Queer Expressions: An Interpretative phenomenological analysis of how Irish Gay Men discuss sexuality with healthcare practitioners

by

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Dedication

I dedicate this thesis to my husband and greatest ally, supporter, and teacher Dr Declan Gilmore-Kavanagh.

Acknowledgements

This thesis would not have been possible without the contribution, guidance, and support of many special people. The PhD journey has seen me transition through two jobs, traverse across countries, experience two health crises, a global pandemic and many moments of doubt.

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Abstract

Queer Expressions offers an insight into the experience for Irish Gay Men of discussing sexuality with healthcare professionals. It clearly establishes a specific understanding of what sexuality and health mean for Irish Gay Men and how this understanding, along with broader social constructs and experiences, impact on how sexuality is discussed in a healthcare context.

Ireland has seen unprecedented progress in the area of LGBT rights in the past three decades; from the decriminalisation of homosexual acts following legal challenges in 1993, to the provision of same-sex marriage following the world's first popular public vote on the issue in 2015 and the election of an openly gay prime minister in 2017.

Despite significant social progress, health disparities remain amongst the Irish gay community, and an EU fundamental rights agency 2020 LGBTI survey (EU, Fundamental Rights Agency, 2020) identified that a quarter of Irish Gay Men have not told any healthcare provider that they are gay.

Through the use of Interpretive Phenomenological Analysis (Smith et al., 2009) the experiences of 12 Irish Gay Men are explored and illuminate the specificities of Irish Gay Men's encounters and discussions of sexuality with healthcare professionals. The layered and multidimensional sexual identities of Irish Gay Men are revealed, along with the ways in which their encounters 'Queer' the provision of healthcare within health professional consultations. The men in the study also provide a unique and specific account of how the concept of health is perceived, experienced and embodied for this group.

The thesis clearly establishes the implications for practice, policy and research around specific considerations for Irish Gay Men in healthcare professional education and training; and within the systems in which healthcare is provided.

Research Outputs

The following conference presentations included content published in this thesis

Gilmore, J. (2019) 'Rights based approach to sexual health education' – National Conference and Youth Summit on Positive Sexual Health. Mansion House, Dublin, October 2019.

Gilmore, J. (2019) Engaging LGBT+ Inclusive Practice. Growing Research and Researchers. Canterbury Christ Church University, June 2019.

Gilmore, J. (2019) Queer Expressions from Proposal to Pedagogy. School of Nursing Midwifery and Social Work Research Conference. Canterbury Christ Church University, June 2019.

Gilmore, J. (2018) Phenomenology IN practice: What healthcare practitioners can learn from 20th Century Philosophy. Medical Humanities Network Conference Maidstone and Tunbridge Wells NHS Trust, March 2018.

Gilmore, J. (2016) The practice of phenomenological nursing: a step beyond person-centredness. Cross-disciplinary Phenomenology: A Readiness for the Questionable. Oxford Phenomenology Network, University of Kent, June 2016.

Gilmore, J. (2015) 'Beyond the delusion of 'Diversity': Towards Equality through intersectionality and Queer Inclusion.' Galway Mayo Institute of Technology conference on Diversity: Promoting Equality, Castlebar, Ireland, November 2015.

Gilmore, J. (2015) Queering Expressions of Sexuality in Healthcare. Queering Paradigms 6 – International Applied Queer Studies Conference, Canterbury Christ Church University, June 2015.

Author Biography

I am a registered general nurse and assistant professor of nursing, currently working in a large Irish university as well as maintaining limited clinical practice in the intensive care unit of a large university hospital.

I hold a BSc in General Nursing from the National University of Ireland Galway, Graduate Diploma in Intensive Care Nursing from University College Dublin and a Masters of Social Science in Human Rights and Social Policy from Maynooth University. I also hold a Certificate in Academic Practice from Canterbury Christ Church University and am a Fellow of the Higher Education Academy.

Complementary to my 12 years working as a nurse in clinical practice and education, I have worked in social care and youth work settings, in voluntary and professional capacities. I have had a passion for social justice and activism since my teenage years, and see my practice as a nurse, educator, scholar and citizen through an emancipatory lens.

I originally come from the West of Ireland and currently reside between Dublin and Canterbury, UK.

Motivation for study

In the arena of Gay Men's health my own identity transcends the patient/practitioner binary, as I am both a Gay Man and a nurse. For my entire adult life, I have always considered my sexuality to be a most central aspect to who I am as a person and therefore important to my wellbeing and in building relationships with others, including healthcare professionals. Starting my journey in nursing, in the early 2000's, during my studies on the BSc in Nursing, sexuality as an aspect of humanity and of daily living, was posited as something which is often left unexplored or not engaged with in a healthcare setting. Indeed, I received no theoretical instruction on the healthcare needs of Gay Men, studying a BSc in Nursing you wouldn't even know Gay Men existed.

Later in practice as a student nurse and then staff nurse I saw the sections 'Expressing Sexuality' in nursing assessments underpinned by Roper, Logan and Tierney's (1980) model of activities of daily living, either ignored, crossed off, or determined as 'not applicable'. Nothing could be more applicable to my own care or treatment, than my sexual identity as a Gay Man.

The EU Fundamental Rights Agency (2013) LGBT survey identified that one third of Irish Gay Men did not disclose their sexual identity to their healthcare providers; to me this presented a clear issue around the access for these men to appropriate and person-centred healthcare. While many studies focus on the barriers to discussing sexuality from a practitioner perspective, I was particularly interested to understand the experiences of those receiving care or treatment, to explore how and why Irish Gay Men engage in discussions round sexuality with healthcare practitioners, or not. As an Irish Gay Man, I was particularly conscious of the massive social progression of LGBT rights in Ireland over a relatively short period and interested to understand the particularities or peculiarities of Irish Gay Men in this context.

Queer Expressions is centrally grounded in lived experiences – as a healthcare practitioner, person-centredness is core to my practice in all fields; taking an interpretive phenomenological approach to

understanding the lived experiences of Irish Gay Men has offered a fruitful and important thesis in this field.

Thesis Layout

Introductory Chapters

The introductory chapters to this thesis provide a scaffold around which the Irish Gay Man and his discussions of sexuality with healthcare practitioners can be framed. This section begins with an adapted concept analysis (Walker and Avant, 2011) on sexuality, which establishes a multifaceted perspective on how sexuality can be understood, and the ways in which it might be discussed. The second introductory chapter considers how sexuality intersects with health, illness and healthcare; including the issues around discussing sexuality in healthcare practice and integrating sexuality in healthcare practitioner education. Next, various socio-historical and theoretical underpinnings of Gay identity are explored. Specificities around psychological models of identity formation and coming out are given particular focus; then Sara Ahmed's (2006) Queer Phenomenology is presented as a novel way to understand sexual orientation as a spatial orientation, considering the things people orientate towards or away from in experiencing and expressing their Gay identity. This section also provides an overview of homosexuality and Gay identity in an Irish context, highlighting some of the socio-historical milestones in Irish Gay identity. The concluding chapter in this section goes on to consider Gay Men's health and considers the health inequalities and disparities particular to Gay Men, exploring some of the underpinning predictors of risk.

Methodology

This section of the thesis lays out the methodological and research design considerations taken through the development of the project. Interpretative Phenomenological Analysis (IPA) (Smith, 2009) is used in Queer Expressions to illuminate and explore the lived experiences of Irish Gay Men of discussing sexuality with healthcare practitioners. The theoretical underpinnings of IPA,

phenomenology, hermeneutics and idiography are discussed and IPA is situated versus other qualitative research approaches and within research on sexuality. A realist social constructionism (Elder-Vass, 2012) is presented as the underpinning ontological and epistemological stance on which this thesis is developed.

Within the method section, a descriptive account of how the research for this thesis was carried out is given. This section details the recruitment and data collection process including sampling and interview strategies. Furthermore, it details the analysis process adopted, a traditional IPA analysis; and ethical considerations taken through the research are presented.

Quality Assurance, Validity and Rigour of the research process are considered, taking into account the central role of the researcher in IPA research. Yardley's (2000) framework for Quality Assurance is presented considering sensitivity to context, commitment to rigour, transparency and commitment, and impact and importance. A discussion on the researcher's role in the research process is explored through the section on reflexivity, and the use of a reflexive diary put forward as an important methodological tool.

Findings

The findings chapters are prefaced by a plotted summary of each of the research participants, in terms of some demographic data and a short overview of the interview, as well as excerpts from the reflexive diary. This provides the reader with a more rounded and contextual view of the data.

Findings are then presented in thematic sequence, with three superordinate themes and twelve sub themes. Superordinate theme one is Layers of Gay identity with subthemes: Being and doing Gay; 'This is the beginning' – evolving Gay identity; Places and Spaces; Gay 'with' others. Superordinate theme two is Queered Consultations, with subthemes: Relevantly Gay; Signs and Symbols 'Straight Laces' and 'Rainbow Stickers'; Disrupting Expectations; Tactical Outing. Superordinate theme three is

Healthy living and 'Risky Business' with subthemes: Actively Healthy; Outness and Wellness; Health as Sexy, Sex as Healthy; Risky Business.

In keeping with the idiographic nature of IPA, the analysis is grounded in and presented around direct quotes from research participants, and does not contain any secondary discursive data.

Discussion

The discussion chapter of this thesis is centred on the themes illuminated in the earlier findings chapter; these are in turn examined in relation to the broader evidence base contained in the introductory chapters. Firstly, the Gay identity expressed by the Irish Gay Men in Queer Expressions is considered alongside the psychological literature on models of gay identity, and specifically with Jaspal's (2019) perspectives of identity and orientation. Ahmed's (2006) Queer Phenomenology provides an alternative lens to understanding sexual identity and orientation and helps to illuminate the orientations and directions that make these Irish Gay men, Gay. The specificities of the Irishness, in the experiences of sexuality, such as intersections with religion and community, and the role of politics are further explained and can be seen throughout the discussion as framing particular shared experiences. Irish Gay Men's experiences of disclosing sexual identity and discussing sexuality with healthcare practitioners are discussed in relation to where they decide and how they decide to come out and how decisions around relevance are made. Varying methods of coming out are examined, the 'sussing out' of healthcare practitioners is a key strategy discussed; more positive experiences in sexual health services are considered and issues such as safety, competence and un-shockability are put forward as enablers The sussing out of healthcare practitioners and healthcare environments was critically examined in terms of pre-conceived presumptions and signs and symbols of inclusivity. When discussing coming out, Orne's (2011) model is particularly considered, but for Irish Gay men the risks associated with coming out in terms of 'explosive knowledge' in healthcare environments are juxtaposed with the risks of not coming out to their health and wellbeing. The participant's views

of health and healthiness were an unexpected point of focus in the thesis. The Irish Gay Men in Queer Expressions presented a view of health which appeared to be greatly influenced by a 'compulsory able-bodiedness' (McReur, 2010); this focus on occupation and activity as outcomes and signifiers of health, are discussed alongside perceptions of desire, aesthetics and masculinity. Participants in the study presented a complex consideration of risk, in terms of their identity and behaviour, which not only impacts their experience of health and healthcare but also their social identity and perceptions of other Gay Men.

The section is concluded with identification of clear original contributions to research on Irish Gay Men's health, as well as signposting how the research answered the questions set out at the beginning of the process. Furthermore, consideration is given to how the knowledge generated through Queer Expressions might be applied in healthcare practice, education, policy and future research; as well as considering conceptual issues of how phenomenology may be considered as praxis.

Conclusion

The overall learning from this thesis is drawn together and summated in the final chapter, reflective consideration is also given to how I leave the study as a Gay Man, nurse, educator and researcher.

Introduction

The central focus of this thesis is to explore and illuminate the experiences of Irish Gay Men discussing sexuality with healthcare practitioners. It is the first study which focuses on the discussion of sexuality by Irish Gay Men in healthcare contexts; the centrality of healthcare encounters and discussions ensure that the knowledge generated can be directly considered and applied in healthcare practice. As foregrounded by McCann and Donohue (2021) it is essential that nurses (and other healthcare practitioners) have a fundamental understanding of the unique needs of LGBTQ+ people and are equipped to practice cultural competence in their care. 1 in 4 Irish Gay Men have not disclosed their sexual identity to any healthcare professional (EU Fundamental Rights Agency, 2020); exploring how and why Irish Gay Men discuss sexuality in healthcare contexts provides a focused lens on this phenomenon, which can translate into practice and policy actions. Prevailing health inequalities faced by Gay Men provide for an urgency in identifying barriers and enablers to this group accessing and experiencing appropriate and effective healthcare. As discussed by Connolly and Lynch (2016)

> *"the extant inequalities for gay men accessing and using health services in the Republic of Ireland require a commitment at all levels of policy, and practice is needed in order to ensure that health and social care professionals are sufficiently educated to understand sexuality and sexual orientation in order to be able to provide holistic and individual care."*
>
> (p. 193)

Queer Expressions provides a unique and specific contribution to the wider knowledge base on Irish LGBT Health which will add to our understanding and ability to provide the kind of care called for above.

This thesis is grounded in the lived experiences of 12 Irish Gay Men; however, in order to contextualise and understand these lived experiences in depth, the following chapters provide a scaffold for the enquiry.

Firstly, the concept of sexuality will be explored using an adapted Walker and Avant (2011) process of concept analysis, facilitating an understanding of the possibilities and boundaries of the phenomenon in focus; this will then further be discussed in terms of how sexuality intersects with health and healthcare in literature. Then, focus will be given to literature on Gay identity, formation and experiences, a number of theoretical perspectives are presented as possible ways to understand Gayness. Specifics around the sociocultural placement of homosexuality in an Irish context are then outlined before evidence around Gay Men's health is presented.

Sexuality: A concept

Sexuality has long been acknowledged by nurse theorists, as an important aspect of care (Roper et al. 1980, Johnson 1980). However, in practice, discussions about sexuality, and of providing healthcare to people as sexual beings, seem to be absent (Savage, 1990; Quinn and Browne, 2009; Saunamaki and Engstrom, 2014). Moreover, there are only limited attempts to provide analysis of the concept at an academic level (White, 2002). With holistic care and person centeredness becoming the primary focus for nurses, and many other healthcare practitioners, the task of including sexuality alongside biomedical aspects of care may prove challenging. Given the complexity of the notions of person centred and holistic care, the process of care-giving can be shaped by broad concepts with nuanced meanings, which differ from provider to provider and from patient to patient. The exclusion of sexuality as an aspect for consideration when providing care may simply be due to a misunderstanding or ignorance of what the concept means (Webb, 1988; Nay et al. 2007) and beyond that, an ignorance as to the relevance of the concepts to health, wellbeing and personhood. Another reason may be that models such as Roper, Logan and Tierney (1980) and Johnson (1980) which are widely used in favour of their applicability, divide personhood into activities or behaviours, perhaps leading to the prioritisation of some elements over others, and the exclusion of aspects which may seem 'non applicable'.

Defining Sexuality

There is continued use of the word sexuality interchangeably with descriptions of sexual acts, feelings and sexual orientation, adding to confusion of what the concept actually means. These descriptions may be seen as quite reductive, given that there are many theories suggesting that the concept goes far broader. Stuart and Sundeen (1978) argue that we are 'sexual in every way, all the time'. They see sexuality as an integral part of the whole person which, to a large extent, determines who we are. Shope (1975) goes further, to suggest that sexuality permeates all other aspects of

being, and when taking these descriptions of sexuality into account, its relevance to nursing becomes very apparent.

By applying an adapted method of concept analysis as suggested by Walker and Avant (2011) this chapter clarifies meanings of sexuality and examines the attributes associated with them, aiming to illuminate a more operational understanding of the concept and its consequences for practice.

Method

Walker and Avant (2011) suggest that a process of concept analysis provides a framework for nurses, researchers and theorists to 'come to grips with' the various meanings and possible meanings within a concept, allowing the phenomenon to be described in a measurable and communicable way. The analysis is essentially a linguistics exercise, examining the elements of the concept, its usage and how it is similar and different from other related words. An adapted Walker and Avant (2011) framework used in this analysis, will consider explore sexuality using the following steps:

- Selection of a concept.
- Determining the aims and purposes of analysis.
- Identifying uses of the concept.
- Determining defining attributes.
- Identifying antecedents and consequences.
- Defining empirical referents.
- Application to practice.

While Walker and Avant (2011) further suggest the development of various cases to illuminate the concept, this might havedetracedt from the rich descriptions and experiences of sexuality garnered through the interviews with Irish Gay Men in this thesis and so was avoided.

Definitions and Uses of the Concept

Walker and Avant (2011) suggest identifying as many uses and definitions as possible, asserting that all uses of the term should be considered. For the purpose of this analysis of sexuality, definitions from philosophy, sociology, psychology, medicine, law and nursing were identified as well as general definitions from dictionaries and thesauri.

The Oxford English Dictionary (2010) describes sexuality as 'the capacity for sexual feelings; a person's sexual orientation or preference; sexual activity'. As mentioned in the introduction, viewing sexuality as being simply concerned with orientation or with sexual practices may be reductive; it can suggest that those incapable of physical sexual relationships, or those who self-define as asexual, with no attraction to others of any gender, are void of sexuality. However, by the addition of the phrase 'sexual feelings' the concept is suitably broadened. While the definition is not particularly helpful in deciphering what a sexual feeling is, it nonetheless allows for a more holistic view of the expression and experience of sexuality. Comparatively, the New Oxford American Dictionary (2010) describes sexuality as 'the feelings and activities connected with a person's sexual desires', while the American Merriam Webster's Collegiate Dictionary (2004) defines sexuality in a different way;

'the quality or state of being sexual; the condition of having sex; sexual activity; expression of sexual receptivity or interest especially when excessive'. The synonyms related to sexuality broadly fit into these groupings, many of which are directly expressed as feelings, including desire, lust, eroticism, sensuality, virility, sexiness, voluptuousness, carnality, bodily appetite, sexual orientation and sexual preference (Collins English Thesaurus, 2014).

While not contradictive to the Oxford definitions the latter introduces an interesting narrative, the concept of sexuality being 'excessive', perhaps leaning towards an approach of pathologising non normative sexual behaviour, which stemmed the following initial interests into sexuality and health.

Sexuality as an historical and social construct

One of the most noted theorists in the realm of sexuality studies is the French philosopher Michel Foucault, whose three part series, *The History of Sexuality* (1976-1984) was amongst the first writings to delve into broadening the meanings associated with human sexuality from a philosophical and theoretical standpoint. When describing the attributes and expressions of human sexuality Foucault focuses strongly on 'the body' as the tool and vehicle for this expression. While at a surface level, given the continuing reference to the body, it may be presumed that Foucault's sexuality is one which solely focuses on the physical elements of sex, Foucault's 'body' is not simply the physical and biological, it is 'an historically and culturally specific entity' (Foucault, 1976). It is one which is not solidified but one which must be viewed and treated differently depending on social and cultural contexts. Today, we may otherwise define this notion today as 'the person'. Foucault specifically views sexuality as an historical construct, pointing to the Victorian culture of regulation and oppression of sexual acts as the dominant precursor to discourse around sexuality as a whole. Foucault's conceptualisation of sexuality is constituted on three axes;

Knowledge about sexual behaviour; Systems of power which regulate the practice of sexual acts; The forms by which individuals are able, are obliged, to recognise themselves as subjects of this sexuality.

These are similar constructs as the modern definitions discussed, however Foucault places significant emphasis on the influence of the Victorian application of control and continually expresses sexuality's function of power. For Foucault, power applies itself in a multiplicity of ways in everyday life; it categorises an individual and has direct correlation to how that individual identifies and is identified. Faubion (2002) discusses how for Foucault, power, makes the individual 'subject'; not only subject to another, external structures and forces of control, but also subject to one's own identity 'by a conscience or self-knowledge' (p. 331).

Judith Butler (1990), further considers these interlays between sexuality and power; building on Foucault's *History of Sexuality* and the direct correlation between sexuality and power, Butler goes on to discuss the preordained and predetermined constructs and limitations of human gender and sexuality – rather than viewing sexual identity as a becoming, much of the constraints and limitations applied to the gendered and sexualised body are in fact already there. Sexuality for Butler isn't simply an attribute or inclination, but nor is it the 'bedrock' of our existence, it is however, for Butler (2004, p.33) 'coextensive' with our existence, it is always there, coinciding.

Jeffery Weeks goes on to further discuss the notion of sexuality being an historical and social construct in his seminal work *Sexuality* (1989). We are given a timeline for the development of the linguistics of 'sex' from its first use in the sixteenth century to divide male and female species, through to the nineteenth century when it described physical sexual acts through to modern understanding of sexuality as the basis for what is most natural about us as humans.

> *"Through it we experience ourselves as real people; it gives us our identities, our sense of self, as men and women, as heterosexual and homosexual, 'normal' or 'abnormal', 'natural' or 'unnatural'."*
>
> (Weeks, 1989, p.3)

While acknowledging the fluidity of sexuality in the realm of social and historical constructs, it is important to acknowledge that sexuality is a lived experience of the present, and so must be dealt with as it is experienced, while continuing to recognise and learn from its social and historical development.

The legal/jurisprudence approach

There is no identifiable definition or explicit mention of sexuality in British or Irish legislation. However, the law seems infinitely interested in control of sexuality, gender and individual's sex lives

and despite a 'progression' from Victorian oppression, theorising sexual freedom remains difficult from a legal perspective (Robson, 2011).

In both the UK and Ireland, Sexual Offence Acts determine which sexual activities are deemed legal and illegal, dealing with issues of voyeurism, sex in public, prostitution, sexual assault and rape, sex with minors and sex with animals (Sexual Offences Act, 2003[England and Wales]; Sexual Offences (Northern Ireland) Order 2008, Sexual Offences (Scotland) Act 2009; Criminal Law (Sexual Offences) Act 2006 [Ireland]). In Ireland the term 'sexual act' is restricted to 'an act consisting of – (i) sexual intercourse, or (ii) buggery, between persons who are not married (Criminal Law (Sexual Offences Act 2006 [Ireland]).

In England, Wales and Northern Ireland the law is broader and subjective, the act deems a sexual act as one in which 'a reasonable person would always consider it to be so; or a reasonable person may consider it to be sexual, depending on the circumstances and intention' (Sexual Offences Act 2003 [England and Wales]; Sexual Offences (Northern Ireland) Order 2008). The Scottish legislation also determines acts to be sexual based on the perception of the 'reasonable person' (Sexual Offences, (Scotland) Act 2009).

In the UK and Ireland, discrimination against persons based on Sexual Orientation or Gender Identity are illegal (Equality Act 2010 [United Kingdom]; Equality Act 2004 [Ireland]), however internationally, homosexuality is illegal in seventy eight countries, and 'State-Sponsored Homophobia' remains a reality (Itaborahy and Zhu, 2014). Caution should be applied to a wider discourse of how systemic and global homophobia are being challenged and dismantled in a progressive way through development and modernity; rights in legislation are not fixed and in cases like India and Russia gay rights have regressed in recent years.

Psychology, Sexology and Medicine

Interrelatedness between sexuality and health is not a new concept, there is a rich history of sexuality being a focus of physicians, stretching back to the ancient worlds. The particular focal point of sexual virility being a sign of healthiness, and converse sexual inactivity as being an indicator of ill health is evident in some of the earliest Greek medical texts (Laios et al., 2015).

Sexuality became a central consideration in medicine throughout the 18th and 19th Century, whether through the treatment of venereal diseases and an emergence of public health considerations (Fries and Winckelmann, 2018), or a more explicit critical discussion on the use of or refrain from masturbation and other sexual practices as a treatment (Stolberg, 2000); there was a clear focus on this, typically hidden, part of human behaviour.

As articulated by Bancroft (2005) medical attention to sex and sexuality is overarched by the contemporary socio-political and moral concerns of the time; stemming from 19th Century puratism, sex negativity in healthcare has prevailed for most historical periods.

Sigmund Freud's work in the early twentieth century set the scene for discourse around sexuality and its relationship to health, one of Freud's most famous quotes asserts:

"The behaviour of a human being in sexual matters is often a prototype for the whole of his other modes of reaction in life."

(Freud, 1908, p.25)

Freud's understanding of the interlinks between innate sexuality and its expression through human behaviour, gave a new perspective. Freud's work encouraged dialogue about sex in order to gain insight into human behaviour, acknowledging that sexuality has an important role in personal development and personhood. This, of course, was in a repressive Victorian era when discourse about sex was immensely frowned upon. While Freudian psychoanalysis remains a popular tool,

particularly in literary criticism, it is critiqued heavily in modern psychology. With suggestions of dishonesty and a lack of scientific rigour and objective standards for testing, Freud's works have become heatedly contested (Crews, 1998). Freud's work although enlightening interest in human sexuality and its relatedness to health, can also be critiqued for an over pathological view of human behaviours, as well as an explicit disregard of female sexuality (Ellis et al., 2009). Freud's work, although pioneering in its presentation of sexual minority identity and behaviour, did little to deconstruct the binaries associated with sexuality. Chodorow (1994) critiques not only the tying of heterosexuality to male dominance and sexuality to gender; but also, the individualism associated with psychoanalysis, negating the role of group identity in sexual minority lives.

Another noted pioneer of what we refer to now as sexuality studies is Alfred Kinsey. Having conducted the first large scale studies into sexual behaviour, Kinsey is identified as the first modern sexologist (Heath and White, 2002). Kinsey was the first to acknowledge that sexual orientation and identities were not a fixed phenomenon, nor a pathological process and that traditional binary views of homosexuality and heterosexuality were myths (Jones, 1999). His work argues that sexual orientation is better presented more fluidly on a spectrum, and his illustration of this comes in the form of a seven-point scale (Kinsey, 1948). Kinsey's work also brought dialogue of sexual behaviours into a normative frame, critiquing the over emphasis on pathologising sexual behaviour as many of his predecessors did;

There is a tendency to consider anything in human behaviour that is unusual, not well known, or not well understood, as neurotic, psychopathic, immature, perverse, or the expression of some other sort of psychologic disturbance

(Kinsey, 1953, p.195)

These seminal works, although flawed in many ways, brought about, at least, an interest into human sexuality and its correlation with health. Contemporary psychological approaches to issues of sexuality, however, appear to avoid the task of defining this broad concept. Instead, the American

Psychological Association deal with issues of sexuality by defining some of the interlinked concepts such as sex, gender identity, gender expression, sexual orientation, coming out (APA, 2011).

It appears that the term sexuality is also largely absent in medical texts. Like the approach of the APA identified above, these texts do not consider the concept of sexuality as a whole. The concept is framed only through discussions of phenomena such as sexually transmitted diseases, reproductive health, sexual orientation, sexual behaviour and sexual dysfunction. Rather than a holistic view of how these issues interlink and relate to holistic personhood, a segregated and biomedical approach ensues (Warrel et al., 2010; Souhami and Moxham, 2004)

Approaches to Sexuality in Health, Medicine and Nursing

Biomedical approach

As illustrated above the concept of sexuality is intrinsically linked to, and intersects with health and medicine. There is a tendency, however, within medicine and health professions to singularly focus on issues of sexuality through a biomedical lens. Despite dominant discourse on the objectivity of biomedical approaches, biomedicine as a lens is implicitly linked to the socio-historical constructions of sexuality discussed in the previous section. Biomedicine itself is a heteronormative construct and the way in which medical approaches have dealt with and continue to deal with issues of sexuality often stem from a pathologising and normative approach to understanding the human body, its functions and issues of desire and behaviour (Spurlin, 2019). Sexual medicine has, however, evolved in many ways, beyond a bodily function and sexual disease approach; even in more contemporary approaches to sexuality, where identity and behaviour are issues of interest, it is often still framed in a pathology centric way (De Block and Adriaens, 2013). A shift, from identity to behaviour, which does little to truly acknowledge sexuality as an intrinsic part of personhood.

Sexuality in Nursing

As mentioned in the introduction, sexuality has had limited explicit consideration in structured nursing theory; however, two widely adopted nursing models do explicitly discuss sexuality as a nursing consideration. Dorothy Johnson puts forward a behavioural system model for nursing (1980) in which human behaviours are seen as expressions and reactions to biological, psychological and societal stressors (Johnson, 1980). She identifies sexual behaviour as a specific subsystem, suggesting that it has dual function of procreation and gratification. It is suggested that the manifestation of sexual behaviour begins with the foundation of gender identity and moves then towards specific 'sex based' roles (Johnson, 1980, p. 214). Johnson's expression of sexuality is problematic as it cements itself on notions of fixed gender identity as the basis for sexual expression, something that is contested today with the phenomenon of non-confirmative gender behaviour, like the 'tom-boy' or 'metrosexual', or indeed in queer and trans culture.

Roper, Logan and Tierney (1980) provide another systems-based model of nursing. Their model centres on 'activities of daily living' (ADL) one of which is expressing sexuality. The model suggests that each AL should be considered in terms of biological, psychological, socio-cultural, environmental and politico-economic factors of influence. As with Johnson, Roper *et al.* (1980) include expression of gender identity as a core element of sexuality. However, their model is less fixed on the correlation between this identity and sexual acts (Holland, 2008).

Person centredness and sexuality

Person centredness has become a core aspiration of healthcare provision globally, a recognition of the needs, context and relationships of the individual in relation to their health and well-being. This approach to providing healthcare is underpinned by the work of Carl Rogers, an early 20th Century psychologist. Rogers' work conceptually acknowledges earlier work of Abraham Maslow (1948) which identifies the condition of human growth towards certain needs, which ultimately leads to

self-actualisation and the experience of optimum living; for Rogers (1951) however, growth is dependent on an environment which provides genuineness and positive regard, leading to acceptance and the experience of empathy. In application to healthcare, McCormack (2004) considers four core concepts which apply to the person, underpinning a person centred approach to care: (i) being in relation; (ii) being in a social world; (iii) being in place and (iv) being with self, applying a sexuality lens to each of these concepts may provide a method of ensuring sexuality-based healthcare needs are addressed. Lipinska and Heath (2020) explore using a person centred framework for engagement with sexuality in a nursing context, and return to Rogers (1980) conceptualisation of person-centredness through Acceptance, Congruence and Empathy. Their proposal is that using this framework, along with an identified needs approach, in their case around dementia, allows for an in-depth consideration of sexuality within their care; they are clear that in exploring concepts of sexuality, nurses consider expressions and behaviours of sexuality seen as core expressions of humanity, rather than problems to be solved.

Sexuality and holism

Differing views on the constructs of sexuality are evident, however the individuality of experience and expression demonstrate a clear lean towards sexuality being a much broader concept than one related simply to sexual function or relationships.

Dailey's (1981) Circles of Sexuality provide a framework for defining sexuality across five distinct areas: Sexual Health and Reproduction, Sexual Identity, Intimacy, Sensuality and Sexualisation. These areas then centre around a values domain, which acknowledges the interrelatedness of these aspects of human experience with an individual's cultural, familial, religious and other contexts. Turner (2020) puts forward Dailey's (1981) model as a strengths based lens to human sexuality for those working in social work, allowing for a consideration of sexuality beyond a biomedical focus,

which can provide a map to develop a client focussed perspective of what a 'balanced' sexuality looks like (p.313).

In terms of operationalising a holistic healthcare approach to sexuality; the World Health Organisation puts forward a definition aiming to represent a more holistic and permeating nature of sexuality:

> *"a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors."*
>
> (WHO, 2006, p.5)

Defining Attributes

Having presented definitions and discussions of sexuality from several perspectives I will now put forward what may be considered as core defining attributes of sexuality. Walker and Avant (2011) suggest that the heart of the concept analysis is in clustering the most frequently associated attributes to the concept to allow a broad insight into the concept. From analysing the different uses and definitions of sexuality as presented above it is suggested that the following are the essential elements to the identification and expression of sexuality:

- Sexuality is experienced and expressed both physically and emotionally, while for many the physical and emotional are expressed simultaneously, the experience can be held independently in either sphere.

- Sexuality is only expressed through conscious, animate beings and a core element of personhood. While inanimate objects may be sexualised and used for sexual gratification, they do not possess a sexuality of their own.
- A key attribute of sexuality is desire. Desire to gratify sexual urges and fantasies, whether it be with another or self-gratification. There is also a desire for oneself to look and feel sexual.
- Sexuality is directly linked to pleasure, positive expressions of sexuality make people 'feel'.

Antecedents and Consequences

Antecedents are the events or incidents which must occur prior to the occurrence of the concept (Walker and Avant, 2011).

In order to experience and/or express sexuality a person must have self-awareness and the ability to acknowledge their own role as a sexual being. There is also a presumption that the individual is able to communicate this role to the external world, to express their sexuality and recognise sexuality in another. While not all sexual acts/thoughts involve another person, it is important for the individual to recognise their feelings/behaviour as sexual. This obviously requires a certain level of emotional development and social knowledge. The communication of feelings and desires is important, both outward communication and self-recognition; while issues of disability and role as a social actor may prevent explicit presentation of these elements, the sexual body must have the ability to experience pleasure and gratification, and be able to interpret desire and gratification from itself and others. Consent and autonomy are also important factors in the development of sexuality, people cannot self-actualise their sexuality under duress.

Consequences, in contrast, are the outcomes of the concept, the events or incidents which may occur after the occurrence of the concept (Walker and Avant, 2011).

The consequences of sexuality are very much dependent on the level and intensity to which sexuality is experienced or expressed. Sexuality can provide for immensely positive experiences for

the individual in terms of sexual gratification, enhanced body image and confidence, and the building of interpersonal relationships. Sexuality however, may also lead to some negative consequences especially where a person's sexual orientation, feelings or desires fall outside of social norms (Altman et al., 2012). An individual or a group may become socially oppressed or discriminated against where their behaviour is seen as non-normative. Where sexual desires or feelings are not met there is also a risk for the individual of feeling rejected.

Sexualisation of an individual or group may occur outside of their own control, and indeed, sexuality and power are inextricably linked. There are also the consequences linked to sexual activities such as sexually transmitted diseases and/or pregnancy.

Empirical referents

As a final stage in the concept analysis process, Walker and Avant (2011) suggest determining the empirical referents, which by their existence demonstrate the reality of the concept itself. They suggest that the empirical referents provide the means of measuring the concept itself.

The empirical referents for sexuality are as follows:

- The physiological need for sensuality and sexual gratification as suggested by Maslow's hierarchy of needs (Maslow, 1943)
- The aesthetics of human attraction and the development of intimate sexual relationships with a certain 'type' of person.
- The phenomenon of sexual orientation and gender identity.
- The desire to be desired. To look good and express one's identity through clothes, makeup, fragrances.

Conclusion

Through engagement with varying definitions, uses, and theoretical underpinnings, a workable understanding of the concept of sexuality has been established. Sexuality not only encompasses issues of behaviour or identity; but also in many ways frames thought processes and presentations. It is historically and contextually specific and it is fundamental that when we consider how sexuality is discussed in healthcare we acknowledge the broad biopsychosocial experiences and expressions. The aspects of sexuality illuminated through this concept analysis provide a framework to engage with the topic through the interviews in Queer Expressions; and important theoretical lenses identified are useful in the analysis of the participant data. In the next chapter, I will explore how sexuality is integrated into healthcare practice.

Integrating Sexuality into healthcare practice

The use of Walker and Avant's (2011) concept analysis as a basis has clearly illustrated that the concept of sexuality is a broad biopsychosocial aspect of personhood. This chapter will identify some of the areas where sexuality might integrate more specifically into healthcare practice.

It is without doubt that sexuality is experienced and expressed in different ways depending on individual needs, behaviours and social circumstances. Indeed, sexuality can permeate many aspects of a person's life, emotionally, physically, psychologically, socially; in behaviour, in appearance and in thinking.

Sexual health

Sexual health might be considered the main frontier of intersections between sexuality and healthcare.

Defined by the World Health Organisation, sexual health refers to:

> *"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*
>
> (WHO, 2006, p.5)

In practice, much of the focus of sexual health provision in health services, is on a more biomedical prioritisation, centring on the prevention of sexually transmitted infections, provision of contraception and management of fertility issues. Within an Irish context the National Sexual Health

Strategy (2015-2020) provides little guidance on issues surrounding sexual identity, rights, mental health or wider issues of psychosexual health considerations (Department of Health, 2015). STI screening, HIV prevention, Vaccination, Fertility and Reproductive rights all intersect with wider concepts of sexuality and sexual wellbeing, but a medicalisation of these priorities often diminish the holistic needs of sexual beings (Spurlin, 2019).

Sexuality physical Health

When considering how sexuality is dealt with in physical healthcare contexts, usually a focus is brought to how the experience of ill health or disability impacts on issues of sexual function, body image and fertility.

Sexual (dys)function is particularly pertinent and in focus in aspects of healthcare which directly deal with the reproductive systems; illnesses related to genitourinary system whereby treatment may cause loss of sensitivity or function are therefore an important point to address. There is an increased focus on how cancer and cancer treatment may impact on one's sexual wellbeing in recent years; Bond et al. (2019) stress the need for health system engagement with issues of sexuality, both to identify predictors of sexual dysfunction in cancer patients but also to address the needs. Traa et al. (2012) identify the complexity and diversity of issues around sexuality and quality of life in patients with cancer and state the necessity of a holistic and biopsychosocial approach.

Sexuality Mental Health

As described in earlier sections, there has been an interest from the psychological sciences in issues of sexuality since the earliest days of psychological and psychiatric medicine. As in physical health contexts, mental health providers are conscious of how certain mental illnesses or treatments may impact on sexual function (Montejo et al., 2018), however unlike in physical health contexts where the impact of disease or treatment on sexuality is a prime focus – in mental health contexts sexuality

is often examined as a symptom of mental ill health. Issues such as low libido, or hypersexuality, in themselves are pathologised (Clayton et al., 2018; De Alarcon et al., 2019). This duality of mental health impacting on issues of sexuality and certain sexual behaviours being predictors or symptoms of mental health often centres on heteronormative perspectives of human sexuality (Kilicaslan and Petrakis, 2019); however, there is scope for the development of mental health research and practice which is more appropriate in holistically addressing issues of sexuality in those experiencing mental health issues by considering sexuality as a holistic concept (Montejo, 2019).

Discussions of sexuality

This thesis centres on the way in which sexuality is discussed in healthcare contexts; sexuality may be discussed as part of assessment, or indeed whereby there is a defined sexuality need related to the patient presentation. In a review on how sexuality is discussed in healthcare, Fennell and Grant (2019) identified that sexual healthcare information is not being widely addressed, the reasons for this were identified as a lack of knowledge, nurses' attitudes and beliefs, nurses' comfort in discussing sexual health and perceived barriers related to time, responsibility and support from the healthcare organisation. In an exploration of mental health nurses' views about discussing sexuality with their patients, Quinn et al. (2011) found that often the approach was to either ignore sexuality, or refer on to another clinician. Klaeson et al. (2017) identified that nurses' comfort level and willingness to discuss sexuality was often dependent on the patient they are caring for; with younger patient cohorts being a more favourable group to discuss issues of sexuality with than older patients. Huang et al. (2013) furthermore identified that the aspect of sexuality discussed impacts on how discussions take place, with more comfort expressed in discussing physical aspects of sexuality over the psychosocial issues. This issue isn't only evident in nursing literature, Dyer and Nair (2012) identified through their systematic review that a majority of healthcare professionals do not proactively discuss sexuality issues with those they care for; their review identified specific issues within non-heterosexual, black and ethnic minority groups and those with intellectual disabilities.

The reluctance of healthcare professionals to engage with issues of sexuality is further confounded by perceptions of patients seeing sexuality as a taboo subject. Traumer et al. (2019) highlighted that patients find it difficult to discuss issues of sexuality in healthcare contexts. The participants in their qualitative research focusing on cancer patients in Denmark found not only did healthcare professionals fail to engage with issues of sexuality but some of the participants felt rejected by healthcare professionals when they tried to address issues pertaining to their sexuality. A study led by Cathcart-Rake et al. (2020) engaged cancer patients to ascertain their views on how issues of sexuality should be gauged in healthcare contexts, the participants acknowledged that this is an important area of care but often overlooked; they identified four ways to facilitate conversations, including implementation of a scale to determine patients' comfort around discussing sexuality, continued engagement in the topic throughout the healthcare journey, ensuring healthcare providers are themselves comfortable and finally eliminating euphemisms. A review of the sexual health communication between adolescent patients and healthcare professionals carried out by Engelen et al. (2020) identified four determinants to facilitate good communication on sexuality attitudes, beliefs, knowledge, and self-efficacy; ensuring a focus on both the patient and the healthcare provider in each area.

Evans (2000) identifies 'institutionalized erotophobia', a fear of sex, as a significant barrier to engaging patients in discussions around sexuality in healthcare practice. It is suggested that the primary approach to dismantling erotophobia in healthcare practice centres on dispelling the myths that exist around sex and sexuality, which are 'intimately bound' to sociocultural and religious norms (p.655).

Sexuality in Healthcare Professional Education

As identified above, healthcare professional knowledge on issues of sexuality can be an enabler or barrier to facilitating integration of sexuality in patient care; Verrastro et al. (2020) highlight that

regardless of the modality, intensity or length of the training, incorporating sexuality based education enhances healthcare professionals' confidence and competence in engaging in discussions and assessments around sexuality with their patients. How sexuality is incorporated into healthcare professional education, however, is varied; while there have been many attempts to incorporate sexuality into undergraduate education, issues such as sexual function and dysfunction, female sexuality, abortion, and sexual minority groups are often absent (Shindel and Parish, 2013). Evans (2011) found that for nurses, particularly in early career, they found themselves ill-prepared to deal with issues of sexuality or sexual health when they were encountered in practice, stemming from an absence of sexual health in nursing education programmes. Evans' (2011) model of sexual health and wellbeing, which can be incorporated into healthcare education. is framed around three domains, Sexual wellbeing as integral to holistic care, Sexual wellbeing associated with other health conditions, and specific sexual health problems and infections.

Conclusion

While the interrelatedness of sexuality and healthcare is evident, there remain significant gaps in how sexuality-based needs are addressed in healthcare contexts. This is a wide-ranging problem which not only impacts on sexual minorities but is especially harmful to those groups for whom sexuality is even more stigmatised and invisible. It is important that the exclusion of sexuality as a consideration in care planning and in care giving is redressed.

By exploring various intersections between sexuality, health, and healthcare, this section illustrates some of the potential interactions and experiences participants in Queer Expressions may recount.

Introduction to Gay Male Identity

This chapter will explore the theoretical underpinnings of Gay Male Identity, as a sexual identity and sexual orientation. It will situate the specificities of Irish Gay Manhood in relation to national identity and historical considerations of homosexuality in Ireland, as well as a more universal understanding of how Gay Male identity is developed and experienced, exploring varying theoretical models of gay identity and a concept of Queer Phenomenology.

Historical & Theoretical Context

When considering the socio-historical context of the Gay Man, it is important not to oversimplify the category and ascribe all homosexual activity in history as gayness or 'impose contemporary ethnocentric meanings around 'the homosexual' on to the past or other cultures' (Plummer, 2002, p.8). Indeed, Michael Foucault argues in his history of sexuality that it was only in the 19th Century that there was an acts-to-identity shift, where through the regulation of sexuality, hetero and homo sexual activities were not only separated, but set up in opposition to each other (Spargo, 1999). Indeed, Eve Sedgwick (2008), in her *Epistemology of the closet*, goes on to further elaborate how the creation of the heterosexual only occurs as a response to homosexual identity formation. Foucault (1976/1981) notes the late 19th century as the period where the 'species' of the modern homosexual is established 'a personage, a past, a case history, a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology' (p.43). While the identity category we know today as 'gay' took sometime later to be established, with Sedgwick (2008) pointing to a post 1970's emergence, this shift from acts to identity is an important one.

Of course, homosexual activities and intimacies have a far earlier and longer history, and indeed link, in many contexts, to concepts of manliness and masculinity; (Edwards, 2005); what theorists like

Foucault and Sedgwick map is a movement between narratives of medicalisation, criminalisation and identity.

> *'the sodomite had been a temporary aberration, the homosexual was now a species'*
>
> (Foucault, 1976/1981, p.43)

While the jurisprudence and medicalisation approaches seem tangential to each other, Weeks (2017) considers how the 'disease model' works to identify homosexuality as a problem, therefore solutions can be proposed, and there comes the divide of criminalisation and/or medical treatment. The medicalisation of homosexuality is nowadays considered to be outdated, and there is an acceptance that being gay is neither a choice to be punished, nor a disorder to be treated. While in some socio-cultural contexts gay people continue to face persecution in the form of laws and medical conversion focussed treatment, an important acknowledgement of homosexuality as identity came from the American Psychological Association in 1973, when homosexuality was 'officially' de-medicalised and removed from the Diagnostic and Statistical Manual (DSM).

Models of Gay identity development

As well as identifying definitions on what exactly coming out is; researchers have taken an interest in how coming out is done. Evidently, the context and specificities around coming out are highly individual, however several models of coming out have been developed, putting forward distinct stages and activities. These models place coming out as a clear and identifiable stage of identity formation, as well as disclosure.

Plummer (1975) was an early adopter of the term coming out and considered it as a clear identifiable stage in the 'career route' (p.134) for the homosexual. Plummer's (1975) model puts forward homosexuality as a 'way of life' developed through 'sensitization, signification, 'coming out' and stabilization' (p.134). This model provided a good foundation to think about homosexuality as more

than a simply innate and inner self that just needs to be revealed, it begins to consider how coming out is part of a wider process of identity formation and realisation.

This approach was taken further by psychologist Vivienne Cass; building on Plummer's work, Cass' (1979) six stage model not only considers the self-realisation as a reflexive process but acknowledges how the interaction with others is a core aspect. Cass' (1979) model considers interactions between how the gay person might perceive their activity and behaviour, with the perceptions of others, with their own self-identity. Identity, for Cass, was much more than self-perception, but included this intrapersonal matrix and interdependence of these elements. Cass' original (1979) model had six stages: identity confusion, whereby initial discovery of being different is considered; identity comparison, where the individual starts to conceptually separate themselves from the heterosexual dominance identity; identity tolerance, with initial exploration and seeking out of other homosexuals; identity acceptance, in which a more positive self-view is taken, linked to the awareness of other sexual minorities around them; identity pride, which establishes a level of contentment with one's homosexuality, as well as a discontentment with discrimination and stigma from others; and finally identity synthesis, whereby one's sexuality is incorporated as a part of one's identity. The model recognises that individuals may not reach the synthesis stage, that in many homosexuals a discomfort prevails, they further consider the concept of 'identity foreclosure', where the individual halts the process from moving to the next stage of the model. Cass validated the model through empirical research with Gay Men, using the 'Homosexual Identity Questionnaire'. The model has been further refined and Cass (2005) puts forward the model as explicitly rejecting the concept of homosexuality as 'an inner or 'true' self that lay dormant within the individual just waiting to be revealed' (p.309), a view which negates the complexity of internal and external processes.

Coleman (1982) presents another model of sexual orientation development which adds a tangential progression of including first romantic relationship as a key stage. A key limitation of Coleman's

(1982) model was its lack of empirical testing, based solely on theorist observation, however an important divergence from Cass (1978) was Coleman's assertion that individuals may not progress in a strict or clear linear fashion. The five stage model consists of the following: pre-coming out, although there isn't a realisation around same-sex attraction here, the homosexual begins to recognise difference from the others; coming out, the acknowledgement of same-sex attraction and sharing of these feelings with others; exploration, where the individual begins to engage in sexual but also societal activities associated with homosexuality; first relationships, where the individual begins to develop relationships beyond physical attraction and sexual activity; and integration, where there is an incorporation of the homosexual self with a public image of self.

While a feature of the above models was that they may occur at different life stages, and thus needed to acknowledge the contextual issues around age and status, Troiden (1989) presented their model of homosexual identity formation in a frame that was age specific. The four-stage model begins with sensitization, while pre-teen boys may develop an awareness of being different from peers, during ages 13-17 this difference becomes related to sexuality. This is followed by Dissociation and Signification, where around the age of 17 homosexual boys consider the potential of them being gay; they begin to establish that same-sex attraction is something that is specific to them. The third phase is labelled as coming out, his work acknowledged that this is conceptualised differently for different men and spans admitting one's sexuality to oneself, as well as engaging in homosexual activities, seeking out relationships and disclosing to others. The final stage in this model is Commitment, where Gay Men fully accept their homosexuality as a way of life. Troiden's model was based on a study of 150 Gay Men and had a very clear focus on presupposing the ages related to identity formation, they made specific observations around certain activities, such as fully identifying as gay at the age of 21.3 and then having a first relationship at 23.9. While the previous models discussed the 'becoming' gay as a developmental process – Troiden put forward that someone 'chooses homosexuality' and these stages represent how that choice further emerges. While progressing through each stage is not inevitable for all Gay Men, it more acts as an indicator

that one will become gay. Troiden (1989), unlike previous theorists makes a clear contrast between those who are gay, as in the homosexual who accepts being gay as a life choice, and seeks meaningful relationships with other men; with those men who solely have sex with men but do not have any desire to enter a relationship with another man. Moreover, Troiden argues that these men have sex with men but do not desire intimate relationships, are exhibiting homosexual tendencies; in contrast the men who enter a romantic and committed relationship with another man a have fully established gay identity. The model is thus presenting relationships with others as being the key indicator of being gay.

Another 'stage-based' model is presented by Lipkin (1999), building on the work of the above theorists, their five stage 'mega-model' includes many aspects of the above: presexuality (often in the pre-pubescent phase), identity questioning, coming out, pride and post-sexuality. This model sandwiches in the 'sexual' elements of identity development between the pre-puberty development which might lead to homosexuality, and post-sexuality as a key stage whereby gay identity is formed as a broader aspect of identity beyond just sexual attraction.

A key challenge to these stage-based models of coming out, is that by and large they presuppose a linear, and almost chronological order to how gay people develop, realise and disclose their sexuality. This uniformity of experience is perplexing, as it appears to whitewash the wider socio-cultural contexts in which gay people exist; indeed Eliason (1996) critiques the homogeneity amongst the research participants in the studies which led to these early theories and identified that there was an overwhelming focus on those who were 'white, middle-class, and well-educated' (p.53). While the broad overview of the theorists above was that sexual identity is not simply revealed, but developed, they in turn seem to ignore the concept of sexual fluidity or contexts of multiple sexual identity expressions. Indeed, it can be argued that identity development, and coming out are too complex processes to be simplified into a sequential step-based summation (Horowitz & Newcomb, 2001).

An alternative approach to coming out, and development of sexual identity is presented by D'Augelli (1994), their life-span model presents the 'becoming' process (p.313) as a complex intertwining of relationship to self and relationship to society. The model suggests that the development of sexual identity is influenced by three broad contexts: subjectivities and actions, in how the individual may form perceptions of their identity and begin to construct this; interactive intimacies, relating early relationships with friends, family and others to the later formation of intimate partnerships; sociohistorical connections both in terms of a presupposed heterosexual identity and an emerging homosexual/bisexual one. By clearly acknowledging the broad socio-cultural contexts in which LGB people live, this model is arguably more geographically and chronologically adaptable.

The three wider contexts considered, go on to impact six distinct processes of identity formation for the LGB person (D'Augelli, 1994): Exiting Heterosexual Identity, whereby the LGB person recognise that their feelings and attractions are not heterosexual, in this stage the individual may disclose this to others; Developing a personal LGB identity status by which one learns how to be LGB, related to other LGB people, while also challenging internalised and external myths around sexual minorities; Developing LGB social identity, where a community and social network of people who know about and accept one's sexual orientation; Becoming a lesbian-gay-bisexual offspring, focussing on one's biological family, disclosing sexual identity and dealing with any consequences; Developing LGB intimacy status, deepening understanding of social structures that govern relationships and develop intimate and romantic relationships; Entering a lesbian-gay-bisexual community, involving oneself in broader social and political settings. While the considerations of socio-historical contexts are evident in D'Augelli's model, it, like the stage-based model still fails to engage with the intersectional lives of LGB people, failing to distinguish the experiences of LGB people from more marginalised groups, related to race, gender, spirituality (Bilodeau and Renn, 2005) nor disability, class, socioeconomic status.

Mohr and Fassinger (2000) suggest conceiving the development of sexual identity across three distinct dimensions of experience: intrapersonal variables, interpersonal variables, and variables related to specific events. Their work initially looked to quantify this development through a Lesbian and Gay Identity Scale. The scale was revised by Mohr and Kendra (2011) as a 27 item measure to assess eight dimensions of LGB identity: Internalized homonegativity, leading to a self-rejection of LGB identity; Concealment motivation, a drive to keep LGB identity secret; Acceptance concerns, a movement towards considering barriers to acceptance; Identity uncertainty, a questioning of one's LGB identity, perhaps as a phase; Identity superiority, a movement to favour LGB identity over heterosexuality; Difficult Process, how difficult the experience of developing one's sexual identity was; Identity centrality, how central the LGB aspect of their identity is to overall identity; Identity Affirmation, how positively one views their sexual identity. Cramer et al. (2017) considered the Mohr and Kendra (2011) model in terms of association with wellbeing and, while their overall conclusion leant more to the negative aspects (Acceptance Concerns, Concealment Motivation, Difficult Process, and Internalized Homonegativity) having good reliability they cautioned, as in the models discussed, the applicability may not necessarily be generalised outside of white, college-educated middle-class LGB people.

While models of homosexual identity provide us with a framework of considering how gay identity may be formed, experienced and expressed, there appears to be no consensus on a model which is applicable to all gay people or that recognises the diverse and intersectional identities gay people inhabit. There is an interesting progression in the models over time, matching the evolution of societal views of homosexuality. This discussion of models is by no means exhaustive, but aims to provide a context for wider consideration of how Irish Gay Men may experience becoming, and being gay. Horowitz and Newcomb (2001) present a paradigm view of sexual identity which may broaden conceptualisation of what it means to be gay, and the journey to becoming gay. They offer three distinct paradigms of sexual identity: Desire; Behaviour and Identity. The focus here is less on

'how' someone identifies and more on what meaning can be drawn from these paradigms. This approach has potential to offer a fluidity and evolving view of gay identity, ever-changing and considerate of multiple intersecting contexts.

Coming Out

Coming out is a foregrounded aspect of much literature and research about Gay Men and the broader LGBT+ community; however, despite its prevalence, there are clear divergences in how the concept is understood. It is important to note that much of the literature on coming out is relatively recent; Eliason (1996) notes that the emergence of commentary on the coming out process is very much reflective of wider unique socio-cultural and historical contexts around when they are considered.

Much of the discourse on coming out is focussed on and describes the concept as an action of disclosing one's sexual identity to others (Heatherington & Lavner, 2008; Waldner & Magruder, 1999). However, others discuss coming out as less of a 'one off' event, and more as a constant and enduring activity, which takes place throughout the life course, not only focused on the encounter but also on the decision making process around whether to disclose sexual identity during every new encounter (Appleby, 2001; Morris, 1997). Mohr and Fassinger (2003) further present self-acceptance as an important aspect of the coming out process, illuminating that LGBT+ people must first come out to themselves and that this is a key first step. According to Heatherington and Lavner (2008), choosing to disclose their sexual identity to others is a most important decision and milestone event in the identity development process for sexual minorities.

Rust (2003) developed a definition of coming out which encompasses many of the intrapersonal and interpersonal aspects. For Rust (2003) coming out is

> *"the process by which individuals come to recognize that they have romantic or sexual feelings toward members of their own gender, adopt lesbian or gay (or bisexual) identities, and then share these identities with others"* (p. 227).

Guittar (2003) highlights that researchers often make the assumption that the concept of coming out shares a common understanding and experience amongst LGBT people; this fails to capture the diversity amongst sexual minorities and how they, themselves use the term. Within their research exploring the meaning of coming out with those who identified as lesbian, gay, bisexual or queer, Guittar (2013) found that although for all participants coming out was transformational, their discussions around the meaning of coming out varied however, spanning from consciously self-affirming to disclosure to others.

Orne (2011) concurs that researchers' approaches to the concept of coming out are varying; they acknowledge that there is also a broader social context often determining how the phenomenon is experienced and discuss the concept of "strategic outness" (p. 682). Strategic outness considers the wide and varying negotiations Gay Men go through when deciding if, how, and when to disclose their sexual orientation to others. Their research identified several common themes around the multiplicity of strategies for coming out discussed by each of the Gay Men. Concluding, Orne (2011) argues that coming out is not only a process of identity formation, but is also considered as the practice of identity management; acknowledging the broad social contexts Gay Men experience.

The implications and impact of coming out on the individual are a focus of much research in this area; indeed as demonstrated in the above section, coming out is a key part of many models of sexual identity development, and a necessity for a more developed gay identity (Cass, 1978). However, others have taken a more nuanced approach, acknowledging the diversity of contexts gay people experience in their lives, and perceived risks of coming out associated with those broader contexts (Orne, 2011; Evans and Broido, 1999).

There have been clear attempts to consider how the experience of coming out and being out impact on the well-being and particularly the mental health of LGBT+ people. Halpin and Allen (2004) applied the Cass (1978) stage model when considering the impact of developing gay identity on mental health. A multi-tool instrument approach with 425 Gay Men, established that a stronger sexual identity correlated with better mental health (Halpin and Allen, 2004); while there was turbulence and negative impacts on mental health through the middle stages (including coming out) of the Cass (1978) model, the research found that overall this negative impact was countered in the later stages where overall happiness, self-esteem and satisfaction with life were improved. The relationship between outness and strong sexual identity is a complex one, and while stage models suggest outness as a key part of identity formation, there hasn't been sufficient empirical evidence to support that being out is a necessity to strong identity. Feldman and Wright (2013) in a study of 192 LGB people considered that coming out and identity formation should be distinguished from each other as constructs, but that there is a correlation; their study found that those with a higher level of outness were more likely to have a stronger sense of identity and that this together led to reporting better mental health and the converse for those who had a more limited sense of identity. The LGBT Ireland study on LGBTI wellbeing (Higgins et al. 2016) noted that coming out was a source of happiness and pride for many participants.

It is important to acknowledge the different experiences around coming out, and indeed research is often flawed in how it incorporates experiences across gender identities and sexualities (Higgins et al. 2016) as well as wider social contexts. There is also a limitation in that even when it is acknowledged that individuals have different experiences depending on context; there is an assumption that individuals have a singular approach in all environments. Manning (2015) explored how individual coming out experiences differ across who they are coming out to and how they come out. The research with 130 LGB people identified seven typologies of coming out: pre-planned, where the LGB person identifies the person/place/time and method of coming out; emergent, where through interaction with another, the LGB person then sees an opportunity to disclose; co-axed,

where the LGB person is supported by another to come out; confrontational, where someone demands an LGB person discloses their sexual identity; romantic, where the LGB person comes out to advance a romantic or sexual relationship; educational/activist, where the LGB person decides to disclose in order to educate others or engage a change process; or mediated, where the LGB person uses a form of communication outside of a conversation to come out such as a letter.

Motivation to come out is also complex, while the process of disclosing one's sexual identity to another may be for pragmatic reasons, or to enable closer relationships; there are also inherent risks associated, especially given the irreversible nature of disclosing to someone, and fears of rejection or other more visceral risks which may stem from disclosure (Ben-Ari, 1995). Evans and Broido (1999) noted that decisions around disclosing one's sexual identity were not necessarily dependent on the level of individual identity development, but rather on one's perception about wider environmental factors. Their study of 20 LGB college students found that decisions around coming out were made around specific and individual relationships and contexts; if there was a belief that disclosing one's sexual identity would lead to rejection, violence or discrimination, then it would be less likely for the LGB person to come out in that specific context (Evans and Broido, 1999).

The LGBT Ireland study on LGBTI Wellbeing identified three themes of enablers to coming out for LGBT+ people in Ireland: Social aspects, including knowing that people would be supportive and accepting, finding LGBTI friends and allies, Support and acceptance of friends and family, changing attitudes in Irish Society, increased visibility of LGBTI people; Personal aspects, developing self-awareness and acceptance; and Practical aspects such as Impact of the Internet/media, Gaining education on LGBT identities, and role of life events or experiences (Higgins et al. 2016). With those who had chosen not to disclose their sexuality in certain contexts the LGBT Ireland study identified a further three themes focussing on 'What would make it easier to come out?' (p.74). The themes identified were: Supports, Visibility, Education, Support services, Schools/Workplaces, Legal protections and social supports; Society-wide changes, More accepting attitude, Normalising of

LGBTI identities, Increasing awareness and understanding, Increasing LGBTI positive behaviour; and Coming out experiences, Not making heteronormative assumptions, Guidance in the process, Less fear of a negative reaction, Knowing the person is accepting, Comfort with self, and moving away (Higgins et al. 2016).

Higgins et al. (2016) further note the decreasing age around LGBTI people self-identifying and disclosing their sexual identity. The most common age for Gay Men to realise they are gay in Ireland was 12 and the most common age to first tell another person was 16; they discuss that younger ages for both activities are more common in the younger participants in the study which included 873 Irish Gay Men aged between 14 and 71.

A Social Psychology of Gay Men

Jaspal (2019) considers the development of gay identity through the lens of social psychology; he distinguishes the concept of gay sexual orientation, in terms of same sex attraction and sexual activity from the concept of gay identity, which he pertains as a more embodied and a 'compartment' within a broader identity structure (p.40).

Sexual Orientation

For Jaspal (2019) there are three aspects to sexual orientation, which he describes as social representation; they are sexual attraction, emotional attraction and sexual activity. He notes the predominance of interest in sexual attraction as a signifier of sexual orientation above emotional attraction, however he suggests that both are congruent for identifying a clear view of sexual orientation. Furthermore, he critiques reliance on self-identification of sexual orientation – suggesting that some men may not be aware that they are attracted, emotionally or sexually, to other men; they may engage in same-sex sexual activity, but not identify this as based on attraction. He notes research he conducted on 'Muslim Gay Men' in Britain whereby homosexual behaviour

was seen more as a British 'liberal norm' rather than intrinsic same-sex attraction (Jaspal and Cinnirella, 2010). Jaspal (2019) furthermore presents the contextual factors which may impact one's sexual activity and examples the male prisoner who engages in same sex sexual activity while in prison, but demonstrates no attraction to men or same sex sexual activity outside of that context.

Jaspal's (2019) discussion on sexual orientation goes forward to engage discussion on the prevalence of homosexuality, noting that despite some dominant narratives, there is no evidence that there are increasing levels of homosexual sexual activity, rather, there is greater visibility of homosexuality in public discourse. The enquiry into sexual orientation goes on to discuss the psychological, social and biological theories around homosexuality, including psychoanalysis, social learning theory and subsequently hypotheses around hormonal and genetic factors in determining sexual orientation. Jaspal's conclusion is that although these varying theories are proven scientifically flawed, their continued reproduction leads to negative social representations of homosexuality as an abnormality and debates on the origins and 'social value' of homosexuality, in particular (p.35). Although distinguished from sexual identity, the social representations of homosexuality as a sexual orientation undoubtedly go on to shape the social context within which sexual identity among Gay Men is constructed and experienced.

Sexual identity

Jaspal (2019) notes congruence between sexual identity and sexual orientation, in that sexual identity is derived and identified through a recognition, exploration and labelling of sexual orientation; but furthermore it is about the thoughts, emotions, experiences behaviours and practices associated and embodied.

> *"sexual identity refers not only to the recognition that one is gay, bisexual or something else, but also to broader consciousness and acceptance of how one thinks, feels and behaves as a sexual being."*

(Jaspal, 2019, p.40)

While for many, sexual identity and sexual orientation are terms used interchangeably, he makes a clear distinction between them and again discusses how behaviours consistent with homosexuality are often displayed by men who do not identify as gay or homosexual, as shown in many middle eastern societies (Maatouk and Jaspal, 2020).

The Cass (1979) model is discussed as an example of a stage-based model of sexual identity, and like other critics, Jaspal (2019) challenges the assumption that individuals progress through stages in a linear fashion and points out that sexual identity may be adopted and expressed in diverse ways and assimilated, accommodated and manifested in contemporary everyday life.

Social Identity or Individual Identity

Jaspal (2019) discusses the divisions of a 'social identity' which is explored through social identity theory and an 'individual identity' explored through identity process theory (p.49).

Social identity theory, while posited by some as a holistic theory of identitym is for Jaspal (2019) an attempt to explain 'one dimension of identity, namely the individual's relationship with social groups and contexts in which the social group becomes a key focal point of the identity structure' p.(43).

It is explored through two distinct processes, Social Categorisation where the individual categorises themselves and others into distinct groups, a them and us; and Social Comparison, whereby the individual understands the social processes which converge or diverge between the in-group and the out-group (everyone else). A strong critique comes in the primary need for a category such as Gay Man to be available in one's cultural context (Jaspal, 2019); as discussed above this simply isn't the case in many cultural contexts. Social identity theory facilitates the individual to identify himself principally as a member of a particular group, such as Gay Man, however this fails to capture the 'total' identity of the individual (p.45).

Identity process theory, conversely, aims to understand how the individual themselves posits their identity through two processes, Assimilation-Accommodation and Evaluation. Assimilation begins with the identification of an identity trait and gradually incorporating this into their identity which then may lead to changes in structure of previous identity, which Jaspal and Breakwell (2014) refer to as accommodation. Evaluation then describes the process of ascribing meaning and values to the formed identity components; this value may be influenced by sociocultural norms, such as whether the society the Gay Man is living within is more homophobic or not (Jaspal, 2019). In this way, identity process theory acknowledges the role social representations can have in the Assimilation, Accommodation and Evaluation of elements of identity, so is not at odds to social identity theory, instead it simply acknowledges that social identity is one part of a broader identity for Gay Men. Indeed. intergroup coping is presented as a remedy for identity threat that Gay Men may be exposed to, through negative social representation of traits of that identity (Jaspal, 2018).

Stepping away from an either/or discussion around models of gay identity, Jaspal (2019) asserts that social psychological theories of identity enhance an understanding, and provide a framework for exploration of gay identity; broadening out a gay identity from the concept of solely being another term for sexual orientation.

> *"Even when construed as a group membership, the category 'gay' comes to form part of the individual's unique tapestry of identity elements."*
>
> (p. 49)

For Jaspal (2019) the Gay Man needs always to be considered in context, whether socio-cultural, geographical, developmental or religious.

Queer Phenomenology

Ahmed's Queer Phenomenology: Orientation, Objects, Others (2006) aims to bring together the disciplines of Queer Studies and Phenomenology; in this work she not only posits Queer theory in

phenomenological thought but also aims to 'Queer' phenomenological thought, particularly in the writings of Husserl, Heidegger and Merleau-Ponty considering their view of the world as applied to Queer embodiment and lived experience.

While Queer Phenomenology goes on to look at issues of race and othering, the central importance of Ahmed's work to Queer expressions is the way in which she considers the concept of sexuality as a lived experience, sexual orientation as a spatial orientation, moving beyond how space is sexualised but considering how we are sexualised by the space we inhabit. A Queer Phenomenology enables reflection on how actions shape bodies and furthermore, our orientations toward the objects we encounter and work with (Kojima, 2008).

Ahmed (2006) diverges from the position of Jaspal (2019), segregating orientation and identity, and questions 'what does it mean for sexuality to be lived as oriented' (p.1). This concept provides an interesting frame to consider the experience of being gay. Queer Expressions aims to illuminate and interpret how sexuality is discussed by Gay Men with healthcare practitioners, and a central part of this is in the investigation of how the participants conceive and perceive the notion of sexuality and the notion of being gay. While the foremost investigation in this study will be an interpretative phenomenological analysis, this will be supported by an exploration of how a Queer Phenomenology is presented through the descriptions of sexuality offered by the participants interviewed.

Orientation towards objects

In order to conceptualise the notion of sexual orientation, Ahmed first turns towards the phenomenological texts and in close reading considers how orientation is poised as a phenomenological question. In this section Ahmed suggests that phenomenology is itself oriented a certain way, she considers how objects appear in the writings of Husserl, Heidegger and Merleau-Ponty and how by bringing some objects forward and relegating other things to the background, a certain orientation is presented. Ahmed takes interest in Husserl's act of 'two-fold directedness',

firstly one is directed towards an object, so they face it, but as a second action a direction is taken by the person towards it, in deciding whether it is attractive to them or not, useful or not. She points towards how this two-foldedness does not always happen in this 'logical' sequence, sometimes perhaps we take a direction towards something before we are directed to it (Ahmed, 2006, p.28), when dealing in the realm of sexuality this may be lived in the guise of compulsory heterosexuality which Ahmed discusses later in her book. We may take a direction towards being heterosexual, because of the heteronormativity of society and other factors; however, when directed towards heterosexuality later, in the form of an act or an object of potential desire, we turn away from it.

Ahmed spends a significant proportion of this section on orientations towards objects discussing the writing table, which first appears in Husserl's *Ideas* (1969). She reflects on his recount of the table, its use, its orientation within the family home towards him and his orientation towards it. In queering the orientation towards this table Ahmed considers what might be in the background, the periphery of this table. Husserl's prime focus is on this writing table but this table is situated in a room, in a house, there may be other furniture; Ahmed suggests that 'by bringing what is 'behind' to the front, we might queer phenomenology by creating a new angle, in part by reading for the angle of the writing, in the 'what' that appears' (p.4). This presents a similar mission to that of the interpretative phase of IPA, in finding meaning, moving beyond the description, accepting and acknowledging, but then investigating where this description came from. Heidegger's concept of 'Equipmentality' is also considered by Ahmed, how the function of the object, what it allows us to do, makes it itself. She references back to Husserl's table as a writing table, it is defined and described based on what it allows Husserl to do, write. When thinking how this would be applied to Queer Expressions, I will consider the things mentioned by participants which 'allow' them to be gay, which 'allow' them to inhabit the gay which they have described for themselves. She also puts forward that objects go beyond what we intend them to be by presenting Heideger's differentiation between using something and perceiving something. The example given is the hammer. It is a hammer because it allows us to hammer a nail, however if the hammer breaks, is it no longer a

hammer? While reflecting on this I began to think of how this relates to sexuality and its relatedness to sexual acts, because we are no longer 'sexually active' are we void of a sexuality? While someone may 'use' sex, or sexual attraction to present their sexuality, when sex or sexual attraction are removed, are we able to perceive sexuality in a different way? Of course, given that Queer Expressions is a phenomenological study, my interest is in the lived experiences of the participants, however this concept of equipmentality and using vs perceiving may give an insight into the orientation of participants beyond their descriptions. This chapter goes on then to consider, rather than the orientation of us to objects or objects to us, how space is inhabited.

Bodies are not the same as other objects and in so inhabit space differently. As Merleau Ponty (1964) proposes, the body is 'no longer merely an object in the world…[instead]… it is our view in the world' (p.5), in that, our views are all unique. What one person orientates towards and frames their embodiment as a Gay Man, another may veer away from but still claim an orientation towards being gay.

Sexual orientation

Ahmed's explicit aim in this section is to 'queer' how we approach sexual orientation by 'rethinking the word 'orientation' in 'sexual orientation' (2006, p.68). To begin conceptualising sexual orientation as a spatial orientation Ahmed visualises the normative and vertical axis; when the line of our direction is asymmetrical with the normative line our direction is queered, we move away from the normative, we ourselves become queer through this orientation. Ahmed argues that phenomenology can help us to see how sexuality involves the way we inhabit space and the way we are inhabited by space. She describes the normative as taking shape in the straight body, aligned with the other lines of heteronormativity. The straight body is aligned with the vertical axis, rather than just being there, we need to see the straight body as being orientated along this axis. She gives the analogy of tracing paper to once again present how compulsory heterosexuality may be

formulated. If we place tracing paper over a vertical axis and draw along it, the line is invisible, until it deviates. Heterosexuality and heteronormativity are only visible when considered in comparison with the queer, the deviating line. She reminds us that in Merleau Ponty's Phenomenology of Perception, sexuality is presented, not as a distinct subcategory, behaviour or compartment, it cannot be separated from the overall bodily experience. So, when considering sexuality in this way how do we deal with the distancing of queer bodies from these queer lines, assertions that 'being gay is just something about me, it isn't who I am'. In historicising the term Ahmed points to its inception coinciding with the term homosexuality, she notes with interest this coincidence and the perception that it is the homosexual who has a sexual orientation, the heterosexual is somehow neutral. Can we not see the line of orientation of the heterosexual, as is does not deviate from the normative axis? This may be of particular interest if the data from Queer Expressions highlights the 'straight-gay' persona, one in which someone relates themselves more to a heterosexual embodiment despite engaging in same sex acts.

Ahmed goes on to examine the concept of orientation, directionality and space within important queer and sexuality theory including Freud, Havelock-Ellis and Judith Butler, continuing to pull out the references to lines, directions, objects of desire. She produces an interesting section on 'becoming straight' (pp. 79-92), again, sexual orientation is laid out as a path or line one follows towards the object of desire, to become straight one must follow the normative line, however if one deviates from the normative line along this path but subsequently returns to the normative object of desire, are they still straight? Does one only 'become' straight through deviating? While certainly an interesting perspective, given that Queer Expressions is focussed on Gay Men, this concept of 'becoming straight' is obsolete for this project. An interesting part of this section however returns to compulsory heterosexuality and presents it as a repetitive strain injury (RSI). Where one manipulates the body in an 'abnormal' position to perform a task on an ongoing basis over time. RSI does not show its damaging effects straight away, but rather at a point in the future where it is no longer possible to manipulate in this way. Is the same true for compulsory heterosexuality? Is there a point

in which the compulsory heterosexual can no longer perform their task and so becomes the homosexual? As with RSI there are long term effects.

The *Contingent Lesbians* section illuminates the various points at which one is said to 'become' a lesbian, is it when one develops the desire, is it when one names oneself as lesbian, is it at the point of contact? This section replicates in many ways ongoing debates within the gay male community. The gay celibate, the man who has sex with men, the formerly Gay Man who becomes the trans woman, at what point is one truly gay?

Ahmed's use of Phenomenological texts, Queer Theory, and her own personal experience as a queer woman provides an innovative and interesting way of considering sexual orientation. A key aim of this study is to consider how Irish Gay Men perceive and express their own sexual identity and the utility of Queer Phenomenology provides a novel way of doing this.

Homosexuality in Ireland

The lives of Gay Men in Ireland have undoubtedly and inextricably changed over recent decades; legislative reform, changes in public attitudes and visibility of LGBT+ people in Ireland have all impacted on the lived experiences of those who identify as gay (Maycock et al., 2009). However, to understand the Irish Gay Man in any way, it is important to acknowledge the recent history around the shifting experiences and attitudes around homosexuality in Ireland. Ireland, like many countries around the world had a penal approach to the control of deviant sexuality, embedded through British colonialism. A change point in the Irish awareness around issues of homosexuality came with the very public criminal trial of Oscar Wilde in 1895; according to historian Diarmaid Ferriter, the trial of Oscar Wilde and further high profile scandals 'ensured that an awareness of homosexual offences became more widespread' (p.60). While British responses to the Wilde trial stirred up repulsive reactions around homosexuality – in Ireland, Wilde's Irishness came into focus and he was

reimagined by later authors. Walshe (2005) discusses this reimagination, in the anticolonial resistance that ensued in the early 20th Century the 'unspeakable' Wilde, now became Wilde the Irish rebel, indeed contemporary coverage of the trial was markedly different in Ireland and in Britain. This mitigation of one's homosexuality through their Irishness, is further discussed by Ferriter (2012) narratives of Irish resistance leaders Pearse and Casement, displace their sexuality in order to venerate them as national heroes; 'you can be gay or you can be Irish but you cannot be both at the same time' (p.62).

While the early 20th Century saw Ireland gain independence from Britain through military and social movements, underpinned by narratives of liberation and equality; the British 1861 Offences Against the Person Act remained on the statutes of the new republic until 1993. Ferriter (2012) notes the particular context around how state bodies and services, traditionally the realm of the British crown offices, notably health and education, became assumed not by the new Irish state, but by the Catholic church; and Ireland, rather than becoming a radical socialist state at the edge of Europe became a pseudo-theocracy. This has had very direct and particularly harmful consequences for Irish Gay Men; as pointed out by Nolan and Butler (2018) the Catholic Church, one of the largest institutions in the world is a source of the most disapproving views about homosexuality in of Ireland and globally.

The emergence of the Gay Liberation movement in Ireland, throughout the 1970s centred around the campaign for homosexual law reform, led by Trinity College lecturer (and later senator) David Norris. The movement was focussed on repealing the 1861 Act and decriminalising homosexual male activity. The 1970s saw the development on many grassroots LGBT+ organisations (primarily lesbian and gay organisations) throughout Ireland, Ferriter (2012) points to an early 1980s International Gay and Lesbian Association (ILGA) conference as evidence of the vibrancy of the Irish Lesbian and Gay community activism scene, with Ireland sending three member organisations while many other European countries represented only had a single member organisation, with many countries not

represented at all. The campaign for homosexual law reform spanned the 70s, 80s and 90s and saw David Norris bring cases against the state to the High Court, Supreme Court and later the European Court for Human Rights, centring his argument around the Irish constitutional right to privacy; in 1988 the ECHR ruled in favour of Norris. The Act was finally repealed in 1993, when Minister for Justice Máire Geoghan-Quinn proposed the Criminal Law (Sexual Offences) 1993 bill, not only de-criminalising male same-sex sexual activity, but also equalising the legal age of sexual consent; which had been a particular focus of campaigning in the UK. Peripheral to the court battle for legal recognition and an end to legislative persecution; Irish Gay Men faced ongoing violence and discrimination within society.

In September 1982, Declan Flynn, a public sector worker in his 30s was murdered by a gang of young men in a park in Dublin, known as an area where men would meet for sex. Declan Flynn's murder was not unique, but the leniency shown to his assailants, none of whom were given a custodial sentence despite being found guilty, sparked outrage amongst the LGBT+ community. Journalist and cultural historian Niall O'Dowd recounts how the murder and subsequent trial led to a 'modern revolution' led by the LGBT+ community in Ireland,

> *"By his death, Declan Flynn transformed the gay community in Ireland who realized they had to organize in order to be protected"*
>
> (O'Dowd, 2020, p.59)

The Flynn murder was the catalyst for organised public action by gay and lesbian organisation opposing violence and discrimination and led to the first Dublin Pride festival in 1983. Legislative reform and public visibility and action became key points of focus for lesbian and gay (later LGBT) organisations, most notably the National Gay (now LGBT) Federation and the Gay and Lesbian Equality Network.

In the midst of the campaign for homosexual law reform, the AIDS pandemic emerged as the world's largest public health crisis – and while towards the end of the 80s the international public health response could be characterised as broadly value-neutral, Nolan (2017) discusses how the predominant institutional influence of the Catholic Church on Irish health policy provided an overall negligent response. Similar to other international contexts, the response to AIDS in Ireland was led by the Gay Community. While simultaneously campaigning for legislative reform, a network of Gay Groups came together to mount a response to the growing international AIDS crisis in 1985, Gay Health Action was subsequently founded, and through its short 5 year life produced the first and several subsequent information campaigns on AIDS while statutory services remained silent (Rose, 1994). A peculiarity around how Ireland's response to AIDS played out was that, while statutory services were hesitant in providing any coherent response because of a dominant Catholic influence on health policy, the first national policy community responding to the AIDS crisis was a National Bishops' Taskforce on AIDS (Nolan and Butler, 2018). Throughout the 1990s sexual health services continued to develop and the highly moralised approach to sexual silence began to dissipate. Nolan (2018) discusses how in Ireland, AIDS forced an initially reluctant dialogue about sex and sexuality; and how the crisis as well as the role Gay Health Action played:

> *"is an important part of the narrative that transformed the "old moral order" to herald an age in which the "liberal minority" claimed the majority position in Irish life"*
>
> (p.123)

Throughout the 1990s and 2000s legislative reform included prohibition of discrimination based on sexual orientation through the Employment Equality Act (1998) and Equal Status Act (2000); The Civil Partnership Act (2010) and the Marriage Equality referendum and subsequent legislation passed by popular vote in 2015. Indeed, the rapid liberalisation related to LGBT inclusion in Ireland now marks it out as a world leader in LGBT+ rights; ranked as 15th out of 49 of the most LGBT+ inclusive countries in Europe (ILGA Europe, 2020). It is important to note however that legislative and policy

change, while important, don't negate the everyday experiences of LGBT people of heterosexism, homophobia, transphobia and other oppression. Indeed, like other historical milestones, responses to this legislative progress were not always positive. High profile commentary on the rights of LGBT people, was met by high profile commentary on why these rights should not be bestowed. In a peculiar series of events whereby the Drag Queen Panti Bliss, called out other public figures for homophobic attitudes on television, this subsequently led to a threat of legal action and pay-out by the National broadcaster, as well as a public apology. The response was a neutralising of discussion around homophobia; essentially for the remainder of public commentary around LGBT rights in Ireland - homophobia could not now be called out in public (Walsh, 2015), those who experience homophobia had no right to describe what homophobia is. Another key issue around the various movements around LGBT rights in Ireland, is the homonormative portrayal of LGBT people. Marriage Equality, like the previous campaigns around legislative reform, consciously put forward a certain 'normative' type of LGBT person avoiding non-conforming and more flamboyantly gay personalities; locating campaigns like same-sex marriage within this normative societal framework avoids the possibility of queering the political (Woods, 2018). Homophobia is thus reduced only for a certain type of Gay identity, this assimilative approach adopted through campaigns for legislative reform creates then, new categories of inclusion an abjection (O'Toole, 2017).

It's also important to note that while Irish Gay Men may be considered as a homogenous group, intersections of disability, class, race and other characteristics mean that Irish Gay Men may face layered and intersectional oppressive factors.

Conclusion

This chapter identifies various ways in which gay male identity may be understood in terms of sociohistorical context, psychological models, a gay social psychology and through a queer

phenomenology. In order to clearly understand how Irish Gay Men experience and express their sexuality in healthcare contexts, it's important to understand 'who' the Irish Gay Man is. This chapter presents varying lenses by which Gay identity can be understood as well as the more specific sociohistorical particularities of homosexuality in Ireland and the current broad social situation for Irish Gay Men.

Gay Men's Health

While Gay Men are likely to use the same health services and engage with the same healthcare professionals, for all of the same reasons as the general public, there are particular experiences and aspects of health, illness and health inequalities, which are more prevalent for Gay Men. It is important to acknowledge the long history of pathologisation and penalising approaches of medical and healthcare professionals around minority sexuality discussed earlier; and to reflect on how these may lead to a more taut relationship between Gay Men and healthcare. As well as the prevalence of particular health issues for Gay Men, this chapter will also present some of the overarching issues related to the unique experiences of and access to healthcare.

Mental Health

Although Gay Men are more likely to experience mental health issues and access mental health services than straight people, there is a complex and intertangled discourse on the relationship between homosexuality and mental health (King et al. 2003). This complication largely stems from the historical pathologisation of homosexuality, whereby for most of the twentieth century being gay was considered a mental illness. As discussed in the previous chapter, homosexuality was declassified as a mental illness by large international organisations in 1973, however stigma and related stresses have long since lingered. Contemporary discourse on the relationship between homosexuality and mental health remains complex, despite a broad consensus that homosexuality is not a mental illness, there is still an larger prevalence of gay people accessing mental health services than straight counterparts, and thus there is potential to conflate the experience of being mentally unwell and being gay (Veltman and Chaimowitz, 2014) It has been acknowledged that the coming out process can have a significant impact on stress and the mental wellbeing of Gay Men (Halpin and Allen, 2004); this time of turbulence may be a point at when Gay Men are more visible to counselling

and psychological services, whether symptoms of mental illness are present or not (Cochran et al., 2003).

Minority Stress

In their study on mental health and wellbeing of LGBT people in Ireland, Maycock et al. (2009) highlight the experience of minority stress as having a significant impact on the mental health and wellbeing of Irish LGBT people. This theory aims to illuminate how health inequalities for sexual minorities can be largely explained by lifetime experiences of homophobia, social exclusion, harassment, discrimination and victimisation (Meyer, 2003).

The minority stress model presented by Meyer (2003) highlights three stress processes experienced by sexual minorities: External events and conditions, which in large relates to the direct experience of discrimination and stigmatisation faced by LGBT individuals; the awareness and vigilance around that discrimination and stigmatisation, being constantly prepared to experience negative responses to sexual identity disclosure; the internalisation of wider discriminatory and oppressive societal attitudes of homosexuality. These experiences of prejudice, expecting rejection, concealing identity and internalising homophobia in turn can lead to maladaptive coping processes (Meyer, 2003). While this adaption is something Gay Men become more familiar and expert with; the stress associated with continual adaptation because of external environment can ultimately lead to negative impacts on both mental and physical health (Dohrenwend et al., 1992).

The theory provides a useful framework to consider how inequalities related to Gay Men's health are complex and dependent not only on internal experiences but also linking these experiences to wider societal conditions. The minority stress model presupposes that the stressors are unique to sexual minorities and not experienced by heterosexual people, chronic (related to social and cultural structures), and socially based (Meyer, 2003).

Higgins et al.'s (2016) LGBT Ireland study on mental wellbeing of Irish LGBTI people concurred that minority stress played a significant role in the development of poor mental health outcomes; although no empirical testing of the theory was deployed, participants in the study commonly reported experiences of homophobia as having a negative impact on their mental wellbeing. Pachankis et al. (2015) examined the effectiveness of an adapted approach to CBT on gay and bisexual men, for the reduction of co-concurring health problems with a source in minority stress. The randomised control trial on 63 gay and bisexual men established support for a minority stress focussed approach when engaging in health behaviour change interventions with gay and bi men. Meyer contends that while the theory has been applied to other minority groups, there is a need for further exploration of how it applies to sexual minority populations (Meyer et al., 2008).

Anxiety, Depression, Suicidality

Ireland's national strategy on reducing suicide 'Connecting for life' identifies LGBT people as having vulnerability to and increased risk of mental ill health and suicidal behaviour (Dept of Health, 2015). A systematic review and meta-analysis on LGB mental health by King et al. (2008) reviewed data from 11,971 non-heterosexual people and compared this with 214,344 heterosexuals; the study revealed mental health inequalities for sexual minorities across several areas including depression and anxiety, increased suicidality as well as substance dependence and substance use disorders. In a controlled, cross-sectional study on the mental health and quality of life of Gay Men and lesbians in England and Wales, King et al. (2003) identified that Gay Men and lesbians experience significantly higher levels of psychological distress than heterosexuals, and that they are more likely to have consulted mental health services in the past, and exhibited self-harming behaviour. More recent research by Chakraborty et al. (2011) on the non-heterosexual population in England shows similar results. This trend is replicated in international research; in the USA Fergusson et al. (1999) found that Gay Men were six times more likely to experience common mental health problems such as depression, anxiety, substance dependence and suicidality than heterosexuals, which corresponds

to similar studies in Canada (Bolton and Sareen, 2011), New Zealand (Skegg, 2005) and Norway (Wichstrom, 2003).

The most recent study into LGBTI mental health in Ireland (Higgins et al., 2016) supports the international trends, with Irish LGBTI people experiencing significantly higher levels of mental health difficulties than the general population. The study which included 873 Gay Men, concluded that Gay Men were at identifiably increased risks of mental health inequalities when compared with heterosexuals, however their levels of anxiety, stress, depression, self-harm and suicidality were lower than that of other sexual minorities (Higgins et al., 2016). While not a direct follow-up, the results of the LGBT Ireland report (Higgins et al., 2016) are comparable in a favourable way with previous research on LGBT mental health in Ireland (Maycock et al., 2009), reporting almost half the prevalence of mental health issues, although the previous study had not applied any validated tools, and relied on self-reporting (Higgins et al., 2016).

While minority stress is not always cited as a direct causative factor around mental health inequalities amongst Gay Men, most research acknowledges clear links between the experiences of homophobia and poor mental health (Douglas-Scott et al., 2004; Freguson et al., 1999; Rivers, 1996). While not necessarily utilising a minority stress framework, Flowers and Buston (2001) suggest that it is a combination of internalised homophobia and chronic stress caused by fear of stigma that has the greatest negative impact on Gay Men's mental health.

Alcohol and Drug Use

Intersecting with narratives of mental health inequalities for LGBT+ people is a focus on drug and alcohol use, and while internationally the most prevalent inequalities shown in research refer to Lesbian and Bisexual Women (King et al., 2008), Gay Men also exhibit higher rates of substance dependence than heterosexuals (Hughes and Eliason, 2002; King et al., 2003; Hughes et al., 2016). Alcohol use in the general population in Ireland is amongst the highest in the world, and in general

men drink more alcohol than women (WHO, 2018). The motivations around drinking alcohol are culturally specific but also gendered, with a masculine prerogative which may be around facilitating aggression, power and risk taking (Hughes et al., 2016); excessive use of alcohol by men is inherently linked to a desire around being manly. The LGBT Ireland study by Higgins et al., (2016) found that in Ireland Gay Men reported more alcohol use behaviour than other members of the LGBTI community. showing a slight increase from the previous study by Maycock et al. (2009).

The use of illicit drugs and development of substance dependence are also featured in the literature on LGBT health inequalities. While the nightlife of the gay scene is often portrayed as a centre for recreational drug use; there is also evidence of significant disparities between the harmful use of prescription drugs by Gay Men when compared to general populations (Li et al., 2018). Again, minority stress theory provides a framework to understand why Gay Men are more likely to use and develop dependence on illicit drugs; and while experimentation and recreational use does not always led to dependence, the higher rates of dependence amongst LGBT communities are significant (McCabe et al., 2013; Mereish and Bradford, 2014). Higgins et al. (2016) established that illicit drug use amongst Irish LGBT people in Ireland was significantly higher than in the general population, with over half of LGBT people having taken illicit drugs within their lifetime compared with only 27% in the general population. The most common substances of use were cannabis, codeine-based drugs and ecstasy, which reflects the diversity in reasons and settings where drug use takes place.

An emerging phenomenon in the literature around Gay Men's health is around the use of drugs during, and for sex. The phenomenon known as Chemsex as described by Stuart (2013), describes how substances such as Crystal Meth, Ketamine, GHB, GBL and Mephedrone are used by groups of Gay Men in a sexualised context. While, like substance use more broadly, not all those who engage in the practice, develop dependence or experience significant harm; Chemsex does involve levels of risk of psychological and social harm, as well as the possibility of overdosing (Bourne et al., 2015).

There are further established risks associated with Chemsex and sexual health, with studies demonstrating clear linkages between the practice, and greater sexual risk taking and transmission of sexually acquired infections (Sewell et al., 2017; Ottaway et al., 2017). Frankis et al. (2018) analysed data from the cross-sectional Social Media, MSM and Sexual and Holistic Health survey, which included 2428, gay, bi and men who have sex with men across the UK and Ireland, and found that more than a quarter (27%) had engaged in Chemsex in the past 12 months, similar results were identified in London populations by Bourne et al. (2014). Glynn et al. (2018) surveyed the attendees at a Gay Male specific sexual health clinic in Ireland, out of the 510 participants in their study, 27% reported that they had engaged in Chemsex, concurring with the Frankis et al. (2018) research. Of the participants in this Ireland specific study, 25% reported that Chemsex had impacted negatively on their lives, and 31% stated that they would like help or advice about Chemsex (Glynn et al., 2018). Pollard et al. (2018) discuss maladaptive coping strategies associated with Chemsex as an outcome of minority stress and multiple levels of stigma. In their qualitative research on Chemsex in South London, Weatherburn et al. (2017) establish two broad motivations underlying practice; one around the role of drugs in increasing confidence, decreasing inhibitions which can 'allow' for the type of sex the person wants to have; the other is around how the drugs enhance the quality of the sex, increasing attraction and a sense of intimacy.

Body image

A systematic review and meta-analysis by Barnes et al. (2020) establishes that sexual minority men have higher body dissatisfaction than heterosexual men; and when compared to previous synthesis (Morrison et al. 2004) the incidence of body dissatisfaction amongst gay and bi men is expanding. The manifestation of body image dissatisfaction can be complex and multifaceted; for some it may be a significant factor in the development of eating disorders (Murray et al. 2017); excessive

exercising and gym use (Fricke et al 2019) or the use of performance enhancing drugs such as steroids (Strubel and Petrie, 2019). Again, minority stress is established as a key factor in body image dissatisfaction amongst Gay Men, but there are also wider sociocultural factors as well as the role of sexual objectivation (Morrison et al., 2020).

While there is an extensive evidence base on eating disorders, much of the literature is focussed on adolescent girls and young women; however, the experience of eating disorders amongst men is significantly different (Murray et al., 2017). Some of the differences experienced by men relate to concurrent experiences of substance use (Carlat et al., 1997); older ages of onset (Mitchison and Mond, 2015) and a history of being over-weight or obese (Carlat et al., 1997). Key issues in the area of male eating disorders link very much to a marginalisation of males who are experiencing eating disorders, and lack of appropriate treatment, but also that muscularity-oriented eating disorders are not encompassed in current classification schemes. While an under-researched topic, relationality between body dissatisfaction, eating disorders and over-exercising is an emerging area of interest. Brown and Graham (2008) in their study on gym-active gay and heterosexual men, not only established that body dissatisfaction was more prevalent in Gay Men; but also found that this dissatisfaction was a prime motivator for gym use as opposed to the heterosexual men who focussed more on fun and reaching hours per week as a benchmark. Another phenomenon associated with body dissatisfaction in Gay Men is the use of performance and appearance enhancing substances. Given the explicit drive for lean and muscular bodies within society broadly, many Gay Men turn to both over the counter supplements as well as anabolic steroid use to enhance their appearance in this way (Strubel and Petrie, 2019). While empirical evidence comparing heterosexual and Gay Men in this area is limited, through analysing data from the Youth Risk Behaviour Study in the USA, Blashill et al. (2015) identified that younger Gay Men were significantly more likely to misuse anabolic steroids.

Despite the health associated risks with this behaviour, it seems to be a rising trend, although more research is warranted (Strubel and Petrie, 2019).

Sexual Health

Within the literature on Gay Men's health, one of the most prevalent themes is that of sexual health, HIV and sexually acquired infections. Comparison between rates of sexually acquired infections amongst heterosexual populations and Gay Men have been longstanding within infectious diseases research (Stenger et al., 2017; Savage et al., 2008; Fenton and Imrie, 2005; Simms et al., 2005; Judson et al., 1980). While epidemiological research into diseases such as chlamydia, gonorrhoea, syphilis had been a longstanding focus throughout the 20th Century, the specific focus on gay, bi and men who have sex with men was something that only really emerged within wider public health research post the AIDS crisis of the 1980s (Stenger et al., 2017). HIV and AIDS had a drastic and tragic impact on gay male communities, not only through high mortality rates, but also in terms of prolonged psychological and cultural trauma (Hammack et al., 2018). While initial decreases in rates of sexually acquired infections were seen during the AIDS crisis in the 1980s and 1990s (Stenger et al., 2017), by the mid-1990s with the advent of more effective treatment for HIV, rates again began to rise (Stenger et al. 2017).

Gay, bi and men who have sex with men represent the highest prevalence of HIV and sexually acquired infections in Ireland (HSE, 2018) and while interventions including specialised health services, community condom distribution, community public health promotion and the rollout of pre-exposure prophylaxis for HIV (PrEP) – rates continue to rise (HPSC, 2019). While rates remain high, an important factor to consider is that there are increasing levels of testing amongst Gay Men every year (HSE, 2018).

Cancer

There are few issues in health and medicine that get as much focus as cancer; as one of the leading causes of death globally, this focus is of course warranted. However, much rhetoric around cancer is generic and generalised; although there is emerging evidence that Gay Men are more at risk of certain cancers than the general population. Lifestyle and behavioural issues are often key factors in the development of cancers; excess alcohol and drug usage as well as the use of anabolic steroids as discussed above, are more prevalent in gay male populations and so may have an impact on the development of cancer.

One of the main types of cancer which Gay Men are specifically at a higher risk of when compared to heterosexual men are those associated with HPV. Anal cancers, although not common in the general population, are particularly prevalent amongst Gay Men, whereby oncogenic high risk HPV is detected in 80%-90% of anal cancer presentation (De Vuyst et al.m 2009). As pointed out by Poynten et al. (2012) there is much focus on relationality between HPV and cervical cancers in women, anal HPV infection is substantially more prevalent than cervical HPV is in women. The HPV vaccine, plays an important role in the prevention of HPV related cancers, and while originally only provided to school aged girls, more recently gay, bi and men who have sex with men have been offered the vaccination through sexual health services (HSE, 2018). While there are clear disparities between the rates of anal cancers amongst Gay Men and heterosexual men, there is a gap in evidence around other HPV related cancers in mouth and throat, which might also show disparity related to gay male sexual practices (D'Souza and Dempsey, 2011).

Prostate cancer remains one of the most prevalent cancers amongst men, however there has been little empirical research on whether Gay Men have any increased risk (Simon Rosser et al., 2016). Spence et al. (2014) examined prostate cancer risks associated with sexual partners. In their study of 1590 men with prostate cancer (including 78 gay and bisexual men) they found that men with 20+

female partners were at a lower risk of prostate cancer, while men with 20+ lifetime male partners were associated with a slight excess risk.Interestingly there was no identifiable correlation between prostate cancer and history of sexually acquired infections (Spence et al., 2014). While the research on rates of prostate cancer amongst Gay Men specifically is scant, there is evidence that Gay Men attend for prostate cancer screening less and have poorer sexual function and quality of life outcomes than heterosexual men (Rosser et al., 2016).

Without doubt, there is a necessity for further research into Gay Men and cancer, both in terms of prevalence and health disparities, but also the specific experience of cancer amongst Gay Men. Recently a cross sectional-study of almost one million adults in the USA identified that Gay and Bisexual men had a higher prevalence of skin cancer compared with heterosexual men (Singer et al., 2020).

Other Chronic illness

As with the areas of health and illness discussed above, data on prevalence and aetiological links between sexual identity and experiences of other chronic illness is sparce, LGBT people are often invisible and if demographic data on sexual identity is not gathered, causative links cannot be identified. As pointed out by Lipton (2004), the dearth of research around Gay Men's experiences of chronic illness aside from HIV plays a particular role in stigmatising gay health issues. Using the American National Health Interview Survey data (Fredriksen-Goldsen et al., 2017) identify that there were some areas where LGB people had higher prevalence of certain disease categories; sexual minority men in particular identified as having higher prevalence of coronary disease and cancer. Jowett and Peel (2009) note that with a universally ageing population, focus should be given to the experiences of LGBTQ people living with chronic illness. Their qualitative survey of 190 LGB people explored experiences related to 52 different non-HIV related chronic illness; the study illuminated four distinct themes; ableism within LGBT communities, isolation from LGBT communities,

heteronormativity within healthcare and homophobia from healthcare staff. Regardless of prevalence of illness or disease, the clear disparities in access, experience and utilisation of healthcare by sexual minorities warrants particular focus. Nowakowski et al. (2019) stress the priority in establishing potential pathways for the integration of LGBT care into the healthcare strategy and scholarship.

Conversion therapy

While it has been well established for decades that homosexuality is not an illness, pathologising and 'treatment' of homosexuality continues in some jurisdictions (Drescher, 2002). While clearly repudiated by all major health organisations, the practice of 'conversion therapies' aimed at 'treating' or 'curing' homosexuality continue (Drescher et al., 2016). As well as being politically unpopular, these conversion therapies can cause actual physical and mental harm to those who experience them, while having little efficacy in terms of sexual orientation conversion (Smith et al., 2004). There has been a movement to regulate and ban conversion therapy internationally, however approaches differ (Drescher et al., 2016). Currently there is no law prohibiting the practice in Ireland, however political representations have been made and a bill drafted which is under consideration by the Irish parliament.

Gay Men's health in Healthcare Education

As highlighted by McCann and Brown (2018) one of the significant barriers to effective healthcare for Gay Men (and other LGBTI+ people) is the need to have confident, competent and knowledgeable healthcare practitioners, aware of the specific healthcare needs. Stewart and O'Reilly (2017) note that for healthcare providers, the gaps in education at both undergraduate and continuing professional development level, around LGBTQ issues, were the key barriers to ensuring appropriate care for LGBTQ patients.

Morris et al. (2019) identified that within medical, nursing and dental students and providers, there were levels of LGBTQ related bias, and identified training as a key strategy to reduce this. In a systematic review on the inclusion of LGBT+ health issue within healthcare education programmes, McCann and Brown (2018) identified that there were significant progresses in terms of LGBT+ inclusion in healthcare education, but that the quality and level of provision remained diverse and often patchy. There isn't a clear consensus on what the best level, modality or content should be provided; Verrastro et al. (2017) also note interprofessional ambiguity around whose role sexuality-based healthcare is.

In conceptualising how the healthcare needs of LGBTI+ people could be incorporated into nurse education programmes, McCann and Brown (2020) propose a triad approach with LGBT+ theory, LGBT+ practice learning and LGBT+ simulation training. This broad programme level approach offers not only engagement with theory in a classroom setting but the incorporation of learning into students practice learning environments; although this type of approach requires significant programme buy in, Whalen et al. (2020) identified that even a single one hour lecture can have impact on both attitudes and knowledge of medical students on LGBT health.

One of the barriers to incorporating LGBT health information into healthcare education curricula, identified by Johnson (2017) is the lack of requirement at a regulatory level for its inclusion – indeed in Ireland, while the Nursing and Midwifery Board require content on inclusion and diversity in nursing education, they do not specify what information should be incorporated (NMBI, 2016).

Health Services

While Gay Men are likely to be service users in almost all healthcare organisations and services, there is a clear dichotomy between Gay Men in general services, and Gay Men using specialist healthcare services.

The provision of specialist LGBT and gay health services emerged through community LGBT healthcare in the USA and is clearly linked to political, social, and scientific associations between LGBT people and health (Martos et al., 2017). Specialist services for Gay Men tend to focus primarily on sexual health with some specific psychological and mental health services also (Koester et al., 2013). Within Ireland there is one specific health service for Gay Men based in Dublin which focusses on sexual health; however more recently there hase been specific guidance on creating more inclusive approaches to providing healthcare to LGBT service users (HSE, 2009; PSI, no date).

Conclusion

Through engagement with the evidence base on Gay Men's health, this chapter clearly outlines some of the specific health disparities applied to Gay Men; it also illuminates some of the broader issues which feed into health inequalities for Gay Men. The complexities of how and why Gay Men have different experiences of healthcare are important to acknowledge; and provide a landscape for understanding how healthcare is delivered and what expectations of healthcare are developed.

Methodology

This chapter aims to present the research strategy used to illuminate the lived experience of Irish Gay Men when discussing sexuality with healthcare practitioners, and further acknowledge the ontological and epistemological underpinnings of same. The chapter is divided into four major sections: Theoretical basis, research process, researching sensitive subjects and quality assurance, validity and rigour. Identifying the deficiencies in quantitative and positive approaches to dealing with experiential research into sexuality, the relative benefits of a qualitative design and subsequent methods are explored. Phenomenology as a theoretical basis is discussed in relation to the chosen investigation method, Interpretative Phenomenological Analysis (IPA) (Smith, 1996). The philosophical underpinnings of IPA are presented and its suitability to addressing the presented research questions is justified. Issues of project promotion, recruitment and sampling are dealt with and following the chapter, goes on to present a brief discussion of the most suitable data collection methods. I summate why semi-structured interviews were chosen as the most appropriate process, giving a detailed outline of the preparation and interview process. Following this a detailed, step-by-step description of the operationalisation of IPA in the study is presented. The chapter ends with considerations of ethical issues and quality assurance for qualitative research.

Qualitative methods in nursing research

Given the history of the development of nursing and its links to the biomedical model of research and practice it is perhaps unsurprising that pre-1980 there was very little engagement with qualitative research by scholars within the discipline (Risjord, 2010). From the 1980s however, there came a realisation that the positivist epistemology of quantitative research was not enough to answer the questions related to good nursing practice. Watson (1981) contended that nursing needed a new kind of science, one which rejected the positivist approach of objectivity and personal detachment. At the same time there was a growing interest in theory and philosophy, and nurses

began to appreciate that the qualitative methodologies being developed in sociology and anthropology had something to offer in the pursuit of this new type of science (Tinkle and Beaton, 1983). Despite a popular view of conflict between qualitative and quantitative approaches in a discipline like nursing, the early nursing scholars saw both methodologies as complementary and consistent (Risjord, 2010). In fact, in more recent times the so-called 'paradigm wars' between these two methods have mostly disappeared, in many jurisdictions funders of health research are now actively encouraging the inclusion of qualitative inquiry (Green and Thorogood, 2014).

Within the realm of qualitative research itself, there is a varied array of approaches and while they can differ substantially in terms of philosophical underpinnings, their data collection techniques, indeed their assumptions of to what extent 'reality' can be researched, they share a commitment to answering the 'why' and the 'how', rather than quantitative research which may be more numerically focussed (Bryman, 2015). Rather than the notion that in order to study things scientifically they must be measurable, qualitative research acknowledges the subjective nature of knowledge. It aims to shed light on meaning rather than trying to find a single 'true' account of a phenomena, it is this commitment to the exploration of meaning that binds qualitative methodologies together (Moustakas, 1994).

Fruitful qualitative research could be framed as perhaps taking a more asset-based approach to studying people in a healthcare context. Instead of starting off from a point of asking what people do wrong, or what they don't know, the focus is on what the participants do know, what their beliefs and attitudes are, and what the underlying reasoning for their behaviour is (Good and Thorogood, 2014). The growing public health agenda is focussed on behavioural change; without a solid comprehension of the rationale behind people's behaviour, how can it be changed? One of the motivations behind the Queer Expressions project is the finding from the EU Fundamental Rights agency LGBT survey (2013) which highlighted that most Gay Men in Ireland (and throughout Europe) have not disclosed their sexual identity to their healthcare practitioners. Without a clear

understanding of how Gay Men view their sexuality, its relatedness to health and wellbeing and how and why this should be discussed with healthcare practitioners it is unlikely that this phenomenon will change. Although there has been a broad acceptance of the utility of qualitative research there can still be scepticism about its rigour, especially from those rooted in more positivist traditions (Green and Thorogood, 2014). What's important however is the consideration of methodology in terms of addressing specific research questions, and thus choosing the most appropriate approach to answer the questions posed. The primary research questions for Queer Expressions are as follows:

1. What do Irish Gay Men understand by the term sexuality?
2. What are Irish Gay Men's experiences of discussing sexuality and coming out to healthcare practitioners?
3. How do Irish Gay Men feel when discussing issues of sexuality with healthcare practitioners?
4. What impacts Gay Men's Decisions on whether to 'come out' to healthcare practitioners or not?
5. How do Irish Gay Men think their sexuality impacts on their experience of healthcare?

After immersion in the literature around Irish Gay Men and Gay Men's health in the area, I believe these questions have not been addressed adequately, and given the in-depth and complex nature of the issues pertaining to these questions, I deemed a qualitative methodology to be most suitable. The chosen methodological frame for this project is interpretative phenomenological analysis (IPA).

Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a qualitative methodology developed by Jonathan Smith in the mid 1990s, designed to allow researchers gain an insight into the lived experiences of participants and furthermore to investigate how these experiences are made sense of by the participant. The IPA researcher takes the side of the participant, trying to understand what the experience is like from the point of view of the person experiencing it. Furthermore however IPA

goes beyond the descriptive and asks critical questions of the texts from participants (Smith and Osborn, 2003). Smith et al. (2009) suggests that when people experience something significant in their lives they go through a process of reflection on the significance of this experience, IPA taps into these reflections. IPA considers there to be a chain between the embodied experience, how that experience is talked about and how the participant tries to make sense of and reacts to that experience (Smith, 1996). While very much rooted in qualitative health psychology, in recent years IPA has broadened its applicability to a diverse range of disciplines most notable in healthcare research, Dowling and Cooney (2012) point especially to a growing interest in IPA within the nursing academy. Smith (2004) suggests that IPA should not be deemed appropriate or inappropriate deemed on sub-disciplinary boundaries, but instead on whether there is a clear link between the research questions posited and the epistemological underpinnings of the methodology. As Biggerstaff and Thompson (2008) discuss, qualitative methods such as IPA give healthcare researchers a real chance to understand illness and healthcare from the patient or service user point of view. Phenomenological research gives us the chance to investigate individual accounts and understandings of the experience of healthcare and of illness, methods like IPA offer to remind us that human beings are the subjects of nursing, not medical conditions (Warren, 1994). Despite the variation in disciplines now embracing IPA as an approach, Smith et al. (2009) still maintain that IPA is a psychological endeavour where researchers from other disciplines carry out IPA they are speaking to the psychological aspects of their own disciplines, 'IPA is psychological with a small p, as well as with a big P' (p.5). The participant and their story are at the heart of IPA, without a centring of this lived experience there is not IPA (Smith, 2011b). However, IPA also acknowledges the dynamic nature of the research process and key and central role of the researcher in making sense of the personal experiences of the research participants (Smith, 2004). In IPA the researcher is trying to get close to the world of the participant, to see the world as they see it, but this of course cannot be done directly or indeed completely. Smith and Osborne (2003) describe how access to this world is dependent on the researcher's own conceptions, however these conceptions can also complicate

this access. IPA must always go beyond the descriptive, Smith (2004) describes IPA as always being interpretative, the analysis engages in what he has coined as a double hermeneutic, the participant is trying to make sense of their experiences in the world; the researcher is trying to make sense of them trying to make sense of their experiences in the world (Smith, 1996), both are active agents in the research process. While the researcher's active role cannot be denied, Barbour (2007) notes caution on claiming discovery in qualitative research, it is suggested rather than a researcher discovering emergent themes we simple bear witness to the experiences. Pringle et al. (2011) question, however, how much of the experience can in fact be brought to light without the active involvement of the researcher in the analytical process. IPA's focus is very much on the distinctiveness and uniqueness of the individual person's experiences, however it also gives us a lens to analyse how these experiences become meaningful for this person within their own context 'both as an individual and in their many cultural roles' (Shaw, 2001, p.48). IPA does not provide a fixed set of prescribed activities, indeed Giorgi (2000) contends that to do so in phenomenological research is in direct contrast with the philosophical underpinnings of phenomenology. Smith et al. (2009) notes the 'healthy flexibility' in IPA as an approach, constituting, instead of a single method of approaching research a set of common processes and principles which are applied in accordance within the context of the particular research questions, sample and researcher preference (p.79). In IPA as an inductive and iterative cycle there is a movement from the particular to the shared and from descriptive accounts to deep interpretation. While this may be a contradiction to the phenomenological perspective I find it helpful to explain IPA in terms of its various constituent parts, in order to fully illuminate and explain its applicability in the context of Queer Expressions.

Theoretical Underpinnings of IPA

While phenomenologists may differ in terms of interests and emphases, there is a common interest amongst them in thinking about what the experience of being human is like, especially in what interests us as human beings, what matters to us and how we are constituted in our lived world

(Smith et al., 2009). Larkin et al. (2006) puts forward that 'reality is better understood to mean something approximate to what is thought about things in general, rather than how things really are when thought is removed' (p.105). A phenomenological frame fits Queer Expressions, given that my main aim is indeed to illuminate what the experience of discussing sexuality is like for Gay Men in a healthcare context, what it is that is important to them, how they understand their sexuality and how it interplays with this aspect of daily life. For me, IPA offers a practical approach to applying a phenomenological frame to my research questions and operationalising it as a research method. Two main schools of thought overarch contemporary phenomenological philosophy; descriptive phenomenology, which maintains the approach of Edmund Husserl, and interpretive or hermeneutic phenomenology which has developed based on the work of Martin Heidegger (Todres and Holloway, 2010). Phenomenological thought across theorists is often as complementary as it is in contrast and IPA as an approach has developed in many ways dependent on which theorists work are adopted. For the purposes of Queer Expressions, the work of Husserl, Heidegger and Monty Perleau have been useful in thinking about how the lived experience and embodiment are constructed, these are further explored through Ahmed's Queer Phenomenology (2006) which provides a novel theoretical lens for the construction of sexual orientation through participant's data concurrent through a more traditional psycho-social perspective.

Husserlian phenomenology is concerned with how people view their world, suggesting that how people view and experience their world directly impacts on the actions they take. Husserl's assertion was that lived experiences could only be described wholly, through one-to-one interactions between the researcher and the participant (Wojnar and Swanson, 2007). In many ways Husserl's work established not only a new philosophy, but a new approach to scientific enquiry (Moran, 2000). Smith et al. (2009) put forward that in fact Husserl ranked 'science' as a second-order knowledge system, depending primarily and ultimately on first-order personal experience. An important concept in descriptive phenomenology is that of bracketing, whereby the researcher consciously abandons his or her own preconceptions and personal bias in order to describe the subject's

phenomenon in a pure and universal sense (Tymieniecka, 2003). Given that this particular project is not only interested in a description of people's experience but also in interpreting what effect and impact these experiences have, a purely descriptive methodology may not suffice to address the research questions.

Heideger was himself a student of Husserl, and although he acknowledges an intellectual debt to Husserl, his work goes beyond the descriptive phenomenology presented previously. In descriptive phenomenology, context is only of peripheral importance. The Heidegerian, interpretative school, however views context as of central importance (Wojnar and Swanson, 2007). Heideger incorporates hermeneutics into his approach, a longstanding philosophical tradition mostly indulged in biblical and theological study (Lopez and Willis, 2004) and a key element of IPA. Spiegelberg (1978) identifies hermeneutics as a method for bringing out what are normally the hidden aspects of human experience. Heideger (1962) asserted that people are so embedded into the world around them that their experiences are inextricably linked with social and cultural contexts. Moreover Heideger (1962) puts forward the concept of 'Dasein', the human way of being in the world (Wojnar and Swanson, 2007), we are always somewhere, always located and always intertwined with or involved with some meaningful context (Larkin et al., 2006). While descriptive phenomenology focuses on enabling people to know about their own experience, the interpretive phenomenologist will further examine the meanings of the lived experience and how these meanings actually influence the choices they make (Flood, 2010). Van der Zalm and Bergum (2000) suggested that hermeneutic phenomenology incorporates both descriptive and interpretative elements, allowing for intersubjective understanding. A key difference in approaches is that while the concept of objectivity and a bracketing method is of great importance in Husserl's descriptive phenomenology, Heideger disputes it. Heideger's assertion is that it is impossible to rid the mind of background perceptions and understanding, it is the perceptions and background understanding that lead the researcher to consider the phenomenon worthy of research in the first place (Koch, 1995). It is further suggested in the field on interpretative phenomenology that not only is researcher personal knowledge

inevitable, but it actually adds value and is necessary for phenomenological research, something which has become a core tenant of IPA. For Heideggerian phenomenologists, it is not possible to investigate or explore an experience without interpreting what that experience means (Smith et al., 2009).

Merleau-Ponty, like Heidegger, moves beyond the descriptive in a wish for a more contextualised phenomenology. While Heidegger very much considers the 'worldliness' of human existence, Merleau-Ponty's work moves towards a different contextualisation by considering and describing our 'embodiment' in the world, the embodied relationship the individual has to the world, and how it forms our perspective of the world (Smith et al. 2009). This view of the person as an embodied being is particularly akin to nursing's concerns and so offers a particularly useful frame for nursing enquiry (Koch, 1995). Moran (2000) contests that Merleau-Ponty has produced the most convincing and detailed example of how phenomenology can interact with medicine, science and art to describe the nature of the embodied person being in the world. While not dismissing the importance of empirical scientific knowledge Merleau-Ponty like Husserl sees it as a second-order knowledge, professing:

> "*All my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view, or from some experience of the world without which the symbols of science would be meaningless."* (Merleau-Ponty, 1962, p. ix)

A point of interest in Merleau-Ponty's philosophy is in how the embodied self is unequivocally linked from the perception of 'the other'. The notion of becoming oneself through encounters with another and 'the other' becoming into being through the embodied self is a core element of Merleau-Ponty's work, in turn giving us a lens to look into the complexity of relationships (Guenther, 2011). This obviously is very relevant to the construction of Queer Expressions, in which relationships are a key part. This prime position of the embodied self also marks an epistemological position filtered throughout IPA. While we can observe and bear witness to the experience of another, we can never

share entirely the other person's experience, their experience always belongs to their embodied position in the world (Smith et al., 2009). For Merleau-Ponty, our manner of being in the world is projected through our sexuality, he critiques thinkers like Freud who conceives sexuality as a substructure and evidence of some subconscious process. Rather, our sexuality has its own 'intentional and meaning giving powers' (Moran, 2000, p.435), sexuality in itself and as itself possesses 'relations and attitudes which had previously been held to reside in consciousness (Merleau-Ponty, 1962, p.158). Given the diffuse and complex conceptualisation of nursing in terms of being a 'caring profession' phenomenological approaches, perhaps in part due to their focus on subjectivity, have proven popular in qualitative nursing research (Green and Thorogood, 2014)

What makes IPA a phenomenological endeavour is its concern with a detailed examination of the human lived experience, in an IPA study the participant's experience is always at the centre, but moving beyond the descriptive, IPA concurs with Heidegger that phenomenological inquiry is, from the outset, an interpretative process (Smith et al., 2009). Phenomenology however is not a theory, it is pre-theory, it is not owned by philosophy the philosophers noted, essentially in everyday life we are all somewhat of a phenomenologist (Halling, 2008). We all listen to the stories and experiences of others and all, in so far as we genuinely pay attention, reflect on our own perceptions. The guidance we get from the philosopher is the formalising of a 'rigorous description of an approach and ability which is elementally a human one' (Smith et al. 2009, p.33). While the development of IPA has not explicitly pinned itself to any one particular type of phenomenology or one particular theorist it is very clear that phenomenology and a commitment to the exploration of the lived experience is at its core, and builds on this core through various approaches. It does not claim a unique epistemological or methodological position when compared to other forms of phenomenological enquiry, it simply proposes a different emphasis or suggests different techniques to engage in the questions posed (Smith, 2004).

A core aspect of IPA is its idiographic approach to data, in that the analysis begins with a detailed analysis of one case until a degree of closure is achieved, then the researcher moves onto a detailed analysis of a second case and so on, only when all cases within a project have been fully analysed is there an attempt of cross-analysis. By taking this idiographic approach, Smith (2004) suggests that not only should one learn something about the important generic themes in the analysis but also gain insight into the life worlds of the participants taking part. As a result of this approach, pragmatically, small sample sizes are used in IPA and thus open to critique. This focus on the particular, the individual, is important however it does not mean that we cannot make generalisations based on this. Phenomenology ascribes that individuals are not isolated in themselves; they are in the world.When we examine individuals in the world we become familiar with their Dasein, and thus can make linkages of how people are in the world. In such an idiographic approach does not abjure generalisability it simply proposes a different way of establishing that generalisability (Harré, 1979).

Another key component of IPA in terms of its theoretical foundation is that it is inductive in nature. Thus, IPA designs must be flexible enough to allow for unexpected themes or issues to emerge during analysis and so apply a form of analytical induction (Hammersley, 2004), attempting to derive theoretical explanations from the case by case analysis. Operationally this involves coming up with a broad set of research questions which in turn guide an expansive collection of data. While there is a clear differentiation between a deductive approach, whereby data is used to test a theory, and an inductive approach whereby theory is developed out of data, contemporary understandings of qualitative research suggest that there is, more often than not an element of each in the other (Bryman, 2016). Queer Expressions is very much an inductive study of the ways Irish Gay Men discuss sexuality with healthcare practitioners, however these discussions are further considered in relation to broader social and psychological influences. IPA, like most other qualitative research techniques encourages this interplay between induction and deduction, however in IPA the inductive phase is always foregrounded (Smith, 2004). IPA is also interrogative. Having stemmed

from psychology, its psychological centre is a core component, despite diverging significantly from mainstream psychology epistemologically and methodologically (Smith, 2011a). Queer Expressions in turn posits its findings in dialogue with other psychological literature, empirical studies on the experiences of Gay Men and also more innovative approaches such as Ahmed's (2006) Queer Phenomenology.

Situating IPA vs other qualitative research

As healthcare professionals, when diagnosing illness or planning care we rely heavily the chain linking a physical condition, to the cognitive process and in turn to how people describe feelings, emotions, symptoms (Smith, 1996). IPA's relativist ontology is firmly assured in that, no matter how flawed, there is a direct link between how people experience a phenomenon, what people think about their experiences, and what they say (Smith et al., 2009).

Grounded theory is described by Strauss and Corbin (1998) as 'theory that was derived from data, systematically fathered and analysed through then research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another' (p.12). This is not dissimilar from IPA in its inductive approach, however Smith (1996) suggests that IPA assumes a more relativist position than grounded theory. Like other broad branches of qualitative research, grounded theory has several different approaches in terms of assumptions and application, some relaying a more realist ontology and some more constructionist. Charmaz (2006) suggests a more social constructionist approach to Grounded Theory, arguing that theories do not emerge from the data in isolation but rather they are constructed by the researcher's own engagement with the data. This central placing of the researcher in the process is very similar to that in IPA however there are differences. As explained by Willig (2001) 'while Grounded Theory was developed to allow researchers to study basic social processes, IPA was designed to fain insight into individual participants' psychological worlds' (p.69) Grounded theory was considered as a possible

methodology suitable for Queer Expressions, indeed it could be argued that all of the research questions could be satisfactorily answered by a grounded theory approach, however the idiographic and person/experience centeredness of a phenomenological approach was more appealing. There was also an ambition for Queer Expressions to approach questions of a queer phenomenology in its data (Ahmed, 2006). While again the inductive process is very much foregrounded IPA analysis often engages directly with existing theory through its interpretative work, which is something that very much distinguishes IPA from grounded theory approaches (Larkin et al., 2006).

Another method considered for Queer Expressions was discourse analysis, whereby the discourse around a phenomenon becomes of central focus, suggesting that the social and personal worlds and versions of society and events are produced in discourse (Bryman, 2016). Essentially discourse analysis is seeking to investigate how a phenomenon has come into being (Parker, 1997), so in terms of Queer Expressions, it would seek to answer why Gay Men are not coming out to healthcare practitioners. Discourse analysis does not only consider the direct data which comes from a physical interview, but moves beyond to consider the social and environmental context within which the interview is taking place. This move away from the lived experience and focus on context outside of the participant's presentation of it is certainly a move away from phenomenology. While DeVisser and Smith (2006) contend that IPA's focus on the lived experience and its meaning does not prohibit the consideration of wider social discourses, Smith et al. (2009) state that 'to understand the experiential claims made by a research participant, we also need a certain level of cultural competence' (p.195). IPA can enable us to gain insight into the shared experiences of people within a particular social context, and in turn examine the relationship between the two. So, while it could perhaps be suggested that Queer Expressions does employ a methodology in line with discourse analysis, this project has a primary focus on the individual, their experience and their story around it. Consideration of the wider social context will simply provide scope for discussion within the thesis.

IPA and sexuality research

Given the complexity and diversity in meanings around sexuality, sexual identity, sex acts, sexual health and so forth. as highlighted in my concept analysis, issues pertaining to these fluxed notions are well placed to be investigated by IPA. There is indeed a strong body of IPA research already established in relation to sex and sexuality (Smith et al., 2009). The scope of these studies are wide ranging, from very specific experiences such as the aforementioned Boyle et al. (2005) study into the experience of genital surgery for intersex people, to much broader areas such as Devisser and Smith (2006) who look at masculine behaviours and their relationship to health. Paul Flowers has developed a significant corpus of research pertaining to Gay Men both in terms of healthcare, risk and HIV (Flowers et al., 1999; 2000; 2001b; 2003) and more generic identity based studies such as Flowers et al. (2001a) looking at the experiences of growing up gay and Flowers et al. (2000) looking at the impact of locale on Gay Men's sexual cultures. Queer Expression's research questions very much span both the particular experience, discussing sexuality with a healthcare practitioner, as well as the broader, gaining an understanding on the experience of being gay, and reflecting on the embodiment of sexuality with the participants involved. Again, within all of these studies what makes them uniquely positioned as IPA is the focus on the individual's experience. Within Queer Expressions my interest is not on the broadest conception of what it is to be gay, it is on what being gay means to the individuals I have interviewed. I am not searching for an all-encompassing definition of viewpoint of sexuality, I am seeking to investigate how, for the men I am interviewing, sexuality impacts on the everyday lived experience.

Critiques of IPA

Identifying the limitations of IPA, Willig (2008) sets out her critique under four major areas. She questions the role of language, 'suitability' of accounts, the descriptive nature of the methods and also questions Smith's assertion that IPA is phenomenological.

In terms of language Willig takes a stance which appears in tune with discourse analysis theory and a social constructionist ontology. She suggests that language does not in fact describe a phenomenon, it actually constructs the phenomenon through the words used. She contends that in describing an experience 'we always construct a particular version of that experience. The same event can be described in many ways.' (Willig, 2008). IPA however has acknowledged that the researcher is not automatically given access to the lived experience of a participant by their description of it. Human beings have agency, they decide what to tell and how to tell it, 'it is acknowledged that interpretations are thus bounded by participants' abilities to articulate their thoughts and experiences adequately and, it would follow, by the researcher's ability to reflect and analyse'. (Brocki and Wearden, 2006, p. 88). Despite these drawbacks, as mentioned above, Smith et al. (2009) contend that there is always a link between the experience itself and how people describe it.

Her second criticism comes in the questioning of whether participants' own accounts of their experiences are suitable for phenomenological analysis. She nods to the fact that phenomenology as a philosophy as it is produced by the theorists mentioned above focusses on introspection and reflection on the philosophers' own experiences. It is then questioned as to whether participants are suitably able to communicate the rich and vivid nature of their experience in a nuanced way. She questions 'how many people are able to use language in such a way as to capture the subtleties and nuances of their physical and emotional experiences' (Willig, 2008, p.67). This was a concern when first approaching Queer Expressions, after all for many people, reflection on sex, sexuality and relationships with healthcare practitioners is not a common occurrence. However, in practice I found that although people used different forms and level of language to articulate their experiences all were able to do so without very much hesitation. To suggest that phenomenological research can only be carried out with articulate participants I think is a bit limiting, after all our interest in IPA is in the meaning of the experience to the participant, not some sort of objective account.

In her third criticism Willig contests the notion of explanation in IPA, suggesting that IPA and other phenomenological approaches cannot truly examine or explain phenomena due to the focus on perceptions. 'While it is able to generate detailed, rich descriptions of participants' experiences of situations and events, such research does not tend to further our understanding of why such experiences take place and why there may be differences between individuals; phenomenological experiences' (Willig, 2008, p.68). To suggest this, I feel, reflects a lack of understanding in the IPA process. Like any research methodology, even with sound philosophical underpinnings and clear guidance, there will be good and bad studies. Smith (2004) has indeed criticised some IPA research as not being sufficiently interpretative. As Brocki and Wearden (2006) point out many of the published IPA works do indeed offer more of a descriptive rather than a full interpretative account, however I don't believe this is evidence of a flawed methodology. Being aware of these criticisms, special care is taken in Queer Expressions to not only illuminate the experiences of the participants but also to critically engage with those illuminations in order to interpret what those experiences could mean for practice.

In questioning whether IPA is indeed phenomenological, Willig (2008) points to the language used in the original proposition of IPA in Smith (1996). She contests the concept of an accepted cognition with being phenomenological. Smith (1996) frames the focus of IPA with 'what the particular respondent thinks or believes arbour the topic under discussion' (p.263). Langdridge (2007) presumes conflict between IPA's phenomenological and cognitive interests, and along with Willlig (2008) suggests this the notion of cognition to be aphenomonological, as it reinforces a separation between 'the knower and the known, between person and world' which phenomenology aims to transcend (Willig, 2008, p.69). Whether or not some IPA studies do in fact enforce this separation may be argued, however this separation is not in fact prescribed for in IPA. Again the exact type of phenomenological underpinning varies throughout IPA studies (Smith et al., 2009), however the centrality of the participant's experience as the focus is a constant, there is never an attempt in IPA to objectify the phenomenon of interest, it is always framed within the context of the lived

experience. Willig does however usefully point out that the use of the term cognition as described in cognitive theory with an object/subject distinction clouds its use in the realm of phenomenological thought. Chamberlain (2011) argues that more explicit linkages must be made between IPA and phenomenological theory, stating that IPA needs to 'articulate its position in regard to the kind of phenomenology it is attempting to be' (p.50). Smith (2011b) rebukes this criticism however, referring the critic back to Smith et al. (2009) and the extensive linkages made to Husserl, Heidegger, Monty-Perleau and others, as discussed in the theoretical underpinnings section above.

In terms of its interpretative stance Chamberlain (2011) criticised IPA of not being truly hermeneutic, claiming that the guidelines which are offered for analysis are overly prescriptive and 'do not really consider hermeneutics' (p.50). Smith (2011b) again challenges this, contesting that IPA inevitably involves doing hermeneutics in a general sense (as described above) and good IPA involves more particular hermeneutics. He further asserts that hermeneutics is a very broad domain with many different perspectives and that '[Chamberlain] has a very particular form of hermeneutics in mind and is disappointed that IPA does not subscribe to it' (p.58).

Ontological and Epistemological stance

This thesis is underpinned by a realist social constructionism (Elder-Vass, 2012); contesting that social constructionism and critical realism are not in fact incompatible but when considered as complementary, they can provide us with a more nuanced way of viewing the world. Essentially, I suggest a critical realist ontology combined with a social constructionism epistemology for this thesis.

Critical realism is a research paradigm first proposed by philosopher of science Roy Bhaskar (1989), essentially as a form of emancipatory social practice. A critical realist approach is one which asserts that in order to understand and perhaps ultimately change the world, we must first come to know the structures at work which create events, experiences, discourses. Unlike positivism, which

maintains that the researcher's conceptualisation of reality is, in fact, reality; a critical realist maintains that scientific enquiry allows us to simply conceptualise one way of knowing reality, while all the time maintaining that there is a reality. This reality however may be understood and conceptualised through language, discourse, culture – Queer Expressions is dependent on the narratives of lived experiences from Irish Gay Men. While some may posit these approaches as in opposition, whereby constructionism is seen undermining the concept of essences of shared reality, Elder-Vass (2012) argues that social constructionism combined with a critical realist social ontology offers us a most coherent approach to developing social theory.

Data collection

There are many methodological approaches suitable to the collection of qualitative data such as that necessary to answer the research questions presented in Queer Expressions each presenting with their own benefits and limitations, many of which allowing for the researchers own creativity and adaptability to the presented scenarios.

By far the most common approach to data collection used by IPA researcher is face to face interview, advocated since the conception of the methodology (Smith, 1996) and providing the greatest amount of data for IPA studies (Brocki and Wearden, 2006). Semi-structured interviews provide the ideal platform for the researcher and participant to engage in deep and meaningful discussions while retaining the adaptability which allow for initial questions to be modified to follow any interesting topics which may come up (Smith and Osborn, 2002). While there is a clear idea of which areas are to be explored from the outset, this method acknowledges that the participant is the expert in their own experience and so they have much more freedom to lead the discussion into the most appropriate areas.

The use of interviewing in qualitative research is not without critique however, because of the reliance on self-retrospective recollection of the original experience. Jaccard et al. (2004) examined

the accuracy of self-reporting in the field of sexual experiences and highlighted issues of self-presentation of the participant and the sensitivity of discussions around sexual behaviour and how they may lead to participants fabricating or withholding information.

Other methods have been used in the collection of data for IPA studies. Flowers, Knussen and Duncan (2003) used focus groups for their investigation into Gay Men's understanding of HIV and testing. Smith (2004) however asserts the importance of exploring the individual's personal experience in IPA and while not ruling out the use of focus groups for IPA, expresses caution as with any group, group dynamics may have a significant impact on the data collection process. While more material and neutral topics may be appropriated to examine using focus groups, Brocki and Wearden (2006) suggest that when discussing more sensitive topics such as issues of sexuality and sexual behaviour using focus groups may lead to a significantly different data set illuminated than that which comes from one-to-one interviews. It may be argued that Flowers, Knussen and Duncan (2003) were in fact exploring issues of a sensitive nature in terms of HIV, however their focus was primarily on issues of testing and understanding of treatments rather than on a personal experience of being gay or of living with HIV. It is also important to note that the inclusion criteria for Queer Expressions is identifying as gay, not necessarily being 'out', so participants may be less likely to get involved in focus group research, especially given the relative small population of Ireland.

Another possible data collection method for IPA proposed by Smith, Flowers and Larkin (2009) is that of diaries, whereby participants would each be given a diary to write in at regular intervals for a specific period of time. This method was used by Smith (1999) in his exploration of the experiences of transitions in motherhood. The benefit of diaries is that this method allows perhaps a more critical probe into participants documented experiences which may not be possible in interview. They also allow for a more longitudinal approach and a sort of real time exploration of the participant's experiences, so not relying so heavily on recall, as interviews do. Diaries were in fact used in the Socio-sexual Investigation of Gay Men and AIDS (SIGMA) and perhaps facilitated a more

open and honest disclosure from the more than 350 men, as there was no human interaction during the writing so less likelihood that they may feel judged (Coxon, 1996). While diaries offer a useful method of data collection for IPA research, the time constraints of a PhD study mean that this method was not suitable for Queer Expressions.

Interview schedule

While as noted above the interview should be led by the participant's own experiences Smith and Osborn (2003) suggest that by using an interview schedule the researcher can, in advance, anticipate any prospective difficulties which may be encountered and decide on strategies to overcome them. Given the potential sensitivity of the research topic I felt it was necessary to carefully construct how questions were worded and to be as clear as possible to avoid confusion and ambiguity, as well as to be careful not to cause offence, upset or embarrassment.

The interview schedule was developed in four main stages, as advised by Smith and Osbourne (2003). First, I identified the area of interest and the issues contained within it. I wanted to find out what the participants' understanding of sexuality was, what came to form their understanding of it, how they present it to others, how it relates to their perception of health and their experiences of healthcare and how they have experienced discussing issues of sexuality through coming out. Secondly the issues were sequenced in a logical manner. Then clear questions were developed to address the interest in the issues and finally possible prompts and probes were considered and noted in case they were required to probe further. Green and Thorogood (2014) differentiate prompts as being the noises made to encourage people to continue and non-verbal cues and probes as including questions like 'anything else' or 'tell me more about that'. There are three distinct types of probes identified by Patton (1990): detail-oriented probes (for example, Who was there? What happened next?) Elaboration probes (such as, . Tell me more about that?) and Clarification probes (, for example Could you explain that again? I didn't understand). I developed a sheet of probes which

were brought with me to each interview, throughout the interviewing process the list was added to and used intermittently.

While undoubtedly the development of the interview schedule was a useful exercise and kept me on track, in reality the questions in the schedule were rarely used as exactly as they were presented. Having the schedule gave me a sense of confidence and preparedness as there was always a fear that participants may be reserved or inhibited in discussing their sexuality, however this was not the case in any of the interviews conducted. While the official schedule was never fully used, all interviews followed a similar flow.

The interviews were by and large narrative in nature, allowing the participants to recount stories and experiences related to coming out and discussing sexuality, they were non-directive and in some cases the response to the initial question that the interview schedule was not referenced for the rest of the interview. Given the breadth of language and euphemism used within the LGBT community particularly pertaining to sex I found myself adapting my own style of language to emulate the participants so as to further build the rapport and not to disrupt the flow of interview.

Recruitment and sampling

Qualitative designs differ significantly from quantitative research in that the interest is not in attaining a statistically representative sample, but rather to have 'information-rich cases for in-depth study' (Patton, 1990, p.182). It is imperative that participants are selected who will enrich our understanding of a phenomenon, in this case of how Gay Men discuss sexuality with healthcare practitioners. While many qualitative methodologies aim to recruit participants who can represent a variety and diversity of experiences which may 'throw light on meaningful differences in experiences' (King and Horrocks, 2010), IPA suggests a more homogenous sample, unless the research aim is specifically to compare different groups experiences (Smith et al. 2009). Homogeneity however could be a contested concept, Larkin (2006) notes that it is a question of

compromise, the level of homogeneity required is dependent on the phenomena in question and impossible to lay down blanket criteria for how similar samples must be. For example, in Bourne and Robson's (2009) investigation into the experiences of risk in sexual activity, their sample included men and women, homosexual and heterosexual, their only linking trait was that they had all engaged in risky sexual behaviour. In contrast Boyle et al. (2005) looked at the experiences of six women with intersex conditions who had all experienced feminising genital surgery. For this project it was decided that all participants should identify as a Gay Man and as Irish. Initially it was presumed that all participants would be resident in Ireland, however there were several enquiries internationally and three participants who currently reside outside of Ireland were interviewed. One potential participant identified as Irish-American, however was excluded as they had never experienced healthcare in the Irish system and had only visited Ireland once.

A mixed sampling strategy was adopted, primarily purposive in that inclusion criteria were quite focussed, 1). Participants should identify as a Gay Man and 2). Participants should identify as Irish. Firstly, however a rather broad convenience sampling method was adopted, by using social media to publicise the project as described below and graphics and posters were developed with basic information and contact details. Concurrently I contacted various LGBT community organisations with information about the project so that they might act as gatekeepers. Posters were sent to OutHouse in Dublin, Teach Solais in Galway, GOSSH in Limerick and the Cork Gay Project as well as the Health Service Executive's Gay Men's health project. As Green and Thorogood (2014) suggest, when working with more marginalised groups such as the LGBT community, using community organisations and community leaders as gatekeepers can provide legitimacy for potential participants. A secondary benefit of this strategy was that I was able to subsequently use some of these organisations' premises to conduct interviews, which provided a safe and welcoming space for participants. A third level to the sampling strategy was a snowball strategy, small business cards were printed and given to participants after their interviews if they agreed to take them and they were encouraged to pass them on to friends and acquaintances.

Guidance on sample sizes for IPA studies remains imprecise, Smith (1996) originally proposed a sample size of six to eight participants for each project, however this was revised subsequently to around three (Smith, 2004). Smith, Flowers and Larkin (2009) summate that really the size of the sample is dependent on many things, the degree of commitment of the researcher to the level of analysis and reporting, the richness of individual cases within the study and the various organisational and time constraints that the researcher is working under. In a review of IPA studies conducted in the field of health psychology, Brocki and Wearden (2006) found a great diversity in sample sizes ranging from a single case study, to a sample of thirty participants. In keeping with guidance set out by Smith et al. (2009) my aim was to recruit between 12 and 18 participants. 12 Irish Gay Men were eventually recruited and details relating to the participants are presented in the Preface to the Findings chapter.

Use of Social Media

Since the advent of the internet the numbers of people accessing information and interacting online has consistently grown, currently estimated at 3.3 billion (Internet World Stats, 2016). The Central statistics office of Ireland suggest that more than 85% of Irish households have access to the internet and social media use is reported as the main activity for 66% of these (CSO, 2016). Over the past two decades the growth of internet usage amongst the general population has led to a great interest from social researchers into the phenomenon of online social networking but also in the development of innovative ways of participant recruitment and data collection via social networking sites (Rife et al. 2016). Social media sites offer a cost effective means of recruitment in both monetary and time costs as well as presenting opportunities to access 'hard to reach' populations (O'Connor et al. 2013) and for the purpose of Queer Expressions Facebook, Twitter and Grindr were used to publicise the project and recruit participants. Facebook advertises itself as the world's most popular social networking site, currently boasting 1.59 billion users worldwide (Facebook, 2016). A Queer Expressions Facebook page was developed and went live on 16th August 2016. The page

contained basic information about the project and contact information, it was liked 140 times and yielded 11 expressions of interest, 7 of whom were interviewed. Twitter was also used as a promotional platform for the project, the poster graphic was placed on a tweet which was 'retweeted' (shared) by 43 users, this yielded 5 expressions of interest, 4 of whom were interviewed. Twitter ranks as the world's second most popular social media site with 320 million monthly users (Twitter, 2016). Another strategy was to share information about the project via Grindr, a location based mobile social networking site which would be switched on when I was in Ireland. Grindr, while yielding 18 queries about the project did not lead to any follow up or interviews. Gudelunas (2012) found in his study of social networking apps amongst Gay Men that such apps were used primarily for the discovery of social and sexual contacts with a sliding scale of anonymity being of primary importance, this may explain the lack of follow up from participants who initially expressed interest via Grindr.

Conducting interviews

All participants were offered the choice to be interviewed at their home or a place convenient or most comfortable for them however most opted to be interviewed in a venue which I had organised. I used offices spaces at the University, at a city centre office location and in two LGBT community centres. One participant opted to be interviewed at their workplace. While the project information and consent form had been sent in advance to all participants, at the start of each interview the information sheet was gone through verbally and consent form signed. Participants were particularly reminded that throughout the interview intimate questions related to their health and their sexuality may be discussed, so as to appropriately inform their consent to participate. With the participants' agreement, the interviews were recorded on a digital recording device. They were reminded that their information would be anonymised and stored securely and of their right to withdraw from the project at any time. As Warren (2002) points out, recording equipment inevitably has difference meanings for different people, while it is difficult to anticipate how people may react

to being recorded, emphasising the confidentiality of the project may alleviate any potential anxiety (King and Horrocks, 2010).

One participant asked for the interview questions in advance before fully agreeing to take part. This posed a dilemma for me; my schedule was just designed as a guide and I worried that having a participant reading it may lead to them preparing set answers rather than having a 'natural' dialogue. However there remained an ethical obligation to ensure the participant was as comfortable as possible and to provide them with sufficient information to give informed consent. In order to effectively compromise, the participant was phoned and the concept of the interview schedule was explained to him and he was given an overview of the themes that the project hoped to explore, he subsequently agreed to participate.

It was important for me to be able to build a rapport with the participants, as King and Horrocks (2010) stress, this is not about being liked by the interviewees, but it is essentially about enabling participants to feel comfortable opening up, a sense of trust. While it is inevitable that some participants will more naturally 'click' with the interviewer, it is important that there was a sense portrayed throughout the interviews that I was genuinely attempting to understand the world-view of those I was interviewing (Green and Thorogood, 2014). Keats (2000) identifies rapport as being a vital component of a qualitative interview. Interviews began with a general discussion and overview of life history, family, employment etc. which may put the participant at ease before discussing more sensitive topics (Hutchinson et al., 2002). The overall style of the interviews was informal and participants were encouraged to be open and honest and not to worry about providing what they might see as irrelevant information, they were told that there were no 'correct' answers and that all of the information they gave was useful for the research process. They were also informed that my role was simply to listen and to ask questions and that I would treat their information in a non-judgemental way.

At the end of the interviews the participants were given the opportunity to add anything that they felt wasn't dealt with in the interview or to ask any questions before the recording was stopped. When the recording was stopped participants were thanked sincerely for their time and once again the aims of the project and information about right to withdraw was presented. All participants were provided with contact details for helplines should anything distressing have surfaced for them and encouraged to get in touch if they wanted to add anything to their interview. They were assured that they would have a chance to review their transcript once available to make any amendments. Transcripts were emailed (using encrypted files) to participants once transcribed, none of the participants made any amendments to their transcripts. Repeat interviews were presented as a possibility to all participants, should I want to deal with some of the issues more in depth and all participants agreed. Given the idiographic nature of IPA as discussed by Smith et al. (2009) I concluded that follow-up interviews were not appropriate, as it may lead to me steering the project to attain data that I may want rather than it being about the participants own experiences.

Transcription

I transcribed all interviews myself, which for me was a first step of analysis, familiarising myself with the data further (Langdridge, 2004). All interviews were transcribed verbatim, directly from the device, cognisant of dialect and emphasis as required by IPA (Smith et al. 2009). While others have suggested that it is pointless to transcribe information which will not be analysed (O'Connell and Kowal, 1995) for an IPA study a 'semantic record of the interview' is required (Smith et al. 2009, p.74). Where there is selectivity over what is transcribed there is already a form of interpretation taking place, perhaps displacing information which the participant values. While the transcriptions were verbatim the prosodic aspects of the recordings were not particularly detailed, such as the length of pauses or the exact sounds of the non-verbal utterances, which may be required for conversational or discourse analysis. Transcriptions were typed into a simple table at first and during

analysis rows were added for the various types of analysis notes. During the transcription process all the names of people or identifiable places were removed to ensure the anonymity of the participant.

Analysis

There is no single method of working with data prescribed by IPA, indeed one of the significant benefits of using IPA is the 'healthy flexibility' in terms of analytical development (Smith et al., 2009, p.79). The key overarching principle of IPA analysis is that it is an iterative and inductive cycle (Smith, 2007). Below the analytical process adopted for Queer Expressions is presented.

In keeping with the iterative and idiographic nature of IPA, each transcript is fully analysed in its own right before moving on to the next. Transcripts are chosen at random for analysis from the available fully transcribed interviews. To date four transcripts are fully analysed. The process for each analysis is the same and began with me reading and re-reading the transcripts and listening to the recordings of the interviews several times so as to immerse myself in the data.

The next step was the initial noting. For this the transcripts were copied into a table with a blank margin either side. The right-hand side for initial notes, the left for emergent themes which will discussed in step three. Initially any points of interest in the transcript were underlined, these sections were then reviewed, and I considered why I underlined them, then initial notes were divided into three categories, 1). Descriptive, focussing on the actual content of what participants have said, these comments are noted in plain text. 2). Linguistic, which reflect the specific language choice of the participant, including metaphors. These comments are in italics 3). Conceptual comments, this level of noting is more interrogative, questioning the content of the participants' input. Where there were connections or repetition throughout the transcript, this was noted in parenthesis. The conceptual comments not only led me to interrogate the transcript with questions like "What is X trying to say here?" But also interrogate my own analysis of the transcript "Do I think something more is going on here? Why?" (Smith and Osbourne, 2003, p.51). This process was

particularly time consuming with several re-checks to ensure that my comments were in fact grounded in the participants' own words rather than being overly interpretative.

Themes	Original Transcript	Initial Notes
	And what's your experience of accessing healthcare, so when I say healthcare I mean that could be GP, hospital care, outpatients. Sure , as a patient I think I've only really attended my GP, am I, thankfully I've never been sick enough to be in hospital, my local GP is, will I give the name or **''it'll be anonymised anyway'''** ok yeah well my local GP anyway, ammm ahh I actually don't attend him ammm, because I don't know, he's got a really large patient base and is oversubscribed and he's actually, ammm, I don't really like him that much as well to be honest ammm so I attend some other doctors in the practice. The reason I don't like my current GP is ahhh he's just a very kind of, he's old, and he's very abrupt and kind of sharp, and ammm in saying that I haven't seen him in about 2 years, I've seen other GP's in the practice for general chest infections or I actually got shingles once which is strange, I was 17 and that was	Thankful for lack of hospital admission Cautious about giving name *Hesitant when talking about GP he doesn't attend* <u>Why does he give excuse of large patient base then after confirm he doesn't like his GP?</u> Has a choice of GP's. Feels able to choose.

	managed by another GP and I've got quite a good relationship with two of them in the practice as well.	Describes shingles as strange Describes relationship as good with other GPs

Once initial notes were made in the right-hand side these were then read through several times and considered along with the actual transcript in order to illicit the meaning behind them and group them together into emergent themes. While in an IPA study the participants' experience remains at the core, the process of initial noting leads to a substantial growth in the data set. Larkin et al. (2006) note that the descriptive note taking exercise essentially provides us with the phenomenological core for the study, the left-hand theme development is where the interpretation takes place. This process was also repeated several times and rechecked to ensure I was indeed rooted in the participant's story and not making generalisations based on my own experiences and perceptions of Gay Men.

Themes	**Original Transcript**	**Initial Notes**
Importance of health Relationship with other Unwillingness to complain Relationship with other	**And what's your experience of accessing healthcare, so when I say healthcare I mean that could be GP, hospital care, outpatients.** Sure , as a patient I think I've only really attended my GP, am I, thankfully I've never been sick enough to be in hospital, my local GP is, will I give the name or **''it'll be**	Thankful for lack of hospital admission Cautious about giving name

Time Categorisation of illness	**anonymised anyway'''** ok yeah well my local GP anyway, ammm ahh I actually don't attend him ammm, because I don't know, he's got a really large patient base and is oversubscribed and he's actually, ammm, I don't really like him that much as well to be honest ammm so I attend some other doctors in the practice. The reason I don't like my current GP is ahhh he's just a very kind of, he's old, and he's very abrupt and kind of sharp, and ammm in saying that I haven't seen him in about 2 years, I've seen other GP's in the practice for general chest infections or I actually got shingles once which is strange, I was 17 and that was managed by another GP and I've got quite a good relationship with two of them in the practice as well.	*Hesitant when talking about GP he doesn't attend* <u>Why does he give excuse of large patient base then after confirm he doesn't like his GP?</u> Has a choice of GP's. Feels able to choose. Describes shingles as strange Describes relationship as good with other GPs

The next step in the analytical process is the development of the master themes, by which the emergent themes are clustered together in order to develop more concise units of meaning. To practically do this I adopted an approach whereby I printed the emergent themes and cut them out individually, then used a wall in my study to group them with similar themes. At this point there were some themes which either I identified as outliers, or which did not address the primary research questions and were discarded. At this point in the analysis of each transcript I took a break

of a day, then returned to the discarded themes to again consider whether they were appropriate for inclusion. In order to consider the label of the master theme the original quotes from the transcript were considered. The new master themes were then typed into a table with the subordinate themes under them in italics, supported by identification of the page and line of the transcript where it occurs, and some key participant words associated.

At this point the next interview is analysed. While the original concept of 'bracketing' is not supported by IPA, Smith (2003) suggests that as much as possible each transcript must be analysed within its own right. Researchers should allow for the emergence of new themes and not be overly influenced by what they have identified in previous analysis, it is suggested that by ensuring the step-by-step process is followed with each case this can happen.

Once I completed data collection and the analysis of each transcript fully in its own right, I focused on finding patterns across the data set. To do this and illuminate the most significant data, a master table was produced, listing all of the master themes across the top and then along the side was each participant's pseudonym so that I could tick off where the themes were identified. Obviously, the language of themes was different and there was some reconfiguring and relabelling, however key questions were considered in order to properly illuminate patterns 'What connections are there across cases? How does a theme in one case help illuminate a different case? Which themes are most potent?' (Smith et al., 2009, p.101).

Researching Sensitive Subjects

'Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict.' (Stake, 2000, p. 447)

There are no issues more private than issues of sexuality and illness, so given the sensitive nature of Queer Expressions, particular regard has been given to the ethical considerations of doing this type of research. I have been cognisant of the potential impact that participation in the project may have

on those who agree to take part; discussing sensitive issues can often be a stressful experiences, particularly when confronting negative experiences (Brannen, 1988). It was important for me to be able create a safe space for the participant to discuss freely and openly their experiences, which they might not have shared in everyday settings but also to recognise the cues that may show that a participant is feeling uncomfortable (Green and Thorogood, 2014). King and Horrocks (2010) note that a participant becoming distressed is not an indication that they are finding the interview experience to be a negative one, they may in fact appreciate the opportunity to discuss difficult subjects with a neural listener. Where I felt that the participants may be feeling uncomfortable, rather than closing the interview I gently suggested moving to a different topic; this has only really been an issue in Paul's interview when he was speaking about the death of his mother. It is important however to be aware of the role of a researcher, my role is to facilitate participants to tell their stories, if participants do get upset, or make disclosures that they may find difficult later, it is important that the researcher does not to provide therapy or advice (Bloor et al., 2001). This can be particularly challenging for researchers who are also healthcare professionals, this concept of role conflicts will be discussed further in my reflexive section. The information sheet provided to all participants included contact details of helplines and support groups, this had to be altered for the participants not based in Ireland. Green and Thorogood (2014) also note the importance of self-care for the researcher, as issues may arise which are difficult for them. Aware of this, supervision meetings were always planned for immediately after a period of fieldwork.

Informed consent

All potential participants who enquired about the project were sent a brief information sheet. The theme and aim of the research was explicitly stated in the information sheet and also on the social media pages. Details and qualifications of both myself and my supervisory team were included in the information sheet, as were the faculty website and contact details so as to stress the bona fide status of the project.

At interview the nature, aims and process of the research were again explained, and the information sheet was provided for the participants to read. Participants were encouraged to speak freely during the interview and not to worry about naming places or individuals as they would all be removed from the interview transcripts. It was clearly emphasised that all effort would be taken to remove any information which may possibly lead to their identity discovered by others who might read the research outputs.

The information sheet and consent form stated that the information provided may be used in the thesis, other publications and conference papers.

Full ethical approval was granted by the Canterbury Christ Church University, Faculty of Health and Wellbeing Ethics Committee, initially approval from an Irish ethics committee was considered but in consultation with the Health Research Board of Ireland it was decided that institutional approval from Canterbury Christ Church University would suffice.

Quality Assurance, Validity and Rigour

The concept of excellence and quality measurement of same in qualitative research is extremely different from the very rigid criteria applied to quantitative research, and obviously so given the different epistemological and philosophical underpinnings. Whereby there is a positive epistemology and acceptance that there is an objective truth to be studied it might be argued that it is easier to measure quality than the subjective nature of an IPA study which aims to illuminate and interpret the individual lived experience of a research participant.

Pringle et al. (2011) note that because in IPA the analysis is essentially the interpretation of one researcher, this may lead to concerns about the validity of IPA studies and the significance of any claims made by the researcher. The original Smith (1996) proposition of IPA doesn't concern itself with validity per se, but stresses the need for internal coherence – the extent to which the argument which is presented and the themes developed are consistent and driven by what is evident in the

data. IPA must always remain grounded in the data. Ashworth (1997) notes that those new to qualitative research are often preoccupied by issues of validity and reliability, he suggests that there is a need to accept that the values and experience lie within the words of the participant and questions the appropriateness of external validation, even if it is available. Smith et al. (2009) however, go on to more explicitly deal with the issues of assuring quality of studies and uses Yardley's (2000) 'characteristics of good research' (p.219) to outline how this is achieved in an IPA study. Yardley stresses the importance of quality checking qualitative research suggesting that quality measurement is 'absolutely necessary, in both senses of the word – both imperative and unavoidable' (Yardley, 2000, p.219). Yardley's criteria are broad and offer the researcher a flexible way to approach the issue of quality assurance offering up a variety of methods to assess each of their four criteria. Smith et al. (2009) suggest that the utility and applicability of Yardley's criteria is irrespective of the philosophical and theoretical orientation of any qualitative study. Yardley (2000) presents her criteria as a broad guide rather than a rigid prescription and suggests that the way in which criteria might be fulfilled will vary depending on the methodology and approach applied. Her four criteria are: 1) Sensitivity to context 2) Commitment and rigour 3) Transparency and coherence 3) Impact and importance.

Sensitivity to context

The demonstration of sensitivity to context may take many forms for the qualitative researcher, including a clearly shown understanding of the theoretical frame, the socio cultural situation, an engagement with current literature on the topic and most importantly a clear placement of the words of the participant (Yardley, 2000). The context is of the utmost importance in qualitative research, instead of aiming to establish wide generalisation as with quantitative studies, the qualitative researcher aspires to the development of theory through 'vertical generalisation' (Johnson, 1997). Instead of focussing on making our research transferable across research settings, qualitative researchers aim to link the particular experience of the individual, to the abstract and

further on by relating it to the work of others. Smith et al. (2009) notes the interactional nature of IPA data collection and suggests that sensitivity to context is made explicit very early on. As Yardley (2000) notes 'since language, social interaction and culture are understood by most qualitative researchers to be central to the meaning and function of all phenomena, awareness of the socio-cultural setting of the study is also important' (p.220). Being a Gay Man myself, I am very aware of the sensitivities of language and possible interactional difficulties; I was very conscious of the need to provide a comfortable setting for interview. An important aspect of IPA is being able to negotiate the potential power play between 'research expert' and 'experiential expert' (Smith et al., 2009, p.180). I was particularly conscious of this power dynamic, as I see myself as having the expertise in both and as discussed in my reflexivity section, being aware that I was the expert in my own experience, not in the participants. An effort was made to ensure that this is explicit in the write-up. The extensive use of verbatim extracts from participant interviews to support the interpretation which I will use shows a commitment to ensuring that the participant's voice is central. This also acts in some ways as an external validator, allowing the reader to check the interpretations I have made. While deeply committed to the inductive nature of IPA, I am committed to situating my analysis and discussion vis-à-vis theoretical and empirical literature focussed on the various themes which emerge.

Commitment and Rigour

Yardley (2000) identifies commitment as encompassing 'the prolonged engagement with the topic (not necessarily just as a researcher, but also in the capacity of sufferer, carer, and other capacities), the development of the competence and skill in the methods used, and immersion in the relevant data' (p.221). Thus the commitment to a study may be demonstrated in many ways, in IPA the commitment should be implicit in the level of attention given to the participant during the data collection and the care with which the analysis of each case is carried out (Smith et al., 2009). Rigour refers to the thoroughness of the study. Smith (2004) suggests that this can be demonstrated

through the appropriateness of the sampling, the quality of the interviewing phase and the extensiveness of the analysis undertaken. The explicit and systematic method of applying IPA to my data collection and analysis as noted in this chapter demonstrates a rigorous project. The rigorousness of the interview can be assessed through the reader engaging with the verbatim quotes and interpretation of same to judge whether sufficient attention has been given, whether cues have been taken and so forth. Smith et al. (2009) points out the caution required to balance 'closeness' and 'separateness', being able to probe without leading, and being receptive to cues (p.181). The prompts and probes used in Queer Expressions interviews were carefully considered and outlined in the interview schedule section. One of the more complex indicators of rigour relates to the completeness of data collection and analysis, in quantitative research data saturation can easily be assessed based on the size of the sample related to population size; this is obviously not appropriate in qualitative research. The size is not important in qualitative research, rather the ability of the sample to supply all the information needed for in-depth analysis. The completeness of interpretation is a core staple of a good IPA study, and as noted several times above, IPA must move beyond mere description (Smith, 2011a). The level of interpretation presented should 'address all of the variation and complexity observed, and may need to be undertaken at several levels of analysis' (Yardley, 2000). Good IPA studies should illuminate for the reader something more than the themes presented; they should tell something important about the individual participants as well as something about the shared (Smith et al., 2011). I have been careful in Queer Expressions to ensure a thorough idiographic engagement with all transcripts to ensure a strong level of rigour.

Transparency and Coherence

Transparency essentially refers to how clearly the stages of the research project are evidenced in the write-up. As Yardley (2000) reminds us 'the quality of the narrative is an integral part of its productive value; a convincing account exerts its effect partly (or sometimes wholly) by (re)creating ta reality which readers recognise as meaningful to them' (p.222) this is the same for the narrative of

the research project. The clear description of each stage of the research project within the methodology chapter as well as the considerations within the reflexive section should provide sufficient transparency. In terms of coherence it is vitally important that there is a strong fit between the research process and the theoretical assumptions of the approach. Although not extensively discussed, Yardley (2000) notes the role of reflexivity in assuring a transparent and coherent study. Smith et al. (2009) points outs that if a study is claiming to be IPA then the phenomenological and hermeneutic sensibility should be apparent throughout the write-up. There has been a clear discussion above as to how IPA is a suitable methodology for Queer Expressions and how methodologically the research is being carried out. To ensure a coherent account, with corresponding themes and a fluid narrative, IPA studies must be carefully written and often require drafting and re-drafting (Smith et al., 2009).

Impact and Importance

> *"It is not sufficient to develop a sensitive, thorough and plausible analysis, if the ideas propounded by the researcher have no influence on the beliefs or actions of anyone else"*
>
> Yardley (2000, p.223)

Yardley (2000) suggests that the ultimate criterion by which any research study is deemed to be of quality or not is its impact and importance. As Smith et al. (2009) note, the real test of validity of a piece of work lies in whether it gives the reader something interesting, important or useful. It is important that to note that impact and importance should always be considered in relation to the objectives of the analysis, the applications it was intended for and the communities with which the findings are deemed relevant for (Yardley, 2000). The impact of Queer Expressions could be in terms of curriculum development for healthcare training, policy influence and practice development.

Reflexivity

Chamberlain (2004) notes that despite the publicised importance of reflexivity, issues of same are rarely incorporated into the write-up of qualitative studies. While this may be due in part to the restrictions of word limits in academic journals, I think it is vitally important to engage in the exercise of reflexivity within Queer Expressions, as the PhD thesis does indeed offer the chance to comprehensively engage in issues of reflexivity which are rarely admissible in other types of publication. Reflexivity however is a term which is widely used, though the meaning may be somewhat abstract and vague, and very often what is described by reflexive engagement differs between scholars. Lynch (2000) however notes caution with the presupposition that the reflexive position is a superior one, he complains that while for some the act of being reflexive is in an aim to increase objectivity, for others it is simply an exercise in trying to undermine objectivism itself. For me being reflexive ensures that the research process itself is subjected to the same critical analysis as the data contained within the project. Green and Thorogood (2014) claim that as qualitative researchers we do not strive for objectivity, we accept that it is impossible to create a research field which is untainted by values and that it is impossible for the researcher to be unaffected by those values, or stand outside the subjectivity. However they note that this does not mean employing an 'extreme relativism', whereby we do not see qualitative accounts as merely individual and subjective with no legitimate claim to enhancing our knowledge of the world. They claim that reflexivity allows us to 'take subjectivity seriously' (p.23), we don't need to abandon all claims to producing useful and interesting accounts of the world. For Davies (1999) reflexivity is a process of turning back on oneself and of self-reference.

This chapter will begin by establishing more clearly what reflexivity means in qualitative research and outlining the approach of reflexivity adopted in Queer Expressions. Further, it will go on to reflect on the epistemological assumptions overarching the project from inception to fieldwork and post, and provide the context of my own personal involvement as a researcher.

Defining and developing reflexivity

As mentioned above there is great variation in the definition and usage of the term reflexivity, Atkinson and Coffey (2002) describe it as 'a term that is widely used, with a diverse range of connotations, and sometimes with virtually no meaning at all' (p.112). Gergen and Gergen (1991) contrast the approaches by those working in the realm of the social sciences, who are very aware of the subjectivity of the research process to traditional 'scientific' researchers who traditionally ignored the role played by themselves in developing the outcomes of the research. Bryman (2016) suggests three types of reflexivity evident in methodological writings in social research. *Philosophical self-reflection*, which is an introspective examination of one's own beliefs sometimes in a confessional and self-critical way. *Methodological self-consciousness* which takes into account the relationship between the researcher and those who are studying and finally *Methodological self-criticism,* which is a much more confessional style, often associated with ethnographic writing. Davies (1999) makes the point that in social sciences the connection between the researcher and the research process and setting is very close, there is potential for one to influence the other either consciously or subconsciously. 'Depending on the extent and nature of these connections (that the researcher has to the research topic), questions arise as to whether the results of research are artefacts of the researcher's presence and inevitable influence on the process' (p.3). For this reason explicit evidence of reflexive thought and presence allows the reader to see to what extent this influence may have occurred. Descriptions of reflexivity very often focus on the personal motivation a researcher has to conduct their research and how the individual researcher's personal beliefs, values or objectives have influence on the research outcomes, this is not necessarily a bad thing. As Maso (2003) suggests:

> "*by being reflexive about their own subjectivity, qualitative researchers can improve the quality of their research. If they make sure that their research question is the expression of a real and living doubt – by studying their own motives and the scientific literature – their*

> *search will be supported by a passionate wish to acquire answers satisfying both to them and to the scientific community. This passion can serve as a guide to enquiry; it can also lead to originality. It fuels a determination to become aware of everything that could contribute to the search for answers and it promotes the persistence in the face of seemingly insurmountable problems"* (p.49)

This focus on the way our beliefs, interests and experience might impact our research, although important, does not represent the entirety of reflexive thought. Willig (2008) suggests that as well as this 'personal reflexivity' there is also an epistemological reflexivity which should be demonstrated. This epistemological reflexivity considers how assumptions of the world have been made throughout the course of the research process (King and Horrocks, 2010). It considers the overall methodology, how the research questions have been defined, how the interview schedule was structured and the process of analysis which was undertaken. While personal reflexivity is concerned mainly with the impact of self and the impact of my own perceptions, thoughts and beliefs on the process, epistemological reflexivity is more concerned with the research tools and techniques employed and the overall methodology. These distinctions however are not totally clear and while I will separate them in the write-up it is important to acknowledge that each will have an influence on the other. Willig (2008) suggests that reflexive issues are either dealt with throughout the write up wherever they arise, or alternatively a reflexive section may be used to deal with the subject as a whole. Elements of both strategies are used in Queer Expressions and although a full account of the reflexive processes within the project can only be made retrospectively I will attempt at this stage to initiate some of the reflective and reflexive work considerations already engaged.

Personal Reflexivity

Researchers are imposed and engaged at all stages of the research process – from the very inception of the idea, to the questions they choose to ask or not to ask, to the participants they include in the

project and to those they avoid, they are an integral part of the analysis and interpretation and so an awareness of one's self as a researcher is of utmost importance (Smith et al., 2009). Smith and Osbourn (2003) remind us that access to the phenomenon we are trying to study 'is both dependent on, and complicated by, the researcher's own conceptions which are required in order to make sense of that other personal world through process of interpretative activity' (p.70). We are reminded of the double hermeneutic Smith (1996) describes where we as researchers are trying to make sense of the participant making sense of their own experience. Despite the absolute assertion of the role of the researcher throughout IPA literature, there is little explicit evidence of reflexive activity in published studies, this of course may be due to the constraints of word limits and other publication parameters as mentioned above. What follows therefore is extensive reflection on my role throughout the research project.

My role as an interviewer

Given the topic of the research I was quite eager to present myself as a serious researcher. Themes of sex and sexuality in particular are often seen as private and I was conscious not to come across as just a nosey stranger! I was expecting these people to open up to me about some potentially private and intimate issues, if I was not perceived as professional my questioning may be perceived as an intrusion. I felt the need to be explicit in the motivation I had to do the project and in my credentials as a nurse and as a researcher. I felt it best to be open about my own identity as a Gay Man and felt that this might help in building rapport. As mentioned in the methodology section, rapport can be a crucial element of a qualitative research project (Keats, 2000). There needs to be an understanding between the interviewer and participant, a level of trust. It is not about being a friend, however I felt it important to be friendly. When listening back to some recordings I was concerned that on occasion I somewhat deconstructed the constructed identity of 'serious researcher'

John: Oh God I've lost my train of thought, I'm so scatty!

Geoffrey: (Laughs)

John: Oh ok yeah, so coming back to stereotypes, how does it feel to be stereotyped? How did it feel on the occasion with your friend?

Transcript of interview with Geoffrey. 29th October 2015

On reflection however this, I feel this self-deprecating humour was less of a deconstruction of the serious researcher identity and more of an attempt to personalise the process, make it less formal, show a human side. Lee (1993) notes that interview situations can be anxious situations for participants, this anxiety can in turn lead to a disorganisation of thinking. When reading my reflexive diary I was reminded of my awareness of a power imbalance within the interview

This interview did not flow the same as my previous one. Geoffrey seemed very cautious about what he told me at the start, he thought a lot before answering, some of his answers were very short. I tried to lighten the mood with some jokes about being scatty, this seemed to work he opened up a bit more, it was less serious. I wanted to reassure him that he was free to chat openly, which I did at the start explicitly but I think breaking down that researcher/participant boundary a bit with humour helped.

Reflexive entry October 2016.

One thing I was reminded about being mindful of when listening back to interviews was that my role as an insider, as an Irish Gay Man was very important. It may have facilitated a more open discussion but also I may have stopped conversations from opening up. There was a perceived notion that I would know about things the participants were talking about.

David: I think that panti bliss says it very well when she says it's surprising if you don't grow up to be homophobic in our society

Transcript of interview with 'David' 28th October 2016

Panti Bliss is a well-known drag artist and community leader in Ireland who came to fame internationally in 2014. While it was perfectly understandable that the participant presumed that I knew about Panti's work I reflected on whether I should have asked him to be more explicit.

> *I really need to remember that just because I'm an Irish Gay Man doesn't mean that I'll interpret things the same way as the people I'm interviewing. David mentioned Panti in his interview and I think I missed an opportunity. I should have asked him about Panti. Even though I know about their work, maybe I might have gotten some interesting insights if I asked David to speak a bit more about who they are and what they've done and why it is important to him. This is where the researcher/participant distance is important*
>
> *Reflexive entry October 2016*

I think this awareness became very important to me. In several of the interviews thus far participants have said things like 'y'know' and I have been cautious to let them continue. At times I feel it's a nervous thing, looking for affirmation but in others I have asked people to elaborate on what they mean or say it in a different way. However the more I continued with interviews the more I became aware of how useful being an insider is. Perry et al. (2004) note:

> *"One of the benefits of possessing 'insider' knowledge and experience might well be a deepened appreciation of the relevant issues as well as a heightened sensitivity toward the perceptions of those under scrutiny"* (p.138)

I had paid a lot of attention to ensuring participant comfort, how I would deal with sensitive issues, what probes I would use to illicit more information if necessary, and considerations of when and how I might have to shut down the interview. I didn't however give much thought to my own vulnerability as a researcher, particularly as a researcher with somewhat a vested interest in the subject matter, as an Irish Gay Man and as a healthcare practitioner. While I knew inevitably people

would have differing opinions to me, I hadn't conceived how these opinions might affect me, upset me or anger me.

> *I really found that interview hard today. There was so much homonegativity, a sense that sexual 'deviance' is something that is really so wrong. I mean I know a lot of Gay Men who have introvert homophobia but in this interview it was so extensive. I really felt sorry for him but also so annoyed and upset that someone would have these feelings. Yes he's gay but does that give him the right to judge me, what I do, how I live my life. I felt like saying to him, yes I've had sex with multiple people, I've danced topless in bars, I love pride. I didn't. I'm glad I didn't. But some part of me wishes I did.*
>
> *Reflexive entry November 2016.*

Reviewing this entry brought up so much for me, first as aforementioned was that I really didn't consider how what I might hear might upset or annoy me. It didn't have a major effect on me, but I was quite conscious that my emotions would need to be managed, which they were. The other thing that I note from this entry was my desire to disclose to him my own views. I did not do this, but what if I had?

Interviewer disclosure can in fact be a useful tool, again building rapport but also presenting the researcher as a human too (Gough, 2003). Perry et al. (2004) contend that the insider's perspective is extremely useful, and it is indeed appropriate to disclose information where relevant.

> *"it is worthy of note that a consequence of disclosing the researchers insider status in an effort to develop tryst and rapport was that the young people were more likely to reveal in fetial the emotional dimension of their experiences and perceptions.""*(p.138)

While I contend that I was right not to disclose in the occasion with Simon, as it may have been seen as confrontational, reflection on the situation and on the issue of insider disclosure made me more aware of the possibility of doing it in another instance.

My role in initial analysis

As illustrated in the definitions of reflexivity a key consideration is on how the preconceived notions, ideas, and opinions about the phenomenon under investigation can influence the research process, and most especially the analysis. While the interview was a fixed point in time with a very clear objective when it comes to data analysis, I am acutely aware of how much impact these preconceived ideas can have some bearing on the outcomes of my interpretation. While during interviews I have at times been shocked, upset, annoyed at what was being said I believe I have been successful in circumventing these feelings and staying focussed on the meaning of what participants said. Given the prolonged exposure to the data during the analysis phase, and my interaction with text and audio rather than a person, this has been more difficult. The review of reflexive diary notes during analysis aided me in the reflexive process, ensuring that any potential bias or leading could be explored in relation to the data gathered

Use of reflexive diary

While formal participant observation is not a congruent method for IPA, the use of a reflexive diary can assist in the researcher in identifying their role in interpretation, making reflexive notes may record the origin of interpretations (Biggerstaff and Thompson, 2008). After each interview I took time to summate my experience of the encounter and note any observations I had about the participant, the encounter or what was said. This allowed, in analysis, for me to engage in 'deep-questioning' of my interpretations (Clancy, 2013). It facilitated the identifying of any potential bias or contextual issues which may detract from the actual narrative of the experience being put forward. It also illuminated my own perceptions and experience of the encounter, which was key in thinking about my interpretation.

Conclusion

Ultimately the adoption of Interpretative Phenomenological Analysis as the methodological process provided me with an in-depth and enriched immersion in participants view of their experiences. The double hermeneutic, making sense of how Irish Gay Men made sense of their experiences discussing sexuality with healthcare practitioners, provides novel and original knowledge which is directly applicable to the field of Irish Gay Men's Health.

Preface to Findings chapters

The following three chapters present the findings of my Interpretative Phenomenological Analysis of the experiences of thirteen Irish Gay Men. As suggested by Smith (2009), following the analysis of each interview individually, the findings are divided into superordinate and subsequent subthemes; this is how the findings are presented throughout these chapters.

Plotted summaries

To give the reader a more rounded and contextual view of the data, the following are plotted summaries of the study participants' biographical information, as well as summaries of the interviews conducted. The aim of these summaries is to make the participants 'come alive' for the reader and allow a more holistic view of the participants; it contextualises the results and interpretive analysis (Silverman, 2013). Caution has been taken in ensuring that biographical information provided would not identify any of the participants. Notes from my reflexive diary were used to provide insight into my feelings and experience as a researcher of meeting and interviewing each of the participants

Brendan

Brendan is a 46 year old university lecturer who lives in the west of Ireland but is originally from Dublin, and grew up there. He is in a long-term relationship and lives with his partner. During his interview he talks about coming out in the 80s and his parents having a negative reaction which disappoints him as they were seemingly liberal at the time. He found a community at university who supported him, but he still feels the negative reaction of his parents impacted him a lot. He is out to friends and some family, but doesn't always feel the need to come out. He is often presumed to be

heterosexual, and when he talks about his partner, people often presume it is a woman. He has a chronic health condition, but considers himself healthy as he is able to manage it. Although he has been hospitalised in the past with flare ups – he talks about health being very much linked to activity;although he has an illness he is healthy as he is able to work, go to the gym and undertake other day to day activities. He discusses the importance of community in his interview and how even with no other obvious commonality that being gay gives a sense of connection with others. He has more recently become involved in the BDSM scene and talks about how this is a more inclusive community than the LGBT community more broadly – he discusses that being more taboo brings people more together. He talks about being open with his healthcare providers about his sexuality, and that it is mostly around him having a male partner. He describes an experience of going to a GP with symptoms of a sexually acquired infection and having a negative response of the GP focussing on HIV transmission and not having much knowledge around sexual health – he talks about travelling to Dublin to a gay health service as he finds it more inclusive and understanding. He discusses the impact of BDSM on his relationship as his partner was not 'into it' and that now they are non-monogamous, but that it had had an impact on his mental health in the past. He talks about broad acceptance of being gay in Irish society and in his life, but that he feels stigma related to being 'kinky' and being in a non-monogamous relationship and this is something he doesn't discuss with many people. He spoke about being uncomfortable in the interview discussing it, but he thinks it is important.

Reflexive diary entry

The interview with Brendan felt very fruitful, he was very articulate and had clearly thought about what he was going to discuss. When he talked about being uncomfortable discussing being in a non-monogamous relationship and being into BDSM, I was unsure how I should respond, but afterwards he said he felt relieved to have discussed it. The interview took place in a private room at Brendan's workplace, he saw a post about the study on Twitter.

David

David is 60 years old and lives in a rural village in the West of Ireland, having lived in Dublin and the middle east in the past. He describes himself as a former teacher and principal, he says he will never retire as he thinks being active is key to staying healthy. In his interview he discusses how important vigilance is when it comes to health, getting check-ups regularly. He says he is 'fit as a fiddle' and very conscious of physical and mental health. His parents are deceased for some years, but he talks about his mother as being instrumental in his identity formation – she told him to get out of the village he grew up in and always supported him. He talks about always being very open and that even though he was told that his sexuality would prevent him from progressing in his career he didn't allow it to. He says he is a lifelong learner and passionate about knowledge and that he is always learning new things about himself and his own sexuality. He says he doesn't find living in rural Ireland prevents him from living a full and active sex life, but that is because of his positive attitude. He sees himself as a role model to others and says he often finds himself giving advice. While he has no chronic conditions, he discusses having regular check-ups. He is open about his sexuality with healthcare professionals, he talks about being open straight off, as he doesn't want to have to worry about it if he was in a position where he needed to discuss it and hadn't already told them – he gave the example of sexually acquired infections. He talks about attending a general sexual health service in a nearby city for regular screening, and talks about the professionals having an 'aura' which makes him feel comfortable – he says he likes his GP but wouldn't want to go there talking about sex, as it's not his specialism. He talks about only gaining confidence in healthcare professionals when they demonstrate knowledge to him and give him information. In his interview he reflects on how different things are in Ireland in the last 5 years, he talks about how it is visibility that makes it better now, there are more gay people visible and while it would be easy to keep his sexuality private he thinks it is important that people see role models of happy older Gay Men.

Reflexive diary entry

David's interview was very relaxed, he told a lot of stories and seemed very at ease discussing all issues. He was very friendly and after the interview asked more about me and the plans for the research. The interview took place in his home. He heard about the study through a friend.

Frank

Frank is a 26 year old graduate student who is from Dublin and has lived there all his life apart from some time abroad studying. He currently lives with friends and has a long term boyfriend. He says he is out to 'most people' but doesn't think too much about coming out. He came out his mother as a teenager and he has a gay sibling, he hasn't come out to his father 'officially' but is told he knows. He talks about being asked not to come out to his grandparents by his mother, and understands this as they are older. He discusses how he avoids telling people he is gay if he perceives them as having conservative views, and often avoids coming out to older people. He describes his boyfriend as being 'very gay' – when asked about this he says he is not flamboyant, but will always make a point of coming out – Frank says he doesn't feel the need. He says he considers himself healthy and has no chronic illness, when asked about discussing sexuality with healthcare professionals he says he has only done so in sexual health services. He talks about discomfort in being asked if he was gay by a sexual health doctor, that he felt a little embarrassed even though it was important that they knew, he says he would prefer if he had the opportunity to put it into a form. He doesn't feel that he should come out to other healthcare professionals as it is not relevant, he talks about how his mother is a healthcare professional, and wouldn't need to know if people she cared for were gay. He says he feels that not being out does affect his relationship with his GP but doesn't see the need to have a relationship with a healthcare professional right now, maybe when he is older he would, or if he had a chronic health condition. He perceives his GP as being very 'straight-laced' and feels that this prevents him from telling him he is gay. He talks about safety on a few occasions, when asked

about what would make coming out in a healthcare environment unsafe, he says that healthcare professionals might 'look at you differently'.

Reflexive diary entry

I came out of Frank's interview feeling a little deflated, it was a short interview, 50 minutes, and while he didn't seem hesitant in his answers, they were quite short and lacked depth at times. I was confused as to why he came for interview, when asked, he said he heard about the study from a friend and felt he should participate as he was also a PhD student. The interview took place in a neutral office space.

Geoffrey

Geoffrey is a 26 year old man who lives in Dublin, he works for a large retail company in administration. Geoffrey grew up in a town in the West of Ireland before going to University in a city in the West. He lives in a house share with two friends and is currently single. When talking about growing up Geoffrey discusses how having a gay sibling impacted on his coming out process, and he is currently out to everyone in his personal and professional life. He spoke in his interview about the importance of community to him and how being an activist has shaped his outlook on issues of sex and sexuality. He considers himself healthy but has attended GPs in the past when he needed to and has regular sexual health check-ups. He reflects throughout his interview on how his views on issues of sexuality have broadened as he grew older and that he is not 'unshockable'. He shares experiences of often being presumed heterosexual, despite being 'very camp' sometimes. He says stereotyping doesn't bother him as he fits lots of the stereotypes of what a Gay Man would be. Geoffrey focuses a lot on the visibility of LGBT issues brought forward in the marriage equality campaign in 2015 and on how he thinks it will lead to more acknowledgement of health related issues for gay people. He discusses that while he is open to everyone he meets about his sexuality, he would prefer it if health practitioners took the lead in consultations on discussing these issues, as

they will know if sexuality is relevant to things. He makes comparisons between his experiences in sexual health services with those he has had in general practice and talked a lot about unshockability being important for healthcare professionals. He was critical in his interview about the role of religion in the provision of healthcare and the need to move away from religious iconography in health settings, which may indicate that it is not safe for LGBT people to be open in those settings.

Reflexive diary entry

I had met Geoffrey before our interview and so conversation flowed well throughout, he was very open in the interview and while we went 'off topic' at time, this ensured, I feel, that he was not just providing me with answers he thought I would like to hear. The interview took place in, a private room in an LGBT resource centre. Geoffrey saw an advert for the study on Facebook.

Harry

Harry is a 20 year old student nurse from the West of Ireland, but is currently studying in the South East of the UK. He lives in a small city during term and had spent summers at home in a small village with his parents and siblings. He is not out to his parents, but his brother and sister know he is gay, and other people from home. He is out to everyone he meets in the UK, he recalls coming out to classmates when he moved to the UK and talks about them being very supportive. He thinks he will come out to his parents soon, but might ask his sister to tell them he is gay. He went to University in the UK as he didn't have the qualifications to study in Ireland, and talks about being unsure of whether he would like to move back to Ireland once qualified or stay in the UK. He discusses not having very many gay friends, but not wanting to have more. He finds that a lot of younger Gay Men only want to have sex and he feels well supported by his current friends who are mostly straight women. He has only ever discussed his sexuality with sexual health practitioners – because his GP is his parents GP too, he feels uncomfortable telling them he is gay, 'just in case it would come out'. He talks about being embarrassed when he discusses sex with sexual health nurses but that they always

put him at ease – his straight friends don't really get checked but he always does as he is aware of a high prevalence of HIV. He discusses his health as being healthy, as in not having any illnesses, but not always living a healthy lifestyle, as he is a student and drinks like 'all students'. He speaks briefly about classmates sometimes saying homophobic things and that he is aware of homophobia in healthcare but hasn't seen any in practice, he feels that healthcare professionals need to be better at discussing sexuality and that they should take the lead.

Reflexive diary entry

Harry's interview was one of the shortest (55 minutes) as he had limited experiences in healthcare settings, while he seemed to be relaxed, his answers were short and he required a lot of prompting. His interview took place in a private room in a university, he found out about the study via Twitter.

Leo

Leo is 19 years old and is a student and works part-time as a waiter. He has lived in Dublin for a year but is originally from a small town in the South East of Ireland. He is single, and currently lives in a house share with friends. Leo's parents died when he was a child but he has a good relationship with his older siblings, he says he is out to everyone and has a large group of gay friends in Dublin, although all of his friends at home are straight. He talks about struggling with his sexuality growing up, and it impacting on his mental health. He discussed this with his GP at 16 and was referred to counselling. He discusses how relaxed the GP made him feel by not over-reacting and talking about having many other Gay patients. This encounter led him to come out to more people at home and to his family, since then he comes out to everyone. He discusses moving to Dublin as being significant in terms of his sexuality, not only having the opportunity to meet gay people but also to see the diversity of gay people. He talks about being out at home and in school but always trying to 'go against' stereotypes whereas when he came to Dublin he felt more free. He makes a lot of comparisons between his 'home' life and his life in Dublin, and his friends in either place. He talks

about being called a faggot when out in clubs at home, but he says it doesn't really impact him, but it makes him angry that it might make others feel bad. He discusses the importance of the Marriage Equality referendum for him becoming more comfortable with his sexuality, and how it felt empowering to campaign for the referendum at home. He links his health to his ability to be active and fit, he talks about experiences of being in hospital because of sports injuries, but at a time when he was unsure about his sexuality. He talks about how the openness of sexual health services makes him feel very comfortable to discuss his sexuality, he has attended a gay health service which he finds very inclusive, just because its designed for Gay Men. He has also attended a general sexual health service and found that practitioners leading the conversation put him at ease. He talks about the relevance of his sexuality to health and thinks it's only relevant sometimes, like with a healthcare professional you will see regularly or with sexual health, he makes a comparison with having both parents deceased, it may not be important for a one off consultation but it would be if he was diagnosed with a long term illness.

Reflexive diary entry

Leo was very open and chatty throughout his interview, I was surprised with how reflective and articulate he was, for an 19 year old. He was very pleasant throughout, smiling and making jokes. He saw the advertisement for the research on his university societies' Facebook page and just thought he'd 'give it a go'. The interview took place in a neutral office space.

Martin

Martin is a 36 year old nurse, originally from the West of Ireland but who has moved to a midlands city in the UK in recent years. He has a long term partner who he lives with. Martin says he is out to everyone he meets personally and professionally and considers himself very comfortable with his sexuality. He talks about his work as a nurse making him very aware of how important it is to be

open and comfortable in oneself. He talks in his interview about living in different places, a rural village, a small Irish town and a large Irish city before moving to the UK and discusses how each place 'made a mark' on him. He talks about having elderly parents and being nervous when he came out to them in his early 20s but how they were very supportive, and that it was very important to him that they voted yes in the marriage referendum. He talks about the anonymity of a big city helping to form his identity but also finding the bear community ('Bear' has a 'natural', masculine, often hairy, build (Prestage et al.,2015)). He talks about how gay stereotypes often made him feel like he didn't belong, until he found the bear community, where there was a different type of Gay Man presented. He talks about having health issues related to his weight, he has high blood pressure and gout, and that he isn't always very upfront about being gay with healthcare practitioners. He talks about sometimes 'testing' his doctors, by mentioning his boyfriend, but only if he gets 'signals' that they'd be ok with him being gay. He talks about the relevance of sexuality to health and how it really only comes into it with long term conditions or sexual health. He talks about the main issue for him in coming out to healthcare practitioners is to ensure that his partner is accepted and included in his healthcare. He talks about being a nurse, and separating out his personal life from his professional life; he says he would challenge homophobia from a colleague but not always from patients as 'they are going through enough'. He discusses how being gay might make him a better nurse, he feels being gay makes him less shockable, especially around issues of sexuality. He also talks about how being a nurse means that he is more able to have difficult conversations and that a lot of his friends come to him for advice.

Reflexive diary entry

Martin's interview was a longer one, it was 130 minutes, often going off topic and discussing issues in nursing. He seemed very open and laughed a lot. He told a lot of stories when answering questions and sometimes needed follow up prompting. He saw a Facebook post mentioning the study and the interview took place in a private room at his workplace.

Noel

Noel is 21 years old, he lives in Dublin and is a medical student. He also works part-time in retail to supplement his living. Noel is originally from Dublin and he lives at home with his parents, he is out to everybody in his familial and social circles; although he is not always out with people he meets in his education and clinical placements. He states that coming out was not difficult for him and his parents were very supportive, in his interview he describes himself as comfortably middle class. He has a boyfriend who he has been with for six months, and says he is very happy. He regularly goes out clubbing and has a large group of friends, of varying sexualities. He discusses his involvement in university societies and how he has learned a lot about LGBT rights and broader social justice issues through this involvement. He talks about his experiences of visiting his GP following a sexually related injury, as well as more general visits to this GP and others and he discusses his experience of sexual health testing in a sexual health clinic for Gay Men. During his interview Noel discusses how his experiences on clinical placements make him wary about the prejudices experienced directly and indirectly by LGBT patients; and gives examples of witnessing homophobic discourse amongst medical staff. He discusses the feeling of stigmatisation because of presumptions around HIV risk and the ban on blood donation for Gay Men. Overall he feels in good health and states he is very aware of his body and when to go to seek medical help. He discusses how, despite facing some discrimination and oppression as a Gay Man he is very privileged overall, and talks about the need to show solidarity with other groups who are less privileged.

Reflexive diary entry

I found the interview with Noel flowed well, he answered all questions posed with ease. He seemed very relaxed and we laughed in parts. He used the phrase ‘you know’ on a number of occasions, which I followed up with a request for him to elaborate more. Noel saw a tweet advertising the

study and emailed, he stated he wanted to help to improve healthcare for Gay Men. The interview took place in a neutral office space.

Patrick

Patrick is 23 years old and lives in Dublin with his parents, having lived in Asia during his early years due to his father's work. He a community worker but currently not in paid employment, he has recently finished a university degree. He is single, and discusses having a small, close group of friends, of varying sexualities and genders. He spent some of his teenage years as part of an LGBT youth group where he learned a lot about sexuality and diversity and discusses his own views as constantly evolving with time. He discusses how the marriage equality referendum brought a focus onto gay and lesbian issues but had a very normative focus and displaced other LGBT identities and he finds this uncomfortable. He talks about himself as being in good health, and laughs about sometimes his diet not being good. His experiences of healthcare focus around routine GP visits and sexual health testing and he makes comparisons between these experiences. He discusses his agency in deciding around healthcare provision, having left a GP following a negative experience – and what made him feel comfortable with the GP he changed to was how she discussed his sexuality in a very calm and non-judgemental way. While he had positive experiences in the sexual health services he attended, he discussed how sometimes individuals can make him feel uncomfortable, and that he has made complaints about individuals acting unprofessionally. He discusses how even LGBT services can be quite normative in their approach, and how sometimes when he himself 'plays with gender' people can be uncomfortable, wanting to put people into simple boxes. He discusses the importance he places on sex as an aspect of personhood, and seeing some juxtaposition between gay sex being pathologized because of risk, but the need to be conscious of risks related to sex, and the need to appropriate sexual health information and education.

Reflexive diary entry

Patrick was very talkative and precise throughout the interview, it felt like he had thought a lot about the interview in advance. While I didn't look at the interview schedule much, I felt we covered all of the areas in depth. He seemed very relaxed and informed. The interview took place in a private room of an LGBT resource centre. Patrick found out about the study on Twitter.

Robert

Robert is a 55 year old accountant who lives in a rural village in the south of Ireland. He works in a large city about an hour from his home, he lives alone. Robert's parents died many years ago, and he never came out to them, he has one sibling, who knows he is gay but 'it isn't really a thing we talk about'. Robert talks about very much separating out his 'gay life' from his professional life. He works for himself but often works on contracts with other companies and talks about being 'a loner' at work. He makes a comparison between this and his gay life, he has a number of gay male friends around his own age who he meets in the city every few weeks for drinks and meals out. He says he is very comfortable with his sexuality but is just a very private person, he talks about growing up as a private person. Robert talks about going to an all-boys boarding school, where he had a few 'gay experiences', but these were never talked about, and he questions whether this is why he has always thought of sexuality as being private. He says he is in 'impeccable health', although he was diagnosed HIV+ ten years ago, he talks about how being HIV+ doesn't make him unhealthy. His experiences in healthcare are mostly around his HIV status, with his regular check-ups, he also accesses sexual health services. He talks about frustration with having to be open about his status with all healthcare professionals, how it makes 'no odds' to his GP, but whenever he goes to the GP his HIV is brought up. He talks about being comfortable about being gay but not feeling it is a big deal for him, he says he understands why others want to make it political but for him it is just about who he likes to have sex with.

Reflexive diary entry

The interview with Robert felt a lot more formal than other interviews, he was always polite and willing to answer questions. He rarely smiled and answered questions with direct answers rather than a narrative, I prompted him several times to give me examples or tell me about 'a time when'. He was interested in how other interviews went, and I told him I had a variety of different responses from a diverse group of men. The interview took place in a neutral meeting room, he saw the study being advertised on a community organisation Facebook page.

Simon

Simon is a 30 year old man who works in a telecommunications and marketing company in Dublin, having studied at a technical college. He was brought up in Dublin and currently lives with his boyfriend and friends in the city. He was brought up mostly by his mother and does not have a good relationship with this father, his parents are separated. He talks a lot in the interview about the priority he gives to health and fitness, and how it is a big part of who he is. He clarifies on several occasions that he is a masculine kind of guy, but that he has 'nothing against' more effeminate men. He also discusses promiscuity as something Gay Men 'have an issue with', that he had been more promiscuous as a younger man but many people 'don't grow out of it'. He discusses that being gay is about more than sex for him, and that he has had sex with many straight men. He doesn't see himself as political but thinks it is important to use social media to build networks and to share positive messages. His first experience of coming out to a healthcare professional was when he was 18 with a GP as he was having urinary symptoms, the GP referred him to a service for Gay Men. He discusses feeling pushed aside by the GP at the time but that he had very positive experiences in the gay health service after that for many years, but doesn't go to get tested anymore as he is in a monogamous relationship. He discusses how most people presume that he is straight and often they are shocked when he mentions his boyfriend – he rarely tells people he is gay, but mentions his

boyfriend so that they know. He recalls an incident of being called a faggot in public once by someone he didn't know and how that left him feeling very isolated – and discussed how if he witnessed this he would step in as it's important not to feel alone. He spoke about how words can have a big impact, and for him that word meant that no matter how successful he might be he is 'only a faggot'. He talks about how it's only important to discuss sexuality in some healthcare contexts, such as sexual health or mental health, he gives an example of breaking a foot, 'you don't break a gay foot'. On several occasions during the interview he talks about how not feeling different is important to him.

Reflexive diary entry

Simon was very chatty throughout the interview and spoke a lot, and very fast. He seemed at ease throughout the interview, however at times it was difficult to keep on track as he would often project onto others or give hypothetical answers, rather than discuss his own experiences. The interview took place in a private room in an LGBT resource centre, Simon saw an advert for the study on Twitter.

Terry

Terry is a 28 year old man who lives in Dublin in shared accommodation, he has a partner, who he doesn't live with but stays overnight quite a lot. Terry grew up in a small town in the east of Ireland , his parents separated when he was young, and his mother died suddenly some years ago, which had a big impact on his mental health. He doesn't have a very good relationship with his father, who has another family now, he has step siblings but doesn't see them. Terry is currently doing a PhD and has a large group of friends, all of whom he is out to. He tells me that he only comes out to those who need to know, some people at work know but he doesn't tell everyone. His father and step siblings do not know he is gay. He talked about having regret that he only came out to his mother as she was

dying. He has supportive aunts and uncles, and is Godfather to a friend's child, he talks about not being out to the child as he hasn't asked their parents yet, both know Terry is gay, but he talks about not knowing how to bring it up, but he'd like to. Terry has a chronic illness which flares up from time to time, and he has required colonoscopies in the past. He states he often doesn't know whether to tell healthcare professionals whether he is gay or not. In the past he has told doctors because he was having a colonoscopy, but felt uncomfortable when then he was asked about sexual health. He talks about preferring to discuss sex within sexual health services which he views as less judgemental. He has received counselling in the past, following his mother's death and discusses how this really helped him to come out to more people, as his counsellor was very reassuring. He mentions his own frustration with not feeling able to discuss sexuality until 'the last minute' with healthcare professionals and thinks that it is something he needs to work on.

Reflexive diary entry

Terry appeared quite guarded at the beginning of his interview, his answers were short and direct. However as the interview proceeded, he opened up a bit more, I shared the interview schedule with him but then the interview evolved into more of a discussion. I felt a little uncomfortable when we discussed sexuality as his answers were very short and he appeared unwilling to give any depth, however towards the end of the interview we discussed these issues in more depth. Terry saw an advertisement for the study through a shared Facebook post. The interview took place in a neutral office space.

William

William is a 32 year old man who is from Dublin city centre where he has lived all of his life. He works in media, and lives with his long term partner. He talks about always feeling different growing up, he went to a private school with a large sports influence which he was never interested in. He says he is out to everyone in his life and that the only people he is unsure about are his

grandparents, who are deceased, they had met his partner but the context of their relationship was never discussed. William talked about his partner a lot in the interview and about how important their relationship is to him. He doesn't consider himself a 'stereotypical gay' and talks about it sometimes being difficult to find a place in the gay community. He talks about other communities, like the gaming community he feels more included in, and how a lot of the people he engages with there are also LGBT, and how sometimes being gay is a point of connection and sometimes it's more about the games. He has a good relationship with his parents who he visits regularly, and talked about how thrilled he was when they supported marriage equality and are so welcoming to his partner. William was diagnosed with a serious cancer a few years ago and discusses his many experiences with healthcare professionals in the context of this. He talks about the most important thing for him about being open about his sexuality is that his partner is included. He says being so ill made his view of health change, he has become more vigilant about health issues and places a lot more priority on staying healthy.

Reflexive diary entry

William's interview was over two hours and he was very open and keen to discuss his views and experiences. He seemed to make a lot of presumptions about me, and used the phrase 'you know yourself' a lot, laughing. On a couple of occasions I prompted him to elaborate and he seemed to struggle a little in explaining. The interview took place in a neutral office space and William was told about the study by a friend.

Findings

Table of themes

The table below presents the supraordinate and subthemes and the prevalence of these themes related to each study participant.

	Brendan	David	Frank	Geoffrey	Harry	Leo	Martin	Noel	Patrick	Robert	Simon	Terry	William
Subthemes	Superordinate Theme 1: Layers of Gay - 'Sometimes it's everything; sometimes nothing at all'												
Being and doing Gay	X	X	X	X	X	X	X	X	X	X	X	X	X
'This is the beginning' – Evolving identities	X	X		X		X	X	X	X		X		X
Places and spaces	X	X		X	X	X	X	X	X	X		X	
Gay 'with' others	X	X	X		X	X	X	X		X	X	X	X
Subthemes	Superordinate Theme 2: Queered consultations												

Relevantly Gay	X	X	X		X	X				X	X	X	
Signs and symbols – Straight laces and rainbow stickers			X	X		X	X	X	X			X	
Disrupting expectations	X	X	X	X	X	X	X	X	X	X	X	X	X
Tactical Outing	X	X	X				X	X		X		X	X
Subthemes	Superordinate Theme 3: Healthy living and 'Risky business'												
Actively healthy	X	X			X	X	X	X	X		X	X	X
Outness and wellness	X			X		X	X	X	X				X

Health as sexy; **Sex as healthy**	X	X		X		X	X	X	X		X		
Risky business	X	X	X	X	X		X	X	X	X	X		

Introduction

Through sharing their views and recounting experiences within and outside of healthcare contexts, the Irish Gay Men in Queer Expressions provided a rich and textured account of how they discuss sexuality with healthcare practitioners. A thorough and in-depth analysis guided by Smith et al.'s (2009) process of Interpretative Phenomenological Analysis yielded distinct areas of focus presented below. This chapter contains in thematic sequence, three superordinate themes and twelve sub themes. Superordinate theme one is Layers of Gay identity with subthemes: Being and doing Gay; 'This is the beginning' – evolving Gay identity; Places and Spaces; Gay 'with' others. Superordinate theme two, Queered Consultations, with subthemes: Relevantly Gay; Signs and Symbols 'Straight Laces' and 'Rainbow Stickers'; Disrupting Expectations; Tactical Outing. Superordinate theme three, Healthy living and 'Risky Business' with subthemes: Actively Healthy; Outness and Wellness; Health as Sexy, Sex as Healthy; Risky business.

Superordinate theme one: Layers of Gay – 'Sometimes it's everything, but sometimes it's nothing at all'.

The ways in which participants describe and experience their sexuality are varied; and the importance they place on being gay as a facet of their identity differs across participants.

> *sometimes it's everything, sometimes it's nothing at all. I think it depends on the person but also on what's going on*
>
> Harry, 19, Student Nurse.

This chapter presents the findings which relate to how the participants discussed how they view their sexuality and identity as Gay Men. Within each interview participants were asked directly how they describe their sexuality and what being gay means to them; however, throughout the interviews the concept of gay identity emerged and was discussed and contextualised repeatedly, relating to varying lived experiences, relationships and interactions of participants.

The positioning of sexuality and being gay by participants, is central to the overall purpose of understanding how sexuality is discussed by Gay Men in healthcare contexts. The rich contextualisation offered by participants in their narratives provided a means by which to locate participants within their own psycho-social landscape. This rich depiction is essential both to the IPA approach and as a means of achieving the aims of this study as it allows broader ideographic understanding of the participants lived world. Participant's descriptions and experiences of being gay are presented below under four distinct themes: (1) 'Being' gay and 'doing gay', (2) 'This is the beginning' evolving identity, (3) Places and Spaces (4) Gay 'with' others

Subtheme one: Being and doing Gay

When describing their sexuality and gay identity, Gay Men broadly do so in two ways; one more passive and innate 'being' gay and one more active 'doing' of gay. For many of the participants in this study, their expressions were layered, encompassing both of these ways of describing their sexuality.

Participants often began their descriptions of being gay as an innate same sex attraction – as a being, something which is a part of them and who they are.

> *I suppose it's just who you are, like deep down, like deep down I'm attracted to men, I want to be with men, it's who I am sexually attracted to*
>
> William, 32, media worker.

For some of the participants, questioning their perception of being gay led to clear reflection, developing their view throughout their answer

> *ammm I'm going to say some sort of state of mind, ammmm I don't know it's more a, like you're not going to, you're almost certainly not going to have a, at least as a Gay Man not going to have a relationship with a woman, I'm almost certainly never going to do that, I don't even know if I could do that*
>
> Terry, 28, marketing producer

The above response clearly situates the experience of being gay, not only within the psychological and emotional space, but also as something which is in some ways limiting. Rather than talking about being gay as leading to him having relationships with men, he responds in the negative; that it means that he won't have a relationship with women – he questions if he even 'could'.

All of the participants described being gay as something that they always were, however while they all clearly positioned themselves as never being straight, for many of them, their sexuality and sexual identity was a process of 'becoming'

> *I mean like I didn't decide I was gay I've never been straight. I've always been gay, but it changes all the time, yeah when I first realised it was just that I realised I fancied boys and not girls, but then it became, I don't know, something more, like I knew that I was different, that I saw things differently and that there's a whole culture*
>
> Leo, 19, student.

The concept of being born gay, and it not being a choice, was discussed by many participants, however in different ways. In the below comments you can see that Robert discusses the innateness of his sexuality as something limiting, and something he would change if he could; Geoffrey comparatively, also acknowledges that his gayness is something which is innate, but his perspective is that he wouldn't change it even if that was possible.

> *it's just a small part of me, and I can't change it, it's not who I am, like in total. God knows it would be easier to be straight, I mean to be honest I would be straight if I could, but that's not who I am so I just have to get in the best I can*
>
> Robert, 55, accountant

> *it's something that's so, so deep, and like as you go on you get to know yourself better, I think, I don't think it changes, you just find out more. It's like a discovery I think of who you really are, and you can't help but discover, I mean you can't just ignore it and be straight instead, and I wouldn't be, it's something I've never thought of, how boring would that be [laughs].*
>
> Geoffrey, 26, retail worker.

Within these initial discussions around sexuality Gay Men provided a layering, and multifaceted description; the innate 'being' of gay which began their discussions was often followed with an active 'doing' – how the Gay Men 'did' their sexuality was broad and diverse.

For all of the participants the 'doing' of gay related to sex and intimacy with other men

> *like at its very basic level, I sleep with men. But like yeah, even if I went through a dry spell I'd still be gay, but men are the things that turn me on, so I think you can't separate that out*
>
> Frank, 26, graduate student

> *[laughs] I mean being gay means that I actually have a very active sex life. I think it's a big positive, as straight people get older often you hear that they don't have so much sex, I could be at it all week if I wanted to be*
>
> David, 60, retired

> *it's probably not the biggest thing, but at the same time it is [laughs] but having sex with other men is what makes me gay really. I don't have a big group of gay friends, I spend a lot of time with straight people, but I do have sex with men*
>
> Harry, 20, student nurse

While the doing of gay sex seems like a very central and clearly apparent factor of 'doing' gay, the concept of discovery with doing gay was a clear theme

> *it's weird like, gay sex is so important to being a Gay Man but like it's still so taboo and secretive. There's no sex education for LGBT kids and you don't see it on the telly or anything. Like when you're learning about being gay you're probably also learning about gay sex, I don't know, like learning on the job*
>
> Geoffrey, 26, retail worker.

For participants, the discovery about how to 'do' gay was about more than sex, gay sociability was also something that participants discussed learning about

> *like you don't get, well especially in the 80s you didn't get any real view of what gay life was like. It was only a negative, you heard about gay discos, but couldn't see them in the same way as you could see straight bars and clubs*

Brendan, 46, university lecturer

> *I mean there are so many stereotypes, like you have a small view of what being gay is, like all twinks dancing shirtless, but then you get to learn that there are lots of ways to be gay in the world, but that takes time I think*

William, 32, media worker

The discovery of gay social spaces and communities was apparent as a clear route for participants, not only to discover what being gay meant (or didn't mean) to them, but also about how they would 'do' or not 'do' gay.

> *it's like pride, or in a club seeing the guys with their shirts off, dancing around; I don't do that but kind've seeing it tells me something about myself too – like I'm not one of those gays*

Simon, 30, telecommunications and marketing

Community and social action emerged as key attributes of personality as well as activities of being gay for many of the participants. As the fieldwork took place some years after the marriage equality referendum in Ireland this became a key discussion point in many of the interviews.

> *I think the referendum brought a clear focus for gay people to actually represent ourselves, as serious and more than stereotypes. Like what motivated me to campaign was to make sure that others weren't representing me, that I was showing them a different side*

Leo, 19, student

like it [marriage equality referendum] turned me into a keyboard warrior kind of – I never saw myself as an activist or anything, but this was about me and my kind; and although I was away I could be part of it, like I really felt part of something.

Martin, 36, nurse

like the [LGBT] society really brought a lot to me, like about how being gay is more than just me, it's about a community; and like as a white, cis man about having so much privilege. I think being gay means you're more open to understanding the plights of other people

Noel, 21, medical student

The discussions around sexuality and what it meant for participants to 'be' and 'do' gay, evolved to how this part of their identity led to other aspects of identity, community and practice which will be discussed in the next section

Subtheme two: 'This is the Beginning' – Evolving Identity

y'know like that RuPaul song, this is the beginning of the rest of your life [laughs]

Noel, 21, medical student

While the identity strand of interest in this study is framed by participants' sexuality as Gay Men, discussions around sexuality and being gay developed into congruent strands of identity by many of the participants. These strands of identity included being ageing, LGBT community, gay subgroups/tribes, gay as activist and gay as role model.

All of the participants discussed their gayness as something which has developed over time, or related to age. For all participants, they view their sexuality as evolving, and most discuss becoming more liberal and open as they grow older'

I think definitely with time you become more comfortable, but also like, more open to different things, like views of sex, like that it's ok to have sex with lots of people, or like if you had a threesome or whatever. Like not that I do it, but I'm more accepting of other people doing it

Simon, 30, telecommunications and marketing worker

I think as I get older I just become more aware of diversity, and of opportunity; and maybe care less about what others think of me. Like with the kinkier side, I think I'd be horrified in my 20s, but now it's just accepted that that's what I like and who I am

Brendan, 45, university lecturer

it's a funny thing, people talk about growing out of being wild, but I think I'm as wild now as I ever was [laughs]. Maybe not really but I've definitely gotten more open minded as I've grown older – maybe straight people get sense and gay people lose it

David, 60, retired

Participants in the study self-selected themselves as Gay Men, however in many of the interviews their gayness was situated within the wider LGBT community. Narratives around the LGBT community not only focussed on shared experiences of oppression, but also on broader common bonds and familiarities.

I mean yeah I'm gay, I'm not a lesbian or trans but there is something in common – it's like there's a shared struggle, but even beyond this even, like in a club, where there are lesbians and trans people, I feel like I belong

Leo, 19, student.

You see it now and it's lovely, a whole community working together, and in a way it's always been like that. I mean lesbians would do their thing and we'd [Gay Men] do ours, but then if

there was an issue we all stood together – it's nice now that there's still a community even though I suppose there are less issues

David, 60, retired

There was some contrast however in Robert's interview, he challenged the notion of community based on sexual and gender identity strongly.

I really don't understand the need for this LGBT community nowadays, I have nothing to do with lesbians, I might, but that wouldn't be because it was a lesbian, maybe it was because a woman was working with me or liked golf or whatever, sexuality doesn't come into it. I don't think it does us any favours being lumped in with lesbians and trans's

Robert, 55, accountant.

When asked to expand on what was meant by favours, Robert affirmed the importance to him of being part of a gay community, but expressed discomfort with wider issues of LGBT politics

I don't want to get down a rabbit hole here, I have no problems with them and I wish them luck, but there are different things at play – everything is gone so political. I mean I actually think that sometimes we get held back fighting other people's battles. What has a transgender issue got to do with me?

Robert, 55, accountant

While not all participants specifically discussed being part of the wider LGBT community as significant to them, Robert's displacement of himself from community action was very much an outlier opinion. For many participants, exploration and development of their gay identity led on to more explicit involvement within community action and activism. The following segment from Noel's interview is from a discussion we had about his involvement in his university LGBT society and attendance at a large LGBT student conference

it just makes you so much more aware of all of the other issues at play, and then when you're aware you want to do something. Like for example we were discussing the ban on Gay Men giving blood, but then you find out that sex workers can't either, and like for them there's a whole lot more issues. I think being an oppressed group just gives you a kick in the butt to get out and help

Noel, 21, medical student

Out of the thirteen participants in the study, eight of them described their roles in various forms of activism and community engagement. The marriage equality referendum was discussed as a significant platform for community engagement and activism for participants.

I think it's just you're more likely to get involved when you see the issues, and not only that, because the LGBT community is so broad and diverse you get to know about other issues. Because racism, sexism and ableism and everything else is experienced within the LGBT community you inevitably get involved in those things too

Patrick, 23, unemployed community worker

I was very involved in the marriage equality campaign, out canvassing and stuff every night, it was important for me, even though I'm single and don't know whether I'd ever get married, but it's about rights. The people I campaigned with are now the same people I'm campaigning against the eighth amendment (abortion restrictions) with.

Geoffrey, 26, retail worker

it's mad, I actually never saw myself as political or anything, but then when the referendum came up I got really involved online, like a proper armchair activist. Now I think I'm definitely more switched on when it comes to this kind of stuff

Martin, 36, nurse

The role of other Gay Men in the lives of participants, whether it be public figures or personally known people played an important part in identity formation and development.

> *sure all you had back when I was younger, and not even that young [laugh] was Mr Humphreys. It was always a very camp and funny portrayal of Gay Men, you couldn't be gay and normal, well that was never shown. It was only when I started to meet other Gay Men, who were a bit more like me, that's when I started to accept it*
>
> Robert, 55, accountant

> *I think just knowing that there were other gays, and they were ok was important. Like there was this lad who worked in the local shop, and he was gay and everyone knew. You'd hear people talk about him but he just didn't give a shit, like I didn't know him, or ever tell him, but seeing him so confident really helped me*
>
> Leo, 19 student

This concept of usualising diverse gay identities was significant for participants, to be able to see themselves through the lives of others. For many participants the need for role models was something which sparked action on their part also

> *I'm so conscious that there's a very clear view out there about what a Gay Man is, well what a man is in general. As a Gay Man you have to be this way or that, but you really don't. I really love to play with my gender, with the view of masculinity, for myself, but also to show other Gay Men that it's ok to go out in a leather harness and a corset and have facial hair – you don't have to be one thing*
>
> Patrick, 23, unemployed community worker

> *I see it all the time, how important it is to be visible, not for myself, for others, young people and old people. Just to know that there are very happy and content Gay Men at my age, single, having a great time*

David, 60, retired

For some of the participants the emergence and discovery of gay subcultures and tribes provided an extra level of inclusivity for them.

> *Ah I don't know, as a big hairy guy you can feel very out of place in lots of gay places with young skinny twinks. When I found the bear community, just the visuals of it, like I feel so much more at ease. Like it's even much more like a normal bar, but we're all gay and all big and hairy [laughs]*

Martin, 36, nurse

> *It's not that I'm not gay or not comfortable with being gay, but like the gaymer community, gamer but with a gay [laugh], like you get all the benefits of having gay friends, but they're also into what you are too, so it's an added benefit*

William, 32, media worker

> *I don't know if it was that I didn't feel comfortable in the gay community, I do, but because of this extra thing, which is more taboo I suppose [BDSM practice], I think there's just more openness, like you're less judged. But then again, being gay you're less judged for it than straight people, it's a strange one; but I've definitely found myself more since being involved in more kinky stuff with others, it's like a real community.*

Brendan, 45, university lecturer

The layered and evolving views on what being gay means to participants was further elaborated on in terms of the places where they are gay, discussed in the next section.

Subtheme three: Places and Spaces

Place and space came up as a significant aspect of identity for Gay Men within this study; places and spaces as enablers of gay identity, but also as setting boundaries and limitations for identity. All participants within the study identified as gay and Irish and the context of being Irish and being in, and of Ireland was presented by many participants as a significant aspect of their identity.

> *It's funny, Ireland wasn't ever a place you could be gay; even up until the 80s and 90s, many of my friends emigrated, it wasn't seen as something you could be here; but in reality you could. I lived in the middle east for years, and when you compare it, it was very similar, you could be gay, but in a different way, more hidden, but almost hidden in plain sight*
>
> David, 60, retired

> *Growing up in Ireland there's a hang up about all things about sex and sexuality, and I think you really feel it when you grow up gay. There's signs of the church everywhere in Ireland, it's like the catholic church is synonymous with being Irish, so being gay and Irish is hard in that way – things are changing but it's still there*
>
> Geoffrey, 26, retail worker

Other participants suggested that the sense of small communities in Ireland led to a more positive engagement for gay people

> *I know that when you come from a small place like Ireland it can be hard, as everyone knows everyone, but in some ways that is a really nice thing, that you're connected in a bigger way. Like you can be a lesbian in Leitrim but because you're from whatever village or whatever and you have roots there, you're accepted.*
>
> Terry, 28, PhD student

For those participants who live outside of Ireland, as well as for those who had moved from rural Ireland to cities like Dublin, anonymity was a focus of their discussion on identity – being anonymous allowed exploration and development of identity which they felt would be limited in a place where they were known.

> *ah it was just completely different moving here [UK city] like no one knows you, or your business, there's less curtain twitching like you'd get back home in [west of Ireland]. No one cares what you do, so you are freer to experiment and be yourself, there's also more variety*
>
> *Martin, 36, nurse*

> *I think because I'm not out at home, coming to England made it easier to like be gay. Like even if I went to Uni in Galway or something, I'd be worried it would get home. Like I'm less worried now, but I think if I was there it would have taken longer for me to be comfortable*
>
> *Harry, 20, student nurse*

> *Like I came from home, to Galway, to Dublin and really each step was a step further into being comfortable being gay I think. Just you feel like you're less likely to be judged I think in a bigger place*
>
> Geoffrey, 26, retail worker

Participants equated living in bigger, more diverse and anonymous places with being able to express their sexual identity in a more authentic way; however for many participants they maintained their connections to other places, very often the place of 'home' or their place of origin or family. The place of home for many participants was a place where they were limited and constrained in terms of their sexuality, and so their identity was often compartmentalised into a home and an away.

> *Even though like I'm from the city, when I'm back home with me ma in [names place in Dublin] it's like I'm a different person. It's not like I'm a flamer anyway, but I'd definitely be more reserved and just conscious of how I'm holding myself*

Simon, 30, telecommunications and marketing worker

oh stop like it's so different at home than in Dublin, it's like I have two different lives, two separate groups of friends, I even have two separate wardrobes [laughs] – they'd take the piss out of you at home for wearing like pink, or skinny jeans or whatever

Leo, 19, student

I mean some might think I have two lives, one is at work and at home, where I just get on with what I'm doing, as I said I'm a private person. You could even say the gay [names himself] only comes out when I go into Cork or whatever.

Robert, 55, accountant

When discussing places and identity, many participants discussed the importance of gay or LGBT spaces, businesses, clubs. That not only was being in a big city or rural area an influence on identity, but also having spaces which are designated as gay was important.

I wouldn't come here very often really [LGBT community centre] but I'm very aware of how important it is to have a space like this. Like even for something like a research project, I'd feel safer having an interview here, than I would in some other community centre. Like with bars and clubs and stuff, yeah. I rarely go to straight places

Patrick, 23, unemployed community worker

Sometimes I bring my straight girlfriends to gay bars, and they love it, it's like a novelty for them, but like for me it's where I know I'm safe, where I can be me and no one will judge that.

Leo, 19, student

I know I said that I feel more comfortable in the BDSM scene, but like even normal gay bars, it's like they can be a bridge for that identity. Like I couldn't go into whatever straight bar in leather gear, but I could go to a gay bar, even if it wasn't a leather bar

Brendan, 45, university lecturer

Subtheme four: Gay 'with' others

like in school when they'd say, oh you're gay with him. Like what does that even mean?

Harry, 20, student nurse

Participants all discussed their sexuality and sexual identity in terms of how it relates in different relationships they have; whether close or casual relationships, Gay Men's identities are communicated and experienced in a variety of ways.

For Gay Men, coming out (or not) to, and being open with their parents about their sexuality is a complex but important part of their identity formation – all participants discussed their coming out experiences with parents as being a time of great stress which had an impact on their identity. The period of coming out to a parent was one of stress to those who discussed it in the study.

when I think about it now, it shouldn't have been anything. Like my older brother is gay and had already come out, and everyone was fine, but it still caused me a lot of stress

Geoffrey, 26, retail worker

I remember psyching myself out for weeks about it, planning it and thinking like what will happen if they go crazy or whatever. Then the reaction was so normal, it was almost disappointing not to have the drama [laughs]

Patrick, 23, unemployed community worker

Like I never told my dad, but he knows through my mum. My sister is gay and she never told mum, but told dad. It's weird like that, how we each told a different one. It was a big deal I remember, like really being worried about being disowned or whatever, but it was all fine. I didn't tell my grandparents though – as my mum asked me not to. I didn't mind that so much as they were older, and it just seemed like hassle

Frank, 26, PhD student

In the following excerpt from Terry's interview, he describes his emotions around coming out to his mother on her death bed

I only came out to my mother at the very end, she had a massive brain haemorrhage and like was on her death bed. She was in a coma like and I knew I had to tell her then, it was just me and her in the room and I knew I had to tell her. In some ways I don't know why, I mean I knew she was dying but I had to tell her – when I did, I felt really relieved. I just went out to my aunts and uncles and told them then, out of nowhere, like because I told her, it didn't matter what they said. I actually regret not telling her sooner

Terry, 28, PhD student

The regret around not telling a parent is something that is expressed in Leo's interview as well. His parents had died when he was a child, before he knew he was gay, but he still felt regret about it.

I didn't even know I was gay when my parents died, like I was way too young, but I still wish they got the chance to see that side of me, I really wish I had gotten the chance to tell them

Leo, 19, student

Siblings were an important gateway into coming out for some participants, as above in Frank and Geoffrey's interviews, siblings often were a testing ground for parental reaction

my brother and sister know like, and they're great. I'm a twin. They are like telling me that mam and dad will be grand about it, but I'm just not ready yet I think

Harry, 20, student nurse

Outside of family networks, participants broadly described their friends as gay friends and straight friends. There was a clear differentiation of what would be disclosed, discussed and experienced between these groups.

I mean all of my friends are very open and tolerant, I wouldn't be friends with them if they weren't. But it's different having queer friends, you can be a lot more open with them

Patrick, 23, unemployed community worker

It's kind of about not feeling judged, I think because Gay Men live the same world as you, like you can be more honest with them. I love my straight friends, but I'd definitely be more hesitant talking to them about sex and stuff

William, 32, media worker

I think sexuality of your friends makes a big difference. I haven't told many people about being in an open relationship, but I'd certainly be less likely to tell straight friends than other gay friends. It's just they're more accepting

Brendan, 45, university lecturer

Many participants discussed how their gayness is presented in their professional life, how it is communicated to colleagues and clients and whether it has any impact on how they work.

at work, I just don't think it comes into it. I don't make any issue of it, if I was asked if I'm married id just say no. I deal with numbers, it just doesn't come into it

Robert, 55, accountant

For many participants, they had clear boundaries around work, they discussed how they were aware of how they communicated and presented their sexuality in the workplace.

> *I mean people, especially older people presume I'm straight. Like ask me about having a girlfriend or whatever, and sometimes I'll say no I have a boyfriend but often I'll just let it pass. I mean the people I meet have cancer and are really sick, they have enough to be dealing with. If they're homophobic, this isn't the place to be challenging it.*

Martin, 36, nurse

> *I don't hide who I am, but I am very aware of how it's presented. It's impacted me on the past you know. When I worked in catholic schools, I was specifically told that I would not progress because I was gay, and I didn't hide it. So I left catholic education [laugh], but the experience did make me more cautious throughout my career.*

David, 60, retired

There was also a focus from some participants on how being gay led to building professional connections with other gay people more easily.

> *so this colleague, we were actually in the gym at the same time, and he said to me, oh do you have a partner? I just said, yes I do, then he asked, what does he do? I didn't know this guy was gay, but he was, and then I just felt more at ease around him. It's funny, he's a colleague, not a friend, but just him being gay also gives me more trust in him*

Brendan, 45, university lecturer

> *it's definitely like when you meet a gay doctor, you just feel that they'll be a bit nicer, sometimes they're not that nice to med students [laughs], but I've found I can build a better connection with the gay ones. Maybe it's just that I feel more open and safe around them*

Noel, 21, medical student

As presented in the quotes above, there was a very clear link between being open about sexuality and sexual identity and maintaining safety. Throughout the interviews the concept of safety was something which presented in many ways, this will be discussed further in the following two chapters.

Superordinate theme two: Queered Consultations

Throughout the interviews, participants were asked to recall situations where they discussed issues of sexuality with healthcare professionals. Without doubt, these situations and experiences hold significance for Irish Gay Men; the narratives of these experiences had depth and specificity, more so than in other parts of the interviews.

This chapter presents feelings, thoughts and actions associated with these experiences; and illuminates shared occurrences, approaches and phenomena. It is apparent from the findings that by discussing sexuality, sexual identity, and sex, Irish Gay Men actively (or passively) Queer the very experience of a consultation or interaction with healthcare professionals – that is they change, unsettle and disrupt what it is to receive healthcare (Johnson, 2014). Throughout discussions a hermeneutic cycle was apparent, with participants evidencing clear reflection into their encounters, andengagement in real sense-making. Below, these experiences are interpreted and presented through four distinct themes: (1) Relevantly Gay, (2) Signs and Symbols – 'Straight Laces' and 'Rainbow stickers', (3), Disrupting Expectations (4) Tactical Outing.

Subtheme one: Relevantly Gay

> *it's not like you go into A&E and start talking about your gay big toe*
>
> Leo, 19, student

Throughout the interviews Irish Gay Men elaborated on the situations where they saw their sexuality as a point of relevance for discussion, with healthcare professionals. There were clear concurrences and divisions across participants' viewpoints, regarding what made them being gay relevant for the healthcare professionals they engaged with.

A key area where Irish Gay Men saw their sexuality as an important issue or area to discuss, was in the field of sexual health. All participants in the study talked about experiences within sexual health services, but also in discussing their sexuality with GPs because of concerns around sexual health or a desire for sexual acquired infection screening. Below, Simon discusses his feelings around attending a GP after he noticed urinary symptoms which he thought might have been related to having a sexually acquired infection.

> *sure it's the one thing where you can't avoid talking about being gay with, like I remember thinking, oh I'll just say a girlfriend, but then I was like, what am I at, this is a doctor they'll just go through what they need to.*

Simon, 30, telecommunications and marketing worker

> *I knew what I needed, a test, and I knew that the sexual health clinics weren't going to be open for some time – I don't think there's much point hiding anything at that point, I was very up front about it as there was no point skirting around thing'*

Brendan, 45, university lecturer

It is clear in the quote from Brendan's interview above, that the preference for sexual healthcare is in a specific sexual health clinic, and this was echoed by many of the participants. The Irish Gay Men involved in this study all discussed sexual health as an integral part of their wellbeing (discussed in the next chapter) but also saw it as something separate from other areas of healthcare need.

> *I'd actually be very hesitant to talk about sexual health stuff with my GP to be honest, or really any other healthcare encounter I might have. I know when I go to the [sexual health] clinic, they know what I need straight away and it's more straight forward*

Geoffrey, 26, retail worker

I mean I wouldn't be going to the local doctor for my regular testing at all, or even if I thought there was something wrong sexually, I'd wait to go into the [sexual health] clinic. It's just never awkward, and you can be totally honest. There's no explaining.

David, 60, retired

As evidenced in David's quote above, there was a frustration for Irish Gay Men in having to explain and get into lengthy conversations with healthcare professionals about issues which they may not see as relevant. Below is another quote from Brendan's narrative on his GP visit, to discuss a possible sexually acquired infection. The following excerpt clearly exemplifies this frustration around irrelevance.

he just focussed so much on HIV, he demanded I have a HIV test, I kept explaining that I didn't, that that wasn't the issue, but he just kept focussing on HIV. Like it was such an awkward position having to explain the different risks. I wasn't refusing a HIV test, but I wanted a full sexual screen, the risks weren't HIV risks, but he just couldn't get it and kept talking about HIV. To be honest it was infuriating, I actually wish I just waited and went to the clinic the following week

Brendan, 45, university lecturer

For other participants, their conversations about their sexuality centred around other aspects of physical health, but in relation to anal sex in particular. Anal sex is a specific signifier of gay identity.

I, ah went to the doctor because I had, am, anal bleeding and I was a little bit worried, like it wasn't heavy or profuse or anything it was just a little like, noticeable and I was wondering if it was related to, to sexual activity. So I went to the Doctor just to kinda get the all clear and am I was ah trying to you know lead up to. I thought it was kind of obvious you know, hello doctor, I've got bleeding from my bottom and I am think its related to my sexual activity.

Noel, 21, medical student

Anal sex and anal health came up as a focus in other interviews also, and conversations around anal sex stemmed particular emotions and reactions.

As seen above, anal sex wasn't always seen as being understood or considered by healthcare professionals. William, 32, presented one encounter which made him feel awkward, but also excluded

> *So like they [oncologist] were going over my chemo, side effects, hair loss, blah blah. Then he said, you may have some loss of sex drive, but if you do have sex, it's important to use condoms as the medication can effect the unborn child, I laughed and said that won't be an issue. He just looked at me, with like a very serious face. So I flipped it on him, I said that I have a male partner, and asked are there risks with us having anal sex. I told him that we don't use condoms. Then he ignored the question kind of, and started talking about HIV, like we're a monogamous couple, there's no HIV risk, I wanted to know if my sperm was toxic or whatever [laugh]. I just felt very pushed aside.*
>
> William, 32, media worker

There was a clear tension within the experiences of Irish Gay Men discussing sexuality with healthcare professionals. The approach of only bringing up issues of sexuality when they saw it as relevant, led in situations, for the subject to be met with a displacement or a diminishment of these issues.

Some participants suggested that while their sexuality was not always relevant to the healthcare being provided, being open about their sexual identity from the start allows for a clear negotiation around its relevance

> *I mean, I think it's easier to have it out there. You know, then if I have any issues where it needs to be brought up, either by the doctor or nurse, or by me, it's not a shock, there's less awkwardness*

David, 60, retired.

I think them knowing [practice nurse], from like the form at the front, or maybe it was in a GP note, but like as I said I was there to get vaccines as I was going to Africa, but because she already knew I was gay she was able to talk about broader issues, as in like just being safe in general. Like real holistic health.

Patrick, 23, unemployed

Another aspect of healthcare provision where participants centred their sexuality as being relevant, was in the realm of mental health support. Ten of the participants referenced their mental health, and at points within their life needing some input from a healthcare professional. Often the need for mental healthcare wasn't necessarily because of their sexuality or related to it, but all participants who experienced mental healthcare suggested that it was important for the practitioner to know that they were gay.

like things weren't good for me, even in school I was being impacted, just really down and not being able to concentrate. So like I went to the GP, there was a campaign at the time about talking to GP about mental health. I think it was mostly just stuff laid over from my parents being dead and other stuff, but being gay didn't help I suppose, and I wasn't out. I just told her, and she was great, she said that she'd find me a good counsellor where I could talk about any issues I'm facing

Leo, 19, student

Well like what good use is a counsellor if you're just telling her bits and not giving the full picture. So once I knew she was going to help, I opened up

Frank, 26, PhD student

It was really as a result of the introspection that came from therapy that made me look I suppose at what I really wanted to, what lived experience I wanted to, to create as a Gay Man. How I was positioning myself as a Gay Man, what kind of life I wanted for myself and what kind of values, so really it was as a result of that process that that came out. I mean you can't do that unless you talk openly and honestly

Brendan, 45 university lecturer

As well as considering their own health and wellbeing needs, in making decisions about disclosing or discussing sexuality; participants, both those single and those in relationships, positioned having a partner as a clear rationale for being open about sexuality. William discusses below how important it was to have his partner included in his healthcare when he was being treated for cancer.

straight away it was something I had to get out of the way, like no way was anyone going to tell [names partner] that he had to sit outside, you hear these horror stories. I think it would hurt if someone said your friend, or your brother, I didn't want to even have to correct anyone so I always said loudly my boyfriend, when he was around, so that they'd know.

William, 32, media worker

I think if I had a partner then it would definitely come into it; definitely in healthcare your partner becomes part of what you go through, so I'd have to be open with them

Harry, 20, student nurse

well you see it in here (hospital) all of the time, like how important a husband or wife is in the experience of the someone who is sick. It would kill me having to pretend my partner was a friend, or a brother. I've seen that, here with gay patients. I'd flip if he was made to feel uncomfortable

Martin, 36, nurse

Subtheme two: Signs and Symbols – 'Straight Laces' and 'Rainbow stickers'

Even when Irish Gay Men consider their sexuality, and gay identity as relevant to discuss with healthcare professionals; their decisions around having these discussions are further impacted, by their perceptions and expectations of how disclosure will be received by the healthcare professionals, and how they will react. Throughout the interviews Irish Gay Men discussed the various signifiers, signs, and symbols, both in terms of material objects as well as a more subjective and abstract milieu, which tell them that discussions around sexuality are 'safe' to have. The concept of safety was important, and elaborated on by many of the participants

> *I mean you need to know that it's safe to come out, you can never really know but like you want to know that they're not going to judge you, or like treat you like a freak*

William, 32, media worker

> *there's something more than just professionalism, and boundaries and all of that. You need to know it's safe, like this can be really sensitive information, and yes they need to treat it confidentially obviously, but if they react negatively that can really scar you*

Brendan, 45, university lecturer

There were two broad approaches when it came to finding signs that coming out, and discussing sexuality would be safe, and appropriate; one in actively seeking signs and symbols and the other was in waiting for signifiers to be shown before any disclosure is made.

> *you find yourself looking around the room, like looking for a poster or something with two guys on it, or like a random rainbow sticker [laughs]. Like the rainbow could be about something completely different, like I don't know, peace or whatever, but if I see a rainbow in*

a doctor's office or whatever, I feel more at ease about telling them I'm gay, it gives you like a green light.

Simon, 30, telecommunications and marketing worker

For many participants, they come to healthcare encounters with a presumption that they may face some homonegative or homophobic treatment. Above, Simon very clearly, actively, seeks out some signs that this may not happen, as a 'green light' to discuss issues of sexuality; but in the following segment from Leo's interview, the default is to keep issues of sexuality quiet, unless as discussed in the previous chapter, it is deemed relevant.

like in a general sense I would expect that, like in a general healthcare setting, not in sexual health or whatever, that you wouldn't want to be opening up too much, I mean you might need to but if it's not important then you wouldn't say anything unless you happen to see stuff, maybe like a poster about LGBT things, or like I don't know, even just more broadly open documentation around. I think sometimes [laughs] it's about who is in the waiting room with you, like what is the patient make up. If you see lots of young people, or visibly LGBT people then you'll be like, oh god yeah, I can say whatever.

Leo, 19, student

As well as looking for affirmative signs, participants also communicated a vigilance for particular, vivid symbols representing that coming out may not be a safe thing to do. These symbols often related to religion.

it's mad like, in 2017, you still have the church so involved in healthcare here. You go into a hospital and it's saint this and saint that, and statues and the likes. I mean that's an instant turn off for me, no matter what you're told and what the people are like, I can't feel comfortable in a place like that

Geoffrey, 26, retail worker

well I mean if you're on a hospital ward and it's Sr Josepha or whatever coming around to admit you, you're not going to feel like you can tell her that you like it up the bum [laughs]

David, 60, retired

Age was something many participants commented on about the healthcare professionals attending to them, there was broad consensus that the older the professional, the less likely they were to discuss sexuality with them, this was particularly interesting given that many participants noted that their own views on sexuality had become more open and liberal with age.

I think I'm definitely more comfortable when it's a younger person seeing me. I'll just open up that little bit more.

Robert, 55, accountant

It's funny my favourite nurse at [sexual health service for Gay Men] is like a lovely middle-aged woman. I remember when I saw her first, I was mortified talking to her about sex, like this woman could be my mam, I just thought I couldn't, but with time you figure out that's rubbish, like she was a sexual health nurse, she's actually great and now I'm more comfortable with her than anyone else.

Patrick, 23, unemployed

Another signifier participants noted as marking a professional as being less likely to be accepting was ethnicity and global experience, there were two competing ideas here; professionals having experience abroad was an enabler, but being 'foreign' in some contexts an inhibiter

I remember being in with a nurse who was talking about her work in Australia, and London, and it just made me think, like that she'd be more, well like less shockable I think, like she wouldn't blink if you were talking about fisting or whatever [laughs]

Patrick, 23, unemployed

I mean this is definitely problematic, but I'll say it anyway, I've been more hesitant talking about sexuality if I presume the name of the doctor or whatever is Muslim or Eastern European. I just have that bias there – it could be totally false, but it would definitely make me think twice.

Noel, 21, medical student

I think sometimes with the foreign doctors you'd be a bit more careful with telling them you're gay. If you don't need to

Robert, 55, accountant

it's funny, when I was in the middle east, and everything is very taboo, but the doctors and nurses were from all over the world, and that worldly attitude, just having wider experience, like it made you feel more comfortable with them

David, 60, retired

The focus on physical attributes of the healthcare professionals themselves was something that many participants were observant of, and based decisions around coming out around. Below Terry talks about a consultation with a GP where he decided not to talk about being gay when asked, because the doctor was older, but also 'straight-laced'.

I knew when I went in, and it was him, that like I wasn't going to be comfortable talking about anything too personal. He had been my GP as a kid, like he's an older man, but it wasn't his age really, it was more, like he's a very straight-laced kind of fellow, you know suit and tie, matter of fact. He asked if I had a girlfriend, and rather than saying no I'm gay, I just said no. I was actually afraid to tell him I was gay.

Terry, 28, PhD student

While ‘straight-laced’ may refer to attire, it is often also used to describe more conservative views. In the section on Tactical Outing I will present how participants attempted to illicit professionals views on broader issues before coming out to them but David’s perception of newspaper reading below illuminates this equating of broad conservatism with decisions around coming out.

> *it’s just come to me as you asked there, one time we, like gay guys, would note what newspaper was on the doctor’s desk. You’d be a little more hesitant with an Irish Times reader than someone who had the Independent for example*

David, 60, retired

For some of the encounters described by participants, they got ‘mixed messages’ and their perceptions were challenged, this is encapsulated by Patrick’s initial perceptions around the sexual health nurse and her age. A further example of this comes from Brendan, when he describes attending a GP with symptoms of a sexually acquired infection. In the quote presented in the previous section Brendan notes his feelings of exclusion and not being listened to; later in his telling of this encounter he talks about a sort of mixed message

> *It was just very disappointing John, you go into the practice, and they have a [LGBT] switchboard poster, they have bloody leaflets about chlamydia in the waiting room, then you’re met with this totally inappropriate response*

Brendan, 45, university lecturer

Participants, while looking for signifiers of inclusion and safety, were aware that some of the signs they may see may be misleading, or superficial. This is seen with Simon’s rainbow sticker described earlier, he knew it wouldn’t necessarily mean inclusion, but there was still some comfort in it. Martin also talks about superficiality but again, visible signs still hold importance.

> *like we fly the rainbow flag here [hospital] for Pride, but like I know there are homophobic and transphobic staff. So it makes you question what’s the point. But I suppose then if you*

see it [homophobia/transphobia] you might be just more aware that you can make a complaint, like

Martin, 36, nurse

Subtheme three: Disrupting expectations

like you, play it out in your mind again and again, just planning what to say and how it'll go

Frank, 26 PhD student

Whatever the setting or encounter with healthcare professionals, it is clear that Irish Gay Men develop expectations, in advance, of how it will proceed, what will occur, or how they will or should engage discussions around sexuality. While invariably many expectations were met, participants discussed how some expectations were disrupted, or challenged, through their encounters. Within the interviews, there were also occurrences of Irish Gay Men discussing their own roles of disrupting the perceptions of the healthcare professionals they engage with.

The factors underpinning Irish Gay Men's expectations around discussions of sexuality with healthcare professionals were broadly aligned to previous experiences in healthcare, but also to societal views of healthcare professionals, as well as the men's experiences outside of healthcare, especially of homophobia.

there is a wariness around opening up, to whoever it is, like every Gay Man has experienced homophobia, in one way or another, so even when you don't really expect it, like from a professional or whatever, there's always the possibility, so you guard up to be ready for it

Geoffrey, 26, retail worker

Well it's a doctor, or a nurse, or whoever you're going to meet in a clinic or whatever. They are educated people, they are people that by in large, you should be able to trust, y'know

Leo, 19, student

The expectation of competence of healthcare professionals was discussed by many participants as a 'taken for granted'. There was a presumption made that healthcare professionals would act in a way which was knowledgeable and informed; and when this didn't happen it was seen to negatively impact the discussion.

you just expect them to know what they're doing. Like it really felt as if I was having to explain to him, all about HIV transmission risks, and why it wasn't an issue in this case. I found it really aggravating that in the end I just gave up. Surely it's basic information that any doctor should know

Brendan, 45, university lecturer

It was really bad, like that he just ignored my question. I think my back was up already because he presumed I was straight, but then when I actually engaged, he didn't know how to react. Like surely in medical school they are taught that there are gay people who get cancer, but instead of getting any information or feeling comfortable I was just ignored, it pissed me off a bit

William, 32, media worker

you just take it for granted, like that they'd have proper answers, and instead I was just left trying to explain myself and it made me become more and more awkward

Frank, 26, PhD student

While there were clear expectations related to healthcare professional competence communicated within the interviews; there were also expectations of judgement and cultural naivety. Brendan talks

in his interview about the levels of disclosure, and while he is open about being gay, other aspects of his sexuality are kept private. Noel further elaborates, on the expected lines and levels of openness Gay Men can present in healthcare contexts.

> *to be honest, for me, telling a doctor or nurse that I'm gay, is something I'm ok with now. They get that. In a sexual health clinic, I can talk about anal sex, oral sex, whatever. But I still don't talk about the BDSM, I still don't tell them I'm in an open relationship. I think it would just be so alien to them, I feel if I opened up, there'd just be an unsettled feeling created*
>
> Brendan, 45, university lecturer

> *I definitely think that there is more knowledge about gay issues now, and like, by in large, I'd be comfortable coming out to a healthcare professional. But I don't think I'd be telling them much more. I think there's a very limited view of what a Gay Man is, amongst healthcare professionals, well and most straight people.*
>
> Noel, 21, medical student

Many participants discussed frustration with experiences of being read as straight in healthcare contexts. They felt that healthcare professionals' 'default' was to presume that their patients were straight unless told otherwise, they discussed an awkwardness when this expectation was disrupted.

> *It's annoying that the default is that you're heterosexual, like there's no questioning unless you bring it up. So the emphasis is on you actually having to almost scream, I'm Gay.*
>
> Patrick, 23, unemployed

> *It can just cause a bit of embarrassment on everyone's part. Like, are you married, no. Do you have a girlfriend, no. Like they nearly go on to the next question and you have to make a point of saying, I'm Gay or I have a boyfriend. It doesn't seem like a big deal, but it just gets annoying, and then they do a whole embarrassed apology. Rather than like just ask do you have a partner, male or female.*

Martin, 36, nurse

Below, Noel discusses the awkwardness which ensued during his consultation about anal bleeding. He expected that a description of anal sex would be accepted as a signifier of gay identity, but discussed how having to actually challenge his doctor's assumption made things awkward.

> *But he assumed I was still in a heterosexual relationship but I don't know if he thought like my girlfriend was using a dildo or something on me but ah, so ah I had to explicitly say like I'm gay, you know, it was my partner am who is a man. Ammm so I had to say it to him then and it was kind of like very, oh it was really awkward and I'm not usually awkward about things, but just because he wasn't getting the message I was so awkward to come out and say I am gay; and then he was so flustered and apologising, and just didn't know what to do.*

Noel, 21, medical student

In several interviews, participants explicitly articulated a presumption that their healthcare professionals were going to be straight, the 'outing' of a healthcare professional was a disruptive activity in itself for these men.

> *when he [radiographer] mentioned his boyfriend, it just threw me, completely like. I was like – oh wow*

Frank, 26, PhD student

> *Like he [anaesthetist] was the one who was going to put me under, it was weird how I felt reassured, just because, at least I read him, as gay. It was also just him being nicer than some of the others, but me thinking or presuming he was gay changed my view. Like I wasn't expecting to have a gay doctor, as if all doctors are straight and as if it made a difference. But it kind of did for me*

Terry, 28, PhD student

Subtheme four: Tactical Outing

The disruption of expectations is not because of a haphazard, or ill thought out approach to coming out, or discussing sexuality; in fact, Irish Gay Men are planning these discussions in a variety of sometimes elaborate ways.

The tactics around coming out and opening up about sexuality used by Gay Men are linked to the need for safety in healthcare contexts; to protect themselves from judgement or avoid an awkwardness ensuing. One of the methods discussed by participants, was the positioning of questions and comments by them, that they viewed as adjacent to inclusive views about sexuality.

> *in the past like, I've tried to figure out how open they'd [GP] be by like by discussing things like homelessness or direct provision [asylum infrastructure in Ireland] or abortion. It's a big leap, but my presumption is that if they're open about those things, they'll be more open about me being gay*

Noel, 21, medical student

> *You can ask tangential questions, to them, I've done that. As I said, I wouldn't be very comfortable being in an open relationship, but if I'm in a sexual health clinic, I'll suss out whether the nurse would be open, maybe by talking about young people, and having a lot of partners, if she responds in a judgemental way, I wouldn't talk about being in an open relationship, or about any of the BDSM stuff*

Brendan, 45, university lecturer

Robert discusses below a depersonalising approach, taking himself out of the conversation topic. He is conscious of the stigma he wants to avoid, around his HIV status, and in order to do this, again he'll 'suss' out the healthcare professional's views and knowledge.

I could write a book about the ignorant things I've heard, even by people who should know better. So I'd be very cautious, I've talked about HIV in the abstract, how it's great the way things have come on, if they are aware, then I'll tell them I'm positive.

Robert, 55, accountant

A counter approach is presented by David, he talks about 'shocking' the healthcare professionals he comes into contact with, he discusses how being up front as an approach can disarm any discomfort.

Oh I just come straight out with it, out of the blue, shock them. I'm gay and I won't accept any homophobia from you. I have done it on the basis that FYI should it be ever relevant I would like you to know that this is important information for me, about me, that you may need to have in certain circumstances. It takes away the awkwardness.

David, 60, retired

Being open, as David discusses above, is a tactic, it isn't a taken for granted, it is done with planning and purpose.

So I'll just say it, get it out there, then nobody can do anything about it. It allows me to see if the person treating me is the kind of person I want treating me. If I get a negative response, then I'll change provider

Patrick, 23, unemployed

Material signs and symbols were also utilised by Irish Gay Men, in a similar way in which they seek these out in a healthcare context, some participants describe how they themselves display symbols as a tactic.

So you can see I like badges [laughs] – like when I'm in a consultation or whatever I'll make sure that I'll have my LGBT ones very visible. It's a quiet way of showing I'm gay myself, but also it's like a warning, like don't be homophobic to me

Geoffrey, 26, retail worker

I definitely think about, and plan how I'll dress, like whether to masc up, or like wear a big rainbow. It depends on if I want them to know. But it's a good way to know, like if you go in with a rainbow pin, or t-shirt and you get a dirty look, you know that it's probably not going to be a place that you can talk about your sexuality

Simon, 30, telecommunications and marketing worker

Those in relationships discussed how they would often use talking about their partners as a modus to coming out; this linked up very much to their feelings about being open as a route to inclusion of their partner or avoiding their exclusion.

I think a clear way into it is talking about my partner. Like I'll make a point to use the term partner, and if they say she or her, I'll correct them. It's kind of an easy way to come out in like a low key way.

Martin, 36, nurse

so everyone who interreacted with me from that stage on, it was me and my partner, ammm so that everyone who was there, when we were there, when he was there with me knew, and anyone who would have dealt with me on my own from that point on would see that I am gay, that I have a partner, who is a man

William, 32, media worker

While participants had various plans, and tactics about how they would come out, and discuss sexuality, by and large they had a preference for healthcare professionals to take the lead in these discussions.

I think if they [healthcare professionals] ask the questions, like in a non-judgemental, matter of fact way, like they'd ask anything else, that would make it easier. Like it's a little bit

embarrassing, because like that happens in sexual health, but you get over that, and it means that you've been given the go ahead to talk

Frank, 26, PhD student

I think the STI clinic is a great example, firstly because they know before you come in what your sexuality is, like you have to fill out a form. So that's that done already. And then like they just ask you all the things they need to know, they're always very nice, and un-judgemental, like you feel like they're unshockable, because they know you might be uncomfortable

Geoffrey, 26, retail worker

The written form was mentioned by several participants as a solution to embarrassment, as well as a way to open up.

I mean not everyone is as bold as me [laughs], but why the information can't just be recorded somewhere, where you don't have to actually bring up your sex life or whatever unless it is relevant, but it's all out there. You know, when you fill out a form to join a practice, that they just ask it, what's your sexuality, or a tick box or something.

David, 60, retired

I find it quite strange that they [GP] don't collect information on sexuality, on admission, or registration I mean. A simple form would make it easier, I mean there still can be an awkwardness if you had to talk about an STI or something, but at least there isn't a big coming out stress

Noel, 21, medical student

Through the recounting of experiences in healthcare contexts, and in discussing their sexuality with healthcare professionals, it becomes apparent that Irish Gay Men, through their very embodiment, but also through the ways in which they are presented, Queer these encounters. Irish Gay Men are conscious of the intersections of health and sexuality, but too, are aware that this doesn't mean appropriate approaches or person-centredness when they receive healthcare. They are thoughtful, and careful, when it comes to disclosing their gay identity; they too reflect on how their gay identity, is perceived, and impacts on healthcare encounters.

Superordinate theme three: Healthy living and risky business

Health consciousness is a common human phenomenon; many of us think about our health and the impacts ill health may bring from time to time. Throughout the interviews Irish Gay Men gave insight into their own views about their health, what it means to them to be healthy and how issues of health intersect with other aspects of their lives. In this chapter Irish Gay Men's experiences of, relationships with, and perceptions around health and ill health are presented under the following themes: (1) Actively Healthy (2) Outness and Wellness (3), Health as sexy; Sex as healthy (4) Risky business.

Subtheme one: Actively Healthy

Within the interviews Irish Gay Men were specifically asked about their views of health, and what it means for them to be healthy. Unanimously this question was answered with reference to some aspect of activity – being healthy for these men directly linked to being able to do.

Physical fitness emerged as an important aspect of health for the men in this study, with many referring to some aspect of physical activity as a signifier of wellbeing.

> *I think my health is pretty good at the minute, I go to the gym about 5 times a week if I can, I was actually there this morning that's why I was late (laughs).*
>
> Harry, 20, student nurse

> *I'm very healthy (laughs). Ammm I mean I'm an active guy, I like to think I'm fit enough, I go to the gym every morning at ya know 7am, I eat well, I generally avoid bad foods, ammmm y'know, I try to lead a healthy life as much as I can.*
>
> Simon, 30, telecommunications and marketing worker

I think health is very much linked to being able to get out and about, like I suppose I have a chronic illness but I think I'm in impeccable health. I don't go to the gym or anything but I get out for a walk most evenings, and I think it's a great thing to do. It's like a benchmark for me, if I can't walk or can't walk quite as far or whatever it tells me that there might be something up.

Robert, 55, accountant

As above, Robert was quite explicit in stating that having a chronic illness (HIV), does not impact on him being healthy. There was concurrence in this view amongst other participants who lived with chronic illnesses, countering a biomedical view of health.

Well like a doctor might think, oh you're unhealthy, like because I have high blood pressure, I'm let's say on the heavy side, but these things don't hold me back. Yes, I take a pill in the morning to bring my BP down but I'm healthy, I get on with what I need to get on with

Martin, 36, nurse

Well am, I suppose on a day to day basis, I'm healthy, I'm in good health. But I do have a chronic condition called Ulcerative Colitis, which I've had for almost 20 years so although it's under control, it's something that am would be there in the back of my mind. There are certain complications, ah coming with it but generally it doesn't affect my life, in terms of missing work or anything, but I do have a chronic condition so I'm on medication all the time. I'm on medication and I probably have more contact with health professionals because of that than perhaps the average person but I'm healthy.

Brendan, 45, university lecturer

This nuanced view of health stretched also to William, who is a cancer survivor. Below he discusses how, even in the acute phase of his illness and treatment his views around his health were dependent on his activity rather than the presence of cancer:

I've definitely changed how I think about health in the last couple of years; like having been very sick, puking, being so, so tired. It's like now, being able to be yourself to get out of the house and do whatever you want to do, I work as a writer as well whether that's write something, to watch TV to play video games being able to do those things that perhaps you're scared of losing out on, like that's health. I don't know, I was sick, I acknowledge that, but some days I was able to do more than others, and felt more healthy than others.

William, 32, media worker

Occupation and health were very clearly associated by participants, as above, with being able to do what it is that 'you do' was very important.

I've never had a sick day. I wouldn't, unless I was on my death bed. I work from home a lot so if I'm not 100% I might skip the office but I'd still think it's important to do a bit.

Robert, 55, accountant

Like we all have things we do, maybe sport or like work, or go to college or whatever. I think when this is impacted it's like then you know your health is effected

Luke, 19, student

'Getting out' and mobility in general were linked specifically linked to the concept of health by Irish Gay Men in the study.

I'm always on the move; whether it be going off for a hike, or jetting off somewhere for a week, a month, whatever. I think that would be something I'd worry about if my health failed

David, 60, retired

Whatever is going on, there's something about being able to get up and about. I think that you can be unwell, but there's something really bad if it starts your ability to function, like get up and about, leave the house, go and do what you need to do.

Frank, 26, PhD student

While within the previous chapters, Irish Gay Men discuss the importance of relationships with their friends, partners and the wider community; when discussing health, the concept of being independent and non-reliance on others emerged strongly.

> *I suppose it just means to be able to do everything for yourself, you don't need anyone to come over, roll you over, like you can get up out of the bed in the morning, get yourself a cup of coffee, make yourself a cup of coffee, you can go out of the house if you want, I suppose you can do whatever you want without having to rely on anyone.*

Harry, 20, student nurse

> *While it's not the same for everyone, for me, being able to carry out my daily tasks is paramount. Just not having to depend on someone for help all the time, I get that I'd probably still feel healthy if I became disabled and needed this assistance, but independence is important for me at this point in time.*

Patrick, 23, unemployed

There was a clear vigilance about health amongst the participants in this study; Irish Gay Men discussed the necessity of being educated about health and illness and discussed actively taking measures to check health status.

> *I would put health, consciously and actively top of my list, I come from a family and a genetic pool of people who died prematurely with one brother having a heart attack at 37 and one at 42, with a father who died young and a whole lot of first cousins who dies young. It sounds arrogant but my health is pristine, well to the extent that I take reasonable care, in that I do reasonable check-up'ing on my health, you need to know where you stand.*

David, 60, retired

There's something about being conscious of your health, so like I have typical Irish man syndrome [laughs] I don't like going to the doctor or whatever, but I make sure to keep myself aware of what's going on in my body. I get sexual health screening regularly, because that's an area that I know I might pick something up, and like because of that I like have read up on symptoms and stuff, but I know there isn't always symptoms.

Geoffrey, 26, retail worker

Subtheme two: Outness and wellness

When asked about health, Irish Gay Men initiated discussions around physical health in the first instance; however, all of the participants made reference to broader aspects of psychological and emotional health also. For many participants their psychological, and emotional wellness in particular, were linked to the concept of being out, and being comfortable with their sexuality. In this section the relatedness between outness and wellness is discussed.

In the previous chapters, coming out was discussed by Irish Gay Men as a significant process in their lives. For many coming out is not a single occurrence, but often an ongoing and repeated process; and while for some, the process itself can cause a level of anxiety and stress, 'being out' was discussed in a positive way, when compared to situations where participants were not out.

I can remember those situations, back when people wouldn't know and you'd be terrified that someone would say something. Like you could have sleepless nights, with the worry and anxiousness. Compared to now, I'm a different person really, just much more relaxed.

David, 60, retired

So how I felt, I suppose I was nervous, but I was also looking forward to getting it off my chest maybe, so it was definitely a relief but there was definitely apprehension because physically having to say I'm gay in front of someone wasn't something I was able to do, like

literally just never done it before. But then there's no pretending – like having to keep part of yourself secret can really do damage.

Luke, 19, student

You end up watching your words a lot, being very cautious, and that causes stress. Like in one way, being in the closet makes you feel depressed that you can't be yourself, but then there's also the pressure to come out, and the stress related to that. Then when you're out that pressure just isn't there.

Terry, 28, PhD student

Coming out in healthcare contexts was discussed in the previous chapter, but closetedness, and its negative impact on health and wellbeing emerged in the interview. While Irish Gay Men clearly articulated their decision-making processes around coming out, there were also views expressed that not being out led to a hesitancy to or delay in accessing healthcare.

like with the STI screening, I go to a gay male service, so although you're discussing intimate issues there, like they know I'm gay, there's no judgement. But say I had a sore throat, like I don't want to go to the GP and have to say like that I was giving blowjobs or whatever [laughs], even if I knew it wasn't sexual. I feel like I'd have to say I'm gay, then there's a presumption. So like I'll most likely just wait and hope it gets better.

Geoffrey, 26, retail worker

I mean I just wanted to ignore it and not have to go to the doctor, like it's the embarrassment of having, like anal bleeding, and then having to say oh it's probably because of sex, and then to say because I'm gay. Like there are so many layers of explanation.

Noel, 21, medical student

it's that thinking twice, or three times before you say something. Like you're thinking, if I say that, they'll know I'm gay, and then you're thinking, do they need to know I'm gay, do I need them to know I'm gay. I think like just it adds another level of having to explain things.

Frank, 26, PhD student

As mentioned above, Irish Gay Men's understanding of health is broad, and encompasses emotional, psychological as well as physical health

'So health in regards to both my mental and physical health, in terms of just generally being healthy, being well and fit; being in shape both mentally and physically and also being able to access healthcare, if in, if in the case of worries or anything like that.'

Patrick, 23, unemployed

There was a clear aspiration articulated by Irish Gay Men in the study for healthcare that is holistic; and there was an acknowledgement that in order to achieve this there was a necessity for healthcare professionals to know the sexuality of participants.

there is an onus on yourself, to be open, if you want the appropriate treatment.

Brendan, 45, university lecturer

it's just better to lay it all out there. There's no guarantee that it will lead to proper care, as I've said, like they don't always have the answers or know how to approach things, but if you don't tell them, like if they don't know you're gay, they'll probably presume you're straight, so you won't get the proper care, well in some aspects.

William, 32, media worker

While the linkages made by the participants in this study between being out and being well in many aspects were clear, there was also some complexity around this, acknowledging prejudices that exist in healthcare.

You need to be quite careful really in some aspects. No one should receive substandard healthcare, but say, if you are very open about your sexuality, and come across a homophobic doctor, like you're in their hands, so like I don't think it's wise just to barge in there with the info without thinking

Noel, 21, medical student

you do need a level of caution, in my experience. While it would be great if you could be open with everyone, not everyone reacts in an appropriate way, so you'd need to question would coming out do more harm than good, in certain ways.

Robert, 55, accountant

Subtheme three: Health as sexy; Sex as healthy

While not directly asked in many instances, all of the Irish Gay Men in this study spoke about sexual health as an aspect of their wellbeing. All participants recounted experiences within sexual health environments, and many discussed how sexual health was a central point of discussion within other more general healthcare services.

The central significance of sexual health for Irish Gay Men, was not only a point of reference for their engagement with healthcare professionals; but also held pre-eminence in their overall views of health and wellbeing.

like not being funny but sex is important for me, very important, so keeping myself as healthy as possible in that side of things is something I take very seriously

Geoffrey, 26, retail worker

like the main interaction I have is going to the sexual health clinic. Like I wouldn't bother with the flu jab, or ignore a pain or whatever but I make sure I do sexual health tests regularly, and like if I had anything wrong down there, I'd definitely go straight in.

Harry, 20, student nurse

Views of what sexual health means diverged amongst participants. Demonstrated below, some demonstrated a more biomedical view of sexual health which included vigilance, testing and absence of disease

It's so important to get tested regularly for me, I know a lot of these things are supposedly symptomless and I wouldn't want to have them, so I guess it's like other things, being free of illness, in a way. So I know most of these are symptomless but they can still cause you harm, so the absence of things that will cause you harm.

Terry, 28, PhD student

I suppose if you're sexually active it's just like STIs and craic like that, I don't know I think my sexual health is fine, I get checked up regularly and it's like always ok, I just make sure that I'm careful.

Harry, 20, student nurse

Others within the study took a broader view of sexual health, and while engagement with sexual health services and testing were important aspects, they acknowledged aspects broader than sexually acquired infections.

You go to get tested obviously but being comfortable and confident and physically healthy with y'know actually having sex, and yeah a good quality sex life, that's a very long winded answer [laughs]. Y'know it's not just the absence of disease per se I do think it's important to

be able to communicate openly about it and ah consent is a big part of it too, like how to talk to partners. There's so much.

Luke, 19, student

It's so individual, in terms of the needs you might have for sexual health. Like for me, I could say going to relationship counselling, it was kind of sexual health, as it was dealing with my relationship and issues of not having sex. When you start talking about sex then so much else might come out.

Brendan, 45, university lecturer

When you see people with cancer and the likes it hits home how much comes under sexual health, like yes, keeping free from STIs, using condoms, all that. But also things like libido, body image issues, things like that, it's important that healthcare workers are engaging with that, it makes a difference to people

Martin, 36, nurse

The issue of body image emerged in several interviews, the concept that looking well, was being well. The Irish Gay Men in this study often referred to the importance of their physical appearance to a concept of wellbeing.

I think that's one of the major issues why I go to the gym, it's not necessarily about how anybody sees me as, it's how I see myself. So that's the reason why I get up and why I'm dedicated to going to the gym, and I'm not the biggest guy in the world or anything but I do it because it helps me to feel better. Y'know health to me is really really important so that's the reason I get up in the morning because looking better makes me feel better.

Simon, 30, telecommunications and marketing worker

I'm definitely not your stereotypical gay Adonis you see at pride [laughs], but I do think a lot about how I look, and being a big hairy bear is important to me. It makes me feel good, like and to be in a community where this body look is appreciated is really important, makes you feel better y'know. I mean if anything happened and I lost my hair I'd be like a big bald baby [laughs].

Martin, 36, nurse

As I've gotten older, I'm actually so much more comfortable with my body and looks, even though they're probably objectively not as good [laughs]. I still take care of myself, I go to the gym, but I'm not as hard on myself. I'm not so superficial when it comes to looks, but when I feel like I look good, I definitely feel good and feel like it's a sign that I'm physically good, health wise.

Brendan, 45, university lecturer

The correlation between wellness and aesthetics was particularly evident in how participants discussed experiences of ill health; the concept of being healthy and being sexy was something which was illuminated through the illness narratives of the Irish Gay Men in this study.

I remember feeling lousy all the time when I was on treatment especially, I lost so much weight and just looked rotten. Like I looked sick. It didn't even matter that I, well my libido wasn't very high; but not feeling sexy, that really impacted on how I felt more broadly.

William, 32, media worker

The overlap between body image, sex, and illness is clearly demonstrated above by William's narrative of his experience of cancer treatment. Illness is not seen as sexy, and not feeling sexy has wider impacts on feelings of wellbeing.

Below, Robert discusses how his initial diagnosis of HIV impacted his view of himself, his body image and feelings around sex and sexuality

I wasn't sick or anything, as in I didn't feel sick, well in advance of the diagnosis. But when I was told I was positive, I felt disgusting. As in, I knew I wasn't going to die, we had gone past those days thank God, but I felt like just getting that call changed me from being a perfectly healthy, y'know fit man, to someone who was sick. I didn't look any different, but I looked at myself differently, do you get me? I thought I'd never have sex again, I'd be isolated, I'd have to think about it and talk about it all the time.

Robert, 55, accountant

As demonstrated in Robert's account above; Irish Gay Men are conscious of how health, and illness may be considered when it comes to attraction and the development of relationships. Below, participants discuss how considerations around current and future relationships came to light through their experience of illness.

I remember when we were talking then about what the options would be if it got worse. Like the doctor was very, matter of fact, discussed the levels of medication and then mentioned surgery and possibly needing a colostomy in future. I nearly died when he said that. It wasn't even the thought of the surgery, it was having a bag. My first thought was literally around sex, imagine having sex with a bag, who would want to have sex with someone who had a colostomy? Like this was before I was with my boyfriend, it really frightened the life out of me

Terry, 28, PhD student

I mean you don't want your partner to end up being your carer, like not at 30 anyway. Being sick is not sexy [laughs]. I'm lucky we've been together for a few years, so like it's more than just sex. You wouldn't want to be starting a relationship at the same time of having cancer.

William, 32, media worker

I mean I think it's something you think about when looking for a partner y'know, not just like do they look fit or anything, but like are they in good health, do they look after themselves

Simon, 30, telecommunications and marketing worker

The overlaps between sex and wellbeing were not confined to how illness and perceptions of illness impact sex and sexuality; the Irish Gay Men in this study discussed how the physical act of having sex was seen as good for them.

There are lots of reasons why sex is important to me, like building connections and stuff but I definitely see it as something that is good for me, physically and mentally. I feel better when I'm having sex, but also it helps me get over stress, to relax and just overall.

Geoffrey, 26, retail

It's a whole picture. Like there's obviously physiological basis for the pleasure you feel but for me it's also the chase, then how it makes you feel desired, you get a buzz and it makes you feel better, better in yourself and better about yourself

Patrick, 23, unemployed

They say everything in moderation, I'm not sure it's that way with sex [laughs]. But yes absolutely there are positives and negatives in sex and having sex with multiple partners. But the BDSM scene has taught me that feeling comfortable in yourself and being able to get that pleasure with others, it just boosts you. As long as you know what you're doing and you're aware of the risks, it's good for you overall.

Brendan, 45, university lecturer

Subtheme four: Risky business

Throughout the interviews, many participants made reference to the concept of risk and how it was conceived, navigated and how it impacted their lives as Irish Gay Men. There was a clear awareness of risks associated with being gay – as evidenced through decisions around coming out, Irish Gay Men contemplated the possible negative consequences of disclosing their sexuality within different groups and through different relationships.

> *I have a gay brother, so it's not like I thought that my parents would disown me or anything, but I just felt that there was that chance of like disappointing them. So like a danger that by coming out, I'd be the disappointment of the family, as if we went over a quota or something [laugh]*
>
> Geoffrey, 26, retail worker

> *like lots of my friends are, lads' lads, pure into sport and boy racers. So it was really taking a chance, at least I felt it was. There was that worry that coming out would leave me isolated, in school and stuff without friends.*
>
> Luke, 19, student

> *I just don't want it to be a thing with work. There's always that possibility, because there are lots of homophobic people still out there, that it would impact my work, if people knew, that they wouldn't hire me. It seems bizarre because my sexuality has nothing to do with my job, and my job is very desk based, but I am mindful not to make it obvious that I'm gay.*
>
> Robert, 55, accountant

> *I was told up front, in no uncertain terms, as a Gay Man, I would never progress in my career in teaching*
>
> David, 60, retired

Aside from the impact on personal and professional relationships – the Irish Gay Men in this study pointed to the danger homophobia poses to them, in a more visceral and physical way.

> *I've often been called a faggot, someone roars it out a car window or whatever when I'm walking with my boyfriend. Like I've never been gay bashed but I'm hyper aware that it's a possibility and those experiences really shake me*
>
> Terry, 28, PhD student

> *I'd be conscious of how I'm dressing, or what I'm saying, like how I sound, in certain environments. Like I avoid places where I feel unsafe as best I can, but sometimes you're finding yourself to be in places where, honestly, you worry you'll get a thump or whatever if someone perceives you as being gay and you have to think about how you hold yourself*
>
> Patrick, 23, unemployed

> *I think it's just being sensible about where you go and who you encounter. Things are definitely a lot better now, I'd feel fine holding my boyfriend's hand in the city centre, but in other parts like you'd know you'd be taking a risk of ending up hospital doing it.*
>
> William, 32, media worker

While these outward risks were evidently something Irish Gay Men are aware of and contemplate in their presentation and decisions around coming out – a more direct link between risk and health was discussed through the frame of sexual health and sexually acquired infections. The Irish Gay Men in this study all discussed a vigilance around their sexual health and the possibility of acquiring a sexual infection; but they elaborated on this in different ways. For some there was a clear acceptance that having sex may lead to the acquisition of a sexual infection and an acknowledgement that responsibility lied with them as individuals around protecting their sexual health.

You absolutely have to be on point with your sexual health, you can't rely on others. Like there's no way to completely avoid the risk of getting an STI or HIV but you can take steps yourself to make sure you limit the risks

Geoffrey, 26, retail

there are always going to be risks when it comes to sex, any kind of sex, some kinds of sex carry more risk than others; it's so important that you take responsibility yourself, to know what you're getting yourself in for, so to speak, and to know the risks associated with whatever activity you're engaging in.

Brendan, 45, university lecturer

This perspective was somewhat contrasted by other participants, who, although acknowledging the risks associated with sex, and the need to be vigilant; very much focussed on the risk that others bring.

you absolutely don't know where someone has been when you're deciding to have sex with them – I think of it like, if I have sex with him, I am also having sex with everyone he has had sex with, and sure any of them could have picked up something and then could pass it on to me, through someone else

David, 60, retired

not everyone is so good with getting tested and stuff. So like even if you're on PrEP or use condoms for some things, like they could give you other things. It's why testing is important as well, because you don't know what could be passed on to you.

Harry, 20, student nurse

we all have our wilder days when we're younger, and y'know not a clued up, but I don't know, some guys just keep going at it. Going to parties, chemsex, barebacking like well into

their 20s and 30s. Like you might think, oh he's sensible and has a good job, but he could give you anything

Simon, 30, telecommunications and marketing worker

Many of the Irish Gay Men in this study expressed a concern with others' behaviour as having a negative impact overall on attitudes to Gay Men in Ireland – there was a discomfort conveyed around how risk and identity were conflated for Gay Men, and how because of the behaviours of others they were in turn stigmatised with a label of riskiness.

As I said, I'm in pristine health and do my best to ensure that I always am. But it's funny how you get lumped in with others, oh he's gay, so he might have HIV, or he's promiscuous and all that. But I'm not. Some are, but not me. So it does get a little frustrating to still have to battle that label

David, 60, retired

It's that catch 22 isn't it, because I'm a Gay Man I'm more likely, well like statistically, to have HIV, or addictions or be promiscuous. So like when I say I'm gay in a medical context I'm more likely to be offered a HIV test before they ascertain that I'm in a monogamous relationship and don't drink or whatever. Like it's important that people do need services and a focus because it is a problem for some, but that same research then prevents me from donating blood, even though I have zero risk of having HIV.

Noel, 21, medical student

I mean yes, there are issues around HIV and STIs or around things like Chemsex and mental health problems, and they are real issues for the Gay community, but that's what gets focus. And it should, I mean, but then for those of us who are gay, but aren't a risk are still labelled as such, so then you have things like the gay blood ban.

Patrick, 23, unemployed

The way in which Irish Gay Men view and experience health and wellness were illuminated through their descriptions. They demonstrate a clear focus on activity and occupational aspects of health and through their definitions and descriptions show some anxiety about disability and loss of ability. There are clear and demonstratable links between sexuality and wellness, in how Irish Gay Men discuss the impact of coming out and being out on issues of health, as well as the more explicit and apparent views on sexual health. Sex for Irish Gay Men is shown as having significance in terms of wellbeing, especially as regards to how sex and feeling sexy boosts their self-image. Along with these views and experiences of health, there is an ongoing perplexity with the risks associated with being, and doing, gay. Vigilance around risk is an ongoing experience for the Irish Gay Men in this study and their concerns and perceptions of risk are complex and intriguing. While for many groups, health presents a focus and shared experience and concern; for Irish Gay Men there are significances in the overlap with their sexuality.

Conclusion

The experiences of the Irish Gay Men in Queer Expressions, and how they make sense of those experiences provide a rich and textured account of Irish Gay Identity, and its sociocultural specificity. The identities presented contain both a being and a doing, Irish Gay Men become Gay through internal thought and external action, their Gay identity is tied up with a national and social identity and is presented in a diversity of different ways. When encountering healthcare practitioners, Irish Gay Men consciously position their sexuality and sexual identity; in Queer Expressions the Irish Gay Men give explicit accounts of how and why they make decisions around disclosing their sexual identity, and how discussions of sexuality play out in healthcare encounters. Throughout the interviews various ways of conceptualising health and healthiness were presented by participants; for the Irish Gay Men in Queer Expressions the concept of health was tied up with activity, and physical ability. Health is important to these men, and not only impacts on how they view themselves, but also how they negotiate relationships with others and perceive issues of risk and conscience.

In the following chapter, the findings illustrated above are considered in light of broader literature on Gay Men, Gay Male identity and experiences of health and healthcare.

Discussion

Below, the specific experiences of Irish Gay Men illuminated in the Findings chapter, are examined through varying theoretical lenses and considered in light of other empirical evidence. Irish Gay identity is placed alongside psychological perspectives on Gay identity development, social identity; as well as observed through Ahmed's (2006) Queer Phenomenology. The ways in which Irish Gay Men experience healthcare encounters are considered in terms of how they perceive issues of safety and appropriateness in healthcare delivery; and also in how they make decisions around whether or not, and how to discuss issues of sexuality. Concepts of health and healthiness are discussed under the frame of compulsory able-bodiedness, and Irish Gay Men's views of health and health issues as they relate to aesthetics and risk are explored. How concepts of health and sexuality intersect in terms of how the Irish Gay Men in Queer Expressions relate to others, in the 'good gay' 'bad gay' dichotomy are further exposed. The chapter then goes on to consider the original contribution Queer Expressions makes to literature on Irish Gay Men's Health, while acknowledging the limitations of this research; and signposts how the original research questions have been answered. Implications for practice, education and research are then put forward as well as areas for future consideration.

Exploring Irish Gay Men's identity - Being and/or Doing Gay

As demonstrated in the Gindings chapter, there is diversity in the ways in which Irish Gay Men describe their gayness. The being and doing of Gay, for Irish Gay Men may firstly be mapped onto Jaspal's (2019) differentiation between sexual orientation, and sexual identity.

The 'doing' of gay for Irish Gay Men centres primarily on sexual acts, and desires to be with other men; this correlates very much with Jaspal's (2019) concept of sexual orientation; while sexual acts were an important factor of the 'doing' of gay for participants, they were clear in articulating the attraction to men was broader than just about sexual acts. For Jaspal, emotional attraction to other

men was a more telling factor around sexual orientation than sexual acts, the phenomenon of men who have sex with men (MSM), who do not identify as gay, nor see themselves as attracted to other men are of particular interest in Jaspal's exploration of sexual orientation. We know that historically, men who had sex with men did not identify as gay, that Gay, as an identity category is historically and culturally specific, so doing gay, is inherently broader than sexual acts. The untwining of sexual acts from sexual orientation or identity is something which is apparent in much public health discourse, discussing the health needs of men who have sex with men. Young and Meyer (2005) however provide an important critique of the overuse of MSM as a behavioural category in public health discourse, as it negates acknowledgement of the broader social dimensions of sexual orientation, diversity in gay sexual practices, and in some ways advances heterosexist views of sexual orientation.

Where to be and do Gay

For the Irish Gay Men in this study, doing gay, had further links to spaces and places, as well as connections with others, which will be discussed in more detail in subsequent sections.

The psychological and emotional 'being' gay might be more related then, to a concept of Gay sexual identity, although within this research the divisions are not as clear as Jaspal (2019) suggests. For Irish Gay Men in Queer Expressions sexual identity was more explicitly important to some rather than others, however the concept of sexual identity allows that fluidity of importance. The Irish Gay Men interviewed in Queer Expressions were reflective in their expression of what being gay meant to them and noted the contextual nature of how important being gay was –

> *sometimes it's everything, sometimes it's nothing at all. I think it depends on the person but also on what's going on*
>
> Harry, 19, Student Nurse.

The subjectivity of sexual identity is something which is apparent through the expressions of the Irish Gay Men in this research – for some, they neatly compartmentalise their sexuality as just a part of their identity, but for others they expressed a more holistic embodiment, with their sexuality and Gay identity. Jaspal (2019) considers sexual identity as a compartment, 'separate from other compartments' (p.40), but as one which interacts with other compartments determined through social contexts.

The de-coupling of Gay identity from homosexual sexual acts seems to perform two roles in establishing an understanding of what a gay sexual identity is; on one hand, it allows for a more holistic view of sexuality, acknowledging the psychological, emotional and social aspects of gay identity. Reducing gay identity to sexual attraction, and physical sexual activity, in some ways might be seen to reinforce heterosexist perceptions of gay being lesser and to delegitimise gay relationships. However, on another hand, sex is important. All of the Irish Gay Men in Queer Expressions discussed (although for some, uncomfortably) the role sexual acts with other men have in establishing a gay identity. A move away from the sexual acts in sexual identity could be seen as a homonormative tangent, an agenda in sanitizing Queer identities, in depoliticising and privatising/hiding the specificities of LGBT identities (Stewart, 2020).

The dichotomy of identity vs orientation is somewhat surpassed in Ahmed's (2006) Queer Phenomenology – here the concept of sexual orientation is reframed, a spatial understanding of sexuality, embodied and expressed through the things we orientate ourselves towards, or away from, through our position and place. Ahmed discussed the discomfort in the family home for many Queer people, normative familial situations such as the dinner table can be a very uncomfortable place for LGBT people. There is a 'two-fold directedness' for Queer people explored by Ahmed (2006, p.28) – the first is what we are directed towards, how familial and societal pressures direct us towards what is heterosexual and heteronormative; the second directedness is how we then in turn direct ourselves towards or away from that which we are directed to. The concept of 'home' was a

strong one for the participants in Queer Expressions, with varying relationships towards it. Home directed the Irish Gay Men to a compulsory heterosexuality; home was a place where potentiality of being Gay was not obvious. The Irish Gay Men in Queer Expressions referred to the leaving of home as an important stage in the development of their Gay identity; for some their gay life was very clearly delineated away from their home life, for others these divisions of their gay self were opposed to a professional self; the possibility of being gay at home, or being gay at work, were not congruent for these men. Not being straight was put forward for many of the participants as what made them Gay, Gay as opposition. Heterosexuality was presumed as a default; the participants in Queer Expressions then directed themselves away from this, although compartmentalising their sexuality when it came to some contexts, such as being home, or being at work.

While this directional approach to gay identity may read as an innocuous occurrence, Ahmed (2006) is conscious of how heteronormative dominance in the positionality of Queer identities can have significant negative consequences. Internalised homophobia has an established negative impact on Gay Men (Jaspal, 2018) – Ahmed considers this an outcome of forced directedness – heteronormative directedness of queer people, continually being orientated towards the heterosexual leading to what she terms repetitive strain injury.

Some of the Irish Gay Men in Queer Expressions reflected on their gayness as a limiting factor for their lives, issues such as marriage and parenthood were contested in their acceptance of their gayness. Throughout the interviews participants provided several narratives of choice, being gay not being a choice; and while biological, genetic and hormonal theories around sexual identity are widely contested (Jaspal, 2019), there seems to be a need for the men in this study to articulate that this is how they were born, and they had no choice. There's an implicit and internalised homophobia within these arguments however; the 'born this way' argument, goes to embedding a heterosexist perspective on sexual minority identity – it is important for us to stress that we have not chosen our

sexual identity because we implicitly consider homosexuality as a lesser choice (Diamond and Rosky, 2016).

This internalised homophobia or repetitive strain injury (Ahmed, 2006) can be correlated in many ways to the negative social representations around homosexuality permeating multiple sections of society (Jaspal, 2019). All of the participants in Queer Expressions grew up in Ireland, and for many, the intersections of their national identity as Irish and sexual identity of being gay was somewhat straining. Ireland was discussed by all participants in terms of change – Ireland was seen as a place in flux – moving towards a more accepting and inclusive place to be gay, but with a history of persecution, and exclusion. The confliction between Irish identity and Gay identity is a complex one in current times; while Ireland is often lauded as a progressive country for LGBT rights, for many of the participants in Queer Expressions, their Ireland was one of deep exclusion; the collective social stigma around homosexuality in Ireland, although largely changed, remains a factor in gay male identity (Rodgers, 2018). In Queer Expressions – the older participants in particular discussed what it meant to be Gay in Ireland prior to decriminalisation of homosexuality – for many there were two options, emigrate or live a closeted life. While the impact of sexuality on migration choices is to the fore in these discussions – because of the impossibility of being gay and being Irish, one less explored phenomenon is what migration did for Irish Gay identity – the diaspora providing a narrative of Gay Irishness (Luibhéid, 2013); in Queer Expressions those who had emigrated provided a narrative of emigration as empowering.

The potentiality of Gay identity is very much dependent for Jaspal (2019) on the actual possibility of Gay identity – in contexts and cultures where being Gay is hidden, illegal or seen as not culturally congruent, same sex attraction or arousal is often detached from identity, or even orientation. Because there is no possibility of being gay in these contexts, these phenomena are understood differently – and often gay sexual identity is rejected (Jaspal and Cinerella, 2010). While very much a different context to those explored in Asian and Middle Eastern countries and communities

(Maatouk and Jaspal, 2020; Jaspal and Cinerella, 2010), Irish Gay Men also understand and express their identity through a lens of previous impossibility. As explored through Diarmuid Ferriter's (2009) *Occasions of Sin* – the possibility of being Gay in Ireland is historically complicated by the dominant narrative of there being no sex in Ireland – the national discomfort around issues of sex and sexuality. That discomfort with sex and sexuality in Ireland was noted throughout the interviews for this research, and particularly prevalent in the discussions with older participants. Like Asian and Middle Eastern contexts discussed in Maatouk and Jaspal (2020) and Jaspal and Cinerella, (2010), Ferriter (2009) explores how religion, particularly Roman Catholicism plays a central role in the cultural identity of Irish people; the Gay Men in Queer Expressions make numerous references to the role of the church in Irish society and discomfort around this. Ryan (2003) considers how Irish Gay Male identity in the 1970s was both explored, confused and ultimately formed in three broad areas, the family, Christian Brothers schools and the Gaelic playing fields. While sport was only discussed by two of the Queer Expressions participants, family experiences were central as well as the integration of religion into state institutions, like schools and healthcare settings.

A common phenomenon in research into LGBT lives is a more urban dwelling for LGBT people, this is also the case in Ireland (Higgins et al., 2016). Many of the Irish Gay Men in Queer Expressions discussed how small and colloquial Ireland is, and while some reflected on how it can lead to an enhanced experience of rooting, and solidarity, most participants pointed to an ease around living in a larger place. The participants in Queer expressions discussed the freedoms associated with living in urban areas, how both anonymity allowed for exploration of sexuality free from judgement; but also how larger population centres offers the possibility to engage more in queer spaces and communities.

Being part of a wider LGBT community was an important aspect of identity expressed by most of the participants in Queer Expressions – describing how their positionality within a wider community provided a context and broader understanding of their own identity. Shared experiences of

oppression and struggle were identified as important markers, which also provided Irish Gay Men with introspection on their own privilege; recognising the diversity within the LGBT community, community engagement allowed for an exploration and understanding of wider social structures. The social categorisation (Jaspal, 2019) conveyed in Queer Expressions is multifaceted – the Irish Gay Men in this study have clearly distinguished themselves as Irish Gay Men; they recognise and differentiate themselves as Gay but for most also as LGBT; as Irish but also as Gay and part of a global gay community. While the approach to collective LGBT identity is becoming more prevalent, and allows for an 'us and them' rather than 'us vs them' social identity boundary, and increased focus on commonalities – there is a risk of losing some of the specificities around the needs of distinct groups within this community and of generalising distinct experiences (Ghaziani, 2011). Indeed, the rather homogenous group represented in the Irish Gay Men in Queer Expressions broadly aligned across gender, racial, socio-economic and educational demographics and so despite clear alignment with LGBT identity do not embody the diverse and intersectional groups which make up this community.

The social comparison (Jaspal, 2019) offered by the participants in Queer Expressions, was of a positive view of Gay Men in terms of being more sexually liberal, fun and outgoing. Participants discussed how their relationships with other Gay Men allowed for more open communication, and trust, a sense of safety. They discussed how there are things they would not feel comfortable discussing with straight friends and family, and some expressed a desire to make more gay friends. However as Jaspal (2019) discussed, there can also be more negative comparisons, the phenomenon of 'good gays' and 'bad gays' (p.45). Some of the negative views participants of Queer Expressions referred to stemmed from traditional stereotyping of the effeminate Gay Man. There was a discomfort espoused by some participants with effeminacy and a directedness away from this 'type' of Gay Man. Participants' further expressed discomfort with representations of Gay Men as being promiscuous – these stereotypes, although rejected by participants, did impact on their views of other Gay Men.

The spaces in which Gay Men socialise, the gay scene, is seen a key factor in identity formation for Irish Gay Men in Queer Experiences. Acknowledging the limitations of some gay spaces in terms of propagating negative stereotypes, for the participants in this research the scene was posited as a place to learn how to be gay. Ghaziani (2014) contends that the important role that gay venues have played in maintaining cultural histories is undoubtedly changing, however challenges that this is a sign of cultural decline. Some of the participants on Queer Expressions discussed the role that online sociability plays in further sexual identity development, and network forming. They note the importance of online connections particularly for younger or rurally situated Gay Men. Jaspal (2017) explores Grindr (a location aware application used by gay and bi men) use and considers the potentiality of network building and support available, but also is conscious of how over-use can lead to identity threats, challenging social and psychological wellbeing.

Being Gay, was presented by the Irish Gay Men in Queer Expressions as an important linking factor, in building connections with other Gay Men. While as discussed above, for some there was a compartmentalisation of their sexual identity as separate to their professional identity, others discussed how shared sexual identity was a focal point for building a stronger connection with gay male colleagues. While these connections were presented in Queer Expressions as an enriching and empowering experience, Rumens (2010) discusses how these connections can sometimes further embed heterosexist divisions of gender and sexuality, and fail to embrace a more complex understanding of how gender and sexuality impact on workplace friendships. Regardless of where the connections with other Gay Men are made, the participants of Queer Expressions positioned other Gay Men as a very important constituent of their own sexual identity.

Other Gay Men, whether personally known by the participants in Queer Expressions or not were very important in identity formation for these Irish Gay Men; this was articulated not only in terms of social categorisation in group identity as discussed above, but seeing other Irish Gay Men as role-models or teachers. The lack of visibility of Gay Men in the media and public life is something

participants discussed as a challenge for them growing up, Gay Men presented as negative stereotypes also compounded internalised homophobia. There was a desire for Gay Men to be represented, but discomfort with some types of portrayal. Having diverse portrayals of Gay Men has potential to provide two forms of identification; similarity whereby Irish Gay Men may see people 'like them' justifying their identity, and also wishful identification, facilitating aspirations towards success (Feilitzen and Linne, 1975). Both of these forms of identification were discussed by participants in Queer Expressions as being beneficial to positive Gay identity affirmation. As well as the ability to learn about Gay culture and history through having discussions about sexuality there was furthermore a desire expressed to 'usualise' (Schoolsout, 2020) Gay identities, to represent Gay Men in a more every day and mundane way, representing Gay Men not only as members of the LGBT community but also of other communities and society more broadly. In turn, participants reflected on their own place as role models for others, as well as how their identity is formed and experienced, the Irish Gay Men in this study discussed a consciousness of how their identity might be perceived by others. There was a consciousness of how individual action and behaviour may be perceived as a representation of the Gay or LGBT communities by straight family, friends and society. Being a 'good gay' (Patrick, 23, unemployed community worker) was very much intertwined with wider homonormative and masculine ideals of Gay Maleness. These set out ideals of gay masculinity can directly impact self-image, as well as relationships with others (Sánchez et al. 2009).

Although broadly discredited, the stage models of gay identity formation have some congruence with the identity narratives and journeys presented by the Irish Gay Men in Queer Expressions. Cass' (1979) six stage model asserts that before there is any congruence and acceptance of Gay identity a stage of confusion precedes, an acceptance of being different, but not understanding why. This was expressed by many of the participants in Queer Expressions; for many, that knowing of difference was an uncomfortable experience. Irish Gay Men in the study recounted how they wanted to fit in as younger boys and men, the identity confusion may be a more pronounced stage in contexts such as Ireland in the 70s, 80s and 90s, where homosexuality was not discussed, and so potentiality of that

identity was absent and compulsory heterosexuality profound. The discovery of other Gay Men and the LGBT community is expressed as an important factor in identity formation by the Irish Gay Men in Queer Expressions as discussed above, but again, in a context of criminalisation and deep societal stigma for some of the participants, these early connections were fraught with hiddenness. While Cass' (1979) model clearly identifies other homosexuals as being an important part of identity acceptance, it fails to explore how negative stereotypes and internalised homophobia can actually cause a rejection of other Gay Men as expressed by some of the participants in Queer Expressions. For Cass (1979) identity tolerance is an important stage of Gay identity development, for Jaspal (2019) this stage might be a direct response to the identity threats experienced in the former stages, such as homophobia and heteronormativity. The tolerance stage is described by others as exploration (Coleman, 1982) or signification (Troiden, 1989) – a period of experimentation and engagement with Gay social identity and opportunities. This tolerance stage, Jaspal (2019) suggests, has more of a interpersonal focus, for Irish Gay Men in Queer Expressions this stage would appear to be prolonged; when discussing their comfort with being Gay and their acceptance, many were hesitant in saying they were completely comfortable with their sexuality. While the Irish Gay Men in Queer Expressions were confident in their identification with Gay sexual identity, there was an acceptance by all that sexuality is constantly evolving for them, so the concept of synthesis or commitment, although apparent, is experienced in this context.

Many of the participants in Queer Expressions were keen to discuss broader aspects of their sexual identity than 'just' being gay; being a bear, being a gaymer, being into BDSM. Depictions in research of Gay Men are often homogenous and the specificities around Gay subcultures are often not explored. Within Queer Expressions the experiences of those who shared subculture identities; whether related to body type, sexual practices or other interests were important for the men to discuss. In their research on Gay health disparities, Lyons and Hosking (2014) identified 44% of Gay Men identified as being part of a Gay subculture. While there is no similar research in Ireland, the experiences shared by participants in Queer Expressions suggest that there is merit in exploring

these subcultures in a more direct way. Within Queer Expressions discussions around subculture identity were presented in a positive way, leading to deeper connections with others and an enhanced sense of inclusion; though there are wider health considerations which may need to be explored further (Prestage et al., 2015). The Irish Gay Men in Queer Expressions did however discuss enhanced stigma and ignorance related to Gay subcultures and a hesitancy to discuss this with people from outside of these communities.

Coming out

All of the participants of Queer Expressions discussed their experiences of coming out in various contexts throughout the interviews. As discussed earlier in the thesis, coming out is an extremely important process for Gay Men in the development, experience and expression of their sexual identity. While coming out is often considered to be the external disclosure of sexual identity, participants in Queer Expressions were reflective in their accounts of coming out to themselves initially. All of the participants referred to being different in teenage years, and as explored in the stage models of gay identity discussed earlier (Cass, 1979; Coleman, 1982) self-realisation of what this meant was important to how they conveyed it to others. For many of the Irish Gay Men in Queer Expressions, coming out was expressed as both an extremely stressful experience, but too as a liberating one. Coming out in the family, especially to parents was a particularly stressful experience for participants in Queer Expressions, indeed some of the participants had never discussed their sexual identity with parents. Hesitancy around coming out to parents is often framed as a response to perceptions of conservatism, religiosity, gender and age (Baiocco et al., 2015); indeed, these broad considerations were expressed by participants in Queer Expressions too. There was a sense of relief and surprise when religious parents reacted in a positive way (David, Geoffrey, Frank) and disappointment and frustration when parents perceived to be more liberal and open reacted negatively (Brendan, Simon). Those who did not come out to parents expressed regret around this, and a feeling that it meant their parent(s) 'never really got to know me properly' (Terry, 28, PhD

Student). The role of siblings as conduits for Irish Gay Men to come out to parents was a common experience expressed in Queer Expressions; many of the men used the experience of coming out to siblings as a 'litmus test' (Geoffrey, 26, retail worker) for parental reaction. The role siblings play in connectedness to family for lesbian and gay people is multifaceted, they often play this role of being the first in the family to be told of a sibling's gay identity; and in circumstances where there is a negative reaction from parents some provide a link to the family from which the gay sibling has experienced rejection (Jenkins, 2005). While not every Gay Man has a positive experience of coming out within the family, family support has been established as an important factor in Gay identity development and indeed positive identity establishment is often mediated by family acceptance (Elizur and Ziv, 2001).

Irish Gay Men in Queer Expressions were clear in their view that coming out is not a singular experience, there are many contexts and environments whereby it is necessary to come out again and again. As discussed by Orne (2011) coming out is as much about identity management, as it is in identity formation. Irish Gay Men choose to whom and why to come out in an ongoing way. Strategic outedness (Orne, 2011) is something which is expressed throughout the interviews in Queer Expressions; while there was a desire to be out to those with whom the Irish Gay Men were interested in developing strong relationships with, some decided not to disclose their sexual identity to casual or professional contacts. Indeed, coming out was also a 'test' (Simon, 30, telecommunications and marketing worker), whereby immediate disclosure of sexual identity was made, and the reaction of the other person was taken as a sign whether to deepen relationship with them or not.

For many of the Irish Gay Men in Queer Expressions, the development of romantic relationships were important points in the development of their sexual identity. When discussing being Gay, participants referred to current and former partners a lot. They discussed their coupledom as a key expression of their sexuality; those who are in relationships used 'us' and 'we' a lot when asked

about their own experiences. Those who were not in relationships oriented themselves towards the possibility and desire to be in a relationship. Intimate relationships play a central role in many of the psychological models of Gay identity (Cass, 1979; Coleman, 1982; Lipkin, 1999) however there is also a counter narrative around how this overwhelming desire for monogamous Gay relationships is a response to homonormative ideals of good citizenship (Stewart, 2020). A fight for Gay relationships to be recognised and respected concurrently delegitimising experiences of Gayness not grounded in a desire for monogamy.

Politicising Gay identity

A key element of the doing of Gay for many participants in Queer Expressions was centred around their activity and activism during the 2015 Marriage Equality referendum. Irish Gay Men in this research focussed on the campaign for marriage equality as a unifying and activating issue for them. Many reflected on how this campaign politicised their sexual identity in a way which they hadn't experienced before; while their outness was considered in terms of direct networks prior to the campaign, participants felt a sense of duty to campaign for marriage equality, coming out as a political tool. As explored by Tiernan (2020), the personalisation of marriage equality was an important strategy in the referendum campaign. LGBT rights had never had such a prominent stage in Ireland, and one of the important factors was the normalising of Gay identities, making LGBT people visible in every part of Irish society. While the campaign was centred in Queer Expressions as an important aspect of Gay collectivism and activism, and facilitated for Irish Gay Men many possibilities to discuss their sexual identity; it also exposed people to homophobia in a very political and public way. Tobin (2016) concludes that from a politico-legal perspective that the referendum was unnecessary, and a crude and uncertain political experiment.

> *"crude because placing the rights of a minority group in the hands of the majority seems almost ludicrous, as a sizeable number of the electorate could have simply voted against the*

issue without being properly informed in the way that elected politicians would usually be when legislating"

Tobin, 2016, p127

While the exposure to homophobic discourse was not a strong recollection of the campaign for participants in Queer Expressions; the foregrounding of monogamous, homonormative relationships was noted, most especially by Brendan, who discussed how marriage equality did open potential for him to discuss his partner more openly, but 'almost compounded and complicated my own decisions around being in an open relationship' (Brendan, 45, university lecturer).

Queered Consultations - The where of Gay healthcare

A range of healthcare environments were discussed by the participants of Queer Expressions in terms of their access and experiences. For some, there was limited engagement with healthcare providers; for others healthcare relationships were more pronounced. Participants discussed engagement with healthcare professionals in primary secondary and tertiary care; those with chronic and enduring illness had more diversity in engagement, but all participants were able to recall encounters with a number of healthcare practitioners. There was an acceptance from the Irish Gay Men in Queer Expressions that engaging across different services, with various practitioners would lead to a diversity of experience, but participants were unanimous in their assertion that more positive encounters were encountered in sexual health services.

While sexual health services were very much aligned to the need for discussion of sexuality issues by participants, in other areas of healthcare provision participants diverged in their approach and assessment of the need to discuss sexuality. The relevance of their sexuality to the healthcare professionals they engaged with, was something Irish Gay Men in Queer Expressions were very conscious of. For some, they made that assessment themselves, for others, a more passive approach

was taken, waiting for the healthcare practitioner to assess the need to discuss these issues. As Jowett and Peel (2009) discuss, overall there is a scarcity in understanding of how sexual identity and issues of sexuality may be relevant to a range of illnesses and encounters with healthcare practitioners, this is both in terms of an evidence base, but also wider perceptions and understandings. For the Irish Gay Men in Queer Expressions the necessity of discussing their sexuality with sexual health practitioners was agreed, but there was divergence in views around what other incidences or areas of healthcare where sexuality was relevant. For some, disclosure of sexual identity was a key part of building therapeutic relationships, whereas for others, it was seen as a much more private issue. Indeed there is disagreement also between healthcare professionals around the relevance of sexual identity to healthcare. In a head to head debate, Ma and Dixon (2018) disagree on the need to discuss sexual orientation with all patients, Ma suggesting that to clarify sexual identity allows for a more holistic approach to healthcare and Dixon suggesting it is 'political correctness gone mad' (p.2). The differing approaches by healthcare practitioners is something participants in Queer Expressions discussed, with large variances across healthcare services as well as practitioners in the same service. The lack of engagement with issues of sexuality in healthcare provision provides a duplicity in negative impact; where sexuality is not discussed the potential impact of illness on sexual health and wellbeing may not be explored, and furthermore evidence of how sexuality impacts on the experience of illness remains invisible. The way in which sexuality relevance was considered outside of sexual health settings for the Irish Gay Men in Queer Expressions, remained focussed on or around sexual acts for many. A number of participants discussed the embarrassment but necessity they felt in discussing their sexuality where healthcare may have an impact on anal sex. Kutner et al. (2020) examine the phenomenon of stigma around anal sex for men who have sex with men, and related health-seeking behaviour. They present how experiences of 'bottom shaming' in social groups compounded with internalised stigma lead to anticipation of judgement from healthcare practitioners. This in turn leads to increased concerns

around anal sex exacerbated by discomfort in discussing anal sex and in turn leading to a reduction in health-seeking behaviour, both during sex and during healthcare encounters.

The how of discussing sexuality.

For most of the participants in Queer Expressions, there was a clear preference for healthcare professionals to lead on discussion around sexuality. Healthcare practitioners initiating a discussion on issues of sex or sexuality was seen as permission to discuss these issues safely. However, barriers exist from a healthcare practitioner perspective to engage with sexuality inclusive care. In a systematic review by Fennell and Grant (2019) four barriers to nurses engaging in sexual healthcare were identified: a lack of knowledge, attitudes and beliefs, nurse discomfort discussing issues of sexuality, organisational barriers related to time, responsibility and support. Along with the decision around when it was relevant to discuss sexuality, Irish Gay Men in Queer Expressions further discussed confusion around who to discuss sexuality with, noting that in many healthcare encounters various different healthcare practitioners were involved. This lack of clarity around whose role sexuality-based healthcare is in multidisciplinary care is a key barrier to engagement and support for sexual wellbeing. In their review of older people's views of sexuality in healthcare, Bauer et al (2016) clearly identify that sex and sexuality remain important aspects of older people's lives, but that there is dissatisfaction with how issues are dealt with in healthcare settings. One of their key findings is the disinterest they experience from healthcare practitioners inhibiting discussions. Some Irish Gay Men in Queer Expressions communicated their frustration around how information they provided around their sexuality was subsequently ignored or brushed over by healthcare practitioners, impacting on their own perceptions of how important sexuality was. The need for explicit confirmation of openness is identified by Clover (2006) as being very important for Gay Men to feel safe and empowered in discussing sexuality with healthcare practitioners. The knowledge and competence of healthcare professionals around issues of sexuality and Gay Men's healthcare was remarked on by many of the Irish Gay Men in Queer Expressions. Stewart and O'Reilly (2017)

identify that gaps in education around LGBTQ issues, both at undergraduate and continuous professional development course level, are a key barrier to nurses engaging positively in appropriate care for LGBTQ patients; many nurses lack knowledge on these issues but don't have access to appropriate training. The participants in Queer Expression clearly identified a need for their healthcare practitioners to receive more training in issues around sexuality, this was perceived through their negative experiences rather than healthcare practitioners discussing this with them. While there is broad agreement in the need for more education and training in this area for healthcare professionals, the ambiguity around whose role sexuality based healthcare is, the modality and level of education and training delivery and indeed the content required necessitates more research (Verrastro et al., 2020). Undoubtedly more sexuality education adds to the knowledge and competence of healthcare practitioners in the area of sexuality-based healthcare provision; however the actual impact of these types of programmes on the experiences of sexual minorities is something which has not yet been established. While education and training are key issues in improving service provision in the area of sexuality inclusive healthcare, the wider issues identified by Fennell and Grant (2019) must also be considered. Indeed, in Ireland a national foundation programme in sexual health promotion has demonstrated a clear positive impact on the knowledge, skills, comfort and confidence of participants (Higgins et al., 2021); however the evaluation report notes that impact of the programme at a service level was only moderate, with many participants reporting that they had not yet undertaken associated activities in their core work (HSE, 2019). While the programme has shown potential, with participants' ability to deliver sexual health promotion impacted positively, as a stand-alone intervention it faces barriers to implementation of service change due to wider contextual and professional issues.

Strong narratives of embarrassment and awkwardness around discussing sexuality were provided throughout interviews in Queer Expressions, with participants reflecting not only on their own awkwardness around the area, but also perceived embarrassment and awkwardness from the healthcare practitioner. Embarrassment around discussing sex and sexuality is a noted barrier for

many healthcare practitioners (Verrastro et al., 2020; Fennell and Grant, 2019; Klaeson et al., 2017; Evans, 2011; Quinn et al., 2011). In considering the underpinnings of this awkwardness and embarrassment, Meerabeau (1999) discusses ambiguity around roles as a key issue as well as the wider societal conditions where the healthcare encounters are taking place. The discomfort in discussing sexuality in Ireland was discussed earlier in the thesis, and indeed it has been demonstrated how this discomfort impacts on identity formation through the narratives of the Irish Gay Men in Queer Expressions. This national discomfort is then evident in the encounters between the Irish Gay Men interviewed in Queer Expressions and the healthcare professionals they engage with. This broad societal and embedded professional discomfort with sex and sexuality might be considered as institutional erotophobia (Evans, 2000). Evans discusses the role of cultural norms and religiosity in embedding an internalised and institutional erotophobia in healthcare (ibid) and as discussed by the Irish Gay Men in Queer Expressions the integration of religion and health services in Ireland has a sustained legacy. Connolly and Lynch (2016) consider this integration of church and health services in Ireland as being a central causation of the omission in focus on gay sexuality. The legacy dominance of the Catholic Church is presented as manifesting a level of cultural inequality around the healthcare of Gay Men in Ireland, compounded by the complexities of embedded erotophobic, homophobic and heterosexist intersections.

An important motivation to discuss sexual identity with healthcare practitioners for the Irish Gay Men in Queer Expressions was their intimate partner relationships; it was important for participants to have their actual or potential partners included as a central stakeholder in their healthcare. Participants recounted occurrences where partners were dismissed or presumed to be friends or brothers as being particularly troubling to them. William, the 32 year old media worker who had experienced cancer care evaluated the inclusion of his partner as the most important driver to disclosing his sexual identity to the healthcare practitioners caring for him; and while Harry, the 20 year old student nurse was single at the time of interviews, he discussed having a partner in the future would be a motivation to come out to healthcare practitioners. Buffie (2011) and King et al.

(2006) suggest that not only does recognition (legal and societal) of same-sex relationships add to a sense of inclusion, but also has a public health benefit; promoting wellbeing amongst same-sex couples. While some of the commentary focuses on insurance access; there were also suggestions that same-sex partner recognition decreased experiences of minority stress and experiences of discrimination (Buffie, 2011; King et al., 2006). Much of this rhetoric is framed with homonormative views on same-sex relationships however, and that in itself may be experienced as exclusionary for those who do not conform (Spurlin, 2019). Within the interviews for Queer Expressions, a particular concern for Brendan, (45 year old university lecturer) was that while being Gay was becoming more accepted, he felt unable to discuss being in a non-monogamous relationship due to the stigma associated and feared judgement from healthcare practitioners because of this.

Safe Disclosures

When discussing the disclosure of sexual identity in healthcare settings, many of the participants in Queer Expressions referred to a consciousness of safety; the potential of negative response to coming out or an experience of homophobia in healthcare was seen as a threat. While homophobia is something that all of the Irish Gay Men in Queer Expressions discussed various experiences of, there was a particular harm associated with homophobia from healthcare practitioners. Stonewall (2018) identified that 1 in 7 British LGBT people had actively avoided healthcare due to fear of discrimination; concurrently participants in Queer Expressions discussed how negative presumptions around how healthcare practitioners may react to their sexual identity can lead to two possible outcomes. If they fail to disclose their sexual identity, there is a possibility of limited care, or they may avoid attendance altogether. One of the challenges noted by the Irish Gay Men in Queer Expressions is that it is not always possible to determine the views or responses of healthcare practitioners in advance.

The Irish Gay Men in Queer Expressions gave a lot of thought to whether and how to disclose their sexual identity to healthcare practitioners; as discussed above there are different motivations

around coming out in healthcare environments, and there were a variety of strategies discussed. Strategic outness (Orne, 2011) is understood through three broad themes, motivations, disclosure methods and social relationships all of which are considered each time a Gay Man encounters a situation where he is not out. Motivations are categorised by Orne (2011) as either 'explosive knowledge' – considering what damage coming out may cause, and 'living a lie', reflecting the dominance of rhetoric around coming out being necessary to living a happy and fulfilled life. The Irish Gay Men in Queer Expressions however, discussed a third motivation in terms of healthcare disclosures, whereby not disclosing may lead to harm, through neglect or negative healthcare. The intersections between sexuality and health are key here and need to be considered – in certain healthcare contexts there may be more motivation or indeed duress to come out whereby sexual identity is deemed as relevant to healthcare need. Orne suggests what makes coming out strategic, is that the motivations to come out, or not, must be considered simultaneously with broader consideration to social contexts (p.696). When considering the social context, Orne (2011) describes the 'social distance' (p.696) as related to the 'space' existing between people in social relationships; there is a complex interplay here in terms of the level of relationship as an enabler or disabler to coming out. While getting to know a healthcare practitioner well might add to a therapeutic relationship and for some make them more comfortable about disclosing their sexual identity, the Irish Gay Men in Queer Expressions relayed some discomfort in discussing sexuality with healthcare practitioners they knew well, especially those who were embedded within local communities. When describing the methods and tactics used around disclosure of sexual identity, the participants in Queer Expressions discussed a variety. Orne (2011) identifies four themes which overarch disclosure methods: direct disclosure, clues, concealment and speculation. The direct disclosure used by Irish Gay Men in Queer Expressions took many forms, David, the 60 year old retired teacher, talked about how he discusses his sexuality straight away in his introduction to healthcare practitioners, while others placed disclosure within contextual discussions around sexual activity, or indeed when asked about relationships. The clues identified by participants in Queer Expressions included their ways of

dressing, voice or indeed presenting broader political opinions linked to a more liberal outlook; with a presumption that people who support asylum seekers rights, or abortion would be inclusive for LGBT people. The Irish Gay Men in Queer Expressions were conscious of how their presentation might be read, this came out in how concealment of sexuality may concurrently occur by changing their presentation, Geoffrey, the 32 year old retail worker, discussed how he took certain badges off his bag to conceal his sexuality in circumstances where he didn't want to be out, but concurrently used them as a 'warning' to healthcare practitioners not to be homophobic around him.

The equation of liberalism around different concerns with inclusive thoughts on LGBT issues was one which the Irish Gay Men in Queer Expressions made numerous assumptions about. They discussed how 'sussing out' (Brendan, 45, university lecturer) the views of healthcare practitioners on what they considered to be tangential issues to LGBT rights, was a tactic in establishing safety around disclosure. This tactic, although applied in many different ways by the participants negatedconsideration of the concept of liberal homophobia (Alonso, 2012); the ways in which some may perceive themselves to be inclusive, and accepting of individual freedom, but concurrently believing that sex and sexuality should not emerge in the public sphere. As discussed by Mos (2020) the broad label of liberalism may be contested in contexts where 'traditional family values' (p.395) are foregrounded. The 'sussing out' of healthcare practitioners also took the form of seeking out visual cues that they may be homophobic, the ways by which they dressed or looked were considered by the Irish Gay Men in deciding whether to come out, a suggestion was made that a more casual dress would signify a more accepting attitude. The interplay between how Gay Men use their visual presentation to either reveal or conceal their sexual identity as discussed above, and how they read the visual presentation of healthcare practitioners is an interesting one. While Gay Men are conscious of how their attire may be perceived, and as described by Clarke and Smith (2014) are aware of the rules around looking 'too Gay' in a context of compulsory heterosexuality; the participants in Queer Expressions do not seem conscious of the social script and motives around how healthcare practitioners dress or present themselves. As identified by Rehem et al. (2005)

impact of attire on perceptions of trust and professionalism is something considered by practitioners; and indeed more formal attire may be more favourable to patients broadly and promoted within practice. An interesting narrative from several of the participants in Queer Expressions was that they would be more hesitant to discuss issues of sexuality with older healthcare professionals rather than younger. While this may again be a presumption around liberalism being more prevalent in younger practitioners – it is somewhat discordant with participant's narratives of their own views. The Irish Gay Men in Queer Expressions discussed their views on sexuality becoming more open and liberal as they age; this age-related discordance between the Irish Gay Men and their perceptions of healthcare practitioners is of note. There was also an uncomfortable racial stereotyping approach discussed by some of the participants; suggesting that they would be hesitant to discuss sexuality with 'foreign' doctors. This displacement of homophobia as a foreign attribute is interesting, given participants' reflections on homophobia in Ireland.

While the presumption of homophobic attitudes in healthcare practitioners was something the Irish Gay Men in Queer Expressions reflected, through a multitude of rationales – participants discussed previous experiences of homophobia and heterosexism as a major factor in their perceptions. While much work is being done to challenge homophobia in healthcare settings, it prevails. A quarter of LGBT healthcare staff interviewed in Stonewall's (2015) Unhealthy Attitudes report stated that they had experienced homophobia in the form of negative remarks from colleagues over the previous five years; the participants in Queer Expressions who worked in healthcare (Noel, Leo, Martin) also recounted experiences of homonegativity in the workplace. In terms of how it was experienced by the Irish Gay Men in Queer Expressions as patients, none of them described what might be considered as explicit or blatant homophobia. A frustration of many of the participants was that healthcare practitioners almost always assumed that they were heterosexual; while compulsory heterosexuality was a common experiences in other settings, the Irish Gay Men in Queer Expressions discussed how in healthcare environments it added to the pressure on them to explain their

healthcare needs as well as their identity. In their commentary on Lesbian invisibility in Nursing, Searle (2019) discusses how homo-invisibility and the institutionalisation of heteronormativity in healthcare can be considered as structural harms and go on to perpetuate systemic vulnerabilities. The Irish Gay Men in Queer Expressions wanted culturally appropriate care, acknowledging their sexuality as part of it, but compulsory heterosexuality was considered as a barrier to this. Another key issue presented was the sexualisation of Gay Men by healthcare practitioners; accounts of over caution around sexual health and particularly HIV was concerning for participants, concerning both in terms of knowledge of the healthcare practitioner but also how it intersected with stereotypical views of Gay Men. While the Irish Gay Men in Queer Expressions discussed the importance of their sexual health to their overall wellbeing; the automatic presumption from healthcare practitioners around STI testing needs outside of sexual health services was a point of contention. Some of the participants discussed a strategy of testing healthcare practitioners around their knowledge of LGBT related issues in order to ascertain their competence. The power dynamic between the 'expert' practitioner and their patient is disrupted in these encounters, where the patient becomes expert (Nimmon and Stenfors-Hayes, 2016). While there was little discussion on conflict between the Irish Gay Men in Queer Expressions and their healthcare practitioners in these instances, it was seen as a barrier for health-seeking behaviour. By adopting the 'expert' position Irish Gay Men in Queer Expressions sometimes discounted the knowledge or skills of the healthcare practitioners they engaged with; a more explicit collaborative approach may be preferential however in meeting healthcare needs, incorporating both practice and system change (Steihaug et al., 2016). There was also a clear hesitancy around engagement with non-homonormative aspects of sexuality as described by Brendan (45, university lecturer), a previous encounter where he felt the healthcare practitioner over-reacted led to a hesitancy around disclosing that he is in a non-monogamous relationship or into BDSM. The importance of non-judgemental healthcare was paramount to Irish Gay Men in Queer Expressions feeling able to discuss sexuality, this was presented as healthcare practitioners being 'unshockable' (Geoffrey, 26, retail worker). Where 'shockability' was evident

participants in Queer Expressions were hesitant; David (60, retired teacher) discussed how his early disclosure of sexual identity was used as a yard-stick to ascertain how future encounters would go. 'Explosive knowledge' (Orne, 2011) was not only experienced by Irish Gay Men in Queer Expressions as a motivational aspect of coming out, but also as a method to determine healthcare practitioners openness.

The openness of healthcare practitioners was not only determined within the encounter itself for participants of Queer Expressions; but also, presumptions came prior to actually engaging with the particular healthcare practitioner. Participants discussed the physical signs and symbols that they sought out to denote safety or unsafety; religious iconography was identified as a particular signal of caution for the Irish Gay Men in Queer Expressions, whereas explicit symbols such as LGBT inclusive posters were seen as an encouragement. As discussed by Wolowic et al. (2017) when analysing the meaning for LGBTQ people of the pride rainbow, these symbols are important to connote safety and support but there are limits to symbolism and their display does not always guarantee inclusive spaces or people. Indeed Brendan (45, university lecturer) described how experiencing inappropriate care in a space which outwardly promoted LGBT inclusion through signage was particularly upsetting. Calvard et al. (2020) discuss populism behind outward LGBT symbolism and seeing such symbolism as corporatism rather than a sign of true inclusion; Martin (36, nurse) describes in his interview, how this move towards rainbow pride flags and lanyards do little to disrupt institutional homophobia or real life occurrences of homophobia within healthcare.

Gay health - Actively Healthy and Compulsory Able-bodiedness

When discussing their views on what it meant to be healthy, the Irish Gay Men in Queer Expressions prioritised physical activity as a key element of health. There was little introspection on how disability and health are categorised or interrelated; and none of the participants disclosed any identity characteristics through a disability lens, despite discussing experiences of various chronic illness'. They prioritised being 'on the move' (David, 60, retired teacher) and 'being able to get up

and about' (Frank, 26, PhD student) as signs of healthiness. Through their narratives it was clear that the Irish Gay Men in Queer Expressions took for granted able-bodiedness as keystone in the embodiment of healthiness and humanity's 'ideal, normal and the mean or default' (Dolmage, 2014). As with the notion of compulsory heterosexuality discussed in an earlier chapter, McReur (2006) establishes the concept of 'Compulsory Able-bodieness' (p.9); here the ideal of heterosexuality is realigned with the concept of an ideal able-bodied identity. In the same way by which compulsory heterosexuality can lead to repetitive strain injury, as explored by Ahmed (2006); a similar process may be considered in how the Irish Gay Men are oriented towards able-bodieness as an ideal and core element of health; this in itself creating a debilitating cycle. Ahmed (ibid) discusses the 'straightening devices' (p.92) which are deployed to realign the Queer body which has an oblique, and off-centre orientation; in a similar way, embodying ideals around able-bodiedness is a straightening activity. For McReur (2010) compulsory heterosexuality is intertwined with compulsory able-bodiedness, because they both work in the (re)production of the ideal, an able and heterosexual body; a queer/disabled perspective thus is necessary in resisting the delimitation of the kinds of bodies that are acceptable. A Queer/Disabled perspective may provide for an acceptance of a healthy ideal, which is not dependent on the able body necessary in the pursuit of physical activity. There was a strong occupational focus from the participants of Queer expressions around what living a healthy life means, health was seen as a doing, a being and a becoming (Wilcox, 2006). The elements of 'doing' most pertinent to the Irish Gay Men in Queer Expressions centred around physical activity, going hiking (David, 60, retired teacher), going to the gym (Simon, 30, telecommunications and marketing worker) or indeed through going to work (Robert, 55, accountant). Being healthy was discussed by participants in Queer Expressions with a focus on health vigilance; there were clear markers around how these Irish Gay Men knew they were healthy. This is obviously related to the physical activity all of the participants discussed, but also through their interactions with healthcare practitioners for screening. While there were varying levels of healthcare engagement by the participants, all of them had regular sexual health screenings. While

sexual health disparities remain for men who have sex in Ireland, sexual health testing is more prevalent than in the general population (HSE, 2018), showing health vigilance as an important trait. Some of the participants noted the importance of delivery of Pre-Exposure Prophylaxis for HIV (Harry, Brendan, Geoffrey) as a health protection tool for Gay Men to combat HIV transmission; as articulated by Geoffrey (26, retail worker) sexual health-seeking behaviour is particularly focused on because it is an area Gay Men are aware there are risks.

Gay Health and Performative Masculinity

Along with a compulsory able-bodiedness narrative in conceptualising healthiness, for the Irish Gay Men in Queer Expressions, their notions and expressions of health and healthiness might be considered as a performative masculinity. Butler (1990) considers sex, gender and sexuality to be performative at their ontological core. Rather than consciously performing masculinity, for Butler, (ibid) gender is constructed through the regulative and normative discourses; for Butler (2004) the performativity of gender is revisited and they clarify that while gender is performed without consciousness, it is not mechanical, but stems from social norms. As well as promoting a sense of fitness and healthiness, participants in Queer Expressions discuss their physical activity intertwined with discussions of aesthetics and also of fraternity; places to meet and interact with other men (Leo, Brendan). The way in which Gay masculinity and physical activity are intertwined is complex, while physical activity may be seen as an inherently masculine trait, Brown and Graham (2008) illuminated that there are specificities and divergences around the motivations and experiences of physical activity between Gay and straight men. Their research found that straight males were motivated to workout for fun, while for Gay men improving appearance was the core driver; straight men who scored highly on their masculinity scale were more likely to be satisfied with their bodies, while Gay men who scored lower were least satisfied (ibid). The Irish Gay Men in Queer Expressions broadly articulated satisfaction with their fitness level, which tied in with their narratives of

healthiness; however the drive to maintain fitness, activity and healthiness feeds back then to concepts of compulsory able-bodiedness as well as masculinity.

Healthy illness

Several of the participants in Queer Expressions discussed their experiences of living with a chronic illness; while this led them to have more interactions with healthcare practitioners, in many instances they referred back to activity. A shared view was that although they had a diagnosed illness, where it did not interfere with their daily activities, they retained a sense of healthiness. As identified in preliminary work by Fredriksen-Goldsen et al. (2017) prevalence of varying chronic illness conditions is higher amongst Lesbian, Gay and Bisexual adults compared to rates in heterosexuals; however there is little attention given to this. In many ways this can be understood as a result of the dominance of much needed health activism in the arena of HIV and AIDS. Lipton (2004) considers the lack of focus on Gay Men living with non-HIV chronic illnesses as an example of the communal trauma that HIV and AIDS and the community responses left.

> *"Because the social response to AIDS has been entirely consuming, it has left little psychological room and even fewer financial or scientific resources with which to evaluate and explore the biopsychosocial impact of sexual orientation on Gay Men living with other health concerns."*
>
> (P.2)

Lipton is clear in his discussion that this is not a critique of HIV/AIDS activism, but rather examines how the needed focus on Gay Men's experiences of non-HIV related chronic illnesses might not have been possible without the radical ways in which HIV/AIDS activism foregrounded Gay Men's health. It is important therefore to build on and learn from the networks and strategies deployed in HIV/AIDS activism. Much of the impact of chronic illness on the lives of the Irish Gay Men in Queer Expressions was articulated as a need to take medication, this was not presented as an

inconvenience or something which disrupted daily living. When rolling out Pre Exposure Prophylaxis (PrEP) for Gay Men a common point of discussion is the need for prescription adherence. It is interesting to note that taking medication is not seen as a disruption by the Irish Gay Men in Queer Expressions; in their exploration of adherence to PrEP amongst Gay and Bisexual Men, Grov et al. (2019) note various ways by which PrEP is incorporated into daily routines and its use normalised; this normalisation of taking daily medication is also apparent For the Irish Gay Men in Queer Expressions.

Independently healthy

Dependence on others was something the participants in Queer Expressions discussed as a concern around ageing or getting ill. Linking back to their prioritisation of physical activity as a signifier of healthiness, the Irish Gay Men in Queer Expressions put forward their independence as paramount and reliance on others as something feared. Lodge and Umberson (2013) consider how this focus on independence is a particularly masculine trait, and while there are some differences in how ageing impacts gay and straight men; notions of independence impact this embodied masculinity. They suggest that for both midlife gay and heterosexual men 'experiences are distressing not only because they run counter to a culturally idealized and defined notion of youthfulness, but also to notions of masculinity.' (p.227). For the Irish Gay Men in Queer Expressions, again, their current or potential intimate partners came into focus, they discussed concerns of dependence, particularly of dependence on an intimate partner.

Aesthetically Healthy

Another concern about ill health was its potential aesthetic impact and subsequent effect on body image. There were varying ways in which participants discussed fears around the impact of illness on how they look, including hair loss, weight fluctuations and the need for stomas; a worry about 'looking sick' (William, 32, media worker). While there are some similar patterns in how masculine body image is experienced between Gay and heterosexual men as explored by Lodge and Umberson

(2013), there are particularities around Gay Men's bodies. Kane (2010) points to the difference being that for Gay Men, the object of their external physical attraction and desire, shares the same gendered embodiment as their own. In their discussions around body image and illness, the Irish Gay Men in Queer Expressions broadly discussed their own appearance, however there was also discussion on how attraction to others would be dependent on a healthy appearance. Sexiness was equated to health, however as described by William, sex and desire continue in illness. The importance of sexual activity to Irish Gay Men's identity has already been discussed, but considering the intersections of sexual activity, sexual desire and illness and disability is something that warrants more exploration. As explored by McRuer (2010), the disabled or ill body is not a constant, there's an important potentiality to be considered; a queer/disabled perspective may provide a resistance to compulsory heteronormative and ableist perspectives of the sexualised body.

The aesthetic impact wasn't only a consequence of illness for the participants, but also a driver for staying healthy, given the compulsory able-bodiedness presented above. While Kane (2010) contests the dominant views that body image issues are more prevalent in Gay Men, there is a body of research suggesting significant impact of body image concerns on the mental health of Gay Men. In their review of how body dissatisfaction impacts on anxiety and depression in men, Barnes et al. (2020) note that while many studies do not report on sexuality, the relationship between body dissatisfaction and poor mental health does appear to be more prominent in Gay Men. Blashill et al. (2016) note that while evidence is continually emerging, approaches of incorporating body dissatisfaction assessments within sexual and mental healthcare for Gay Men may be a pertinent strategy. Kane (2010) suggests that it is possible that Gay Men's concerns around body image are more 'announced' rather than 'pronounced' (p.315), in that heterosexual men might be more subtle in their presentation of concern, but there is a need for practitioners to be vigilant of the subtlety of all men's views and concerns. While the Irish Gay Men in Queer Expressions did not disclose overtly negative views of their appearance or harmful behaviours, it was apparent that physical appearance is very important to them. Vigilance around body image concerns could be an important health

factor, given a possible predisposition for Gay Men to internalise these concerns and potentially develop harmful behaviours (Strubel and Petrie, 2019).

Conflictingly out

As discussed in the previous chapter, a motivation to disclose sexual identity for the Irish Gay Men in Queer Expressions, was the impact it could potentially have on access to and experiences of appropriate healthcare. Being out, was implicitly considered as a healthy way to be; for the participants in Queer Expressions, coming out in itself benefited their wellbeing, with many recounting alleviation of stress and anxiety through the coming out process. As identified in the LGBT Ireland study (Higgins et al., 2016),coming out was identified as an important enabler of positive mental wellbeing for LGBTI people in Ireland and indeed there is a noted trend of decreasing age for Gay Men in realising and disclosing their sexual identity.

Another narrative presented however was the threat exposure that coming out leads to; while only two of the participants in Queer Expressions discussed experiencing physical violence due to homophobia, the possibility of physical violence was discussed by several participants. This is how coming out might be considered in a frame of 'explosive knowledge' (Orne, 2011, p.696), a fifth of participants in the LGBT Ireland study had experienced physical violence because of homophobia or transphobia, and indeed fear of being outed was seen as a significant threat for younger participants especially.

Risky categories

When discussing various approaches to healthcare, the Irish Gay Men in Queer Expressions were conscious that provision of healthcare for them was often dependent on risk categorisation – however there was some discomfort with this. The participants were aware that there was higher prevalence of sexually acquired infections and HIV amongst Gay Men and indeed this contributed to their health vigilance and protective behaviours, but being categorised as 'at risk' for being Gay

evoked a discomfort. The public discourse around risk categorisation of Gay Men is most evident and explicit in debates around restrictive blood donation policies for Gay Men; in Ireland Gay Men cannot donate blood if they have had sex with another man in the previous 12 months, prior to this 2017 regulation there was a lifetime ban for men who had sex with another man. Again, discourse on HIV dominates discussions on risk and blood donation, and while there is higher HIV prevalence in communities of men who have sex with men, there is a building consensus that a behaviour-based donation policy would be more equitable (Skelly et al., 2020). There is disquiet around the policy too amongst Gay Men themselves; Grace et al. (2019) established that Gay and Bisexual men found the practice of exclusion deferrals based only on who you had sex with rather than individualised behaviour assessments to be inequitable. When discussing the 'gay blood ban', Patrick, a 23 year old unemployed participant in Queer Expressions described frustration that 'community issues' are used to discriminate against all Gay Men. The Irish Gay Men in Queer Expressions were broadly agreed, that specific health interventions were required within Gay Male communities to deal with issues around sexual health, mental health and harmful substance use; but these issues were 'othered' in the discussions. There was a tension between narratives of community healthcare need in response to sexual health issues and harmful substance use and reflections on how the behaviours of other Gay Men which impact on public perceptions and treatment of the Irish Gay Men in Queer Expressions. As discussed in the earlier section on Gay identity, this threat to social representation emerges in discussions of healthcare need. Implicitly the participants start to categorise themselves as 'good gays' in opposition to 'bad gays' (Jaspal, 2019, p.45); they do not want to be treated differently based on the behaviours of others which they see as harmful, such as promiscuity or Chemsex.

This exposure to negative stereotypes and homophobic attitudes was something that the Irish Gay Men in Queer Expressions were acutely aware of, but didn't always consider how this broad structural homophobia may directly impact on their own wellbeing. As described by Meyer (2003), minority stress is firstly impacted by external stressors, those direct experiences and awareness of

homophobia; participants in Queer Expressions recounted many accounts of this but were often quick to generalise and externalise these experiences. As Meyer (ibid) points out this awareness leads to vigilance around homophobia as interactive proximal stressors where there is an innate response to protect oneself; clearly illustrated through the Irish Gay Men's coming out strategies, the sussing out of safe places to discuss their sexuality. For Meyer, these processes culminate in the internalising of these proximal stressors, the development of negative internalised feelings about oneself and ultimately causing harm. This can be externalised through maladaptive coping strategies, such as harmful drug use or sexualised behaviour as discussed by Jaspal (2018); or indeed negative projection onto others, thus threatening gay social identity (Jaspal, 2019). The participants in Queer Expressions did not discuss any of the more problematic coping strategies as discussed by Jaspal (2018), however there was clear projection onto other Gay Men's behaviours as discussed above. As well as these more negative outcomes of minority stress, Hendricks and Testa (2012) discuss how the interactive proximal stressors can emphasise the importance of community and social support, therefore possibly enhancing a sense of social identity; demonstrated through the Irish Gay Men's focus on the importance of social networks of other Gay Men.

Good Gays and Bad Gays

The Irish Gay Men in Queer Expressions presented a broad consciousness of the power dynamics tied up in structural homophobia and heteronormativity; they were aware how these structures impacted their lived experiences and those of others. The marriage equality campaign was posited for many as a resistance to these oppressions but there was a stark absence of acknowledgement in how homonormative assimilative discourses around marriage were in themselves oppressive for others (Woods, 2018). The multifaceted nature of power presented by Foucault is understood by the Irish Gay Men in Queer Expressions at the level of being subject to external forces, but there is an absence of introspection of how their own identity and self-knowledge (Faubion, 2002) operates in this way.

When narrative of risk comes up in interviews this tension around power is eluded to – there is a discomfort in how broadly heteronormative health systems categorise these men as at risk, for being gay but the narrative then shifts and projects onto others – the bad gays, who are not monogamous, who are promiscuous, or engage in chemsex. When considering Jaspal's (2019) social identity theory, these 'bad gays' are a risk to the Gay communities developed by the Irish Gay Men in Queer Expressions, as their behaviour brings on this negative public perception and stereotyping. As described by O'Toole (2017) this social organisation creates new categories of inclusion and abjection; the 'good gays' become the oppressive power structure. Similarly, when oriented towards a compulsory able-bodiedness, and driven towards narrow occupational and aesthetic views of health and desire, the Irish Gay Men in Queer Expressions are simultaneously displacing the queer/disabled figure into a place of abjection and other. Clear "regulation" as described by Butler (2004, p40) is evidently taking place within Irish Gay male communities – inclusion into the category of, good gay, as healthy or as desirable, coming at a price of excluding others.

Original contribution

This thesis makes many unique and original contributions to the discourse and research on Irish Gay Men's Health. At its core this thesis focusses on the interactions, encounters and discussions that take place between Irish Gay Men and healthcare practitioners; healthcare is relational and understanding how these relationships are built is fundamental to the delivery of high quality care. Queer Expression illuminates for the first time how concepts of sexuality, health and national embodied history all contribute to the Irish Gay Man's identity. This is the first study which identifies how interactions with healthcare practitioners impact on the lived experiences of Irish Gay Men; it also unearths the many complex perceptions and considerations Irish Gay Men have around discussing sexuality in a healthcare context. Uniquely, this study explores what health means for

Irish Gay Men, and considers how a compulsory able-bodiness (McReur, 2010) underpins perspectives of what it means to be healthy for this group.

Research Questions

In approaching Queer Expressions, following a broad review of issues around Gay Men's health, a number of research questions were set out for the project. The chosen methodology, Interpretative Phenomenological Analysis is very much inductive, and with a grounding in phenomenological thought, there is potential that research questions and focus will evolve throughout the research process. However, Queer Expressions was successful in answering the research questions originally set out.

1) The participants described an understanding of sexuality which was holistic and affected various aspects of their identity and lived experiences. Sexuality was described as innate, a being - identity; and related activities and orientations – a doing. For Irish Gay Men in Queer Expressions sexuality was very much grounded in relationships – with other individuals, communities but also spaces, places and objects. Queer Phenomenology (Ahmed, 2006) provides an interesting lens to explore the relationships, spaces and objects that Irish Gay Men orient towards, or away from, in embodying their sexuality.
2) The Irish Gay Men in Queer Expressions described a variety of experiences of discussing sexuality with a number healthcare practitioners. When evaluating these experiences through their narratives, the participants identified some very good practices around un-shockability and non-judgemental, culturally competent care. However, they also described experiences of compulsory heterosexuality, sexualisation and dismissal.
3) When describing their feelings around discussing sexuality in healthcare contexts, the Irish Gay Men in Queer Expressions revealed that embarrassment and awkwardness were common. While some of the participants were confident in their expression, they

acknowledged their perception that embarrassment and awkwardness was common amongst the healthcare practitioners they conversed with.

4) A key consideration for Irish Gay Men in Queer Expressions around disclosing their sexual identity, was the relevance of their sexual identity to the encounter. For some this concept of relevance was very broad, acknowledging their sexual identity as a core part of themselves, which was relevant to all interactions. For others their sexual identity was more compartmentalised, and disclosure was limited to encounters where it was deemed necessary to discuss sexual activity or their intimate relationships. The Irish Gay Men in Queer Expressions were conscious of how coming out can be understood as 'explosive knowledge' (Orne, 2011); by coming out they are at risk of homonegative and homophobic attitudes and possible damage to therapeutic relationships. However, they too, were conscious of how in healthcare contexts, withholding their sexual identity could lead to inadequate or inappropriate care.
5) The 'explosive knowledge' (Orne, 2011) contained through disclosing sexual identity meant that by coming out there was potential for therapeutic relationships between Irish Gay Men and their healthcare practitioners to be altered. Participants in Queer Expressions discussed their concerns around being judged, or stereotyped. There were also concerns around the ability of healthcare practitioners to provide them with culturally appropriate care as Gay Men.

The use of Interpretative Phenomenological Analysis meant that as well as answering the primary research questions set out for this study, Queer Expressions unearthed and illuminated a lot more knowledge around how Irish Gay Men discuss sexuality with healthcare practitioners. An unexpected outcome was a very specific and unique approach to meanings around health. For the Irish Gay Men in Queer Expressions the most central element of healthiness was around physical activity; there was an intertwining of compulsory able-bodiness (McReur, 2010) with concepts of being healthy.

Further to this, discussions around health led to a focus on risk, risk categorisation and a discomfort around sexual identity being linked to risky behaviours.

Limitations

As with many qualitative research studies the sample size in Queer Expressions is small, transferability or comparability around similar groups or similar contexts is not the aim, however. The idiographic nature of Interpretative Phenomenological Analysis means a smaller, broadly homogenous sample is necessary; so the findings of this thesis needs to be understood in relation to the Irish Gay Me who took part. The experiences of the twelve Irish Gay Men who participated may not necessarily be representative of the experiences of other Irish Gay Men. Ireland is changing – as is the Irish Gay community; the last European Men who have Sex with Men Internet Survey reported that 1 in 4 respondents in Ireland were born outside of the country (Casey et al. 2019) – whereas all participants in Queer Expressions were Irish born. The participants were also all white, cisgender and none identified as having a disability. The self-selected nature of the sample means that transferability is also unpredictable.

Queer Expressions was not designed to provide an objective account of how Irish Gay Men discuss sexuality with healthcare practitioners – and while interviewing participants about past experiences may be affected by recall bias, this doe nott really matter. Subjectivity, is of course a factor in this study; I was the sole researcher, and while my reflexive processes aided in vigilance around research bias; the lack of other researchers may have impacted on the breadth or depth of the analysis. IPA, however, is not about providing a single or objective account – it aims to provide a credible and detailed explanation of a phenomena, which this research has done.

Implications for practice, praxis and policy

Through illuminating the experiences of Irish Gay Men discussing sexuality with healthcare practitioners, Queer Expressions has unearthed specific and significant knowledge, which can be

considered in praxis of healthcare delivery, practitioner education, research and policy outlined in this section.

Identifying sexual identity in healthcare practice

While the EU Fundamental Rights Agency LGBTI Survey (2019) identifies that 1 in 4 Irish Gay Men are not out to any healthcare professional, it is not clear why this is. Of course it could be because Irish Gay Men have decided not to come out, that coming out is 'explosive knowledge' (Orne, 2011) or that they have deemed that their sexual identity is not relevant to their healthcare. However, as discussed by the Irish Gay Men in Queer Expressions, sometimes it is not clear when or how to come out. These men identified the awkwardness of having to bring up their sexual identity in healthcare contexts where relevance is not made explicitly clear, there was a shared view that healthcare practitioners leading on these discussions was preferred, it gave permission. The discussion of sexual identity, and consideration of its relevance to healthcare need not be an awkward encounter; however, as discussed by some of the Irish Gay Men in Queer Expressions simply recording sexual identity in patient files or forms on admission may avoid this awkwardness. As a frontline healthcare practitioner, collecting demographic data is an everyday practice; encouraging disclosure of sexual identity may not only ensure appropriate and person-centred care but also normalise discussions around sexuality within a healthcare context.

Sexuality in holistic assessment and delivery of person-centred healthcare

The Irish Gay Men in Queer Expressions demonstrated through their narratives and experiences how important sexuality is to their daily lives and indeed experiences of health and healthcare. Participants discussed sexuality in the context of their physical, emotional and psychological wellbeing and illuminated the overlapping of these areas. A clear framework to support integration of sexuality into healthcare is person-centredness, however as discussed in this thesis, the wider socio-cultural issues surrounding sexuality may mean that unless given specific consideration it may be overlooked or ignored under a more generic approach. Even when sexuality is explicitly

identified, as in the Roper Logan and Tierney (1980) model of nursing, in practice this area of assessment is often overlooked or ignored; therefore educating on the importance of sexuality to health concurrently needs to be considered.

Challenging discrimination and Explicit inclusion

With continued experiences of homonegativity, homophobia and discrimination by Irish Gay Men in healthcare contexts, clear frameworks for challenging discrimination in healthcare could be useful in creating more inclusive spaces. The power dynamic implicit in patient-practitioner encounters and hierarchal structures within healthcare means challenging discrimination is often complex and has many barriers which must be considered.

The Irish Gay Men in Queer Expressions identified the need for clear and explicit inclusion; participants recounted their strategies of 'sussing out' which was a less than perfect way of establishing safety and comfort. Too, the practice of superficial symbolism, through the rainbow flag/pin/lanyard was deconstructed and its inclusiveness challenged. Inclusion work takes time and a systemic and cultural change; rainbow flags are important indicators of inclusion for Irish Gay Men, but must be met with inclusive healthcare practice. Previous experience of healthcare was the most prominent consideration for the Irish Gay Men in developing their disclosure methods.

Curriculum Design Usualising and Specificising

Discussing healthcare encounters with Irish Gay Men demonstrated the varying different healthcare environments they engage with; Irish Gay Men are likely to use the same services as Irish straight men or others. Therefore it is imperative that we recognise that Gay Men are potential service users in varying settings when we design and deliver education to potential and current healthcare practitioners. By adopting a usualising approach to curriculum design for healthcare practitioners - whereby people with diverse sexual identities are presented and discussed in varying different healthcare situations, not just particular to a Gay Men's health specific focus, the 'explosive

knowledge around coming out may be somewhat dismantled.; visibility and potentiality become normalised for the healthcare practitioner. There is also a need however to specify the very specific needs that sexual minority patients might have – this will in turn enhance healthcare practitioners knowledge around sexual minority health and ability to provide more specific care. A whole programme approach such as that conceptualised by McCann and Brown (2020) may facilitate an enriching and holistic learning experience for learners as well as a clear applicability of knowledge.

Gay Men's Health Policy

Ireland's Sexual Health Strategy (2015-2020) has come to its end, however no final review or schedule for a new strategic period has yet been published. Given the ongoing sexual health disparities Irish Gay Men face it is imperative that they receive specific and targeted focus. There is also a need for broader health policy in Ireland to become cognisant of the inequalities around access and experience of healthcare for Gay Men. With 1 in 4 Irish Gay Men not disclosing their sexual identity to healthcare practitioners (EU Fundamental Rights Agency, 2019) it may be useful to incorporate focus on Irish Gay Men in broader healthcare policy too.

Future research

Queer Expressions has raised many questions which appear broadly unanswered. As highlighted in this thesis, research on Gay Men and non-HIV related illness is sparse, and there is huge potential to illuminate potential etiological links and experiences of other illnesses. While etiological research would require a normalising of gathering sexual identity information; this could be crucial in identifying and dismantling further health inequalities and disparities for Gay Men. However improvements in healthcare delivery for Gay Men could also benefit from specific enquiry into how Gay Men experience varying illnesses and healthcare experiences, allowing for tailored interventions from healthcare practitioners and organisations.

The Irish Gay Men in Queer Expressions exemplified how a broader socio-cultural context of Ireland intersects with issues of heteronormativity and identity development, impacting on how sexuality is discussed in healthcare. It would be pertinent to explore how varying experiences of socio-cultural engagement and identity embodiment impact these discussions within different groups, both within sexual minorities and the general population.

While this thesis was grounded in the experiences of Irish Gay Men discussing sexuality with healthcare practitioners, it would be interesting to consider how healthcare practitioners experience these encounters.

Phenomenological Praxis

Dowling and Cooney (2012) put forward a strong justification for phenomenological research in Nursing and healthcare science; given our central focus on caring for people, and understanding how they experience health and illness, the fit is clear. Phenomenology too, I argue, should be considered as a praxis in healthcare, a way of not only understanding the lived experience of those we care for, but also as a way of enhancing person-centredness. By taking a phenomenological stance in nursing practice, we not only deliver care based on the person as we see them, but through their lived experiences. Queer Expressions demonstrates the varying ways in which Irish Gay Men experience healthcare, through their encounters with healthcare practitioners; how they perceive their experience may differ from how the practitioner perceives it. Creating a praxis which focusses on the lived experiences of the 'person' rather than on a healthcare practitioner's view of 'the person' may yield more effective and appropriate care practices.

Conclusion

It is clear from the discussion that the Irish Gay Men in Queer Expressions embody their sexual identities in ways which broadly correspond to notions of individual and social identity, while at the

same time the orientation, and doing of Gay is centrally important. For Irish Gay Men their Irishness intersects with notions of Gay sexuality; and specific orientations are taken towards, and away from various spaces, places, people and practices; Ahmed's (2006) Queer Phenomenology provides a useful lens to explore this, and to illuminate the repetitive strain injury caused through the specific straightening devices employed in an Irish context. The broad straightening devices deployed in an Irish context in the form of national and religious symbolism along with other heterosexist norms clearly impact on how Irish Gay Men discuss sexuality with healthcare practitioners. A 'sussing out' is imperative for Irish Gay Men to establish their safety and also to negotiate relevancy of their sexuality in healthcare contexts. There is an acute awareness of the 'explosive knowledge' (Orne, 2011) and risk that accompanies the coming out process for Irish Gay Men, but uniquely they consider the implications of not coming out in healthcare contexts, two competing narratives, both implicating safety and wellbeing.

Health was shown to be an important focus for the Irish Gay Men in Queer Expression, but their concept of healthiness was inextricably linked to notions of compulsory able-bodiedness (McRuer, 2006). There was a troubling unconsciousness around how healthiness and disability may not be mutually exclusive, for the Irish Gay Men in Queer Expressions, health was about being able to do; the concepts of health and intersections with aesthetics further establishes an able-bodied masculine ideal (McRuer, 2010). The risk categorisation surrounding Gay identity was troubling for the participants in Queer Expressions, and while acknowledging diverse needs of other Gay Men, risky categorisation became a social identity threat, and a clear line differentiation for the Irish Gay Men in this study and a regulatory system.

Thesis Conclusion

Queer Expressions provides a unique and in-depth account of Irish Gay Men's lived experiences of discussing sexuality with healthcare practitioners. Presenting literature on the breadth of perspectives on sexuality, its integration and relationality with health and healthcare; as well as specificities around Gay identity, Gay Men's Health and homosexuality in Ireland, underpinned the exploration of how this phenomenon occurs with Irish Gay Men. Twelve Irish Gay Men took part in interviews, sharing their perspectives, perceptions and lived experiences which were subsequently analysed using interpretative phenomenological analysis. The qualitative approach taken in this study provided for in-depth and inductive exploration, illuminating rich descriptions of how Irish Gay Men view their identity, how they interact with healthcare practitioners and how they perceive health and healthiness. The application of IPA ensured a responsiveness to what the participants themselves discussed, an inductive approach which not only answered the research questions set out when the study was initiated, but also provided a particularly unique view of how Irish Gay Men perceive the concepts of health and healthiness. While the small sample in this study limits its generalisability, the reflexive approach and adherence to a widely used research approach means that theoretical perspectives can be considered in relation to other groups, settings or contexts. Considering the findings of this study concurrent with broader theoretical and empirical knowledge, shows clear convergence in some of the aspects of Gay Identity theory, but also diverging with specificities in how Irish Gay Men perceive their sexuality in tandem with other aspects of identity. An understanding has been garnered in terms of how and why Irish Gay Men discuss sexuality in healthcare contexts and also in how they perceive inclusivity and safety. The Irish Gay Men in Queer Expressions present a very distinct perspective on health and healthiness, which is examined alongside perspectives of masculinity and able-bodiedness, providing a unique lens.

The originality of this thesis is clearly presented, and applicability to healthcare practice, policy and education outlined – The experience of Irish Gay Men in discussing sexuality with healthcare

practitioners is demonstrably socioculturally specific and needs to be responded to in a socioculturally specific way.

Reflections as I exit the study

Engaging in PhD scholarship, while working full-time, maintaining family life and indeed just living has been a complex experience. In many ways the PhD has been an apprenticeship, not only in the field of research, but also in becoming a more reflexive and rounded nurse and nurse educator. The privilege afforded to me by Canterbury Christ Church University, by my supervisors and most importantly by the participants of Queer Expressions, reminds me of the very special and privileged role researchers have, in illuminating lives and solving problems. The trust invested in me to complete this important work was a persistent tension, to do a good job, to complete that job – I now need to ensure that the knowledge and perspectives from Queer Expressions lead to real life application, through my own scholarly and practice endeavours. I am not only invested in Gay Men's wellbeing as a Gay Man myself, and as a nurse, but now as a researcher in Gay Men's health – the obligation to ensure high quality and high impact research in this area is now something embodied.

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Appendices

Ethics Approval Letter

17th July 2015 Ref: 15/FHW/15
038

J Gilmore
School of Nursing

Canterbury Christ Church University

Email: j.gilmore534@canterbury.ac.uk

Dear John

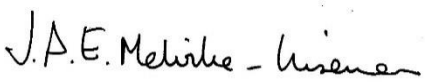
Project Title: Understanding gay men's decisions on discussing sexuality and coming out to health-care practitioners: A phenomenological analysis of Irish gay men's experiences.

Your application was reviewed by the Faculty of Health and Wellbeing Research Ethics Committee virtual panel which concluded on 22nd June 2015. The Committee agreed that the conditions set out in my email of 3rd July 2015 should be met before final approval could be given.

As Chair of the Committee, I am content that these conditions have now been met in full, and I am writing to give formal confirmation that you can commence your research. Any significant change in the question, design or conduct of the study over its course should be notified to me as Chair, and may require a new application for ethics approval. You are also required to inform me once your research has been completed.

With best wishes for a successful project

Yours sincerely



Dr Janet Melville-Wiseman

Chair, Faculty of Health and Wellbeing Research Ethics Committee

Tel: 01227 782116

Email: janet.melville-wiseman@canterbury.ac.uk

cc: Lynne Middleton, Research and Innovation Assistant

Advert

Queer Expressions is a research project looking at how people discuss their sexuality with healthcare practitioners (Doctors, Nurses, Therapists etc.)

For part I we're looking for Irish Gay men to volunteer for an informal research interview which will take about an hour, at a time and place which is convenient.

We hope that the results of this research will go on to inform and improve practice and care of LGBTQ people.

If interested please email
queerexpressions@gmail.com
or pass on these details to anyone you think might be interested.

Many thanks in advance!

www.facebook.com/queerexpressions

Ethical approval has been granted by Canterbury Christ Church University, Health and Wellbeing research ethics committee.

John Gilmore

BSc. Grad. Dip. MSoc. Sc.

Doctoral Researcher

Canterbury Christ Church University

Canterbury Christ Church University

Interview Schedule

1. Opening questions, tell me a little about yourself, where are you from, where have you lived, what do you work as/study/do?

2. What's your understanding of the term sexuality? How does your sexuality impact your life?

3. Tell me a little bit about what it means to be an Irish Gay Man? What does it mean to be gay? How does being gay impact on your life?

4. Tell me a little about 'coming out'. Who have you come out to? What was it like? Anyone you haven't come out to? Why?

5. Can you tell me about some experiences you've had of accessing healthcare?

6. Can you tell me about any experiences you have had around discussing your sexuality with a healthcare practitioner? Any experiences where you didn't disclose your sexual identity?

7. What were the things that motivated you to discuss your sexuality with a healthcare practitioners?

8. Were there any barriers to discussing sexuality with a healthcare practitioner?

9. How would you describe your experiences of discussing sexuality with healthcare practitioners, were they positive or negative?

10. Anything you would like to add?