nature as possible. In the current study, the experience of disclosing sexual orientation in healthcare consultations is examined. Findings are considered to be relevant to emerging adults, from which the population was recruited, however the findings may have clinical implications for all healthcare consultations with LGB people, so may be considered by professionals. However the findings do not claim to be representative of any greater population than the participants involved.

Resonating with readers

The study should be written in a way which makes sense to reader; it should add to an understanding of a topic or experience and should be presented in a way which is easily readable. The current study has provided background information about LGB people in Britain, literature around the subject matter and detailed analysis of the participants' experiences.

Reflexivity

One of the criticisms of qualitative research is that the researcher's own assumptions and beliefs shape the findings of the study (Madill, Jordan, & Shirley, 2000). As IPA considers that the researcher's own position in relation to the study cannot be avoided, the practice of reflexivity allows this position to be considered throughout the research process (Elliot, et al., 1999; Oates, 2006). Reflexivity can be used to describe a multitude of practices, including reflecting on the act of reflection, a mainly introspective, personal experience. Reflexivity can also mean reflection which includes the socio-political context relevant to the experience and its impact on the subject matter. Thirdly, reflexivity can also be used as a term to describe the act of reflecting during an experience (Freshwater & Rolfe, 2001). Reflexivity in its different forms has been undertaken throughout this research process. In line with this, it is considered good practice to include a reflective statement, presenting one's own values, assumptions, and approach to research. This allows the reader to consider the context in which the researcher made their interpretations (Elliot, et al., 1999). I will therefore inform the reader of my own position in relation to sexual orientation and experiences of healthcare.

Fore-conception

As mentioned I identify as a lesbian, although I believe that sexual orientation is not necessarily fixed and may change over an individual's lifetime. When accessing healthcare I have been struck by the variety of responses when having to disclose my sexual orientation to a healthcare professional. These ranged from very positive to humiliating and I have been shocked by the ignorance I encountered at times. When I spoke to others about my experiences, they also reported variations in responses. They described NHS staff not understanding LGB issues and incidences of discrimination. I felt that if people I knew had had these experiences, then it was likely that others would have similar experiences.

I thought during this process that the participants would describe both positive and negative experiences. I expected to hear about the extremes of consultations, the very good and the very bad. I think I assumed that the average experience would not feel relevant enough to come and be interviewed about.

Dealing with fore-conceptions

As I expected to find experiences which were both very positive and very negative, I consciously devised the topic guide in an attempt not to influence the participants' responses. I was very concerned about coming across as having an 'axe to grind', which wasn't my intention; so I tried to use open-ended, non-directional questions, allowing the participant to lead the conversation as much as possible.

CHAPTER 3: ANALYSIS

This chapter presents the results of the study in three sections. First, there is a brief description of the participants, including details of their self-identified sexual orientation and healthcare consultations. Second the analysis for each individual participant is outlined, before presenting the group analysis showing the master themes which were found across participants. Further reflexivity is included at the end.

Section 1: Participants

Of the six participants, two were male, four were female; three identified as gay, one as lesbian and two as bisexual. One participant was in a relationship; three spoke of multiple partners or short term relationships and two were single (see table 2).

Table 2 Participants demographics

Pseudonym	Age	Self-Identified Sexual Orientation	Approximate interview duration (minutes)
Adam	20	Gay	40
Ben	21	Gay	50
Camilla	19	Gay	70
Danielle	22	Lesbian	60
Erica	19	Bisexual	50
Freya	19	Bisexual	40

I rated each specific healthcare consultation and disclosure of sexual orientation described during the interviews as positive, negative or neutral. When a participant expressed more positive than negative feelings about a consultation or professional, the consultation was rated as positive. If the expressions were more negative rather than positive, it was rated as negative. If the participant mentioned the consultation but did not use strongly positive or negative expressions, it was rated as neutral. Disclosures were rated separately to the consultations, but using the same criteria. For example, when Camilla disclosed during a sexual health consultation, she described it without using particularly positive or negative expressions, so disclosure was rated as neutral; however she was unhappy with how the nurse dealt with her questions so the consultation was rated as negative.

Table 3 shows the type of consultations discussed in interview, number of consultations, number of disclosures of sexual orientation, number of times the consultation was experienced as positive, neutral or negative and number of times disclosing sexual orientation was positive, neutral or negative. Three participants were foreign students. They talked about experiences in their home country's healthcare system as well as the NHS. As this study is concerned with experiences in the British system, distinction is made between the two.

Table 3 Healthcare consultation details

Type of consultation	No. of consultations discussed across				No. of Disclosures			
	all participants							
	Total	Positive	Neutral	Negative	Total	Positive	Neutral	Negative
UK GP	6	3	2	1	0	0	0	0
UK Sexual health	6	3	0	3	6	3	2	1
UK Other	2	0	0	2	1	0	0	1
Non-UK healthcare	3	1	1	1	2	1	0	1

Table 3 shows that there were six GP appointments described. None of these included a disclosure of sexual orientation, and all participants mentioned that they had not disclosed to their GP. Sexual health appointments were also described, all of which included disclosures of sexual orientation as part of the assessment. Three consultations were perceived as positive, and three disclosures as positive. Positive disclosures did not necessarily occur within positive consultations i.e. the disclosure may have been neutral but the overall consultation may have been rated as negative. Two other healthcare consultations were described, where sexual orientation would not normally be asked about directly. Both consultations were negative and the only disclosure was perceived as negative also. The individual analyses follow, including a pen portrait of each participant to provide a context in which to consider their experiences. The Tables 4, 5, 6, 7 and 8 give overviews of the super-ordinate and sub-ordinate themes for each participant. Each theme is then discussed in detail, illustrated by quotations from the interview.

Section 2: Analysis for Individual Participants

Adam

Adam is a medical student. He came out just before he came to university and has experience of both working in the NHS and being a patient. He reported regularly accessing sexual health

services and his GP. He reported finding making an appointment for either service problematic, although he described being confident when speaking to the staff and offered examples of challenging them. He talked about experiences with GPs in general and described one consultation in more detail. He also described experiences of disclosing his sexual orientation to both a nurse and a doctor in the sexual health clinic. Adam's interview was the first interview undertaken in this study. He appeared nervous at interview and had only a limited amount of time in which he could meet with me. He seemed intimidated by the recording device, and tried to turn away from it to clear his throat during the interview. He was softly spoken and at times it was difficult to hear him.

Table 4 Super-ordinate and subordinate themes

Themes	
Super-ordinate Theme	<i>Identity</i>
Sub-ordinate Themes	Doctor versus Patient
	Discomfort with sexual orientation
	Integrating identities
Super-ordinate Theme	<i>Living with discrimination</i>
Sub-ordinate Themes	Sensitivity to discrimination
	Fear of discrimination
Super-ordinate Theme	<i>Acceptance from others</i>
Sub-ordinate Themes	Being matter of fact
	Feeling accepted
Super-ordinate Theme	<i>Coping</i>
Sub-ordinate Themes	Anger at the individual
	Humour
	It was an isolated incident

Identity

Doctor versus patient. As a medical student Adam appeared to believe standards were important and set these for himself as a professional and others in the healthcare profession. He viewed himself as a role model, saying, "I do medicine so I feel I have to live kinda healthy." Adam seemed to perceive himself as an assertive person. He reported finding it easy to talk to staff, and thought it was important that patients challenged healthcare professionals as they do not always get it right. In situations where his doctor identity was prioritised, Adam seemed to find being

assertive easy and reported using this assertiveness in other areas of his life than healthcare. This assertiveness appeared to be the pivotal point between the doctor –patient identity.

Adam seemed to view his identity as a medical student as highly important. He took this part of his identity into many situations, including situations where he was a patient. However there were times when this identity appeared to slip. This appeared to happen when Adam experienced a strong negative emotion. At these points Adam’s patient identity seemed to take over. This identity seemed to be almost the opposite of the doctor identity. Whereas Adam’s doctor identity was confident and competent with strong opinions and standards, his patient identity appeared unable to be assertive and he reported becoming a passive participant in the situation. Only once he escaped the situation and the doctor identity was reprioritised did this ability reappear. This is illustrated by the following extracts where Adam talks about his experience of the sexual health clinic. In this consultation he saw a female doctor. The doctor’s manner in the appointment led Adam to believe she lacked confidence in her work which made him worry about what would happen in the appointment. The first extract shows Adam being assertive and showing the doctor how to complete the paperwork, but already his anxiety had been raised by her manner. By the second extract, the humiliation he felt at being left exposed and vulnerable left him unable to be assertive and ask whether the tests had been completed.

“...she didn’t really understand the forms and I had to tell her how to use them. And she wasn’t very confident in what she was doing and it came across really badly. ‘Cause then it made me worry about [...]when she was doing the swabs did she know what she was doing? [...] she asked questions twice and when she was looking at the forms she had to kind of figure it out[...] It was just the general [...] approach to it...”

“...she kind of just left me on the couch with my trousers down my legs [...] rather than being like, ‘right we’ve finished, get dressed.’ She left me there for like two minutes while she was doing the swabs and writing on the notes. Which I kind of think is quite bad. ‘Cause it’s not, really preserving my dignity... It just made me feel quite vulnerable.”

As a patient, but with his doctor identity prioritised, Adam found accessing healthcare inconvenient. He found it difficult to arrange appointments around his work, so often waited for some time before contacting a GP or other service. When booking an appointment he considered the purpose of the appointment and asked for a longer appointment if necessary, taking a list of issues with him. This seemed to provide him with a sense of using healthcare to his advantage, making it work around his priorities. He also seemed to judge services, making choices about where he accessed healthcare. He judged individual healthcare professionals’ abilities and these influenced his choices when making appointments. These judgments were based on information

he had heard about them or past experiences. These judgements affect how Adam viewed the treatment he received; those experiences that matched his standards were perceived as positive, those that did not were perceived as unacceptable.

Discomfort with sexual orientation.

Adam appeared unsure of his own sexual orientation. During the interview he showed discomfort when disclosing his sexual orientation. He also described anticipatory anxiety prior to attending an appointment where he knew he would be asked about his sexual history and relief when he was asked only about his sexual history and not for a definition of his sexual orientation (i.e. gay, bisexual etc). Throughout the interview Adam described struggling to know when disclosing sexual orientation was appropriate. Adam viewed sexual orientation as a private matter, something which should only be disclosed to people you know well or when it is necessary; because of this he has not disclosed his sexual orientation to his GP. This is contrary to his thought that GPs are able to help gay people access appropriate healthcare and that they can be a person to talk to when you are having a difficult time.

"...do you have to disclose you're gay every single time? I mean to the GP. And is it really relevant to 'I've got flu...?'[...] I would feel uncomfortable every single time I went to a GP disclosing my sexuality. And I would also feel uncomfortable if it came up on my notes."

Integrating identities.

Adam seemed to not always find his identities of doctor, patient and person with a sexual orientation as compatible. He described his doctor and patient identities as often co-existing. However his identity as a person with a sexual orientation appeared separate. He was concerned about people at work discovering his sexual orientation and felt that work might not be an appropriate place to discuss it. He felt that sexual orientation was a private matter and that it should not always be disclosed.

"I feel that people shouldn't necessarily know your sexuality. And it's fine for people who I am friends with and I know well (I Yeah) But it's not really anyone else's business who I sleep with. And maybe that's the same for GPs as well. That they shouldn't necessarily know unless its relevant, but maybe it is relevant, and I haven't just deemed it relevant. I don't know."

"...It does worry me that maybe someone will find out that I'm gay but it's not an appropriate place to find that out..."

Living with discrimination

Sensitivity to discrimination.

Adam reported no direct experiences of discrimination due to his sexual orientation. He reported experiencing teaching where the consultant advised that a chaperone should be offered to women, and men who look gay. This experience affected Adam, he felt discriminated against and offended that they were being taught to 'look' for gay people. He became anxious about whether this might happen to him and mentally prepared

himself for what he could do if it did. Adam also seemed to interpret the consultant's words with more discrimination than may have been intended. Adam seemed to interpret the consultant to mean that he was at risk of being assaulted by a gay man, rather than that a chaperone was needed to ensure that the doctors' examination was conducted appropriately. This assumption of more discrimination might suggest that Adam's sensitivity to discrimination is heightened, influencing how he perceived experiences.

Fear of discrimination. Adam feared discrimination due to his sexual orientation. This fear affected to whom he disclosed his sexual orientation. He recognised that not disclosing his sexual orientation could result in not accessing healthcare which he was entitled to, but he did not feel that it was worth the risk.

"... disclosing your sexual orientation can be put on your medical records. And then can be counted against you in things like life insurance and other things like that. Which I would really not want [...] to have that limitation because of my sexuality. I do acknowledge that sometimes [it is] important for your GP and health practitioners to know your sexual orientation but I'm not really willing to risk like my mortgages and my life insurances, things like that, opportunities like that to just tell a GP."

When Adam did access services his fear made him anxious about how he would be perceived as a man who sleeps with men. After a positive appointment the anxiety would diminish, only to return prior to the next appointment where disclosure was likely. This fear also meant that he felt unable to come out at work, judging it to be an inappropriate place to talk about sexual orientation.

"I felt quite daunted by telling someone about it [...] But it wasn't that bad in the end [...] what would they think about me being gay and sleeping with men? Like do they often deal with this kind of thing? And are they going to be funny about [...] having anal sex and things like that. Like having sex with different people and having lots of partners and things like that."

"...It does worry me that maybe someone will find out that I'm gay but it's not an appropriate place to find that out..."

Acceptance from others

Being matter of fact. Adam's perception of the healthcare professional's behaviour and manner affected how he experienced the consultation. In the sexual health clinic when the healthcare professional was approachable, explaining what was happening and asked if Adam had questions, he found the consultation positive. By asking questions in a friendly but 'matter of fact' manner, the nurse seemed to put Adam at ease and allay his anxieties.

"I had a nurse and she was really nice [...] like she took a date of all the people I had slept with and what we'd done and just asked in a nice way. And it was just really positive and we went on to do the swabs [...] she explained it so I knew what was going on. I knew that some of it might be

uncomfortable. [...] It was over really quickly. She asked like if you've got questions at the end and these kind of things so it was really nice."

Feeling accepted. Adam feared discrimination due to his sexual orientation; however when the nurse did not ask Adam for a definition of his sexual orientation this not only lessened his anxiety about disclosing his sexual history but also seemed to make him feel more accepted and that his behaviour was normal.

"they don't ask specifically your sexual orientation... She asked [...] "when was the last time you had sex, and was it with a man or a woman? [...] Was it oral or anal, protected, unprotected, giving, receiving?"[...] The way they did it was quite a blunt way. Just straight in there, but I think that's quite effective. Cause it makes it seem just much more normal. Like a normal thing to ask. Which makes it a lot more better I think. Rather than you know, being awkward about it."

Coping

Anger at the individual. Adam reported coping with negative experiences by becoming angry with the individual, blaming them for the experience. When calmer, he thought about the wider system, considering if these attitudes existed in more people than the individual he encountered. This extract related to the teaching Adam described.

"I thought he was an idiot anyway but even more so and it would really worry me if that actually happened. I would find it upsetting. If that happens a lot or if it's just him."

Humour. Adam's use of humour was evident throughout the interview, when he described experiences where he felt judged, discriminated against or vulnerable. In each case he made a joke out of the situation, describing it in a manner so that it would appear ridiculous, and tried to draw me into the laughter.

"it means that I have a million condoms at home that I'm never going to use, because I don't have like sex with hundreds of people! (Laughs)"

"Does he really expect them to just leap across the bed and just start bumming him? (laughs)"

It was an isolated incident. To protect himself from the negative impact of some experiences, Adam justified them as isolated incidents. He attributed responsibility to the healthcare professional involved and considered it was their fault, rather than a service wide issue, as illustrated by this extract:

"I take that as an isolated incident [...] usually the GUMs clinic are really good and the staff are really nice. I think that was just, she was just a bit of a funny one. Hopefully won't get her again."

Ben

Ben is a dental student. He has experience of working in the NHS as well of being a patient. He came out a year prior to the interview and described himself as a 'straight gay guy', preferring to socialise with lesbians rather than gay men. He described experiences with GPs in general and experiences of disclosing sexual orientation to male and female healthcare workers at a sexual health clinic. Ben discussed GP consultations in general, dental appointments from the perspective of the professional and two sexual health consultations in detail. Ben appeared relaxed in the interview. He commented before the start that he felt it was important for gay people to take part in research and asked if he could take a poster to give to his friends, to which I agreed. He spoke freely and confidently and informed me that if I wanted any more help or needed a further interview then he would be happy to be contacted again.

Table 5 Super-ordinate and sub-ordinate themes

Themes	
Super-ordinate Theme	<i>Expecting prejudice</i>
Sub-ordinate Themes	Expectation of prejudice by gender Judgements and blame
Super-ordinate Theme	<i>Searching for acceptance</i>
Sub-ordinate Themes	Affinity with women Conforming
Super-ordinate Theme	<i>Values applied to life</i>
Sub-ordinate Themes	Accessibility of healthcare Freedom of expression Professionalism

Expecting prejudice

Expectation of prejudice by gender.

Ben reported experiencing insults being shouted due to his sexual orientation. He seemed to expect these experiences, seeing them as part of being gay. He seemed sensitised to other people's reactions to his sexual orientation, noticing when people stare if he is wearing certain clothing or holding his boyfriend's hand. Although he reported that the majority of people do not care, he was resigned to the idea that he will always experience some prejudice.

“To be honest, being gay, you get some... you get some much worse things than a doctor being a bit judgemental. So, like I say, it doesn’t affect me at all, really.”

This expectation appeared to lead him to be wary of people who he saw as threatening, avoiding them if possible. Ben appeared to view men as more threatening than women. He seemed to view heterosexual men as dominant, aggressive, judgemental and unable to understand gay men. Similarly, he described flamboyant gay men as ‘camp’, judgemental, aggressive and unrepresentative of the gay population. He seemed to perceive women as less threatening than men and easier to talk to, although still appearing to view some lesbians in a similar way to men, seeing those who he called ‘butch’ as aggressive and intimidating. The expectation of judgement from these groups seemed to result in Ben judging them as stereotypes, avoiding them before he could test if his expectation was accurate.

“... I already know what guys are like so I already know how to act around them, and what makes them uncomfortable and what doesn’t.”

His expectation of judgement appeared to also affect accessing healthcare. He reported becoming anxious prior to an appointment, particularly if needing to discuss something personal. He reported that his anxieties about heterosexual men mean that he usually requests a female healthcare professional, as he expects to be more able to talk openly.

“Some healthcare...Dentists, I wouldn’t mind going to a male. Doctor, [...] I wouldn’t go to a male if it was a general enquiry [...] If it was something like a lump or something like on an arm or a broken hand or something, girl, no end. But when it’s something intimate and private, yeah, like that’s when it becomes different. You want someone who will understand you a lot better, which is perfectly fine.”

Judgement and blame. Ben came across as anxious to preserve his health. He reported receiving regular health checks and considered that there was a wide choice of services available but sometimes struggled to choose between them. He seemed to make choices by judging services based on others experiences of the professionalism of the staff and their treatment. Ben described taking steps to ensure his physical and mental well-being and becoming distressed if he was unable to do this. He was prepared to pay to ensure that he is healthy.

“...when I’ve got money, I’ll probably get it done, [...] I save up for things that I want. Like I’ve had my eyes done [...] I’m saving up to have my teeth done. [...] If you want something done, you’ll get it done, especially for your own health, like for peace of mind...”

As part of maintaining his health, Ben reported accessing a sexual health clinic. When he disclosed his sexual history the doctor responded by giving Ben statistics of how likely he was to have

contracted a disease. He also allegedly told Ben how many patients he had diagnosed with AIDS that week. Ben was left feeling judged, frightened and unwilling to come back to the clinic. This experience seemed to evoke anxiety about his health, leading him to justify his sexual behaviours, providing explanations for why he had attended the clinic.

“...I was like, “Crap! What have I done?” [...] I’m never not safe. [...] I obviously wore a condom every time but the one time that I didn’t was when I got tested, and it did scare me but the... the guy I was with was quite sensible.”

When negative events did happen Ben seemed to try to attribute blame in order to understand the situation. When he felt judged by the doctor at the sexual health clinic Ben reported blaming the individual doctor for the incident, feeling that he was unprofessional, judgemental and unapproachable. Outside of healthcare consultation, when he experienced verbal abuse shouted at him, Ben reported blaming the people who were shouting to have the problem, rather than perceiving society as a whole as discriminatory. However there have been times when Ben discussed blaming himself for attracting attention by being too obviously gay. He believed that incidents occurred due to him wearing effeminate clothes, socialising with women, or being openly gay with his boyfriend.

“if I walk down the street in um... a Jack Will’s gilet and Ugg boots, you get looks just ‘cause you’re a boy. And then if you walk downtown like holding a boy’s hand, you’ll get looks.”

“...I’ve had problems before in nightclubs ‘cause I go out with girls.”

Searching for acceptance

Affinity with women Ben’s discomfort with heterosexual men and flamboyant gay men appeared to leave him searching for acceptance, feeling that he did not fit in with either group. His individuality seemed important to Ben and he searched for outlets to express himself without judgement. Ben found this when he socialised with those he called “girly girls”. He reported finding them emotionally available, approachable and able to understand him, qualities which he identified in himself. He discussed finding them easy to talk to about men he likes and feeling accepted. He made sense of this as them having sexual acts with men in common.

“I talk to girls all the time about boys and things like that [...] So, I think, in that respect, disclosing it that way to females, I just don’t feel embarrassed at all. It just, it feels normal whereas guys [...] I don’t think they’d understand because obviously they don’t do the same activities I do, and it’s... I think they don’t get it, and it feels a bit weird. So, I don’t know what it is about it but it just doesn’t feel right.”

Despite Ben's views of flamboyant gay men in his correspondence prior to the interview he came across as quite flamboyant. During the interview he commented that he was dressed for work, and did not appear as flamboyant as his correspondence suggested, although at one point he referred to himself as a flamboyant gay man.

Conforming. In his group of female friends, Ben reported standing out as the only male. He seemed to have an urge to stand out from the crowd in general, using his appearance to reflect his personality, including wearing bright colours, jewellery and dying his hair. He described the process of coming out as finding himself and to hide his sexual orientation would be to deny himself the freedom that coming out allowed him.

"...it was the first thing I ever did to show that I was gay, 'cause your right ear, you're gay. So, I felt like if you're taking that out, it strips you of something you're part of, who you are. [...] I always have one bit of jewellery on this side of my face just for that pure fact."

Ben discussed the pressure to conform at work. He has a professional role and felt professionals should act in a uniform manner, adhering to standards of behaviour and appearance. However he appeared to believe that to be professional he must hide part of himself, something he struggled with. This had led to him rebelling against the requirements to conform, maintaining individuality in all aspects of his life.

"You do change as you walk onto a clinic. [...] you have to change your mind set to think, "Okay. I'm doing this." You have to change the way you speak to people. [...] You have to change the way you dress like I would never normally dress in black if I could help it and plain clothes but you have to... it's just you have to conform to what it is. [...] Like I know it's weird to say this but I felt when I did dentistry, I was stripped of my personality ..."

Ben's attitude to conformity seemed to show a paradox between his willingness to conform to traditions associated with being gay, such as piercing his ear but his unwillingness to conform at work.

Values for society

Accessibility of healthcare. Although reporting being prepared to pay for treatment, Ben believed that healthcare should be provided to all in need. He gave the example of not being allowed to have the HPV vaccination as he was male. The argument he reported being given was that he was not at risk as he was male. However, he has been informed that HPV can be passed orally between men and thus described his indignation that he believed he had been discriminated against due to his sexual orientation; something he believed showed a lack of morality in the NHS.

“If it’s given to girls for free, what difference is it gonna make if I was a girl or boy? Why can’t I just have it? I could be another girl in the world, and they wouldn’t have any problem with it, giving it to me.”

Professionalism. Ben seemed to view healthcare as invasive. To compensate he described strong feelings that professionals should be competent and knowledgeable, non-judgemental and approachable, which included dressing in a conservative manner. When he was a professional, Ben reported struggling to conform to the dress code but recognised that he alters his mind-set for work, trying to be accepting of all his patients and treating them without judgement. He expects the same when he attends services as a patient.

“It’s a bit invasive, anyway, ‘cause they’re going in your mouth. So, you want somebody you feel comfortable with. [...] they’re professional, and their knowledge of the topic has to be quite high up as well. I’d put [...]knowledge above [...] personality ‘cause you’re there for an answer and help rather than five minutes of discomfort...”

When he visited the sexual health clinic Ben found the doctor unapproachable and related this to his appearance, describing him as tattooed, muscular and not dressed smartly. When he disclosed his sexual orientation, Ben felt the doctor skipped over it; however he reported that when he disclosed his sexual history the doctor responded by telling Ben how many patients he had diagnosed with AIDS that week. Ben felt the doctor had not been professional in this case and had not offered care and understanding. He seemed to believe that this experience was made worse by the doctor being male. His perceptions of straight men seemed to already make Ben feel intimidated by the doctor; this was heightened by the doctor’s appearance. Ben reported believing that if a female doctor had given him statistics he would still have been frightened, but that the delivery of those messages would have been in a gentler manner, which he would have coped with better.

Camilla

Camilla described experiences with GPs in general and the University of Leeds student counselling service and sexual health services in detail. She reported dislike with being defined by her sexual orientation and that although it is part of her, it does not dominate her identity. She described herself as a nervous person, finding it difficult to know when to disclose her sexual orientation in conversation, meaning that she tended to allow people to assume that she is straight unless the topic arose. Camilla had cancelled two interview times, the most recent being cancelled the previous week at the last minute by email. She said she was ill and happy to rearrange. This was the third time the interview had been arranged. Camilla arrived early for the interview and

seemed apprehensive. I tried to put her at ease and she began to relax as the interview progressed. Camilla spoke quickly, and in great detail during the interview, although she rarely made eye contact.

Comment

The analysis of Camilla's interview became problematic. Although she spoke of experiences with GPs in general and spoke of one consultation with sexual health, she did not go into detail about these events. She seemed unwilling to speak to me about the significance of the sexual health appointment and focussed the majority of our discussion on her experience of counselling. This seemed most pertinent to her and as the interviews were being conducted in a semi-structured way, she was able to direct the conversation significantly. This resulted in a more detailed experience of the episode of counselling, rather than a discussion around healthcare more generally and her thoughts around disclosing sexual orientation. In addition, although broad themes of 'judgement and blame', 'hiding' and 'wanting to be found' emerged from the data, these did not seem to fit into the pattern of super-ordinate and sub-ordinate themes, but seemed to colour all her experiences, including healthcare, by affecting her perception of interactions with others. Camilla discussed experiences in such a way that there appeared to be a process which emerged from the data. Interpretation in qualitative research should be driven by the data (Stiles, 1993). As the data suggested a process that Camilla engaged in, the data will be presented in that format. Figure 1 represents that process diagrammatically. Each stage of the process will then be discussed in turn, illustrated with quotations.

Reflexive Comment

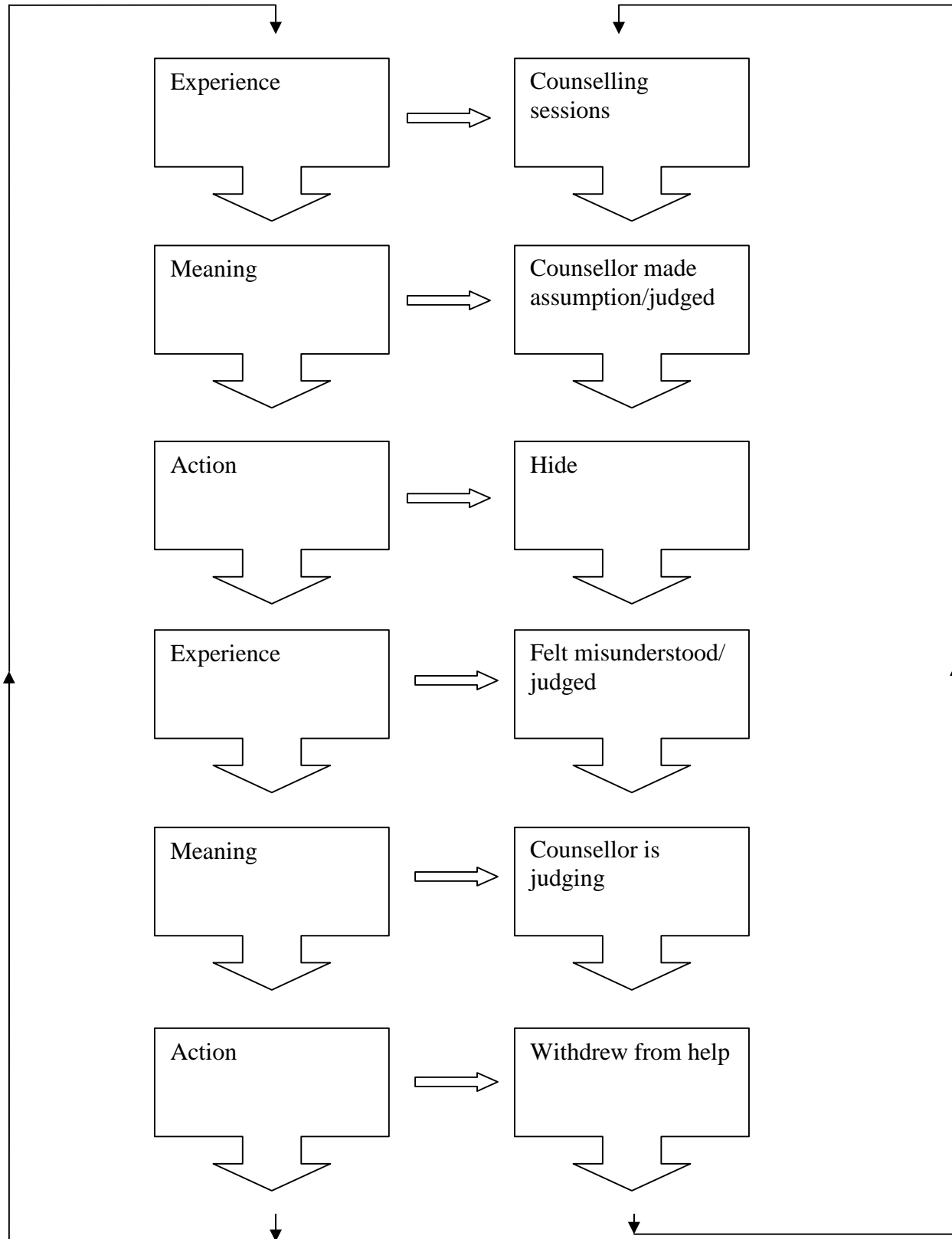
During the interview Camilla alluded to difficult experiences in her past. She compared me to one of her counsellors and knew that the research was being completed as part of my training in clinical psychology. Because of this I believe I may have experienced Camilla in a similar way to her counsellors.

Camilla spoke freely during the interview, elaborating with little encouragement; however when we neared an experience which she found difficult, she briefly appeared anxious and immediately withdrew from the conversation, changing the topic and making me aware that she was not prepared to talk about it. As this was an interview and not a clinical session, I did not pursue the topics, being aware that her wellbeing was paramount. I did wonder about her comparison of me to her counsellors and whether she might have withdrawn from conversations which evoked painful experiences during counselling as well. I wondered about the influence on healthcare of both her expectation of judgement, subsequent blame and withdrawal; both reactions seemed unhelpful as they may contribute to her not accessing the care she requires or not being able to use it once she gets it.

Process of interactions for Camilla

Figure 1 represents this process diagrammatically. It uses Camilla's experience of accessing counselling sessions to illustrate this. The process shows Camilla's subjective experience, the meaning she made of it and her actions resulting from her interpretation.

Figure 1 Diagrammatical representation of Camilla's process for interactions



Counselling sessions Camilla described herself as a nervous person. She appeared to demand standards of behaviour from others, preferring people to behave in predictable ways, which seemed to lessen her anxiety. Camilla seemed to particularly demand standards from healthcare professionals, believing that they should always be approachable, trustworthy and knowledgeable.

"Someone who I feel like I can just talk to, like someone who isn't gonna sit there and be like, 'well, you're doing this wrong' or even like someone who's gonna say 'you're doing this right'. Someone who can listen [...] and relate things in a way that I understand them cause sometimes they talk and I don't really know what they're saying."

Despite having standards, when Camilla began counselling sessions she already had expectations of being judged, which she reported having as a result of previous experiences in counselling.

"... I just don't like counsellors very much [...] I just feel that they [counsellors] are basically paid to judge"

Although expecting to be judged, Camilla seemed to hope that the counsellor would live up to her standards and would accept her. She seemed to yearn to be allowed to live her life as she chose, without boundaries and constraints, and to be accepted for all she is.

"...I don't want people to judge me and I don't want to be stereotyped and stuff. I don't want to be put in a box about it."

Counsellor made assumption Camilla appeared to have no tolerance for anyone who did not meet her standards, giving them no opportunity to redeem themselves. During her first session, Camilla reported that the counsellor used the word 'boyfriend' rather than mirroring Camilla's use of the word 'partner'. Camilla did not see this as the counsellor making a mistake, but seemed to understand this as the counsellor assuming that she was heterosexual, something she seemed angry about and remained angry about throughout the sessions.

"she said something like, "ok, so you've had this happened and this happen and you've had problems with your boyfriend" and I was just like I didn't say that. That's wrong in my head to say that to someone because it's an assumption and like, I'm 19 there's no reason I would say partner other than that."

Camilla's sense of self seemed to be vulnerable to others' perceptions; the counsellor's assumption seemed to cause anxiety and feelings of being constrained. This seemed to result in Camilla feeling that her self was under attack from others and needed protecting.

“Like I think that we're all capable of doing whatever we want to do really and we should be given this space to do that. And if people are just judging you and putting you in boxes [...] you can't do something if everyone's telling you that that's not what you do.”

Hiding Camilla's interpretation of the counsellor making assumptions about her sexual orientation seemed to affect her response. Instead of correcting the counsellor, Camilla described going along with it, hiding her sexual orientation, despite saying that she needed to talk about it. Camilla seemed to try to control others' perceptions of her, keeping parts of her 'self' private, only sharing chosen aspects about herself. This hiding seemed to be an ineffectual attempt at protecting herself from further discomfort.

“I guess I just want to like, retain a bit of mystery about myself I guess”

“... she'd judge me if I told her. I didn't really trust her. I didn't really feel like talking to her...”

Feeling misunderstood/ judged Despite hiding information, Camilla appeared to experience being misunderstood by the counsellor. Sensing that others had misunderstood her seemed to be particularly distressing for Camilla. It seemed to cause anxiety that she was being judged and desire to correct the assumption.

“It just weirds me out to think that someone would think that I'm straight like. So I just like, yeah... I didn't want to leave her thinking that.”

Counsellor was judging Camilla appeared to dwell on the counsellor's mistake throughout therapy and believe that the counsellor was judging her. She seemed to understand therapy as a process where she was told she was living life incorrectly, something which appeared to increase her anger.

“just felt weird because she had this massive like picture of me in her head that wasn't me because of that one thing[...] I wanted to tell her because I felt so annoyed that she'd, like assumed that about me. That I was [pause], I had to tell her.”

Withdrawing from help By understanding the counsellor as judging her, Camilla seemed to withdraw from help. Although she reported attending all sessions offered, she appeared to choose topics of discussion which although important, avoided some of the issues she had sought counselling for. She seemed to resent the counsellor not realising that she had hidden some information about herself and appeared to want to show the counsellor her error, whilst not having to deal with the consequences.

During the last few minutes of the last session, Camilla reported correcting the counsellor's mistake. Although occurring at a time when it was impossible to be discussed in detail, Camilla seemed to view the disclosure as an opportunity to correct the counsellor's perception of her.

"Yeah, it didn't feel relevant because it was the end of the session so I wasn't going to see her again [...] It was just kind of like I had to tell her because I didn't want to leave her with an image of me that wasn't me and I think it was quite important for me to do that."

By choosing to disclose when it was unable to be discussed, Camilla seemed to preserve her opinion of the counsellor as someone who judged. If she had used the opportunity earlier in therapy, there was the possibility that she would have had to change her opinions of counsellors, something which seemed difficult for Camilla to do. She seemed to blame the counsellor for not allowing her to talk about her experiences, ignoring her own part in the interaction.

The effect of this process seemed to be that Camilla assumed she was likely to have more negative experiences of healthcare in the future. To lessen these chances she reported asking others' opinions of professionals to predict how she would experience therapy with them.

"I'd be really careful the next time I tried to find a counsellor [...] it would probably make my experience bad again because, I guess I'd go in there think something's going to happen. Something bad's going to happen because it has in the past[...] I'd probably not trust them again and so I think I'd have to find [...] I'd have to find the right person. Which I think is true anyway, but I think more so with me because I've had the bad experience of it, of more than one bad experience of it."

Summary The process described here used an example of healthcare consultations, however Camilla's account seemed to suggest that fearing being judged, experiencing judgement and subsequent hiding in order to protect herself were prevalent in most of Camilla's interactions with others. It seemed that if others around her lived up to her standards, Camilla would gradually share more information with them, although there appeared no tolerance for anyone who did not meet these standards. When this happened Camilla attributed blame for a negative experience either to the other person or to herself. For example, when attending a sexual health clinic Camilla asked about lesbian safe sex; she reported that the nurse did not answer her questions. Camilla described being surprised that the nurse had no knowledge on this issue, and seemed to blame herself for not asking correctly.

"... Maybe I [...] wasn't clear enough that I wanted information. [...] I remember expecting to hear something, like some sort of answer and she just didn't really say anything."

Camilla appeared to really hope for acceptance from others, but great resentment towards those who did not live up to her standards. The sense of trying to protect herself from judgement appeared to colour all experiences and influence her behaviour, not always in helpful ways.

Danielle

Danielle is a postgraduate foreign student. Her home country is a westernised society with a highly developed healthcare system, including both private and public healthcare services. She has accessed healthcare both in Britain and her home country. She has only disclosed her sexual orientation in her home country. Danielle discussed three experiences with a GP in Britain, a family doctor in her home country and a specialist consultant in her home country in detail. Danielle was early for the interview. In her email she told me that she felt it was important for gay people to take part in research, one of the reasons she wanted to share her experiences with me. Before the interview began she asked questions about my accent and the phrases I used, such as 'ta' instead of thank you. She appeared confident and spoke freely and clearly throughout the interview. She made direct eye contact almost constantly through the interview, which was uncomfortable at times.

Table 6 Super-ordinate and sub-ordinate themes

Themes	
Super-ordinate Theme	<i>Searching for acceptance</i>
Sub-ordinate Themes	Expecting discrimination
	Comparing societies
	Measuring against past experiences
	Wanting acceptance
Super-ordinate Theme	<i>Active management of healthcare</i>
Sub-ordinate Themes	Strategically managing healthcare
	Avoiding negative experiences

Searching for acceptance

Expecting discrimination. Danielle seemed to expect a certain amount of discrimination because of her sexual orientation. She discussed her beliefs that society is becoming more positive for gay people but related homophobia to racism, seeing it as needing a new generation to grow up accepting difference as the norm, for society to really change.

“...you try to argue against it but then you just realise that’s how they were brought up [...]It would take a really strong person at 45/50 years old to sort of change their whole way of thinking”

Analysing and judging society. Danielle appeared to judge a society based on its laws, its reputation and her own experiences. She seemed to judge how safe she would be based on these factors. If a country has laws which prevent discrimination against gay people, she reports expecting more tolerance there. Nonetheless, she discussed noticing that even if a country had these laws and it was politically incorrect for people to be openly intolerant to gay people, she still sensed when people are uncomfortable with it. When she sensed others discomfort it appeared to make her anxious, ruminating over the experience and thinking of ways she could have made it less uncomfortable.

“It just kind of made me feel awkward, for having told her. Then I thought maybe I just should have said “No I’m not sexually active” and just left it at that [...]it wasn’t like I wasn’t going to say anything, but...maybe I would have said it in a different way, or...I don’t know.”

Measuring against past experiences. Danielle seemed to measure her experiences against those of her home country. She described the area where she grew up as religious and conservative, where discrimination for sexual orientation was commonplace. It appears that Danielle scrutinised each new experience, to see if it is better or worse than her past experiences. This is particularly true of her experiences of healthcare. In her home country she was used to a lengthy appointment with a family doctor, someone she had a long relationship with, who would have a general chat with her before moving on to the reason for her visit. She compared her experiences in Britain with this template of care. She reported feeling that the shorter duration made British appointments more efficient, but the lack of relationship with the doctor made it difficult to explain her reasons for attending. She also noticed a difference in the thresholds for care in Britain. In her home country she reported accessing healthcare as soon as she felt unwell. In the UK she attended the GP thinking she had the flu. She reported feeling that the doctor dismissed her concerns, sending her home with general advice for staying well. This differed from her experiences in her home country where the doctor would do tests for flu or other infections. She appeared to make sense of this experience as needing to wait longer before she accesses UK healthcare, trying to get well by herself before seeking help.

“I might wait longer here to go to the doctor than I would back home. [...] I might wait till it’s you know, something [pause] that prevents me from going to class or something like that, before I would go. Whereas back home if it’s just [pause] if I really wanted to go to class I could go but it’s sort of like a [sigh] I feel really really crappy type thing, I might go ahead and go to the doctor because it’s not...I mean it’s not a big deal to do that.”

Wanting acceptance. Danielle appeared to search for acceptance as a gay woman and as an individual. Her judgement of society meant that she chose to live somewhere where she felt there was more likelihood of acceptance, but on an individual level Danielle still seemed to look for indicators, suggesting that a person would be accepting. She appeared to use her past experiences of the relationship to judge how they would react to her sexual orientation. She judged when and where to disclose, taking into account individual factors about the other person including age and religious background. She not only wanted acceptance from the other person but did not want them to feel uncomfortable, so was prepared to hide her sexual orientation to prevent this.

“you sort of know when it’s appropriate and when it’s not appropriate to talk about it. [...] I wouldn’t talk about it with some of the older members of my family. It [...] wouldn’t come up because I knew [...] it would be a controversial issue, [...] and maybe if I meet someone new and they are 40/45/50, I probably wouldn’t say anything unless it was sort of they asked a very explicit question, and [...] there was no other way of getting around it.”

Her desire for acceptance stretched into healthcare. When she visited professionals she wanted her experiences to be validated and to feel that her individual needs were considered.

“I don’t know I’ve had the flu before, and I’ve also had mono before, [...] and it was sort of immediately “Ah, you probably have a cold, if it gets worse come back” sort of [pause] brushing things aside,...”

Active management of healthcare

Strategically managing healthcare. Danielle has experience of private healthcare. She reported high expectations of healthcare and a willingness to search for professionals who meet these expectations. She described not routinely disclosing sexual orientation but an awareness that this allows the GP to make choices about the most appropriate healthcare for her individually. She reported planning her return to her home country and considering searching for a gay-friendly doctor there. She appeared to believe that it was important that a doctor knew about specific healthcare needs of gay people and by finding such a doctor, she could be assured of their acceptance, feel reassured.

“when you join a new doctor. It’s sort of that first [...] appointment, anyway, is sort of them getting to know you a little bit, [...] I think it might not be as easy to sort of have a conversation about myself if I wasn’t totally okay that the other person was going to be accepting.”

Avoiding negative experiences. Danielle appeared to be searching for a place where she could settle and be accepted. She seemed to want a place where there would be the least chance of discrimination and her comparisons with her home country illustrate this. However even in her daily living, Danielle seemed to make choices to avoid potentially negative experiences; she

reported judging if sexual orientation was relevant and if not, choosing not to disclose. By searching for a gay-friendly doctor she might limit the possibilities of negative experiences in healthcare. By taking these steps she may ensure as much as possible that her environment is a positive one.

Erica

Erica is a foreign student. Her home country is a less developed nation, where many people hold strong religious views. It has a private health system, where only the very wealthy can afford healthcare. Erica reported accessing healthcare in both Britain and her home country but only disclosing her sexual orientation in Britain. She compared her experiences in Britain with the customs of her home country and how LGB people are perceived there. She discussed experiences with UK GPs in general and experiences with the sexual health service, vaccinations and an experience of non-UK healthcare in detail. Some time occurred between the initial contact with Erica and the interview. She had agreed to the interview early on, but did not respond to contacts regarding the date of the interview, requiring it to be rearranged. She arrived early for the interview and appeared nervous, although grew in confidence as the interview progressed. She used her facial expressions throughout to emphasise her feelings about the topics she talked about. At times I got the sense that it was difficult to discuss some aspects of her experience, particularly those that occurred in her home country. I was aware that she was not resident in Britain and would be returning to her home country and so was mindful of how she appeared to be coping with her thoughts.

Table 7 Super-ordinate and sub-ordinate themes

Themes	
Super-ordinate Theme	<i>Measuring against previous experiences</i>
Sub-ordinate Themes	Experiences of powerlessness
	Shame associated with sex
	Fear of punishment
Super-ordinate Theme	<i>Growing sense of self</i>
Sub-ordinate Themes	Disclosing as freeing
	Gaining independence
	Exploring own ideals

Measuring against previous experiences

Experiences of power. Erica described her home country as very traditional. Young people are under the care of their families until they are married. There are different expectations of men and women; as a young woman, Erica reported being expected to be respectful and behave in a way which could not bring shame upon her family. Once she was married she believed she would be allowed more freedom. Although these were the rules of society, Erica reported that her parents were particularly lenient, allowing her to go out sometimes with friends as long as she abided by their rules. As she was unmarried, Erica was taken to doctors by her mother. She reported that the doctor would speak mainly to her mother rather than Erica. Erica's understanding was that the doctor would share all information with her parents as they were responsible for her until she was married.

"... they're laidback for the boys [...] even my brother goes out a lot and he's 16 [...] he doesn't do anything crazy but he goes out, he is allowed to go out clubbing, come home by 1 you know, but for the girls its very, very different, girls it's not allowed and I don't know when that ends because I know my sister she's 24 and she's not married yet and yeah she doesn't go out much"

"like back home usually your parents come with you and they handle most of the talking"

Erica reported first accessing healthcare in Britain for vaccinations necessary for her attending university. She seemed to expect a similar level of healthcare as in her home country, where the doctor would explain what was happening and why before carrying the procedure out. When she attended for vaccination she reported having no information on the reason for vaccination or what it would protect her from. She arrived in the room, was injected and reported that the nurse gave her no information. Erica described feeling dismissed, confused and unsure if she needed to go back another time. She reported seeking information about the vaccination from others and found out it was not necessary to return. This seems to have left her with a sense of being ignored by the nurses and unsure about what healthcare would be like in Britain.

"They didn't explain what they were doing, I just kinda went there [...] then she just kind of jabbed me [...] And then I was sent out the door I mean in Kenya the doctor would sit down and talk to me and explain to me this is what we are doing, this is why, but here it was just like you just go in and come out. Which I guess is good cos it's fast but it's very different."

Shame associated with sex. Erica seemed to view sex before marriage as unacceptable in her home country, even though it happens. She reported that her parents were aware that she has had sex before marriage, although not of her sexual orientation. She believed they were happy with this and accompanied her to the sexual health clinic for checks. Although the checks were

completed with her parents present, Erica reported feeling attacked for having sex before marriage by healthcare staff in her country. When accessing healthcare for issues around her reproductive system she spoke of being taken into a room away from her mother and asked if she had been having sex and if she was pregnant. Erica was not pregnant, but discussed feeling that the nurse was trying to make her feel ashamed of her behaviour.

“she told my mum to get out of the room so she could talk to me and she was telling me it’s ok you can tell me if you know you’ve been having sex and if you’ve been doing stuff and if you think you might be pregnant and just asking probing questions and it kinda of felt like I was being attacked and like afterwards, like if I had been pregnant or something I know they would have gone and shared this information”

When she arrived in Britain, Erica saw an advertisement for a sexual health clinic in the city centre. She seemed shocked at how public this advertisement was and surprised by the lack of shame associated with sex and sexual health. Erica attended the clinic but from her description, appeared concerned that she would be reprimanded for her behaviour during the appointment. The nurse appeared to have noticed Erica’s concerns, reassuring her that her behaviour was normal and that she was being sensible by having health checks.

“she didn’t talk about it like I had, like what I had done was wrong or what I am doing is wrong she was just like open minded and really nice ...”

Fear of punishment. Erica seemed anxious about disclosing her sexual orientation. Her knowledge of society in her home country and the consequences for being gay there appeared to leave her feeling that she must hide her sexual orientation at all times. She seemed to view being LGBT as inherently wrong, having a large amount of shame attached to it. She came across as certain she would face discrimination if she disclosed in her home country and that her parents would probably disown her for bringing shame upon them. Her knowledge of her home society seemed to affect her disclosure of her sexual orientation even whilst in Britain. She seemed worried that if she disclosed here, then someone who knew her family would tell them and there would be consequences back home. When accessing the sexual health clinic, Erica reported being extremely concerned that the nurse would have to tell her parents about her attendance. If the nurse had had to speak to her parents, Erica reported that she would not have disclosed her orientation, but the nurse made Erica feel safe and reassured her of confidentiality.

“... just the stigma I think, I mean here it’s more free definitely, I know that the union has a club, the lesbian, gay, bisexual club but then I don’t know I am still worried cos back home it’s a big no no [...] sometimes when I think about it or when I think I’m going to see, just, just worried that maybe someone I know might find me there like one of the friends I haven’t

told, 'cause some of them I have friends here who are friends of my family [...] they might tell my parents and stuff."

Growing sense of self

Disclosing as freeing. Erica disclosed her sexual orientation to a professional for the first time in Britain. Her positive experience with the sexual health nurse seems to have left her feeling that her sexual behaviour was normal and as she was assured of her confidentiality, she was able to disclose without fear of negative consequences back home. This experience appeared to have made Erica feel that as her sexual behaviour was acceptable in Britain, she could allow herself to socialise and have sex without the shame attached to it. This seemed to offer an opportunity for freedom that Erica felt she was not going to miss out on; however as she must return to her country, Erica was worried about how constrained she may feel in comparison to Britain.

"she was just like yeah, you know, it's your first year in Uni, you are meant to have fun and get excited and do things [...] She just she made me feel nice. [...] I think maybe I came off as a bit worried that what I had done was bad [...] she was just like yeah no, everybody does it, its fine and have fun ..."

Gaining independence. Erica had been used to others looking after her in her home country. Coming to Britain has meant she has had to do more for herself. She has sought healthcare, managed her own appointments and reports gaining the confidence to ask healthcare professionals questions, something that she would not have done in her home country. She seems to have also started making her own choices, socialising with others her age, learning to live with others and not relying on parents for guidance about behaviour and support in accessing healthcare. This appeared to have given Erica a growing sense of pride in managing these things for herself. They are so far removed from what is expected in her home country that she had not considered how much she could do for herself. This pride appeared to be pushing her to do more things independently and have the confidence to ask questions and find out the things she wanted to know.

"I had mixed feelings because [...] I was worried I hadn't asked some questions [...] but on the other hand it felt good to finally be on my own...."

Exploring own ideals. Erica's growing independence appeared to have allowed her to explore her own thoughts and values about life. She seemed to find her home society constraining. She reported being expected to do as she is told, expected to marry and was unable to disclose her sexual orientation for fear of discrimination and reprisal. Coming to Britain seemed to have reduced these constraints, she reported being treated as a person who can make her own decisions, as such she has begun to question the values of her home society. I sensed that Erica's

own views about her sexual orientation were that it was normal, but that she was afraid to say that to others because of the potential consequences. Socialising in Britain has allowed her to explore her own wishes, such as going out clubbing and drinking as well as having sex. Her own views and opinions seemed to be beginning to develop, although I wondered if these were restricted to protect her from the effects of having to return to her home country.

“I keep coming back to [home country], it’s very different you’re not[...] like the first time I actually went out was when I came here, cos back home you are not allowed to so, yeah.[...] I think I went wild for the first 2 weeks.”

Freya

Freya is a foreign student, originating from a less developed country where holding strong religious beliefs is the norm. In her country, she is privileged, as only the wealthy can afford to access the country’s private healthcare system. She has not disclosed her sexual orientation to healthcare professionals in either country. She has accessed healthcare in both countries and compared the two systems. She described visiting the GP in Britain in detail and healthcare experiences in her home country in general. Freya arrived extremely early for the interview. I asked her if she wanted to start early and she agreed. She appeared nervous and spoke very quietly. During the interview she made little eye contact and her voice dropped to inaudible levels at times when speaking of difficult experiences. We moved the recording equipment in an attempt to capture her speech, but I struggled to hear her, and had to ask her to speak a little louder repeatedly. During the interview I became worried about Freya. She appeared to find it difficult to come to terms with her sexual orientation and experienced it as very negative. After the interview I explained that there were people she could talk to confidentially if she wanted and provided her with contact details of the Samaritans and the University counselling service.

Table 8 Super-ordinate and sub-ordinate themes

Themes	
Super-ordinate Theme	<i>Adjusting to UK life</i>
Sub-ordinate Themes	Adjusting to differences of culture
	Finding independence
Super-ordinate Theme	<i>Non-acceptance of bisexuality</i>
Sub-ordinate Themes	Shame associated with sexual orientation
	Fear of punishment

Adjusting to UK life

Adjusting to difference of culture. Freya described adjusting to a different society when she moved to the UK. One of the ways she seemed to make sense of these changes was by comparing her UK experiences with those in her home country. She compared her home country to a prison, where she felt trapped and restricted. She described that society as religious, where she was expected to behave in ways which would not attract attention to herself or bring shame upon her family. She was restricted regarding going out with friends and socialising.

“It’s actually good ‘cause it used to be like [...] so locked down and under so many rules and having to do what other people want me to do so over here yeah I can just be free do what I want...”

Freya seemed to find UK society very different and appeared to idealise living in the UK. She seemed to view the UK as a free society, where people could do as they please without restriction or discrimination. She reported seeing more openly gay people in the UK and assuming that because of this visibility, LGB people are always accepted in the UK. She appeared to believe that British LGB people would have support around them as they are seen as a normal part of society. She also reported thinking that LGB people in the UK are happy being gay and comfortable with their sexual orientation, something which she is not.

“Yeah over here people are more open but... its still, still doesn’t make it any easier for me personally [...] I’m just always not sure how people will respond well I know cos back home people wouldn’t take it well and even though over here you know it seems to be ok I just I don’t know I think I fear.”

Freya also noticed differences in healthcare. She reported that back home she was expected to attend healthcare appointments with her mother, which offered no opportunity for confidentiality. She reflected that in her home country she would usually wait before accessing healthcare as she had to pay. In the UK she reported accessing healthcare much sooner than at home. Although she described being unsure of how to go about arranging an appointment, Freya reported accessing healthcare by herself and seemed to find this freeing.

“when I am back home and I don’t feel like I am ok I wouldn’t necessarily go straight away I would [...] wait a while see what’s happening but over here I’d [...] go straight away cos yeah its easier [...] to get someone to see you, so I’d probably just go even when I’m probably sure it’s not such a big deal or something just still go.”

“Yeah I was also happy you know that I did it by myself.”

Finding independence. Freya's experience of having her behaviour restricted in her home country seemed to have left her unsure of own abilities. She expressed a desire to do things independently and has had the opportunity to do this in Britain. She appeared to have enjoyed the freedom of being able to see friends when she wanted and to make decisions by herself. She has accessed healthcare by herself, something she felt very nervous about beforehand, but was left feeling as though her worries were allayed and proud that she had accomplished something by going alone.

"It was fine I just went away like I felt like everything what I was worried about was sorted. So it was ok. [...] I was also happy you know that I did it by myself. [...] I wouldn't be as scared to go again ..."

"Well they make conversation with you they just don't get into the 'what's wrong?' you know straight away. [...] they ask you a name, how you are things like that which is ok."

It seemed that this experience had been validating for Freya, allowing her to begin to find out about her own wants and desires. Despite this apparent freeing effect for Freya, it also appeared to make her anxious about returning home and living a restricted life again. She reported that this anxiety left her feeling that she couldn't fully enjoy her freedom.

"Its going to be weird getting used to [it] again, just having to be like indoors all the time or having to do what my parents want me to do yeah I won't have that freedom I think it will just be weird losing that freedom again."

Non-acceptance of bisexuality

Shame associated with sexual orientation. Freya appeared to believe that her upbringing in a society where being LGBT was not tolerated contributed to her own negative perceptions of being LGBT. She thought that being LGBT was wrong and that she is bad for being bisexual. She described herself as mad, something which seemed to relate to her struggling to cope with her sexual orientation and how to live with it. The first extract relates to Freya's comparison with British LGBT people, the second illustrates her thoughts on being bisexual.

"They seem to be comfortable with themselves and their sexual orientation yeah it doesn't seem to be a problem and I feel that I am mad."

"I know it's wrong it's not something that [pause] and especially since people are very religious back home and [pause] its always like as in God doesn't accept those kind of people it's like evil it's a bad thing so sometimes I also tend to believe that it is a bad thing."

Freya appeared to believe that her parents would distance themselves from her because being LGBT is so shameful. Freya's shame about her sexual orientation was evident in the interview. She spoke very softly but often became inaudible when speaking about being bisexual. She averted her eyes when it was mentioned and I had to manage her distress in the interview, making sure I did not ask questions which I felt probed too deep, preserving her wellbeing as best as I could.

"I wouldn't ever tell my parents that 'cause it's also like they would be ashamed and embarrassed and would want to distance themselves from me"

Fear of punishment. Freya's negative thoughts about her own sexual orientation coupled with experiences of friends negative reactions to other LGBT people seemed to have made Freya scared to disclose. She reported worrying that others would not want to be near her or be friends with her if they knew she is bisexual. This fear appeared to result in her looking for evidence of what reaction people may have to her disclosure before even considering it. Having a close relationship with someone seemed to allow Freya to be more certain about their reaction, making it safer to disclose. Freya reported that there was only one friend who knew about her bisexuality.

"I just worry about you know how if people are going to accept me, if they want to be with me, if they will still hang out with me, or if they will treat me differently so... I wouldn't want to just go out there and just tell anyone."

Freya did not seem to see a time when it would be necessary to disclose her sexual orientation to a healthcare professional, but if she is looking for evidence of others reactions then having a good relationship with the professional would help her to gauge this.

Section 3: Group Analysis

This section contains the findings of the group analysis. Following the individual analyses, the themes and sub-themes from all participants were combined. Themes which appeared to refer to shared experiences were grouped together, refined and a name befitting them all was created, forming the master themes. The relation of these themes within the experience of accessing healthcare and disclosing sexual orientation is then presented diagrammatically. Table 9 shows master themes and indicates which of the participants shared experiences in each of these.

Table 9 Master themes

Master Themes	Adam	Ben	Camilla	Danielle	Erica	Freya
Somewhere safe to be free	*	*	*	*	*	
Discomfort with defining sexual orientation	*		*		*	*
Searching for acceptance	*	*	*	*	*	*
Anticipation and fear of punishment	*	*	*		*	*

Somewhere safe to be free

All participants except Freya seemed to describe a group of friends, a place or environment where they felt safe. For example Ben described feeling most at ease with women, particularly 'girly girls'. When around them he described feeling free to be himself without hiding any part of his personality. In this safe world all participants appeared to feel free and safe to expose aspects of themselves without fear of punishment.

"...girls are more open and tolerant about it. [...] I have more female friends than male friends for that particularly[sic] reason that girls get you more than boys do. So, I think in that respect female health workers are more approachable than males."

Outside of this safe environment people's responses seem not to be as predictable. Individuals may experience prejudice, discrimination or punishment due to their sexual orientation. Coping with the unpredictability of others' behaviour seemed to be anxiety provoking. Participants appeared to spend as much time as possible in their safe environment, when outside of this, they seemed to search for the person or environment which would be most accepting of them.

"what would they think about me being gay and sleeping with men? [...] are they going to be funny about you know having sex and having anal sex and things like that..."

Healthcare consultations seemed to be affected by participants' search for acceptance from others, and their fear of punishment from others. The fear of punishment seemed so great that if the participant considered that disclosure of sexual orientation was not relevant to the

consultation, such as in many GP appointments, they made the choice to not disclose, protecting themselves from potential punishment.

“I’m not really willing to risk like my mortgages and my life insurances, things like that, opportunities like that to just tell a GP”

During consultations where the participant considered disclosure of sexual orientation to be relevant, the healthcare professional seemed to be interpreted by the participants as either accepting, and therefore safe to disclose to, or not accepting and therefore likely to punish.

Freya was the only participant who appeared not to have much of a safe environment. She was also the only participant who openly stated how wrong she felt her sexual orientation was and did not accept her minority sexual orientation. She appeared to have no social group where she felt comfortable enough to be herself and seemed to exist in a world where others are unpredictable and punishment is anticipated and feared.

This theme has provided more information about participants’ experiences than can be described through sub-themes. It suggested a shared experience in the way that participants in this study had to move away from their safe environment in order to approach and experience healthcare consultations, including disclosure of their sexual orientation. This process will be illustrated further after the remaining master themes have been described.

Discomfort with defining sexual orientation

Outside the participants’ safe world they sometimes seemed obliged to define their sexual orientation as gay, lesbian or bisexual. Not all participants appeared comfortable doing this. Four participants discussed their discomfort with defining their sexual orientation. For Erica and Freya this centred on their feelings of shame around being bisexual, stemming from their upbringings in restrictive societies. For Adam, his discomfort when disclosing sexual orientation during the interview, in combination with his positive experience of being asked about his sexual history rather than for a definition of sexual orientation, suggested he felt uncomfortable disclosing. Camilla seemed to feel similarly uncomfortable in labelling her sexual orientation; although she felt comfortable in her sexual orientation, for her labelling it seemed to suggest that it could not change.

“I think I have a problem with the whole idea of sexuality and labelling. [...] Like, there's gay you know, and there's bi and that. And there's loads of degrees of it you know. [...] Because everyone's different types of them as well.”

Searching for acceptance

All participants seemed to describe searching for acceptance from others. Adam and Ben appeared to struggle to reconcile their professional and personal identities; trying to preserve a sense of self, whilst maintaining a professional demeanour. Camilla also seemed to have a desire for acceptance from others. Danielle, Erica and Freya were all non-UK born. They had experiences of different societies and healthcare systems and used comparison throughout their accounts. This comparison seemed to focus on searching for people and places where they would be most accepted. The comparison extended into preparing for the future, whether by searching for the most accepting society (Danielle) or by preparing to re-enter a more restrictive society (Erica and Freya).

“I think I would probably find a doctor that had been recommended within the gay community as sort of being gay friendly [...] because I think it does make you feel better that [...] you know from the beginning that there’s not gonna sort of be any awkwardness in the situation if you ever do sort of disclose that information...”

Participants seemed to find consultations positive when professionals asked about sexual orientation in a ‘matter of fact’ manner. This style of questioning appeared to make the participants feel at ease and that their behaviour was accepted.

“she asked me for the last three people I’d had sex with [...] I just remember it not being a big deal.”

During consultations where sexual orientation was not disclosed, participants seemed to feel more accepted if the professional appeared interested in them as people rather than just their symptoms. Similarly when the professional explained decisions to them they seemed to perceive the consultation as more positive and described a greater willingness to return.

“... you know they are taking the time to explain things to you and it’s not just like come in explain what your issue is and the doctor just prints you off [...] your prescription”

Anticipation and fear of punishment

Participants appeared to share the experience of anticipating and fearing punishment from others. This seemed to be mostly related to disclosing sexual orientation, but also seemed to occur in relation to expecting judgement from others or negative evaluation not necessarily associated with sexual orientation. Anticipation reflects the cognitive element of this theme and fear reflects the associated arousal.

By anticipating punishment from others, the participants appeared sensitive to discrimination or judgement, presuming more negativity from situations than may have been intended. Examples of this include Adam's assumption that the consultant suggested a chaperone for a gay man to protect himself, rather than to protect the patient's dignity during examination. Ben also seemed to expect negative reactions from heterosexual men he says:

"... I just think that as much as you can be okay about something like 'I don't care if you sleep with men, that's your choice', at the same time I feel like they don't understand it. [...] some people think you catch it or you're too camp in their face or something. They're just a bit wary about it so they just don't think they can like open up to you as much ..."

The fear of punishment happening to them appeared as prevalent as the anticipation. Erica and Freya both discussed their fear of being punished for disclosing sexual orientation, potentially losing their families and friends and being discriminated against in the healthcare systems in their home countries.

"...I don't think they would want to treat me; first of all they wouldn't want to be associated with someone like that..."

British born participants also described fear and recounted taking measures to protect themselves from discrimination by not disclosing sexual orientation unless it was relevant.

"I don't see the point of telling people for the sake of telling people"

Although not all participants held a fear of punishment there was a sense throughout the interviews that discrimination on the basis of sexual orientation was a very real threat and needed to be managed in some way.

The approach to healthcare consultations and disclosure of sexual orientation

The process by which participants approached and experienced healthcare consultations and disclosure of sexual orientation will now be presented. Figure 2 illustrates this process diagrammatically. Participants' apparent anticipation and fear of punishment coupled with a desire for acceptance from others seemed to affect their expectations of healthcare professionals. Most participants described expectations that professionals should be non-judgmental and trustworthy, reflecting their positions as people who are entrusted with private information. They also seemed to look for qualities suggestive of being more accepting, such being approachable; However they seemed to fear the consequences if these expectations were not met.

“I do actually prefer a nurse, I think they’re more [...], holistic and more unjudgemental about stuff some of the doctors can seem a bit stuck up and bit dry [...] I’d prefer to have someone a bit more friendly”

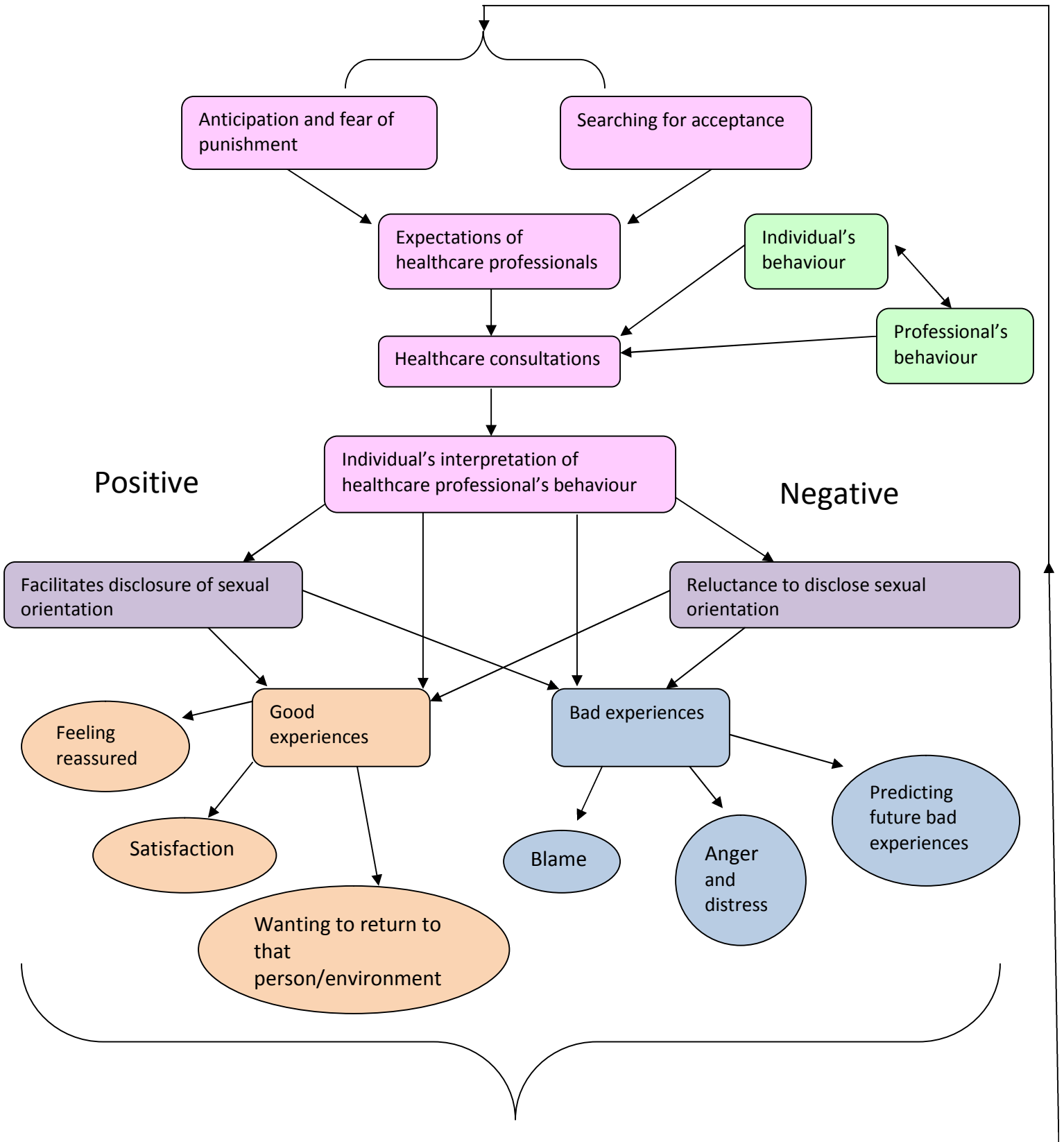
The participants’ expectations appeared to affect their approach to consultations and their behaviour during it. The interactions then appeared to depend on each party’s behaviour during the consultation, for example, Camilla’s counsellor asked about her boyfriend; Camilla’s reaction to that question influenced the remainder of therapy. The participant’s interpretation of the professional’s behaviour, in particular if the professional met their expectations, seemed to affect how positively they perceived the consultation. When sexual orientation was relevant to the consultations, if the participant felt accepted by the professional they seemed more likely to disclose their sexual orientation.

Alongside professionals’ behaviour during consultations, reactions to disclosure seemed to affect participants’ perception of interactions. If they perceived an interaction as positive, participants seemed to feel reassured and satisfied as well as a willingness to return to that person or environment.

“it just seemed that it was a good thing to go back and get checked again. And yeah, they were really nice.”

When expectations of professionals were not met, participants recounted being distressed by the consultation, becoming angry and attributing blame for the negative outcome. Consequentially, participants seemed to describe increased anxiety and greater sensitivity to punishment, including discriminatory comments, potentially increasing the likelihood of anticipating future negative experiences. The effects of both positive and negative consequences seemed to affect future consultations, either lessening or increasing the anticipation and fear of punishment and the hope for acceptance from others.

Figure 2 The approach to healthcare consultations and disclosure of sexual orientation



Section 4: Reflexivity

In this section I will reflect on my own approach to the research process, focussing on the interviews and findings and the thoughts and feelings they brought up in me.

During the interviews I often found myself becoming angry at the participants' experiences, and upset that they would have to cope with the effects of their negative experiences; however what struck me more was my frustration with a couple of participants. They justified their negative experiences away, believing them to be an isolated incident, seemingly unaware that they had told me of more than one 'isolated incident'. I was surprised by their hope that these negative experiences were sole events and their continued faith in the NHS. This made me consider my own views about accessing healthcare. I previously believed that I knew my position on this, but until this point I had not acknowledged some of the resentment I held towards healthcare professionals nor the anxiety that I have prior to disclosing my sexual orientation in that setting. I also noticed my feelings of willing the participants to fight back, to complain about the treatment they received. This feeling was tempered by noticing that some participants were still making sense of their experiences, some were recent occurrences, where it may have been protective for the participant not to acknowledge the extent of their distress following the experiences. I was also aware of the age difference between myself and my participants, the youngest participants were eight years younger than me, and would have come through senior school after section 28 was repealed. I wondered how I would have dealt with negative experiences like theirs at that age, but as I did not come out until later than most of the participants, I struggled to know what I would have done. Acknowledging my own feelings brought up during the interviews made it easier to notice when these influenced my interpretation. I repeatedly asked myself if I was focussed on the participant when I was interpreting the data. If I felt that an interpretation was being influenced by my own fore-conceptions, I left it, distracted myself with other tasks and returned later. This gave me the opportunity to reconsider the data whilst gaining some distance from any fore-conceptions which may have been evoked allowing me to be more assured that I was interpreting the data, rather than my own thoughts.

CHAPTER 4: DISCUSSION

This chapter will discuss healthcare consultations described in this study before presenting a review of the main findings in relation to existing literature. Limitations of the study and suggestions for future research will be discussed. Finally, clinical implications and final reflections will be presented.

Aims of the study

This study aimed to explore LGB people's experiences of healthcare consultations, disclosing sexual orientation and the sense they made of these experiences. The research questions were:

- What are young adult lesbian, gay and bisexual people's experiences of healthcare consultations?
- What are young adult lesbian, gay and bisexual people's experiences of disclosing sexual orientation within healthcare consultations?
- What sense do they make of these experiences?

The study addressed these questions by interviewing young LGB people about their experiences of healthcare and disclosing sexual orientation. These interviews were analysed using IPA. The themes produced helped to answer these questions by suggesting how participants appeared to approach consultations, how this affected their behaviour and their perception of the professional's behaviour during the consultation; and how their interpretation of this interaction affected their approach to future consultations. These findings will be discussed throughout the discussion.

Summary of findings

Findings of the current study support previous studies examining the disclosure of sexual orientation in healthcare consultations (Hitchcock & Wilson, 1992), adding the experiences of males and emerging adults in UK healthcare consultations. The master theme of anticipation and fear of discrimination is also in support of Swim et. al (2008) reported finding that fear of discrimination associated with sexual orientation was constantly experienced for LGB participants. This theme also suggests links with research into disclosure of HIV serostatus, where fear associated with disclosure (Bairan, et al., 2007; Klitzman & Bayer, 2003; Serovich, et al., 2010).

Section 1: Instances of healthcare consultations and disclosure in this study

Six GP consultations were described, none of which included disclosures of sexual orientation. This low number is consistent with other research, which found low numbers of participants disclosing to their family doctor (Allen, et al., 1998), and that doctors do not routinely ask about sexual orientation (Dahan, Feldman, & Hermoni, 2008) and may feel uncomfortable discussing LGB issues (Hinchliff, Gott, & Galena, 2005). In contrast, six consultations in sexual health clinics all included disclosures of sexual orientation. This is likely to be due to the nature of the consultation, although several participants commented that the professionals asked for a sexual history rather than a definition of sexual orientation. Two consultations were described from other forms of UK healthcare, one of which included a disclosure.

All participants had experienced several healthcare consultations in the UK. All but one participant had disclosed their sexual orientation to a healthcare professional at some point. All participants described at least one positive or neutral experience of healthcare consultation and at least one negative experience. Positive aspects of accessing healthcare included the ease of access and making the appointments, explanations given by healthcare professionals for the medical decisions and consultations where participants felt listened to and treated as an individual. Negative experiences of healthcare included the sense that appointments were too short and were too rushed. When the professional asked only about their symptoms, some participants felt ill at ease, dismissed, unheard or depersonalised.

When disclosure did occur, participants reported wanting professionals to acknowledge it in a matter of fact manner, asking only as much as is necessary. Some participants expressed discomfort with their sexual orientation; some appeared to be unwilling to label themselves as gay or bisexual, while for others this was coupled with a sense of shame and negative cognitions associated with sexual orientation. Positive responses to disclosure both within and outside of healthcare consultations seemed to be associated with a sense of acceptance and freedom. However uncertainty about others' reactions appeared to result in several participants not feeling able to be themselves during healthcare consultations, often hiding, conforming or manipulating the way that others would view them.

Section 2: Findings in relation to existing literature

The experience of healthcare consultations described in the study will now be compared against existing literature. Findings supporting existing literature will be highlighted alongside any findings which differ or add to the evidence base.

Anticipation and fear of punishment

Participants appeared to have a shared experience of anticipation and fear of punishment, particularly associated with disclosure of sexual orientation. This finding supports previous literature where LGB patients described an insecurity in disclosing to nursing staff (Röndahl, 2009) and is also in line with Swim et al. (2008), who found there was a constant fear of prejudice or discriminatory acts experienced by LGB people in their study. The findings of the current study also relate to the literature on disclosure in HIV, where regret, fear, stigma and homophobia are linked to disclosure (Bairan, et al., 2007; Klitzman & Bayer, 2003; Serovich, et al., 2010). If the anticipation and fear of punishment is severe, it seems likely that it may affect attendance at healthcare services. Non-attendance at services could affect patients' health. This is supported by research which found that although there is a stigma attached to those who do not attend for healthcare appointments, people may also not attend for self-protective reasons (Buetow, 2007). Furthermore, literature suggests that people who do not attend do not see their behaviour as problematic, but focus on others' negative perceptions of their behaviour. This focus can contribute to a further deterioration of the relationship between the patient and professional (Buetow, 2007; Martin, Perfect, & Mantle, 2005).

Anticipation and fear of punishment could also be viewed from a social constructionist position, i.e. that we construct our reality in different ways and that there is no absolute 'truth'. Social constructionists believe that all experience is understood from a particular perspective, and that our perspective will be shaped by our previous experiences as well as the language we use, amongst others (Burr, 2001). From this perspective, earlier negative experiences of consultations are likely to shape the participants' perspective on future encounters where they anticipate they are most vulnerable to negative evaluation, such as when disclosing sexual orientation. Early negative experiences associated with sexual orientation may also affect a person's internal view, and contribute to anticipation and fear of punishment. Societal pressures associated with heteronormativity and the high levels of homophobic bullying (Stonewall, 2007) suggest that people in this age group may already have had to cope with negative experiences associated with their sexual orientation, even if these occurred prior to the time they officially 'came out'.

Discomfort with defining sexual orientation.

This anticipation and fear of punishment may link to the shared experience of discomfort with defining sexual orientation. Several participants seemed to describe their discomfort with labelling themselves as having a particular sexual orientation. This may have related to fearing the consequences of doing so, but may also have been linked to their stage of identity development. The participants in this study were recruited between the ages of 19 and 24, suggesting that they were in the period of emerging adulthood (Arnett, 2004b). Emerging adulthood is thought to consist of five parts, 1) identity exploration, 2) instability, 3) self-focus, 4) feeling in-between, 5) possibilities. All participants in this study were students, undertaking education prior to finding employment; they were also living away from where they called home, offering a new freedom to explore their identities. Even the participant who had a long-term committed relationship, and who therefore may be seen to have adopted a more 'adult' rather than 'emerging adult' role, described many life changes.

Instability in emerging adulthood (Arnett, 2004b) is to some extent normative: young adults instigate and experience change regularly while finding the path which most suits them. All participants had moved house, some had changed countries, societies, friendship groups and had different sexual partners. All these experiences fit with the idea of an emerging adult, finding their identity by experiencing change and seeing what feels right to them. This identity exploration can be distressing (Wängqvist & Frisé, 2011), which is perhaps reflected in the struggles that participants described in integrating their different identities and discomfort in disclosing sexual orientation. The participants' accounts may also be understood in relation to the instability experienced during this time which has been associated with low self-esteem and depressive symptoms (Luyckx, De Witte, & Goossens, 2011). For example, Freya seemed intensely uncomfortable with her sexual orientation, which appeared heightened by her realisation that she would have to return to a restrictive society where she would not be allowed to express or explore it.

Self-focus during this time is expected and seen as a necessary means for individuals to explore their identity. This self-focus may help explain some of the findings in the current study, where participants' anticipation of punishment from others seemed to make them sensitised to any action which could be viewed as negative, and therefore likely to perceive negativity in a situation

which others may perceive differently. This sensitivity could be viewed as hypervigilance. Hypervigilance and avoidance of negative experiences have been shown to maintain high levels of social anxiety in clinical and non-clinical populations (Bögels & Mansell, 2004), suggesting that the participants in the study may be maintaining their fear of negative evaluation by using hypervigilance as a safety behaviour.

The feeling of being in-between described in emerging adulthood is seen in all accounts but might be seen most clearly in the accounts of Erica and Freya, who spoke of going to healthcare consultations without their parents for the first time; they reported that these experiences gave them a sense of pride and taking responsibility for themselves. Emerging adulthood as a time of possibilities was clearly seen in the findings from this study. Participants talked about exploring their identities, trying new things, doing things for themselves and looking to the future.

One of the reasons for discomfort with defining sexual orientation may be that the participants were still in the process of sexual orientation identity development. Several models of sexual orientation development describe a period where sexual orientation identity is explored before being committed to (Cass, 1979; Coleman, 1981a; Rotheram-Borus & Langabeer, 2001; Troiden, 1988). As some of the participants appeared either to still be exploring their sexual orientation, or reported discomfort with defining sexual orientation, then it would appear that these findings fit with the idea of stages of sexual orientation identity development as not all participants appeared to have reached the stage of acceptance or comfort with their orientation.

Discomfort with defining sexual orientation may indicate that the individual is still experiencing a period of exploration; however it could also be understood from the position of self-acceptance. LGB people have been suggested to vary in their levels of self-acceptance (Mohr & Fassinger, 2003). An individual's experiences during identity formation may affect their self-acceptance in relation to sexual orientation (Cass, 1979; Mohr & Fassinger, 2003).

One aspect of experience which has been proposed to be related to self-acceptance is attachment. Adult attachment has been linked to an individual's ability to cope with fear-provoking or challenging situations, including emotional regulation and help-seeking behaviour (Lopez & Brennan, 2000; Mohr & Fassinger, 2003). Fear provoking and challenging situations have been linked to the identity formation process for LGB people (Mohr & Fassinger, 2003), suggesting that participants' attachment will affect their ability to cope with defining and disclosing their sexual

orientation. This concept is supported by research with gay men, that greater secure attachment led to greater self-esteem and positive social behaviour, and that this relationship was mediated by their attitudes towards their own sexual orientation (Jellison & McConnell, 2004; Mohr & Fassinger, 2003).

Searching for acceptance

The participants seemed to crave acceptance in all aspects of their life including healthcare. They wanted to feel accepted in society, with the non-UK born participants appearing to compare societies, searching for a place they would feel most accepted and able to be themselves. In healthcare, wanting acceptance seemed to be coupled with anticipation and fear of punishment, affecting how participants approached consultations, particularly in relation to disclosing sexual orientation. This finding supports previous research suggesting that LGB young people consider that a close relationship is an important part of deciding whether or not to disclose sexual orientation (Savin-Williams & Ream, 2003). The master theme of searching for acceptance may help understand the master theme of 'somewhere safe to be free', where acceptance is assured within the safe world, but not outside it.

Somewhere safe to be free

Participants seemed to value the experience of an environment where they felt free to be themselves. Within this safe environment appeared to exist those friends and relatives who accepted them for who they are. As a result they seemed to feel free to express themselves as they chose. Outside of the safe environment, it seemed as though acceptance could not be assumed. Past experiences appeared to influence which people or situations were viewed as safe. In order to find the most accepting people and places outside of their safe world, participants seemed to use comparison to understand how that particular experience fitted in with their past experiences. Comparison in order to make sense of experiences is not a new phenomenon. Comparison is thought to have an evolutionary basis, used to compare one's own attributes against others; this could be used in mate selection, with the effect being that any offspring may have a selective advantage over others (Dvash, Gilam, Ben-Ze'ev, Hendler, & Shamay-Tsoory, 2010). This same process may be used to compare the most positive attributes in consultations, which would have the most likelihood of positive outcomes for the patient and may therefore be advantageous for the patient. Comparison with others has also been associated with self-evaluation and emotional reactions (Festinger, 1954).

This theme could also be understood as part of the participants' identity exploration as emerging adults. This exploration may have allowed them to find others with whom they feel free to be themselves, however they may still be exploring how to conduct themselves outside of this safe environment. This is supported by several participants struggling to manage different aspects of their identities, particularly in situations where they felt more vulnerable (such as at work). As described, this identity exploration can be distressing (Wängqvist & Frisé, 2011), which may help understand the uncertainty seemingly experienced by participants when interacting with others outside of the safe environment. The uncertainty may also be a product of the sense of instability and feeling in-between experienced by emerging adults (Arnett, 2004b). These are people who may live away from home, but still be reliant on financial support from parents. As students they are also not fully immersed in a profession or career; some may not know what they want to do after university. This uncertainty about how to interact with the world outside of the safe environment may reflect their uncertainty about who they want to be as adults and how to achieve their goals.

Expectations of healthcare professionals

The themes of anticipation and fear of punishment and searching for acceptance both appeared to contribute to participants' expectations of healthcare professionals. Expectations are part of social interactions (Conley, Evett, & Devine, 2008). Darley and Fazio (1980) present a model of expectancy-confirmation in interpersonal interaction. They suggest that expectations affect the dynamics that occur in an interaction. People who approach an interaction expecting negativity are likely to behave more negatively, which in turn is likely to elicit negative responses from the other individual, which confirms their expectation of negativity (Conley, et al., 2008; Darley & Fazio, 1980). This example of a self-fulfilling prophecy (Crano & Mellon, 1978) may explain some of what occurs when LGB people access healthcare; however it seems important not to assume that LGB people experience negative consultations purely because they expect to: they may also experience negative consultations as a result of poor practice on the behalf of the professional. Having expectations of negative experiences could also be explained by an experience of inter-group relations. If the patient and healthcare professional view each other as very different, and see themselves as belonging to a different group (i.e. LGB/heterosexual or patient/professional) they may behave differently than if they perceived they were similar (Conley, et al., 2008). Blascovich et al, (2001) found that during inter-group interactions people experienced an increase

in physiological arousal (Blascovich, Mendes, Hunter, Lickel, & Kowai-Bell, 2001). This increase in arousal could then affect behavior, making a negative consultation more likely.

Research on expectations has found that distress is associated with the violation of expectations (Bartholow, Fabiani, Gratton, & Bettencourt, 2001; Cramer, Lipinski, Meteer, & Houska, 2008) and that violation results in more extensive cognitive processing of the event, thus increasing better recall of violations, than confirmations of expectations (Bartholow, et al., 2001). In this study, several participants reported expecting professionals to behave in certain ways, such as Ben and Camilla who expected them to be trustworthy and professional. Both Ben and Camilla appeared to have experienced violations of expectations by professionals who behaved in a more negative manner (in their perception) than expected. Nonetheless, Erica appeared to have expectations that professionals would break confidentiality and punish her for her behaviour. She also seemed to experience a violation of expectations, but in a positive manner, suggesting that less distress was associated with the violation of expectations.

Previous experiences of having positive expectations of healthcare consultations met has also been linked to satisfactory outcomes of the consultation (Ruiz-Moral, Pérula de Torres, & Jaramillo-Martin, 2007), in line with findings of the present study.

Healthcare consultations

All participants had experience of accessing healthcare in the UK. They discussed experiences with GPs, sexual health clinics and a counsellor in detail. These represent different types of consultation and so will be discussed separately.

GP

Participants generally seemed to find accessing healthcare for general physical ailments through a GP easy, although there were some of the common concerns, e.g. several participants commented that appointments were not always convenient, but reported that this did not stop them accessing services. Those who had come from other countries found UK healthcare very different to back home. Two of the three non-UK participants found that UK GP appointments were shorter in duration, leaving less opportunity for introductory general questions, which would have allowed them to build a stronger relationship with the healthcare professional. When the professional asked only about their symptoms, some participants felt ill at ease, dismissed, unheard or depersonalised. It is argued that one of the most important elements of consultations is that a healthcare professional understands and responds to the patients' concerns (Weingarten, et al.,

2010; Zimmerman, et al., 2007). The short duration of appointments may make this process more difficult for the professional as they must prioritise what information to seek during the consultation.

The short duration of appointments may have contributed to participants feeling unwilling to disclose sexual orientation, as it may not have seemed as high a priority as a physical ailment. This need to prioritise due to the short duration coupled with fearing the consequences of disclosure may have made participants reluctant to disclose to a GP without clear reason. As the short duration was felt to hinder the building of a relationship with the professional, the participants would also have no evidence of the professional's potential reaction to a disclosure, which may have made disclosing seem more risky.

Nonetheless, in agreement with previous studies, participants seemed to value explanations given by professionals for the medical decisions made, (Beiseker & Beiseker, 1990; Hagihara & Tarumi, 2006) and consultations where participants felt listened to and treated as an individual. This seems to fit with literature around shared decision making, where patients feel involved with their care. Evidence suggests that shared decision making is associated with higher patient satisfaction, which seems to be echoed in the results of the current study (Carlsen & Aakvik, 2006; Kidd, et al., 2004).

Sexual Health

When healthcare was concerned with a personal problem, or when participants feared that they might have to disclose their sexual orientation, it seemed to become anxiety provoking for participants. Sexual health consultations represented a type of consultation where all participants expected to be asked about their sexual history. What seemed to make this experience less anxiety provoking was to be asked in a matter-of-fact manner about sexual history (i.e. have you slept with men and/or women?) rather than for a definition of sexual orientation (i.e. are you straight/gay/bisexual?). However, several participants reported conflict in consultations with professionals. Conflict is not unusual in consultations (Weingarten, et al., 2010), and has been previously found to be concerned with differing beliefs about the patients' illness and expectations for treatment (Vanderford, et al., 2001). In the current study, conflict appeared to be around having expectations of professionals which were not met. In this study, conflict was described more in relation to sexual health appointments than other forms of consultation. Some participants reported expectations that professionals should be non-judgmental, trustworthy and

approachable. These expectations are reflected in the General Medical Council's (GMC) good practice guidance (GMC, 2006), suggesting that the expectations of participants were similar to those of a professional body. The participants may have been more sensitive to the perception of expectations being met in a sexual health setting, due to the personal nature of the consultation, which may have been anxiety provoking on its own.

Counsellor

One participant in the current study described consultations with a counsellor. She reported explicitly using a cue to signal disclosure of sexual orientation, which appeared to be missed by the professional. Missing cues is not an unusual finding (Zimmerman, et al., 2007). In one study, GPs missed 79 per cent of patients' cues about important matters (Levinson, Horawara-Bhat, & Lamb, 2000). Professionals have also been shown to display behaviours which discourage disclosures of information, such as asking closed questions (Del Piccolo, et al., 2007; Street, et al., 2005; Zimmerman, et al., 2007). However, these were not short consultations and would be qualitatively different to GP appointments. This participant appeared to view the counsellor not picking up the cue as a conflict. Conflicts have been suggested to inhibit patients' ability to participate in the consultation actively (Weingarten, et al., 2010) Active patient participation has been associated with greater satisfaction with the interaction and although it has been found to be mainly patient-initiated, healthcare professionals have also been found to under-use behaviours such as active listening and summarising which can foster a more collaborative interaction (Schouten, et al., 2007; Street, et al., 2005), although this seems unlikely to have occurred in a counselling session.

Summary

Positive experiences of consultations appeared to include patients feeling accepted and involved in the consultation. However, negative experiences of healthcare were also described in this study. This is in contrast to research which found that participants were unwilling to directly criticise their care (Staniszewska & Henderson, 2004). It seems possible that participants may have been more willing to criticise their care as the research was not associated with a particular NHS organisation and therefore their thoughts would not be passed onto the relevant services.

Disclosure of sexual orientation

Hitchcock and Wilson (1992) found that the women in their study used scanning methods to ascertain whether the environment was safe in which to disclose their sexual orientation. The participants in the current study, both men and women, also looked for evidence of others'

reactions prior to disclosing. The strategies used in assessing whether or not disclose help answer the research question about the experiences of disclosing for LGB people. These findings suggest that almost twenty years after Hitchcock and Wilson's (1992) study LGB people still assess how safe it is to disclose. The findings of this study also suggest that males may utilise similar strategies to females as they described looking for evidence of a person's reaction prior to disclosing; although Ben in particular appeared to use a more general strategy of preferring females, as he felt they were more accepting.

The strategy of looking for evidence of others' reactions appeared to be related to the themes of anticipation and fear of punishment as well as searching for acceptance. This is in common with Swim et al's study (2008) where fear of discrimination was found to be constantly present for LGB participants. It also suggests a similarity with research concerned with disclosure of HIV serostatus, where fear, stigma and homophobia were all found to be related to disclosure (Bairan, et al., 2007; Klitzman & Bayer, 2003; Serovich, et al., 2010).

The themes of anticipation and fear of punishment as well as searching for acceptance appeared to relate back to both the first and second research questions, examining not only LGB people's experiences of consultations, but of disclosing sexual orientation within a consultation. In this study, the young LGB people seem to hope for acceptance from the other person, but fear the consequences of disclosing, anticipating that the other person will react in a negative manner towards them.

Interpretation of healthcare professionals' behaviour

The interpretation of healthcare professionals' behaviour appeared to help answer the third research question of what sense the participants made of their experiences. Participants appeared to understand positive consultations as the healthcare professional treating them as an individual and caring about them. They seemed to feel accepted and validated by these consultations. If a healthcare professional's behaviour was felt to match expectations, it appeared to be viewed as positive, even if not perfect. These positive experiences seemed to be understood as meaning that the professionals were understanding and non-judgemental, resulting in participants feeling validated. When sexual health consultations were perceived as positive, this seemed to have the effect that the participants considered that their behaviour was normal and not shameful. The effects of this understanding were that some participants felt freer and adopted a more positive viewpoint of their own behaviour.

Negative consultations were often described as isolated incidents despite participants reporting several 'isolated incidents'. These negatively perceived consultations may have contributed to participants' heightened sensitivity to punishment from others and thus increased anxiety about future consultations, particularly those where they may need to disclose their sexual orientation. One consequence of negative experiences in this study seemed to be that participants felt they did not want to return to that service. This might increase the likelihood of individuals not receiving the most appropriate healthcare. This seemed to suggest that the participants were expecting a repetition of the negative consultation, even though they described it as an isolated incident. It seemed that although they were reporting 'isolated incidents', some participants were also taking steps to avoid future negative experiences, including not wanting to return to the same service.

Some participants blamed the individual professional and became angry with them following negative consultations, others blamed themselves. Self-blame is known to occur when a person experiences a negative experience; evidence suggests that the amount of self-blame may vary depending on whether the person's trust was violated, with higher levels of self-blame associated with greater violation of trust (Efron & Miller, 2011). Efron and Miller (2011) studied financial decision making. They surveyed students about their willingness to invest \$100 in a number of hypothetical companies where the source of risk varied (e.g. risk of failure due to market forces or risk of failure due to fraud). If the participants experienced a loss where a violation of trust had been involved (e.g. fraud), they found that they experienced greater self-blame when compared to a loss where trust was not involved (e.g. market forces). The participants in the current study appeared to expect healthcare professionals to be trustworthy, therefore when professionals did not behave in a manner which the participant expected of them, this might have constituted a violation of trust. This may have been the case for Camilla who perceived the counsellor as judging her, thus behaving in a way which violated her expectations of trustworthiness. Camilla then described both blame directed at the counsellor and self-blame. Avoidance of self-blame has also been shown to lead to less risk-taking behaviour (Efron & Miller, 2011). If we consider disclosure of sexual orientation as risk-taking behaviour; if the individual considers that the risk of a negative experience is too high, and therefore carries a high-risk of self-blame, then they may choose not to disclose in order to protect themselves.

Section 3: Strengths and limitations of the study

This study is the first to the author's knowledge which attempted to use IPA to examine the experiences of healthcare consultations and any disclosure of sexual orientation described by a sample of young LGB adults in the UK. It is also the only study to the author's knowledge that examined LGB peoples' experiences of healthcare consultations and disclosing sexual orientation using a qualitative approach since 1992 (Hitchcock & Wilson, 1992). It provided an understanding of the sense participants made of these experiences and identified shared experiences across participants, adding up-to-date evidence to a small but growing evidence base around LGB people's healthcare needs. There were several strengths and limitations of the study, which will now be discussed.

Recruitment was driven by the use of bright, eye-catching posters which were clear about the study. The information sheet was also considered clear and concise and provided not only information about the study, but of the Samaritans, to provide support for participants if they should need it. Improvement could have been made by seeking feedback from participants on content of both the poster and information sheet. Piloting the information sheet would have allowed any alterations to be made prior to the study, enabling potential participants to have a clearer idea of the aims of the research and make it as relevant as possible to the target population.

The topic guide used was considered structured enough to glean relevant information from participants, but was able to be used flexibly during interviews, allowing participants to recount their experiences without interruption if they were answering the questions. Although it was piloted with a member of the QRSg, a small pilot study could have been conducted to ascertain if the topic guide helped facilitate conversation during the interview around the research questions, potentially improving the data generated during interviews.

The sample selected for the study were all eligible according the inclusion criteria specified in the method. However, in line with IPA principles (Smith, et al., 2009) a more homogenous sample could have been recruited. Although all participants had experienced UK healthcare, the sample included three participants who were not British nationals. The University of Leeds has a large proportion of foreign students (University of Leeds, 2006), so it is unsurprising that they are represented in this research; however it was surprising that they made up half the sample. Having a diverse sample could have been viewed as a limitation; having foreign students participating in

this study, however, has provided an added a cultural aspect to the research which was unexpected. This added element of culture has added to our understanding of disclosing sexual orientation to healthcare professionals, highlighting how the cultural differences in upbringing appear to have influenced participants' attitudes towards disclosing their sexual orientation. The analyses also appeared to indicate that comparison with previous experiences appeared to influence participants' expectations of services as well as their interpretations of their treatment. Although all participants had previous experiences of accessing healthcare which seemed to have affected their fore-conceptions of services and interpretation of their treatment, foreign students had the added experience of accessing more than one healthcare system and so compared their UK healthcare with alternative systems of care. This was an unanticipated element of the research, which adds an important element to the study. Britain is a country where many foreign students choose to study, and people from a huge range of cultures live and access healthcare here so it seems appropriate that the sample in this study represented this to some degree.

The diversity of the sample has impacted on analysis, and although it adds an unanticipated element to the research, there is a dearth of literature in this area, so a study with a more homogenous population may have produced findings which would understand LGB people's experiences of healthcare in greater depth. The sample also included participants who were healthcare professional trainees. They understood their experiences of consultations from perspectives of both patient and professional. As such they had high expectations of their own healthcare, perhaps reflecting the standards they are expected to adhere to as trainees. Although diversifying the sample further, this added a realistic perspective to the study, as NHS employees are also patients and this change of role may impact on how they make sense of their experiences of consultations. Having healthcare professional trainees as participants may also have increased the likelihood of finding a shared experience of comparison, as they compare between the expectations that others have of them, and the expectations they have of others. They also experience healthcare from a position where the organisational structure and culture are apparent, something which people who are not employed in healthcare would experience. There is a tension for these participants in being both users and providers of healthcare, which may be harder to resolve at this early stage in their careers. The issue of identification with healthcare provider roles and its relation to identity is likely to affect their perceptions of their own healthcare consultations.

By using a student population the findings may not be as generalisable to the general population. University students are expected to have achieved a certain level of academic success in order to attend. The effect of their studies might be that they understand their experiences of healthcare in a different way to those who have not attended university, or more precisely those who have not achieved the same academic success. They may also have different experiences to emerging adults of a similar age who are employed or out of work. These groups of emerging adults may have different priorities when accessing healthcare or understand their experiences in different ways to a university population.

Limitations existed in the interview method; although semi-structured interviews are a recognised method of data generation for IPA (Smith, et al., 2009) and offer the opportunity for open questions, allowing the researcher to enter the participants' world, they also have their limitations. Smith and Osborn, (2003) suggest that caution should be used when conducting interviews which rely on prompts. They believe that the researcher may inadvertently impose their own structure onto the interview which may hinder their ability to enter the participants' world, leading to different data being generated (Oates, 2006; Smith & Osborn, 2003). This may have occurred in the current study, as my own fore-conceptions may have led me to focus on elements of the participants' experiences which resonated with my own. Employing a reflexive approach allowed me to monitor my decisions of which elements of the participants' accounts I pursued; however my own interest in the topic meant that there are likely to have been times that I pursued one particular route to a greater degree than another researcher might have. Rigour could have also been increased by conducting an analysis of the questions posed during interviews by the researcher. This could have enabled a check on whether the questions were sufficiently linked to the research questions, increasing the strength of the findings.

In line with (Elliot, et al., 1999) my reflective stance made it easier to process my own reactions throughout the interview process, noticing when it was impacting on analysis and how this could be understood in relation to the themes emerging from the data. Analysis will have been influenced by the researcher's own standpoint on the topic. Another researcher may have approached the data in a different way. During analysis they may also have focused on different themes, developing them in an alternative way to this study. The findings of any study using IPA will always be affected by the researcher as by the nature of the method, the researcher interprets the participants' interpretations (Smith, et al., 2009). I was also inexperienced with the use of IPA.

Although this was not necessarily a limitation, a more experienced researcher may have presented the data differently, or identified more complex themes arising from the data.

Quality checks have been conducted throughout the study, including sharing parts of the analytic process with my supervisor, to ensure that the themes could be logically traced from the data. There were alternative checks which could have been incorporated. Multiple analysts could have been employed, as this would have allowed greater checking of when my own position on the subject matter was impacting on analysis, something which may have reduced as my supervisor became more familiar with the study and my way of thinking. My understanding could also have been verified by relating the themes back to the individuals and asking for feedback. This was not utilised as it was felt that due to the nature of the study, my interpretation of the participants' experiences may differ greatly from theirs. This is consistent with studies using IPA, as the interpretative element can take the researcher further from the participant's original words into a more abstract understanding (Smith, et al., 2009).

Clinical Implications

The findings from this study can be used to inform clinical care. This study suggests that, in line with existing guidelines on good practice (GMC, 2006; GMC & Stonewall, 2009) professionals being approachable, trustworthy and non-judgemental during consultations were perceived positively. Professionals might help patients to feel accepted by showing that they have heard and understood the patient's concerns, perhaps checking back with them to ensure correct understanding. By improving communication between both parties the patient may feel more comfortable sharing personal information, which may help the professional make clinical decisions about their care. These findings are related to the experience of healthcare consultations in general, and should not necessarily be considered specific to LGB people. One of the specific risks for LGB people is avoidance of routine healthcare, which is affected by professionals' communication with the patient and the assumption of heterosexuality (Bonvicini & Perlin, 2002; Harrison & Silenzio, 1996); therefore the findings of this study may be used to improve healthcare for LGB people.

Healthcare professionals should be aware that disclosing sexual orientation can be anxiety provoking, though there are some measures they could adopt to make it easier for patients. One measure is being sensitive to a patient's language, particularly their use of gender neutral words such as 'partner', by doing this, they may allow the patient opportunities to disclose. If these

opportunities are offered by the professional, the patient may feel safer to disclose, perceiving the professional as accepting of their orientation. Following this, the professional could be open to patients cues around sexual orientation, noticing use of same-sex pronouns, and mirroring this in their further questions. Services may also be able to alleviate anxiety in LGB people by providing LGB-friendly reading material in waiting rooms, suggesting that the service is familiar with the needs of LGB people.

Acknowledging the disclosure may help the patient feel more accepted. Participants seemed to want professionals to respect confidentiality, so it may be helpful to ask who they want that information to be shared with, and checking their consent to it being included in their notes. Some participants appeared to value a focus on sexual activity rather than a requirement to define sexual orientation. This implies that if a sexual history is needed for the patient's treatment, it may help to ask about sexual behaviour rather than for a definition of sexual orientation (ie, "do you have sex with men or women or both?" Rather than "Are you gay or bisexual?"). The implications of asking for a definition of sexual orientation might be that if a LGB person is still exploring their sexual orientation, or wishes to be label-free, they may find it difficult to disclose being gay or bisexual as they may not identify with this label. If their distress around defining sexual orientation is high, they may avoid disclosure, affecting the treatment they are offered.

Clinical implications: summary

- Having an awareness that disclosing sexual orientation can be anxiety provoking
- Sensitivity to cues around sexual orientation (e.g. using the word partner)
- Acknowledging disclosure
- If sexual history is necessary, asking for behaviour rather than sexual orientation

Future research opportunities

The findings of this study suggest options for future research. As the study used a small sample, a different sample using middle adults, or a non-student emerging adult population, also investigating LGB people experiences of healthcare consultations might provide findings which suggest other clinical implications. A study investigating LGB people's experiences of healthcare consultations using discourse analysis may also provide more information about the language used during consultations, which could be used to inform training around providing healthcare for LGB people.

It could be useful to investigate healthcare professionals' perception of healthcare consultations where sexual orientation has been disclosed, helping to understand the professional's perspective and offer suggestions for making those consultations easier for all. A study where the experiences of both professionals and patients could be investigated could also provide more information about specific consultations which could then be used to inform practice. This could be carried out by interviewing both parties about a specific consultation, or through direct observation, which would allow the verbatim transcript of the consultation to be analysed. If this was conducted alongside interviews of both parties, the interpretation of both patient and professional could be analysed for the same appointment.

Conclusion

The LGB people in this study seemed to approach healthcare consultations anticipating negative evaluation, judgement and fearing these experiences happening to them. They hoped for acceptance and searched for this in their lives and in healthcare, wanting to feel heard and validated. When they disclosed their sexual orientation to professionals they wanted it acknowledged in a non-judgemental manner. When this occurred, the LGB people in this study felt more positive about themselves, which lessened apprehension about attending future appointments and the consequences of future disclosures. This suggests that future care could be improved by having an earlier positive experience, with further positive implications for health throughout their lives, including early diagnosis of conditions which might impair health. When participants in this study did not disclose their sexual orientation, some were aware that this may have meant that they did not receive the most appropriate care, but were unwilling to risk the consequences of disclosure. The implications of non-disclosure could have meant that they remained at risk of certain conditions, potentially affecting well-being later in life.

Clinical implications from this study include increasing training around LGB issues and making clinicians aware that disclosing sexual orientation is anxiety provoking, therefore they can make the process as easy as possible for the patient by picking up any cues offered, acknowledging their disclosure and responding in a non-judgemental manner. They may also help to alleviate any anxieties in their patients by providing LGB-friendly posters or leaflets in waiting rooms. Then if people employed the strategies of looking for evidence of a reaction prior to disclosure, they may feel that the service in general is more open to hearing these disclosures. These efforts may increase people's likelihood of attending future appointments, lessen anxiety about disclosing and

fear of judgement as well as increasing their likelihood of future disclosures during healthcare consultations which may help professionals refer them for the most appropriate healthcare.

Final Reflections

At the beginning of this study I felt sure that some people felt a bit nervous before having to disclose their sexual orientation. I experienced feeling those nerves myself, wondering about the reaction of the others. But during this process, I did not expect to find the fear that some participants seemed to have about the consequences of disclosure. I was surprised at how similar some of their experiences were and how there appeared to be a common way of approaching healthcare consultations. I reflected on my own experiences of disclosure, not only in healthcare consultations, but in everyday life. I realised that prior to some disclosures I had been quite anxious. Whilst writing up this study I chose to disclose my sexual orientation again. I noticed that I was more aware of my anxiety during the disclosure, and ruminated about their response. I am unsure whether this newly noticed anxiety has always been there, or whether I have become so immersed in my data that I have been sensitised to the reactions to disclosure.

This study has made me wonder about the future for LGB people in Britain, and what the impact will be of any future changes in legislation, or changing public attitudes will be on healthcare consultations. Will LGB people in Britain ever feel entirely safe to disclose their sexual orientation? This feels like a research area with great scope, and potential for great influence.

CHAPTER 5: REFERENCES

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Appendix B: Information Sheet

Lesbian, Gay and Bisexual people's experiences of healthcare

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the project's purpose?

The study aims to look at the experiences of healthcare for lesbian, gay and bisexual (LGB) people. In particular we'd like to find out what LGB people's experiences are of accessing healthcare, disclosing sexual orientation to a healthcare professional and what sense people make of their experiences.

This will help us gain a greater understanding of how healthcare professionals are responding to LGB people, how they behave when a person discloses their sexual orientation and how LGB people are left feeling at the end of a consultation.

Why have I been chosen?

We are looking for gay, lesbian or bisexual participants who are currently students between the ages of 18 and 25, who are currently living away from where they grew up (i.e. not at home), especially ideally people who have disclosed their sexual orientation to a healthcare professional in the past year.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet to keep. There will be no effects from declining to join or withdrawing from the study. You do not have to give a reason.

What will happen to me if I take part?

I will ask you to sign a consent form and then I will arrange a date with you to conduct an interview which will normally last between 60 and 90 minutes.

This interview will be audio recorded so that I can make sense of our conversation. I'll be using interpretative phenomenological analysis which is a way of trying to draw out important themes from your account.

After completion of the interview you will be given £10 to cover your expenses.

What are the possible disadvantages and risks of taking part?

We will be talking about your experiences in with healthcare professionals and particularly how they responded to issues related to sexual orientation. This may be a difficult subject for you. If you find you would like to talk to someone further the contact details for the Samaritans is provided below.

The Samaritans
93 Clarendon Road, Leeds, West Yorkshire
LS2 9LY
United Kingdom
0113 2456789

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will help us understand how healthcare professionals are responding to sexual orientation and this may lead to suggestions for further research or training for professionals.

Will my taking part in this project be kept confidential?

All the information about yourself that you provide during the course of the research will be kept strictly confidential and will be stored securely. You will not be able to be identified in any reports or publications. The responses will be coded to ensure anonymity is preserved.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

The interviews will be about your experiences with healthcare professionals and how they responded to sexual orientation. This is to find out what your experiences have been and therefore whether healthcare professionals are responding appropriately to lesbian, gay and bisexual people within a healthcare setting.

Will I be recorded, and how will the recorded media be used?

The audio recordings of your interview made during this research will be used only for analysis. No other use will be made of them without your written permission.

What will happen to the results of the research project?

The results of this study will be written up as part of my doctoral thesis. This will be submitted in summer 2011. They may then be written up for publication in a journal or presented at conferences. Although I will include short quotations, any words will not be recognisable to others as yours. You will not be able to be identified in any report or publication.

Who is organising and funding the research?

This study is being undertaken and funded as part of the Doctorate in Clinical Psychology Programme, Institute of Health Sciences, University of Leeds.

How do I complain about the study?

If you wish to complain about anything that happens as part of your involvement with the study, you may contact:

Contact for further information

Please contact me for any further information on:

Emma Berkman-Smith
 Programme in Clinical Psychology
 Charles Thackrah Building
 University of Leeds
 101 Clarendon Road
 Woodhouse
 Leeds
 LS2 9LJ
umelb@leeds.ac.uk
 0113 343 2732

You may also contact my supervisor:

Dr Carol Martin, Programme in Clinical Psychology, Charles Thackrah Building
 University of Leeds, 101 Clarendon Road, Woodhouse, Leeds, LS2 9LJ
c.martin@leeds.ac.uk. 0113 343 2732

Thank you for taking part in this study.

Checklist

Participant number	
Age	
Student at Leeds	yes/no
Living away from home	yes/no
Sexual orientation	

**Consent Form****Lesbian, Gay and Bisexual people's experiences of healthcare**

Name of Researcher: Emma Berkman-Smith, umelb@leeds.ac.uk

Please initial box

1. I confirm that I have read and understand the information sheet provided, explaining the above research project and I have had the opportunity to ask questions about the project.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline.
3. I understand that my responses will be kept strictly confidential. I give permission for members of the research team and those typing up the interviews to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
4. I agree to take part in the above research project.

Name of Participant
(or legal representative)

Date

Signature

Lead Researcher

Date

Signature

To be signed and dated in presence of the participant

Copies:

Once this has been signed by all parties the participant will receive a copy of the signed and dated participant consent form, the information sheet and any other written information. A copy of the signed and dated consent form will be kept with the project's main documents in a secure location.

Appendix D: Topic Guide

So, today I'd like to ask you about your experiences of healthcare. If you have any questions, please feel free to ask.

Accessing healthcare:

Just to start, I'm interested in your life and how healthcare fits into your life, so I was wondering whether you would describe yourself as a healthy person?

Would you describe yourself as someone who sees a healthcare professional often (by that I mean the GP, nurse, physio, psychologist etc)?

So in the past year which healthcare professionals do you think you've seen?

Could you tell me a bit about how you find accessing healthcare? By that I mean, do you find it easy to get an appointment, do you feel it's easy to speak to the staff?

-Thoughts?

-Feelings?

-How does that affect how you access healthcare?

-What sense do you make of that?

What about any experiences of having routine health screening, like vaccinations or smear tests?

-Thoughts?

-Feelings?

-How does that affect how you access healthcare?

-What sense do you make of that?

Disclosing sexual orientation:

Could you tell me about the times you have disclosed your sexual orientation to a healthcare professional?

- When?
- Where?
- Who?
- How did you tell them?
- Why did you tell them?
- What was their response?
- What happened next?
- How did you feel at the time?
- How did you feel afterwards?
- -Thoughts?
- -Feelings?
- -How does that affect how you access healthcare?
- -What sense do you make of that?

What sense do you make of these experiences?

How do you think these experiences have changed your perceptions of healthcare professionals?

How do you think these experiences have changed your thoughts about accessing healthcare?

What sense do you make of these experiences?

Why do you think they happened?

Appendix E: Confidentiality Statement for Transcribers

Ethics Committee, School of Psychology, Leeds University

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.

As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the Ethics Committee of the D.Clin.Psychol course requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

- 1) I understand that the material I am transcribing is confidential.
- 2) The material transcribed will be discussed with no-one.
- 3) The identity of research participants will not be divulged.

Transcription procedure

- 4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.
- 5) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.
- 6) All materials relating to transcription will be returned to the researcher.

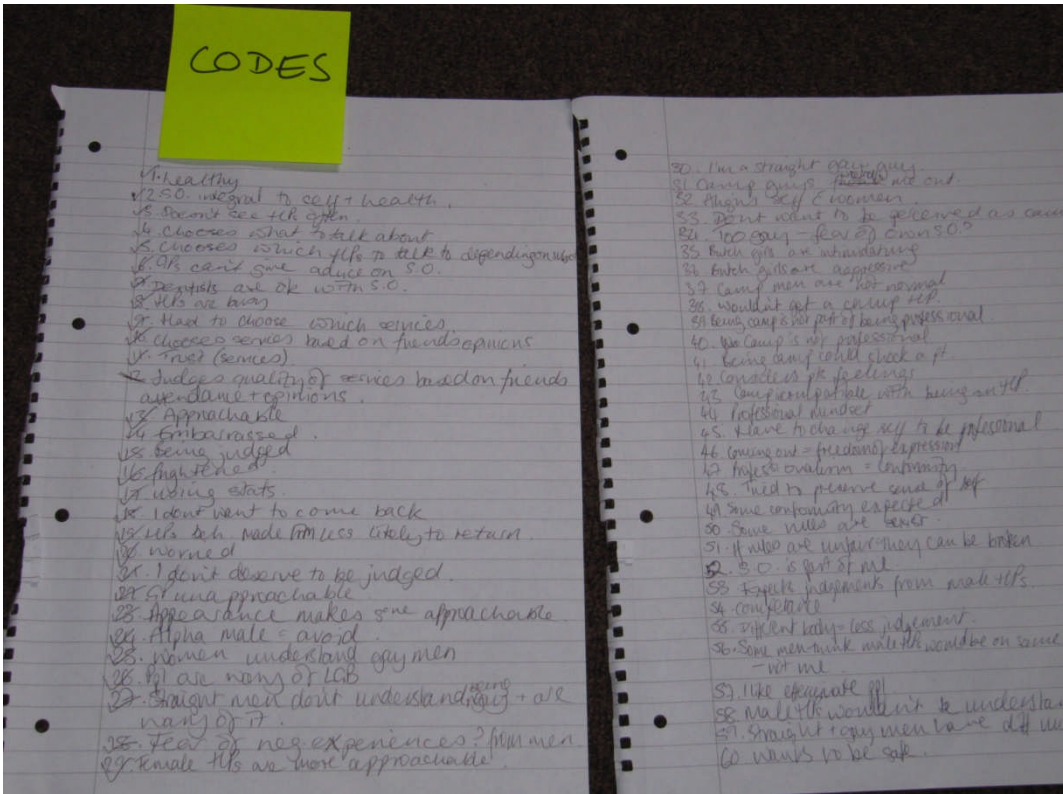
Signed.....**Date**.....

Print name.....

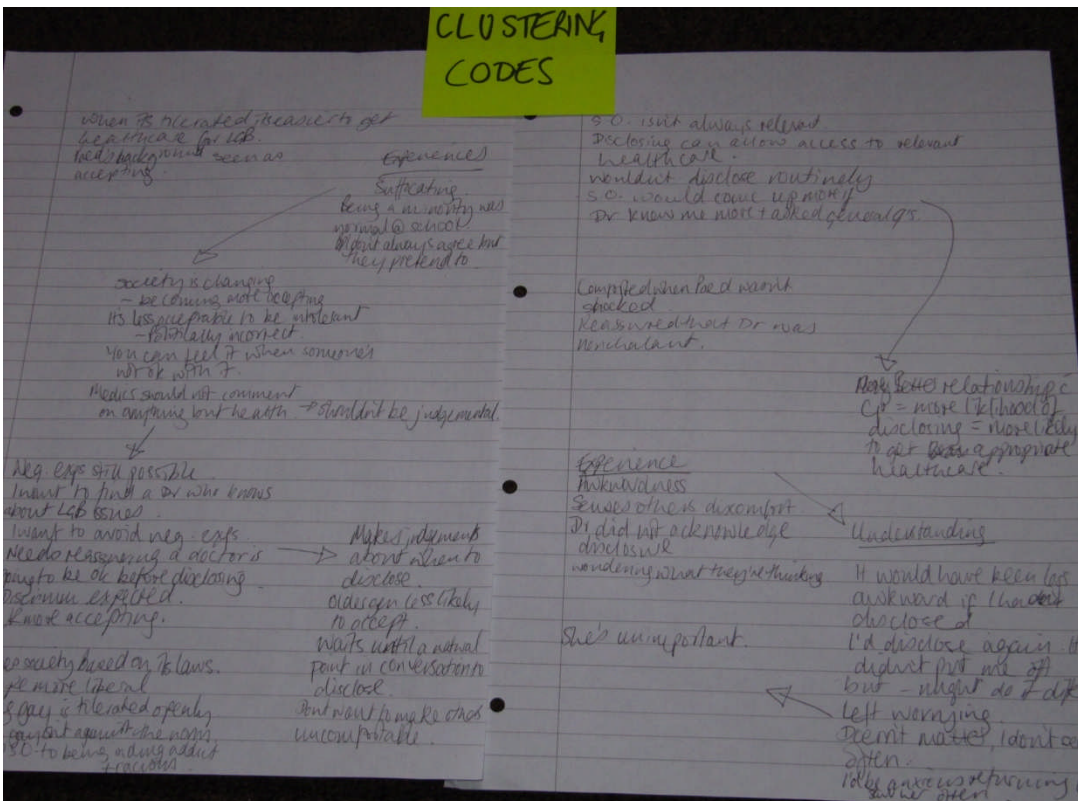
Researcher.....

Project title.....

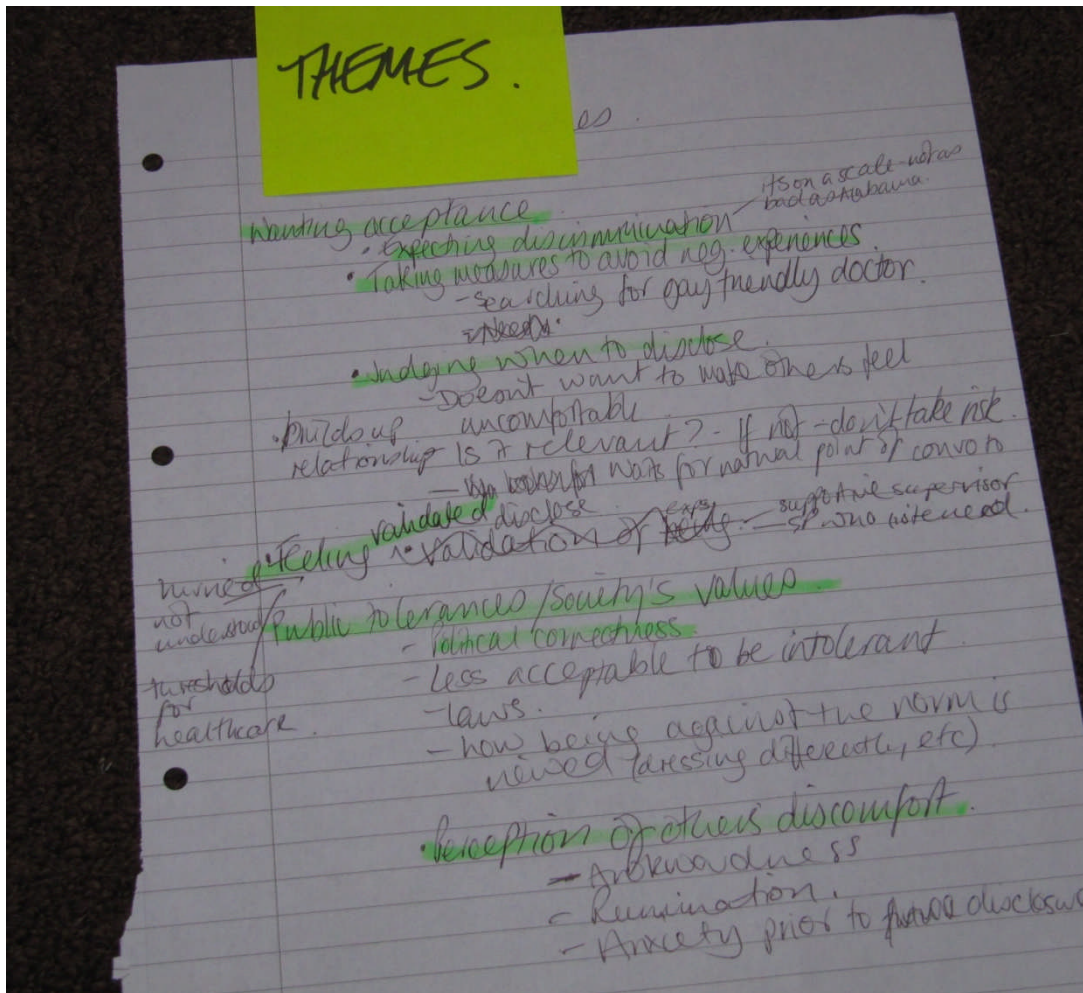
Codes



Clustering codes



Emerging themes



Appendix G: Correspondence with Ethics committee

Faculty of Medicine and Health
Research Office

Room 10.110, Level 10
Worsley Building
Clarendon Way
Leeds LS2 9NL

T (General Enquiries) +44 (0) 113 343 4361
F +44 (0) 113 343 4373



UNIVERSITY OF LEEDS

Miss Emma Berkman-Smith
Programme in Clinical Psychology
Leeds Institute of Health Sciences
Charles Thakrah Building
University of Leeds
101 Clarendon Road
LEEDS LS2 9LJ

02 December 2010

Dear Emma

Re ref no: HSLTLM/10/ 005

Title: Lesbian, Gay and Bisexual people's experiences of healthcare

I am pleased to inform you that the above research application has been reviewed by the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics (LIHS/LIGHT) joint ethics committee and following receipt of the amendments requested, I can confirm a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation at submitted at date of this letter.

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information (r.e.desouza@leeds.ac.uk)

I wish you every success with the project.

Yours sincerely

A handwritten signature in cursive script that reads "Laura Stroud".

Professor Alastair Hay/Mrs Laura Stroud
Chairs, LIHS/LIGHT REC

NOTICE OF SUBSTANTIAL AMENDMENT

To be completed in typescript by the Chief Investigator in language comprehensible to a lay person and submitted to the Research Ethics Committee that gave a favourable opinion of the research

Details of Chief Investigator:

Name: Emma Berkman-Smith
 Email: umelb@leeds.ac.uk

Full title of study:	Experiences of disclosing sexual orientation in healthcare consultations
Name of REC: School or Institute:	LIHS/LIGHT School of Medicine
Ethics reference number:	HSLTLM/10/005
Date study commenced:	December 2010
Amendment number and date:	Four amendments.11.3.11

Type of amendment (indicate all that apply in **bold**)

(a) *Amendment to information previously given on the UREC application form*

Yes

If yes, please refer to relevant sections of the UREC application in the "summary of changes" below.

(b) *Amendment to the protocol*

No

If yes, please submit either the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.

(c) *Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study*

No

If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.

Is this a modified version of an amendment previously notified to the REC and given an unfavourable opinion?

No

Summary of changes

Briefly summarise the main changes proposed in this amendment using language comprehensible to a lay person. Explain the purpose of the changes and their significance for the study. In the case of a modified amendment, highlight the modifications that have been made.

If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

1) To aid recruitment, I would like to advertise the study through facebook, using the lesbian, gay, bisexual and transgender group pages linked to the University of Leeds and Leeds Metropolitan University. The University of Leeds LGBT society uses this page as its main source of communication and therefore offers the opportunity to publicise this study to a wider audience.

2) I would like to use a safe-stick to back up my data, so that there is a copy which is encrypted, but can be used if anything happens to the data stored on the university's system. The safe stick will be kept in a locked filing cabinet when not in use, and on my person when data is being transferred.

3) I would also like to use the safe stick to analyse data using Dragon Dictation software (Naturally Speaking 10). This software transcribes audio data. By using this program, I would be less likely to need to use transcribers, thus minimising the number of people who would have access to the data.

This software is on my own computer, however having a safestick would allow me to analyse data directly from the stick and save it back to the stick, without it ever needing to be saved on my hard drive, thus protecting confidentiality of the participants. This software is not able to access data stored on the university system remotely using the 'desktop anywhere' facility, therefore without the safestick this software will not be able to be used to aid transcription.

4) I would like to have the option of using transcribers for my data. The data would be given directly to the transcribers by using a safestick and would contain no identifiable information. The transcribers who are suggested by the DClinPsychol course understand the importance of confidentiality and are experienced at transcribing data for research purposes. Once complete the transcriber would give the data back to me using the safestick.

Any other relevant information
Applicants may indicate any specific ethical issues relating to the amendment, on which the opinion of the REC is sought

Declaration
I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.
I consider that it would be reasonable for the proposed amendment to be implemented.

Signature of Chief Investigator or student:

Signature of Supervisor

Print name:

Date of submission:

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UNIVERSITY OF LEEDS

Emma Berkman-Smith
9 Genoa Street
Mexborough
S64 0DD

03 May 2011

Dear Emma

Re ref no: HSLTLM/10/ 005 - Amendment
Title: Lesbian, Gay and Bisexual people's experiences of healthcare

I am pleased to inform you that the amendment to the above research application has been reviewed by the Lead Chair of the Leeds Institute of Health Sciences and Leeds Institute of Genetics, Health and Therapeutics and Leeds Institute of Molecular Medicine (LIHS/LIGHT/LIMM) joint ethics committee and I can confirm a favourable ethical opinion on the basis described in the amendment documentation as submitted at date of this letter.

Please notify the committee if you intend to make any further amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics and Governance Administrator for further information (r.e.desouza@leeds.ac.uk)

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I wish you every success with the project.

Yours sincerely

Laura Stroud

Professor Alastair Hay/Mrs Laura Stroud/Dr David Jayne
Chairs, LIHS/LIGHT/LIMM REC