UNIVERSITY OF SOUTHAMPTON

FACULTY OF MEDICINE, HEALTH AND LIFE SCIENCES

School of Nursing and Midwifery

# Negotiating Sexual Identities: The Experiences of Lesbians and Gay Men Accessing Mental Health Care

by

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# ABSTRACT

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# NEGOTIATING SEXUAL IDENTITIES: THE EXPERIENCES OF LESBIANS AND GAY MEN ACCESSING MENTAL HEALTH CARE

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This thesis explores the mental health care experiences of lesbians and gay men when they are 'coming out'. It looks at how lesbians and gay men negotiate their sexual identities in mental health care contexts in which they have to manage the institutional homophobia and heterosexism embedded in the practice of nurses and other mental health care professionals. It is a qualitative study in which 48 lesbians and gay men, aged 17-55, participated in in-depth face to face interviews about their health care experiences. Innovative sampling approaches were used which reduced the sampling bias common in studies of hidden populations, and studies of lesbians and gay men in particular. Such sampling bias relates to social class, educational achievement, age, ethnicity and lesbian/gay community attachment. The data were analysed using a material-discursive approach which straddled epistemological divides in an attempt to side-step and overturn the dualisms which not only construct experiences but also limit our ability to conduct research into experience. The analysis was a bricolage using Interpretative Phenomenological Analysis, Positioning Theory and some deconstructive techniques. This allowed an engagement with both the material aspects of experience which were more readily articulated and the discursive aspects of experience which were often in the realm of the ineffable. The analysis permitted an understanding of the ways that lesbians and gay men are silenced and pathologised in their mental health care encounters, how they resist pathologisation and erasure, and how such resistance restricts access to care. Recommendations are made about how nursing and health care can be made more accessible to lesbians and gay men with mental health issues relating to their sexual identity, through depathologising sexual identities and through questioning the usefulness of the concept of individualised patient care; this approach does not lead inevitably to cultural competence and can reinscribe oppression through erasure. Homophobia and heterosexism create a barrier when lesbians and gay men are trying to access mental health care. Therefore, nurses and other health care practitioners need to find ways of making lesbian and gay identities more visible in their practice. In doing this they can help to create a health care environment where lesbian and gay identities are normalised thus making it safer for lesbians and gay men to explore those sexual identity issues which do impact on their mental health.

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# Chapter 1: Introduction - Disordered Identities

**Figure 1: Demonstration against Section 28 at Westminster** [1]

This work has its beginnings in a piece of political and professional activism instigated by the Conservative government's attack on the human rights of lesbians and gay men when they introduced a Clause into the Local Government Bill in 1987; this later became Section 28 of the Local Government Act which was designed to prevent the "promotion of homosexuality and pretended family relationships". On attending local "Stop the Clause" meetings and a lobby of parliament, I began to realise the serious potential health implications of this proposed legislation. Later, when participating in a lobby of the Houses of Parliament, I was particularly struck by the number of placards demonstrators were holding which said:

No more
teenage
suicides

1 in 5 lesbian
and gay
teenagers
attempt
suicide

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[1] The copyright for this photograph is held by Equality and Alliance and as the aims of this thesis are commensurate with the aims of Equality Alliance permission has been granted to reproduce it here.

The feeling at the time on seeing these placards was one of dissociation and a sense of anachronism; how was it possible for shame and pride to co-exist here? Out, proud, and confident demonstrators were pointing to the shame carried within us. In retrospect this was the first moment of conscious recognition and engagement with the binary. However it has taken several years of activism, experience and academic research for this moment to be understood in a more complete and useful way; this has involved a journey of contesting and reconstructing binaries – these binaries which shape our lives, our experiences and our understandings are a product of the dualistic world we live in. One abundantly clear binary at this stage was the heteronormativity of society against the spectre of the pathologisation of homosexuality; at this germinal stage of the thesis homosexuality was still listed as a mental illness in the WHO International Classification of Diseases and a newly published text book of social sciences for the first Project 2000 nursing diploma students listed homosexuality as a sexual perversion alongside bestiality.

It has been difficult to step aside from these binaries and not to simply reconstruct another set elsewhere - this journey has involved stepping back from the comfort zone of well adjusted lesbians and gay men in our own communities and it has involved resisting and contesting the forms of knowledge through which we attempt to understand experience and identities. It has also involved finding non-dualistic ways of understanding the resistance to these binaries in lesbians' and gay men's accounts of their mental health care experiences. Furthermore, the project has required an engagement with silence and silencing – a process which defines the health care experience of lesbians and gay men and which further complicates the research endeavour. This erasure was brought into sharp relief by the nursing profession's response to Section 28 and it is worth outlining that history to contextualise this thesis.

As an associate of the Radical Nurses' Group, the London Lesbian Nurses' Group and as a member of the Royal College of Nursing (RCN) I contrived to use the power of my Union to represent concerns about the mental health of this vulnerable group and to oppose the proposed legislation on the grounds that it would be damaging to people's health. I contacted my local RCN branch to propose an emergency resolution to congress and put a notice in the nursing press urging RCN members to take similar action. The reactions of members of the nursing profession and the establishment of the RCN to this call were salient and informative. This marked the beginning of the trail of a story; the story is one in which binaries and dichotomies stack up and shore up a particular kind of oppression which is replicated in health care. This thesis sets out to understand how these binaries assert and reproduce themselves in our experiences, in health care and in research, mapping onto each other and layering themselves creating an impenetrable web of power and silence. The injustices in health care are mapped onto the inequalities in research whereby few people are prepared to sacrifice themselves on the altar of institutionalised homophobia, and the research methods most appropriate to investigating such matters are marginalised and devalued in much the same way as their potential objects of enquiry.

Those of us who sought to oppose the proposed legislation through our Nursing Union faced a further layer of opposition – this layer of opposition was within our own profession and it became clear that the homophobia behind the proposed legislation was also within the nursing profession. RCN congress rejected the emergency resolution about the proposed legislation and so further lobbying took place during congress. It was at this point that the enormity of the struggle became apparent and the union which was supposed to represent its members seemed intent on silencing some of us – our publicity materials (for fringe meetings and our exhibition stall at congress) were confiscated by security guards and we were apprehended when we tried to enter the building. When we demonstrated outside the building RCN members told us that we were bringing shame upon the nursing profession. When we unfurled a banner over the balcony in the congress hall the General Secretary of the RCN ordered the congress delegates to avert their eyes. I also received homophobic and abusive phone calls at home on several occasions. However, whilst on one side of the binary divide there was clearly an attempt to shame and silence, on the other side some RCN activists rallied to the cause and a long struggle commenced within the organisation (for a more detailed history of this see Platzer, 1992).

What was most apparent during the early stages of this struggle was the silence and the silencing and this was linked to shame in a profound way (at one point we renamed the RCN as the Royal Closet of Nursing). By revisiting the message that was on the placards held at the parliamentary lobby it became clear to us, as a group of activists and as nurses, that there was an emerging body of research evidence showing the health vulnerability of lesbians and gay men and also (from North America) a clear evidence base of homophobic attitudes amongst nurses and other health care professionals and discrimination in health care (for reviews see Platzer, 1990; Platzer, 1993). It seemed remarkable that attempts to put this on the nursing agenda were so vehemently denied and moles within the RCN reported public floggings for staff who attempted to break the silence. However, given the cultural taboo about sexuality, the general level of homophobia within society and the conservatism within the profession, the situation was not totally surprising. Furthermore, in terms of conducting sensitive research, it is well known that researchers avoid the taint of stigma contagion wherever possible (Lee, 1993). There was thus little in the way of "proof" to counter claims that we were merely misguided trouble makers when we claimed that there was evidence of discrimination towards lesbians and gay men in the nursing profession and in nursing care.

Eventually the RCN set up a working party to investigate these claims and set us the onerous task (with little in the way of resources) to prove the case. It was notable in the discussions that preceded this that entire meetings could be held with RCN staff in which the words "lesbian" or "gay" were never uttered by those who were meeting with us to discuss lesbian and gay nursing issues. Indeed whole conversations could be had with people occupying the categories of interest without any signifying terms being uttered - hiatuses in the conversation stood in at each unspeakable moment. This was for me the dawning moment of beginning to understand the epistemology of the closet; as the project unfolded it became clear that there was a complex relationship between identity, and at least education and class, and unspeakability. It seemed we hadn't moved far from the 19th Century in which the term "an unspeakable of the Oscar Wilde sort" was coined and in which Oscar Wilde himself referred to "the love that dare not speak its name" (Sinfield, 1994). The RCN's tactic of setting up a working party to "prove" that there was discrimination in nursing towards lesbians and gay men could be described under the heading of "new ways to silence troublesome activists"; however after some time the working party had interviewed approximately 60 lesbians and gay men about their experiences of nursing care and conducted focus groups/workshops with nurses about the nursing care of lesbians and gay men. The research evidence that we produced showed quite clearly that there was homophobia in health and nursing care and that lesbian and gay patients were discriminated against (Rose and Platzer, 1993; James et al., 1994; Platzer, 1995; Platzer and James, 1997; Caulfield and Platzer, 1998; James and Platzer, 1999; Platzer and James, 2000). The working party also produced a number of good practice guides and other RCN publications (Royal College of Nursing, 1994; Royal College of Nursing, 1998b; Royal College of Nursing, 1998a; Royal College of Nursing, 2000).

Most of the accounts about the nursing care of lesbians and gay men that we collected related to general nursing care and our findings were commensurate with those which had been published earlier in North America. Amongst these though were a smaller number of accounts about experiences of mental health care and the impact of homophobia in health care on the mental health of lesbians and gay men; it was these accounts, together with that earlier realisation outside the Houses of Parliament of our particular vulnerability, which really inspired the further work undertaken in this thesis. This thesis then set out to further explore the mental health care experiences of lesbians and gay men with an understanding that this was a vulnerable group; vulnerable because of homophobia in society generally and with a further vulnerability because of homophobia within nursing and other health care professions. The background literature is explored in chapter 2.

Another aspect of the research which came to light as a result of the earlier work with the RCN was the difficulty of researching a sensitive topic with a hidden population. It was clear from looking at research into sampling hidden populations, and research on sensitive topics, that tried and tested methods for finding research participants tended to produce a class and race bias. In spite of adopting efforts to overcome this we found, as in many other qualitative studies and studies of hidden populations, that our sampling methods turned in on themselves leading to a white, professional and highly educated homogenous group. These biases may have been partly a reflection of the shame and unspeakability around the whole enterprise; on the whole the lesbians and gay men who participated in the study we conducted for the RCN were not unspeakable – they were mostly positively identified lesbians and gay men with professional jobs who were well and truly out of the closet. However, it was notable even amongst these people that being "out" in a health care setting was more problematic. This thesis set out to further develop the work conducted for the RCN and in particular to focus in on mental health care for people who were accessing care at a time when they were struggling with their sexual identity and it was impacting on their mental health – i.e. those people who were represented in the placards outside the Houses of Parliament. In doing this it was important to develop innovation in sampling approaches in order to challenge (or at least understand) the apparent class, race and education bias in previous studies. It was felt at this stage that any investigation into the mental health of lesbians and gay men would need to engage with research participants who were not only at the pride end of the shame/pride dichotomy i.e. to investigate the experiences of lesbians and gay men whose sexual identity was implicated in their mental health. It was important to try and do this in a way which did not reproduce the shame/pride dichotomy i.e. not to re-pathologise lesbians and gay men in the process of undertaking research but also not to elide the issue of shame.

This point helps to situate the research and make sense of the political and social context which created an absence of research on this topic – whilst mainstream researchers may have neglected the topic because of homophobia and heterosexism, it had also clearly been neglected up until this point by academics in the emerging field of lesbian and gay studies and in gay-affirmative psychology. In both these areas, a great deal of effort had gone into conducting research which refuted pathologising models of homosexuality and in the political drive to gain lesbian and gay rights, research which drew attention to mental health vulnerability created a hostage to fortune. It was as if the stigma of mental illness was too much to bear alongside the stigma of homosexuality; gay-affirmative psychology and lesbian and gay studies had to make sufficient inroads alongside gains in human rights before it was tenable to revisit psycho-pathology. However, certain inroads had been created as the balance of power shifted towards a more tolerant society and during this time some research came to the fore which did highlight the specific mental health needs of lesbians and gay men; this came with a shift in understanding that it was minority stress, or the effects of homophobia, rather than sexual identity itself which was linked to mental health vulnerability. However, the findings of such studies have yet to be incorporated in health or research policy. Section 28 caused a retrenchment and made it difficult to continue this momentum. However, post Section 28 two key studies were conducted in the United Kingdom which demonstrated that homophobia in mental health care settings was alive and kicking (Golding, 1997; MacFarlane, 1998). In a sense another binary had been created through the pursuit of gay-affirmative research which was that of the pathologised homosexual versus the well-adjusted lesbian or gay man – even in research into mental health care experience this binary remained intact (see chapter 2).

This thesis set out to go beyond the limits of those recent studies by disrupting that further binary embedded in them which is itself a product of the dualisms and binaries which fore grounded such research. These recent studies highlight homophobia in health care but do not really engage with how this subsequently affects access to health care and health itself. They also elide the problematic relationship between sexual identity and mental health. Furthermore, much of the existing research on lesbians' and gay men's experience of nursing care is atheoretical and as a result makes it difficult to understand and assess the impact of discrimination in health care. More importantly it makes it difficult to engage in any serious debate about what is going on in nursing practice and nurse education that allows such discrimination to go unchallenged – again silence and silencing are significant here and one of the major challenges for this thesis is to get beyond the liberal "we treat everyone the same/we treat everyone as an individual" approach. This often seems to be invoked by the nursing profession as a defence against any evidence that discrimination towards lesbian and gay patients does occur. This "treating everyone the same/treating everyone as an individual" is part of the liberal humanism embedded in nursing practice and again this can be seen to part of the dominant dualistic thinking of modern western society.

This thesis sets out to disrupt and problematise the dualisms, binaries and dichotomies which construct and define identities, nursing practice and health care experiences: "binary oppositions thus become analytic sites of ongoing struggle and contestation" (Cheek and Rudge, 1994, p. 19). In doing this there was not a clearly defined body of nursing knowledge or nursing theory to draw upon and a theoretical framework emerged which drew on a range of disciplines including psychology (e.g. Smith, 1991; Mathieson and Stam, 1995; Parker et al., 1995; Osborn and Smith, 1998; Yardley, 1998; Ussher, 2000), sociology (e.g. Charmaz, 1987; Henwood, 1993; Clarke, 1996), geography (e.g. Bell and Valentine, 1995; Chouinard and Grant, 1996; Duncan, 1996), cultural studies (e.g. Hart et al., 1981; Richardson, 1981; Hall, 1997b) or in some cases on work that claimed to be post-disciplinary (such as Butler, 1990). Some of these works were applied to identity, some specifically to sexual identity, and some to health care experience but at this point no research had been done which brought together the mental health care experiences of lesbians and gay men and their coming-out experiences.

Whatever discipline was drawn on, it tended to be work that was itself at the margins of that discipline and which was pushing methodological and epistemological boundaries. This led to further enquiry about the epistemological, ontological and methodological debates in these disciplines and this lent a critical lens through which to view previous work which had been done on mental health, coming out and sexual identity and through which to critique the emerging literature on the mental health care experiences of lesbians and gay men. Within all this, tensions repeatedly arose about how identity and experience could be understood and polarised positions reasserted themselves whether in the description of experience, the understanding of identity, the sampling methods to be used or in the way that data can be analysed and interpreted. The particular dualisms which asserted themselves during the development of a theoretical framework for this thesis were those of essentialism and social constructionism in terms of how identity is understood, and realism versus relativism in terms of how research is undertaken. These map onto each other with essentialists tending towards realist methods and constructionists tending towards relativist methods.

The theoretical framework for this study arises as much from methodological debate about how experience can be investigated as it does from any prior empirical studies of experience – in fact another dualism which created tensions throughout this research project was that between the empirical and the theoretical (these dualisms are explored in chapter 3). Where identity or experience had been theorised it had rarely been empirically investigated and vice versa. When identity and experience had been investigated it often relied on methodological approaches on the positivist side of the dualism and seemed to swing to the social constructionist when the theorisation began. Even where researchers had adopted a social constructionist approach to their investigations of sexual identity, they often seemed to backslide into essentialist definitions of sexual identity when obtaining a sample for empirical investigation (these issues are explored in depth in chapters two and four). The notable exceptions were in some studies of sexual health where the relationship between sexual identity, behaviour, social class, community attachment and sampling has been investigated with more intellectual rigour (e.g. Dowsett et al., 1992; Flowers et al., 1997b; Weatherburn et al., 1998).

In an attempt to advance knowledge about the relationship between sexual identity and mental heath care experience these dualisms have been resisted and side-stepped throughout the thesis; this side-stepping attempts to bring together the empirical and the theoretical in order to be able to say something about those experiences in a socio-political-cultural context; in other words to develop a situated and grounded knowledge base that locates the contingent nature of identity and experience without relegating them to the realms of the unreal. This required not only then a side-stepping of the dualisms which define our experiences, our identities, and define nursing practice, but also a side-stepping of the dualisms that limit how we can investigate those experiences, identities, and practices. In disrupting the dualisms in mental health and sexual identity, this thesis also disrupts the ontological and epistemological dualisms which determine and limit methods of inquiry. This approach to research is innovative and in its early stages of development of attempting to straddle epistemological divides; in allowing tensions arising from the mixing of methods it becomes possible to thoroughly analyse tensions which arise in people's accounts of their health care experiences. This approach to conducting research has been referred to with a range of different terms which vary according to the academic discipline from which they arise; thus both the terms critical realism (see Bhaskar, 1989; Pilgrim and Rogers, 1997; Sayer, 2000) and material-discursive approaches (see Ussher, 1997a; Yardley, 1997d) have been used to describe such approaches. Denzin and Lincoln (1994; 1998) have referred to these paradigm shifts (or rather mixing of paradigms) as the fifth and sixth moments in qualitative research and refer to research arising from these approaches as a bricolage, and the researcher as a bricoleur. This approach "provide(s) distinctive insights into nursing practice and allows us to interrupt the particular historical, situated systems of oppression which inform nursing activities" (Manias and Street, 2000, pp. 50-51).

The approaches used to undertake this disruption of dualisms in this thesis are located in both the sampling strategies and the methods of data analysis (see chapter 4). The sampling strategies used in this thesis problematised the binaries embedded in how people define and locate themselves in recognition of the unspeakability of some stigmatised existences and experiences – the sampling strategy sought to use a variety of innovative sampling approaches drawn from sexual health research and research with intravenous drug users in order to attempt to access a diverse research population whose diversity might map onto vulnerability in mental health and mental health care. There was an intention to research beyond the usual suspects who could be relatively easily captured through lesbian and gay community networks and to identify a sample of people who were at least diverse in terms of lesbian/gay community attachment, race, social class, age and educational background. Again this is part of the attempt to disrupt dichotomies – it seemed to be possible that the shame/pride dichotomy at work might obscure important differences in people's experiences of mental health care and might also obscure how accounts of those experiences were accessed. The innovation in sampling methods used in this thesis sets out to address these issues and explore the complex relationship between identity, community, mental health and access to care and to consider how this complex relationship can itself affect the process of undertaking research.

In the attempt to problematise the whole sampling strategy – by undertaking the research that cannot speak its name - further innovation was required in the analysis of data. By entering the realm of the ineffable, both in terms of the research topic itself and through the deliberate sampling of lesbians and gay men who had been silenced and perhaps silenced themselves as a strategy of resistance, it was important to find ways of interpreting and making sense of the data which had been obtained from a large number of research interviews. One way to achieve this was by straddling epistemological divides and treating the data in both realist and non-realist ways i.e. creating a bricolage by viewing the data through different lenses. Some aspects of people's accounts of their experience could be analysed through the realist lens of Interpretative Phenomenological Analysis – such analysis was grounded in people's verbatim accounts of their experiences and is presented in chapters 5 and 6. However, there were also aspects of people's accounts that seemed to be more rhetorical and which needed a constructivist, non-realist lens through which to make sense of those experiences. There were also significant silences and contradictions in people's accounts of their mental health care experiences and a discursive analysis using positioning theory helped to make sense of and further interpret those aspects of people's accounts. This is presented in chapter 7. By juxtaposing these methods of analysis it was possible to produce not a only a description of homophobia in health care but it was also possible to develop a deeper understanding of how homophobia in health care is resisted and negotiated (see chapter 8); hence it becomes possible to understand more about the nature of that health care interaction and its impact.

# Chapter 2: Isolating Resistant Strains in the Literature; the persistence of the pathologisation of lesbian and gay sexual identities

## Introduction

The rationale for this study emerges from a social context in which prejudice against lesbians and gay men remains commonplace (Citizenship 21, 2003) and in which negative attitudes towards lesbians and gay men are held by a significant number of nurses and other health care professionals (Bhugra, 1988; Bhugra and King, 1989; Bond et al., 1990; Rose, 1994; Annesley and Coyle, 1995; Eliason, 1996; Bartlett et al., 2001; Phillips et al., 2001). There is an established body of empirical literature which demonstrates clearly that lesbians and gay men experience the effects of homophobia and heterosexism in nursing and health care (Stevens and Hall, 1988; Stevens and Hall, 1990; Stevens, 1992; James et al., 1994; Eliason, 1996; Platzer and James, 2000). Homophobia is defined as an irrational fear of lesbians and gay men, whereas heterosexism is a broader term which shifts the focus away from individual attitudes towards a more general understanding of how negative attitudes are embedded in social practices and institutions; through these social practices heterosexuality is privileged and seen as more normal and desirable and this contributes to the oppression of lesbians and gay men (Eliason, 1996).

More recently researchers have begun to focus specifically on lesbians' and gay men's experiences of mental health care. Again the social context for this is particularly important as it was only in 1992 that the World Health Organisation officially de-classified homosexuality as a mental illness (Davies and Neal, 1996). In spite of this de-classification, a number of recent studies have shown that lesbians and gay men experience homophobia in mental health care. In particular they report that their lesbian or gay identity is still pathologised by mental health care practitioners in that it is viewed as a mental illness or something which can potentially be cured or changed (Proctor, 1994; Golding, 1997; Annesley and Coyle, 1998; MacFarlane, 1998).

The other body of literature relevant to informing the aims of this study is that which looks at the mental health of lesbians and gay men. There is a significant amount of empirical work now to suggest that lesbians and gay men have a higher than expected incidence of mental health problems, and in particular a higher than expected rate of attempted suicide when compared to the general population (for a review see Rivers, 2002). Furthermore, this empirical research shows that lesbians and gay men are particularly vulnerable to suicide attempts when they are "coming out"; that is, when they are realising their sexual identity and coping with decisions and consequences related to disclosure (i.e. deciding whether or not to tell others about their sexual identity). Although some of the literature on health care experience looks at issues relating to disclosure to health care practitioners, none to date has looked specifically at how people manage mental health encounters when they themselves are realising (or "coming to terms with") their own sexual identity.

This study seeks to explore this area further by investigating how people experience mental health care when they are at this juncture of their lives. The overall research aim was to conduct an exploratory study to investigate the mental health care experiences of lesbians and gay men when they are negotiating their sexual identity (or "coming out"). In order to set the scene for this and to develop specific research questions the following literature is reviewed:

- The mental health of lesbians and gay men
- The nature of the "coming out" process and how people negotiate and manage their sexual identity
- Lesbians' and gay men's mental health care experiences

The literature search was initially conducted in early 1997 systematically using the following electronic data bases and search terms, mesh headings or descriptors in order to locate published material of relevance to the overall research aim:

**Databases:**
ASSIA (1987-1996)
CINAHL (1983-1996)
Medline Express (1966-1996)
PsycLIT (1990-1996)

**Search Terms:**
Adolescence
Attitude of health personnel
Coming out
Disclosure
Gay
Health
Health-care-delivery
Health-personnel
Heterosexism
Homophobia
Homosexual/s/ality
Lesbian/s/ism
Mental health

Mental health services
Parasuicide
Professional-patient relations
Self-harm
Self-injurious behavior/behaviour
Self-mutilation
Sexual identity/y/ies
Sexual orientation
Suicide
Suicide, - Attempted
Suicidal behavior /behaviour
Suicidal ideation
Suicidality

In addition the grey literature was searched through the use of databases such as Dissertations Abstracts International, Department of Health National Research Register and the Cochrane library and through word of mouth, social and professional networking (particularly with community and voluntary sectors providing services for lesbians and gay men with mental health needs) and attendance at relevant conferences. The review of the literature was ongoing and repeated at a number of times and more recently using the Ingenta, ISI Web of Knowledge (including Social Science Citation Index), and Ovid Online (including Medline, Cinahl, Embase, PsychInfo and BNI) electronic databases most recently.

In reviewing the literature it was clear that there is an extensive body of literature about mental health and coming-out, and there was also a growing body of literature on the mental health care experiences of lesbians and gay men. There was however no specific research which brought these bodies of literature together. The specific research questions which emerged from this review of the literature were:

1. How do homophobia and heterosexism manifest themselves in mental health care encounters when lesbians and gay men are “coming out”?
2. How do homophobia and heterosexism affect lesbians’ and gay men’s access to mental health care when they are “coming out”?

Each body of literature will be reviewed in turn i.e. the mental health of lesbians and gay men; coming-out and mental health; health care experience. Most of the studies reviewed are empirical studies framed loosely within a psychological or sociological framework. The review of these studies will be followed by a discussion of the more theoretical literature which was drawn on in order to inform the methodology of the thesis and subsequently the analysis and interpretation of the findings.

## The Mental Health of Lesbians and Gay Men

There is a large body of empirical evidence suggesting a higher than expected incidence of a number of mental health problems amongst lesbians and gay men. It is important to note that there is no inherent psychopathology associated with lesbian or gay identity (Gonsoriek, 1991) but gay-related (or minority) stress caused by homophobia in society may lead to mental health problems (DiPlacido, 1998). In particular there seems to be a relationship between the time in people's lives during which they are realising their sexual identity and higher than expected rates of attempted suicide as compared to the general population or matched controls.

Two large scale studies and two smaller scale studies at the end of the 1960s and early 1970s showed a higher than expected incidence of attempted suicide and suicidal feelings amongst lesbians and gay men as compared to control groups of heterosexuals (Roesler and Deisher, 1972; Saghir and Robins, 1973; Jay and Young, 1977; Bell and Weinberg, 1978). In Bell and Weinberg's (1978) study, approximately a third of the lesbians and gay men in the sample had attempted suicide compared to about 10% in the heterosexual controls; 20% of the gay men had made a suicide attempt when they were under the age of 20. Bell and Weinberg (1978) also found that of those who reported previous suicide attempts 58% of gay males and 39% of lesbians felt that their first suicide attempts were related to the fact that they were lesbian or gay. More recent analysis of this data found that among gay men, being troubled over one's sexual identity during adolescence was related to subsequent attempts, and "data reveal that for both males and females, negative feelings about one's incipient homosexuality are associated with suicidal feelings and may explain some of the suicide attempts that occur during late adolescence and early adulthood" (Harry, 1989, p. 358). In the Jay and Young study (1977) 39% of the total sample of lesbians of all ages attempted or seriously contemplated suicide and 33% of these said that it related to their sexual identity. 40% of the gay men had attempted suicide and 53% said it related to their sexual identity. In the Saghir and Robins (1973) study five of the six gay male attempters had made their attempts before the age of 20 during conflict with family members or within themselves over their emerging sexual identity and six of the seven lesbian attempters had made their attempts during their 20s during a depression following the break-up of a relationship.

It could be argued that these high rates of attempted suicide relate to a historical period when the criminalisation and pathologisation of homosexuality led to more repression and oppression of lesbians and gay men and that such findings would not be reproduced today. However, more recent studies have continued to show higher than expected levels of attempted suicide amongst lesbians and gay men as well as an increase in incidence of mental health problems such as depression (Trenchard and Warren, 1984; Bradford and Ryan, 1987; Hetrick and Martin, 1987; Saunders et al., 1988; Schneider et al., 1989; Remafadi et al., 1991; Schneider, 1991; D'Augelli and Hershberger, 1993; Proctor and Groze, 1994; Trippet, 1994; Geraghty, 1996). In these studies the incidence of attempted suicide ranged from 18% - 42%. Bradford and Ryan (1994) found an overall attempted suicide rate of 18% in their sample of lesbians but in those aged 17-24 it was 24%. Where specific lesbian and gay youth populations have been sampled the rates found were 42% (D'Augelli and Hershberger, 1993); 32% (Geraghty, 1996); 20% of those presenting for services (with a higher incidence amongst those calling the helpline) (Hetrick and Martin, 1987); 40.3 % (Proctor and Groze, 1994); 30% (Remafadi et al., 1991); 31% (Roesler and Deisher, 1972); over 1/3rd (Schneider, 1991); and 20% (Schneider et al., 1989). These rates of attempted suicide in lesbian and gay youth are higher than the rates of 6-13% found in high school students (D'Augelli and Hershberger, 1993).

Schneider et al (1989) compared suicide attempters and non-attempters and found that the attempters were aware of their sexual orientation at an earlier age but did not feel positive about it. Trenchard and Warren (1984) found that 19% of their respondents had attempted suicide because they were lesbian or gay. Harry (1989), in a review of the literature, notes that the average age of coming out coincides with the period when most gay men are at risk of suicide attempts. Some of the studies have shown that the younger lesbian and gay youth are when the coming out process begins (in terms of awareness of same-sex attraction) and the younger they are when they disclose their sexual orientation to another person, and the more rejecting key social supports are to disclosure, then the more vulnerable they are to suicide attempts (Schneider et al., 1989; Remafadi et al., 1991; D'Augelli and Hershberger, 1993). It is of further interest that in some of the studies young people report that they had no emotional difficulties and no problems with their families until they themselves became aware of their sexual orientation (Hetrick and Martin, 1987; Schneider, 1991). Proctor and Groze (1994) in a survey of 221 lesbian, gay and bisexual youth found an association between poor family relations and suicidal ideation and suicide attempts. Another study by Rotherum-Borus et al in 1992 (cited in Savin-Williams, 1994) of 139 lesbian and gay youths aged fourteen to nineteen, found that suicide attempters and non-attempters were no different in terms of general stressful life events, but the attempters experienced more gay related stressors including coming out to parents and fear of being discovered to be lesbian or gay by parents or other family members.

Many of these studies have been criticised on the grounds that they tend to draw from youth groups and will thus inevitably find a disproportionate number of distressed youth who attend the groups for support. Furthermore, the purposive sampling approaches used in most of the studies makes it difficult to find a meaningful comparison group. However, Rotherum-Borus (cited by Prenzlauer et al., 1992) compared three groups of minority youths and found that 41% of the lesbian and gay youth had attempted suicide compared to 28% in the other groups. The most compelling evidence that there is an association between suicidal behaviour and sexual orientation comes from a study which used probability sampling methods. In addition the data collection instruments guaranteed a high level of anonymity and the overall survey had an exceptionally high response rate (Bagley and Tremblay, 1997). Questions about sexual identity and behaviour were embedded in a questionnaire with a wider remit other than finding out about sexual orientation and suicide attempts. The findings from this study were that gay and bisexual males were 13.9 times more at risk of a serious suicide attempt than heterosexual males.

A number of authors have postulated reasons for an increased incidence of suicide and attempted suicide in lesbians and gay men on the basis that they are a marginalised group subject to the effects of stigmatization and minority status. Saunders and Valente (1987) have argued that Durkheim's theory regarding alienation as well as an increased risk in interruption of social ties would predict an increased risk of suicide for lesbians and gay men. Hetrick and Martin (1987) discuss the effects of social, cognitive and emotional isolation on lesbian and gay youth and argue that the minority status of lesbian and gay youth is worse than for other minority groups as they are not socialized into or prepared for their minority position by their families or their culture: they have no sense of "we" versus "they" as a minority within their own family and community (Hetrick and Martin, 1987). There is also evidence that lesbians and gay men and youth are at increased risk of a number of other factors which could predispose them to suicidal behaviour: violence (Hunter and Schaecher, 1987), including from their own families (Martin and Hetrick, 1988), victimization and bullying (Hunter, 1990; Remafadi et al., 1991; Hershberger and D'Augelli, 1995; Rivers, 1997b) and rejection by their families leading to homelessness (Trenchard and Warren, 1984; Hunter and Schaecher, 1987; Gonsoriek, 1988). In addition the research reports a high incidence of drug and alcohol abuse which may predispose lesbians and gay men to suicidal behaviour (Bradford et al., 1994; Hershberger and D'Augelli, 1995).

The empirical literature then strongly suggests that the higher incidence of mental health problems in lesbians and gay men relates to the stress associated with negotiating a marginalised and stigmatised identity. This stress will be particularly salient at that point in people's lives when they are themselves realising their sexual identity and also trying to cope with decisions and consequences in relation to disclosure of this to others. This time of realisation and decisions about disclosure is often referred to as coming out. This term is problematic in that it has various usages with loaded political meanings and socio-cultural specificity. Also much of the literature on coming out assumes that it is a finite process rather than a matter of on-going negotiation and day-to-day management of sexual identity. Ideas about coming out, management of sexual identity and mental health are further explored in the next section.

## "Coming Out", Negotiating and Managing Sexual Identities

The meaning of the term "coming out" is variable and has also shifted over time; pre-Stonewall (i.e. before the Stonewall riot in New York in 1969 which coalesced an emergent gay rights movement) the term referred to a debut within the secretive homosexual sub-culture or coming out to other homosexuals (the term "homosexual" is problematic associated as it is with a pathological identity – it is used in this thesis where it is "historically correct" and when in the context of studies which pathologise lesbian and gay identities. A full discussion about the language assigned to lesbian and gay identities follows in chapters three and four and is related to sampling procedures). However, after Stonewall it acquired a political meaning and related to the building of a mass movement, public declaration of one's lesbian or gay identity and increasing visibility. It can also be taken to mean either identifying oneself as gay or lesbian, or to mean disclosing that self-recognition to others (Troiden, 1992; D'Emilio, 1993). That the term is problematic, and has different meanings, also leads to methodological problems which are discussed further in chapter four as is the problem of naming identities. Nevertheless, it is necessary at times to use it as a short-hand to stand for something which occurs when people become aware of and subsequently act on (or do not act on) the awareness of their same-sex desire.

There is a popular idea that coming out involves a sequence of stages which lesbians and gay men go through when they are realising and disclosing their sexual identity. This is reflected in the development of several models derived from empirical data which describe this process (e.g. Cass, 1979; Troiden and Goode, 1980; Plummer, 1981; Troiden, 1992). In addition to this a certain amount of empirical work seeks to look at the relationship between these stages and mental health. The models

> "attempt to organize and interpret ... coming out experiences in relation to homosexual identity formation (which) progresses from an initial awareness of same-sex feelings through homosexual behaviour to eventual self-labelling, self-disclosure, and the final stabilization of a positive gay identity" (McDonald, 1982, p. 48).

The assumptions that have been built into these stage models are that self-recognition followed by disclosure of one's lesbian or gay identity is directly related to the acquisition of a positive identity and some form of psychological adjustment. A further assumption built into such models is that gay/lesbian community involvement, or the adoption of a gay/lesbian lifestyle, is an intrinsic component of a developmental and linear progression towards resolution of a confused identity to an integrated and stable identity relating to same-sex attraction (e.g. Plummer, 1981).

These stage models, and the assumptions derived from them, have been critiqued in a number of ways: a number of authors have put forward empirical evidence to refute the linear and sequential nature of the stages. For instance McDonald notes that Troiden's (1992) model insisted that gay men only formed relationships with each other when they were in the final stages of the coming out process whereas McDonald's (1982) study showed that men could be in long-term relationships with other men for years before identifying themselves as gay. Other critiques of these linear and sequential stages have been offered by Markowe (1996) and Rust (1993). Both argue that coming out is not a linear and finite process but an ongoing life-long process mediated by changing social circumstances and interactions. Others have argued that the models tend to be based on gay and white male experience and they fail to take account of variation relating to gender (e.g. Grammick, 1984), cultural differences (e.g. Herdt, 1992) or social class (Harry, 1993). Many of these biases built into the models probably derive largely from sampling artefact and cohort effects (see chapter four for further discussion). Some studies have looked at how different cultural contexts will affect identity development, management and disclosure (Tremble et al., 1989; Herdt, 1992; Chan, 1995). It has been suggested that one of the salient differences for minority-ethnic cultures relates to collectivism, family ties and associated obligations (Abdulrahim, 1998). One particular study investigated how gay men manage their sexual and Jewish identities. It was found that Jewish gay men's socialisation informed by particular religious doctrines and cultural expectations created another set of conflicts and difficulties which had to be negotiated and managed. The religious doctrines and cultural expectations also informed the particular homophobic reactions which the participants had experienced (Coyle and Rafalin, 1999).

The sampling bias which is built into many studies of lesbians and gay men reinforces essentialist ideas that sexual identity is fixed, stable, binarized and universalized. More recent social constructionist approaches to understanding the development of sexual identity have questioned the assumptions of these early simplistic models of coming out. (Essentialism and social constructionism, and the wider implications of the dualisms they represent, are explored further in the last section of this chapter and fully discussed in chapter three). The essentialist models assume a position in which lesbian or gay identity is a "true" identity waiting to be realized. Rust (1993) argues that even Plummer (1981) who adopts a constructionist approach to his model of coming out ultimately adopts an essentialist goal-orientated view with the idea of acquiring a stable identity. Rust goes on to say that from a social constructionist point of view

> "identity is the result of interpretation of personal experience in terms of available social constructs... and coming out is the process of describing oneself in terms of social constructs rather than a process of discovering one's essence" (Rust, 1993, p.68).

This idea of linear progression, bound in essentialist notions, is linked to ideas that coming out and disclosure as well as attachment to the lesbian/gay community are good for one's health and general well-being. Again, in an early developmental stage model of coming out, Plummer (1981) asserted that coming out to the gay community will be a positive experience. However, in another early model, Ponse (1980) argues that the lesbian community would provide both support and pressure for conformity. It is notable that early coming out models of lesbian identity models adhered less to notions of sequential stages than those exploring the development of gay male identity. A number of studies have shown a relationship between disclosure of sexual identity, a positive lesbian or gay identity and improved psychological adjustment (e.g. Schmitt and Kurdek, 1987; Miranda and Storms, 1989). Griffin (1991) and Markowe (1996) have defined this more in terms of the need for authenticity. This, together with the available developmental coming out stage models, has led to assumptions that coming out and disclosure relates to self acceptance but these ideas have been questioned in a number of ways. Franke and Leary's study (1991) found that disclosure was very variable, even in groups who were at least partially out, and that disclosure related more to the imagined reaction of the person disclosed to, than it did to self acceptance. Cohen (1996) also found that disclosure was not always related to feeling positive about one's identity but related more to the availability of support when making such disclosures, especially to family members. Harry (1993) has argued that disclosure relates more to an individual's circumstances in relation to occupation, income and area of residence than it is indicative of a late stage of a coming out process.

However, it seems that ideas about strategies around disclosure have become conflated with ideas about coming out trajectories. As a number of authors have argued, it is sometimes hard to see what is about developing a lesbian or gay identity and what is about stigma management (de Montflores, 1993; Healy, 1993; Brown, 1995). It is also difficult to disentangle the direction of relationships between variables such as identity formation and psychological adjustment (Miranda and Storms, 1989). The same caveats apply to interpreting evidence that belonging to a lesbian or gay community promotes psychological well-being which has been found in some studies (e.g. Geraghty, 1996; Coyle, 1998). There is no intention to dismiss findings that coming out can lead to psychological benefits (including coming out in the context of a supportive lesbian/gay community) or to dismiss the idea that passing (non-disclosure) (see e.g. Berger, 1990; Cain, 1991) can create psychological strain. However, it is clear that these relationships are more complex than suggested by linear stage models of coming out. In order to begin to understand these complexities more recent work on how sexual identity is managed and negotiated on an on going basis will now be discussed.

A number of studies have begun to explore the complex ways in which lesbian and gay identities are managed in different public and private spaces and contexts. These studies question the idea of linear progression in coming out and show quite clearly the ongoing and day-to-day necessity for identity management, and to a certain extent the effects of the need for such management on people's lives. Some studies have highlighted the need for ongoing identity management in the workplace and the contextual factors which will affect degrees of disclosure (e.g. Schneider, 1987) and others have gone further to suggest that such identity management will impact on career decisions and opportunities (e.g. Boatwright et al., 1996). A number of studies have explored identity management strategies and the effects of having to manage one's identity in the work environment of physical education school teachers where disclosure of a lesbian identity can be especially problematic. Clarke (1996; 1998) found that these identity management strategies and their effects pervade not only the public work space but extend into private and social space. She argues that when lesbian women do not feel safe to disclose their sexual identity in the workplace then this has effects on mental health leading to low self-esteem and self destructive behaviour. Squires and Sparkes (1996) also report these findings from their research in a similar setting. It can be seen from these studies then that coming out is an ongoing process.

The assumptions built into much of the work on the mental health of lesbians and gay men, and associated ideas about coming out, are that lesbians and gay men are most vulnerable when they are coming out in their youth and that once they have disclosed their sexual identity they will be on a trajectory which leads to lesbian or gay community support, self acceptance and improved mental health. Whilst this may be part of the picture it is possible that much of this theorising is limited by the sampling approaches used in many of the studies. Most of those researched have been attached to lesbian or gay communities and have come out during their youth. The need to sample more diversely from the lesbian and gay population is further explored in chapter four. The critiques of stage models of coming out, alongside social constructionist accounts of identity management which take into account the ongoing need to deal with stigma, suggest a need to broaden our thinking about the relationship between coming out and mental health. As Richardson and Hart say, coming out then is not only something implicated in the *development* of identity but also in its *maintenance* (Richardson and Hart, 1981).

## Health Care Experiences of Lesbians and Gay Men

The previous discussion indicates that the negotiation of a marginalised sexual identity in a heterosexist and homophobic culture will be difficult. It is important to ask how this will map onto a health care setting; how do homophobia and heterosexism operate in health care settings and how do people manage their identities in such settings? There is a substantial body of empirical work to show that nurses and other health care professionals share the anti-gay and anti-lesbian attitudes of the wider culture and they do not have specific training to counter this (Stevens, 1992; Proctor, 1994; Annesley and Coyle, 1995; Eliason, 1996; Hardman, 1997; Milton and Coyle, 1999). There is also a substantial body of empirical work to show that lesbians and gay men experience overt hostility, refusal to care or withdrawal of care, verbal, sexual and physical abuse, and voyeurism at the hands of nurses and other health care providers in general health care settings (Stevens and Hall, 1990; Stevens, 1994a; Eliason, 1996; Platzer and James, 2000; Scherzer, 2000). There is also a reluctance to disclose sexual identity in such settings for fear of such reactions and a reluctance to seek health care; this has been found to be the case in both general nursing and health care settings (Paroski, 1987; Stevens and Hall, 1988; Stevens, 1992; Stevens, 1994b) and in mental health care settings (Bradford and Ryan, 1987; Hetrick and Martin, 1987; Golding, 1997; MacFarlane, 1998). However, disclosure of sexual identity is linked to greater satisfaction with health care (Dardick and Grady, 1980).

This issue of non-disclosure is of vital significance to the mental health care setting but to date studies investigating experiences of nursing and health care have not focused specifically on what might be happening here beyond an assumption that non-disclosure relates primarily to the avoidance of abusive homophobic reactions from health care staff. There is no doubt that this is part of the picture, as discussed in the next paragraph. However, it is important to interrogate these findings further and ask what else might be taking place, particularly when lesbians and gay men are coming out and seeking mental health care in relation to this. Although no studies of health care experience have specifically explored non-disclosure, some of the literature on gay affirmative psychology and the effects of internalised homophobia are relevant to this discussion. These discussions, alongside theoretical writings about identity, help to make sense of these gaps in the empirical literature and will be discussed further in the next section of this chapter.

In relation to mental health care recent studies have shown that lesbian and gay mental health users experience homophobic abuse and that health care professionals continue to work to a medicalised model of homosexuality in which it is seen as a type of psychopathology (Hetrick and Martin, 1987; Golding, 1997; Koffman, 1997;

MacFarlane, 1998). Many studies have shown that people who present to health care providers because they are struggling with their sexual identity often feel unable to disclose this (Bradford and Ryan, 1987; Hetrick and Martin, 1987; D'Augelli and Hershberger, 1993). If they do disclose, they are often met with a pathologising discourse in which their identity is construed as problematic rather than the struggle to cope with it in a homophobic society or they are met with a discourse which constructs homosexuality as an immature and temporary phase (Hetrick and Martin, 1987; Schneider, 1991). Some of this literature has begun to explore the impact of these encounters as seen in suggestions that experiences of homophobic practice may lead to avoidance of future health care. Hetrick and Martin (1987) have suggested that counselling approaches which trivialise or pathologise homosexuality will delay or postpone the work which has to be done in coping with a stigmatised identity.

Another common experience of lesbians and gay men in mental health care settings is that they are silenced in relation to their sexual identity i.e. they are told they should not talk about it or the subject is avoided by health care practitioners (Proctor, 1994; Golding, 1997; MacFarlane, 1998). There has been little theoretical discussion in the studies of health care experience about what is operating when such silencing takes place. However, there has been some discussion about how liberal humanism, as an approach which tends to ignore difference, can have the effect of silencing lesbians and gay men about their sexual identities and associated mental health needs (Annesley and Coyle, 1998). In broader terms, a number of writers have problematised the way that liberal discourses can mask subtle forms of prejudice and which allow heterosexism to erase and deny lesbian and gay identities in mental health care (Kitzinger and Coyle, 1995; Coyle et al., 1999; Peel, 2002). It is important to be alert to this as liberal humanism underpins modern nursing philosophies and ethics of care. Hart and Lockey (2002) argue that the liberal humanism underpinning nursing practice often fails to take account of difference and inequality. McDonald and Anderson (2003, p. 698) argue further, in relation to liberal humanism, that individualism and heteronormativity within nursing have led to "resistance within the discipline to value and research social determinants of health (which) raises questions about our complicity in dominant ideologies of health and healthcare".

Whilst there has been no empirical research which looks specifically at how such nursing discourses affect health care experience, it is important to remain cognizant of the accruing evidence about silencing and explore it further. A theoretical framework for understanding this, and the way that it is embedded in dualistic thinking, is developed in the next section. This helps to inform not only silencing, but also the silence imposed by lesbians and gay men themselves through non-disclosure of their sexual identity. The empirical evidence suggesting that self-silencing is important will be discussed in the final part of this section. Then both silencing and self-silencing will be re-visited in the final section of this chapter where more theoretical work is drawn on to help contextualise this, begin to understand its significance and begin the process of developing a framework for investigating the mental health care experiences of lesbians and gay men.

There has also been some work which explores the protective strategies that people can employ to help them cope with potentially threatening health care encounters; in particular avoidance of further health care encounters has been identified as a protective strategy (Stevens, 1994b; MacFarlane, 1998). Silence, or non-disclosure, has been identified as a strategy of resistance by lesbians and gay men to stigmatisation in general social settings in relation to sexual identity (Murphy, 1989; Cain, 1991; Griffin, 1991; de Montflores, 1993). The strategy of silence and non-disclosure has been less thoroughly investigated in relation to mental health or mental health care, with Martin and Hetrick's work (1982) being a notable exception in terms of raising this for discussion. However, other empirical studies which explore how people manage threatened identities in social situations (Breakwell, 1986; Susman, 1994) and more specifically in health care encounters (Bloor and McIntosh, 1990; Huby, 1997; Abdulrahim, 1998, p. 42; Heaphy, 1998) lend some understanding to how silence is used as a strategy of resistance to that threat. These strategies of resistance map onto those discussed in the previous section on mental health and coming out, and the management of sexual identity in the workplace where it was noted that "passing" (or non-disclosure) is used as a strategy by lesbians and gay men to avoid homophobic reactions from others. However, none of these studies specifically explore the impact of non-disclosure when the non-disclosure relates as it were to the "presenting" issue. More theoretical work on identity, and discussion in the gay-affirmative literature helps to illuminate this further and also begins to point to how difficult it is to empirically explore such phenomena, embedded as they are in shame, unspeakability, silence and the ineffable. This theoretical work will now be discussed.

## Theorising Resistance

It is particularly important to ask about the non-disclosure of the very issue that may be part of the reason why a person has "presented" for mental health care. The review of the empirical research to date on health care experience, the development and management of lesbian and gay identities, and the mental health of lesbians and gay men showed that such work has not yet been done. There is an unspoken tension in the existing literature on the mental health care experiences of lesbians and gay men; this tension is between the counter-claims to pathologising research (in which there is an insistence on the normality of lesbian and gay sexual identities and evidence of the psychological adjustment of lesbians and gay men) and the other body of research which insists on the mental health vulnerability of lesbians and gay men. This tension is not particularly problematic if it is taken as given that the vulnerability arises from the effects of homophobia rather than being an inherent psycho-pathology linked to sexual orientation; however it does not map so easily onto mental health care situations where coming out is implicated in mental health. In the existing research into mental health care experiences of lesbians and gay men there is an insistence of the lack of relationship between sexual identity and mental health – so when evidence is reported that a lesbian or gay man has had their sexual identity pathologised the counter-claim is implicitly that such as an approach is just plain wrong. However, it may be more complicated than that.

In turning to the gay-affirmative literature on the counselling needs of lesbians and gay men, there is some discussion of the effects of shame and internalised homophobia in terms of the impact on mental health (Sophie, 1987; Gonsoriek, 1988; Shidlo, 1994; Davies, 1996; DiPlacido, 1998; Meyer and Dean, 1998; Tasker and McCann, 1999; Mair, 2000) and the beginnings of discussion about the difficulties of articulating this in a therapeutic encounter (Shidlo, 1994; Mair, 2000). An understanding of internalised homophobia and how it is understood "psychologically" in terms of the coming out process provides a link to theory which might provide a framework for understanding the ways in which homophobia and heterosexism disrupt mental health care encounters. Garnets et al (1990) have described the task of coming out as part of the inter-related challenge of overcoming internalized homophobia created by heterosexist stigma which involves a "process of reclaiming disowned or devalued parts of the self, and developing an identity into which one's sexuality is well integrated" (Garnets et al., 1990, p. 369).

In turning to theory on how lesbian and gay identities are "constructed", there is much discussion about how identities are formed in relation to, and in opposition to, homophobia and heterosexism. Butler, drawing on the work of Foucault, said that

> "even the most noxious terms could be owned, that the most injurious interpellations could also be the site for a radical reoccupation and resignification ... Called by an injurious name, I come into social being ... I am led to embrace the terms that injure me, precisely because they constitute me socially ... As a further paradox, then, it is only by occupying - being occupied by - that injurious term that I become enabled to resist and oppose that term, and the power that constitutes me is recast as the power I oppose" (Butler, 1995, p. 245).

What Butler is referring to here is the resistance to being treated as "Other" where "Othering" takes place through splitting and binarisation (Rutherford, 1990a); this splitting into binaries relates to a process of projection where all that is bad, devalued or otherwise undesirable is projected onto one half of that binary (Sibley, 1995; Hall, 1997b). These binaries relate to sexual identity, race, gender and other categories which are constructed in relation to difference. With sexual identity, these binaries have split people along the heterosexual/homosexual continuum and the projection of madness and badness on to lesbian and gay identities is seen in the criminalisation and pathologisation of homosexuality (Rutherford, 1990a; Fuss, 1991; Stevens and Hall, 1991; Butler, 1993; McColl, 1994; Sibley, 1995; Davies and Neal, 1996; Hall, 1997a; King and Bartlett, 1999). Othering takes place not only through projection but also through erasure and silencing (Butler, 1991); silence and shame are also entwined (Wilton, 2000) and as noted in the section on health care experience, the liberal humanism underpinning nursing can have the effect of silencing and erasing difference. In terms of identity the process of Othering, in which a person feels that they have not lived up to ideals can result in a sense of shame (Giddens, 1991).

Resistance to "Othering" has been identified through the study of lesbian and gay communities (e.g. Hart et al., 1981; Shotter and Gergen, 1989; Richardson, 1992; Sampson, 1993; Bell and Valentine, 1995; Duncan, 1996; Munt, 1998) and by looking at how people identify in relation to community (e.g. hooks, 1990; Weeks, 1991; Butler, 1995; Myslik, 1996; Clarke, 1998; Clark, 2002). However, to date, such studies have not really explored resistance to pathologising identities where people are also suffering from mental health problems; what has taken place has been the study of the celebratory – the study of survivors who have resisted pathologisation and made their own identities and communities. In such celebration the shame/pride dichotomy has unwittingly been re-inscribed with pride being a place that can only be inhabited by the well adjusted. However, these studies, through their theorisation of "Othering" lend an understanding to how resistance can be understood and made sense of. In particular a theoretical understanding of the process of Othering allows an exposure of the underlying dualisms which shape our identities.

Research methods which help to uncover or side-step these dualisms are the most appropriate way of analysing experiences where such dualisms are at work – such approaches are identified in chapter three following a detailed methodological discussion about the limits of both realist and constructionist approaches to understanding and interpreting both identities and experiences and in interpreting resistance and silence. The methodological position arrived at following this discussion, is that both realist and constructionist approaches lend some understanding to interpreting data about people's identities and experiences, but ultimately an approach which straddles this epistemological divide (in this case the use of positioning theory) helps to give a fuller and more complete understanding of how people resist, negotiate and contest the erasure and pathologisation of sexual identities in health care; very little research has been done on illness and identity, or healthcare and identity, using such approaches but where it has been done there are striking parallels between negotiating sexual identities and negotiating other pathologised or stigmatised identities in health care settings (Parker et al., 1995; Ussher, 1997a; Yardley, 1997d; Willig, 1999d). These studies are explored in more detail later in the thesis in the light of the findings from this study.

## Conclusion

The literature clearly points to inadequacies in the delivery of care and the pervasiveness of homophobia and heterosexism in both general and mental health care. In particular it would seem that the pathologisation of lesbian and gay identities, silencing about sexual identity and issues relating to non-disclosure are especially relevant in mental health care. However, the literature to date gives little indication of how these processes affect people if they are seeking mental health care at a time in their life when they perceive their mental health issues to be associated with their struggle to negotiate their sexual identity (i.e. coming out). Given the research to date showing the mental health vulnerability of lesbians and gay men who are negotiating and managing their sexual identity, it seems important to investigate further the nature of mental health encounters at such times. A further in-depth exploration of these experiences might usefully point to ways in which access to mental health care can be improved for lesbians and gay men who are coming out. This study then set out to look in detail at the nature of these mental health encounters with a view to developing understanding about the ways in which homophobia and heterosexism operate in mental health care settings and their impact on people who are presenting with mental health issues in which their sexual identity is implicated. The initial review of the empirical literature helped to refine the original research aim and to design a study which would build on the existing knowledge base. The theoretical work, much of which came from a broadly post-structuralist perspective, helped to situate those empirical research findings and give a purchase on how descriptive "experience of illness" type studies could be built on to further inform understanding about access to care in a more sophisticated way. The theories of identity which were located in a post-structuralist framework highlighted some of the methodological challenges for this investigation. The tensions in the shame/pride dichotomy which set this research project in motion were mirrored by tensions in epistemology and methodology arising from a further set of dualisms – these are now fully discussed in the next two chapters.

# Chapter 3: Methodology – on not grasping the nettle

## Introduction

The particular research questions asked in this research, and the nature of those questions, together with the lack of coherent or robust prior theory demand an approach to the research which is exploratory and which may enable concept development rather than an approach which is hypothetico-deductive. The research needs to be located within a qualitative paradigm premised on a search for meaning or *Verstehen,* in which a phenomenological approach is adopted in order to gain an understanding of experience from the point of view of the research participants. Within the qualitative paradigm there is also a recognition of the process of interpretation, the negotiation of inter-subjective meanings and the importance of understanding the complexity of experiences in context (Henwood and Pidgeon, 1992; Henwood and Pidgeon, 1994). The selection of appropriate methodology to address the research questions in terms of how to gather data, how to analyse the data and how to assess the status of the research findings, requires a consideration of the researcher's positions regarding epistemology and ontology.

This consideration can be located within wider debates which have engaged those adopting qualitative approaches in psychology and other human sciences. Qualitative methods and inductive approaches, such as grounded theory, have been used now for some time in the human sciences. However, an increasing dissatisfaction within psychology with the continued dominance of positivism even within qualitative approaches (Woolgar, 1996; Davies, 1998) has led some psychologists at the critical edge of the discipline to call for more attention to be paid to the ways in which a social constructionist or constructivist perspective can inform understanding of social and (broadly defined) psychological processes. This shift has been marked by some as the discursive turn in psychology leading to the adoption of methods such as discourse analysis (Harré, 1995; Stainton-Rogers, 1996) and contextualist or constructivist revisions of methodologies such as grounded theory (e.g. Woolgar, 1996; Davies, 1998).

However, continued methodological debate has led more recently to a position which also questions the usefulness of constructionist approaches and cautions against exclusive use of this perspective as it too can lead to the loss of a vital perspective on how the world is understood (Gergen, 1998). Increasingly researchers are developing methodological positions which allow us to view and interpret data through multiple lenses (Denzin and Lincoln, 1994; Denzin and Lincoln, 1998). Up until recently, such mixing of methods would have been regarded as flawed if the methods or lenses used were underpinned by different and incompatible epistemological positions. However, these approaches are becoming more common and in epistemological terms they straddle the polarised and dualistic positions between realism, positivism and empiricism on the one hand, and relativism, idealism and constructionism on the other hand. Some have defined this epistemological position as critical realism and others have characterised it as a material-discursive approach (Ussher, 1996; Pilgrim and Rogers, 1997; Yardley, 1997d; Sayer, 2000).

In this study the data were interpreted using multiple lenses which belonged within different epistemological traditions. This combination of approaches produced an interpretation within a material-discursive framework; this allowed a phenomenological thematic interpretation of some aspects of the data clearly grounded in people's accounts of their experiences and also allowed an interpretation of other aspects of the data which were more complex and which were better informed by a constructionist world view. In this study the data were analysed initially using a technique called Interpretative Phenomenological Analysis which shares many of the assumptions of grounded theory. A further analysis was then conducted using discourse analytical approaches. By combining these approaches it is possible to begin to see how lesbians' and gay men's experiences of mental health care are mediated by the social context in which these experiences are embedded and the positions which people adopt or are placed in. In order to locate the methodology used in this study, this chapter sets out how debates about epistemology regarding the analysis of qualitative data have developed over recent years. This begins by looking at developments from positivism to handle data in a post-positivist light and then looks at the contribution of social constructionist approaches. It will be seen that debates about epistemology polarised; this will be followed by a consideration of how a critical-realist, or material-discursive, approach which straddles this epistemological divide may help to arrive at a more complex understanding of the data collected for this study. The resulting approach is one in which the researcher works as a bricoleur in the way described by Denzin and Lincoln (1994; 1998) in their discussion of the developments of the fifth and sixth moments in qualitative research.

## Questions of Epistemology and Ontology

Questions of method are secondary to questions about the nature of reality and how that reality can be known or the relationship between the inquirer and the world they attempt to understand. Within the natural sciences a realist ontology is assumed (i.e. there is a tangible world out there which can be discovered along with its deterministic laws of cause and effect) and it is assumed that this world can be known through methods of enquiry which emphasise objectivity and control. The application of this positivist paradigm - with its associated empiricist epistemology, experimental methods and concerns with issues of validity and reliability - to the study of human beings rather than the natural world has long been criticised (Smith et al., 1995c; Smith et al., 1995b). Henwood and Pidgeon (1992) highlight the role of the 19th century philosopher Wilhelm Dilthey who argued that the human sciences should be premised on a search for meaning or understanding (*Verstehen*) rather than a search for causal relations and deterministic laws. The alternative epistemological positions are seen in the interpretative or naturalistic paradigm which has been influenced by hermeneutics, phenomenology and constructivism (Henwood and Pidgeon, 1992).

This alternative paradigm is less concerned with (and sometimes denies the possibility of) detachment and objectivity on the part of the researcher and is more concerned with acknowledging the role of the researcher in interpreting or even co-constructing reality with those who are being researched. The roots of the epistemological positions and associated methodologies in this alternative paradigm differ according to the discipline and theoretical concerns of those conducting the research. There are a number of influences including symbolic interactionism, social constructionism and phenomenology, and more recent post-structuralist and post-modernist perspectives (Yardley, 1997c). Whilst these different traditions share a scepticism about the value of positivism in understanding the human sciences and tend to privilege qualitative methods as legitimate modes of enquiry, there remains considerable debate and tension concerning ontological and epistemological positions.

Part of the critique of positivism, and its associated realism, has been that it adopts a dualistic framework for understanding the world, and in particular the mind-body dualism limits our ability to understand psychological processes (Yardley, 1999). Other dualisms set up within this paradigm are those between subjectivity and objectivity (Yardley, 1999) and the individual and society (Griffin and Phoenix, 1994).

The implications of the individual/society dualism will be discussed first. The individual/society dualism within health psychology has reproduced the medical gaze of the body which is seen in biomedical discourse and whilst it has incorporated the mind this is still at the expense of any understanding of social processes (Murray and Chamberlain, 1999). It has also been argued that positivism has had a strong influence on nursing practice and nursing research through the influence of the patriarchal medical model; this has led to dualistic thought patterns and the intolerance of diversity which contribute further to the oppressive nature of nursing (Wilson-Thomas, 1995). The individual/society dualism dominates western or modernist thinking and it is therefore the hardest to register as it is so thoroughly normalised – it underpins liberal humanist thinking which represents the dominant value system of our society. Furthermore Lister (1997) argues that the enlightenment discourse of the primacy of the individual is a central feature of modernist nursing but, in line with critiques of liberal humanism generally, he argues that this stance unduly emphasises personal responsibility for health and fails to take account of the ways in which the socio-cultural-political world impacts on nursing practice. The individual/society dualism implicit within liberal humanism privileges the individual as a rational, unitary subject with free will and free choice (Rothfield, 1990). In this scheme of things society is no more than an aggregation of individuals and society, or the social, is absolved on any responsibility for the actions of individuals (Parker et al., 1995).

Further dualisms which map onto the privileged unitary individual are the splits between private and public life and between the personal and the political. Liberal humanism erases difference (Seidler, 1994) whilst at the same time it is hetero-normative and patriarchal; this means that anyone who is different will be treated as if they are the same as that which is at the centre of this discourse i.e. the privileged subject who is at least white, heterosexual, and male (Rutherford, 1990a; Jackson, 1996; Hall, 1997b) . If they are not the same then they will be construed as deviant and as the Stainton Rogers have said:

> "liberal-humanism is not half as benign or egalitarian as it has been made out to be. It can be profoundly ethnocentric, and it can serve to bolster the power injustices that run through the relationships between men and women, the rich and the poor, and indeed anywhere where there are differentials of power" (1996, p. 75).

Furthermore, the discursive practices inscribed by the dominant value system of liberal humanism are only one short step away from victim-blaming (Parker et al., 1995; Nightingale and Cromby, 1999).

However, it would seem that the attempt to counter the dominance of the positivist paradigm in the human sciences has spawned its own set of dualisms: the material versus representations (Ussher, 1997c); cognitions versus discourse (Smith, 1996a); realism versus idealism; empiricism versus relativism and foundationalism versus relativism (Maynard, 1994). A further polarisation or dualism can be seen in the debates between essentialists and social constructionists. This perhaps can account in part for Yardley (1996) and Ussher's (1997c) observations that the physical dimensions of health and illness are often missing from accounts about the personal experiences of health and illness. There have been critiques of what has been represented as the *nihilistic relativism* of discursive and social constructionist approaches where nothing can be "decided" about the world (Pilgrim and Rogers, 1997). There have also been attempts to reconcile the binary divide between material and discursive approaches (e.g. Ussher, 1997c; Yardley, 1997c) and to transcend disciplinary and epistemological boundaries by mixing methods when attempting to address particular research questions (e.g. Henwood, 1993; Willott and Griffin, 1997; Boyle and McEvoy, 1998; Gough, 2002). However, before attempting to transcend dualisms and disciplinary and epistemological boundaries it would be useful to look at the contributions and limitations of social constructionist and discursive approaches and the extent to which they can be utilised to inform this particular enquiry. According to Yardley (1997c, p. 1) discursive approaches recognise the "socially and linguistically mediated nature of human experience" and they are theoretically informed by the perspectives of post-modernism, post-structuralism and social constructionism. These perspectives have "converged to argue that knowledge and identities are fractured ... (and) ... (h)ence, they promote a radical scepticism about the possibilities for knowledge" (Henwood and Nicolson, 1995, p. 110). Those arguing for a discursive approach to psychology have challenged psychology's object of study as a bounded individual because of the problems of incorporating social processes. They argue that discursive psychology can help to analyse the diversity and complexity of individual experiences within an account of how that experience is mediated by and lived within a social context (Morgan, 1999).

The underlying ontological and epistemological assumptions of social constructionist and discursive approaches are idealist and relativist. That is, what is taken to be real is seen as a construction in the minds of individuals and meaningful constructions are multiple and conflicting (Schwandt, 1994). Furthermore, constructivists take an anti-essentialist position. They take what is assumed to be self-evident and question whether the taken for granted is actually the product of complicated discursive practices (Schwandt, 1994). Discursive practices are "the different ways in which people, through their discourses, actively produce psychological and social realities" (Spink, 1999, p. 88). "Discourse" can be taken to mean the institutionalised use of language or language-like systems (Spink, 1999), seeing language, talk and text as constructive of reality rather than a way of getting at an underlying reality (Gill, 1996), or used to refer to a coherent system of meanings (for example, a 'biomedical discourse') (Yardley, 1997b). This latter definition is more Foucauldian than the others in that it infers more about knowledge and power relations. One further use of the term discourse is to refer to the way in which talk and texts function as social practices in local and flexible ways through "interpretative repertoires" (Potter, 1996). An interpretative repertoire is defined as a set of terms, descriptions and figures of speech, often clustered around particular metaphors, which are used as building blocks for constructing versions of events or for performing specific functions (Yardley, 1997b).

Coyle (2000), in attempting to bring together the disparate ways in which the term discourse is used suggests that discourses can be seen as "sets of linguistic material that have a degree of coherence in their content and organisation and which perform constructive functions in broadly defined social contexts" (p. 245). It is important to note that any such use of language is not necessarily seen as intentional. The different ways in which the term discourse is used, either to mean local interpretative repertoires or in a wider more Foucauldian sense will vary according to whether a micro or macro analysis of discourse is undertaken (Stainton-Rogers, 1996). Some discursive researchers will combine both in order to show "how people draw on wider systems of meaning to construct and defend their own particular position or perspective" (Yardley, 1997b, p. 32).

Thus social constructionist and discursive approaches have been used to create alternative ways of seeing things, challenge existing practices and power relationships, publicise suppressed discourses (Yardley, 1997b), and to contribute to ideological critique and understanding of the ways in which power relations of "domination and subordination are reproduced and justified" (Gill, 1996, p. 156). Examples of how discursive research has been used in psychology are given by Willig (1998b). These include Parker et al's (1995) work which questions what is taken for granted such as psychopathology. A further example of how discursive research is used in psychology is given by Potter (1996) where it has been used to help to understand how racist practice and the blaming of minority groups is legitimated and how blame and responsibility are managed. Discursive and constructionist approaches would then seem to be particularly useful for looking at how sexual identities are managed and in particular how they are negotiated in health care encounters. However, a further set of debates and tensions concerning the utility of this approach have developed.

These debates are particularly relevant to this study as they are concerned with the ways in which constructionist approaches may fail to take account of material conditions such as oppression and the corporeal dimension of illness. The aim of this study is to explore and understand an illness experience which has a strong social dimension. That is the mental health problems and mental health care that the participants in this study had received, needed to be understood as having a material dimension in terms of how homophobia and heterosexism contribute both to the development of mental health problems and subsequent health care experiences.

A number of authors have questioned the applicability of extreme social constructionist approaches to understanding areas of human activity which have a material or embodied aspect and in so doing question the extreme ontological idealism and epistemological relativism of these approaches. Yardley (1996) argues that such approaches have merely inverted the dualisms of more traditional scientific modes of enquiry and little account is then taken of what she terms the "material". Ussher (1996) goes on to argue that some of the material aspects of experience which get neglected are the influence of biology, age, social class, race and sexual identity; Gergen (1998, p. 147), more dramatically, says that although social constructionism was born of opposition and appealed to the marginalised "the constructionist axe turned back to gash the hand of the user. There was no power structure, race or gender oppression ... that was not itself constructed". Extreme relativists argue that their approach challenges the taken for granted and say that this should allow for openness and change (Edwards et al., 1995; Potter, 1998). However, it has been argued that extreme relativist approaches are not used to effect social change and the inherent deconstruction of these approaches makes it difficult to talk about oppressed groups because the categories themselves are problematised (Burr, 1998). Ultimately, a number of authors have argued for attempts to reconcile material and discursive approaches as both on their own limit the ways in which we can usefully know the world (see edited collections by Ussher, 1997a; Yardley, 1997d; Parker, 1998b).

The discussion so far might indicate that researchers can only position themselves on one side or other of epistemological and ontological dichotomies as either realist empiricists or idealist relativists but there are a number of other possible positionings (Hammersley, 1996). For example, Schwandt (1994) holds that a constructivist need not be an anti-realist and Davies (1998) argues that critical realists and ontological relativists attempt to straddle the binary divide between realism and relativism. There is also debate about the extent to which a researcher must position themselves in consistent and compatible ways. Ensuing debates concern the transgression of disciplinary boundaries and appropriate use of methodologies and methods. Some researchers attempt to reconcile and combine seemingly incompatible epistemological positions and methodologies (e.g. Henwood, 1993; Yardley, 1996). These same researchers also argue for the need to transgress disciplinary boundaries. It is important to be mindful of this when addressing issues relating to "validity" and note Potter's (1996) caution that such inter-disciplinarity can lead to superficial theorising and loose analysis.

However problematic, this mixing of epistemological positions and methodological approaches is becoming increasingly common within the qualitative paradigm and fits with the general call by Denzin and Lincoln (1998) for the qualitative researcher to be a "bricoleur". The researcher as bricoleur works within and between competing and overlapping paradigms and perspectives, piecing together multiple methods and strategies in a pragmatic, reflexive and strategic manner in order to address particular research questions which are understood to have a context. The result is a bricolage which is

> "a complex, dense, reflexive, collage-like creation that represents the researcher's images, understandings, and interpretations of the world or phenomenon under analysis" (Denzin and Lincoln, 1994, p. 3).

Such a stance is consonant with material-discursive and critical-realist approaches to investigating issues relating to health psychology which break away from a necessary link between particular epistemologies and associated methodologies, instead advocating the use of multiple methods, although they would be used in a sceptical manner (Ussher, 1996).

Material-discursive approaches attempt to straddle the divide between realism and relativism. They attempt to embrace physical and material aspects of existence and experience in a non-realist manner and in so doing attempt to side step dualist frameworks (Yardley, 1999). They also attempt to explicate the mutual and reciprocal influence between discursive practices and the material domain (Ussher, 1997c) but in a way which goes beyond a simple notion of interaction as in the bio-psychosocial model which remains dualistic and mechanistic (Yardley, 1999). However, arriving at a non-dualist perspective is not necessarily easy - requiring a profound and disturbing shift - but is one which would lead to a different research objective, namely

> "to develop a detailed, multi-layered, insightful interpretation of a phenomena, and to consider explicitly the way in which the context, the participants and the researchers have jointly contributed to the understanding acquired in the course of the investigation" (Yardley, 1999, p. 32).

One way in which this can be achieved, and it is emphasised in critical realist and feminist standpoint approaches, is by accepting, although not necessarily privileging, the legitimacy of lay knowledge and investigating a phenomenon through the participants' eyes (Ussher, 1996). A further advantage of this approach is that it has the potential to produce explanations that are less pathologizing or victim-blaming than many of the models produced by mainstream research (Stoppard, 1997). Such an approach is consonant with the aims of this project which are to investigate the health care experiences of lesbians and gay men whilst taking account of the material conditions of homophobia and heterosexism without blaming or further pathologizing those whose experiences are being investigated.

Adopting a material-discursive position, together with the particular objectives of the research, requires then a consideration of the most appropriate way of gathering data and its analysis. The approach taken to data collection was in-depth semi-structured interviews in order to engage with the meanings and complexities of personal experiences of health care. This epistemological commitment to the qualitative paradigm also required a method of analysis which explicitly acknowledged the interpretative role of the researcher whilst attempting to gain an "insider" perspective on the participants' worlds (Smith et al., 1997). Further though, in adopting a material-discursive approach, another method of analysis was also required which took account of the social context of individual experiences and discursive practices which constructed those experiences. The method used initially in this study was developed by Smith and is known as Interpretative Phenomenological Analysis or IPA (Smith et al., 1997). Following this analysis, a discursive analysis was also conducted and the two methods of analysis were juxtaposed to produce a material-discursive understanding of participants' mental health care experiences. The method of IPA will now be discussed in detail leading to an explication of the limits of this method of analysis for this particular study, followed by a discussion of how it was juxtaposed with a more discursive approach.

### Interpretative Phenomenological Analysis (IPA)

Epistemologically, Smith (1995, p. 10) adopts what could loosely be viewed as a critical realist perspective in which it is

> "assumed that what a respondent says in (an) interview has some ongoing significance for him or her and that there is some, though not a transparent, relationship between what that person says and beliefs or psychological constructs that he or she can be said to hold".

IPA seeks to engage with the way participants think and act in order to reflect their perspectives through allowing them to tell their own stories and in their own words. It is thus concerned with personal accounts rather than objective statements although these personal accounts are seen as representing some sort of psychological reality (Flowers et al., 1997a; Smith et al., 1997). It is thus underpinned theoretically by phenomenology and also symbolic interactionism, itself influenced by Husserl's phenomenology, which in turn leads to an emphasis on interpretation in elucidating the negotiated meanings of participants (Smith et al., 1997).

In terms of where IPA is situated in the debates about ontology and epistemology, Smith (1995) argues that his approach is consonant with the grounded theory of Charmaz (1995). However the position that both Smith and Charmaz take is not all that clear. Charmaz (1995) argues that grounded theory can bridge positivistic and interpretative methods and is credited with a constructivist revisioning of Glaser and Strauss's (1967) grounded theory (Henwood and Pidgeon, 1994), However, Charmaz (1995) ultimately argues for an empiricist position. Smith also argues that the underlying ontological position of IPA is realist assuming a chain of connection between accounts, cognitions and behaviours (Flowers et al., 1997a), but also paradoxically argues that phenomenological and discursively oriented approaches could potentially be combined (Smith, 1996a).

Where Charmaz and Smith concur, however, is in the idea that the data are actively co-constructed by the researchers and their participants (Charmaz, 1995; Smith, 1996a). Researchers travelling this particular route invariably invoke the idea of reflexivity to try to address the problems arising in this interpretative process from the researcher's own pre-conceived ideas and effects of prior experience (Henwood and Pidgeon, 1994; Flick, 1998). What becomes apparent in this exploration of epistemological and ontological positioning, is that one can either try to grasp one of the nettles or move around in the middle and get stung from all sides. The idea that it is not a matter of grasping nettles is perhaps best put by Henwood and Pidgeon when they say that there is

> "an epistemological tension at the heart of the naturalistic paradigm, which Hammersley (1989) calls the 'dilemma of qualitative method'. Put simply, this arises from a simultaneous commitment to, on the one hand, realism (and inductively reflecting participants' accounts and naturalistic contexts), and on the other, constructivism, which includes, amongst other things, actively encouraging the researcher in the creative and interpretative process of generating new understandings and theory. Philosophically speaking, theory cannot simply emerge from the data. Observation is always set within pre-existing concepts, and this then raises the question of what grounds grounded theory?" (Henwood and Pidgeon, 1994, p. 232).

Henwood and Pidgeon's solution to this dilemma is to work with a more constructivist version of grounded theory which they have characterised as a process of 'flip-flop' between data and conceptualisation which they link to Charmaz's (1995) constructivist revision. This explicitly acknowledges the role played in the analysis by the researcher's prior frameworks derived from schools of thought, disciplines and personal experiences. Ultimately it would seem that there are a number of ways of working with this tension but what is fundamental is that the tension must be worked with, not against (see for example Fine, 1994; Holland and Ramazanoglu, 1994; Hammersley, 1996). It is perhaps only through using particular methods and realising their limitations that one can arrive at a position of beginning to work with that tension. It would seem appropriate then to take some time to consider the use of IPA in more detail and then explore ways of dealing with the tensions which arise in the interpretative process.

## IPA as a Method

The aim of IPA is to undertake a detailed exploration of the participant's view of the topic being investigated through the analysis of verbal material derived from in-depth semi-structured interviewing in which the researcher attempts as much as possible to enter the psychological and social world of the person interviewed (Smith, 1995; Smith et al., 1999). (Further discussion on the construction of the interview schedule and the process of interviewing is given in chapter four). It is recognised that in the attempt to get close to the phenomenal world of the participant, the researcher's own conceptions are necessary but complicate access to and interpretation of that world. Smith et al (1999) state quite clearly that there should be no prescriptive way of conducting analysis as the process of interpretation is ultimately personal but they do suggest working in detail with one initial interview transcript before incorporating other interview material, with the gradual and cautious build-up of theory or more general categorisation. This falls within a more general idiographic approach (Smith et al., 1995a; Smith et al., 1999). There is more discussion about the theory generated by such an approach and its relationship to prior theory later in this section.

The analysis of verbatim transcribed interview material requires a "sustained engagement with the text and a process of interpretation" which is an iterative not a linear process (Smith, 1995, p. 18). That is to say that each of the many re-readings of the initial material analysed is likely to throw up new insights and, as new themes emerge from later material, the earlier material must be re-visited to test out the new themes. These new themes may "enlighten, modify or become subordinate to (those) previously elicited" (Smith, 1995, p 21). Smith suggests a close reading and engagement with the text against which the analyst should note anything which strikes them as interesting or significant; these might be emerging themes, connections between themes, or preliminary interpretations. This is followed by an attempt to cluster themes into some sort of hierarchical order of super and sub-ordinate categories with an instance given for each master or super-ordinate theme identified (Smith, 1995). This process is repeated cyclically and with additional interview material until a final coherent list of master or superordinate themes is produced. This ultimately requires a process of selection, not on the basis of prevalence but based on the richness of the data and the extent to which each theme illuminates other aspects of the account (Smith et al., 1999).

This method of analysis can be applied to a single case study, or an initial interview can be analysed in this way and used as a starting point for subsequent analysis of a small number of interviews which may lead to cautious generalisations. The method can also be used to analyse larger data sets, either following the same procedures, or starting with the analysis of a small subset of cases to generate themes which are then searched for, elaborated and refined in the larger data set (Smith, 1995). Smith et al (1999) also suggest that handling large data sets may require a more exploratory analysis in which one or two themes of mutual relevance across the data are identified early on and theorised at a group level. These are then focused on in more detail, allowing a consideration of how these themes interrelate as well as considering personally distinct experiences within those themes. This approach still requires an in-depth engagement with one initial interview or subset of interviews but undertakes a broader level of coding than in the case-study approach. The analyst is then primed or oriented to looking for previously identified clusters of themes in subsequently analysed interviews. It also allows for a greater degree of initial selection of which themes to focus on for further analysis (Smith et al., 1999). A larger data set can also be used to begin generating grounded theory (Smith et al., 1997).

Regardless of the approach used in relation to the size of the data set, Smith et al (1999) suggest that as part of the iterative process the analyst should continually return to the original transcript material. This is in order to check that as themes are clustered or organised the connections work for the primary source material or what the person actually said, as a way of reducing the researcher's bias in the process of selection. A further point is the insistence with the use of IPA that themes should be seen to "emerge" from the data; i.e. material should be introduced by participants without cues or prompts from the interviewer and such material should be clearly reflected in verbatim content (Smith, 1995). This method has been used in a number of studies to access the phenomenal worlds of people in relation to health care and illness experience (e.g. Flowers et al., 1997a; Jarman et al., 1997; Golsworthy and Coyle, 1998; Osborn and Smith, 1998) but it relies on people being able to articulate that experience as the analysis must be grounded in the participants' own words (Osborn and Smith, 1998).

Herein lies a tension when attempting to interpret ambiguities and silences in people's accounts and also in exploring further the impact of their experience. Smith et al (1995a; 1999) say that the method can be used to explore ambiguities and complexities. Rennie et al (1988) make this point regarding grounded theory. Smith

(1996a) also makes the suggestion that IPA could be used with discursive approaches but as yet no publications have explored this possibility. Osborn and Smith (1998) argue that there is a place for both types of analysis in that, despite seeming incompatible theoretical perspectives and epistemological positions, people's accounts can be seen as both indicative of people's underlying beliefs *and* can also be seen as linguistic devices which people use to account for themselves in particular ways. They say that people's accounts do both things, not one to the exclusion of the other and they go on to argue for an intermediate position in which people's accounts are seen as:

> "complex, dynamic and shifting entities formed and reformed, in this case, as patients struggle to make sense of their condition and to articulate that struggle to the listener" (Osborn and Smith, 1998, p. 80).

However, there remains a tension in adopting this position and using IPA when attempting to interpret omissions, silences and contradictions, partly because of the previously mentioned insistence on grounding analysis in the participants' own words but also because of the relationship between IPA and prior theory. Although Smith has argued that developments need to be made to see how phenomenological and discursive approaches can be integrated (Smith, 1996b), this work remains to be done.

This study attempts to resolve the dilemma by juxtaposing IPA with a more discursive analysis, following the recent call to adopt the use of mixed methods, complementing phenomenological analyses and grounded theory approaches with discursive analyses and tolerating multiple viewpoints (Yardley, 1997c; Yardley, 1997b). Yardley (1997b) has been critical of the "experience of illness" approach arising from a phenomenological perspective which has been slow to recognise the socio-cultural processes in the construction of shared meanings. In a similar vein, Pilgrim and Rogers (1997) have been critical of the individualism intrinsic to interpretive humanism or Verstehen approaches. So, although Smith (1996b) has argued that IPA could be used in a more discursive way, in practice published studies, which adhere to the methodological insistence on thoroughly grounding findings in verbatim accounts, tend towards analyses which are more phenomenological than interpretative. They may take account of the local social context but not the broader social and discursive practices in which the subject of enquiry may be embedded. However, having said this approaches such as IPA and grounded theory are particularly useful at beginning exploration of areas where there is little in the way of prior formal theory to draw upon.

This use of grounded theory and IPA to explore under-theorised areas of research needs further discussion both in terms of their contribution to research and the limitations of the approaches. They allow the exploration of a field where formal theory or grand theory is either lacking or inadequately explains the problems of interest to the researcher (Henwood and Pidgeon, 1992; Henwood and Pidgeon, 1995; Smith et al., 1997), or is confining because existing theory or models are for example androcentric (Henwood and Pidgeon, 1995). Furthermore, Smith (1995a) has argued for the need in psychology to build theory from case studies using an idiographic rather than a nomothetic approach. These methods are thus particularly useful in nascent disciplines (Archer, 1988) such as nursing, health psychology and lesbian and gay psychology. They allow an openness to exploring complex problems (Flick, 1998) with recognition of the "extent to which we share with our participants all the problems of and possibilities of making sense of the world" in a way which quantitative approaches obscure (Grbich, 1999, p. 23). They can also "represent context-specific understandings, as well as guarding against overwriting participants' internally structured subjectivities with externally imposed 'objective' systems of meaning" (Griffin 1986 cited in Henwood and Pidgeon, 1995). However, this position forces a return to the question posed earlier; i.e. what grounds grounded theory?

Henwood and Pidgeon, and Charmaz in their call for a constructionist revision of the method of grounded theory more fully explicate the relationship between prior theory and grounded theory. The grounded theory approach has been characterised as purely inductive with some going so far as to claim that the researcher would not even conduct a review of the literature before embarking on a study (e.g. Morse and Field, 1996). However, Flick (1998) argues that this is a mis-representation of grounded theory and that the postponement relates not to theoretical structuring but to hypothesising. Charmaz (1990) argues that the researcher's perspective should be informed by their discipline, personal experiences and values leading to a set of sensitising concepts. Pidgeon (1996) goes on to argue for a more discursive form of analysis within grounded theory that leads to "the 'everyday' being interpreted in terms of wider social contexts and power relations" and says that the method of constant comparison "with its emphasis upon exploration of variety and difference in meaning, might potentially serve as a vehicle for a deconstructive form of analysis" (p. 83). Henwood and Pidgeon (1995) also discuss how a feminist research perspective can move us on from a purely phenomenological approach or pure induction through highlighting the centrality of women's accounts but these are nevertheless accounts which are mediated by social and cultural frameworks. Stoppard (1997) explicates further this relationship between women's accounts and available discourses arguing that an understanding of women's depression must start from the perspective of women but women's uses of dominant discourses may obscure the social relations of depression. She does go on to argue though that these accounts may reveal the limitations of contemporary conceptualisations of depression. Smith has been less forthcoming than Henwood and Pidgeon on how IPA might be applied in a more discursive way and it would seem that both methods, IPA and grounded theory, cannot adequately account for silence and omission in texts. Whilst this ultimately might say something about the limitations of relying on interview material it would seem most appropriate at this juncture to juxtapose IPA with another method of analysis. In this case a discourse analysis was also undertaken following in the trend to mix methods in this way when exploring complex issues. A discursive analysis may also help to explicate the interpretative framework of the researcher as well as the researched (Fine, 1992; Fine, 1994; Gillett, 1995).

## The (Re)turn to Discourse

The necessity to combine discourse analysis with IPA emerged through an engagement with the texts (when analysing the interviews using IPA) in which it became clear that participants often seemed unable to articulate certain experiences or remained silent. Gill (1996) has argued that discourse analysis requires a sensitivity to language but also to what is not said. One of the central procedures of discourse analysis is deconstruction. This is a process of revealing the ideological constraints on what can and cannot be said through searching for dichotomies. These dichotomies reveal dominant discourses and sub-ordinate discourses which are hidden or stifled (Yardley, 1997b). In one particular study which was a grounded theory and discursive analysis of women's experiences of abortion, prior theory including what is known about currently available discourses about abortion, was used to interpret some of the silences, contradictions and apparent uncertainties in women's accounts (Boyle and McEvoy, 1998). Heaphy (1998) has also argued that we must listen beyond what is explicitly voiced in interviews to understand silences and to arrive at possible interpretations. Such interpretations relate to power relations between the researched and researchers as well as between the researched and health care providers implicated in the health care experiences being researched.

What was required in the analysis of the data for this project was an explicit recognition of the power relations between the researched and their health care practitioners. This required a prior theoretical commitment to locating these experiences in wider discursive practices relating to medicalisation and the effects of homophobia and heterosexism. This necessitated using a macro-discourse perspective in which it was possible to interpret and understand the accounts of the research participants about the ways in which they positioned themselves in relation to discursive practices.

## Discourse Analysis

The decision to undertake a discursive analysis requires a further discussion about types of discourse analysis (DA), their theoretical roots and epistemological differences between proponents of different perspectives. Ultimately all proponents of discourse analysis adhere to a social constructionist epistemology (Coyle, 2000) but within this there are different perspectives about degrees of constructionism and the uses to which DA can be put (Gillies, 1999). What discourse analysts have in common is that they understand language to be constitutive of reality. This may be seen in broad social terms whereby the power to define something in a particular way produces knowledge and power. Such a position arises from the influences of the French philosophical traditions of structuralism and post-structuralism and most notably from the work of Foucault (Burr, 1995). Another way of seeing language as constitutive of reality focuses on the performative aspects of discourse and what people do with their talk (Burr, 1995). This approach has its roots in work on conversation organisation and rhetoric (Potter and Wetherell, 1995). Potter and Wetherell (1995) have made the distinction between different types of DA as a difference in focus on either discourse practices (what people do with their talk) or on discursive resources (the devices people draw upon when engaged in discursive practices). They argue that although these two approaches can be distinguished they may also be used together depending on the nature of what is being investigated.

Burr (1995) has also argued that the two approaches are not incompatible but that they have different concerns and says that the macro discourse perspective tends to be more theoretical and less empirical than the micro-discourse perspective. However, Potter et al (cited in Burr, 1995) have argued that what they do can be rightly termed

DA whereas those such as Parker are engaged in something which should be termed "analysis of discourse". Deconstructive approaches are subsumed within "analysis of discourse" (Burr, 1995). Lying beneath this are epistemological differences wherein Potter and others adopt an extreme relativist position whereas Parker and others, in resisting this slide into relativism, adopt a critical realist position (Burr, 1995; Gillies, 1999). Whilst being mindful of these epistemological tensions, it is possible to say something about what is being engaged in when analysing discourses whether at a macro or micro level; it is possible to develop hypotheses about the purposes and consequences of language (i.e. its functions) (Wetherell and Potter, 1988) and look at how people construct their versions of the world and what they gain from these constructions (Coyle, 2000). Although DA is not strictly a method there are tools and approaches which can be used to assist the process of analysis. Ultimately these approaches are not markedly different whether one is in engaged in a macro or micro-discourse analysis. However, with micro-discourse analysis more stringent methods are used with transcribed material (Burr, 1995).

Another way in which concepts such as identity can be analysed through discursive practices is to look at how subjects are positioned. This approach comes from a different tradition within discourse analysis and relates to the work of Davies and Harré (1990). In this understanding of identity, individuals are constructed through discourses which they can accept, with their attendant obligations, or resist. Furthermore, people's accounts of themselves require some sort of co-operation and therefore negotiation with others in terms of how they are positioned or position themselves. Identities are thus produced in relation to culturally and socially available discourses (Burr, 1995). These positions provide us with our subjectivity and we come to experience the world from that perspective (Davies and Harré, 1990). Furthermore, how positions are "offered, accepted or resisted in everyday talk are the discursive practices by which discourses and their associated power implications are brought to life" (Burr, 1995, p. 147). Willig (2000) has argued that even these approaches do not go far enough to enable us to understand people's experiences. She says that positioning theory up until now tends to offer an explanation of subject positions offered by current discourses but fails to explain how these are implicated in the constitution of subjectivity, experience and identity:

> "Our focus needs to shift from the *availability* of discursive resources in the culture to the individual's *appropriation* of (some of) these over time" (Willig, 2000, p. 560)

Willig (2000) goes on to say that positioning theory can be used to explain how some subject positions become internalised (in contrast to social constructionist approaches which view discursive formations as transient and contextual) and come to actually structure an individual's private experience and subsequently define and constrain possible ways-of-being.

DA then is an important tool for understanding and interpreting the mental health care experiences of people who are negotiating their sexual identities in a context where dominant discourses pathologize those identities. It also allows an interrogation of the data in terms of the way participants position themselves and the ways in which they may be positioned by health care practitioners. Furthermore, one of the few ways of resisting the dominant discourses around lesbian and gay identities is through silence and DA and deconstruction in particular provide useful ways of theorising, contextualising and interpreting such silences and resistance. In this study then a discursive analysis was used as an adjunct to the more grounded and phenomenological approach of IPA. This allowed an analysis of data initially which thematised shared experiences of health care grounded in verbatim data. The discursive analysis allowed another layer of interpretation with particular attention being given to contradictions and silences in people's accounts.

The methods used in this study all fall within the qualitative paradigm and there have been many concerns about the "validity" of these methods. The term validity is specific to methods used within the positivist paradigm and alternative terms and criteria are evolving for qualitative research (Henwood and Pidgeon, 1992; Smith, 1996b; Elliott et al., 1999; Lyons, 1999; Yardley, 2000). These will now be discussed as they relate to this study.

### Criteria for Evaluating the Worth of Qualitative Research

Once a non-realist epistemological position is adopted, the relationship between the knower and what can be known is immediately problematised (Henwood and Pidgeon, 1992). The traditional criteria for evaluating rigorous research in the positivist paradigm, (i.e. validity, reliability with associated notions relating to objectivity, and generalisability) then become untenable (Guba and Lincoln, 1994). Constructionists' attempts to address the issue of how to evaluate qualitative research, with alternative criteria such as trustworthiness and authenticity, have not yet resolved the issue as "their parallelism to positivist criteria make them suspect" (Guba and Lincoln, 1994, p. 144). Henwood and Pidgeon (1992) present a number of good practices in this area, as do Elliot et al (1999) and Smith (1996b). Smith (1996b) and Elliot et al (1999) argue that alternative criteria can only be presented as work in progress at this stage. Lyons (1999) also makes the point that any such guidelines will vary with the paradigm in which different qualitative researchers locate their work. Yardley (2000) argues that there can be no fixed criteria for establishing the worth of non-realist and non-positivist research where meanings are negotiated and communally co-constructed. Instead she argues for the adoption of criteria which are themselves open to flexible interpretation as otherwise

> "we would limit the criteria for truth (which) would mean restricting the possibilities for knowledge, and would also privilege the perspective of the cultural group whose criteria for truth was deemed 'correct'" (Yardley, 2000, p. 217).

The criteria offered by Henwood and Pidgeon, Smith, and Yardley have a considerable degree of overlap save for some criteria specific to particular methods such as grounded theory (e.g. theoretical sampling and negative case-analysis). However, the criteria offered by Yardley are more comprehensive and will therefore form the framework for this discussion. Yardley (2000) suggests four key dimensions which can be used to assess the quality of research using qualitative methods:

1. Sensitivity to context
2. Commitment and rigour
3. Transparency and coherence
4. Impact and importance

The concern with sensitivity to context concerns the importance of prior theory; whilst prior theory will influence interpretation, and may even be necessary, there is also a need to remain sensitive to the data itself (Yardley, 2000). Henwood and Pidgeon (1992) suggest making explicit how categories are arrived at by the researcher and call this sensitivity to the data "the importance of fit"; i.e. the fit between interpretation and data. Another component of sensitivity to context discussed by Yardley, is the need to be aware of the socio-cultural setting of the research and the impact of that on the meaning and function of phenomena. As Altheide and Johnson (1998, p. 306-7) have stated " a valid interpretation without a context is impossible" and an account needs to "point out the multiplicity of meanings and perspectives, and the rationality of these perspectives, by setting forth the contexts(s)". Context is important here in terms of the research setting and the researcher:

> "the listener contributes to what is said ... by actively or passively invoking the relative identities and shared understandings which provide the framework for speech" (Yardley, 2000, p. 221).

Denzin and Lincoln discuss how postmodernist and poststructural thinking has attacked the notion of objectivity and also attacked the idea that the subjective meanings of individuals' experiences can be accessed:

> "there is no clear window into the inner life of the individual. Any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity. There are no objective observations, only observations socially situated in the worlds of the observer and the observed. Subjects, or individuals, are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories ..." (Denzin and Lincoln, 1998, p. 25).

Yardley (2000) goes on to argue that the design of a study must take into account the positioning of the researcher. How this can be worked towards is discussed further in relation to transparency and reflexivity. Whilst Yardley's (2000) focus here is on the researcher, Elliot et al (1999) also argue for the need to "situate the sample". This entails giving sufficient background information about research participants to enable the reader to judge the relevance of the findings.

A further element to evaluating sensitivity to context is to consider participant involvement (Yardley, 2000). Henwood and Pidgeon (1992) say that it is frequently suggested that theory which has a good fit should be recognisable to participants. They argue that this can be problematic but go on to say that some researchers may seek to negotiate interpretation and meaning with participants. This dimension to assessing the quality of research they term "sensitivity to negotiated realities". Smith (1996b) also argues that this approach can be problematic and is not always viable, but, whilst not able to reach an absolute truth, can lead to fuller understanding. In one particular study he argues that this approach led to obtaining richer data (Smith, 1996b).

Further dimensions to judging qualitative research are commitment and rigour (Yardley, 2000). Commitment concerns a prolonged involvement with the topic with immersion in the data, and using methods in a skilled and competent manner. Rigour refers to the completeness of the data collection, not in terms of sample size or representativeness, but "in terms of its ability to supply all the information needed for a comprehensive analysis" (Yardley, 2000, p. 221). This relates to the coherence of the analysis discussed subsequently. Rigour also relates to the completeness of an interpretation which should address complexity and variation. One way in which complexity can be addressed is through the use of triangulation (Yardley, 2000) although Yardley (1997b) suggests that such a stance implies weak realism. Another way in which rigour can be worked towards is through a recognition of the inherent limitations of any perspective and instead adopting a combination of analytic approaches (Yardley, 2000).

A transparent and coherent account of a research study should be convincing and meaningful to the reader, with a fit between theory and method and clear exposition of the analysis (Yardley, 2000). Such an account should disclose all relevant aspects of the research process, perhaps through a paper trail (Yardley, 2000). As Smith has argued such a paper trail allows others to check that the account is credible or warrantable. That is not to say that only one definitive account is possible nor is there an attempt to suppress alternative readings or reach consensus but it allows an attempt to "validate one particular reading" (Smith, 1996b, p. 193). Others have argued for the need to provide credibility checks through for example, having more than one analyst, or conducting member checks or using an "auditor" (Elliott et al., 1999). A transparent account will address concerns about the importance of fit (Henwood and Pidgeon, 1992) and by keeping close to the data will "allow the reader to interrogate the interpretation that is being made" (Smith, 1996b, p. 192). However, it has been argued that providing a transparent account is far more problematic and a more complex achievement than is normally acknowledged (Reicher, 1994). Attempts to theorise our own position and consider our impact as researchers in terms of how we interdependently shape and constitute the object of enquiry (Henwood and Pidgeon, 1992) come under the rubric of reflexivity which has received considerable attention from qualitative researchers.

Yardley (2000) describes reflexivity as a kind of disclosure which is necessary for researchers who believe that their assumptions, intentions and actions profoundly affect our experience of the world and will therefore also affect the findings from a research study. Altheide and Johnson (1998) adopt an analytic realist perspective in which they reject the conceptual dualism of realism and idealism. They argue from this perspective that the social world is an interpreted world and that a dualistic approach is incompatible with interpreting the nature of lived experience and its interpretation. What follows from this is that all knowledge is perspectival and it behoves the researcher to show their hand, write for an audience and specify what their perspective is (Altheide and Johnson, 1998). They argue that the authority of an account can only come through paying attention to context and through reflexivity - that is through a recognition that the researcher is part of whatever it is that they are attempting to understand and represent (Altheide and Johnson, 1998). A more radical position on reflexivity is that the researcher is producing a purposeful construction and this should be made explicit in order to make the researcher more accountable (Coyle, 2000).

A number of ways of providing a reflexive account have been developed and it is common for the author to write themselves in through some kind of biography. Whilst this is necessary, it may not be sufficient and many authors have suggested that such attempts can be at best tokenistic (Bola et al., 1998; Ahmed, 1999). Fine (1994) is particularly instructive on reflexivity arguing that we must continue to worry about relationships in the research process and "work the hyphen" by keeping discussion open about what is and what is not "happening between" researchers and informants and the negotiated relations of whose story is being told. She goes on to say that we must mine our own experiences in order to interpret and that we have a responsibility to position ourselves in relation to our data (Fine, 1994; Kidder and Fine, 1997). Others have also argued that ultimately the researcher must take responsibility for their own interpretations and the assumptions behind them (e.g. Holland and Ramazanoglu, 1994; Maynard, 1994; Reicher, 1994). This relates to the discussion in the next section of this chapter on the crises of representation and interpretation. The data does not and cannot speak for itself; it is not possible to capture the informant's voice but it is possible to

> "elucidate the experience that is implicated by the subjects in the context of their activities as they perform them, and as they are understood by the ethnographer" (Altheide and Johnson, 1998, p. 296).

But as Altheide and Johnson (1998) go on to say, these endeavours are not easy and the attempt to locate the author and their perspective cannot be achieved through heroic diligence or empathic virtue. In a similar vein, Holland and Ramazanoglu (1994, p. 133) have argued that "we cannot break out of the social constraints on our ways of knowing simply by wanting to". Thus any attempt at reflexivity can only be "partial, temporary and tentative" (Kidder and Fine, 1997) but must acknowledge the inter-subjectivities between the researcher and the researched implicated in the interpretative process (Smith, 1996a).

Yardley's (2000) final dimension to judging qualitative research is impact and importance. She argues that the worth of a piece of research may be judged by its theoretical impact in terms of developing understanding of a topic as well as by its impact in a more political sense being either useful to a local community or through wider social effects by influencing the beliefs and actions of others. Henwood and Pidgeon (1992) discuss the impact and importance of research in terms of "theory that works" and in terms of transferability where they argue that such theory will suggest its own sphere of relevance.

If a transparent account is presented, it should be possible for the reader to make some sort of judgement about coherence and the relevance of the research as well as the researcher's commitment, rigour and sensitivity to context. As Potter (1996) has noted, readers are themselves skilled interactants so they can make judgements about claims. As one of the key components of providing a transparent account is through reflexivity the author must write themselves into the research account. The discussion of what a reflexive approach entails raises implications not only for analysis but also for how data are collected. This is discussed in more detail in relation to sampling and interviewing in chapter four. A further issue, which a reflexive approach requires consideration of, concerns representation once data has been collected and analysed. The debates about these concerns in the literature have been referred to as the crisis of representation and the crisis of interpretation.

## The Crises of Representation and Interpretation

The earlier discussion on epistemological differences foregrounds a debate about how we interpret and represent those we seek to understand through the process of research. Denzin and Lincoln (1998) characterise five moments or periods in qualitative research. Denzin (1998) also marks a current crisis in interpretation in which, following postmodern and poststructural sensibilities, there can be no privileged claims for authority or knowledge. Denzin and Lincoln (1998) argue that there was a crisis of representation following challenges to the application of the positivist paradigm to the human sciences and its associated realist stance of an objective ethnographer distanced from the observed subject (Fitzgerald, 1996). This crisis of interpretation led to challenges to realist and modernist approaches which claimed to provide authentic accounts through narrative devices using the 'voice of the other' accompanied by personal accounts to convey the author's honesty (Fitzgerald, 1996). The challenges were to the authority of the author to claim the voice of the other, and to the notion of the possibility of an objective account (Fitzgerald, 1996; Denzin and Lincoln, 1998). Denzin and Lincoln propose that the fifth moment in qualitative research is characterised by tensions and diversity in which observations can never be objective, only situated. Coffey (1999) states that this characterisation of five moments is over simplistic and obscures the history of ethnographers struggling with tensions including those relating to representation. The struggle with these tensions does have a long history and is ongoing - Denzin and Lincoln (1994, p. 560) suggest a developing sixth moment characterised by reflexive, experimental texts that are "messy, subjective, open ended, conflictual and feminist influenced" . It is worth spending some time discussing these tensions as they relate to representation and interpretation. Some of these tensions have been discussed in earlier sections on the criteria for evaluating the quality of qualitative research, status of the data and reflexivity. A further issue of particular importance for this study is the status of the researcher as an "insider".

There are particular issues to be aware of regarding representation when conducting sensitive research on vulnerable populations. There are concerns about perceived colonisation by academic researchers investigating the lives of "others" (e.g. hooks, 1990). Some of the ways in which this dilemma has been addressed are through an insistence on insider research, calls for participatory research and co-operative enquiry, and letting the data speak for itself. There are arguments for insisting on insider research but, although this may be necessary in terms of access to hidden populations (discussed further in chapter four), this can also be problematic. It is problematic but it restricts the researcher to studying their own kind (Lee, 1995) and furthermore is almost always inevitably incomplete (Oguntokun, 1998). Some, such as Fine (1994) have even gone so far as to argue against insider research on the grounds that it leads to essentialism. Others have claimed that only an outsider can create the distance or Otherness needed to make data productive during the analytic task (Pujol, 1999). Further, there is a case for reversing the process of Othering and 'writing back' as in cases where for example lesbians have written about heterosexuality or black women have written about whiteness (see Kitzinger and Wilkinson, 1996). However, Ahmed (1999) has argued that even from a relativist perspective, there is something to hold onto in the claim that insider status (albeit partial) permits not only access and facilitates data collection but can also be vital to the interpretative process. She argues that shared cultural membership, shared language and tacit reasoning can help or even be a requirement for discursive analysis.

Whatever one's sympathies about insider research, there is always likely to be something "outside" about the researcher and once again a way of working with rather than against the arising tensions must be found. Edwards (1996), drawing on arguments by the black feminist Patricia Hill-Collins, suggests that it is possible for white women to understand black women's experience through empathic dialogue although she remains sceptical about how such understandings can be represented in academic enquiry. Oguntokun has also suggested, drawing on Goffman's (1963) work, that one can be "wise" and become knowledgeable and sympathetic to the accounts of others. Such wiseness can also lead to action. However, Oguntokun is speaking from a partial insider perspective in relation to her research participants and it is unclear to what extent a more complete outsider or insider status affects the interpretative process. Fine has convincingly argued that researchers must find ways of working with the tensions that arise in the process of representing others and also argues against the idea that researchers can somehow let the data speak for itself (Fine, 1994; Kidder and Fine, 1997).

A further issue in terms of representation and interpretation are the limits of verbal data and written analysis. The difficulties of interpreting silence in people's accounts were discussed in an earlier section ("the (re)turn to discourse"); a related issue is to what extent people are able verbally to articulate their experiences which brings into question reliance on the method of interviewing. Huby (1997), drawing on Rosaldo, argues that people cannot always describe what matters to them most; Foster (1998) argues that people do not always have a readily available language to express their experience, particularly when that experience involves loss, trauma and powerlessness. This is of particular relevance to this study where for many participants coming out was experienced in a traumatic way which involved loss. Furthermore lesbian and gay identities are often lived through silence (Sedgwick, 1994) and many people have problematic access to a language to describe or negotiate these identities.

Furthermore, Foster (1998) argues that if such experiences can be articulated they are more likely to be represented as stories or metaphors which serve to distance the narrator from the horror and reality of that lived experience.

Holland and Ramazanoglu (1994) argue that interview material should be supported by fieldnotes and say "the unvoiced can never be fully grasped in an interview, and we can only negotiate recognition of what may be hinted at" (p. 140). Altheide and Johnson also discuss the limits of language in describing experience and say that it is important to acknowledge the "realm of *tacit knowledge*, the ineffable truths, unutterable partly because they are between meanings and actions", and they also argue for ethnographic work which reflects that "tacit knowledge, the largely unarticulated, contextual understanding that is often manifested in nods, silences, humor, and naughty nuances" (Altheide and Johnson, 1998, p. 296-297). Again the use of discourse analysis, fieldnotes and observations allowed an engagement with and interpretation of, ineffable aspects of the material in this study. Final methodological considerations which also relate to representation concern sampling, and how the meaning of terms in relation to sexual identities and coming out are negotiated with potential research participants. These are discussed in detail in chapter four.

## Conclusion

This chapter has set out an argument for mixing methods in order to investigate aspects of identity and experience. It is particularly important to find methodologies which disrupt the dualisms which not only construct identities and experiences but also constrain the possibilities for investigating those experiences. It is important to be able to find ways of interrogating data through different lenses which will allow an exploration of experience without further essentializing it (Cosgrove, 2000). In using a phenomenological approach to interrogate experience it should be possible to disrupt the subjective/objective dualism of positivism (Cosgrove, 2000). However, on its own phenomenology becomes essentialist as it does not allow an interrogation of the socio-political realm resulting in a "backslide into empiricist notions of truth" (Burman and Parker, 1993, p. 161). By also using the lens of social construction, and in particular the tool of deconstruction, it may be possible to interrogate data further taking account of the socio-political context. However, again on its own this approach may fail to take account of experience and most importantly it may fail to take account of resistance (Cosgrove, 2000). Of particular relevance to this thesis is that social constructionist identity theories rely ultimately on the binaries they seek to de-stabilise (Butler, 1993) and fail to take into account those who refuse these binary positions (Fine, 1994; McDowell, 1996). It is only by using phenomenological and constructionist approaches together that it is possible to develop an understanding of resistance and to begin to theorise resistance and resilience (Cosgrove, 2000). In this thesis this will be attempted through the use of IPA as well as deconstructive approaches and the use of positioning theory which itself attempts to disrupt the dualism created by extreme constructionist approaches.

# Chapter 4: The Research that Cannot Speak its Name – Design, Methods and Analysis

## Introduction

The aim of the research was to explore the mental health care experiences of lesbians and gay men when they are negotiating their sexual identity (or coming out) in order to answer the following questions:

3. How do homophobia and heterosexism manifest themselves in mental health care encounters when lesbians and gay men are coming out?
4. How do homophobia and heterosexism affect lesbians' and gay men's access to mental health care when they are coming out?

There were two factors which largely determined the design of the study and the methods used. The first factor related to the overall aim of capturing accounts of people's experiences and the meanings they attribute to such experience. The second factor related to the hidden nature of the population under study and the sensitive nature of the research topic. These two combined to make the use of qualitative interviews, with lesbians and gay men about their experiences of mental health care, the most appropriate way to gather data.

It is common practice with studies of lesbians and gay men to recruit through lesbian and gay community sources. However this approach, along with approaches in general to studying hidden populations, tends to lead to samples with a race and class bias. Given some of the points noted in the review of the literature, it is likely that class and race differences are theoretically significant so considerable attention is paid in this chapter to finding ways of accessing hidden populations which reduce such bias. Another bias which tends to be built into studies of lesbians and gay men is the degree to which research participants are "gay-community attached". Again the review of the literature suggests that this may be theoretically significant and this too is considered in relation to sampling techniques. Alternative methods to sampling hidden populations, drawing on work done with intravenous drug users and more broadly peer education programmes, are explored as well as the use of advertising. There is also a discussion about how important it is to attend to issues such as the use of language, access to research participants, insider status and approaches to interviewing when conducting sensitive research. This is followed by a description of the sampling approaches used in this study and the recruitment and profile of the sample which was obtained. The aim was to obtain a diverse sample which matched the demographic characteristics of the wider local population in the area where the study was conducted. The relative success of the different sampling approaches used in this study is then discussed. Following this discussion of sampling procedures the method of conducting qualitative interviews is explored alongside the ethical considerations which were built into the study. Finally, the approaches used to analyse the interview data are discussed.

### Rounding up the Usual Suspects; Theoretical Background to Sampling Issues

Research on lesbians and gay men necessitates finding ways of accessing and sampling a hidden population. Not only is the population under study hidden but it is rare (i.e. it is estimated that only about 6% of the total population identify as lesbian, gay or bisexual) and the research is generally considered to be sensitive. Two modes of recruiting this population have evolved. Historically, research into lesbians and gay men drew on prisoners and psychiatric patients, many of whom were incarcerated or hospitalised in relation to the criminalisation and pathologisation of homosexuality. That such samples would be un-representative of the wider lesbian and gay population hardly needs to be said but a fuller discussion of the implications of such sampling strategies can be found in Gonsoriek (1991). Once the political climate had moved towards de-pathologizing and de-criminalising homosexuality, and shifted towards a more gay-affirmative psychology, sampling strategies also had to change. Initially, in order to disprove the assumed absolute relationship between homosexuality and psycho-pathology, it was only necessary to find cases of lesbians and gay men who were not psychologically maladjusted (Gonsoriek, 1991). In these circumstances a convenience sample drawn through lesbian and gay community networks, rather than a clinical population, would probably be sufficient to address the aims of the research. This was the case in Hooker's classic and ground-breaking study which was conducted almost 50 years ago (Hooker, 1992, originally published in 1979). In this study a sample of gay men drawn through gay networks was compared to a matched sample of heterosexual men and it was found that there were no significant differences between the two groups in terms of psychological adjustment. This seriously challenged the position taken up until that point that homosexuality was a mental illness. The subsequent use of convenience samples drawn from lesbian and gay networks, social organisations and clubs and bars to study lesbian and gay lifestyles can be understood in the historical context of a drive to de-pathologise homosexuality.

### *Problems in the use of convenience sampling*

However, the continued use of such convenience samples is problematic, particularly when research questions broaden beyond such a limited de-pathologizing agenda and more diverse samples are required. They restrict respondents

> "not only to those groups who identify as gay, but to that subset which is more articulate, more ready to respond to published appeals, more likely to join social and political organisations, in short the middle class" (Davies, 1990, p. 23).

Many convenience samples of lesbians and gay men are also biased towards those with higher education (e.g. Bradford and Ryan, 1988; Davies et al., 1993) and do not have sufficiently large enough sub-samples of minority ethnic groups to enable meaningful comparisons (Wyatt, 1991; Davies et al., 1993). This class and race bias is not confined to studies of lesbians and gay men but tends to be a feature of qualitative studies and survey type research (Research and Decisions Corporation, 1984; Kalton and Anderson, 1986; Cannon et al., 1991; Fassinger, 1991; Patrick et al., 1998). Given that a number of studies demonstrate that there are important theoretical differences to attend to, within the lesbian and gay population, on the basis of social class (Dowsett et al., 1992; Flowers et al., 1997b; Weatherburn et al., 1999; Flowers and Buston, 2001) and ethnicity (Anzaldúa, 1990; Doll et al., 1992; Rotherum-Borus et al., 1992; Bradford et al., 1994; Cochran and Mays, 1994; Greene, 1994; Chan, 1995; Tafoya, 1997; Coyle and Rafalin, 1999) it is important to find approaches which increase the likelihood of achieving a diverse sample.

There is also evidence that the degree to which lesbians and gay men are attached to lesbian and gay communities and the degree to which they are "out" can have implications for people's health (e.g. Geraghty, 1996; Coyle, 1998). These degrees of attachment and "outness" interact in a complex way with ethnicity and social class which needs to be further understood (Doll et al., 1992; Dowsett et al., 1992; Bradford et al., 1994; Weatherburn et al., 1996). As well as degree of community attachment and "outness" there is also probably a complex relationship between how people identify themselves, if at all, in terms of sexual identity and the relationship between self-definition, social class and attachment to lesbian and gay communities. Doll et al.

(1992) and Weatherburn et al. (1996) found that few of their predominantly working class sample used gay pubs and clubs or the gay media and that many of them did not identify as gay. Flowers et al (1997b) have argued that these differences in sexual identities are important in relation to sexual decision making and Dowsett et al (1992) have argued that these differences impact on the effectiveness of sexual health promotion.

It is also therefore important to consider sampling in ways which are not totally dependent on convenience sampling through lesbian and gay community networks. Allowing sampling bias to persist can seriously threaten the validity of theory emerging from studies. For example, Cannon et al (1991) found from analysis of their results that had they failed to recruit black women raised in middle class families and white women raised in working class families then this would have seriously distorted their conclusions about how race and class affected current occupation and class position.

### *Difficulties in obtaining random probability samples of lesbians and gay men*

If the need for, and utility of convenience samples has passed, then the logical starting point would be to consider the feasibility of obtaining representative probability samples for further studies. However, it is generally agreed that it is extremely difficult to generate a sampling frame for such populations from which a representative sample could be drawn (Davies et al., 1993; Lee, 1993; Fish, 2000). The authors of the largest sex survey conducted in the United Kingdom, using random probability sampling by residential address, concede that their methods result in an under-estimation of the prevalence of homosexual behaviour and lifestyles (Johnson et al., 1994; Fenton et al., 2001; Johnson et al., 2001; Copas et al., 2002). Further corroboration of the likelihood of such an under-estimation comes from research with Sigma's[2] (Davies et al., 1993) sample of gay men. Respondents in this sample of gay men were asked if they would have participated in the national survey had they been approached but 50% of the sample said they would not have participated. The Sigma authors suggest that given that their sample was comprised of largely "out" and confident gay men, the actual refusal rates in the national survey were likely to have been much higher.

A number of approaches have been developed to adapt random sampling methods in order to find rare and hidden populations. These methods include

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[2] Sigma Research is a social research group in the UK specialising in the policy aspects of HIV and AIDS and they have undertaken more than 50 research and development projects in the last 7 years.

multiplicity sampling (Rothbart et al., 1982) which relies on members of randomly selected households nominating members in the sought after population. However, this method is unlikely to work when trying to generate a sample of lesbians and gay men as many lesbians and gay men are not "out" (e.g. McDonald, 1982) and because of the sensitivity of the information. Another potential way of generating a random sample of a rare or hidden population, which is less resource intensive than household sampling, is to undertake telephone screening (McCann et al., 1984). It has been suggested that this could be used to access a lesbian and gay population (Harry, 1990) but it has met with limited success when it has been used (Hatfield, 1989). The samples obtained share the characteristics of more easily generated convenience samples in terms of race and class bias and the extent to which people are "out" (Fassinger, 1991; Martin and Dean, 1993). This sampling method also tends to under-represent people on low income, people from ethnic minorities and those who are single or divorced (Kalton and Anderson, 1986). Thus, multiplicity sampling and telephone screening do not always overcome the sampling bias of convenience sampling and they are more resource intensive.

The only exception known where probability sampling methods seem to have been used with success to identify homosexual behaviour and gay identity was in Bagley and Tremblay's (1997) study. They found the incidence of homosexuality or bisexuality on the basis of self-identification was 12.7% and the incidence of reported current homosexual activity was 9.2%. This suggests a higher rate of disclosure than is normally found. It is noteworthy that the main purpose of the study was not to identify a gay population but the questions were inserted into a questionnaire asking young men about previous childhood sexual abuse. The study also had an unusually high participation and completed response rate. The authors attribute this to the use of "peers" to collect the data and the use of a lap-top computer for self-completion which assured an unusually high degree of anonymity and no possibility of follow-up. Whilst this methodological break-through is exceptionally encouraging it precludes gathering any qualitative data. Whilst it may help to enumerate a hidden population it could not be reproduced to explore issues specific to lesbian or gay identity. A study on this scale was also beyond the scope of this study. There are compelling arguments against the use of probability sampling methods and it only remains possible to explore the extent to which non-probability sampling methods can be used to study lesbians and gay men.

### *The development of snowball or chain-referral sampling*

Historically snowball, or chain-referral, sampling was developed to study people with drug addiction and the even more hidden population of people who had recovered from opiate addiction without treatment (Biernacki and Waldorf, 1981; Waldorf and Biernacki, 1981). Snowball sampling shares many of the features of theoretical or purposive sampling which tend to be used in grounded theory approaches (Glaser and Strauss, 1967). Snowball or chain-referral sampling approaches have also been applied to the study of other hidden populations such as active burglars, including those who have never been apprehended (Wright et al., 1992). They are also commonly used to study lesbian and gay populations including studies specific to understanding the epidemiology of HIV infection (Davies et al., 1993; Martin and Dean, 1993).

Snowball, or chain-referral, sampling was developed to access hidden populations when researching sensitive issues and it relies on using insiders to locate others who share some knowledge or characteristic of relevance to the research (Biernacki and Waldorf, 1981). It is based on a technique whereby the first set of research participants refer the researcher onto another set of participants through their own personal contacts. This next set of participants then refer the researcher onto another set and so on. These sets of participants are called waves or generations. However, it is not self-propelling, as the term snowball might imply, but requires active initiation and control with pacing and monitoring. Biernacki and Waldorf (1981) also recommend the use of multiple starting points, or seeds, and monitoring the eligibility of respondents in terms of the research criteria. Another recommendation is to use some respondents as paid or unpaid key locators who will require at least minimal training. They refer to these individuals as de facto research assistants. They are similar to the significant informants, sponsors, patrons or guides used in sociological field studies. Such a person, once convinced of the trustworthiness of the researcher and worthiness of the research project, can act as a bridge to other key individuals and gatekeepers and can indirectly facilitate the acceptance of the researcher by others (Lee, 1993). They can relatively easily contact data sources and are therefore more efficient in recruiting participants than the researchers themselves (Biernacki and Waldorf, 1981).

Martin and Dean (1993) used chain-referral sampling in their research into the epidemiology of AIDS in a community sample of 746 gay men. They note how by generating this community sample, lower estimates for alcoholism and HIV prevalence are obtained than from the usual convenience samples drawn from bars or clinics.

Martin and Dean (1993) argued that they had obtained a clearer picture of the gay community than had they "simply advertised for volunteers, (or) relied on a single recruitment strategy" (p. 96) and when conventional probability sampling is not possible these alternative methods "can result in samples that approach representativeness of the population of interest and can be considered scientifically valid by virtue of their explicitness and replicability" (p. 97).

Martin and Dean's study is noteworthy in that it follows guidelines for best practice in snowballing in that it has multiple starting points and continued for five generations. Whereas many smaller qualitative studies use snowballing but generate little more than a convenience sample of the researcher's immediate personal contacts (e.g. Coyle and Rafalin, 2000), Martin and Dean's study should be more robust. However, neither Biernacki and Waldorf's original (1981) study or Martin and Dean's (1993) study managed to successfully recruit the expected numbers of minority ethnic group participants to reflect the overall population. This also seems to be a feature of snowball sampling in studies of lesbians and gay men (e.g. Troiden and Goode, 1980; Davies et al., 1993). Other studies using this technique, trying to find quite different populations and with regard to less sensitive topics, have found that the snowball method is less effective than other recruiting methods in accessing members of ethnic minorities (Patrick et al., 1998). Part of the problem of using snowball sampling to access lesbians and gay men is that the initial seeds or starting points should be, but are not usually, randomly obtained. The initial seeds are usually obtained through lesbian and gay community sources and these networks have a habit of turning in on themselves and are unlikely to be able to recruit lesbians and gay men who are not attached to lesbian and gay communities.

It is difficult to establish whether race, education and class differences in samples of lesbians and gay men derived from snowball sampling are sampling bias or evidence of some naturally occurring skew in the population. There is often little meaningful data to make comparisons with given that discussion about the difficulties of obtaining a representative probability sample as noted by Kalton:

> “distributions of important background variables are seldom known for a rare population: the use of hypothesised distributions in place of known distributions introduces its own potential biases” (1986, p. 79).

However, with snowball sampling it is occasionally possible to compare the sample obtained with official statistics as in the case of Lee's (1993) work on mixed catholicprotestant marriages in Northern Ireland. He found that there was a disproportionate number of middle class couples in the snowball sample as compared to census data which revealed the numbers of working-class couples in mixed marriages. There is little information available to make such comparisons about samples of lesbians and gay men but Lee's observation should caution us against settling for samples which do not reflect the diversity of the wider population. A case in point here relates to the numbers of minority ethnic groups in lesbian/gay community derived samples of lesbians and gay men. Some of this can be explained by white lesbian and gay in-migration to cities where research is conducted (Snape et al., 1995; Scott, 1998). However, in the US census where same-sex co-habiting couples were able to declare themselves, the number of couples from minority ethnic groups was representative of the wider population (Black et al., 2000). These discrepancies suggest once again that it is necessary to work harder to recruit some sub-groups than others and as Davies et al. (1993) have argued any minority group needs to be over-sampled to allow comparisons to be made.

It is clear that although snowball sampling can be successful up to a point in recruiting hidden populations, as a method it tends to under-recruit those groups least likely generally to participate in social research i.e. people with less education, those from lower socio-economic groups and those from minority ethnic groups. Adaptations to snowball sampling are much more successful in reaching populations who generally have low participation in research studies. Snowball methods have been further developed in response to the need to understand, and respond to, changing patterns of drug abuse (Kaplan et al., 1987). Further developments or adaptations to this technique to overcome some of its limitations have included the use of indigenous interviewers (Power and Harkinson, 1993), privileged access interviewers (Griffiths et al., 1993), peer-driven interventions (Broadhead et al., 1995b; Grund et al., 1996), and incentive schemes and respondent-driven sampling (Watters and Biernacki, 1989; Heckathorn, 1997). These approaches develop the potential to use insider status and build in incentives in research.

### *The use of insiders and incentives*

One method for increasing participation in research with groups who are typically under-represented, or hard to reach, is to include members in the research team who are indigenous in relation to the targeted population. These approaches are not only used for research purposes but also to recruit people into health-education programmes. In terms of conducting sensitive research such approaches often come under the heading of using "insiders" as researchers as they are more likely to be trusted by potential research participants (Lee, 1995). This was a feature built into Biernacki and Waldorf's (1981) original approach to snowball sampling in their use of de facto research assistants. In the practice-related field there are many similarities with outreach efforts (Wiebel et al., 1993; Wiebel, 1996). Where research is sensitive it is often extremely difficult to recruit participants into a study and insider status may be the only way in which access can be gained (Lee, 1993). There are many clear examples of potential research participants refusing to co-operate with researchers perceived to be outsiders (e.g. Sophie, 1987; Edwards, 1996; Farquhar with Das, 1999). The use of insider status of openly gay and lesbian research teams to gain access to lesbian and gay populations has been demonstrated (Davies et al., 1993).

However, the use of insiders as research workers does not always increase access to minority participants (e.g. Biernacki and Waldorf, 1981; Phoenix, 1994a). This may partly be because insider status is unlikely to be unitary and there will be other ways in which we differ from our potential research participants which affect access (Phoenix, 1994a, p. 70; Heaphy et al., 1998). Insider status is important but not sufficient for gaining access and it can be more successful if used alongside other more labour intensive approaches to sampling (Cannon et al., 1991; Patrick et al., 1998) and with an outreach worker approach (Wiebel et al., 1993). This may be because outreach workers are offering a service and/or they have more of a peer relationship with research participants. However, as with snowball sampling there is a tendency for outreach workers to only recruit people with whom they share characteristics and for the process to stagnate or lose momentum (Broadhead et al., 1995a; Broadhead et al., 1995b).

Thus the use of insiders as paid research workers or outreach workers is limited by the number of diverse people who can be employed on a project. The diversity of the research team can be extended by enrolling peers to help recruit, collect data or conduct health-education programmes (Broadhead et al., 1995a) and these approaches have been found to increase the diversity of the sample obtained for research or the group reached for an intervention (Griffiths et al., 1993; Power, 1994; Kuebler and Hausser, 1997). Such methods will reach a more diverse audience or create a more diverse sample simply because the research team itself has expanded on its own diversity. The extent to which such methods rely on the peer relation between participants is unclear; whilst it may help if they share certain characteristics such as ethnicity, ultimately what matters is that those who are reaching the hidden population have privileged access (Griffiths et al., 1993). However, the use of indigenous interviewers (Power, 1994; Kuebler and Hausser, 1997) rather than outreach workers or research assistants will allow for greater diversity simply because resources can be spread further. Such methods then combine the advantages of diversity and privileged access.

Approaches which use peers, privileged access interviewers, or indigenous interviewers are particularly successful when incentives are built in. They are successful in terms of keeping snowball samples moving through waves or generations and in terms of producing a diverse sample. Griffiths et al (1993) paid 22 interviewers for each interview that they conducted and through this method reached a diverse group of 400 drug users who were members of a range of different local drug sub-cultures. In a similar design Kuebler and Hausser (1997) paid 31 privileged access interviewers to conduct 917 interviews. Heckathorn (1997) argues that a dual incentive scheme will be more effective in recruiting members of a hidden population whereby those who are recruited, as well as those who recruit, are given a reward and each person who has been recruited can go on to receive further rewards by continuing to recruit. He also argues that this design overcomes the inherent bias of snowball sampling which does not commence with an initial random sample. Instead the dual incentive scheme produces a final sample with characteristics which are independent of the characteristics of the initial seeds.

In Heckathorn's (1997) study the dual incentive scheme produced a sampling method which did not stagnate and produced a diverse sample that was representative of the wider population in terms of local demographic data. Grund et al. (1996) also used this method to generate a sample of drug users in which the first 50 interviewees had never been interviewed before. In another study of active residential burglars, one initial seed who was an ex-offender led to referral chains through which a total of 105 participants were recruited into the study (Wright et al., 1992). Again a dual incentive scheme was operating in this study although it evolved through the innovation of study participants rather than being inherent in the original design.

It is hardly surprising that incentives will increase participation in research and this has often been demonstrated to be the case in survey research (Willimack et al., 1995). In addition, incentives have been found to be effective when accessing hidden populations (Deren et al., 1994; Cottler et al., 1995). With the peer-driven and respondent-driven approaches discussed previously, it is worth considering the nature of incentives offered. Whilst the appeal of a monetary incentive may seem obvious, not all members of a hidden population will find this sufficient or necessary. Other incentives include the desire to talk to a researcher (Wright et al., 1992; Lee, 1993); the desire to help one's own community and protect one's own health, as in peer-driven programmes to prevent HIV infection amongst intravenous drug users (Heckathorn, 1997), and the need for practical help (Watters and Biernacki, 1989; Wright et al., 1992).

Whilst all these adaptations to chain referral or snowball sampling may improve on the class and race bias of previous studies, it remains unclear to what extent such network dependent methods can reach isolates. This is particularly important when sampling lesbians and gay men as theoretically, degree of community attachment and patterns of identifying may impact on health. Claims have been that peer-educators drawn from gay-attached sources can begin to penetrate the hidden population and reach more isolated, less gay-attached individuals (Shepherd et al., 1997) but this remains to be explored further. One way in which the potential sample can be broadened to reach such people is to use publicity and advertising in media which will reach people who are not attached to lesbian and gay communities.

### *The use of advertising*

One final approach to reaching hidden populations is through the use of advertising and publicity through the media. However, studies advertised in the lesbian and gay press have found that very few people respond to such advertising (e.g. Annesley, 1995; Webb, 1999). Historically, prior to the existence of the lesbian and gay press adverts were placed in the mainstream media. Harry (1986), noted that those men who answered adverts for Bell and Weinberg's (1978) study, in which data were gathered between 1969 and 1970, were different from the men recruited through homosexual organisations. They were more likely to identify as bisexual rather than homosexual, they also had lower self-esteem than men obtained through homosexual organisations and they were less likely to part of a gay network. This suggests once again that attachment to lesbian and gay communities, and that the way that people identify in terms of sexual identity, is theoretically important when considering mental health and needs to be taken account of in sampling approaches.

Further evidence that advertising in mainstream media will reach a less gay-community attached population comes from a more recent study by Weatherburn et al.

(1996). This study recruited 745 behaviourally bisexual men but the researchers estimated that 20-34,000 men responded to the advertising and attempted to get through to the phone-line during an eight week period. The demographic characteristics of the sample more closely matched those of the general population than any other study of men who have sex with men and most of the sample were not gay-community attached. Furthermore, when asked about their sexual identity many of the men did not see themselves or define themselves in such terms:

> this suggests that a high proportion of behaviourally bisexual men do not see their sexual practice as central to their sexual identity or, that when they do, the catch-all terms that describe broad sexual preference (bisexual, homosexual, gay) are not appropriate to the way they view themselves (Weatherburn et al., 1996, p. 20)

Weatherburn et al. (1996) used a form of wording in their advertisement which used a behavioural definition of bisexuality rather than relying on self-definition. It was also targeted at bisexually active men. The fact that Weatherburn et al's sample differs so markedly from many snowball generated samples of lesbians and gay men in terms of socio-economic status, levels of education, lesbian/gay community attachment and self-definition of sexual identity suggests that considerably more attention should be paid to how researcher's define the population they are targeting and the words they use to do this.

### *The use of language in sensitive research*

Weatherburn et al's (1996) study focused on a group of behaviourally bisexual men for the purposes of studying sexual behaviour. They used explicit language in their advertisements which referred to sexual activity between men which was embedded in a behavioural definition of sexual identity. However, if a research project is interested in mental health then narrow behavioural definitions may not be adequate. Bagley and Tremblay's (1997) study showed that one of the most at risk groups for suicide attempts, suicidal thoughts and depression were celibate gay-identified men. This should caution us against using behavioural definitions of sexual identity particularly when researching mental health. There is a tradition in recent studies of lesbians and gay men of using self-definition to allow people to select themselves into studies (e.g. Kitzinger, 1987; Kitzinger and Wilkinson, 1995; Fish, 1999). This was partly a response to, and rejection of, the use of behavioural definitions which had been associated with the pathologisation of homosexuality. However, Weatherburn's (1996) study also showed that not everyone identified with terms such as gay or bisexual and thus self-definition can also be problematic when trying to recruit lesbians and gay men into a study. Paul (1996, p. 436) has argued that

> "nominal categories based on sexual preferences may say more about the individual's socio-political affiliations than about her or his erotic experiences and desires."

That such labels are derived from socio-political affiliations may go some way to explain the persistent race, class and age bias of so many studies of lesbian and gay lives.

There has been debate about how problematic such labels are, whether they are arrived at through self-definition or cast upon us it were by external behavioural definitions (Plummer, 1981; Herdt, 1990; Plummer, 1992b; Fox, 1995; Tafoya, 1997). There is a recognised need to problematise these categories or they fix people into inappropriate concrete and binarised categories (Jenness, 1992; Plummer, 1992a; Kitzinger and Wilkinson, 1996; Mills and White, 1997). However, there is little evidence in the empirical literature of this being translated into applied research. One recent development is the use of the term "non-heterosexual" in Weeks' et al's (2001) study even though they continued to recruit only through lesbian and gay community networks.

Resistance to the use of particular terms, or reluctance by research participants to identify with terms used by researchers, is not confined to studies of lesbians and gay men but is generally a feature of sensitive research. Examples of this come from studies of sexual harassment and violence, (e.g. Brannen, 1988; Fine, 1989; Herek and Berrill, 1990). However, in studying lesbians and gay men there is an extra hurdle to be overcome which is that lesbian and gay lives have a long history of being unspeakable and unnameable (Sinfield, 1994; Ussher, 1997b) and this is still reflected in recent coming out stories (e.g. Troiden, 1993; Markowe, 1996). It has also been noted that people with emergent sexual identities are unable to associate with the terms lesbian or gay until they feel positive or at least neutral about adopting such a term for self-definition (Sophie, 1987; Watney, 1993). Furthermore language is often unstable and can cause serious misunderstandings in the research process (Wellings et al., 1990; Davies et al., 1993; Healy, 1993; Harvey, 1997; Harvey and Shalom, 1997; Mills and White, 1997).

This all points to a need to seriously consider how to present the research topic to potential research participants, paying close attention to the use of language when trying to recruit people into the study. Brannen notes that in sensitive research the researcher is faced at the outset with whether and how to name the topic under investigation and said:

> "it is important not to pre-judge the research problem by labelling it or defining its boundaries too closely; respondents may thereby define the problem in their own terms" (Brannen, 1988, p. 553).

One way of trying to progress with this agenda is in the use of focus groups to empower participants to help conceptualise strategies to access hidden populations and conduct sensitive research (Ayella, 1993). Focus groups can also be used to access the colloquial or sub-cultural language that participants may be more at ease with (Andrade, 1995). Power (1994) also recommends using focus groups, and training sessions, to explore the knowledge and experience of indigenous or peer researchers to help conceptualise the research.

### Sampling approaches used in this study

Given the theoretical issues discussed it was considered important to obtain a sample that was diverse and broadly representative of the local population in terms of social class and ethnicity. It was also considered important to not only sample through the lesbian and gay community because of the theoretical significance of lesbian/gay-community attachment. It was clear that, for the purposes of this study, it would be impossible to draw a representative probability sample or to use methods such as multiplicity sampling or telephone screening. However, it was also clear that a convenience sample would be inadequate. Ultimately, where a probability sample cannot be generated it would seem to be good practice to use a range of approaches. As van de Goor et al have stated:

> "in studying hidden populations no best or worst method exists... Rather, diversity is a strength and different approaches are complementary. It is unlikely that totally new methods in the study of hidden populations will arise" (1994, p. 34).

It was therefore decided to use a range of approaches to sampling which included:

- conventional snowball sampling through lesbian and gay community networks
- the use of sponsors or key informants to gain access

- peer researchers who were offered incentives to recruit through their privileged access to research participants
- advertising and publicity in media not targeted at the lesbian and gay community

A number of methods were used to gain access to key groups and individuals within the local lesbian and gay community to provide initial seeds for snowballing and to recruit peer researchers. The term peer researchers is used in this study to mean people who were enlisted to help recruit participants into the study to be interviewed about their experiences of health care. They were only involved in recruitment, not in interviewing, but they were similar in other respects to privileged access interviewers and indigenous researchers. Incentives and training were built into this use of peer researchers. In addition to this attempts were also made to access lesbians and gay men who were not part of the local lesbian and gay community through placing publicity and advertisements in the local mainstream press and in the local community. These adverts and publicity invited participation as an interviewee or as a peer researcher. Further attempts were made to recruit lesbians and gay men from minority ethnic groups through targeted publicity and advertising. Incentives were also offered to those targeted through such advertisements and publicity. By confining the sampling to a specific geographic area, rather than obtaining a national sample, it was hoped that there would be a greater degree of penetration of the hidden population to reach more isolated individuals and a more diverse group. The sampling methods used for this study will now be discussed in detail with a discussion of how effective these were in terms of the aim to achieve diversity within the sample.

The first stage of recruitment involved gaining access to key figures in the local lesbian and gay community who, by virtue of their position, act as gatekeepers to outside communities including the research community. The researcher had a degree of insider status but was not part of, or familiar with the local scene or community. Four key points of contact in the local community were identified which would provide potential initial seeds for snowball sampling and recruitment of peer researchers. These were:

1. Local lesbian and gay friendly youth services and the local lesbian and gay youth group
2. Local lesbian and gay student groups
3. The local gay men's sexual health project
4. User groups run by the local branch of the mental health charity MIND

Contact was made with one local health worker who as part of her professional work and her social life was connected to the first three areas. This person, known from here on by her pseudonym Maggie, was central to gaining access and she could be regarded as a sponsor or patron as discussed by Lee (1993). Maggie helped gain access to the three previously mentioned areas and helped to locate many other points of contact within the local lesbian and gay community in which to publicise the project and try to recruit initial seeds for snowballing. Maggie also offered to provide a free counselling service to any research participants. This was within the remit of her job description and it also worked as an indirect incentive for some participants. Some of the individuals to whom Maggie introduced the researcher also acted as sponsors allowing further introductions and facilitating access. These were again people who were well networked, had local knowledge and the respect of many members of the lesbian and gay community.

### *The use of focus groups*

Once initial contacts had been made with gatekeepers the next stage was to set up focus groups amongst existing groups. There were several purposes to this approach. The first was that it was a less threatening, and more informative, way of contacting individuals who might be willing to participate in an individual interview and/or to act as peer researchers; it allowed a relatively informal opportunity to introduce the purpose of the research and the individual researcher and begin to build trust and rapport. This use of focus groups has been recommended by others conducting sensitive research (Andrade, 1995; Farquhar and with Das, 1999). Further, the gatekeepers were keen for the researcher to give something to their existing groups. The youth group leader and the student group leader felt that their groups would benefit from a discussion about coming out and health. The focus groups were therefore run in such a way that participants had a chance to discuss these issues and receive resources to facilitate their own coming out processes.

The focus groups were designed using Krueger's (1994) guidelines. Focus groups are formed to bring people together who have something in common (in this case sexual identity) in order to tap their real-life interactions and get in touch with their perceptions, attitudes and opinions in order to identify trends or patterns rather than arrive at consensus. They are used to identify major themes rather than to analyse subtle differences. However, the moderator is interested in getting people to disclose their opinions which may differ from others in the group. There are many reasons for using focus groups but the ones of relevance to this study are as follows:

They are used:

1. as part of a needs assessment
2. when insights are needed as part of a preliminary study
3. when there is a difference in levels of power e.g. between users and professionals
4. when the researcher wants ideas to emerge from the group
5. when the researcher wants to capture open-ended comments

In order to facilitate disclosure, rather than presentation of the public self, the moderator needs to create a permissive environment. This involves bringing people together who have something in common, and de-emphasising any differences in status, whilst encouraging difference of opinion. This is partly to encourage participation but also because people form their opinions through interacting with others. Attention must be paid to the size of the group, the structure of the group and the wording and style of questions (Krueger, 1994) as well as the way that participants interact (Kitzinger, 1994).

Krueger (1994) recommends a structure to the group which has a strict order of types of questions to help participants to focus gradually on the topic under study and to explore their opinions. The structure and types of questions are as follows:

1. Ice breakers and opening questions: Ice breakers should be quick, factual, and show what participants have in common. They should not reveal differences in status.
2. Introductory questions: These should provide an opportunity to reflect on past experiences and see their connection with the overall topic. They should foster conversation and interaction.
3. Transition questions: These should help participants envision the topic in a broader scope linking the introductory and key questions and making them aware of how others view the topic.
4. Key Questions: These questions drive the study and there should be two to five of them. In these focus groups some self-completion items were given to facilitate disclosure of sensitive information by all participants.
5. Ending questions: these bring closure to the discussion but allow reflection on what has already been discussed. They may therefore include summary questions and give participants a chance to say what is most important to them or to add in anything they think has been missed.

This structure was used to develop a focus group interview schedule.

It was intended originally to conduct four focus groups but attempts to set up two of these were unsuccessful. In the first case, a letter was sent out by a worker for women's user support groups at the local MIND inviting interest in the research. This letter was sent to 105 women but yielded only two responses from people who were not eligible and unlikely to network to other participants. In the second case, an attempt to run a focus group with a young gay men's peer-education sexual health project was unsuccessful as access was denied by the Gay Men's Health Project. In this case the project leaders felt that the population under study was being over-researched locally. However, later this project invited the researcher to recruit individual participants following the sponsorship of Maggie. There are a number of possible explanations for this initial denial of access. One is that the researcher may have lacked sufficient insider status to access the community through these particular gatekeepers. Another contributing factor was that the peer-education group was itself not well functioning well and was unable to support such research activity.

Attempts to set up focus groups with the local lesbian and gay youth group, and a lesbian and gay student group were successful. The first one with the local lesbian and gay youth group and was attended by two workers (one man and one woman), two volunteers (both women), nine young people (six young men, one young woman and two young transgender people). The second focus group was conducted with the lesbian and gay group at the local college of higher education. This was attended by fifteen students: eight men and seven women. The two focus groups which were conducted were attended by 26 young people of whom ten agreed to participate further in the research. Eight of these were interviewed and all of the ten volunteered to act as peer researchers. The age range of the focus group participants was 18-30 with a median age of 20.5.

Of the ten original focus group participants who agreed to become peer researchers, five actively recruited. Between them they recruited a further nine participants. In terms of snowballing there were no further referrals from these participants i.e. only one wave was generated. The first aim of setting up the focus groups to gain access, establish rapport and trust and invite further participation in the research can be said to have been met. The second aim of conducting the focus groups was to get participants to help conceptualise strategies for accessing hidden populations or for conducting sensitive research (Ayella, 1993) and to access the colloquial or sub-cultural language that they may be more at ease with (Andrade, 1995). Participants were asked about how they were defined by others, how they defined themselves and how they preferred to be defined or referred to with regard to their sexual identity. In the focus groups, the participants articulated how lesbians and gay men are represented in dominant discourse as sinful. They described popular images of lesbians and gay men as corrupting of children, as having uncontrollable and undiscriminating sexual urges, and – in the case of gay men in particular - as dirty or disgusting.

Whilst the participants' discussions about images of lesbians and gay men can be understood as part of the dominant discourse, what was more revealing in the focus groups was the lack of any consensus on acceptable alternatives which would allow for self-definition. The focus group participants were almost uniformly ill at ease with the use of terms such as "lesbian" and "gay" and where there was consensus it was to say that they preferred to be called by their own names, and hated labels, and that they wished to be seen as human. The participants were also ill at ease with the use of the term "coming out" which some felt had an overly confessional ring to it. These themes continued to be discussed and explored in subsequent training sessions with peer researchers who were helping to recruit others into the study. The focus groups provided no easy solution to finding an inclusive and non-threatening way of naming the project but it served to alert the researcher further to the need to pay attention to the use of language. As a result of this consultation, and consideration of the available literature, it was decided not to rely exclusively on the terms "lesbian" and "gay" in the publicity about the project; instead the following wording was used in much of the publicity: "Are you lesbian, gay, bisexual or don't like to define yourself?" As the project proceeded early observations about the problematic use of the term "coming out" and "lesbian/gay" were confirmed and in later advertisements both were played down with the project title changing to "Mental health and sexual orientation". These later advertisements were placed in the local non-gay press. The aim of using the focus groups to help conceptualise strategies for accessing a hidden population were met in part and this work continued in the training sessions given later to peer researchers.

### *Preparing the peer researchers*

The next stage of the research was to train the peer researchers so that they could recruit more participants for interviewing. The model for conducting this training followed guidelines by those using indigenous interviewers and peer education programmes (Griffiths et al., 1993; Power and Harkinson, 1993; Power, 1994; Broadhead et al., 1995a; Shepherd, 1997). This involved offering incentives which were not only financial but also social and community based. Thus a £10 incentive was offered to cover expenses for each participant recruited into the study and the training itself was offered as an incentive. Guidelines were given to the participants to show them how they could use the training opportunity for their own personal development and the training also provided a social space with refreshments in a lesbian and gay community venue. A further incentive was an altruistic one in that participants might believe that the research was of potential benefit to their community in terms of improving access to mental health care. Another incentive was the potential for immediate access to a lesbian and gay-friendly counselling service following Lee's (1993) suggestion that providing a service can help to access participants where the research is sensitive. This, and the interview itself, was for some participants an opportunity for catharsis which again Lee (1993) has suggested can motivate people to participate. Unfortunately a key feature of the intended research design was not possible as the Local Research Ethics Committee refused to allow permission to follow Heckathorn's (1997) model of respondent-driven sampling with dual incentives. In this case as well as offering a financial incentive to the peer researcher for recruiting, the participant would have also have been offered a financial incentive for agreeing to be interviewed. So although permission was gained to offer the peer researchers financial incentives, it was not possible to offer such an incentive to those being interviewed which would have been necessary to follow Heckathorn's dual incentive model. This was unfortunate as feedback from peer recruiters suggested that such dual incentives would have initiated and perpetuated referral chains.

In addition to using peer researchers with the use of incentives, conventional snowball sampling was tried with participants recruited through other channels. Other recruitment approaches used in the study involved approaching established groups in person or in writing, and distributing flyers about the research; leaving publicity about the research in health clinics and with health projects, and lesbian and gay projects; press releases and advertisements in the local free press; posting on lesbian and gay internet sites; and personal networking.

### Recruitment and profile of the sample obtained for this study

The aim of the sampling methods used for this study was to obtain a diverse sample in terms of socio-economic background, ethnicity and degrees of lesbian/gay community attachment. Overall 49 interviews were conducted of which 48 were eligible and fit the criteria for the study. Of the 48 interviewees, 22 were women and 26 were men and they were aged between 17 and 55. The sample was more diverse than that found in many comparable studies and had a closer match to the local population in terms of demographic characteristics than many similar studies. Each of the different recruitment strategies used varied in the extent to which it enabled recruitment of different sub-groups within the lesbian and gay population. These different approaches and how they led to recruitment patterns on the basis of socio-economic status are shown in figures 2 and 3. The advertisement in the mainstream press was particularly successful at recruiting men and women from lower socio-economic groups, and men with lower educational attainment, than all the other approaches. Although the numbers are small, conventional snowball sampling, without incentives, led to recruitment of more middle-class participants as has been found in other studies. The peer researchers varied in their capacity to locate a diverse range of research participants. The advertisement in the mainstream press was more successful than other approaches in recruiting lesbians and gay men who were less lesbian/gay-community attached than other sources and more of these people identified as bisexual rather than lesbian or gay. Each of these differences will now be discussed in more detail alongside a discussion about the different recruitment strategies and how the comparisons were made.

### *Comparing social class and educational attainment*

As stated before many chain-referral samples, qualitative studies, and studies of lesbians and gay men have a bias towards the middle-class and highly educated. In order to make comparisons between the sample obtained for this study, other studies and census data it is necessary to use a similar approach to measuring social class. Flaws in the measurement of social class are acknowledged (Abbott and Wallace, 1990; Scambler, 1997; Prandy, 1999), as well as recent trends to try and improve the way it is measured (Dowsett et al., 1992; Office of National Statistics, 1999; Pilgrim and Rogers, 1999; Prandy, 1999). However, in order to be able to make comparisons with recent census data and other published studies, it was necessary to use the Standard Occupational Classification derived from the Registrar General's social class classification. In this study an attempt was also made to gather information about current or recent occupational status and the occupational status of parents when the participants were growing up. As in the Sigma studies (Weatherburn et al., 1992; Davies et al., 1993; Weatherburn et al., 1996) the data which were gathered about people's occupations were assigned to a category by the researcher using the Registrar-General's Social Class Schema or Standard Occupational Classification (Office of National Statistics, 1999). Again, in order to make the comparison data meaningful the conventions followed in these other larger published studies were followed: i.e. social classes 1 and 2 (professional, managerial and technical occupations) were grouped together and social classes 3, 4 and 5 (non-manual and manual skilled occupations, partly skilled occupations and unskilled occupations) were grouped together. These two broad groupings correspond roughly to middle and working class categories.

Many studies of lesbians and gay men (e.g. Martin and Dean, 1993; Creith, 1996; Markowe, 1996; Hickson et al., 1998; Henderson et al., 2002) do not collect data about occupation or income on which to base an assignment of social class. This may be because such data are difficult to collect because of their sensitive nature. Many studies do however collect data on educational attainment which may serve as a proxy for social class. However, there is increasing evidence that there is not a straightforward relationship between socio-economic status and educational attainment in the lesbian and gay population with higher than expected levels of education in people living in poverty or on low incomes (Klawitter and Flatt, 1998; Calandrino, 1999; Black et al., 2000). For these reasons then an attempt was made to gather data in this study on the educational attainment of participants as well as their occupation.

This data on occupation and education was then compared to other studies of lesbians and gay men and to census data. From census data one would expect approximately 1/3rd of the age group studied to come from social classes 1 and 2 or to be in professional and managerial occupations. These figures are derived from census data (Office of National Statistics, 2000). In terms of education using the same sources we would expect between 13% and 24% of the working population to have a university degree. Most studies of lesbians and gay men have samples where 50-70% of the participants are in managerial and professional occupations (e.g. Bradford and Ryan, 1988; Davies et al., 1993; Kitzinger and Wilkinson, 1995; Dunne, 1997; Webb, 1999). In this study approximately 1/3 rd of the participants were in professional and managerial occupations (or if they were too young to have started work their parents were in such occupations). There were no differences between the men and women in the study in this respect. In terms of education many published studies have samples in which between 34% and over half of the participants hold a degree qualification (e.g. Davies et al., 1993; Dunne, 1997). In this study 19% of the men and 40% of the women held a degree qualification. In this study then a sample was obtained which had a closer match to expected demography from census data than many other published studies. It is particularly useful to compare this sample with Webb's as both were obtained in the same geographical area. Webb (1999) obtained a sample of 544 gay men of whom 53% were in professional and managerial occupations (data on educational attainment was not collected). Webb only recruited through gay community sources and through snowballing which confirms that such approaches tend to produce a class bias. In this study a closer match to the general population was obtained with regard to social class, and to a certain extent for education. The conventional snowball sampling approach used through gay community sources reproduced the trends towards middle class recruitment found in other studies but the use of advertisements in mainstream media, and to a certain extent the use of peer researchers, produced more diversity within the sample. These trends can be seen in figures 2 and 3. The effect of each of the different sampling strategies will now be discussed in more detail in relation to the social class and educational background of participants.

The use of advertisements and publicity in the local (non-gay) press led, as in Weatherburn et al's (1996) study, to a sub-sample which much more closely matched the demography of the national population in terms of socio-economic position than the sub-sample obtained through lesbian and gay community sources. One advert in the free weekly paper distributed in the city where the study was conducted led to seventeen enquiries. These led to the recruitment of eleven interviewees as well as one peer researcher who recruited one further interviewee. All of the men recruited through this advert were in working class occupations (or came from working class backgrounds but had never worked) and only one out of the nine men had a university degree. With the women recruited in this way they closely matched the general population in terms of occupation but were more likely to have a university education than women in the general population.

The sub-sample obtained through conventional snowballing and through the peer researchers was more variable in terms of the social class of the participants and overall this sub-sample was more educated and disproportionately from social classes 1 and 2 than the general population. This may be because the seeds or starting points were more likely to be middle class. However, some peer researchers and individual snowball seeds were much more able than others to recruit working class participants. The reasons for this are unclear: obviously the process is network dependent which is variable. However, it may also be that some individuals were more comprehending of the researcher's aims regarding diversity.

Figure 2: Recruitment Patterns and Demographic Characteristics (Social Class by current or most recent occupation, or parent's occupation if still in full-time education)

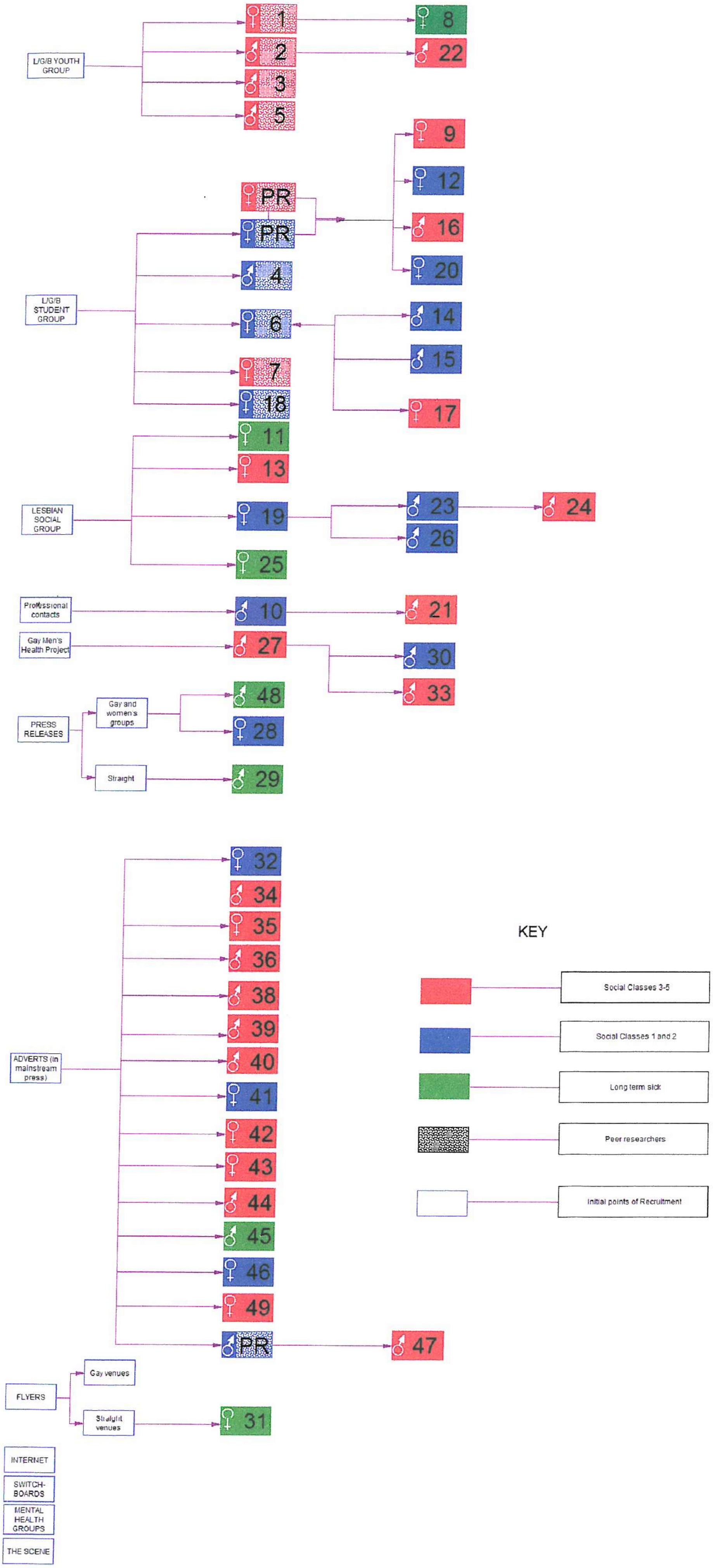
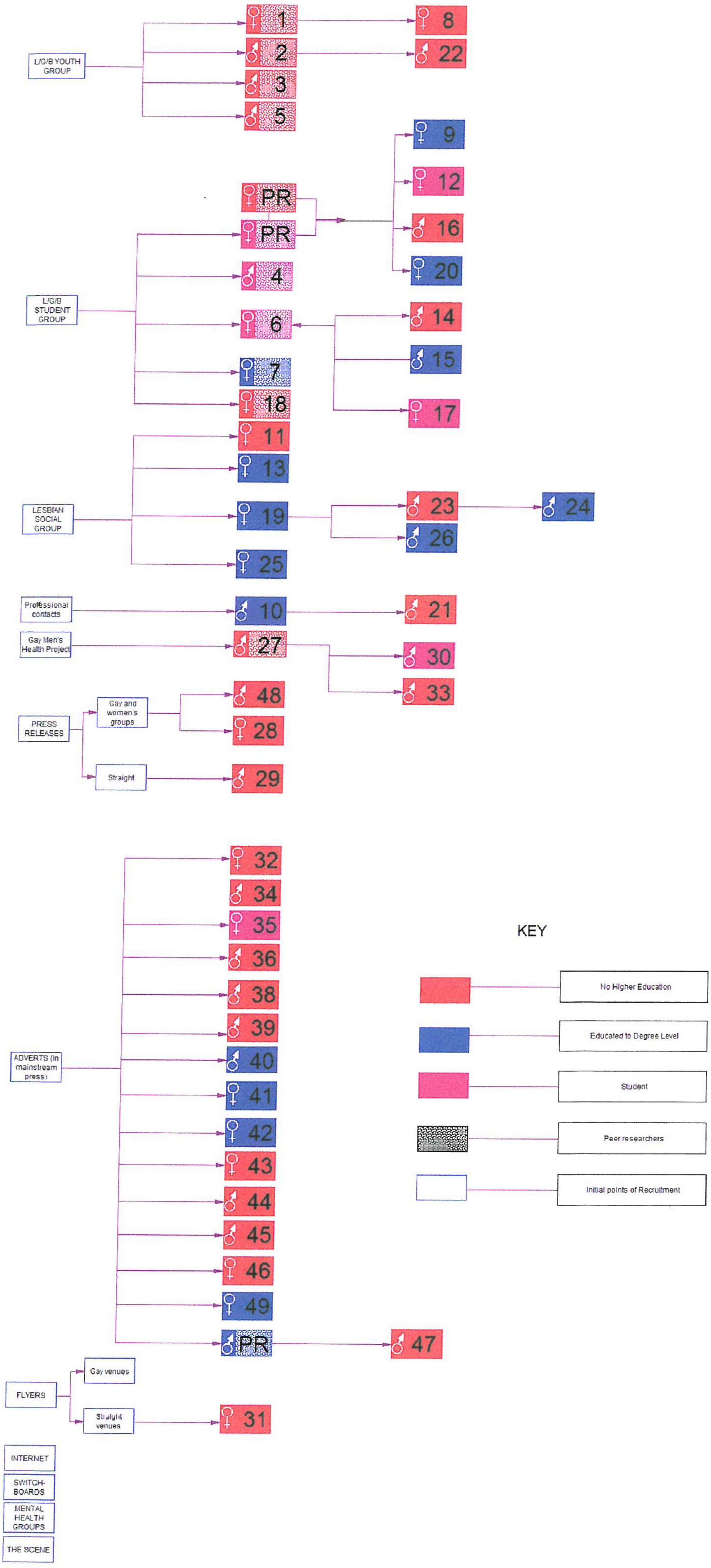


Figure 3: Recruitment Patterns and Demographic Characteristics (Highest Educational Qualification)



As well as the effect of the peer researchers and the location of publicity, there are other factors which may have increased working class participation. The use of incentives in the form of re-imbursement of incentives may have had the effect of conveying to potential participants that their story was of interest and value to an academic researcher. This is not something which has received much attention in the methodological literature on sampling but it would be worthy of further exploration. Another factor may be the tenacity of the researcher as it is commonly reported that reaching under-represented groups often requires more labour intensive approaches. For example Phoenix (1994a) reported that considerable effort was required on her part as a researcher to recruit women into a study of teenage mothers. On many occasions appointments for interviews were broken including one where the interview was not conducted until the 27th attempt. Phoenix is wary of such data being used to reinforce stereotypes of an already stigmatised group and argues that for people living in unpleasant and cramped conditions, waiting in for a researcher is not a priority. Similarly, in this study a number of participants repeatedly failed to arrive for appointments and in each case they were in low paid unskilled occupations, were unemployed or were single mothers with children. Two of these were interviewed on the second attempt, one could not be contacted again and another two had appointments re-scheduled four times but had still not been interviewed by the end of the period of data collection. The recruitment methods used in this study were successful in terms of recruiting working class participants.

### *Ethnicity of the sample recruited*

The recruitment methods used were less successful regarding the participation of people from minority ethnic groups. The percentage of minority ethnic participants in this study was 6.25% (i.e. three out of 49 participants) as compared to 4.7% of the local population. Again it is useful to compare this with Webb's local (1999) study using gay community sources and conventional snowballing, in which only 1.5% of the participants were from minority ethnic groups. However, the aim of over-sampling this sub-group in order to be able to make meaningful comparisons was not met. Advertising and publicity was not successful in recruiting minority ethnic participants into the study but the use of peer researchers and key informants was. The approaches used will now be discussed in more detail.

As stated before, recruitment of minority ethnic groups into research studies often requires more labour intensive approaches (Cannon et al., 1991; Phoenix, 1994b; Patrick et al., 1998). In this study a number of approaches were used. All the peer researchers were white and there were no obvious starting points in the local area to recruit peer researchers from, or to snowball from, which would correct this imbalance. As with the peer researchers, the main researcher had no insider status in relation to minority ethnic status. However, the peer researchers were asked to make special efforts to recruit typically under-represented groups. One minority ethnic participant was recruited in this way. This participant was unable to recruit other lesbian or gay minority ethnic participants as she had no such community attachments. Another minority ethnic gay man who worked for a Gay Men's Health Project was recruited through professional networking and he was able to recruit one other minority ethnic participant. This participant, although he knew other Asian gay men, was unable to recruit them into the study because of a high level of fear of exposure within his ethnic community.

However, as Davies et al (Davies et al., 1993) have stated, where the overall proportion of minority ethnic groups is small, we must over sample if meaningful comparisons are to be made. Other attempts to recruit ethnic minorities included a race targeted advertisement in the local press, publicity in the African-Caribbean community centre and publicity in a health centre which served the geographic area with the highest density of minority ethnic groups in the city. None of these yielded any participants from minority ethnic groups.

### *Gay and lesbian community attachment of the sample*

It was noted earlier that lesbian and gay community attachment is probably related to both mental and sexual health and that many studies of lesbians and gay tend to only recruit those attached to lesbian and gay communities. It was also noted that there is a complex relationship between community attachment, sexual identity, social class and educational background. Some have argued that community leads to identity (Kramer, 1995; Rothenburg, 1995) and that lack of gay attachment can be because of economic disadvantage (Dowsett et al., 1992; Binnie, 1995). Thus it seemed to be important to account for lesbian and gay community attachment and variation in sexual identities when conducting this study but this raises questions about how to assess these variables.

In Weatherburn at al's (1996) study, gay community attachment was indirectly inferred from where men found their sexual partners. However, such an approach would not be adequate for a study into mental health. Dowsett et al. (1992) have a more sophisticated approach to understanding gay community attachment which was more useful in this study. They noted that this can include both social and sexual engagement (what would be referred to as the "scene" in the U.K.) and also politico/cultural involvement with the latter being a more middle-class terrain than the former. A further dimension to gay attachment which Dowsett et al (1992) make is to distinguish between participation in the gay community versus integration into it with politico/cultural involvement being more likely to lead to integration in the form of developing stable and enduring social networks and friendships.

Another dimension to lesbian and gay community attachment and lesbian and gay identity is to consider at what point participants were or were not attached to the lesbian/gay community. It may be that if lesbian/gay community attachment has an impact on mental health it does so at key times in a person's life when any support from that community is particularly important. Coyle (1991) argued that high levels of gay community involvement may relate to early stages of awareness and construction of a gay identity when the support which can be derived from such communities is most needed. Coyle noted that it is important to know whether participants in studies looking at psychological well being are, or ever have been, involved in a gay community. This is not always clear when trying to make comparisons. For instance Seidman et al. (1999) say that they obtained a sample in their study which was not gay attached. However, most of their participants reported that they felt that they were part of a gay community and that they had participated in gay community group activities when they were at an earlier stage of gay identity formation and when they were more closeted. Seidman et al. (1999) say that many of their participants were "beyond the closet" and had post-identity sexual politics where their sexual identity had become routinised and normalised and was no longer a core part of their identity. At the other end of the spectrum Watney (1993) has also argued that emergent or pre-gay identities are not established as gay identities until there has been some kind of engagement with a gay community or the "scene". These differences in degree of gay-community attachment and when it takes place, which may relate to stages of identity development, suggest a need to be sensitive to this in research. In this study an attempt was made to explore this in research interviews using the criteria adopted by Dowsett et al. (1992) in terms of participation versus integration into a lesbian or gay community and whether or not participants had ever had such involvement. It was not possible to obtain any kind of accurate measure of attachments to lesbian and gay communities but it was considered important theoretically to attend to these nuances when gathering data and to consider sampling strategies which were more likely to produce a diverse sample in terms of degrees of lesbian and gay community attachment.

Some trends in the effects of different recruitment strategies could be noted in the sample obtained for this study. The lesbians and gay men recruited through the advertisements and publicity placed in the non-gay local newspapers were less lesbian and gay community-attached than those recruited through other means. One of those who did describe themselves as "part of the scene" was very much of the type described by Dowsett (1992) who was "on the scene" but not integrated in it. They were also more likely to have been unaware of the existence of the gay scene when they were coming out and more likely to have used contact ads in "straight" newspapers to meet same-sex partners. Also the people who answered the advertisement were more likely to describe themselves as bisexual than those recruited via lesbian and gay community networks and via (most of the) peer researchers. The peer researcher recruited via the advertisement was not gay identified and two of the interviewees had had the advertisement shown to them by heterosexual friends.

These trends can only be tentatively suggested from the data and their possible significance, and inter-relationships with other factors such as social class, explored further in the analysis in the data. However, they are trends which are consistent with larger published studies (e.g. Weatherburn et al., 1996) and which raise issues not only about sampling but also about associated theoretical considerations. Another related theoretical consideration is the significance of how people do or do not identify in terms of sexual identity. The trend towards more bisexually identified people responding to advertisements and publicity in the non-gay press may not only be to do with location but also the wording used. The wording used in the advertisements deliberately avoided the terms lesbian and gay, using instead the term sexual orientation. This practice was developed partly in response to the lack of universal comfort with the terms lesbian and gay even amongst the lesbian and gay-community attached focus group participants.

## Interviewing and Ethical Considerations

The aim of this project was to gather rich data which could be used to explore and understand the meanings of the participants' own worlds. An approach was required then which would allow participants to tell their stories in as much depth and with as much complexity as possible. A structured interview schedule would not be consonant with such an approach (Smith, 1995) and would run the risk of over-writing the participants' meanings and subjectivities with prior theoretical assumptions on the part of the researcher. A less structured approach allows for the development of trust and empathy and opens up the possibility of the interview entering previously uncharted territory and the production of richer data (Smith, 1995). Smith (1995) argues that any attempts to structure the schedule in advance should be for the sake of making one's research agenda clear and anticipating possible ambiguities and sensitivities in relation to question wording. Further, as in analysis, this should be an iterative rather than a linear process with ongoing adaptations to the schedule.

It is noteworthy thus far that the term "richer" data has been used rather than "better" data. In keeping with the epistemological and ontological positions taken in this study, the data produced in interviews can be regarded as somewhere between a veridical ("truthful") account and a rhetorical account, and the way that one goes about conducting the interview will have some bearing on what is produced. Sapsford and Abbot (1998) have discussed how the depth interview should give rise to an account which gets underneath people's public rhetorics. Although some research approaches aim to explicate these public rhetorics, in research with a more phenomenological purpose there is a need to consider how and whether the interview does reflect the personal worlds and meanings of participants. There has been much attention paid to how quite subtle wording changes to questions can dramatically alter the response of the person interviewed. For instance May (1991) discusses how unskilled questioning, in which questions are framed within prior knowledge, can lead to the interviewee merely reproducing the received lay or scientific view on a topic rather than their own experience of it. Jones (1985) also discusses how we are likely to receive a rehearsed script, rather than a depth interview, if participants feel threatened. This raises many issues concerning the conduct of sensitive research, including insider status, how best to develop rapport and trust, and ethical issues including consent, support and representation.

Notwithstanding this discussion about the multiple realities which can be co-constructed between different researchers and those they interview, consideration should be given to the ways in which interviewing techniques will affect the quality of data produced. There are considerations to be made about ways of getting past the rehearsed scripts, public rhetorics and defensive postures mentioned before through attention to issues of trust and rapport as well as questioning styles. Whilst there are a number of techniques, the epistemological position taken thus far would indicate that it is not possible to fully know whether such techniques are effective. However, again through reflexivity we can interrogate our analyses to see if we have learnt anything new from our participants. If we have then we might be assured that to an extent we have conducted "good" interviews and subsequent analyses rather than merely having succeeded in getting our informants to reproduce what we already know. Referring to the earlier discussion on "validity" of qualitative research, Flick (1998) has argued that the researcher must adopt an attitude of evenly suspended attention; otherwise they may be blind to the structures of the person they are studying. It can be argued that this applies as much to interviewing as it does to subsequent analysis.

May (1991) suggests that one way of not super-imposing our own or popular theoretical frameworks onto the participant is to use their own language as much as possible. The use of focus groups to access the street language and conceptual devices of hard-to-reach and hidden populations prior to conducting in-depth work (Ayella, 1993; Power, 1994; Andrade, 1995) has already been discussed in relation to this study. There are also a number of tried and tested techniques for producing depth interviews which relate to questioning style through the use of open-ended questions, rather than closed or leading questions, avoiding jargon and the use of prompts, probes and funneling (Smith, 1995). The schedule for semi-structured or open interviews should serve as a guide allowing for a build up of rapport, in which the order of questions can be flexible, and should allow the interviewer to pursue interesting areas that arise during the interview and follow the concerns and interests of the individual being interviewed (Smith, 1995).

Furthermore, it has been suggested that the researcher should attempt to be fairly explicit about their own research agenda so that the participant knows what to focus on (Jones, 1985). However, with sensitive research there are caveats and this must be done in very broad terms (Brannen, 1988). A related issue here is that participants may not be committed to giving a detailed account unless they can see some purpose or value in the project (Lee, 1993, Jones, 1985 #426). A further point to consider is that it may be beneficial to unload certain sensitive questions through the use of pre-supposition questions or by making a statement that other interviewees have divulged a range of extreme positions on the subject (Patton, 1990). A pre-supposition question embeds a statement that other people have revealed sensitive information in a research context. Another recommendation is that long interviews on sensitive topics should use ending questions which allow the interview to end on a positive note (Charmaz, 1990). Such questions aside from ethical considerations may also generate more useful data (Charmaz, 1990). Furthermore, the use of ending questions in focus groups, although not designed to be uplifting, also have the purpose of generating further data (Krueger, 1994). Interviews rely on conversational practice (Cunningham-Burley, 1985) and there can be no hard and fast rules about the use of leading, loaded and open questions as their use depends ultimately on the relationship with the person being interviewed (Jones, 1985). A case in point is Potter and Wetherell's (1995) suggestion that it may be more analytically revealing to argue with research participants. This latter position throws into relief the need to consider ethical issues in relation to interviewing when researching a vulnerable population on a sensitive topic as in this study.

The potential exploitation of research participants has been one of the main concerns of feminist researchers. A further concern for feminist researchers has been the ease with which women can get other women to talk about private and upsetting aspects of their lives. It is felt that in its own way this ease of access is potentially abusive and exploitative (Finch, 1984; Leonard, 1993) but the potential exploitation can be minimised by having a reciprocal relationship with the interviewees and disclosing something of oneself (Edwards, 1993). Also fears that research participants will be unnecessarily traumatised by disclosing emotionally disturbing events and memories are countered by participants who often claim that the interview was useful and cathartic (Brannen, 1988; Edwards, 1993; Renzetti and Lee, 1993). A further way of attending to ethical concerns arising through interviewing is to use basic counselling skills within interviews in order to support interviewees and facilitate cathartic disclosure; however, this is not intended to "do therapy" in an explicit or purposeful way (Coyle and Wright, 1996). A further dimension to ethical considerations following interviewing is how the data are analysed and how participants are represented. This has been discussed in the previous chapter in the section on "The Crises of Representation and Interpretation".

Local policies meant that approval for this study had to be sought from the Local Research Ethics Committee even though participants were not being recruited through the health service. The application included protocols for obtaining informed consent and maintaining confidentiality. It also included protocols for providing support and resources for participants. The committee required specialised support to be available for any participants under the age of sixteen from whom parental consent could not be obtained and this was arranged. The application also sought approval for making payments to peer researchers and those they recruited. Approval was obtained for all aspects of the study except, as noted earlier the payment to participants recruited via peer researchers.

## Methods of Data Analysis

The goal of the data analysis was to arrive at a detailed multi-layered interpretation (Yardley, 1997b) of lesbian and gay men's accounts about their mental health care experiences. The necessity to break away from strict disciplinary and epistemological divides was discussed in the methodology chapter with the conclusion that it is sometimes most appropriate for the researcher to work as a bricoleur (Denzin and Lincoln, 1994). This requires using whatever methods are most suitable to make sense of the data and working with the epistemological tensions such mixing of methods might engender. This should enable the researcher to escape both the limitations of positivism and the tyrannies of relativism. In this study an approach similar to grounded theory (Interpretative Phenomenological Analysis) was used to interpret some of the data and this was juxtaposed with a more discursive analysis to interpret other types of data for which the first approach was inadequate. The first approach is situated in a realist epistemology whereas the second approach is situated in a more relativist epistemology.

This combination of both types of analysis would until relatively recently been seen as combining epistemologically incompatible viewpoints (Denzin and Lincoln, 1994; Fine, 1994; Guba and Lincoln, 1994; Denzin and Lincoln, 1998). However, some recent studies have taken this approach of combining grounded theory with more discursive forms of analysis (e.g. Henwood, 1993; Gough, 2002). This allows what Yardley (1996) would call a material-discursive analysis and allows the data to be analysed using different lenses. It allows us to explore the mutual and reciprocal influence between discursive practices and the material domain but in a way which goes beyond a simple notion of interaction as in the bio-psychosocial model which remains dualistic and mechanistic (Ussher, 1997c; Yardley, 1999). So in this study it allows us to understand how dominant discourses, such as the pathologisation of homosexuality, and associated power relationships directly and indirectly mediate lesbians' and gay men's experiences of mental health care.

When the data had been collected and subjected to a preliminary analysis it was clear that there were two kinds of data which leant themselves to different forms of analysis and which needed to be viewed through different lenses. To begin with there were clear accounts of people's shared experiences of homophobia in health care and experiences of being silenced so that they were unable to bring concerns about the effects of homophobia on their health into a health care encounter. These accounts were grounded in the data and could be analysed using Interpretative Phenomenological Analysis (IPA). This is a method which is underpinned by a realist epistemology in which participants are able to articulate their experiences (Osborn and Smith, 1998). The approach has been used to analyse people's accounts of coming out, bereavement, chronic pain, eating disorders, transitions in identity in relation to motherhood, sexual risk taking (Smith, 1991; Flowers et al., 1997a; Jarman et al., 1997; Flowers et al., 1998; Golsworthy and Coyle, 1998; Osborn and Smith, 1998). The underlying epistemology of IPA and its relationship to grounded theory was discussed in detail in the chapter 3.

Within the data there were also many ambiguities and silences which were more complex to interpret and which did not lend themselves to such a phenomenological analysis. Some of this interpretive work related to what participants could not or would not say. This seemed to point towards some sort of resistance to the pathologising and silencing identified in the first part of the analysis using IPA. In order to explore these silences and ambiguities a discursive approach was used. This situated such silences and ambiguities within wider discursive practices and allowed an exploration of how participants attempt to position themselves in relation to such discourses when they were negotiating their sexual identity in a mental health care encounter. Such approaches allow us to move away from the individualism inherent in phenomenological approaches and situate people's experiences in a broader social context (Pilgrim and Rogers, 1997; Yardley, 1997b).

There are many different approaches to discourse analysis and as discussed in the methodology chapter, some of these take an extreme relativist or social constructionist position (e.g. Edwards et al., 1995). The different approaches to discourse analysis were discussed in detail in the methodology chapter. The most useful approach to understanding the data in this study was one which enabled an understanding of the way that participants were positioned by dominant discourses in their mental health care encounters. These approaches to discourse analysis (sometimes termed analysis of discourse) take a macro-discourse perspective and are characteristic of much of the work of Parker (1993; 1995; 1996; 1998a; 1999) and Davies and Harré (1990) . This is very different from the more empirical micro-discourse analysis characteristic of much of Potter and Wetherell's work (e.g. Wetherell and Potter, 1988; Wetherell and Potter, 1992). Analysis of discourse, or macro-discourse perspectives, are embedded in a critical realist epistemology and allow us to understand, through a process of deconstruction, how people negotiate and resist the positions that are offered to them within broad social practices (Davies and Harré, 1990; Burr, 1995; Burr, 1998). These approaches are particularly useful for interpreting silence and resistance (e.g. Boyle and McEvoy, 1998). Each of the approaches to data analysis which were used in this study will now be discussed in more detail.

### *The use of Interpretative Phenomenological Analysis*

The analysis commenced with a technique known as Interpretative Phenomenological Analysis (IPA) allowing an initial engagement with the data which focused on the thoughts and feelings that participants had about their experiences and the meaning of those experiences. This technique was particularly useful for exploring an area where there was little prior theory in relation to health care experience to draw upon and it helped to develop conceptual work grounded in the data. This conceptual work could then be related to broader social theory to locate these experiences within a wider framework. IPA is used as a method to look for shared experiences particularly, as in this study, where there is a large data set (Smith, 1995). One potential problem with this type of approach to qualitative data analysis is that it can purge variability from the data but that such variability may be important (Potter and Wetherell, 1987; Wooffitt, 1993). Again, by combining different approaches to analysis and viewing the data through different lenses, the strengths and weaknesses of different approaches can be used to complement each other.

Prior to analysis the interviews were transcribed verbatim with a level of detail which included relatively gross features such as corrections, hesitations and pauses which provided sufficient detail for the IPA. It was also sufficiently detailed for a discursive analysis which focused on content themes and ideological practices on a broad scale rather than interactional specifics (Potter and Wetherell, 1995; Potter, 1996). The data analysis then commenced with the method described by Smith et al (1999) for analysing large data sets. The method is more exploratory than the idiographic or case-study approach used with smaller data sets. It focuses on broader conceptual categories with an emphasis on discovering shared experiences among participants. All the interviews were scrutinised with annotations made in the margins to note preliminary interpretations, emerging themes, associations and connections, as well as noting anything else striking or of interest. These early codes tended to be used to mark chunks of text rather than a detailed line-by-line approach in order to keep the coding at a broad level. However, at times small amounts of text or silences and pauses were also noted as the researcher had already made a commitment to engage in a more discursive analysis. In addition to this, the preliminary coding involved simply marking out and grouping chunks of text that might be relevant at a later stage purely for the purpose of making the analytic task more manageable (Potter and Wetherell, 1994). As each transcript was coded in turn new preliminary themes emerged and earlier texts were re-visited to check for connections which may not have been salient previously. Initially the first six interviews which had been conducted were coded in this way following the procedures recommended by Smith (Smith et al., 1999).

These preliminary themes were used as a template as the sequential analysis of each interview proceeded and each of these themes continued to emerge in other interviews. Although the researcher was therefore primed or oriented to looking for these themes in subsequent transcripts an attempt was made to keep open to the possibility of further themes emerging. Following this initial preliminary coding of each interview an attempt was then made to cluster the emergent themes into meaningful groups. Examples of some preliminary coding of transcripts, which were later clustered into a particular category, are shown in Appendix 1. Although Smith et al (1999) suggest that this should be undertaken after the preliminary coding of each interview the analysis of such a large data set precluded this. This clustering was not an attempt to develop higher order themes as might be undertaken in a case-study approach but to look for patterns of shared experience in the data which could be grouped together to form broad categories. Once the themes had been clustered the data extracts were grouped together under each of these headings allowing a closer inspection of a corpus of data. This was then re-examined with a more focused lens in order to explore patterns and inter-relationships. The aim of this process was to arrive at a super-ordinate organising device in order to understand the shared aspect of these experiences (Smith et al., 1999).

### *Analysis of discourse*

As noted earlier, there were elements in people's accounts which did not lend themselves to a method of analysis grounded in verbatim data. Silence has been noted as a strategy of resistance to pathologizing and disciplining strategies both in the research interview and in actual health care encounters (Huby, 1997; Heaphy, 1998). Silence is also a feature of sensitive research in which participants may not have a language to describe their experience or they may deny it (Brannen, 1988). It became important to find a way of interpreting such data which allowed a consideration of the context of the described health care encounters and also the context of the research interview. A method of analysis which paid heed to such power relations and allowed an engagement with the silences, contradictions and rhetorical functions of the accounts was required and thus a deconstruction or discursive analysis of the texts was juxtaposed with the IPA. Deconstruction has generally been used to examine texts in which expert and dominant discourses are embedded –for instance, in relation to the pathologisation of homosexuality, deconstruction would be used to look at the way in which psychiatrists talk or write about homosexuality rather than looking at how lesbians and gay men experience health care. Similarly, with discourse analysis of the Potter and Wetherell school, the material most likely to be subjected to analysis is that in which dominant discourses are taken up: thus Wetherell and Potter (1992) used DA to understand how people draw on discourse to justify and maintain racism but this approach has not been used to explore how people experience racism. Other work adopting a similar approach looks at how homophobic discourse is maintained and justified (e.g. Gough, 2002) but tends not to be used to explore how homophobia is experienced.

Exceptions to this are to be found in work by Yardley (1998) and Boyle and MvEvoy (1998). Yardley (1998) used deconstruction to examine how people with chronic dizziness attempt to negotiate and resist dominant discourses and identities in relation to illness and coping. Boyle and McEvoy (1998) explored how dominant discourses about abortion affect the ways that women experience abortion. Other researchers have attempted to look at how dominant discourses are implicated in the maintenance of certain kinds of health related behaviour in the areas of, smoking and sex education (e.g. Woollett et al., 1998; Gillies, 1999; Willig, 1999b). Again though, in common with earlier uses of DA, these studies tend to focus on uptake of dominant discourses to justify certain kinds of behaviour. However, these studies go further (as does the work by Yardley, and Boyle and McEvoy) in the sense that they try to say something about the relationship between discourse and experience or behaviour. Willig (1999b) argues that there is a need to use deconstruction to do more than offer a critical commentary in order to be able to challenge discourses which constrain or limit behaviour. Gillies, Willig and Woollett do this by using positioning theory to help explain these relationships.

Positioning theory has been developed in the works of Davis and Harré (1990), Hollway (1989) and Parker (1992). As discussed in Chapter three, positioning theory attempts to account for subjectivity in the ways that discursive resources constrain and enable what can be thought, said and done by individuals. Individuals are constructed through available discourses which they can accept or resist – these positions provide us with our subjectivity and we come to experience the world from that perspective (Davies and Harré, 1990). Individuals may be positioned by the discursive practices of others or they may position themselves in relation to available discourses. Thus, Gillies and Willig (1999) analysed interviews with women smokers in terms of how the women positioned themselves in relation to available discourses about smoking behaviour. Harden and Willig (1998) explored the ways that young women were positioned in relation to discourses about contraception in order to explain the subjective experience of contraception in order to gain a (non-individualistic) understanding of what influences use of contraception.

It was noted in Chapter three that amongst the varied approaches to Discourse Analysis, those in the "analysis of discourse" tradition or macro-analysis tend to be more theoretical than those within the micro-analysis tradition which tend to be more empirical. It was also noted that the two approaches were not incompatible. Given that this analysis was more within the "analysis of discourse" approach, but was attempting to analyse empirical material, it made sense to borrow tools or methods from both micro and macro discourse analysis. These tools and methods encompass both tangible and concrete methods such as thematic coding of data as well as more conceptual approaches to looking at data. It has been argued that there are no recipe-like instructions for engaging in discourse analysis (Coyle, 2000). Willig (2000) has also commented that there are limitations to the degree to which discourse analysis has been operationalised which make it more difficult to analyse experiences. However, in spite of these limitations there are some key pointers and tools which can be used when conducting discourse analysis and deconstruction. What is required is the development of scholarship or an analytical mentality in which beliefs about what is normally taken for granted about language use are suspended, and in which we look at how people construct their version of the world and what they gain from these constructions (Coyle, 2000). Variation, or contradiction, in people's accounts can be used as a lever to analyse discursive practices and provides clues as to what function is being performed (Potter and Wetherell, 1994). Such an analysis requires a close reading of the text mindful of the action orientation of the text and the wider context in which it is embedded (Wetherell and Potter, 1988; Coyle, 2000). A close reading requires attention to details such as pauses, repairs and word choice which can be made possible by having a detailed transcription of texts such as interview material (Potter and Wetherell, 1994).

On being mindful of the action orientation of talk and its context it is important to consider what that talk might be designed to counteract (Coyle, 2000). Alternative versions are not always mentioned explicitly making awareness of the context all the more important in the analytic task (Parker and Burman, 1993). Silences and omissions may signal dichotomies which support ideological positions and dominant discourses which impose limits on what can and cannot be said (Feldman, 1995). It is here that deconstruction becomes an important tool for analysing polarities and dualisms; here language is understood to be a self-referent system in which meanings and concepts such as identity can only be understood by what they are not; such oppositions are often forgotten or repressed and can be revealed through deconstructing texts (Burr, 1995). Yardley and Beech (1998), in their deconstruction of accounts of dizziness suggest examining interview transcripts for inconsistencies, omissions and moments of conversational awkwardness.

Thus silences and contradictions alert the analyst to the presence of dominant discourses and sub-ordinate discourses which might be brought to the fore. Part of the analytic task was to look for variability and omissions in the interview data to begin to uncover these sub-ordinate discourses. Notes in the researcher's diary signalled inconsistencies early on in the research process. A two to three hour interview might proceed with good rapport and disclosure of intimate details only to be followed by a short conversation on leaving, in which material was introduced which seemed to contradict the overall account given during the interview. Such apparent contradictions often related to how the participant revealed themselves in the interview as being "out" to all the significant people in their life and feeling comfortable about their sexual identity. However after the interview they said they did not feel safe enough to disclose their sexual identity to people they lived with or that they had reservations about discussing their participation in the research project with a parent. This early observation suggested the possibility that participant's accounts served a rhetorical function or had an action orientation to present lesbian and gay identities in a positive light during the research interview. During interviews other inconsistencies were noted where participants claimed that lesbian and gay lifestyles were as good as and similar to heterosexual lifestyles but would then say they believed that lesbians and gay men should not have children because their relationships were inherently less stable than heterosexual ones.

Parker et al (1995) have argued that we need to move beyond the text to deconstruct the polarities that underlie and structure power relations. They also argue that psychiatric knowledge and practices are intertwined with institutions and power. A material discursive approach to the data helps us to move beyond the text by considering the role of material factors intersecting with discursive practices in medicine and psychiatry. Clearly sexual identity, and its discursive construction as psychopathology, was operating as a material factor in the health care encounters. In addition to this there were the further material factors of age, social class, race and religious and cultural differences operating which further affected the power relations in health care encounters. These discursive practices led to further material consequences for participants in the form of affecting access to health care and further identity work. Parker et al have suggested that a practical deconstruction can overturn polarities in favour of the less privileged or sub-ordinate term and can allow the construction of less pathologizing or more emancipatory 'realities', open up new spaces of resistance and arrive at new concepts and new practices (Parker et al., 1995; Parker, 1998a). Further deconstructive work then was required in the analysis to consider further how other material differences affected the negotiation of sexual identity in mental health care encounters. This requires a sensitivity to what is not said against a knowledge on the part of the researcher of the potential significance of such silences in relation to dominant discourses and local cultures and politics (Gill, 1996; Yardley, 1997b).

In this study the analysis of discourse was conducted using the techniques discussed, within a framework based on Parker's (1992) steps in the analysis of discourse. This involved initially reading and re-reading the interview transcripts and organising the material according to themes; this first part of the discursive analysis had already been achieved in the initial analysis using IPA. However it also involved a process of "exploring the connotations, allusions and implications which the texts evoke" (Parker, 1992, p. 7) in order to identify the discursive meanings constructed in relation to the mental health care encounters of lesbians and gay men. In this framework discourse means "a system of statements which construct an object" and text refers to the interview transcripts. Silences within the interviews were also treated as text (Morgan and Coombes, 2001). When silences were noted during the course of an interview there was a need to take ethical considerations into account so as not to force participants into discussing topics they did not feel safe with. However, at other times further probing could lead to further discussion about some of the contradictions and difficulties experienced. Appendix 2 gives some examples of early coding of data which identified instances of silence during interviews. In this stage of the analysis attention was also paid to dissimilarities or the contrasting nature of what was said (Gillies and Willig, 1997). The next stage, following Parker's steps, was to look at the way that discourses contain subjects and to consider the ways in which subjects were positioned by the discourses so far identified; Parker states that in Althusserian terms we have to ask how a discourse is hailing us and what rights we have to speak when positioned by a discourse. Thus this approach to discourse analysis involves:

> "specifying what types of person are talked about in this discourse...and speculating about what they can say in the discourse, what you could say if you identified with them" (Parker, 1992, p. 10)

Parker's steps were developed to give clearer guidance than that offered in other descriptions of DA which tend to suggest that the process is intuitive or implicit. However, Parker (1992) suggests that these steps need not be followed in a rigid or mechanistic way and for this study those steps which enabled a focus on discursive positioning and the identification of polarities were adopted.

## Conclusion

In the undertaking of this thesis an opportunity arose to pay attention to sampling strategies and map them to theoretical discussion about identity and analysis of experience. To begin with the commitment to try and obtain a more diverse sample arose from unreconstructed positivist reasons concerning notions of generalisability, but also for political reasons concerning ideas about inclusivity (although of course at this time this latter term had not been invented). In doing this, peer researchers were used, alongside key informants, incentive schemes and advertising for recruitment for the study outside lesbian and gay community locations and media. As the recruitment work progressed discussions took place with peer researchers and key informants about different aspects of the insider status of the main researcher. It also became clear that the further away the researcher was from lesbian and gay recruitment sources, the more diverse the sample became in terms of social class, ethnicity and educational background. The significance of lesbian and gay community attachment and the terms or categories people used to signify their sexual identity also came to the fore. Clearly the main researcher was identified by the research participants, either via the peer researchers or through their own enquiries, as an identifiable lesbian and feedback from participants suggested that this was of importance to them. Although in some cases this will have helped to gain access in a sensitive area there could be other cases where recruitment had failed for the very same reason. Such cases are of course unlikely to have come to the attention of either the researcher or others engaged in the recruitment process but to an extent the insider/outsider dualism in sensitive research was disrupted.

By taking a different approach to sampling a hidden population some of the problems of class and education bias were overcome which enabled further theoretical development about identity, community and health. The approach taken problematised the essentialist thinking built into many sampling approaches with this population whereby research participants have to subscribe to a particular identity politics and affiliations before they are likely to be included in the study. Such approaches to research reproduce assumptions about the group studied because arguments about identity and community become self-fulfilling. The basis on which research participants are generally recruited into such studies is through self-identification as a lesbian or gay man, or through lesbian/gay community affiliation. Both identification and community attachment are related to social class and community in ways which do not become apparent if homogenous groups are sampled. The essentialism built into these sampling strategies rests on the unproblematic adoption of lesbian and gay as self-referential terms of sexual identity. By definition then such an approach will tend to recruit lesbians and gay men who are proud, thus re-inscribing the shame/pride dichotomy through the exclusion of those who are ashamed.

Whilst the usual approaches to sampling in studies of lesbians and gay men approach may suffice in the study of lesbians and gay communities, or in the study of the development of lesbian and gay identities, the extrapolation of these approaches to applied research in either sexual health or mental health is clearly flawed. Curiously, even though a critique of such essentialism has come from social constructionists, when social constructionists conduct research into the lives of lesbians and gay men, they too fall prey to ill-considered essentialism in their sampling strategies. In this study, by questioning the usefulness of the terms available for people to construct their stigmatised and threatened identities, sampling strategies were developed which allowed a degree of side-stepping of the dualism built into essentialist sampling strategies (i.e. those which rely on a positive (affirmative) lesbian and gay identity and the adoption and use of these terms). Thus in advertising in particular ways and in particular places, in using peer researchers who may or may not themselves be lesbian or gay identified and who were trained to be sensitive to this issue of language and identity, a more heterogeneous sample was obtained than is usually the case in studies of this kind.

In order to evaluate the success, or otherwise, of the sampling strategies used in this study, it is useful to return to the question of whether or not the researcher's own assumptions had been challenged. In a sense it was the success of the bold recruitment strategy which was the very thing which disrupted the researcher's own world view; as the sample became more diverse, more participants entered the study who gave accounts of being, and remaining, conflicted about their sexual identity. This took the researcher well outside any comfort zone and yet allowed a better engagement with the tension identified early about the relationship between sexual identity and mental health. The comfort zone was to hear accounts which were told like Damascene conversion stories which would read something like this:

> *"I was screwed up about my sexuality for a while, I had some mental health problems, was pathologised along the way but then I realised my true sexual identity, accepted it, came to terms with it and joined a lovely caring sharing lesbian and gay community"*

To make this story complete, if the participant was asked at the end of the interview whether or not they would take a pill to make them straight, they would answer a resounding “NO”. Clearly though, as the thesis progressed and as the sampling strategy developed, more people came in who would have taken that pill or at least given it some consideration. As will be seen in chapters five and seven, it was in these accounts that some of the richest data emerged in terms of the second research question. As the sampling strategy progressed, the insider status of the researcher was dislocated and disrupted and as this happened new insights were arrived at. Again, no claim will be made here that such knowledge was complete, and it will be offered as a partial and situated perspective. A claim is made however that certain important boundaries were pushed but there is also a recognition that they could have been pushed further. However, the boundaries were pushed beyond essentializing frameworks which would have reproduced circular arguments and self-fulfilling prophecies. In doing this a more vulnerable group has been reached and the analysis and interrogation of their accounts will lead to further insights about how homophobia and heterosexism operate in mental health care encounters and how they affect access to care.

## Chapter 5: Identity Parade – experiences in the line up for mental health care

### Introduction

In this chapter part of the dataset from the 49 in-depth interviews which were conducted, are thematically analysed using Interpretative Phenomenological Analysis (IPA). The first section sets out how this first data set was extracted for this analysis with a view to conducting a further layer of analysis using more discursive approaches. Following this the procedures for using IPA are described alongside presentation of the data according to the themes which emerged from the analysis. Further discussion of these thematic categories follows in chapter six.

### The Data Corpus Extracted for Initial Analysis

As described in Chapter four, 49 interviews were conducted of which 48 fit the criteria for the study. One interview (no. 37) was not included in the analysis as the participant did not identify as lesbian, gay or bisexual. The difficulties associated with being clear about eligibility criteria when conducting research with hidden populations has been noted by Biernacki and Waldorf (1981) and this was discussed in chapter four. A further element to this issue of eligibility, which also arises from issues discussed in chapter four about conducting sensitive research, was that not all of the 48 remaining participants had experienced mental health issues or had any related mental health care. In fact 36 of the 48 identified that they had experienced mental health problems which they attributed to being connected in some, but not necessarily total, way to their struggle with coping with their sexual identity. Of these 36, 32 had related experiences of mental health care. The mental health problems which participants identified ranged from mild and untreated anxiety and depression through to hospitalisation for severe depression and eating disorders. Many other participants had been treated or had been referred by their GPs for depression, panic attacks, self harm, or misuse of alcohol and many had been referred for counselling. Others had accessed counselling privately or through student services.

There were methodological reasons for keeping the brief about the criteria for the project fairly loose when recruiting participants for the study. This was because of the sensitive nature of the research and also because of the recruitment strategy in which one participant might snowball to further participants. For example Anthea (participant no. 19) had experienced no mental health problems but she did recruit further people into the study who had relevant experience. Furthermore, Brannen (1988) notes that when conducting sensitive research, participants do not always readily talk about the research topic even though they have volunteered to participate. Thus, the use of peer researchers and chain referral meant that this had to be taken into consideration and it was important to allow some latitude about the degree to which recruiters could be expected to determine the eligibility of participants in relation to the specific aims of the study.

There were also theoretical reasons for keeping the brief wide when recruiting which again relate to the difficulties of defining sensitive research in advance. Again these difficulties have been noted by Brannen (1988) and they were discussed in chapter four. Brannen argues that participants should be allowed to define the problem in their own terms and that they may have difficulty in expressing their experiences or may even deny their experiences; keeping the brief wide to include general exploration of issues relating to "coming out", and then later on making it even more broad so it was defined in terms of "sexual orientation and mental health" facilitated this. This initial approach to allowing participants to discuss their sexual identity and coming out to friends and family allowed time for rapport to develop in the interview before honing in on more sensitive and threatening issues relating to mental health and mental health care.

This strategy towards the recruitment and the interview process itself was labour intensive but worthwhile in that a diverse sample was achieved. This diversity produced data which could further our understanding about the experiences of coming out and the nature of related mental health issues and related health care experiences. The wide range of data produced also allowed some insights into factors associated with mental health issues and coming out experiences and allowed these experiences to be set in a wider socio-cultural and inter-personal context. It was not the purpose of this study to investigate the relationship between coming out and mental health, but rather to focus on mental health care experiences. However, it could be seen from this large data set, which included some people who had not experienced mental health problems, that there were probably many other significant factors in people's lives which contributed to their mental health problems. Many of the participants in fact attributed their struggle with their sexual orientation as the "last straw" in a chain of events leading to mental illness. It was striking when conducting the preliminary analysis of the data that a large proportion of those who had suffered mental illness had experienced significant stressful life events many of which were unrelated to their sexual identity. Examples of those which were not directly related to sexual identity included the death of a parent during childhood, childhood abuse including sexual abuse, witnessing a murder or witnessing other stressful events, rape, and loss of a child. Other events more directly related to sexual identity included being evicted from the family home and other kinds of family rejection, homophobic violence from family members and peers, and bullying. The interviews also contained a wealth of material about the relationship between coping with sexual identity for those participants who were part of religious communities. However, as noted before, it was not the purpose of this study to examine these in detail but the context can be illuminative; for instance some participants described how members of their family viewed homosexuality as a mental illness which should be cured and this had some bearing on participants expectations and experiences of mental health care.

Another factor to consider in relation to the total sample was that four participants identified that they had experienced mental health problems which they associated with their sexual identity but they did not have any related mental health care experience. This lack of health care experience did not appear to be related to the severity of mental illness but may have been related to factors such as age, cultural difference and other sources of support. However such investigation was not the main purpose of the study but it does illustrate the potential strength of the recruitment methods used as such diversity may be theoretically important. Some of these cases where participants experienced mental health problems, but did not seek health care, help to illuminate our understanding of factors affecting access to care. These are brought into chapter seven and build on the understanding developed in this chapter and chapter six about non-disclosure of sexual orientation during mental health care encounters.

For the purposes of this study then, in order to address the specific research questions about mental health care experiences, a sub-sample of 36 interviews, of the original sample of 49, were analysed. Eighteen of the participants are presented in this chapter and discussed further in chapter six. These eighteen interviews included material about mental health care experiences which leant themselves to a method of analysis grounded in the verbatim data describing participants' experiences and in which these experiences could be thematised i.e. Interpretative Phenomenological Analysis. However, not all of the material in these eighteen interviews could be analysed using this method and a further more discursive approach to the analysis follows in chapter seven. This analysis uses further material from the eighteen participants presented in this chapter as well as introducing more material from the remaining participants in the sub-sample of 36. This subsequent analysis is situated within a more constructionist epistemological framework than IPA. It uses a different lens to view those aspects of the data which were more contradictory and which participants seemed to find harder to articulate. The further analysis subjects those aspects of people's experiences, and their accounts of those experiences, to further interrogation and pays particular attention to the silences, omissions and contradictions in those accounts.

## Interpretative Phenomenological Analysis (IPA) of the Interview Data

For the IPA the interviews were transcribed and subjected to a thematic analysis using the procedures described in chapter four. The approach taken to the IPA was that recommended by Smith et al (1999) for use with large data sets. To begin with the first six interviews which had been conducted were scrutinised. From this preliminary interpretations, emerging themes and anything else striking or of interest were noted. Preliminary themes which emerged from these first six interviews were:

- Experiences of health care in which health care practitioners seemed to view lesbian identity as an abnormality caused by childhood sexual abuse
- Concerns about being viewed as abnormal and therefore not disclosing sexual identity or associated concerns to health care practitioners
- Feeling that health care practitioners did not want to discuss issues relating to gay identity

The first preliminary theme of lesbian identity being viewed as abnormal and linked to childhood sexual abuse can be seen in Mandy's account[3]. In the following extract Mandy refers to the childhood sexual abuse by identifying herself as a survivor:

> *I went to see my doctor and he sent me to a counsellor and I was seeing a counsellor because I'm a survivor and my counsellor ( ) definitely was turning round and telling me the reason why I was gay was because I was a survivor.* (Mandy – IV1)

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[3] Verbatim extracts from the interviews are shown as indented quotations in italics; empty brackets indicate that material has been omitted, information in brackets has been added to provide clarification and ellipsis points (…) indicate a pause in the flow of speech following the convention by Golsworthy and Coyle (1999).

The second preliminary theme which emerged was non-disclosure of sexual identity in mental health care encounters because of fears of being seen as abnormal. This can be seen in Josh's account of why he couldn't bring himself to tell the clinical psychologist that he was seeing that he felt that his depression was linked to his negative feelings about his emerging gay identity:

> *I just thought (...) if I did say 'I'm worried about my sexuality', they might go (...) I probably thought that they would um (...) they would just think that I was some sort of I (...) freak.* (Josh – IV 2)

The third preliminary theme of feeling that health care practitioners did not want to discuss issues relating to gay identity can be seen in Alec's account. Alec had sought counselling when he ended his relationship with his girlfriend at the time that he was realising his gay identity but he felt that the counsellor was reluctant to discuss his concerns about his sexual identity:

> *I perceived her to be skirting around certain issues and not wanting to talk about certain things that I wanted to talk about because I considered it to be an issue. A lot of it was revolving around sexuality and lifestyle and things like that. Things that I wanted to talk about and speak my mind on but things that I don't think that she was quite prepared to have at her table, as it were.* (Alec – IV 5)

Alec felt that the counsellor wanted to concentrate on his previous heterosexual relationship and wouldn't pursue topics relating to his gay identity:

> *It always used to somehow pan back to (my ex-girlfriend) which I think is perfectly natural because that was the initial problem I went to her with, so it would seem logically that a lot of things would stem from that. But it generally did try (...) or she tried like 'What about when you were with (your girlfriend) or what about when you did this or that?' Sort of almost like rebuffing me basically. (Alec – IV 5)*

These three preliminary themes of experiences of mental health care in which lesbian or gay identities were seen as abnormal, were ignored or were difficult to disclose because of fears of being seen as abnormal, were used as a template when analysing the rest of the interviews. Further examples of all three emerged from the data demonstrating that these were shared experiences. Although primed to look for these preliminary themes in the larger data set, new themes also emerged. These were:

- Experiences of health care in which health care practitioners seemed to view lesbian or gay identity as a phase which was immature or attention seeking

- Experiences of health care in which health care practitioners seemed to view lesbian or gay identity as the cause of mental illness
- Potential causes of mental illness unrelated to sexual identity not considered by health care practitioners
- Feeling that issues relating to sexual identity were trivialised by health care practitioners
- Feeling that issues relating to sexual identity were ignored by health care practitioners
- Feeling rejected by health care practitioners following disclosure of sexual identity
- Feeling that health care practitioners distanced themselves following disclosure of sexual identity

Following this initial preliminary coding of each interview an attempt was then made to cluster the emergent themes into meaningful groups. Although Smith et al (Smith et al., 1999) suggest that this should be undertaken after the preliminary coding of each interview, the analysis of such a large data set precluded this. This clustering was not an attempt to develop higher order themes as might be undertaken in a case-study approach but to look for patterns of shared experience in the data which could be grouped together to form broad categories. At this stage of the analysis three broad categories were developed:

1. <u>Non-disclosure of sexual identity:</u> The first category related to non-disclosure of sexual identity because of fears about being pathologised or receiving homophobic abuse.

2. <u>Experiences of being pathologised:</u> The second category related to experiences of being pathologised in which lesbian and gay identities were seen as indicative of arrested development and therefore potentially curable.

3. <u>Experiences of being silenced:</u> The third category related to experiences of being silenced which included having issues relating to sexual identity ignored or trivialised or in which health care practitioners became hostile or rejecting.

The data extracts will now be grouped together under these the three broad theme headings which emerged from the clustering of preliminary themes to allow a closer inspection of the corpus of data. This allows a re-examination with a more focused lens in order to explore patterns and inter-relationships (Smith et al., 1999). The data clustered under the three broad category headings will be presented in this chapter and the following chapter will discuss how these findings relate to existing research findings and literature. The aim of this process of analysis was to arrive at a super-ordinate organising device in order to understand the shared aspect of these experiences (Smith et al., 1999). This will also be discussed in the next chapter alongside a discussion of how such an understanding is informed by existing theory.

*Non-disclosure of sexual identity*

Several participants did not disclose their sexual identity to mental health care practitioners even though they felt that some of their mental health problems were related to their anxieties about coming to terms with their sexual identity. It was seen in the preliminary analysis of the first six interviews how Josh felt he could not disclose to the clinical psychologist who was treating him for depression in case he was seen as a freak. Other participants also described this fear of being seen as abnormal or being pathologised:

> *I thought there was too much potential to have the GP thinking "God, you're some kind of freak, or whatever" () it seemed too risky as much as anything.* (Oscar – IV 36)
>
> *I was worried the counsellor would think that "you're abnormal, that there's something wrong with you. Or that you're disgusting.* (Lauren – IV 35)
>
> *I guess it was about confirmation of my worries that I was abnormal, that if somebody at the time it didn't matter particularly whether it was the counsellor or my mum had a bad reaction or confirmed that it was something to be ashamed of or that was abnormal in society or that was bad or that was an illness, any of those things it was fear of that () My fears with the GP is that they would only see it in terms of the medical model.* (Sarah – IV 20)
>
> *I remember sitting there and thinking I know what the problem is but I can't tell you. I can't tell you what it is. And so I'm sat there saying I really don't know, I just, I always feel low in the winter, and you know, and I, I couldn't tell him.* (Len – IV 39)
>
> *I just don't want to feel like I'm under stud(...) As a freak or something, you know. It's one thing (...) but I don't know I think maybe it's also just the homophobia, afraid that I'm going to get their homophobia.* (Annie – IV 41)

For Simone and Claudia this was not expressed in terms of being seen as abnormal but as a fear that health care practitioners would see only their sexual identity as an issue and not be able to look beyond that to see the whole person:

> *I guess it's about them thinking less of me or seeing that as the only issue and not seeing me underneath. Not being able to get past me being gay and that's it.* (Simone – IV 9)
>
> *And I thought as well the whole emphasis of the counselling is going to be on that issue. And because that wasn't the only thing I made it so we didn't talk*

> *about it at all which was wrong whereas it was an issue but not the only one. That's probably one of the things I worry about most is that it is going to be the only thing people can see. Any other attributes of your personality will go because there - there's Claudia and she's - however people term me - that's going to be the only thing they can talk about and their only thing of interest. And I think that was my fear with the counsellor really.* (Claudia – IV 49)

Some participants gave their concerns about receiving general homophobic abuse as a reason for non-disclosure rather than specific fears about being pathologised:

> *I would always (say I was) heterosexual because I thought it's easier. Otherwise it's like in a hospital you know there's this kind of (...) where all the staff know about you, everything you ever do is passed on to all the staff, regardless of whether or not they're on duty. Everybody knows then. () Also your treatment can depend so much on how the staff see you. If they like you, you get an easy run; if they don't, you can be sedated, sectioned, you know, kept in a room on your own, put in the intensive care unit, denied leave –anything can happen. They can make your life hell. () And when you're there seven days a week, 24 hours a day, and you've got no way out, you just don't want to give anybody any more ammunition.* (Jane – IV 8)

> *You know there's, there's homes, hospitals that you can go to and be locked away in, that kind of thing, that's what worries me and that there's people out there that would still try and do that, and it, it still scares me. (Lauren – IV 35)*

These fears about being seen as abnormal, or not being seen as a whole person but only in terms of sexual identity were realised by many of those who did not disclose their sexual identity as can be seen in the next section. Finally in this section, Len's account gives an insight into what practitioners need to do to make care more accessible. This links to later theoretical discussion about how heterosexism makes lesbian and gay identities invisible so that people accessing care have no indication of whether or not it would be safe, or even appropriate to disclose:

> *Had there been literature around the place, maybe I would have felt that I could talk to the GP because there are leaflets saying that you can talk to your GP about all sorts of other things but there's nothing that says you can talk to your GP about your sexual orientation or you know, so maybe had I seen something there, saying well I don't know, saying that you can discuss um these kind of issues with your doctor, then I'd have felt yes I could because I could go in there and I could talk to him and I wouldn't be dismissed because it says here that you know, my GP will point me in the right direction, give me, give me somewhere to go, or you know, someone, at least give me somebody else to talk to.* (Len – IV 39)

### *Experiences of being pathologised*

A number of participants who disclosed their sexual identity in mental health care settings recounted experiences of having their sexuality pathologised. It was seen in the preliminary analysis of the first six interviews that Mandy described a health care experience in which her lesbian identity was seen as an abnormality that had been caused by childhood sexual abuse. Both Jane and Julie described similar experiences in which mental health care practitioners seemed to view their lesbian identity as an abnormality caused by childhood sexual abuse:

> *I've had the 'Oh you're just gay because your dad abused you.' (). I've had it suggested by Community Psychiatric Nurses who've been trying to counsel me. 'Do you think that might just be because (...) because of your father?'* (Jane – IV 8)
>
> *Well everybody blames (the childhood sexual assault) (). I won't argue about it with anybody, my parents or my psychiatrist because I think that's () that's what he believes, he thinks I'm frightened of men, so he's that's what he says: ' You're not gay, you've got, you've got a men phobia' () . (My psychiatrist says that) because of what happened to me when I was very young and being afraid of men, I've just been spending all this time afraid of men, and then I started being worried about my, or confused about my identity and then I became ill and that's when I got my sexuality back to front.* (Julie – IV 42)

Alice (IV 16) said that she was told quite directly by a counsellor that it was abnormal to have same-sex attraction or relationships. Charlotte also experienced a sense that her counsellor viewed homosexuality as something abnormal, or unhealthy, for which a cause could be found such as having a difficult relationship with her mother:

> *(She) just made me question it so much in a negative sense that you know and the cause and um, just where I was going to go with it and is it really healthy and maybe I will get over it. () and almost trying to relate it to the fact that my (relationship with my) mother is a result of this, and I just thought well no () it was like yeah she wanted to get to the bottom of why I like women.* (Charlotte – IV12)

The previous extract from Charlotte's interview also shows how she experienced the counsellor suggesting that her lesbian identity was something which could be cured or grown out of ("maybe I will get over it"). For Julie there was a similar experience in that her psychiatrist seemed to be suggesting to her that "she was not really gay" but simply hadn't yet developed enough to be able to have mature heterosexual relationship because she was "afraid of men". Other participants had similar experiences where they felt that their sexual identity was seen as a phase. Nicki's experience with her psychiatrist gave her a clear message that homosexuality was seen as an immature and possibly attention-seeking phase:

> *The psychiatrist (said) () I'm not really (gay but) I'm just fooling myself with shock tactics.* (Nicki – IV 31)

Nicki had further experiences of having her certainty about her sexual identity questioned as if it was something which might be a temporary phase which she would grow out of:

> *Some of the nurses were a bit sort of like 'Are you sure?' – I was like yes thank you. Then they'd say 'Would you like a chat, would you like a chat'.* (Nicki – IV 31)

Charlotte also experienced her counsellor implying that her lesbian identity was a phase she would grow out of and that she would eventually meet someone and have a heterosexual relationship:

> *I don't think (the counsellor) really took me very seriously with me being so young. You know I think she sort of said to me 'Well look wait a couple of years you know, you might meet someone'.* (Charlotte – IV 12)

Roger also felt that his GP viewed his gay identity as something he should just be able to get over:

> *I saw the GP and when I said you know 'I'm er gay' and er sort of mentioned it to him, he he was just sort of was very dismissive and said 'How long have you been like this?' and I said 'Always' () and then he said 'Well you want to sort yourself out' he said 'Your problem is you're shy of women'. (). He said 'Pull yourself together and go and get a girlfriend'. (Roger – IV 45)*

It can be seen from the above extracts that the way in which lesbian and gay identities were pathologised was primarily through it being viewed as a developmental abnormality caused either by childhood sexual abuse or difficult relationships with parents. Within this it was seen as an immature phase with an implication that people would grow out of it or that they could in some way be helped to become heterosexual.

The other aspect to pathologisation was that other potential causes of mental illness were not explored. Wayne described how when he was suffering from severe depression, his illness was attributed to his confusion about being gay even though he himself felt that he had accepted his sexual identity:

> *They were bothered if there didn't seem to be a valid reason to be depressed but the only valid reason they saw in my case was to be confused about my sexuality (). It may have helped if the psychiatrist actually listened to what I was saying. Didn't just listen out for what they wanted me to say. And if I was referred to some type of counselling or therapy, some sort of talking therapy to*

> *try and iron things out. Even they may have found they were totally right, my whole problem was "coming out" but I didn't think so and I still don't think so now. But we could have sorted things out, dealt with different areas individually with what was wrong and how they all affected each other. I certainly think that would have helped.* (Wayne – IV 34)

Wayne felt that much of his depressive illness could be attributed to his experiences of bullying at school and having to take on caring responsibilities as a child rather than any confusion or lack of acceptance of his gay identity. However, his experience was that his gay identity was perceived as the cause of his mental illness:

> *With the nurses and the doctors, their answer to it all was me being gay ( ) It was Wayne the gay – that's really the sum total of it.* (Wayne – IV 34)

Wayne's experience parallels the concerns expressed by Simone in the previous section where she said she did not disclose her sexual identity for fear that she would be seen only in the light of this. There were thus two kinds of pathologising stance operating in people's health care experiences. The first was where sexual identity was seen as the problem which needed attention in the sense that it was seen as having a cause and therefore a cure. The second one experienced by Wayne was where confusion about sexual identity, rather than sexual identity per se, was seen as the problem with the solution being acceptance of gay identity. In both types of pathologisation, the focus on sexual identity over-rides any attention to other potential causes of people's mental health problems such as childhood sexual abuse, bullying and other kinds of stress. For instance, childhood sexual abuse is seen as the cause of homosexuality rather than a possible direct cause of mental illness.

### *Experiences of being silenced*

It was noted in the preliminary analysis that Alec had the experience in which he felt that his counsellor did not want to discuss his gay identity or any associated concerns. Further analysis of the other interviews showed similar experiences for a number of participants. Sandra, like Alec, found that the health care practitioner she saw did not seem to want to discuss any issues relating to lesbian or gay identity:

> *I did have um, I think it was, fifteen weeks CAT[4] Therapy, that was the NHS stuff that I got um (...) and (...) my being Gay was literally sort of noted down and passed over. It didn't figure in anything that was subsequently said. It just*

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[4] Cognitive analytical therapy

> *didn't figure. (It was like they said) 'Yea, OK fine () I don't have a problem with that'.* (Sandra – IV 25)

Another participant who was suffering from depression had approached her GP and requested a referral to see a counsellor to talk about her sexuality. She knew that her GP had made this clear in his referral letter to the counsellor but during the counselling sessions she felt that all her attempts to broach the subject were ignored:

> *The GP had written a referral letter to that counsellor which actually said I wanted to talk about issues of sexuality and that counsellor must have known from the beginning yet didn't bring it up or didn't enable me (). I think she could have explored it because I hinted so much, there were lots of things I hinted about.* (Sarah – IV 20)

For both Sarah, Sandra and Alec, their attempts to explore what they saw as a link between their mental health problems and their difficulties in adjusting to a lesbian or gay identity were ignored. Julie's experience of this was being told not to discuss her sexual identity rather than being ignored. She was initially encouraged by one nurse to discuss her concerns relating to her sexual identity in group therapy. However, another nurse then told her that this was not an appropriate place to discuss her sexual identity:

> *Well the male nurse encouraged me to talk about it, to bring the issue up in group therapy but you see this other female nurse said 'Well you know it's not really applicable to the group is it?' Which I, I was so shocked by I couldn't really argue because he had specifically said you know band it out in the group, that's what it's for, you know, and it would have been very difficult for me to say well this is one of my real problems. But I thought oh well no, I'll ask the female nurse about it and she just said 'Well you know it's not, not really anyone else here with that problem'. (Julie – IV 42)*

A further way in which participants were silenced about their concerns about their sexual identity was through trivialisation. Roger and Julie had similar experiences in that they both felt that they needed help coping with their sexual identity but when they tried to raise this and get help they felt that their concerns were dismissed and trivialised:

> *I think there's things, lots of things that I want to talk about and I'll always get shut up when I see one of the psychiatrists or whatever about the OCD[5] because by the time I've spoken to them about the OCD there's never time really to speak about the sexuality and if I do try to talk about it there's never enough time because it's always at the end of the interview and they say well just get on with it, you know I need to talk about it, you know? (Roger – IV 45)*

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[5] Obsessional compulsive disorder

> *Well, one nurse said 'Look why don't you just go somewhere and sort yourself out, all this business' you know all this business, it's like a fundamental part of my life ( ) but I couldn't come to terms with what was going on as far as I was concerned, my identity and stuff and ( ) a lot of nurses used the word 'responsibility' to me, I wasn't being responsible, I've had to take it all on board for myself to sort out.* (Julie – IV 42)

What these extracts show is that health care practitioners seemed not to understand the impact of homophobia, gay-related stress and internalised homophobia on people's ability to adjust to a lesbian or gay identity and the impact that this has on their mental health.

One further shared experience which also had the effect of silencing was perceived distancing from health care providers after a disclosure about sexual identity. Julie regretted disclosing to one nurse who she felt became hostile towards her afterwards and more difficult to talk to:

> *I spoke to a female nurse about it but I instantly regretted it ( ) at the time that I discussed it with her I was on my re-feeding programme and I felt afterwards that she was grilling me a bit more than the other girls, we used to eat together, about six of us at dinner and um I used to think that she picked up on my little tricks more than everybody else's, but you don't know how much of it is you know, your own paranoia. I'm sure she did, um but you know you can't really be sure ( ) and I just thought she, you know, maybe she thinks that I fancy her and er you know she's too understanding, maybe she's really worried about coming back to talk to me now because she thinks I'm going to leap on her or something. Um you know it was probably completely unreasonable to think that but ( ).* (Julie – IV 42)

What Julie was describing here was a sense that the nurse to whom she had disclosed had become less friendly towards her and was now less likely to spend time talking with Julie about anything, including her concerns about her sexual identity. This experience also fed into Julie's own concerns about being seen as abnormal or the kind of person who would be sexually predatory towards the nurse she had disclosed to. In another case the counselling sessions were abruptly terminated just after Sarah had disclosed her sexual identity to a nurse who was counselling her. Sarah experienced this as a rejection and it made her feel that the counsellor had ended the sessions because of negative views about lesbians and gay men even though the reason given was that the nurse was leaving her current post:

> *Part of me believed that she wasn't really going to another job she just, it was because I was gay and I was an awful person and it had to stop.* (Sarah – IV 20)

These experiences of being pathologised, silenced, ignored and rejected left participants feeling angry, upset, let-down, disappointed, vulnerable, insecure and confused about their sexual identity. Jane, Julie and Sarah describe how being ignored or feeling that they had been silenced made them feel:

> *I mean to be honest, when people ignore it it's worse than saying that it's bad.* (Jane – IV 8)
>
> *It made me think 'God, why am I such a complete bag of nuts then, I must be, must be really weird if these people can't do anything for me'.* (Julie – IV 42)
>
> *I think she could have explored it because I hinted so much, there were lots of things I hinted about ( ). Whether that was about prejudice towards gay people or not wanting to talk about it I don't know but ( ) for me because it was quite close to that time of just coming to terms with it and accepting it, I guess the first thing I was thinking of was oh, it was because she, it was because I was gay and she didn't want to talk about it ( ) so there must be something wrong.* (Sarah – IV 20)

In the above extracts both Julie and Sarah identify how the silence on the part of their counsellor led to them feeling that their was something wrong with them because of their sexual identity.

Nicki and Charlotte describe how they felt as a consequence of their sexual identity being viewed as an immature phase which they would grow out of. Nicki felt that her integrity and authenticity as person was being undermined and Charlotte was left feeling confused by the experience:

> *When they turn around and say that all you're planning is complete sham, (it's) not so good, it doesn't help. It doesn't help at all. It makes me really, really upset.* (Nicki – IV 31)
>
> *I was in a clinical situation and it was nice to sort of talk to someone that I thought could help but unfortunately it did the opposite, made me question maybe more, you know which isn't very good.* (Charlotte – IV 12)

Mandy describes how she felt angry and let-down when her lesbian identity was pathologised by being linked to childhood sexual abuse:

> *I was really, really pissed off that he said it and it really left me ( ) confused ( ) and then I was left with even more questions because he'd made me really confused and I was angry with the fact that he was able to do that. And it was being seventeen it wasn't very helpful. It was an issue which was coming up a lot in my life as well at the time. I was having great difficulty feeling that I was a survivor ( ). I was going to see the counsellor ( ) and then it turned into a great big flop , it was not very helpful at all. A pretty big let-down.* (Mandy – IV 1)

Julie who was also pathologised in this way by her psychiatrist felt that this led to her being more confused about her sexual identity and unable to accept it:

> *He's the one person who says 'You're not gay you know' and I think how can he say that? But it's quite interesting to know his opinion, because er you know I've been seeing him for two years so he must know me pretty well but so that confuses me when I'm just sort of trying to find my feet myself, and because* of *the sort of, because of the way I've grown up doubting myself and worrying about what I am, who I am, my identity and stuff, as soon as someone says something different I start thinking well, and questioning myself you know, so I don't know if I could give a really true account of how I really did feel. So because every time I get to accepting it, something happens and I become depressed again.* (Julie – IV 42)

In the previous extract Julie attributed her mental illness in part to the denial and lack of validation of her lesbian identity by her psychiatrist and other mental health care workers. Some participants identified that these experiences led to them avoiding further mental health care encounters, or maintaining a silence within health care encounters which meant that they couldn't get any help with some of the problems they were experiencing. This was the case for Mandy and Jane who both felt that this effect on their access to mental health care had led to a worsening of their mental health problems. In the following two extracts it can be seen that the effect of being pathologised for Mandy was to delay seeking any further help for another two years and for Jane it led to her not talking to the people who she should have been getting therapeutic interventions and support from:

> *He just said that he thought that the reason why I was gay was the fact that I was a survivor. I mean, he basically said do you want to come back and have a specialised talk about it so I said 'Fuck off' and then walked out left it at that ( ). I didn't get any other help for quite a while, about a year or so. ( ) I mean it put me off going to get more help. And it really put me off counselling. So he really did put me off looking for help for a long time - eighteen months to two years.* (Mandy – IV 1).
>
> *I've had it suggested by CPNs who've been trying to counsel me. 'Do you think that might just be because ... because of your father'? Just like yeah, okay, goodbye there. As soon as I hear that it's like I know it's not even worth it any more talking to them so.* (Jane – IV 8)

Mandy and Jane both felt that this lack of access to appropriate mental health care led to an exacerbation of their mental health problems:

> *I've done a lot of things because I didn't have the support from my GP enough or from my counsellor ( ). I've had a lot of suicidal feelings and I've had an*

> *alcohol problem and I had that when I was seventeen actually. ( ) I've suffered from bulimia, I've had eating disorders, cutting myself up ( ) and if he hadn't have said what he said I might have got the help I needed so I wouldn't have gone through that.* (Mandy – IV 1)

> *I overdosed when I was in hospital at various times. I was doing it because I needed somebody to talk to me and to listen to what I had to say. Part of the fact, part of what I had to say was that I was gay. Just the fact of saying it, because it was a part of me that I couldn't ignore any more.* (Jane – IV 8)

Wayne felt that the effect on his mental health of being pathologised, and the insistence by medical and nursing staff that his problems all related to his confusion and lack of acceptance of his gay identity, along with side effects from medication was actually making his life more difficult. However, unlike Mandy and Jane he felt that he had benefited from avoiding further encounters with the mental health care system:

> *There are all sorts of other side effects and I just decided that I thought I'm blowed if I'm going to take these for the rest of my life, gave them up, didn't go back to the doctor and I basically thought bollocks to it and I'm going to get on with my life. Well I've done that for four and a half years now. ( ) I can remember my actual encounters with the medical profession caused me as much stress as the symptoms I was going along with. I thought let's cut this out, it really got to seem like a load of rubbish. Let's cut this cycle, let's stop it. If I don't go along to the doctors I won't get any support but at the same time I won't get any stress. If I don't have the medication it won't give me a miracle cure but at the same time it won't give me any of the side effects which are just as bad as the original problem. Really I just thought I'm fed up at the time I was 22 or 23 and I thought I'm not going to have this caper for the rest of my life. And I just gave up the medication, felt a lot better, tried to think positive, didn't see doctors so I didn't get stressed, just carried on really. ( ) I had to make the best of a bad situation ( ) and there really was no help in finding myself sorting myself out as Wayne not as a gay person. Sorting out my confidence and things like that so I had no choice but to do it. I had to do it myself or I'd be a victim forever, you know. Victim of the system.* (Wayne – IV 34)

The thematic analysis of the dataset identified three themes in relation to lesbians' and gay men's mental health care experiences when they are coming out. These three themes of non-disclosure, pathologisation and silencing will be explored further in the next chapter in the light of previous research and theory.

# Chapter 6: Mistaken identities through a Phenomenological Lens

Each of the three broad categories which emerged from the clustering of the preliminary themes in chapter five will be discussed in turn in relation to existing literature and research findings. This will be followed by a discussion of how these shared experiences can be understood and how this understanding can be informed by prior theory. The three themes which emerged from the Interpretative Phenomenological Analysis (IPA) were non-disclosure of sexual identity, experiences of being pathologised and experiences of being silenced. Following discussion of each of the themes, and through relating these themes to prior theory, the final stage of IPA is undertaken to arrive at a super-ordinate organising device. This lends further understanding to the shared aspects of people's mental health care experiences.

## Non-disclosure of Sexual Identity

It was seen in the previous chapter that several participants did not feel able to disclose their sexual identity to their mental health care practitioner, even though they felt that anxiety about their sexual identity was contributing to their mental health problems. The participants who described this experience were Josh, Oscar, Len, Jane, Simone and Sarah. The experiences of feeling unsafe to disclose lesbian or gay identity to health care practitioners have been found in other studies of lesbians' and gay men's experiences of health care. This has been found to be the case in relation to general health care (Paroski, 1987; Stevens, 1994b) and also in relation to mental health care (Bradford and Ryan, 1987; Hetrick and Martin, 1987; Golding, 1997; MacFarlane, 1998). Bradford and Ryan (1987) found in their survey that 10% of their sample had seen counsellors who they had felt unable to come out to. Golding (1997) found in her survey that 84% of the sample had concerns about disclosing their sexual identity to mainstream mental health service providers. Like the research participants in this study, they were concerned about being pathologised or experiencing other forms of stigmatisation or prejudice. MacFarlane (1998) also found that a number of participants in her study did not feel able to disclose their sexual identity because of worries about being pathologised or stigmatised. In Hetrick and Martin's (1987) study, nine of the lesbian and gay youth who were under treatment within mainstream services for suicide attempts had not told their therapist that they were lesbian or gay and that they felt their sexual identity was a factor in their suicide attempt.

There have been a number of studies which look at the effects of non-disclosure although none of these relate specifically to people who are in mental health care settings. There may be some psychological benefits from non-disclosure (e.g. Healy, 1993) and this becomes particularly important when individuals are negotiating their sexual identity in hostile environments (e.g. Clarke, 1996). However, non-disclosure is also associated with psychological strain (Berger, 1990; Cain, 1991). Griffin (1991) has discussed the effects of tensions between the fear of disclosure and wanting self-integrity and feelings of authenticity that can only come from disclosure, with isolation resulting from strategies involving passing, deception and secrecy. Markowe (1996) also found in her study that lesbian women identified a need for feelings of authenticity which could only be acquired through disclosure. Another study of lesbian physical education teachers found the continual need for identity management led to emotional distress including self-blame, internalised homophobia and apologetic, passive acceptance of a subordinate role (Squires and Sparkes, 1996, p. 84). Squires and Sparkes go on to describe how daily fear of detection leads to potential stress and how the willingness to compartmentalise falsely dichotomised private and public lives reflects powerlessness and oppression. Clarke (1996) argues that although lesbian identities can be successfully concealed the cost of maintaining a coherent but false heterosexual identity was dissonance, personal turmoil, anxiety, and inability to form close relationships with colleagues leading to isolation, lowering of self esteem and self destructive behaviour.

This non-disclosure of sexual identity can be further understood by looking at the experiences of those who did disclose. This sets the fear of non-disclosure in its social context of likely homophobic reactions from health care practitioners and other reactions. These reactions serve to convey the message that lesbian and gay identities are somehow undesirable and can somehow be discouraged. It will be seen that it is not only homophobia which operates here but also heterosexism; in this world view homosexuality is not necessarily pathologised, nor overt hatred directed towards lesbians and gay men. However, heterosexism operates through processes of invisibility in which the message that heterosexuality is superior, more valued and more desirable is conveyed. These concepts will be explored in more detail later in this chapter.

### Experiences of Being Pathologised

It can be seen that the fear of being pathologised in those who did not disclose their sexual identity, was realised for several of those who did disclose. The participants who described this experience were Roger, Wayne, Mandy, Jane, Julie, Charlotte and Nicki. As with non-disclosure, this experience of being pathologised has also been found in other studies of lesbians' and gay men's experiences of mental health care (Hetrick and Martin, 1987; Golding, 1997; Koffman, 1997; MacFarlane, 1998). In this study there were similar reports of experiences of lesbian and gay identity being seen as an immature or attention-seeking phase, something which would be grown out of, something which had a cause and therefore presumably a cure, or something which led in and of itself to mental health problems. It is not surprising that lesbians and gay men have such experiences if we look at the training which mental health care providers have and the pathological model of homosexuality which underpins their training. Homosexuality was not de-classified as a mental illness in the ICD (International Classification of Diseases) until 1992. This is the disease classification system used by British psychiatrists and psychologists. Although homosexuality as a disease was removed from the ICD in 1992 a further category was established called "Psychological and behavioural disorders associated with sexual development and orientation". Within this are listed "Sexual maturation disorder" and "Egodystonic sexual orientation". These new classifications incorporate ideas that mental illness arises from confusion and uncertainty about sexual orientation. Such classifications continue to pathologise lesbian and gay identities (Parker et al., 1995; Davies and Neal, 1996).

These psychiatric classifications are underwritten by a psychoanalytical model of homosexuality (Parker et al., 1995). Furthermore, many mental health care practitioners are influenced and trained within a psycho-analytical model of homosexuality (Ellis, 1994; Milton, 1998; Bartlett et al., 2001) and haven't received any training to counter negative social attitudes towards lesbians and gay men (Annesley and Coyle, 1995). The extent to which homophobic attitudes are embedded within some of the leading training institutions is epitomised in their policies of not admitting openly lesbian or gay candidates for training (Ellis, 1994; Phillips et al., 2001). Malley and Tasker (2001) argue that psychoanalytic thinking about homosexuality filters down to the psychiatric profession and also other health care practitioners. In a similar vein Markowe (1996) has pointed out the profound impact of psychoanalytic thinking on common-sense ideas. This dominant thinking, which is influenced by psychoanalysis, views lesbian and gay identities as immature, developmentally inferior to heterosexuality, and arising from a failure to resolve pre-oedipal wishes (Stevens and Hall, 1991; Coyle, 1998; Taylor, 2002). This translates into ideas that childhood sexual abuse will lead to such a state of "arrested development". It has been argued that this stance also underpins a pathologising model (Milton, 1998; Coyle et al., 1999). Pathologisation is part of the dominant discourse – the nature of discourses and dominant discourses was introduced in chapter three and is re-visited in chapter seven following the thematic exploration of experience in this chapter.

In previous studies, research participants who have been pathologised describe experiences where they were told that they were mistaken about their lesbian or gay identity, or that they could become heterosexual and that their mental health problems would dissipate if they did so (Golding, 1997). In this study Roger was quite clearly given the message that he should be able to leave his gay identity behind him and choose to be heterosexual. In previous research it has been found that young lesbians and gay men were likely to be told that their lesbian or gay identity was a phase which they would grow out of and that they were only saying they were lesbian or gay because they were attention seeking (Hetrick and Martin, 1987; Schneider, 1991; Koffman, 1997). In this study Nicki's experience was very much cast within that psychoanalytical model where lesbian identity is seen as immature and attention seeking and is similar to some of the cases described by Schneider. Nicki was also questioned about her certainty about her sexual identity implying that she could be mistaken. Charlotte also had the experience of having it suggested to her that her lesbian identity was a phase she would grow out of and at one point Julie was told that she had mistakenly believed she was a lesbian due to her mental illness.

Hetrick and Martin noted a number of years ago that to suggest to a young person that they are too young to know that they are lesbian or gay, or that it is a phase that they will grow out of serves to

> "reinforce the denial of membership in the hated group, partly through confirmation of the belief that to be homosexual is not a thing to be desired. The difficulty with such reinforcement is that it postpones and complicates the whole process of dealing with a stigmatised social identity" (Hetrick and Martin, 1987, p. 38).

The apparent practice of not taking young people seriously, and dismissing their sexual identity as a phase, is particularly worrying in the light of other research which shows that the younger people are when they become aware of their lesbian or gay identity the more likely they are to make a serious suicide attempt or have serious mental health problems (Remafadi et al., 1991; Schneider, 1991).

Another common experience reported in other studies was that of being told by mental health care practitioners that lesbian or gay identity had been caused by past sexual trauma or abuse (Golding, 1997; Koffman, 1997; Milton, 1998). Again this finding was also replicated in this study with Mandy, Jane and Julie describing health care encounters with psychiatrists and mental health nurses where this assertion was made. Charlotte also had a sense that her counsellor was searching for a cause for her lesbian identity. It was noted earlier that this stance underpins a pathologising approach to lesbian and gay identity formation and it is important to consider the effect this will have on the therapeutic encounter. As with approaches which convey the message that homosexuality is an immature phase, assertions that it is an abnormality caused by developmental problems is equally damaging to the self-esteem of someone trying to integrate an identity which is socially stigmatised. Julie described how she relied on the support of her consultant but his stance towards her lesbian identity made it difficult to accept herself and she felt this contributed to her mental illness. The finding that this unmet need for acceptance can impact on mental health comes from Vincke and Bolton's (1994) study. They found empirical evidence that low self-acceptance follows depression contingent on low social support rather then low self-acceptance precipitating depression.

Furthermore this focus on the presumed aetiology of homosexuality by practitioners means that life events which may explain people's mental health status are not considered and people are not offered support in relation to them. So Mandy, who identified her experiences of childhood sexual abuse as something with which she needed help, was not offered help in relation to this. In previous studies it was also found that there was this focus by practitioners on the cause of homosexuality rather than other potential factors which may have affected people's mental health (Golding, 1997; MacFarlane, 1998). Also in Golding's (1997) study people reported being told that they were confused about their sexuality when they themselves did not feel that they were. Mandy's experience echoes these findings and also Wayne experienced being told he was confused about his sexuality when he felt that he was not. Again that other factors which may have contributed to mental health problems were not considered. It would seem from Wayne's account that he was probably diagnosed as suffering from "Egodystonic sexual orientation" which, as noted earlier, is listed in the

International Classification of Diseases. Although Wayne said that he felt quite positive about his sexual identity and was living openly with his male partner he said that all the mental health staff caring for him were convinced that his severe depression arose from non-acceptance of his sexuality. He was never offered any therapeutic space in which to explore other possible reasons for his depression such as homophobic bullying which Rivers' recent study showed is linked to long term mental health problems (Rivers, 1997a; Rivers, 1999; Rivers, 2000).

### Experiences of Being Silenced

In this study lesbians and gay men found that they were silenced about their sexual identity in a number of ways during mental health care encounters. These were through having issues relating to sexual identity ignored or trivialised, being told not to discuss such issues, and caring relationships being withdrawn. The participants who described this experience of being silenced were Alec, Roger, Sandra, Sarah and Julie. Again these findings are similar to those from other recent studies of lesbians' and gay men's experiences of mental health care (Proctor, 1994; Annesley and Coyle, 1998; MacFarlane, 1998). The silencing of lesbian and gay voices has also been noted in relation to psychotherapeutic training, texts and practice (Coyle, 1998; Milton and Coyle, 1999). Some of the experiences of being silenced were ones such as Sandra's where the health care practitioner made a statement to the effect that they were not prejudiced themselves but failed to pick up on whether there were any issues relating to sexual identity which might need to be explored. Such displays of liberalism, it has been argued can serve to deny differences and are oppressive in that they fail to acknowledge the stress related to being lesbian or gay in a homophobic culture (Kitzinger, 1989; Burns, 1992; Seidler, 1994; Hardman, 1997; Annesley and Coyle, 1998). They have also been identified as a subtle form of prejudice (Coyle et al., 1999; Peel, 2002).

A further understanding of liberal discursive practices in society may help to illuminate these reported health care experiences and the associated feelings of blame and responsibility. In the context of psychiatry, Parker et al (1995, p. 8) have remarked that this "rhetoric on the individuality (of the patient) functions to wrench the person from the various social contexts that have contributed to their distress". Furthermore, the discursive practices inscribed by the dominant value system of liberal humanism are only one short step away from victim-blaming (Parker et al., 1995; Nightingale and

Cromby, 1999). Such victim-blaming was seen in Julie and Roger's accounts where they were told by nurses and doctors to "sort themselves out" or "pull themselves together". It is important to consider this further as liberal humanism underpins the dominant value system and ethic in nursing. It is important to address this for any advances made in the de-pathologisation of homosexuality are followed by the re-entrenchment of homophobia through the erasure, invisibility and silencing of lesbian and gay experience. There could perhaps be no more ripe a site for such reinscription of homophobia than in nursing which is thoroughly immersed in a liberal humanist discourse of individualised patient care with its inherent dualisms of same/ different, public/private, self/society.

The approach of individualised patient care has been noted to fail remarkably when applied to groups who do not fit within dominant cultural norms (e.g. Marshall et al., 1998; Gerrish, 2000). Where the concept of individualised patient care has been problematised, it has been in the context of critical social theory (Wilson-Thomas, 1995) or the application of postmodern ideas to understanding the disciplining and positioning of the nursing profession (Lister, 1997) or, most saliently, through work on inequalities in health care (Hart and Lockey, 2002). Gerrish (1997), in her observational study of community nurses, found that cultural difference, and nursing care responsive to such difference, was not easily accommodated within the ideology of individualised patient care. She argued that the whole concept was ethnocentric and in practice served to further disadvantage minority groups. A parallel argument can be made here that the individualized patient care approach is also profoundly heterocentric and serves to reinforce the oppression which in many cases has brought people to mental health care settings in the first place. The denial of difference (see the slippage from "we treat everyone the same" to "we are not bothered by homosexuality" to "don't talk about that here because it is of no concern to anyone else") reproduces the violence of erasure and the violence of Othering on the outside which has brought this person to the inside of a mental health care setting; that this denial of difference can be so disingenuously framed within an apparently humanist and holistic approach to care makes it profoundly damaging and disempowering leaving little room to resist pathological positioning for the person who is presenting with mental health problems relating to their struggle with their sexual identity.

Hart and Lockey (2002), following on from their study of disadvantaged groups of women in relation to midwifery care, argued that the concept of individualised care enshrines a liberal approach to inequality which rarely takes account of structural issues. Most importantly they argue that health care workers, socialised into this individualistic way of practicing, are rarely able to understand the relationship between difference and disadvantage. In a similar vein, McDonald and Anderson have argued that individualism and heteronormativity within nursing have led to

> "resistance within the discipline to value and research social determinants of health (which) raises questions about our complicity in dominant ideologies of health and healthcare" (McDonald and Anderson, 2003, p. 698).

They go on to argue that "when nurses have an increased knowledge and awareness of power structures in the health care system, they can more effectively participate in disrupting them" (McDonald and Anderson, 2003, p. 709) and taking material-discursive research into health care experience as an example, they say such research can be used to disrupt heteronormativity in nursing discourse.

### Effects of Pathologisation and Silencing

It can be seen from the previous discussion that in different ways lesbians and gay men receive a clear message in their mental health care encounters that their sexual identities are abnormal, undesirable and not to be encouraged. For those who fear disclosure there is no clear message to counter concerns about such reactions. It is important to ask what the effect of these messages is likely to be on someone's mental health. As discussed before, Hetrick and Martin (1987) have argued that such reactions in health care providers will inflict further damage on the self-esteem of someone who is trying to integrate a stigmatised identity. It is apparent that some research participants, such as Mandy, Nicki, Charlotte and Wayne, disclosed their sexual identity with relative ease because they did not feel that it was related to their mental health problems and they had felt quite positive about their lesbian or gay identity up until this point. However, for some of these participants being questioned about their certainty about their sexual identity and possible (pathologising) reasons for it led to confusion and distress.

Breakwell (1986) has argued that if people's coping mechanisms are disrupted when their identity is threatened, then it is likely that mental illness will ensue. Both Giddens (1991) and Breakwell (1986; 1992) assume a position that threats to identity require some kind of work and psychic re-organisation. Some of the coping mechanisms which Breakwell describes which are relevant to people coping with a stigmatised sexual identity are changes in self-definition and support structures which allow re-evaluation of a previously learnt negative social representation. In the mental health care encounters described in this study, it can be seen how negative messages about lesbian and gay identities will disrupt existing coping mechanisms, or fail to encourage the development of effective coping mechanisms. Research participants such as Mandy, Charlotte and Wayne who had started off in their mental health care encounters feeling positive about their sexual identity had found their coping mechanisms disrupted leading to uncertainty and distress. For those who did not feel so positive about their gay or lesbian identity, such as Julie, these negative messages reinforced their feelings that there must be something wrong with them. Giddens (1991) has also argued that shame can result from feelings of not living up to ideals. Implicit or explicit messages from health care providers about the undesirability of lesbian and gay identities, either through pathologisation or through silencing will reinforce any feelings that lesbians and gay men have about failing to live up to ideals imposed by society's dominant values.

In order to understand this process better it will be useful to consider the broader social context in which these negative messages about lesbian and gay identities are heard in relation to dominant values and the processes which operate to reinforce dominant values. It is not only active discrimination through homophobia and pathologisation which is at work here but also heterosexism and the way that operates through silencing and invisibility. This takes us forward to a further analysis of the data to arrive at what Smith (1999) has called a super-ordinate device for understanding the shared experience of the research participants. The experiences of being pathologised and silenced can be understood as shared experiences in the wider social context of how minority and stigmatised groups are marginalised and oppressed. As Breakwell (1986; 1992) has said, these threats to identity and related coping strategies only make sense when seen in the light of dominant social beliefs and cultural expectations, and it is the subjective knowledge of the social world which is important. Both the processes of pathologisation and of being silenced render groups of people as "Other" from the dominant norms and values of society. This process of "Othering" and the way it operates for lesbians and gay men in their mental health care encounters will now be explored further.

### Experiences of "Othering"

Two of the main categories which emerged from the data of being pathologised and being silenced. It can also be argued that non-disclosure was a form of silencing as it occurred in a context where no clear message was conveyed that it would be safe to disclose. For the further analysis then, being silenced will include self-silencing and non-disclosure of sexual identity as well as being silenced or ignored following disclosure. What is common about these experiences of being pathologised and being silenced is that they both had the effect of casting lesbians and gay men as outside or "Other" in relation to dominant social norms and values. It is useful at this juncture to see how both pathologisation and silencing have been theorised in relation to this process of "Othering" and the ways in which it is considered to be oppressive. Pathologisation as a form of "Othering" will be discussed first.

Rutherford (1990b) argues that it is characteristic of the modern western world that identities are forged through polarities such as black/ white, or heterosexual/ homosexual in which one term is dominant and the other subordinate. He argues that through binarism, which operates in the same way as splitting and projection, the centre or dominant position, expels anxieties, contradictions and irrationalities onto the subordinate position. This process of marginalizing the Other is at the core of the violence and aversions of dominant discourses and identities as seen in practices such as racism and homophobia. Sibley (1995) further explores this process of creating the "Other" to show how those who are different are rendered deviant and excluded. This is often signified through representations of dirt, disease, pollution and ugliness in which negative stereotypes are created which simultaneously provoke feelings of repulsion and desire (Rutherford, 1990b).

Such splitting in which the acceptable is divided from the unacceptable often uses the strategy of stereotyping. Negative feelings are associated with such stereotypes and those assigned to stereotyped groups are excluded marginalized and oppressed (Hall, 1997b). Stereotypes accorded to groups who do not fit with or are different from dominant norms rely on symbolism which renders difference as pathological, deviant or unacceptable (Hall, 1997b). It was seen in chapter five that lesbians and gay men experienced being cast as "Other" in their mental health care experiences through being pathologised. Rendering someone who is different from societal norms and expectations as "Other" can be done through casting that person or group of people as sick or diseased (Sibley, 1995) and the pathologisation of homosexuality in medicine, psychiatry and psychology has a long and continuing history (Stevens and Hall, 1991; McColl, 1994; Davies and Neal, 1996). This representation of homosexuality as an illness has been part of the systematic oppression of lesbians and gay men (King and Bartlett, 1999) which marginalizes lesbian and gay voices and casts them as "Other" (Coyle, 1998).

This particular version of "Othering" which operates through the pathologisation of lesbian and gay identities can be understood as a sub-set of homophobia. However, "Othering" also takes place through less obvious forms of discrimination which is better explained by the concept of heterosexism. Plummer has defined heterosexism as

> "a diverse set of social practices - from the linguistic to the physical, in the public sphere and the private sphere - in an array of social arenas (e.g. work, home, school, media, church, courts, streets, etc.), in which the homo/hetero binary distinction is at work whereby heterosexuality is privileged" (Plummer, 1992b, p.19).

Garnets et al (1990) have described heterosexism as "an ideological system that denies, denigrates and stigmatizes any non heterosexual form of behaviour, identity, relationship or community" (Garnets et al., 1990, p. 369).

Butler (1993) has explained heterosexism further to show the way in which it operates to make it appear as if heterosexuality is natural and superior to lesbian and gay sexuality. It is thus a system which both privileges heterosexuality and makes it normative i.e. it is seen as a better, more desirable and more normal state so it can be seen from this that the pathologising of lesbian and gay identities renders them less normal, less desirable and inferior. Butler (1993) goes on to argue that the privileging of heterosexuality relies on the spectre of the Other which involves the full-scale rejection and repudiation of homosexuality. The effect of such a world view on those who do not or cannot fit into these norms is best explained by Segal who links this to identity; it is argued that we live in subjective worlds in which discourses about gender, tied inextricably with ideas about heterosexuality and the naturalness of both, are central to our sense of self (Segal, 1997).

Whereas homophobia and pathologisation operate through stereotyping and explicit actions and statements which imply deviance, heterosexism can also operate through what is not said and through what it taken for granted. Lesbians' and gay men's experiences of mental health care in which they were silenced are more within this realm. Butler has argued that the oppressive process of "Othering" can also take place through erasure, invisibility and "through the production of a domain of unthinkability and unnameability" (Butler, 1991, p.20). Absence and silence impart a message that something is unimportant, shameful or doesn't exist (Wilton, 2000). It can be seen from research participants accounts, such as Alec's in which he felt rebuffed, and Sarah's in which all her hints were ignored, and Julie's where she was told not to raise certain issues in group therapy, that erasure of lesbian and gay identities is operating. They were being given a clear message that this is a realm which cannot be spoken about and which is implicitly unacceptable.

In health care this domain of unthinkability and unnameability means that lesbians and gay men have little in the way of reliable information to help them manage their identity. If invisibility is sustained then the only information available to most lesbians and gay men is based on negative cultural stereotypes. A possible consequence of invisibility is that the most readily available negative images become internalised leading to a negative view of one's self (Richardson, 1981). This introjection is often referred to as internalised homophobia (Malyon, 1982; Sophie, 1987; Meyer and Dean, 1998). A further consequence of silencing is that it leads to and contributes to the isolation of lesbians and gay men who are unable to find images with which they can identify (Markowe, 1996). Such isolation is thought to contribute further to lowering self esteem (Wilton, 2000) and symptoms of emotional disturbance which resolve rapidly once lesbians and gay men are exposed to non-stereotypical role models and peer support (Hetrick and Martin, 1987). Robertson (1992) discusses how assumptions of heterosexuality in health care contribute to the invisibility of lesbians and the perpetuation of negative experiences. Silencing has also been found to disrupt coping mechanisms (Flowers and Buston, 2001) and to lead to the exacerbation of mental health problems (Proctor, 1994). Garnets et al (1990) have described the task of coming out as part of the inter-related challenge of overcoming internalized homophobia created by heterosexist stigma which involves a "process of reclaiming disowned or devalued parts of the self, and developing an identity into which one's sexuality is well integrated" (Garnets et al., 1990, p. 369). It can be seen though that many people's mental health care experiences of being "Othered", through pathologisation and through being silenced, will have the opposite effect and will reinforce internalised homophobia rather than helping lesbians and gay men to overcome it.

What is most useful about Butler's understanding of the ways in which lesbians and gay men are "Othered" is that it shows how pathologisation and silencing operate together to marginalise and oppress. As noted earlier homophobia operates through explicit prejudice and discrimination in which lesbian and gay identities are repudiated whereas heterosexism operates through what is assumed and also what is not said. Fuss (1989) has observed that much theory to date has looked either at homophobia or heterosexism but there is a need to understand how they operate together in order to account for both the social and the psychological. It can be seen from the previous analysis that some research participants in this study experienced both pathologising and silencing simultaneously; for instance Julie was given the message by her psychiatrist that her ideas about her sexuality were mistaken due to her illness and previous childhood experiences but also given the message that her sexual identity was not something which she could explore or try to come to terms with. Her lesbian identity was negated and silenced by being told that she was mistaken at the same time as being pathologised. Other research participants, such as Nicki, Alec and Charlotte were simultaneously pathologised and silenced; they were pathologised by being told their sexual identity was a phase or had been caused by abuse, and at the same time they were silenced by being told that they might yet discover that they were heterosexual, by being encouraged to focus on heterosexual relationships.

### Resistance to being "Othered"

It has been seen that several participants did not disclose their sexual identity, or stopped discussing it or avoided further health care interactions because of feelings that they had been pathologised. Again this confirms findings from previous studies (Stevens, 1994b; MacFarlane, 1998). This can be seen in a broader context of resistance to being "Othered". Most of the work on resistance to being Othered has taken place in the context of understanding how alternative lesbian and gay communities and lesbian and gay identity politics develop (e.g. Fuss, 1991; Butler, 1993; Bell and Valentine, 1995; Duncan, 1996). However, this space is not generally available to people who have mental health problems associated with the coming out process. However studies in other areas of health care may help to understand this process of resistance. Heaphy (1996) has considered the ways in which the identities of people with AIDS or HIV (PWA/HIV) are negotiated in relation to interactions with medical practitioners and health care professionals. Heaphy suggests that Gidden's (1991) work provides a clearer way of understanding how such resistance comes into play and describes the ways in which PWA/HIV resist the dominant discourse of the health care professionals and its attendant policing and judging. The main strategy identified by Heaphy in his study of PWA/HIV was silence which was used to resist medical practitioners attempts to know them and place them in terms of categories of normality which are arguably part of a process of pathologising and disciplining (Heaphy, 1998)

Huby (1997) has also argued that silence in medical encounters may be an effort by the patient to prevent the powerful and invasive medical system from disrupting their own coping strategies. Bloor and MacIntosh (1990) observed a number of strategies of resistance to medical surveillance by health visitors amongst working class mothers, and within therapeutic communities. They noted that concealment was a common strategy which provided a way of gaining control without confrontation. Others have argued that non-utilisation of services and non-compliance to professional advice by minority-ethnic populations, can also be interpreted as a form of resistance to the dominant culture and its "imposed and stigmatising cultural and community identities" (Abdulrahim, 1998, p. 42).

Self-silencing and non-disclosure serve to act as protective strategies. However, in the context of presenting for health care with the very thing that cannot be spoken about, it is important to ask what the effect of this is and whether any further understanding and analysis of the data can help to illuminate a path towards improving access to care. The whole process of being "Othered", whether it is through pathologisation or through erasure, relies on a dualistic framework of binary opposites in which one position is subordinate and inferior. In this case heterosexuality is seen as normal and privileged over other forms of sexuality whereas lesbian and gay identities are cast as deviant, abnormal, undesirable and unspeakable (Fuss, 1989; Fuss, 1991). It is at this point that a more discursive analysis, which explores how dualisms operate, will help to further understand the difficulties research participants had in negotiating a path in which it was possible to explore uncertainties and any negative feelings about their sexual identity and the impact of that on their mental health. This will be further explored in the next chapters through a discursive analysis, using deconstruction and positioning theory.

If nurses and other health care professionals are to engage with the findings from this thesis thus far, there is a need to not only repudiate pathologising inscriptions of lesbians and gay men, which included unsubscribing to arguments that suggest homosexuality is a phase which patients will (hopefully) grow out of, but there is also a need to engage with and disrupt heteronormative discourses. In the absence of overt pathologisation, these discourses continue covertly to pathologise lesbian and gay identities through invisibility, silencing and erasure. Without this further step, the overturning of one dualism through which oppression is operated, will simply be replaced by another. The discursive practices which will step into any void created by the abandonment of pathologisation are encoded within liberal and individualized approaches to care and are not easily shaken off. These practices are those which deny difference and the impact of the social whilst at the same time claiming to be treating patients as individuals.

## Chapter 7: Resistance and Renegotiation; A Discursive Analysis of Resistance to Mistaken Identities

In chapters five and six the thematic analysis using IPA led to three broad categories; these related to non-disclosure of sexual identity in mental health care encounters and the pathologisation and silencing of those who did disclose. These three broad categories were organised under a super-ordinate theme of experiences of being "Othered". It was clear in the thematic analysis that lesbians and gay men were subjected to the dominant discourse of homosexuality as mental illness (i.e. a pathologising discourse) in their mental health care encounters. Dominant discourses operate through institutional bases such as medicine or the family and they "may be considered as regimes of truth that determine what counts as important, relevant or truthful" (Manias and Street, 2000, p. 53). The dominant discourse, in which homosexuality is seen as a mental illness, has been well documented as a feature of society in general and medicine in particular (Parker et al., 1995; Wilton, 2000; Taylor, 2002). In order to make more sense of how people negotiate health care, when pathologisation is the dominant discourse, it is necessary to ask how lesbians and gay men are positioned and how they position themselves in relation to this. This was done using Parker's (1992) framework of steps in the analysis of discourse as outlined in chapter three.

The coding of interview data into categories and themes which was done in chapter five fulfilled the requirements of the first stage of the analysis of discourse. Whilst conducting the IPA the researcher was mindful of the further layer of analysis to be conducted and remained sensitive to "the connotations, allusions and implications which the texts evoke(d)" (Parker, 1992, p. 7) in order to achieve this. The next stage of the discursive analysis, again following Parker's (1992) framework, involved looking at the data to identify the discursive meanings which participants constructed in relation to lesbian and gay identities and then to look at how they were positioned and positioned themselves in relation to available discourses. The data were then analysed to identify the discursive meanings which participants constructed in relation to lesbian and gay identities. The next stage, following Parker's steps, was to look at the way that discourses contain subjects and to consider the ways in which subjects were positioned by the discourses so far identified; Parker states that in Althusserian terms we have to ask how a discourse is hailing us and what rights we have to speak when positioned by a discourse.

The discursive meanings for participants about being lesbian or gay were embedded in their concerns about disclosure seen in chapter five; most participants had concerns about being seen as a freak, as disgusting, as sexually predatory, or as immature. There were many examples in chapter five of how lesbians and gay men reported directly being pathologised themselves as a result of disclosing their sexuality in a health care encounter. Some participants also talked about their awareness of this as a general discourse within psychiatry even if they did not disclose their sexual identity[6]:

> *I'd also heard in hospital psychiatrists talking about homosexuality as if it was an illness. You know, okay, she's got psychosis, she's delusional, she can't sleep – and she's gay. (). Again it was another symptom.* (Jane – IV 8)

This dominant discourse of homosexuality as illness was also experienced by lesbians and gay men in their interactions with their families. Max talked about how his grandmother suggested he be taken for a cure for his homosexuality and Jack also talked about how his mother suggested that he could be cured in relation to his sexual identity:

> *My Nan, you know, she turned round to my mum and said 'Oh there's injections for being gay ( ) take him down the hospital and get him sorted out'.* (Max – IV 16)
>
> *(My Mum) said 'If there was a problem with your washing machine you'd go out and fix it'. She said 'It's obviously something you ( ) if something goes wrong in nature, try and heal it'.* (Jack – IV 3)

As well as these discursive meanings in which lesbian and gay identities were constructed as unnatural and perverted, participants were concerned about being rejected, ostracised and punished. Oscar's account reflects these concerns when he talks about why he did not disclose his sexual identity to his GP even though he felt it was implicated in his mental health problems at the time:

> *If my parents found out they would probably have crucified me, then it could have gotten back to school, where I was already having problems () and as was proved at college, these things have a nasty habit of getting round. There's nothing people like better than a piece of tittle-tattle. And really fear of alienating myself even further from those people who possibly weren't too bad. Not that there were very many of those, but certainly mates at school.* (Oscar – IV 36)

Patrick suffered from physical and sexual abuse from two different nurses when he was an in-patient in a psychiatric hospital. He felt that this was some sort of punishment

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[6] Verbatim extracts from the interviews are shown as indented quotations in italics; empty brackets indicate that material has been omitted, information in brackets has been added to provide clarification and ellipsis points (…) indicate silences or a pause in the flow of speech following the convention by (Golsworthy and Coyle, 1999)

suggesting further that the discursive meanings associated with homosexuality are that it is bad and punishable:

> *And I did feel, especially after the incident (of being sexually abused by a nurse) () I did feel that there was probably, I was probably being punished for my sexuality. Um I mean, he took advantage of me and then when it appeared that I was going to come up and say something he knocked me senseless, you know. (And then with the other nurse who sexually abused me) I thought, well is he trying to teach me some sort of lesson. Is this supposed to put me off from being gay. It did appear that he might have been doing that.* (Patrick – IV 29)

Julie's account of how she perceived her parents to find mental illness less stigmatising and shameful than homosexuality is another powerful example of the negative discursive meanings attached to lesbian and gay identities:

> *When I got really thin and I didn't really care about anything, couldn't really think about – that's why I became anorexic I think, you know I was so thin I couldn't think about anything let alone have any feelings, sexual feelings so (). I just wanted to disappear so you know, that seemed to be a good way of doing it, and er my parents found that much more acceptable to focus on than my sexuality, so instead of them just being embarrassed about it all they could say oh our daughter, you know, she's mentally ill, she's got anorexia, you know?* (Julie – IV 42)

Ranjit also talked about how homosexuality was constructed as something shameful:

> *I feel very, very ashamed of myself (). I will feel very, very guilty that (...) I let my family down and most importantly I've let my children down.* (Ranjit – IV 21)

The discursive constructions of homosexuality as bad and sinful were particularly strong for participants who were part of faith communities. They were particularly concerned with being cast out by their families and communities and being rejected and punished. Simon, Tim and Jane had grown up within Christian faith communities and they felt very strongly that they would be ostracised by their communities if anyone knew about their sexual identity. Anwar was part of a Muslim community and also felt that he would be cast out. Ranjit, who was part of a Sikh community feared for his life and thought that if people in his community found out they would find him and possibly kill him:

> *I thought I would have to give up my Christianity (...) um (...) I suppose I wouldn't have actually have given up everything of it. I, I probably would have stopped going to church um and I would have lost contact with a lot of people that I've known for a long time.* (IV 23 – Simon)

> *And so, I was worried that that I would, um be rejected from the church and um rejected from my friends and that I'd find myself in an isolated position.* (Tim – IV 24)

> *It was like in my head when I was like fifteen and stuff, it was either you're straight or you're completely on your own. People turn their backs on you in the street, spit at you, stuff like that. And that was horrible, really isolating, but fit with what I knew with church as well about being punished and all that.* (Jane – IV 8)

> *Oh it's so sad, it really, really is. And how it affects your state of mind because the way I felt is that I came from this huge extended family so yeah, I never really needed to have friends for external support, I had two wonderful parents and all these siblings and all these cousins and I actually think that that kind of environment is brilliant to grow up in and I wouldn't change it for the world and I was in that and I was loving it and it's incredibly supportive and it's incredibly stable, generally speaking, but it's only those things as long as you conform.* (Anwar – IV 10)

> *If people in my Gurdwara, in my Sikh temple found out I think they would probably, they would probably want to execute me or something. () I think they would probably want to exterminate me (). (My friend) says to me 'The way you defend gay people I think you're gay' () he says that if he found out that anybody, any of my friends were gay (...) he'd shoot the hell out of them and I've been friends with him for five or six years. ( ) I feel (...) trapped in a cage ( ) wherever I went, wherever I go we've got cousins in almost in every city in the UK and Wales and Scotland. People would hunt me down.* (Ranjit – IV 21)

On many occasions participants in this study were positioned as "Other" in terms of discursive positions in which homosexuality is constructed as mad or bad with consequences of rejection and punishment or "treatment". In the context of mental health encounters this positioning was more likely to occur within the dominant discourse of homosexuality as mental illness i.e. their homosexuality was seen as a mental illness or psychological maladjustment by mental health care practitioners. As discussed in chapters three and four, such positions within discourses can be accepted, rejected or resisted. There were few examples in the data of people accepting the dominant discourse of homosexuality as psychopathology but many examples of rejection and resistance.

One striking example of being positioned and positioning oneself within the dominant discourse of homosexuality as a mental illness was found in Patrick's account. Patrick was admitted to a psychiatric hospital as a teenager and he had this to say about how he viewed his situation at that time:

> *It was kind of like um it didn't matter if I was gay there because I was mad anyway so you know, what did it matter. It was kind of () it was almost like I was in the right place.* (Patrick – IV 29)

This part of Patrick's account suggests that at the time he accepted the positioning of homosexuality as mental illness. Earlier, part of Max's account showed how he was positioned by a member of his family as ill. Max went on to recount how being positioned as mentally ill by his family led to him also positioning himself within that pathologising discourse:

> *My Nan said 'There's injections for being gay', do you know what I mean, 'take him down the hospital and get him sorted out', do you know what I mean. () and that's when I thought I was a real, I was ill, do you know what I mean () because I didn't, you know, they were my family, I looked up to them anyway, do you know what I mean.* (Max – IV 16)

Julie and Fiona also gave accounts in which they positioned themselves as having a mental illness which was related to their sexual identity:

> *I'm sure that if I wasn't confused about my sexuality I'd have a clearer identity and I wouldn't have become depressed, I don't think that would have happened. () I just cannot merge the two lives, and just, maybe it will come with time, but when I do try to merge them I get really unsettled and a bit mad.* (Julie – IV 42)

> *I think my life would be a lot easier if I was straight () I'm not happy being gay () Why do I have to be gay? (). I just think for the rest of my life really I'll suffer from depression, I'll suffer from anxiety, anxiety I think is my problem, not depression sorry, and you know and I, I wish I didn't, and I know a lot of that is to do with being gay, I know it is, and of course you just feel like giving up, I mean I feel like giving up.* (Fiona – IV 43)

In stark contrast other accounts suggest a wholesale rejection of such positioning. Charlotte was quite clear that her mental health problems were unrelated to her sexual identity:

> *I knew that that wasn't the reason why I was depressed, I've always been positive to the fact that no, my sexuality's got nothing to do with the fact.* (Charlotte - IV 12)

Mandy was also quite clear in her account that her mental health problems related to her experiences of childhood sexual abuse and were unrelated to her sexual identity:

> *I was quite secure about the way I felt about men. I was quite secure about my sexuality.* (Mandy - IV 1)

She vehemently rejected being positioned within a pathologising discourse as seen in chapter five when she described how she walked out of the health care encounter. Wayne also was clear in his rejection of being positioned as having a mental illness because of his sexual identity:

> *I developed quite severe depression at that time which the health care profession were quite worried about but at the same time they would only deal with the fact that I was gay and they were a little bit worried that I would deny that I was gay so they wanted to make sure I was. It was slightly the opposite to what I thought. (). There are all these professionals telling you you've got to leap from chandeliers and shout about it. () I was very fed up with the word gay, fed up with talking about it, and it seemed to be the be all and end all. It seemed to hide me.* (Wayne – IV 34)

It was clear from chapters four and five that the dominant discourse of homosexuality as mental illness was a significant factor in the mental health care experiences of lesbians and gay men. A further dimension to the normalising and disciplining nature of the expert discourse of homosexuality as pathology can be understood through a further exploration of its dichotomies. Polarities are chronically embedded in discursive structures which are unconsciously reproduced to maintain expert systems and preserve the social order (Merttens, 1998). There were polarised positions which could be taken by participants. They could position themselves as being lesbian or gay with their sexual identity being unrelated to their mental health problems as seen in the accounts of Wayne, Mandy and Charlotte. Alternatively they could accept the dominant discourse as seen in Patrick, Julie, Fiona and Max's cases. Another polarised set of opposing positions was reflected in the stances taken by practitioners. From participants' accounts, it would seem that practitioners either saw homosexuality as the cause of mental illness (the pathologising position seen in the accounts of Mandy, Jane, Julie, Charlotte, Nicki, Roger and Wayne) or they seemed to dismiss it as completely unrelated (reflected especially in Sandra's account). So the accounts point to positioning, and positions being taken up or rejected which are polar opposites.

Further interrogation of the data, in which contradictions and tensions in the data were analysed showed where participants resisted rather than rejected or accepted the positioning of the dominant discourse. This stage of the data analysis used Parker's (1992) approach to identifying positions available within a discourse by asking what kind of space the discourse makes available for particular kinds of self to step in. It also involved using Willig's (2000) understanding of how discursive positions are appropriated or resisted by individuals and how they come to form part of an individual's subjectivity. In order to conduct this stage of the analysis particular attention was paid to silences, hesitations, contradictions and awkward moments during interviews (Gillies and Willig, 1997; Yardley, 1997b; Harden and Willig, 1998; Willig, 1998a; Yardley, 1998).

It was noted in chapter four that some interviews gave an overall impression of how a person presented themselves in terms of "coming out" and their mental health; in some interviews participants gave an account that suggested they were confident about their sexual identity but on some occasions new material was introduced at the end of, or after, an interview which contradicted this. For instance after an interview a participant (who had suggested throughout the interview that they had disclosed their sexual identity to all the significant people in their life) might express concerns about telling their housemates or one of their parents about the research interview as they had not yet "come-out" to those people. Notable silences were also observed early on in the research process. This noting of contradictions and silences were amongst the reasons for taking an epistemological position, and seeking a method of analysis, which would allow closer examination of these tensions in the data.

Silences were noted during some participants' accounts and these often happened at times during the interview when participants were talking about an episode in their life when they were likely to be positioned within a pathologising discourse, either by mental health care practitioners or by friends and family. For instance, Mandy was talking about a friend who had recently had a baby and how the father of the baby refused to let her be involved with the baby. The following extract from the interview shows how Mandy (IV – 1) became silent when asked to speculate on why she had not been allowed to look after the baby[7]:

> *M: He wouldn't even let me look after their little girl, despite the fact that I'd been there all the way through the pregnancy, all the way through the birth and was looking after her all that time but he wouldn't let me see their little girl and that was quite hurtful. ( )*
> *H: What did he think would happen if you looked after his little girl?*
> *M: Um, to be honest, I don't know, I don't know. I don't think he knew, that was something that he had to explore to find out, which was fair play to him, he wanted to protect his little girl (...). But it was (...) he realised in the end that he didn't need to protect her from (...).*

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[7] In extracts where the interviewer's talk is included, it is prefixed by "H" with the participant prefixed by the initial of their first name (pseudonym)

There are notable silences in this part of the interview – Mandy doesn't finish her sentence when she refers to what the baby might need to be protected from. In a similar way Mandy became silent again when asked to discuss further how she had felt when the psychologist she had seen said that her lesbian sexual identity was caused by childhood sexual abuse:

> *I don't know. I don't know, I didn't go down that (...) I don't know what the consequence is going to be.* (Mandy – IV 1)

Simon had a similar response when he was asked during his interview about what his concerns were about disclosing his anxieties about his sexual identity to his doctor:

> *I probably thought that (...) um (...) Don't really know. Can't think about it (...) Anyway um (...).* (Simon – IV 23)

Jane's account clearly shows how she used silence as a strategy of resistance to pathologisation when she was an in-patient in a psychiatric hospital:

> *It was one of those things that I knew but I had to deny. () I mean I was sat in a psychiatric hospital and I didn't want to face that one because it would have just (...). It had such a big impact that I would have found it really difficult to cope with, but because of the stigma and people, everybody else's opinions, they would have found it difficult to cope with as well, so it's not like I would have just had to face up to it, they would have had to face up to it and I would have had to face up to their reactions and protect myself against them as well. I couldn't do that. It was too difficult. () I just remember at the time how I felt, it made me feel so isolated because it was like I knew but I couldn't know, because if I did it was just going to be another one of my symptoms.* (Jane – IV 8)

Charlotte's account also suggests silence as a strategy of resistance to a pathologising discourse:

> *The reason I didn't tell my mum or anyone in my life was that I'm afraid that people are going to say to me it's just a phase, you'll get over it.* (Charlotte – IV 12)

These silences in people's accounts, and Jane's account of using silence, can be seen as strategies of resistance to be being positioned within a pathologising discourse. As well as these silences in people's accounts, and their accounts of using silence, there were also contradictions both within and across accounts. These contradictions are a reflection of the polarised discursive positions available; the contradictions within accounts can also be taken as signs of resistance to being positioned within a pathologising discourse. Those contradictions across accounts were found where some participants firmly positioned themselves as having mental health problems which were unrelated to sexual identity issues (e.g. Wayne and Mandy) whereas others, such as Patrick, Julie and Fiona, positioned themselves as having mental health problems more directly related to sexual identity issues. The contradictions within participants' accounts included Nicki's where she positioned herself as both confused and not confused about her sexuality:

> *The confusion about it has stayed and got worse. I don't doubt myself anymore, I just doubt absolutely everything else. () it doesn't bother me, it's just me (). I'm not confused now about my sexuality anymore. Did I just say that? It's true anyway. I'm not confused about that anymore. I know that bit.* (Nicki – IV 31)

Len also positioned himself differently at various points in his interview – early on in the interview he positioned himself as suffering from depression because of his sexual identity but later in the interview he says that they were unrelated:

> *I was depressed and I didn't know why, but I think deep down it was all to do with my sexuality, and the doctor was actually very concerned um because I think at the time I felt suicidal as well (). I can't explain it, I don't know why I suffer, like I say I think we're all potential candidates for depression, it's just - I just think it's, it's an illness and it's something that you can get treatment for () . So I mean I don't blame me being gay for my depression.* (Len – IV 39)

It was seen earlier that Charlotte was very definite that her sexual identity and her depression were unrelated – i.e. she positioned herself against the pathologising discourse. However, again if her account is analysed further there are contradictions within it. Charlotte alternately attributed her mental health problems to her parents' divorce when she was a teenager or to her struggles with "coming out". She positions herself as having mental health problems unrelated to her sexual identity but then goes on to position herself as needing a lesbian helpline. In these extracts where she refers to "suppression" and "questions asked in my head" Charlotte is referring to her sexual identity:

> *I had to go on anti-depressants unfortunately, um that was when I was about sixteen (). I went to see my doctor and he just didn't really understand and I hadn't told him, I haven't sort of come out to him (). He prescribed me anti-depressants, and I mean it just seemed that that's what I was going through, depression, just you know sort of belated depression due to the divorce (of my parents) () and er my just my general well-being just went, just downhill, I don't know if it was a result of the questions being asked in my head all the time and the suppression, I don't, I think I might have struggled with it a little bit, um, whether it was the underlying problem or not I don't know, I don't think so. () I think that it doesn't help when you're harbouring, when you're bottling things up. () Well the doctor mentioned the counselling, but he didn't give me a name*

> *of, of anyone, um, er, you know I mean, I suppose if he had said to me, personally or given me like you've given me a list of helplines you know, is there anything on this helpline list that you might, might think might help you,, and if I had just maybe pointed out yeah, maybe that one, you know, may, the Lesbian helpline or anything like that.* (Charlotte - IV 12)

There is another aspect in the dominant discourse on homosexuality which may have an impact of the way that participants positioned themselves and struggled to negotiate their mental health care. In the dominant discourse, homosexuality is seen as fixed and determined and part of a bi-polar dichotomy against its opposite – heterosexuality (Fuss, 1989; Butler, 1990; Butler, 1991; Weeks, 1991; Richardson, 1996). This is usually referred to as essentialism and the pathologising discourse can be part of it in that lesbian and gay sexual identities are seen as being fixed and determined either by genetic or early childhood experiences. It can also be seen that in resisting pathologising positions, participants seeking mental health care also resisted essentialising positions. Both Lauren and Michael described mental health encounters where they were asked about their sexual fantasies as a way of ascertaining what their sexual identity was:

> *I started to go and see this psychiatrist but he was very very bizarre, very weird, and he just got straight into the um, like towards the end of the first session it was like straight into like masturbation and I was like 'Where are you coming from?'* (Lauren – IV 35)

> *(The psychiatrist) was sort of saying, he said, what you fantasise about when you masturbate is a really good sort of sign about how you feel. () I think at that point I was just sort of like after a distinct answer: yes or no. And from that I think I actually got the answer I was looking for. () And I thought well, okay, cos it's sort of coming from somebody that's sort of trained in that sort of field.* (Michael – IV 38)

Again it can be seen that a polarised discursive positioning is taking place here – people are either lesbian or gay or they are not. This can make the whole process of disclosure much more threatening to people's identities. Furthermore, the polarised positionings available within the dominant essentialising discourse can make it difficult for people to negotiate health care when they themselves feel uncertain about their sexual identity. In the first extract Lauren is talking about an episode in her life when she saw a psychiatrist. In the second extract Kate is talking about how she had attempted suicide at the age of ten and why she had been reluctant to seek any help with her concerns about her sexual identity:

> *I think, part of me was worried that he was going to turn round and say 'Yes you are gay', because then that would be admitting to it, um and part of me was frightened that he was going to turn round and say 'No, you're not really, it's just a phase you're going through and it will be OK'. Because I didn't want that either, so it was like I was just really sort of stuck that I didn't actually want to hear anything he said, because it was either going to confirm something or it was going to not confirm something and I didn't want anything confirmed. I wanted to stick along the middle there, like not really being anything, just there, not admitting to anything. Because then it wasn't reality, it wasn't the truth.* (Lauren – IV 35)

> *I knew I was but I didn't really want to admit it. () I think it was more the fact that if I turned round and said I'm gay then I am gay, () It would have confirmed it yeah I suppose and it was something that I didn't really want to do.* (Kate – IV 6)

Len also talked about how disclosing his sexual identity to his GP or his psychiatrist would have positioned him as definitely gay within a discourse in which it is seen as something fixed and definite:

> *I couldn't tell him, I could not tell him, so I guess I still hadn't accepted it myself (). If I had looked up and told the psychiatrist that yes I'm gay, that's the problem, um mm, I'm not quite sure what I'm trying to say now, because I mean I knew, I knew I was gay (). I guess confirming it was um a lot harder because of the way I was brought up I guess.* (Len – IV 39)

It has been shown then that the people in this study who were seeking mental health care, could accept or reject the polarised positionings available in the dominant discourse of homosexuality as something essentialised and fixed and homosexuality as pathology. It has also been demonstrated that these positionings can be resisted through silence and non-disclosure. Resistance was also seen in the contradictions within and across accounts. However, resistance to being positioned as pathological is particularly problematic for those participants who did have mental health problems which they, in part, attributed to their own conflict about their sexual identity and the associated stress in terms of being victimised or ostracised. Much of the work on resistance to dominant discourses about homosexuality has looked at how such resistance is played out in the forming of lesbian and gay communities (e.g. Rutherford, 1990a; Valentine, 1993; Bell and Valentine, 1995; Butler, 1995; Duncan, 1996).

However, to date no work has been done on how individuals might resist this discourse when they have no alternative community with which to identify as would be the case when individuals are still negotiating their own sexual identity, and furthermore when they do have mental health problems which they associate with their sexual identity. As noted in chapter three current research on the mental health care experiences of lesbians and gay men takes as given that mental health and sexual identity are unrelated and that any attempt to connect them is necessarily a form of pathologisation. There is no room within the polarised positions available for lesbians and gay men to deal with their uncertainties and conflicts about their sexual identity. This is reflected both in the current literature on health care experience and in these accounts of people's health care experiences. This is not surprising and a material-discursive approach can be drawn on to interpret these experiences. As Parker et al (1995) have argued, drawing on the work of Cixous (1975), the ubiquity of particular types of discourse makes its impossible for their subjects to 'think or even imagine an "elsewhere"'. For the participants in this study many of their silences could be interpreted as the inability to imagine an elsewhere. The polarised positioning available within dominant discourses is difficult to resist. However, further analysis of participants' accounts shows resistance which does begin to point to the "elsewhere" that can be so difficult to imagine. Parker et al note that people can resist being positioned by discourse:

> "for those who are able to grasp the action function of discourse, and are able to reflect upon themselves as the objects of a scientific discourse, there is the possibility of successfully resisting marginalization or devaluation" (Parker et al., 1995, p. 89).

Parker et al (Parker et al., 1995; Parker, 1998b) also say that successful resistance requires an overturning of polarities in order to make other spaces available. Again by further interrogation of the data it is possible to begin to see how the polarities can be overturned so that lesbians and gay men would be able to negotiate their mental health care from a position of uncertainty and conflict about their sexual identity. Annie talked about how she was confused about her sexual identity but at the same time was clear that she wanted to resist being pathologised and wanted help to deal with her concerns about her sexual identity:

> *It's like if somebody told me it's a phase or it's a difference, you know, like that's a part of you that's not healed, and especially because I feel confusion about it. And yes, if I did, you know, come with like I've had this confusion and yes it's going to be about that (...). They're not going to () understand the subtleties of that to help me negotiate that in an empowering way rather than telling me what (...).* (Annie – IV 41)

Fiona also talked about how she felt that her mental health problems stemmed from her conflict about her sexual identity and her difficulties in adjusting to life as a member of a group that is stigmatised and marginalised. In an earlier extract, it could be seen that she positioned herself as having mental health problems which were related to her sexual identity. However, she also resisted the pathologisation that might go with such an admission but that meant that she didn't feel able to work through these concerns.

> *If somebody said to me 'I'm gay and I'm feeling a bit depressed - I think I might go and see the doctor", I'd be going "no, because they'll think it's because you're gay".* (Fiona – IV 43)

Fiona went on to say later in her account that in order to be able to deal with her conflicts she would have to first be sure that a mental health practitioner wasn't going to position her within a pathologising discourse:

> *I think it's, like I say if GPs or doctors or whatever had the attitude that being gay wasn't all there was to you then it would be so much easier to say to them you know I, I'm not comfortable being gay. And their attitude would then be gay is normal would be fine, OK, well we do have somebody who helps people come to terms with them being gay um. () I think you know attitudes have got to be you know gay is normal but if you're not happy being gay or you've got a little bit of a problem coming to terms with being gay for whatever reason, you know then we do have somebody who will help you.* (Fiona - IV 43)

Nicki also said in her interview that she did feel she needed to work through her conflicts about her lesbian identity but couldn't do this unless she also knew that she was not going to be positioned within the pathologising discourse:

> *There probably are a few things that I could do with sorting out. But it's not something, it's something I would probably only talk about with (someone I already trust) if I knew (they weren't) going to make an issue of it, but having had so many people make an issue of it, it's really hard to try and do. () It just becomes – like if everything's put on the gay thing, then being gay is just part of you and everything's just part of you and nothing can be dealt with the way you are, and it makes it really hard to blow away a few cobwebs and get rid of some of your garbage, next to impossible to do it. I don't think it's really fair to put that on someone, decidedly off to make someone feel like that. But it happens all the time.* (Nicki – IV 31)

Both Fiona and Nicki's resistance to being positioned as pathological meant that they did not disclose their concerns about their sexual identity in mental health care encounters. Max also talked about the need to be de-pathologised but how this did not happen when he was referred to a counsellor:

> *I suppose really all I wanted somebody to do was to turn round and say you know oh it's not horrible to be gay, do you know what I mean, it's not unusual, do you know what I mean, it's normal, do you know what I mean, but no one did.* (Max – IV 16)

In a similar way Michael and Eve talked about how their mental health encounters left them without any further reference points with which to find out more about their sexual identities:

> *There could have been more feeling - somebody to associate with, rather than sort of just getting a cold yes or no answer from the psychiatrist. () I think that would have sort of put my mind at ease, would have sort of made me feel a lot better about myself, if I'd sort of known that somebody else had gone through those same sort of problems.* (Michael IV – 38)
>
> *Well, although she helped me sort of come to terms with things, I don't think she really provided me with any sort of further reference, like she could have, I mean even giving me say a rape crisis centre phone number or even an LGB switchboard number, or anything like that, there was no further information given, so both in terms of the rape and in terms of my sexuality most of the things I've, er, sort of learnt, have been through you know literature and materials because I wasn't given any other option.* (Eve – IV 13)

Ashley talked about this need for normalisation, which would allow an exploration of the specific stresses gay people experience, in relation to getting more understanding from a gay counsellor:

> *You need like a gay counsellor () just to make you look at things in a different way because I mean I was looking at things in a negative way all the time and like oh, do you know what I mean, and never being told that wasn't my fault, you know, you shouldn't be feeling like this, you haven't done that to deserve that and that's, yeah, if I had that, I think I would have been a lot better than I am now () it's just, yeah, it seems to be a bit more sympathy, not sympathy, sympathy's not the right word, more empathy, because when you sort of going through things, and yeah being gay you are exposed to a lot more crap than so-called straight people go through.* (Ashley – IV 47)

There were no examples in the participants' accounts of being able to successfully overturn the polarities and dominant discourses about homosexuality in mental health care encounters. This is important in terms of accessing health care. In the previous extracts it can be seen clearly that participants resisted pathologising positioning and expressed a need for lesbian and gay identities to be normalised. Although there were no examples of this happening in health care, some participants talked about how gay or lesbian community support (usually through an LGB youth group) had helped them to resist dominant discourses in which their identities were pathologised or "othered".

> *Possibly I would have benefited from meeting other gay people earlier. (), just knowing that they were normal ordinary people because I was never too sure, I only had what I saw on TV or what my dad told me to take into account, and I never had any real proof and I wanted to know what they were like, I had, I*

> *knew that they were ordinary people but I needed to meet them in order to be um to have my expectations proven.* (Lewis – IV 22)

> *I just felt really depressed about the whole thing. I felt like I hadn't really answered any questions and I just felt that I didn't fit in to society, I just felt really, oh, um, (...) very different and stuck out like a, you know, sharp stick, or something like that. I just (...) I hadn't been (...) Nobody had explained anything to me about the history of the gay community or anything like that - Stonewall. I just needed loads of questions answered. I needed to speak to somebody, just be with people, you know. And I hadn't had any of that. Just literally going to (the LGB youth group) and being with other people just gave me reassurance, you know.* (Josh – IV 2)

> *(The lesbian and gay youth group) is a good project because it, it supports people, you know people are very young when they come out. They say that pub environments are the best place for - but it isn't necessarily the best place for them to erm arrive and be on their own and em it's much better to be able to, to ask questions and to be in a safe, completely safe environment and that's the key is it's safe.* (Maynard – IV 27)

> *And then I met these two women from the helpline and I thought these are true lesbians and I'm like, am I going to be scared of them? And I wasn't. You know I thought like you were saying, like the stereotype, I thought I might be scared of them like they'd be quite hard or wouldn't want to know a little old sixteen year old sort of want to talk to me. But they were just really nice and just fun, friendly and chatty. You know we weren't always talking about gay issues, we were talking about everything really, college life and just stupid things, the weather and that, and it was like humanising the situation.* (Charlotte – IV 12)

The idea that lesbian and gay identities need to be normalised before care can be accessed is explored further in the next chapter in relation to internalised homophobia, gay affirmative therapy and further theory on how people cope with threatened identities. As has been seen in this chapter many lesbians and gay men who are trying to cope with a threatened identity, and who are seeking mental health care in order to try and integrate their sexual identity, do not get this sort of help from the helping professions. This is best summed up in a quote from Lauren:

> *I think it was like um, like cracking an egg with a sledge hammer kind of, a nut with a sledge hammer, it was like I didn't need to go and see the GP or a psychiatrist, you know that wasn't the problem, getting you know it wasn't, again I was sort of thinking like 'Why a psychiatrist, like am I sick in the head?' That kind of thing, and it was counselling I needed. ( ) I could have done that myself, I could have gone and found a counsellor, and done it that way, but I didn't know how to. So it was probably me I did it wrong in the first place anyway and then the doctor carried it on by sort of like sending me to the wrong place.* (Lauren – IV 35)

In beginning to theorise and understand resistance, it can be seen that the health care experience is not something which is done to people – people bring expectations, fears and hopes with them to the mental health care encounter – they are already struggling and resisting and negotiating their sexual identity in a socio-cultural-political context and health care is an extension of that context. The success of that negotiation depends partly on what the "patient" brings to that encounter and their resilience and it also depends on what they find when they get there. The "what they find when they get there" is the health care practitioner and the health care setting. A homophobic and/or heterosexist context and practitioner will make this negotiation of sexual identity all the more difficult and will reinforce dominant discourses about normality and acceptability. The next chapter explores further how problematic access to care is for this vulnerable group by bringing together the different layers of analysis of the mental health care experiences of lesbians and gay men.

## Chapter 8: Disintegrating the Dualisms and Reintegrating Identities

This chapter sets out to bring the different layers of analysis together and further develop theoretical understanding about how material and related discursive practices influence health care. It brings together the phenomenological experiences of pathologisation and silencing in health care with an understanding of how such practices are resisted and negotiated. This is done through further theoretical discussion about threatened identities and oppression, and through further exploration of how material differences such as the age, social class or culture of participants mediated the discursive practices of pathologisation and erasure.

The overall aim of this study was to investigate the mental health care experiences of lesbians and gay men when they are negotiating their sexual identity (or "coming-out"). The first research question asked how homophobia and heterosexism manifest themselves in mental health care encounters when lesbians and gay men are "coming-out". In Chapters five and seven there were clear accounts of lesbians and gay men being both silenced and pathologised in their mental health care encounters. These findings were commensurate with the extant literature. Silencing and pathologisation are clear manifestations of the ways in which homophobia and heterosexism operate in mental health care encounters when lesbians and gay men are "coming-out". The approach used to data analysis (IPA), with its underlying epistemological position, assumed a relationship between people's accounts and their experiences and thoughts about those experiences (Flowers et al., 1998). It could be argued, taking this critical realist position about the data analysed in this way, that these mental health care experiences were injurious. It can be seen from people's accounts that these negative experiences led to delays in seeking further health care. Again these findings are commensurate with the extant literature in which health care avoidance has been noted to be a consequence of homophobia in health care (e.g. Stevens, 1994b; MacFarlane, 1998; Scherzer, 2000).

These experiences also had implications for disclosure; both pathologisation and silencing made it more difficult for lesbian and gay participants to disclose their sexual identity to mental health care practitioners. Again this fits with, and corroborates, the findings from previous research studies (e.g. Dardick and Grady, 1980; Hitchcock and Wilson, 1992; Turner and Mallett, 1998; Henderson et al., 2002). If lesbians and gay men are presenting for mental health care and are unable to disclose an important piece of information about current causes of stress and anxiety in their lives, then this obviously acts as a barrier to obtaining appropriate health care. When pathologisation and silencing lead to non-disclosure and health care avoidance then a barrier to accessing equitable health care is in place.

The second aim of this research study was to explore how heterosexism and homophobia affect lesbians' and gay men's access to mental health care when they are "coming-out". It is abundantly clear from this study that silencing and pathologisation act as barriers to accessing health care, and again the extant literature is full of this (e.g. Stevens, 1992; Eliason, 1996; Peterson, 1996; Wilton, 1999). However, what is less clear from the existing literature and the first layer of analysis in this study, is the ways in which silencing and pathologisation operate in more complex ways. It is also less clear how heterosexism and pathologisation operate specifically in relation to lesbians and gay men who are themselves currently "coming-out" or negotiating their own sexual identities. The more complex ways in which homophobia and heterosexism can affect access to mental health care were found through a further layer of analysis; the researcher was initially alerted to the need for such further analysis through observation of tensions in the data and the resistance to "Othering" of which an exploration was begun in chapter six. This was explored further in chapter seven through analysis of discourse giving a multi-layered account of the data which had begun with the IPA. Whilst the IPA took a critical realist position assuming a relationship between people's accounts and experiences, the discursive analysis took a more problematic view of how people's accounts could be interpreted in order to try to make sense of some of the tensions and contradictions in the data. This approach to analysis allows a better understanding of the more complex ways in which homophobia and heterosexism operate.

It is contended here that that the mental health care experiences of silencing and pathologisation described by participants were deleterious to their mental health and affect access to care. In order to understand this it is useful to turn theoretically to the literature on gay-affirmative therapy, and to re-visit, in more depth, some of the literature already explored on internalised homophobia, minority stress and threatened identities. A first reading of the data, using IPA, points to deficiencies in clinical practice arising from ignorance and prejudiced attitudes. This signals a clear indication that health care professionals need further training to update their knowledge and skills and this point has already been made on a number of occasions (see Annesley and

Coyle, 1995; Davies, 1996; Milton, 1998). However, there is a further layer to the process of making practice more emancipatory which can come from a deeper understanding of the data. This deeper understanding comes from interrogating the data further to explore the contradictions and tensions in participants' accounts. A closer reading of the texts does reveal some insight into how practices need to change to allow the space to negotiate a non-pathologized sexual identity in mental health care encounters. This was done through the analysis of discourse which allowed an exploration of the tensions in participants' accounts and through understanding the data as both representing some concrete experience as well as revealing something about aspects of that experience which were ineffable and unsayable.

By sampling a group that was more diverse than many in other studies which seek to explore this issue, these unsayable aspects of experience came to the fore. By taking a material-discursive approach to the analysis, further understanding was enabled by simultaneously treating the data as both material and discursive; i.e. there was a material aspect to people's accounts as well as an element to these accounts which operated in a more discursive way. Participants were giving accounts of their material experiences and also simultaneously their accounts could be understood as operating at a discursive level i.e. their talk was **doing** something as well as **telling** something. The participants were giving accounts of their experiences of threatened identities and at the same time were resisting threats to their identity. In the same way that Heaphy (1998) saw interviews as accounts of resistance to medicalisation both within the health care experience and within the research interview itself, these accounts could be understood as also operating at both levels. Thus, the IPA revealed something about the health care experience and the discursive analysis revealed something about resistance to what was happening during those health care experiences and resistance within the interview itself.

As noted earlier, a return to the literature on internalised homophobia, minority stress and threatened identities and a turn to the theory developing in relation to gay-affirmative therapy helps to better understand this. It is vital to do this in order to move beyond a position which only highlights the grosser manifestations of homophobia and heterosexism in health care. Those who seek to apply discourse analysis have argued that interventions have to be tactical and provisional (Parker et al., 1995; Willig, 1999a) but with continued vigilance as new practices can "reassert the old problems in new guises" (Harper, 1999, p. 128). Clarke (1996), for instance talks about how new kinds of homophobia have emerged in ostensibly less oppressive times under the guise of liberal democratic pseudo tolerance. Others have also argued that liberal ideologies can uniquely reassert homophobia and that they do so principally through the way in which difference is ignored (e.g. Kitzinger, 1989; Seidler, 1994). This danger of unwittingly reproducing homophobia whilst endeavouring to improve practice will be returned to later in this chapter and in chapter nine where recommendations arising from the research are made. The key to developing practice lies in understanding the binaries and polarities which position people; such an understanding can be informed by the material-discursive approach to analysis which was conducted which sought to find ways of understanding the dualities which discursively produce experience. An analysis of tensions and contradictions in the data gave a particularly useful lever for doing this.

The main tension observed in the data was the part played by conflict over one's sexual identity and its relationship to presenting mental health care issues. The obvious polarity, revealed through using deconstructive methods and positioning theory to analyse the data, was that both participants and practitioners see sexual identity as either totally related to mental illness or completely unrelated to it. Markowitz (1991) has referred to this as the twin errors of assuming homosexuality has everything or nothing to do with the presenting problem in therapy. As noted in chapter six, there is an assumption embedded in the mental health care experience literature that homosexuality has nothing to do with the presenting problem i.e. participants' accounts are accepted uncritically when they say that they feel that their sexual identity has been pathologised and the possible relationship between sexual identity and mental health is not problematised. This reproduces an unhelpful polarity which can only be moved beyond by adopting a material –discursive approach in order to analyse and interpret the contradictions and tensions in participants' accounts. This further layer of analysis suggested that sexual identity was implicated in a complex way with the mental health of those participants who were "coming-out" when they presented with mental health issues.

It is perhaps of significance that most of the research on the mental health care experiences of lesbians and gay men has not really focused on participants who are "coming-out" at the time of the health care experience. Furthermore, the gay-affirmative literature on "coming-out" tends to focus on the clinical expertise of practitioners rather than the experiences of clients. It is possible that this arises from the difficulties of researching this particular topic and the relative lack of methodological approaches which allow analysis of data within the realm of the unsayable. That this research topic is within the realm of the unsayable is illustrated by a quote from a participant in Milton and Coyle's study of psychologists. The participant (a practising psychotherapist) was commenting on how difficult it is to challenge the homophobia and silencing embedded in psychotherapy training courses:

> "it makes it more unspeakable, you know it makes it more unthinkable, it's { } seen as { } something you simply can't ask, because it's too appalling to ask" (Milton and Coyle, 1999, p. 55)

The ineffability of many topics of sensitive research, and in particular the unspeakability of lesbian and gay identities, were discussed in chapters three and four (Brannen, 1988; Holland and Ramazanoglu, 1994; Sedgwick, 1994; Huby, 1997; Altheide and Johnson, 1998; Heaphy, 1998) and became evident in research participants' accounts in chapter seven. The unspeakability of people's experiences can be understood in the light of Butler's work on how discursive practices define what can and cannot be spoken about: "discourses not only constitute the domains of the speakable, but are themselves bounded through the production of a constitutive outside, the unspeakable, the unsignifiable" (Butler, 1995, p. 238). Butler also argues that silencing is part of the process of oppression:

> "here it becomes important to recognise that oppression works not merely through acts of overt prohibition, but covertly through the constitution of viable subjects and through the corollary constitution of a domain of unviable (un)subjects – *abjects*, we might call them – who are neither named nor prohibited ... Here oppression works through the production of a domain of unthinkability and unnameability" (Butler, 1991, p. 20)

This research study attempts to engage with these ineffable and unsayable aspects of people's experiences by using sampling methods and analytic approaches which enter this realm. Of particular note here were the accounts of Mandy, Simon and Jane in chapter seven where it was clear that there were realms of experience which they were unable to articulate or perhaps even think about.

It was noted in chapter five that the pathologising and silencing of lesbians and gay men, in general and in their mental health care encounters, can reinforce internalised homophobia and delay the process of integrating a positive sexual identity. The literature on gay-affirmative therapy is helpful in understanding this further. It has been found that internalised homophobia, the introjection of negative feelings about lesbians and gay men, is a cause of mental health problems such as depression, low self esteem and psychological distress (Shidlo, 1994; DiPlacido, 1998; Meyer and Dean, 1998). Similar findings also apply to the effects of non-disclosure or concealment of sexual identity (DiPlacido, 1998). Gonsoriek (1982) has also noted that the stress of coming-out can produce florid symptoms of severe emotional disturbance. However, it has also been noted by a number of gay-affirmative practitioners that internalised homophobia rarely manifests itself overtly (Gonsoriek, 1988; Davies, 1996; Tasker and McCann, 1999; Mair, 2000). Given that internalised homophobia affects mental health, it follows that any behaviour on the part of mental health care practitioners which reinforces internalised homophobia, will be injurious (Shidlo, 1994; Meyer and Dean, 1998) and can even lead to further self-pathologisation (Milton et al., 2002). This tendency towards self-pathologisation was noted in Sarah and Julie's accounts in chapter five.

Furthermore, it has been noted that it can be very difficult for lesbians and gay men to disclose their concerns which relate to internalised homophobia (Mair, 2000). Shidlo (1994) observes that there can be shame about shame. Seu (1998) in her research into women's experiences of shame, found that silence is often used as a way of coping with shame. There was one explicit reference to feeling shame in Ranjit's account. However in more cases, as seen in chapter seven, the interpretation of silences and conversational awkwardnesses showed that internalised homophobia or feeling negative about one's (emergent or current) lesbian or gay identity was indeed a very difficult topic to bring up with a mental health care practitioner. It was also difficult for participants to discuss within the context of the research interview. As previously mentioned silence and conversational awkwardness was particularly noticeable in the accounts of Mandy, Simon and Jane. An interpretation of variation and contradictions in accounts also led to a further understanding of how participants resist their identities being constructed in relation to homophobic discourses, whether internalised or external. In resisting potential pathologising positions they are unable to access appropriate care to help them manage their conflict and the consequences of their sexual identity. These contradictions, interpreted as resistance, were notable in the accounts of Charlotte, Len, Fiona and Nicki.

In order to further understand what might be happening in these mental health care encounters and the nature of the added burden created by the reinforcement of homophobia it is useful to continue an exploration of the theory on identity work which was introduced in chapter six. Giddens (1991) argues that the integrity of the self is maintained through the ability to maintain a feeling of biographical continuity. This autobiography at the core of self-identity in modern life has to be worked at and is both robust and stable. Shame can result from feelings of not living up to ideals and anxiety results from feelings about the adequacy of one's narrative for sustaining a coherent biography. Giddens suggests that fateful moments such as receiving a medical diagnosis become transition points which have major implications for self-identity. Breakwell (1986; 1996) argues that threats and coping strategies only make sense when seen in the light of dominant social beliefs and cultural expectations, and it is the subjective knowledge of the social world which is important. Both Giddens and Breakwell assume a position that threats to identity require some kind of work and psychic re-organisation. Saari, drawing on the identity theory of Lichtenstein also refers to the need for biographical continuity but also emphasises the damaging effects of trying to maintain an identity where there are conditions of negative evaluation and prohibition – Lichtenstein referred to this set of conditions as the "malignant NO" (Saari, 2001, p. 648). For lesbians and gay men who are coming-out, there is a threat to identity because of the way in which negative and prohibitive social values will affect their sense of continuity and living up to ideals. This can then impact on self esteem and may lead to feelings of shame. If homophobia or heterosexism occurs in the mental health care encounter then there is an added threat to identity.

In terms of the effects of shaming – and it is argued here that homophobia and heterosexism in health care encounters have that effect - Butler (1993) has argued that discourses are injurious. Although Butler, does not use the term material-discursive, it can be seen from her writing that there is a theorized relationship between the discursive and the material – she argues that power acts materially on our bodies and minds even if the discourse which produces that power is abstract (Butler, 1990). Butler (1995) goes on to argue that categories tend to be instruments of regulatory regimes and that the subject (in this case the lesbian or gay man) is produced through the shaming interpellation. In theorising this relationship, Butler is drawing on the work of Althusser who argues that a subject is constituted through being hailed, addressed or named. In the case of lesbian and gay identities, where homophobia and heterosexism are intrinsic to the dominant discourse, Butler argues:

> "if, then, we understand certain kinds of interpellations to be identity-conferring, then those injurious interpellations will constitute identity through injury" (Butler, 1995, p. 246).

Butler also explores the way in which being hailed or interpellated as a member of a social category can be paralyzing through the violence of its totalizing reduction of identity. The hesitations and resistance which research participants described in relation to their difficulties of making a disclosure about sexual identity in mental health care encounters can be interpreted in this context. In the extracts in chapter seven this reluctance to disclose, because it would have brought them into being as that kind of subject, was expressed in Kate, Lauren and Len's accounts.

Whereas Butler (1991; 1995) goes on to draw on the work of Foucault to theorize how such injurious interpellations can be resisted through occupation, such modes of resistance cannot really be seen in the accounts of participants describing their mental health encounters. Such resistance to homophobia and heterosexism can be seen in the many studies of identity politics and development of lesbians and gay communities (e.g. Hart et al., 1981; Shotter and Gergen, 1989; Richardson, 1992; Sampson, 1993; Bell and Valentine, 1995; Duncan, 1996; Munt, 1998), but is important to note that such spaces were not available to the lesbians and gay men in this study who were coming-out, who were isolated, and who were experiencing mental health problems which they associated in some way with their sexual identity. As Sophie (1987) observed, from research and clinical experience, it can be difficult to identify with the terms lesbian or gay until one has managed to feel at least neutral if not positive about the category. For lesbians and gay men then, who have no attachments or support from alternative lesbian and gay communities and who have mental health problems associated with coming out, the only form of resistance available was self-silencing which serves only to produce a further barrier to accessing appropriate health care.

Butler and other writers on lesbian and gay identities (e.g. hooks, 1990; Weeks, 1991; Butler, 1995; Myslik, 1996; Clarke, 1998; Clark, 2002) have theorised a relationship between homophobia, heterosexism and identities and communities and have looked at how injurious interpellations are resisted. However, these theorists have not explored this in relation to those lesbians and gay men who have emergent identities and who are struggling, in a psychological sense, with those emergent identities although some recent work has started to focus on how sex education may need to be re-thought for those groups of gay men who are in the process of "coming-out" (e.g. Watney, 1993; Flowers et al., 1998). Cosgrove (2000) has stated that resistance needs to be theorised in order to develop our understanding of lived experience. In the absence of developed theory around resistance in this context, some parallels can be drawn by looking at studies in which people negotiate their identities in relation to illness and in relation to health care encounters.

A number of psychological and sociological studies have explored how people have to manage their identities in relation to illness and medical encounters (e.g. Charmaz, 1987; Mathieson and Stam, 1995; Squires and Sparkes, 1996; Faircloth, 1998; Nochi, 1998; Sparkes, 1998; Yardley, 1998; Mathieson and Barrie, 1999). Mathieson and Stam (1995) argue that the psycho-social experience of chronic illness can be understood in terms of a re-adjustment of the person's whole identity. This requires identity work entailing biographical work and evaluating meaning in a social context; cancer patients have to re-negotiate their identity which is threatened by physical changes and changes in social relationships and encounters with medical institutions. They argue that there is an added psychological strain imposed by medical encounters in which there is a discrepancy between their lived experience of illness and the way that they are constructed in their health care encounters by their disease state. In a later piece of work Mathieson goes on to state that one of most common themes in research participants' experiences:

> "speaks to unsatisfactory patient-health care provider interactions. Its common presence suggests that, of all the roles patients must navigate, negotiating one's identity with health care providers may be the most constant and difficult one and this story may not be easily constructed, or listened to" (Mathieson and Barrie, 1999, p. 599)

Mathieson's work is informative as it elucidates the problematic nature of the health care encounter as well as the illness in terms of the implications for identity work. Although not explicitly drawing on some of the theoretical approaches to identity previously discussed (e.g. Breakwell, 1986; Giddens, 1991; Butler, 1995) it is consistent with these approaches in terms of recognition of the need for continuity, psychic re-organisation and psychological burden when identity is threatened. Much of the research to date on illness and identity has focused on physical illness rather than mental illness – these studies are useful for informing this research in so far as they speak of the need for negotiation of identity in relation to illness and health care encounters but it is argued that the negotiation of identities in relation to mental health care encounters is more fraught. Research on the negotiation of identity and mental health care experience has not been conducted to date, but the studies by Yardley, Ussher and Heaphy are more salient to this current study. Both Yardley and Ussher have looked at experiences in relation to illnesses thought to have a strong "psychological" component (where there is potential for pathologisation) and Heaphy (Heaphy, 1996) has looked at the experience of an illness which is very much constructed within homophobic discourses.

Ussher (1996; 1997a; 2003) has used material-discursive approaches to understand the experiences of women with premenstrual syndrome (PMS). Ussher has argued that social constructionist approaches to understanding PMS tend to dismiss the "real" experiences and suffering of women with PMS whereas more realist approaches tend to mis-attribute (or position) unrelated difficulties of a social and emotional nature to PMS resulting in pathologisation. There are parallels here for this study where there was similar over-emphasis on a unitary cause of illness. In this case, sexual identity was seen as the cause of mental illness with the negation of other potential causes of psychological distress such as bullying and other major life events. This was particularly evident in the accounts of Wayne, Mandy, Jane and Charlotte. Ussher (2003) argues that some stresses in women's lives may be inappropriately positioned as PMS; this bears a striking resemblance to the inappropriate positioning of sexual identity as the (sole) cause of mental distress for some participants in this study. There are also some striking parallels between the findings of this study and those in Yardley's work.

Yardley (1996; 1998; 1999) has used a material-discursive approach to understanding the health care experiences of people who suffer from chronic dizziness. Yardley's work is particularly salient in relation to this study as it looks at an illness where people are struggling to cope with a debilitating condition; they are placed in a dilemma between getting recognition and support for their illness without appearing to be passive and therefore undeserving of sympathy or assistance. This creates a delicate balancing act between coping and getting help to manage the illness. Yardley (1998) argues that these dilemmas and the resulting resistance to, and negotiation of, an illness identity account for the tensions and contradictions in people's accounts of coping with this particular illness. Yardley (1998) also argues that these dilemmas are in part materially produced by the inadequacies of dominant discourses available to people with chronic illness. There is a parallel here for people struggling with their mental health when they are coming-out; the inadequacy of dominant discourses around sexual identity and mental health make it difficult for people to position themselves in a way which allows for both uncertainty and conflict about one's sexual identity and the positive management of that identity. Yardley and Beech (1998) also observe that there is a common thread in the nature of these health care experiences and encounters; they say that people who have to negotiate their identity in relation to chronic illness are disempowered in a way which is comparable to the disadvantage experienced by lesbians and gay men. In this study this disadvantage was multiplied in that participants were having to negotiate their sexual identity and their mental illness simultaneously making then especially vulnerable to the material effects of discursive practices which Yardley (1998, p. 324) has dubbed "cruel dichotomies". A further understanding of these "cruel dichotomies" is central to thinking about how practice can be improved and making recommendations as a result of this research. However, before exploring this in more detail the relevance of Heaphy's work will be discussed. Heaphy's work was introduced in chapter seven and it is useful to look at this in more detail as it is one of the few studies which has really addressed the issue of how silence in health care encounters is used to resist dominant, and often dichotomised, discourses.

Heaphy (1996) has considered the ways in which the identities of people with AIDS or HIV (PWA/HIV) are negotiated in relation to interactions with medical practitioners and health care professionals. Again it is important to locate the discursive context in which these health care experiences take place:

> "we should not underestimate the effectiveness of the rarely questioned proposition that AIDS is primarily medical. While dominant medico-scientific discourses may be challenged from various positions, they retain a privileged position in defining what is rational, sane and true" (Heaphy, 1996, p. 158).

Heaphy (1996) argues, drawing on Foucaldian ideas about the relationship between dominant discourse and power, that PWA/HIV will be subjected to the dominant bio-medical discourse about AIDS and HIV. His study shows that in that subjection, practitioners go beyond giving information and managing the illness to police moral issues and to act as judges and teachers of self-discipline. He then goes on to look at how such disciplining and regulation can be resisted drawing on Foucault's idea of reverse or counter discourse and goes onto say that the dominant medical discourse is continually contested and challenged. Heaphy suggests that Gidden's (1991) work provides a clearer way of understanding how such resistance comes into play and how PWA/HIV are active agents in the creation of their own identities through re-skilling, or empowerment, which can take place at fateful moments. Such empowerment may develop as a result of interaction with expert systems such as in the use of counselling or therapy. Such resistance is akin to that theorized by Butler in that it depends on some kind of counter-identification but as noted previously, in the mental health care encounter for lesbians and gay men who are themselves coming-out such types of resistance may not be possible. Furthermore, whilst Giddens and Heaphy suggest that fateful moments can lead to empowerment as a result of interactions with expert systems such as counselling, in the context of this research it was these very expert systems which constituted the fateful moment and further threats to identity. The other kind of identity work observed by Heaphy (1996; 1998), which is more pertinent to understanding the mental health care experiences of the lesbians and gay men in this study, was the strategy of silence as resistance to pathologising and disciplining:

> "from my own research it is clear that PWA/HIV often employ silence in an effort to resist medical practitioners' attempts to know and place them in terms of categories of normality" (Heaphy, 1998, p. 33).

In the same way that Heaphy argues that PWA/HIV are subjected to medical discourses and that the medical discourse retains a privileged position, the lesbians and gay men in this study were subjected to the dominant medical pathologising discourse about homosexuality which likewise occupies a privileged position. The dominance of medical and psychoanalytical discourses about homosexuality is such that they pervade the practice of all health care professionals, not just those who are medically or psychoanalytically trained (Malley and Tasker, 2001). There was a suggestion in some of the participants' accounts that nurses were caught up in medical discourses and practices, apparently passively following the pathologising approach set in motion by the diagnostic practices of psychiatrists involved in the same "case". A number of writers have commented on how inseparable much nursing practice is from dominant medical discourses resulting in similar patterns of interaction and power dynamics between patients and nurses as is often seen between patients and doctors (May, 1992; Wilson-Thomas, 1995; Porter, 1996; Manias and Street, 2000). May (1992) has also observed that patients resist these power relations with nurses and other health care providers through silence. In this study resistance to pathologising and disciplining was seen in the silences in people's accounts and the accounts of their silences in mental health care encounters.

In summary then, in terms of the two main research questions posed, it can be seen that homophobia and heterosexism operate in particular ways in mental health care encounters for people who are coming-out. The silencing and pathologisation of lesbian and gay identities in these settings compound the vulnerability of this particular group and create further harm and injury. This makes it difficult for lesbians and gay men to access appropriate mental health care. The harm and injury encountered in mental health care is an extension of the harm and injury of homophobic and heterosexist oppression already encountered in day to day life. Mental health care practitioners cannot be held to account for oppression arising from social conditions but they can reflect on their practice and look at how there own practices support such oppression. As Willig (1999b) has argued, there is also a need to challenge material and social structures which support limiting and oppressive discourses. It is clear from the study so far that the oppression of lesbians and gay men is reproduced in mental health care encounters and discussion follows about how such practices can be overturned. However, before doing this the experiences of participants in this study can also be interrogated to look in more detail at other material and social conditions which add to the vulnerability of lesbians and gay men who are coming out and seeking mental health care. Ussher (1996), has stated that material aspects of people's experience, such as social class, often get neglected in constructionist approaches and it is important not to omit consideration of such factors in this analysis. The particular sampling methods used in this study allowed such an exploration as a diverse group of participants were included. In particular, analysis of the data suggested that factors such as social class, religious identity, cultural identity, youth and lack of lesbian/gay community attachment added to the vulnerability of those lesbians and gay men who sought mental health care and increased the barriers to accessing appropriate care. These observations are linked to the extant literature and are offered cautiously as the methodology chosen does not allow for a robust analysis of difference based on factors such as social class. However, in-depth data about participants' degrees of community attachment, religious and cultural identities and social class were collected during the interviews and some powerful trends were observed in relation to material conditions which add to vulnerability.

A remarkable number of participants came forward for inclusion into the study, who had grown up within fairly closed fundamentalist Christian communities without purposeful sampling techniques in relation to this. Purposive sampling also included participants from other religious communities. It seemed from these participants' accounts that they were more vulnerable to isolation from positive lesbian and gay role models and found it more difficult to access alternative lesbian or gay community support. They were also more prone to psychological techniques for curing their homosexuality (offered by religious groups not health care professionals) and more fearful about their physical safety should their sexual identity be discovered. They were also more concerned about disclosing to their health care practitioners due to fears about confidentiality within closed communities and further taboos within such communities about seeking external help with mental health problems. These concerns were particularly reflected in the accounts of Simon, Jane, Tim, Anwar and Ranjit seen in chapter seven. The conflict between religious identity and sexual identity has been noted in other studies (e.g. Coyle and Rafalin, 1999). Coyle and Rafalin note that such conflict not only relates to religious identity but also to cultural identity where family values and community ties are salient. This has also been suggested by other authors (Greene, 1994; Chan, 1995; Abdulrahim, 1998). It has also been suggested that what is often salient about cultural difference in the nature of collective and family ties is the way that individual identities are not privileged over expected social roles (Chan, 1995; Abdulrahim, 1998).

Working class participants in this study also seemed to have an added vulnerability in terms of being less likely to be attached to lesbian and gay communities and less likely to be able to access talking treatments once they had presented for health care. It is known that social class makes a difference to how people negotiate their sexual identities and their access to gay communities which in turn affects sexual health (Dowsett et al., 1992; Flowers et al., 1997b; Flowers et al., 1998; Weatherburn et al., 1999). It seems likely then that there will be some kind of social class vulnerability in relation to mental health and lesbian and gay identity. Whilst some research has been conducted which explores the relationship between mental health and lesbian or gay community attachment (e.g. Coyle, 1992; Geraghty, 1996), less research has been done to explore the relationship between social class, lesbian and gay identities and mental health. However, Bridget and Lucille (1996) have suggested a model of multi-oppression in which factors such as lower socio-economic status and minority ethnic status add to the vulnerability of young lesbians when they are "coming-out" making them more prone to serious mental health problems. Social class is a known indicator affecting mental health and access to mental health care (Pilgrim and Rogers, 1999) and it has been found that both social class and sexual identity can affect access to talking treatments (NHS Executive, 2000). It has been suggested that practitioners construct the symptoms of working class patients in more biomedical and pathologizing terms thus seeing types of severe mental illness thought to be less amenable to talking treatments (Pilgrim and Rogers, 1999). In this study there was an apparent trend for working class participants to be referred to psychiatrists and more middle class participants to be referred, or self-refer, to counselling. This was aptly reflected in Lauren's account at the end of chapter seven where she likened her psychiatric referral to "*using a sledgehammer to crack a nut*".

Finally youth created an added vulnerability because of the way it intersected with dominant pathologising discourses in which homosexuality is seen as an immature phase. This made it difficult for young people to disclose any conflict or worries they had about their sexual identity for fear of being dismissed as being attention-seeking or "too young to know" or if they did disclose they were more likely to be subjected to this pathologising discourse. They were also worried about being made to self-doubt when they had struggled on their own to form a positive identity and identified how their young age made them more pre-disposed to rely on the authority of parental and medical accounts. These concerns and actual experiences were noted in the accounts of Nicki, Charlotte, Alex, Max and Sarah.

The multi-layered material-discursive analysis of the data in this study showed that lesbians and gay men who were coming-out, experienced continued oppression in their mental health care encounters. These oppressive practices can be seen as part of the wider discursive practices of disciplining and regulating gender and sexuality in a hetero-patriarchal society (Plummer, ; Wilkerson, 1994; Ussher, 1997b; Adam, 1998), with added vulnerabilities created by other oppressive practices in relation to class, culture, community and age. What is critical to a study of this kind is to find ways of overturning the polarities and dualisms which lie at the heart of these oppressive practices otherwise, as noted earlier, such oppressive practices can be easily reasserted in new guises. Some of these potential overturnings were discussed in chapter six in relation to liberal humanism in nursing practice. In order to develop this understanding it is useful to look at other studies where overturnings have been attempted, and to reflect on the strengths and limitations of the methodological approaches used in this study.

Those who seek to apply discourse analysis have argued that interventions have to be tactical and provisional (Parker et al., 1995; Willig, 1999a) and successful resistance requires an overturning of polarities in order to make other spaces available

(Parker et al., 1995; Parker, 1998b) . It is also necessary to challenge material and social structures which support limiting and oppressive discourses (Willig, 1999b) otherwise we come full circle to victim blaming. What might such tactical interventions be then in this case? The polarities identified through a phenomenological analysis of people's experiences and a discursive analysis using deconstruction and positioning theory, were those of complete pathologisation of sexual identity at one end of the continuum and the negation of minority stress related to sexual identity at the other end of the continuum. These could be encapsulated in the epithets "mad to be gay" versus "glad to be gay" and are further elucidated in the binary identified by Smith (1997) in which the good homosexual is tolerated but the dangerous queer is not. A lesbian or gay man who is experiencing mental health problems, whether attributed to sexual identity or not, simply cannot fulfil the criteria to qualify as a "good homosexual". As Yardley (1998) observed, people suffering from chronic dizziness simply cannot position themselves other than in relation to the cruel dichotomy of poor copers versus real victims. This polarisation and dichotomisation which discursively produced people's experiences does not allow for a position in between or outside these dualisms. In this study such positioning made it impossible for participants to articulate their mental distress in relation to their sexual identity. In a similar vein Boyle (1998) observed how the dominant social and medical discourses about abortion made it difficult for women to articulate their emotional distress and conflict about undergoing abortion.

Parker et al (1995) have deconstructed discourses about psychotic illness and pathological speech in order to try to overturn the polarity between normality and abnormality which has the effect of marginalising, pathologising and silencing. They are not attempting to deny the reality of psychotic illness but argue that more emancipatory realities could be arrived at if psychosis and pathological speech were seen as different rather than deviant. Such an overturning, they argue, would move us beyond the current denial of psychotic patients' experiences and the subsequent denial of a talking cure. In Parker's work on this, a discursive analysis is used to provide a critique and alternate account of how particular practices can be seen in order to open up a space for resistance (Willig, 1999c). Another example is given by Willig (1999b) on how discursive analysis can be used to overturn dominant discourses in relation to sex education. Willig argues that sex education tends to reproduce dominant discourses about sexual activity which make it difficult for people to negotiate safer sex. She argues that in order for sex education to become more emancipatory there must be explicit knowledge of desire (rather than the current constructions about of loss of control and constructions of women as passive).

Yardley (1999) talks in terms of sidestepping dualisms rather than overturning polarities. In her work on disorientation and chronic dizziness she produces a material-discursive analysis of that experience in which she argues that dizziness and disorientation (following vestibular impairment) become chronic, disabling and unmanageable because of a number of Cartesian dualisms which construct the experience of illness. In particular the mind-body dualism of western medicine is operating here. Other dualisms in this case relate to control, dilemmas concerning the "reality" of such illness, and expert knowledge in which passive behaviour is encouraged by social and environmental conditions which prevent the recovery of balance mechanisms. Yardley (1997a; 1999) sidesteps these dualisms to arrive at an alternate analysis and understanding and goes onto suggest that these disabling practices can only be overturned by seeing the ways in which the mind and body are intimately linked and by shifting the focus of debate away from a futile discussion about primary aetiology. She also argues that more attention needs to be given to the role of attitudes, social relations and the built environment in terms of how these mediate the construction and experience of the "illness". The parallels between Yardley's work and with this study, in terms of the clinician's obsession with the "cause of homosexuality" and the role of attitudes and social interactions in the production of illness and the experience of illness, are striking.

It has been argued throughout this thesis that previous research on both the health care and the coming out experiences of lesbians and gay men obscured the effects of discursive practices encoded in silences and silencing. This was also obscured in the first stage of analysis in this study. The presence of pathologising discourses and the effects of pathologisation are more accessible to researchers. Their starkness, whilst still not obvious to a practitioner who has reified psychoanalytic theory, is in the public realm. This means at least that the pathologisation of homosexuality can be contested and can be spoken about, even if the ground still needs to be shifted much further. However, conducting further analysis within the realm of the unsayable (which is embedded in heteronormative practices in nursing and medical discourse), has also made visible the effects of pathologising and heterosexist discourses in mental health care.

In this study, the material-discursive analysis has provided indications of how dualisms operate in the field of mental health care for lesbians and gay men when they are "coming-out". It has also provided some insights into how these dualisms can be side-stepped or how the polarities can be over-turned to produce more emancipatory practice. Practitioners need to attend to how pathologisation is resisted through silence and develop ways of facilitating disclosure about sexual identity and any associated concerns. It was clear from some of the participants' accounts that such disclosures can be facilitated by practitioners first normalising lesbian and gay identities in order to open up spaces where minority stress and its effects can be dealt with in a therapeutic environment.

The unfolding story embedded in the research participants' accounts and embedded in their silences was a story of resistance to binary positioning and a refusal of pathologising binaries. In this process of engagement with the heteronormative, and often homophobic, oppressive regime of mental health care (itself part of a homophobic and heteronormative society), lesbians and gay men were phased out, missed out, out-classed, cast(e) out, found out, kicked out, ruled out, rooted out, and whited out but very rarely helped out. The mental health care professionals from whom these lesbians and gay men sought therapeutic help were outmoded and out of order and the only morally acceptable response to this should be a collective outcry. In the process of trying to negotiate a stigmatised and threatened identity, lesbians and gay men have to undertake further negotiation in order to access the "helping" professions; it was the resistance to further pathologisation and the refusal to have their identities mistaken, stolen, confiscated or confuscated which lies of the heart of how homophobia and heterosexism affect access to mental health care. It is only when nurses and other health care professionals also refuse these binaries and pathologisations that they can truly engage in a therapeutic process.

What is required then is not only a shift in the practice of pathologisation but a further step is needed to enable disclosure and subsequent identity work – this then would have to be an overt and courageous statement or "position" taken by nurses and other mental health care practitioners that they too were refusing the binaries that their patients are resisting in order to go together beyond the dualisms. Such a refusal of dualisms would lead towards a more emancipatory and more therapeutic exchange that would not force people into binary positions of "definite lesbians and gay men with no uncertainty" versus those who were confused, arrested in their development or "unaccepting" of their sexuality. It would be possible in this world of mental health care where constrictive dualisms had been overturned, to be sad or mad as well as glad to be gay; to be sad about being rejected by one's peers or family but also proud of (or accepting of) one's identity i.e. to be enabled to traverse the shame/pride dichotomy rather than having it re-inforced and being constrained, constricted and constructed by it.

What this would mean in practice is that nurses and other health care professionals would help lesbians and gay men in the negotiation of their sexual identities; this would mean that instead of lesbians and gay men having to be sure and certain and unconfused and definite and positive before it was (relatively) safe to come out in a mental health care setting, they could present for health care and be helped to work out their identity struggle; they would be able to do this without being told that their confusion was a sign that they were really heterosexual or perversely (in some cases) that they hadn't come out enough, or being told by a well-meaning liberal that their sexual identity was of no consequence or interest. Such a journey would demand a certain level of self-awareness and a politicisation of nursing and medical knowledge and an understanding of the relationship between medical knowledge and nursing knowledge. As well as calls for critical social theory to be applied within nursing knowledge (Wilson-Thomas, 1995; Lister, 1997; Cheek, 2000; Manias and Street, 2000; McDonald and Anderson, 2003), Hart et al (2003) have suggested a model underpinned by reflective practice to enable this. They caution against trying to map this onto models of individualized care or cultural competence.

Unless that negotiation is framed in its social, cultural and political context dualistic thinking will re-assert itself re-inscribing new patterns of oppression. The individual will be individualised – they will be wrenched from their social context and if their negotiation is successful it will be seen as a sign of individual resilience – if they are not successful they will be re-pathologised, victim-blamed and found deficient. Further dualisms in relation to gender, social class, age, race and ethnicity will be mapped onto the individual/society and heterosexual/homosexual binaries creating further layers of oppression through erasure. If nurses (and other mental health care professionals) are to enter into a therapeutic relationship with lesbians and gay men who are negotiating their sexual identities in mental health care settings, then they have to disrupt the dominant discourses which pathologise and invisibilise lesbians and gay men and they would have to disrupt the individualisation embedded in nursing philosophy which itself is embedded in liberal humanism. In particular the shame/pride dichotomy must be disrupted so that it is possible to be both ashamed **and** proud **or neither** of these – as practice currently stands a lesbian or gay man risks their mental health if they access mental health care without the certainty of pride. The irony of this of course should not be lost on the reader – a certain and proud lesbian or gay man is less likely to need to access mental health care than a shamed or uncertain one. However certain and proud lesbians and gay men do have mental health problems which may be unrelated to conflict as such about their sexual identity – with the shame/pride dichotomy intact access to care for such people is also problematic as they too become re-pathologised.

If the shame/pride dichotomy could be disrupted then it would be possible for lesbians and gay men to access mental health care regardless of where they were positioned in relation to this dichotomy because health care practitioners would help them to negotiate that path; any re-positioning could then emerge from a therapeutic engagement rather than a non-therapeutic reinscription of pathologisation and/or, marginalisation. In disrupting this, essentialist questions about the aetiology of homosexuality and its permanence would become redundant. The responsibility for this endeavour must lie with nurse educators, nurse researchers and nursing organisations as well as individual practitioners: "if the potential constraining effect of a particular discursive frame's dominance in the health arena is recognized, then it is possible for space to be opened up for other discourses or ways of thinking" (Cheek, 2000, p. 25). de Lacey (2002), has applied this way of thinking to how nurses can either reproduce or disrupt pathologising discourses of infertile women and has argued that nurses must and can rupture negative stereotypes through their practice and the way they interact with their patients. Such new ways of thinking will require a challenge to current models of training and the development of reflective practice.

## Chapter 9: Conclusion

### Reviewing the situation

In the introduction (chapter one) the social, political and historical context was set out alongside a rationale for undertaking this thesis. It was argued that the mental health care experiences of lesbians and gay men needed to be given particular attention in the light of the long historical period during which homosexuality has been pathologised and the social context of ongoing prejudice and discrimination towards lesbians and gay men. The political context is salient because it has affected the lives of lesbians and gay men and has also set (or set back) the research agenda in relation to their experiences. The research agenda has been affected by politics in terms of what is researched as well as how it is researched in relation to lesbian and gay lives; the politics of researching lesbian and gay mental health care experiences not only affect research topics and questions but they also influence the methodologies available to undertake enquiry; these methodologies are limited by dualistic thinking. Dualistic thinking limits not only methodology, but also has a profound influence on the nature of experience and identity. These methodological limitations, and the attempts to reach beyond them through innovative methods and an epistemology that attempts to straddle and side-step dualistic thinking, were explored in considerable detail in chapters three and four. It is crucial to position the researcher in such an enquiry and this is done later in this final chapter.

Dualistic thinking is very much a product of modernity which makes it extraordinarily difficult for people to think of themselves, or others, in ways which do not immediately invoke a binary. It has been argued throughout this thesis that such binaries restrict our ability to understand and investigate experience. This is particularly important when investigating experiences in relation to sexual identity as identity formation tends to be experienced in either/or terms; thus people tend to experience their sexual identity as something fixed and stable along a bipolar continuum. Similarly they will tend to be positioned by others in relation to such a bipolar continuum or binary. Dualistic thinking has spawned a further set of binaries onto those with lesbian and gay identities through pathologisation and criminalisation; the good versus the bad "homosexual". In this scheme of things, which can be summed up as the dominant discourse, the normal (natural) heterosexual occupies the privileged side of the binary and all that is bad, unnatural and deviant is projected on to the "Other" side of the binary; in this case the mad, bad or sad (but always shameful) homosexual.

These binaries and dualisms are reproduced further in the research on lesbian and gay men's lives leading to unresolved tensions and polarised positions around pathologisation. There was a long period of research activity in which clinical and prison populations of homosexuals were studied to "prove" the theory that homosexuality was a form of psychopathology; this was followed historically, post Stonewall and a gay rights political movement, with its polar opposite – gay-affirmative psychology – which set out to disprove the pathologising research preceding it and win the political and scientific argument in favour of the well-adjusted homosexual. Much of this early gay-affirmative research was fairly self-fulfilling, a prime example of which is the early research into coming out and stage models thereof. This research was critiqued in chapter two and threw up early warning signals about the need to pay careful attention to sampling issues which were explored in considerable depth in chapter four. Following the gay-affirmative psychology period (an empirical body of literature that tended to be atheoretical), there was a further wave of more theoretical literature on the formation of lesbian and gay identities and communities. What both these bodies of literature have done, has been to reinforce the dualism between the good and the bad, or the pathologised and the celebratory. Research on the celebratory side of the binary, although a necessary condition for the de-pathologisation of homosexuality, has not been a sufficient condition and this thesis sets out to begin to address this.

These bodies of literature have ignored the tension created by the stark evidence that lesbians and gay men suffer from a much higher incidence of attempted suicide and other mental health problems than control groups of heterosexual people. This tension is reproduced in the literature on the mental health care experiences of lesbians and gay men; it was seen from the review of literature in chapter two that there is considerable empirical evidence that health care practitioners hold homophobic attitudes and that their training neither counters such views nor allows space to understand about the health care needs of lesbians and gay men. There is also considerable empirical evidence that these negative attitudes translate into poor practice with many accounts of verbal, physical, and sexual abuse, hostility, withdrawal of care, and voyeurism in general and mental health care settings. Within the mental health field in particular there are accounts of experiences of being pathologised and silenced. In addition there is evidence of the experience of heterosexism in health care, often encoded within a more liberal and less pathologising discourse.

The existing literature on mental health care experiences brings into play research evidence about the vulnerability of lesbians and gay men in terms of their mental health – this evidence was missing from the early lesbian and gay psychology literature and from the theory on lesbian and gay identities and communities. It was also missing from the pathologising research which preceded both of these. A tension arises then when claims are then made (by research participants and researchers) that sexual identity and mental illness are unrelated whilst at the same time presenting evidence of added vulnerability and a higher than expected incidence of mental health problems. This added vulnerability is reported to be associated with a period in lesbians' and gay men's lives when they are coming out; so whilst this tension can be ignored if research is being conducted into mental health care experiences which post-date coming out, it cannot be ignored if research is to be undertaken about mental health care experiences at the time of coming out.

This thesis set out to work with the tensions arising from such elision; in so doing has had to extend the available methodologies and their applications, tackling the limitations imposed by dualistic thinking in both theory and method. Whilst no grand claims are made to have gone beyond dualistic thinking, some claims are made to have extended the limits of our knowledge though methodological innovation applied specifically to an area where previous empirical research was sparse and theory limited. So whilst dualistic thinking has to some extent been side-stepped allowing a further interrogation of data than would have otherwise been possible, it is probably currently beyond the capacity of either individual or collective imaginings to completely overturn the polarities which mediate our experience and our interpretations of experience.

The data that have been presented, and analysed, in this thesis have been interpreted through different lenses which straddle epistemological divides – this relatively new and innovatory approach has been termed a "bricolage" in the methodological literature. In doing this it has been possible to go some way beyond the essentialism of so much lesbian and gay affirmative psychology, and the lesbian and gay health care experience literature, but to also pull back from the brink of nihilistic social constructionism. This brings these disparate bodies of thought together to theoretically and empirically inform our understanding of how homophobia and heterosexism in mental health care encounters impact on the person who is struggling with their sexual identity. The side-steeping of dualisms throughout this thesis has allowed a more sophisticated approach to sampling than is often found with research into hidden populations. This allowed more attention to be paid to the complex ways in which identities and community attachments are formed and mediated by material conditions such as social class, culture and religion. By pushing the boundaries of sampling strategies with hidden populations and reaching a more diverse group in terms of how sexual identities inter-relate with lesbian and gay community attachments, social class and cultural differences, the researcher was confronted with a dataset that was not in a sense ready theorised or self-fulfilling. The researcher entered the realm of the unsayable by extending the sampling to include those who "dared not speak their name" – had the usual suspects been interviewed (i.e. a snowball sample of white, middle class, lesbian and gay-community attached, university educated professionals) then it is highly likely that some of the complexities of how homophobia and heterosexism impact on patient care may have been lost. Up until now most applied researchers have been silent on the issue of silence and research into the ineffable has remained at the margins of academic tolerance. By engaging in an analysis of the ineffable this thesis has also challenged the common practice of excising methodological detail when conducting sensitive research which has been noted by Lee (1995). Such excision does not occur here and this thesis also challenges and refuse the binaries of methodological purists (or rather what has been coined as "methodolatory" (Elliott et al., 2000; Reicher, 2000)).

By analysing the data through multiple lenses which allow a realist exploration of some aspects of people's experiences alongside a discursive analysis of some of the contradictions and tensions in people's accounts of their mental health care experiences, it has been possible to come to a deeper understanding of the complex ways in which homophobia and heterosexism operate in mental health care encounters. This deeper understanding takes account of the discursive production of identities and the discursive production of nursing and health care, and health care experience. It also takes into account the role of language in the production and maintenance of identities, and the role of language in the mental health care encounter as well as in the research interview. The discursive analysis which drew on positioning theory also allowed a deeper understanding and interpretation of the silences and contradictions in people's accounts which mirrored their silences in their mental health care encounters. It was only through this kind of engagement, using innovative methodologies and theories that have rarely been applied to empirical enquiry, that it was possible to go beyond a surface claim that homophobia and heterosexism in health care are harmful and begin to understand the complexities of how they operate in mental health care and the ways in which they affect access to care.

The more realist lens through which the data were analysed, using interpretative phenomenological analysis (IPA), enabled the first research question to be addressed. This was:

- How do homophobia and heterosexism manifest themselves in mental health care encounters when lesbians and gay men are coming-out?

The analysis of the data using IPA clearly showed that lesbians and gay men experienced homophobia and heterosexism in their mental health care encounters. These experiences were commensurate with findings in the extant literature; i.e. lesbians and gay men experienced hostility, abuse, withdrawal of care, pathologisation and silencing. The one feature in the literature on general health care experiences which does not seem to occur in mental health care settings was voyeurism. It is as if the spectacle of the Other in settings where physical health is attended to is that of the physical freak who must be looked at – hence the voyeurism whereas in mental health care settings the process of "Othering" is through pathologisation of the mind – in this case the mental freak.

Thus far then the research had confirmed what was already known from previous studies. However, the second research question had not really been addressed in the extant literature other than by passing reference to "health care avoidance" as a consequence of homophobia and the observation that in many cases lesbians and gay men do not disclose their sexual identity in health care encounters. The second research question was more concerned with the effects of homophobia and heterosexism:

- How do homophobia and heterosexism affect lesbians' and gay men's access to mental health care when they are coming out?

It seemed vital to address this further question if health care professionals were to be convinced of the need to reflect on their practice. The existing research presents the evidence of homophobia and heterosexism in health care and within that there is a self-evidentiary assumption that homophobia and heterosexism are harmful. However, many health care professionals remain to be convinced of this and as the health care experience literature shows, those service users who complain about homophobia in mental health care are often told that they will have to get used to it; it is as if the fault lies in their deficient character being unable to cope with homophobia rather than homophobia being understood as an unacceptable and violating form of oppression. This victim-blaming approach has also been found in schools where research into homophobic bullying showed that many teachers thought young people should learn to cope with such bullying as it was " a part of life" (Douglas et al., 1998). The key to understanding the way in which homophobia and heterosexism affect access to mental healthcare lay in the non-disclosure of sexual identity frequently reported in people's accounts. This non-disclosure even occurred when participants felt quite sure that their presenting issue was linked to their struggle with their sexual identity. Further understanding of the way that homophobia affects access to care also lay in the contradictions within people's accounts about the extent to which they felt they had accepted their sexual identity and the extent to which they felt that their sexual identity was linked to their mental health problems. However, interpreting these data was not without its challenges as many participants found this aspect of their care very difficult to articulate.

It was clear early on in the study that there were some aspects of people's experience which required an epistemological position and a method of analysis which took account of these silences and contradictions in people's accounts. The methodological literature on conducting sensitive research was particularly helpful in this respect as were theoretical understandings about identities. Of particular use was methodological reflection where researchers had undertaken work in areas where there were parallels i.e. that people were talking about the experience of illness or health care in relation to a disease that was contested. Yardley's work (Yardley, 1998) on people's experience of chronic dizziness and Heaphy's work (Heaphy, 1996) with People With AIDS were both oases in a methodological desert of silence about silence. Heaphy's reflections (Heaphy, 1998) were all the more illuminating as he commented on how silences in health care encounters mirror silences in research interviews. This phenomenon had been noted early on in the research process with this thesis; this observation, with Heaphy's work and the methodological literature on social constructionism, made it imperative to find another lens through which to analyse the data in order to make sense of this extra layer of meaning. What was needed was an approach to analysis that took account of the rhetorical aspects of language and the ways in which meaning is constructed through language. Furthermore, experience is constituted through language. That is to say that a position was taken in which it was understood that language does not mirror reality but is constitutive of reality; thus an interview cannot necessarily be seen as a direct and true account of experience. What was noted in the interviews conducted for this thesis was that parts of people's accounts seemed at times to be rhetorical – participants might present a particular account of their sexual identity, coming out and mental health that could be understood to be rhetorical i.e. it served a purpose in terms of constructing and presenting their identity in a particular way. The researcher was alerted to this in a number of ways but one definable way was when material was introduced into the interview which directly contradicted the previous "construction". It also seemed to be possible that these constructions within the interview process might mirror something which also happened in the health care encounter. It was at this point that Heaphy's reflections were particularly salient but it also became clear that the most common method arising from the social constructionist framework (i.e. discourse analysis) would be difficult to apply to this kind of data.

Discourse analysis is usually used to analyse text in which power relations and discursive meanings are analysed with the focus most often being on how people use dominant discourses to persuade others of their arguments or perhaps to justify their arguments; thus Wetherell and Potter's classic study (Wetherell and Potter, 1992) looked at how people talked about racism i.e. how their racist practices were embedded in and constructed through the way they talked. Similarly discourse analysis has been used to analyse and understand how other dominant practices such as sexism and homophobia are produced and reproduced in talk. What is specific about most discourse analysis empirical research is that it seeks to uncover the ways in which dominant discourses operate within the way that people talk. So if one applied discourse analysis to an understanding of the dominant discourses in relation to the pathologisation of homosexuality then it would make sense to analyse the talk of mental health care professionals. A discourse analysis could uncover the ways in which lesbians and gay men were constructed as pathological in the talk and diagnostic practices of professionals. To apply such an approach to an analysis of health care experience is immediately problematic as the process becomes one removed from such practices – it is the experiences of such practices not the practice of such practices which are being analysed and discourse analysis does not lend itself to this enterprise as it has developed around an analysis of the oppressor rather than the oppressed.

Where discursive analyses have attempted to analyse health care experience or the experience of the oppressed then they have tended to be more theoretical and less empirical than those studies that have used discourse analysis. Parker at al's (1995) work is a case in point where a discursive analysis is applied to the experience of having an identity which is pathologised rather than a focus on the pathologiser; however these studies are theoretical and not empirical. Willig (1999a) has argued that it is necessary to develop methods which allow for an empirical discursive analysis of experience so that it can be applied and used in such a way that practice can be challenged and developed. She says that the only researcher who has managed to achieve this challenging task is Yardley who has applied such an analysis to an understanding of the experience of chronic dizziness. However, it has also been recognised that such approaches are necessary to really understand nursing practice (Cheek, 2000). Willig (1999a) goes on to argue that the theoretical approach which allows an understanding on how people experience the effects of oppressive discourses is positioning theory. Again this has rarely been applied to empirical data and as in the case of Parker's work it tends to hover above the text rather than engage with the text.

This thesis breaks new ground in that a discursive analysis using positioning theory has been applied to an empirical data set about people's experiences of discursive practices. It brings together and therefore takes further two disparate sets of work; on the one hand there is a body of empirical (but atheoretical) work about people's health care experiences or their coming-out experiences and on the other hand there is theoretical work about identity which has not been applied or used to interrogate empirical data. In bringing together these two approaches more can be said about the nature of those experiences than could be said by using either approach alone. Furthermore, this combined approach, or bricolage, was applied to a topic which had up until now been neglected by both approaches – there was neither empirical investigation nor theoretical work specifically in relation to mental health care experiences and coming out.

Interpretation of data in this thesis (about silencing, non-disclosure and being pathologised) through the discursive analysis led to a clearer understanding of what was at stake. This was illuminated by uncovering the dualisms and binaries at work. There are clear pairings or binaries through out this thesis which are identified in the theory about identity and the process of "Othering". These clearly link to the empirical data with regard to the research participants' experiences of mental health care. To re-iterate, these binaries construct the pathological deviant homosexual within a discourse of hetero-normativity. These findings as they stand, if presented to the nursing profession as evidence of malpractice, would not be highly contested. With current policy shifts towards greater equality legislation and codes of professional practice about the fair and equal treatment of people regardless of race, religion, sexual orientation etc, this fairly hard evidence of homophobic abuse and pathologisation would probably be considered unacceptable practice in most liberal circles. However, the underwriting of psychiatry by psycho-analytic thinking and psychiatry's enduring influence on nursing practice in mental health makes the task of presenting such evidence more problematic in mental health care contexts. The findings from this thesis could be condensed to a statement about the need for mental health care practitioners to normalise lesbian and gay identities so that lesbian and gay patients feel safe enough to disclose some of their ambivalences, uncertainties and concerns about coping with, managing or negotiating a stigmatised identity. Whilst these findings might be accepted at face value this seems unlikely. As noted earlier, overturning of dualisms is problematic and power relations are all too often re-inscribed in a new form. The key to understanding where the danger lies in nursing of such re-inscription is also to be found within this thesis through an understanding of one final and underpinning dualism.

This underpinning dualism was explored in chapter six and it is the individual/society dualism embedded in liberal humanism. This underpins both nursing practice, in the guise of "individualised patient care" (Wilson-Thomas, 1995; Lister, 1997) and in lesbian and gay psychology through unproblematised use of the concept of internalised homophobia (Kitzinger, 1997) As noted in chapters two and three, in attempting to overturn dualisms power relations reassert themselves in new guises; it is the guise of liberal humanism which is central to understanding where nursing practice erases difference through its dominant ethos of individualised patient care. This perspective enables sense to be made of those mental health care experiences in this thesis where participants described being silenced. It also helps to make further sense of some of those anomalous experiences where participants described being told that their problem was they hadn't accepted their gay identity (i.e. they were not a "well-adjusted homosexual").

In attempting to overturn the dualisms which pathologise lesbians and gay men there is a danger that the re-inscription of homophobia will pathologise them in new ways. As dualistic thinking rears its head again it threatens to subsume subtleties about the relationship between sexual identity and mental health through binarising the confused homosexual – research participants' accounts were replete with resistance to such positioning and it is important to ensure that in an attempt to sum up the message from this research that "confusion" about sexual identity (as in stress associated with managing a lesbian or gay identity) is not conflated with the "confusion" of not knowing what or who one is. Research participants' accounts clearly showed that their non-disclosure was often a form of resistance to being positioned as "confused" – a binary position on which the pathological model of homosexuality relies. It is this distinction between mental health problems which arise from having to deal with a stigmatised sexual identity as opposed to that sexual identity being a sign in and of itself of pathology (whether that is assumed to be one which will be grown out of or one which is permanent) that is crucial to understanding the non-disclosure in mental health care encounters and the pathologisation of those who do disclose. There is also of course a relationship between these two phenomena as the non-disclosers resist the pathologising identity which is imposed by mental health care practitioners on many of those who do disclose. Furthermore the individualism of nursing care threatens to erase difference and lead to victim-blaming. For nursing practiced to be emancipatory it must disrupt these dualisms, and in particular it must disrupt the shame/pride dichotomy; it can do this through both normalising lesbian and gay identities and tolerating, but not imposing, any uncertainties people bring to their mental health care encounters.

### Reflecting on the Situation

In this thesis I, as a researcher, have made claims to have straddled epistemological divides and produced a bricolage through mixed methods and interpretation of the data through different lenses. The main argument in this thesis about methodology has been that the researcher has worked as a bricoleur; in order to research any aspect of cultural practice methodological purity must be eschewed (Brown, 1999). Concerns about undertaking such research are that it inflicts conceptual violence on theoretical systems (Parker et al., 1995) and it lays the researcher open to charges of ontological gerrymandering (Harper, 1999). However, these concerns can be addressed by asking about the "quality of the results, how well they serve to inform us about the issue in question, (and) what kind of work they make visible" (Brown, 1999, p. 40). Brown says further that this judgement can be informed for the reader by asking:

> "are my analysis and implications persuasive, taking what you know of my assumptions and politics into consideration?" (Harper, 1999, p. 140).

This requires the writing of a transparent account which demonstrates sensitivity to context, the importance of the findings and which positions the researcher. The context and position of the researcher were given in chapter one and then re-visited throughout the thesis in terms of the insider status of the researcher and the use of innovative sampling strategies. These approaches disrupted the researcher's own worldview as discussed in chapter four and these, alongside material-discursive methods of analysis, have made visible the kind of work which other studies have up until now obscured. In doing this no grand claims have been made to have completely overturned dualisms – in short to claim to have single-handedly reversed centuries of Cartesian thought – and any claim to have extended knowledge will be partial and situated. However, the claim made here is that the shame/pride dichotomy has been disrupted as have a number of other supporting ontological, epistemological and methodological dualisms. This process opens a window into how the practice of nurses and other mental health care professionals could make their practice more emancipatory through further disruption of individualism.

## Appendix 1 – Examples of preliminary coding from an early stage of data analysis using IPA

Examples of some preliminary coding of data are shown in here. Much of the data coded here was later clustered to form the category “Experiences of being silenced”. The preliminary codes were:

1. Experiences where Health Care Practitioners said sexual identity was not relevant
2. Experiences of sexual identity issues being trivialized by Health Care Practitioners
3. Experiences of sexual identity issues being ignored by Health Care Practitioners
4. Experiences where Health Care Practitioners became hostile after disclosure of sexual identity
5. Experiences of rejection by Health Care Practitioners after disclosure of sexual identity

The data is shown here after it had been organised under these preliminary codes using NUD-IST (a computerised qualitative data analysis programme). This stage of data management took place after preliminary coding through annotation in the margins of each interview transcript. The numbers in the left hand margin refer to the line number of the interview transcript

### 1. Data marked up under preliminary code “Experiences where Health Care Practitioners said sexual identity was not relevant”

ON-LINE DOCUMENT: IV 25

1448 *you say that the counsellors that you did see, they were kind of OK
1449 about it, as in they were tolerant, but that was as far as they
1450 were, that was as far as it went. They didn’t have this extra
1451 bit of understanding....

1453 *: I would say that that was as far as it went. Yes, um..

1455 *: so it was kind

1457 *: OK, I don’t have trouble with you being gay, you know

1459 *: and that was the end of the discussion

1461 *: um ... ... pretty much. Yes, pretty much ..

2010 *: So did you feel you needed to talk about your sexuality to
2011 get the help you wanted at the time.

2013 *: Yes, and quite frankly, even when I did, I actually, I don’t
2014 think Good God, I don’t think I even mentioned the fact that I

did have um, I think it was, fifteen weeks CAT, [ ] Therapy, that was the NHS stuff that I got um … and …my being Gay was literally sort of noted down and passed over. It didn't figure in anything that was subsequently said. It just didn't figure. Yea, OK fine.

*: How did you feel about that at the time?

*: ..er … God, I don't know. Disappointed. …… …

*: So did did you say you were Gay quite early on in the fifteen weeks?

*: Yes, I did. Um …. .. Yes I did.

*: And you got that sort of, 'That's fine'.

*: Yes, Yes I don't have a problem with that, but you know ..

ON-LINE DOCUMENT: IV 42

* Well he encouraged me to talk about it, to bring the issue up in group therapy but you see this other female nurse said well you know it's not really applicable to the group is it? Which I, I was so shocked by I couldn't really argue because the male nurse had specifically said you know band it out in the group, that's what it's for, you know, and it would have been very difficult for me to say well this is one of my real problems. But I thought oh well no, I'll ask the female nurse about it and she just said well you know it's not, not really anyone else here with that problem.

**2. Data marked up under preliminary code "Experiences of sexual identity issues being trivialized by Health Care Practitioners"**

ON-LINE DOCUMENT: IV 42

* Well, one nurse was quite nice about it and she said look why don't you just go somewhere and sort yourself out, all this business, you know all this business, it's like a fundamental part of my life, you know and er she said you know it doesn't really matter, people are what they are, you shouldn't worry about it, but that was the only inkling of any kind of support for what I was really going through that I had, um and they say you keep, keep taking these overdoses or slashing your wrists or whatever, it's not going to straighten you out. Um you know that sort of thing, and I think maybe if I wasn't

part of the profession I wouldn't have picked up on it.

* A pain in the neck because I couldn't come to terms with what was going on as far as I was concerned, my identity and stuff and um just doing things to myself and my environment so that someone else could pick up the pieces, um, I, a lot a lot of nurses use the word 'responsibility' to me, I wasn't being responsible, I've had to take it all on board for myself to sort out.

* So did you get the impression that they thought you should just be able to come to terms with being gay and get over it?

* Mm.

* But they didn't actually offer any help or support with that?

* No.

ON-LINE DOCUMENT: IV 45

* Odd experience really because um I tried to mention it to a GP when I was about 21 and really it was impossible, he was ex Army er Medical Corps and really not interested, said pull yourself together and go and get a girlfriend, sort of thing, which you know parents were absolutely hostile and as were my whole family and friends or perceived to be you know with no positive stereotypes when I was young of being gay I mean I, I didn't meet my first known gay person

### 3. Data marked up under preliminary code "Experiences of sexual identity issues being ignored by Health Care Practitioners"

ON-LINE DOCUMENT: IV 12

infatuated with someone that's distracted me on my course you know, nothing, nothing major um, you know infatuation, I just want to get away from being infatuated but yeah, it was just something that I don't think was I don't think she really took me very seriously on being, being so young. You know I think she sort of said to me well look wait a couple of years you know, you might meet someone, that's what it seemed like, and I just it's not right, it's not what I want.

ON-LINE DOCUMENT: IV 13

* Like she wasn't really negative but she just wasn't you know, she didn't take it that one step further to sort of help me yeah, she sort of helped me discuss whether I should tell my friend but that's

where it went, I mean there's more to it than that, that's just one

ON-LINE DOCUMENT: IV 20

being able to bring up the sexuality because I was so embarrassed and what I did was talked about all the stuff with my dad again which I'd done, and which was dealt with and it's nice to talk about something you know it's nice to talk about some I'm sure we all benefit from counselling all the time but it was kind of old ground and I covered it up basically. And um it wasn't until the very end of those sessions because they were time limited and I think I had something like four months and then I knew it was going to come to an end, and again it wasn't until the very end that I started talking about it, by which time there was no real value because I had to go. Erm and I remember some time later being at the health service for something else and I actually got given my medical records to sit outside an office and wait for a GP and they didn't used to seal them up, they do now, interestingly, and I read them, and it was appalling, not only all my psychiatry referrals because I was just treated you know there was one line somewhere saying mildly clinically depression, leave on Prozac, and um, one of the other things that I read was that the GP had written a referral letter to that counsellor er which actually said talking about issues of sexuality and that counsellor must have known from the beginning yet didn't bring it up or didn't enable me to and I remember feeling very very angry about that because I think even though it may not have been appropriate for her to sit there and say right you think you're gay you want to talk about it I think she could have explored it because I hinted so much,

* Where you'd specifically said you wanted to talk about sexuality to the GP and that she never picked up on anything, or any hints.

* No. And I wondered you know afterwards, I remember reading those notes and feeling so angry about it, um I didn't particularly like her very much as a person anyway and I just remember feeling um you know but you knew, you know like in one of these dramatic film scenes when someone's saying something in their head, I felt like that, I just felt like saying but you knew, but you knew all alone that I wanted to talk about my sexuality and you let me go on for nine weeks or however many sessions it was about things which really you know, I was wasting your time as well as mine and I, you know I wondered what that was about, was that you know for me because it was quite close to that time of just coming to terms to it and accepting it, I guess the first thing I was thinking of was oh, it was because she, it was because I was gay and she didn't want to talk about it, and maybe it

1810 was a little bit about that so it must be something wrong but I think
1811 by then at least I'd had other positive experiences and inputs that
1812 wasn't too detrimental, but potentially it could have been, it could
1813 have just reinforced everything I was worried about, um and I don't
1814 know what that was about and unfortunately I'll never have a chance,
1815 you know because you don't at the time do you, you know I'd love to
1816 now, I'd love to say well didn't you know and why didn't you pick it
1817 up, and there's always two sides to every story, and I'm fully aware
1818 that she couldn't have gone into the first session and said so you
1819 think you're gay, let's talk about it, because that would have been
1820 bad practice too, and the chances are I might have run a mile but I
1821 have to say that some of the time when I talked to her I'm sure there
1822 were little things that I must have dropped in, I may have even
1823 talked about Sue or I may have even talked about the straight girl
1824 that I had a crush on, and although I would have never explicitly
1825 said anything I would have implied it and if she knew that there was
1826 something about sexuality she could at least have said something

ON-LINE DOCUMENT: IV 25

2025 *: So did did you say you were Gay quite early on in the
2026 fifteen weeks?

2028 *: Yes, I did. Um ….. .. Yes I did.

2030 *: And you got that sort of, 'That's fine'.

2032 *: Yes, Yes I don't have a problem with that, but you know ..

2068 *: And and did you feel at the time that it was relevant and
2069 that it was part of the equation.

2071 *: Very definitely, very definitely. Yes, I mean, Christ um …
2072 when I had the CAT, we're talking sort of early 95, no, October
2073 94 to February 95, that was the period I think. Yes, it was,
2074 um so that, by that time I'd known, [ ] for a year and
2075 I'd spent a considerable amount of time. I, by that time I had
2076 Lesbian friends um .. you know, getting to know Gay people,
2077 getting to know myself then … um ..

2079 *: And what what were the things that you felt you needed to
2080 sort out in that space if you'd been able to ..

2082 *: … I still had a lot of qualms which which I gather, you
2083 know, from most of my lesbian friends um, those who didn't know
2084 from a very early age that they were gay, I still had qualms

about actually entering into a relationship um.... Pretty dam scared um, you know, it its that mixture of ... ... ... ... um ...

*: Can you say a bit more about what you were scared of.

*: woa.... God .... ... I suppose there was on some level still a feeling that lesbian sex would be somehow dirty and in point of fact my feeling now is exactly the opposite. That heterosexual sex is dirty! Lesbian sex - lovely - thank you very much. .. but, but, you know in that period it was still an issue. It was still ... um .... My God you know what what will it be like, um

ON-LINE DOCUMENT: IV 35

* Um I actually went, I started to see a counsellor, or psychiatrist as he was then, um and I was on tablets, I can't remember what they were then, because I used to cry all the time, I'd cry for anything, um anything could happen, someone could knock on the door and I'd cry, um, and it was, so I was on these tablets and they were like to take that off, to stop me sort of like getting so emotional, erm and so I started to go and see this psychiatrist but he was very very bizarre, very weird, and he just got straight into the um, like towards the end of the first session it was like straight into like masturbation and I was like where are you coming from, I don't understand this, and then the next week I turned up and there was a woman there as well and he said oh I hope you don't mind and I was like actually I do, I'm not comfortable with, I'm not comfortable talking about this in front of a woman, how I feel, um, but like I just felt I couldn't do anything about it, and then he was just straight into this like um what I do to myself all the time and I was like I really don't understand where this is coming from and I sort of said to him look you know I don't understand where we're going here, I didn't want to be talking about this, and he was like, oh no, no, no, we're finding, we will get on to it, and I was like - so I didn't bother going after that and I just sort of like, I kind of, I suppose I mean I just worked through it, I certainly didn't tell anybody else, I didn't talk about it with anybody else, um.

* So did you tell that psychiatrist what, what you were sort of trying to deal with? Or you just talked about masturbation anyway.

* Um, no, because he didn't, I didn't actually get a chance to say how I felt, he was just like totally into this, I don't know where, I mean I just can't see, I'd never go and see a psychiatrist again, I

mean counselling's brilliant because you just don't, it's nothing like that, and I can remember a friend of mine, he was having problems, he was like um, he was having these fantasies about sleeping with a man, and um he said to me oh like I'm going to go and see a psychiatrist about it and he phoned me up the next day and he said you went to see a psychiatrist, yeah I did, did he talk about masturbation? Yeah. Well that's all he talked about for a whole hour. And I was like, I don't, I just don't see the connection, but this was in Basingstoke, and his was in Basingstoke as well, I don't know if it was the same guy. Probably was. And er that was what they seemed to be fixated in down there, so no I didn't get a chance to talk to him about how I felt, erm.

* I mean did you say anything to him about what was going on?

* No, not really, all I said was that I fancied a friend of mine, a female friend of mine.

ON-LINE DOCUMENT: IV 45

* check, you know is this really the person I am you know, and I went through a sort of bad depressed period over that, and saw the GP and he didn't want, he didn't like it, he didn't want to discuss it and when I said you know I'm er gay and er sort of mentioned it to him, he he was just sort of was very dismissive and said how long have you been like this and I said always and he didn't ask you know to pursue that any more, and er what was his next classic comment oh he said did I have a partner, I said no, did I have casual contacts, I said very rarely, I said I've got good friends, and then he said well you want to sort yourself out he said your problem is you're shy of women, which I thought was a classic, but he really did say it at a

* was sort of, she didn't flinch, but she was quite dismissive and she said er oh the only reason you're attracted to somebody of that age group is 'cos you, you um want to be that age again and re-live it she said, and she, and I said well, and at that time I was going through a sort of spell sort of saying well I'm saying to myself accept it but I can't do anything about it so just dismiss it totally and she sort of said well that's a good avenue to pursue and I thought, and afterwards I thought well that's stupid because you can't just dismiss it, it doesn't just go away you know and so that reaction was strange. Um, another couple of people I saw there, it was all on the notes and what was annoying, seeing different people each time you went, you had to start from square one again, so you only get sort of 40 minutes to chat to them and by the time I'd been through my background, there was no time to talk about current

456 problems or sexuality or anything er, and all you know, so it was a
457 bit of a waste of time really. But they were, I would say,
458 relatively dismissive. I think it very much depends on the person
459 that you see. Um and I know from talking to other er friends and
460 people I've bumped into, they've often had similar experiences with,
461 with GPs and counsellors, and if you do get somebody who sort of
462 accepts that it's OK, they perhaps don't delve into the detail that
463 you, you really need to go into, it's fine for somebody to say well
464 fine, what's your problem, get out and do it, but it's not easy for
465 you know for a huge number of people actually, huge numbers.

ON-LINE DOCUMENT: IV 5

573 wasn't as sympathetic as I could have hoped for. Don't get me wrong,
574 she was exceptionally professional during the whole things, but I
575 perceived her to be skirting around certain issues and not wanting to
576 talk about certain things that I wanted to talk about because I
577 considered it to be an issue. A lot of it was revolving around
578 sexuality and lifestyle and things like that. Things that I wanted to
579 talk about and speak my mind on but things that I don't think that
580 she was quite prepared to have at her table, as it were.

618 that a lot of things would stem from that. But it generally did try
619 ... or she tried like what about when you were with H, or what about
620 when you did this or that? Sort of almost like rebuffing me
621 basically.

ON-LINE DOCUMENT: IV 8

1630 answers were. But it's ... if somebody listened to what I have to
1631 say, including the fact that I was gay, and not judged me and said
1632 that was wonderful rather than ignored it or said that it was bad. I
1633 mean to be honest, when people ignore it it's worse than saying that
1634 it's bad. Then it would make so much difference because it's a
1635 response you get. So many people have that support but I was

## 4. Data marked up under preliminary code "Experiences where Health Care Practitioners became hostile after disclosure of sexual identity"

ON-LINE DOCUMENT: IV 1
306 * ... We sat down - this sheet of going on in my life. My parents were
307 one of them - - , being a survivor, college and my girlfriend at the
308 time. And he looked kind of not shocked, he accepted what I was
309 saying, however he prejudged me to be something - - , he had a
310 prejudgement in the sense that sometime I was working with kids and

311 being gay. He was kind of I don't know if I need to go into the
312 office. But he just didn't seem to respond as I would do now
313 when I'm counselling. It was more stand- offish. - - after that who said
314 that. I'd been in there the whole ... roughly the whole hour and he

ON-LINE DOCUMENT: IV 12

587 * Yeah, because she wasn't very supportive.

1860 * And when you did sort of mention about somebody of the same sex and
1861 everything did it alter the way she behaved towards you?

1863 * I think so, it felt that way yeah.

1865 * In what way?

1867 * But I would keep still going back to her. Um, well just the,
1868 because I would always comment on her and her body language and
1869 different things like that, because I was very much into psychology
1870 at that time and I was just sort of reading up on things like, and I
1871 remember sort of saying to her oh you know you seem a bit offish
1872 today, she was like well don't concentrate on me, concentrate on you,
1873 and things like that and I was like oh right, and I just found myself
1874 being a bit kiddish around her like you know why am I really here you
1875 know in my head, thinking you know am I just here for someone to
1876 listen to me you know because people in my life weren't really
1877 listening, and I think that's what she got out of it and because she
1878 was a female counsellor you know I think maybe, I felt more
1879 comfortable to talk to her, I don't know if I could do that with a
1880 male counsellor, I mean maybe, maybe he would have known how to be
1881 with me or maybe, I don't know, it just seemed that, she was for me
1882 someone that I could, I could talk to so she obviously gave that
1883 impression but then when I did tell, start telling her things, you
1884 know I could feel her getting a bit anxious because I was talking
1885 about this obsession that I had with someone, an older woman, you

### 5. Data marked up under preliminary code "Experiences of rejection by Health Care Practitioners after disclosure of sexual identity"

ON-LINE DOCUMENT: IV 5

562 *professional counsellor. I phoned her up and said, well look, I've
563 broken up with my girlfriend, I'm really low about it. And that's
564 where it started, the first couple of times I saw her it was all
565 about accepting the loss and things and then it got on to why we

broke up and that's what basically opened the flood gates and it all went downhill from their.

*What happened?

* Counselling should be a positive thing but I viewed it very negatively after it started becoming the gay issue, as it were. She wasn't as sympathetic as I could have hoped for. Don't get me wrong,

being perfectly natural and things like ... I've experienced a loss so I'm going to feel really crap about it basically, and it just seemed like she was full of understanding and full of like knowledge and wisdom and then suddenly when it turned to like basically the gay scene, that seemed to all sort of close off suddenly, and it felt very cold, very sort of impersonal as it were.

*So what do you think she thought of you once you sort of come out as it were?

*Um. I think her opinion of me sort of dropped actually. I mean that could have been just my personal perception. But she ... when we were talking, I sort of picked up on it most that she wasn't ... no that's the wrong, that's cruel ... I perceived at the time as though she didn't really want to talk about stuff that I wanted to talk about and for want of better words, didn't seem to care. And that is

that a lot of things would stem from that. But it generally did try ... or she tried like what about when you were with H, or what about when you did this or that? Sort of almost like rebuffing me basically.

ON-LINE DOCUMENT: IV 42

* Um and one of the male nurses who was really good about it. Um, and I spoke to a female nurse about it but I instantly regretted it, I don't really understand the mechanics of it because I didn't feel, I was really kicking myself about owning up um but I don't really know what the dynamics of it are all about really because I didn't feel that way when I spoke to the male nurse about it.

* What happened with the female nurse?

* I don't know, nothing different, I think it might be that she, well the male nurse was married, but she was married with a family and stuff and I just thought she, you know, maybe she thinks that I fancy her and er you know she's too understanding, maybe she's really

worried about coming back to talk to me now because she thinks I'm going to leap on her or something. Um you know probably completely unreasonable to think that but -

* But that was how you felt?

* Mm.

* So I mean did she keep her distance after that or not?

* Yes, because at the time that I discussed it with her I was on my re-feeding programme and I felt that she was grilling me a bit more than the other girls, we used to eat together, about six of us at dinner and um I used to think that she picked up on my little tricks more than everybody else's, but you don't know how much of it is you know, your own paranoia. I'm sure she did, um but you know you can't really be sure.

## Appendix 2: Examples of silence during interviews

Notable silences are signified in the transcripts with three dashes (---) and numbers in the left hand margin are line numbers from the original interview transcript.

ON-LINE DOCUMENT: IV 1

177 * my friend was cool, she didn't have a problem whatsoever. Her husband
178 did at the time. Her husband did at the time and, um, to begin with
179 he wouldn't even let me look after their little girl, despite the
180 fact that I'd been there all the way through the pregnancy, all the
181 way through the birth and was looking after her all that time but he
182 wouldn't let me see their little girl and that was quite hurtful.
183 But I knew he was doing what he had to do and given time he will
184 come round and did.
185
186 *What did he think would happen if you looked after his little
187 girl?

189 * Um, to be honest, I don't know, I don't know. I don't think he
190 knew, that was something that he had to explore to find out, which
191 was fair play to him, he wanted to protect his little girl --- But ---

440 *It didn't leave me insecure about my sexuality because I knew
441 that wouldn't happen. It left me unsure about my reasons for my
442 feelings for women.
443
444 *H: And what would that have meant?
445
446 *I don't know. I don't know, I didn't go down that --- I don't
447 know what the consequence is going to be ---

ON-LINE DOCUMENT: IV 2

642 * Yes it would have, but I just felt that these people that I was
643 seeing, over periods of time, I couldn't really --- I just felt that
644 big, I was speaking to the wrong person.

646 * Can you say a bit more about why they were the wrong person?

648 * I don't know. They --- like somebody. They didn't feel like
649 somebody friendly that I could talk to. I don't know, like somebody
650 in my family I could talk to. What have you. I just felt that ---

* How do you think they would have seen you if you had said what was going, what was the problem?

* That's just another thing, I just thought --- I was wondering that myself, you know. If I did say 'I'm worried with my sexuality' --- I don't know, especially speaking to a psychologist. I don't know, I can't relate to telling him anything like that.

## ON-LINE DOCUMENT: IV 23

*Did you think it would change the way people behaved towards you if they knew?

* Um --- Yep.

* What did you think would happen?

* I probably thought that --- um --- Don't really know. Can't think about it --- Anyway um ---

## ON-LINE DOCUMENT: IV 29

* aware of it at that point, but um---. Yes, so, so I mean I was kind of aware of that and I was aware that I was probably um --- gay. That wasn't a word which I ---.it took me a lot --- you know its, words are important when you are an adolescent, its, its kind of things, and gay just didn't seem to fit at all. It was, it wasn't until I was a lot older that I felt remotely confident in saying I

## ON-LINE DOCUMENT: IV 31

* There probably are a few things that I could do --- cope with a sorting out. But it's not something --- it's something I would probably only talk about with Lausanne and a psychologist, if I knew a psychologist wasn't then going to make an issue of it, but having had so many people make an issue of it, it's really hard to try and do.

## ON-LINE DOCUMENT: IV 41

*Do you think she could have done anything or said anything that would have made it easier for you to be open with her?

*Um --- I don't know, I don't know how --- That's a difficult one to --- Yes I'm thinking, talking of thinking like I am absolute, really distrusting of talking to people about that and so I don't know if there's anything more she could --- Because she actually was really good and I don't know if there's something that, you know, if it could be either way listed that they offer this counselling but you know, then does that single out people who feel strange?

*So what was the distrust about or worst-case scenario in your mind?

*Um, that somebody would tell me like they told my friend I got the phase within, try to analyse me. Talk about your forebear. Just have that kind of --- There's a certain like kind of therapy that I just think whole Freudian kind of analysis and I just stay away from and I'm always thinking I'm going to get ... somebody who's like one of those people who's trying to like prove that, you know, it's genetic or it's ... And because I have been --- I mean I think that I've always been queer since very young and I now have memories of things that happened when I was a kid --- I don't know, it's something --- I just don't want to feel like I'm understudy the ... Does that make sense? As a freak or something, you know. It's one thing - - but I don't know I think maybe it's also just the homophobia, afraid that I'm going to get their homophobia and yet I could hang out with this guy like L and me you know. But in some ways that's much more superficial than actually trusting somebody with all ---

*So how would it make you feel if somebody first said, you know, you're like this because of your relationship with your girlfriend

*That would be just like --- like I know that would make me feel I would be angry about that.

*What is it about it that makes you angry?

*Um, because it's like disempowering me to like understand myself or like that kind of approach of therapy as well, that's what I mean like Freudian analysis, where it takes the power of my kind of understand myself. I kind of --- She was using a therapy, you're not familiar with all the --- But like asking me how, you know, where do

*H: But in a counselling situation

* I mean that's the thing. It's like if somebody told me it's a phase or it's a difference, you know, like that's a part of you that's not healed, and especially because I feel confusion about it. And yes, if I did, you know, come with like I've had this confusion

and yes it's going to be about that --- They're not going to underst ... What I said earlier about not being able to understand the subtleties of that to help me negotiate that in an empowering way rather than telling me what ---

So it sounds like you don't really get a chance to work on that confusion then because of those things.

* Yeah. I also --- I think, I mean just from talking about this it's good because I feel like I can see where I could be more assertive and just take the risk and just go, yeah, I'm queer. Which is a way that in San Francisco I'd be much more likely to deal with it. There's this kind of confrontational attitude almost in terms of --- It's like I'm queer and this is my --- But here it's ---

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