NICOLE WILLIAMS BSc (Hons)

EXPLORING NARRATIVES OF YOUNG LGBTQ+ PEOPLE IN PHYSICAL HEALTH SERVICES

Section A: What do physical health care staff say about their knowledge, attitudes, and beliefs regarding providing care for LGBTQ+ people? A systematic review and thematic synthesis.
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Section B: "*I didn't come here for your judgement"* alongside "*they understand you and encourage you*"*:* Exploring the narratives of young black and mixed-race LGBTQ+ people who have a physical health condition and their experiences within physical health services.
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Acknowledgements

Thank you to all the young people who shared their stories openly and bravely with me. Your voices matter and you deserve to be heard.

Thank you to my supervisors, Dr James McParland, Dr Shreena Unadkat, and Dr Jaymie Huckridge who all implicitly understood the value of listening to young LGBTQ+ people and who helped me to think about my own position as a researcher and psychologist.

Finally, thank you to everyone else who supported me along the way.

Summary of MRP Portfolio

Section A: This section is a systematic literature review and thematic synthesis of qualitative research exploring the perceptions of healthcare staff towards lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) individuals. The review included nine studies, all of which had been published in the past nine years. The review generated four analytical themes: *A willingness and desire to provide quality care; A lack of knowledge and experience; Working in heteronormative spaces; Whose responsibility is it?* Clinical and research implications are discussed.

Section B: This section employs a narrative analysis approach to consider the experiences of young LGBTQ+ people who have a physical health condition and their relationships with their identity. Eight participants were interviewed. Their narratives indicated that healthcare staff held an important role in their lives, and were overall doing a good job in supporting them. The importance of role models and communities that can uphold and celebrate identity for these young people were present in all narratives, and the study discusses how healthcare staff can step into these roles to further boost the development of positive identity in young LGBTQ+ people. Clinical and research implications, as well as study limitations are then considered.

Section C: Includes all appendices and supporting material.

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SECTION A: LITERATURE REVIEW

WHAT DO PHYSICAL HEALTH CARE STAFF SAY ABOUT THEIR KNOWLEDGE, ATTITUDES, AND BELIEFS REGARDING PROVIDING CARE FOR LGBTQ+ PEOPLE? A SYSTEMATIC REVIEW AND THEMATIC SYNTHESIS.

Word Count: 7,967 (+279)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
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Abstract

Background: Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) people face significant health inequalities. Research has begun to find that healthcare professionals hold limited knowledge about LGBTQ+ people and lack confidence in working with them. How healthcare professionals understand their lack of knowledge, and the possible impact of this, was not fully understood.

Aims: Qualitative literature was reviewed to answer the question 'what do physical health care staff say about their knowledge, attitudes, and beliefs regarding providing care for LGBTQ+ people?'.

Design: Four electronic databases were searched, and nine research papers were identified. Papers were quality assessed and thematic synthesis was used.

Findings: Four key themes were identified: A willingness and desire to provide quality care; a lack of knowledge and experience; working in a heteronormative space; whose responsibility is it?

Clinical and research implications: Clinical implications included the need for better training opportunities for clinicians, including embedding LGBTQ+ health issues through training programmes, and providing reflective spaces for staff to continue their process of examining the stigma and biases they may hold. Research implications included the need to explore the experiences of LGBTQ+ youth and the clinicians that care for them as much understanding currently is based on LGBTQ+ adults.

Keywords:
LGBTQ+, HCP, perception, knowledge, healthcare

Introduction

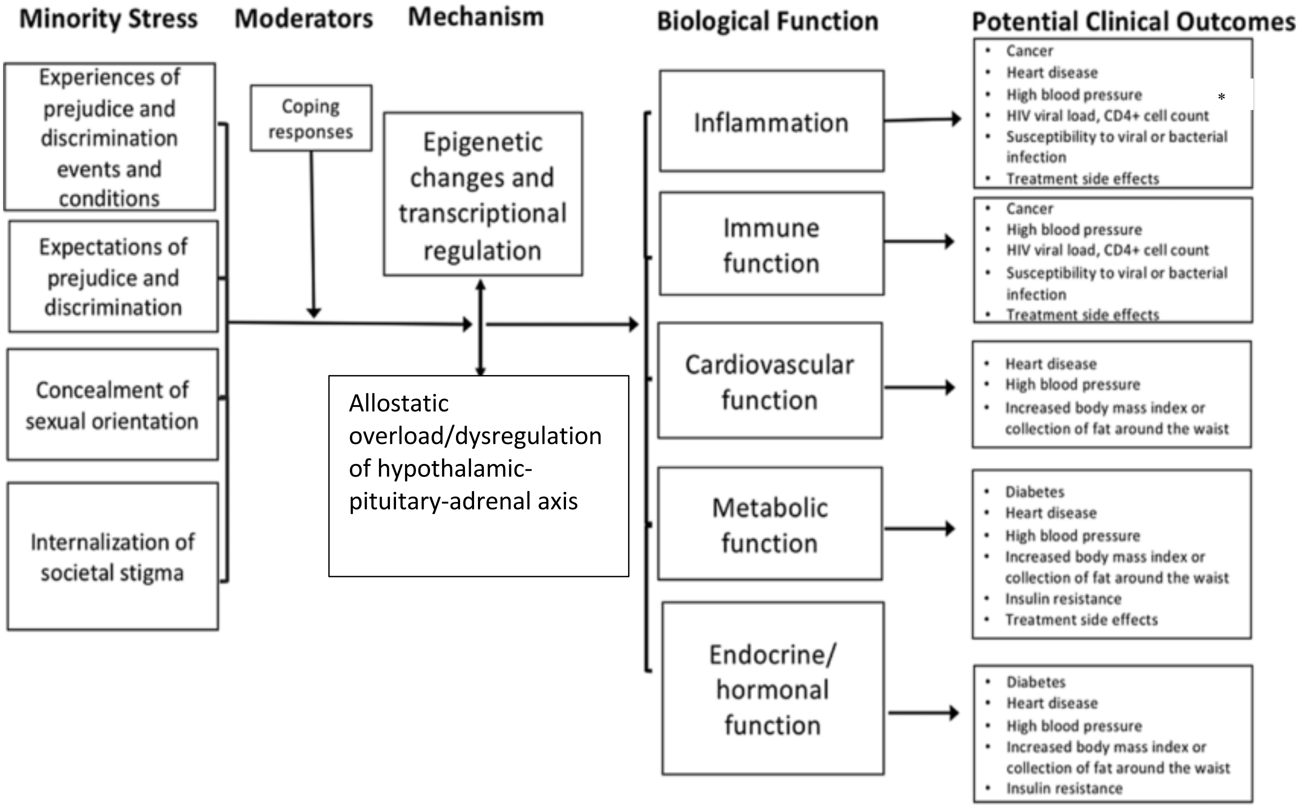
Health inequalities

Research has shown that lesbian, gay, bisexual, transgender, and queer and/or questioning (LGBTQ+) people have poorer health outcomes than heterosexual people, including experiencing higher rates of chronic diseases, such as certain cancers (Institute of Medicine, 2011). LGBTQ+ individuals also experienced worsened health and social circumstances due to the coronavirus pandemic, exacerbating the health inequalities that already existed (Nowaskie and Roesler, 2022). Furthermore, LGBTQ+ people can regularly face difficulties including discrimination, and stigma which can contribute to health inequalities (Huebner et al., 2004). Meyer (2003) suggested that LGBTQ+ people can experience unique stigmatizing events, such as discrimination, due to their ‘minority status’ (e.g., sexual orientation, gender and/or ethnicity) as well as their ‘minority identity’ (e.g., identifying as a gay male). Meyer suggested a minority stress theory (MST) in which there are both proximal (e.g., internalised homophobia and expectation of rejection) and distal stressors (e.g., discrimination from an organisation). MST suggests that stressors can contribute to poorer mental health in LGBTQ+ individuals. Minority stressors have been suggested to predict negative psychological outcomes in both LGBTQ+ adults (Kaufman et al., 2022) and youth (Kelleher, 2009). These studies have considered the link between minority stress and the increased rates of mental health difficulties in LGBTQ+ people.

MST has also been related to poorer physical health outcomes for LGBTQ+ individuals (Frost et al., 2015; Lick et al., 2013). Flentje et al., (2020) conceptualised how minority stressors may impact on the biological functions in the body. They theorise that experiencing minority stressors may constitute as chronic stressors, which place an overload on systems that impact the functioning of the immune system and cardiovascular system. Figure 1 shows a conceptual model of how experiencing minority stress may impact biological mechanisms, ultimately resulting in impacted health.

Figure 1

Flentje et al., (2020) conceptual model



*Human Immunodeficiency Viruses (HIV), white blood cell (CD4+) count

LGBTQ+ service users (SU) within the United Kingdom (UK) National Health Service (NHS) report overhearing negative and homophobic comments made by staff, which can be minority stressors (Somerville, 2015). LGBTQ+ SU also report delaying access to health services. There has been a push to promote the safety and inclusion of staff and SU with an LGBTQ+ identity in the NHS to change this (Hancock, 2020). Grassroot initiatives such as the NHS rainbow badge project have been crucial to this (NHS Rainbow Badges, 2021). Experiences of LGBTQ+ people encountering stigma from healthcare professionals (HCPs) have been researched across the world (e.g., Hudaisa et al., 2017; Institute of medicine, 2011; Zaza et al., 2016). The link between MST and the health inequalities that LGBTQ+ people face has been reviewed (Villemure et al., 2022), with findings suggesting that experiences of concealment, expectation of rejection, and internalized homo-and/or transphobia can contribute to health inequalities. This study suggested that to improve care for LGBTQ+ SU, it is important for HCPs to focus on rapport development and increase their knowledge and competence when working with LGBTQ+ people. Various health groups have pledged their commitment to researching and improving education about LGBTQ+ health needs, including within cancer care (Griggs et al., 2017).

Current research and missing voices

Research regarding the experiences of LGBTQ+ people in health care has often either focused on their mental health (e.g. Cartwright & Neal, 2022), or on the experience of disclosure (e.g. Ching et al., 2021) of LGBTQ+ identity within clinical settings. This type of research is important to better understand the role of identity within healthcare. For example, it is important for HCPs to be aware that certain identity groups are at a higher risk of health conditions. Lesbian and bisexual women have higher risks of developing certain cancers, such as cervical cancer, compared to heterosexual women (Boehmer et al., 2012). Despite this, lesbian women may be less likely to attend cancer screenings (Loud & Murphy, 2017) and have reported their fear of discrimination as one reason for low attendance (Ceres et al., 2018). Furthermore, some were also informed they do not need to attend cervical cancer screening due to their orientation (Walding, 2018). This raises concerns about what knowledge or stigma HCPs hold about the LGBTQ+ community, and the impact this has on LGBTQ+ healthcare.

Current research exploring health inequalities for LGBTQ+ people and possible ‘reasons’ for this often cite a lack of provider knowledge or ‘comfort’ in discussing LGBTQ+ matters as a main barrier (Stern, 2021). There are mixed experiences in the literature as to experiences of LGBTQ+ SU interactions with HCPs. Some have reported having negative experiences of meeting with HCPs (Colpitts & Gahagan, 2016) and others report positive encounters (Sharek et al., 2015). Research is starting to look more broadly at the experiences of LGBTQ+ SU within healthcare. However, these studies are usually diagnosis and identity specific, and only explore adult experiences. For example, considering lesbian, gay men, and bisexual people's experience of cancer care (Fish & Williamson, 2016), and transgender people's experiences within mental health or gender identity services (Benson, 2013; Ellis et al., 2015). The voices of LGBTQ+ youth and the HCPs that care for them are less present within the literature. This may be due to false conceptions that young people would not be developing their sexual orientation or gender identity.

Some studies have also begun explicitly understanding knowledge HCPs do hold about LGBTQ+ experiences and how this affects their healthcare journey. For example, a recent review considered both the experiences of LGBTQ+ youth and HCPs working in paediatric settings (Stern, 2021). The two studies focused on HCP knowledge reported they generally did not feel equipped to support LGBTQ+ SU, due to lack of knowledge and resources (Kitts, 2010; Zelin et al., 2019). However, both studies reviewed used quantitative surveys to consider the knowledge that HCPs held and did not gather a qualitative view of the understanding that HCPs hold about why this lack of knowledge existed for them. A different review qualitatively considered the attitudes, knowledge, and beliefs of nurses and midwives regarding caring for LGBTQ+ SU (Stewart & O'Reilly, 2017). Themes from this study centred on the impact of lack of training, and the different ways in which stigmatised or discriminatory views could seep into healthcare despite HCPs best intentions. The authors of this review reflected on how studies that focus on HCP attitudes and knowledge rarely focused on specific staff disciplines or their training. This review suggested that future research could focus on interventions that can help to facilitate disclosure and disrupt the heteronormative assumptions that HCPs can hold. Broadly, research in this area raises concerns that HCPs lack sufficient knowledge to provide appropriate care to LGBTQ+ SU. HCPs routinely call for LGBTQ+ health concerns to be embedded within their teaching (Lena, 2002).

Markey et al., (2014) conducted research into barriers to providing anti-discriminatory healthcare within Ireland. Their findings suggested that HCPs needed to be aware of and understand their own personal, social, and professional values to be culturally competent. Although current research into HCPs attitudes has routinely come to similar conclusions of the lack of knowledge and training that HCPs receive regarding LGBTQ+ SU, there has been less focus on the understanding that HCPs hold about their attitudes and beliefs in this area. To better achieve the interventions suggested by Stewart and O'Reilly (2017) it would be helpful to consider how HCPs talk about their lack of knowledge regarding LGBTQ+ issues and how they make sense of the attitudes and beliefs they hold towards SU in the research that already exists. While quantitative literature has begun to give a clear account of what knowledge HCPs do or do not hold about LGBTQ+ health needs, focusing specifically on qualitative literature may allow for a greater understanding of how HCPs make sense of the way they work with LGBTQ+ SU.

As such, this review aims to critically review the qualitative literature available to answer the question ‘what do physical health care staff say about their knowledge, attitudes, and beliefs regarding providing care for LGBTQ+ people?’.

Methodology

Scope

This review systemically examines the literature for qualitative studies focused on the experiences of HCPs providing healthcare for LGBTQ+ people. Clear inclusion and exclusion criteria were developed to help select relevant articles. Each article was subject to quality appraisal, following which thematic synthesis was completed (Thomas & Harden, 2008).

Inclusion and exclusion criteria

Inclusion criteria:

- Studies published in the England language
- Studies that were peer-reviewed
- Studies where the central voice was those of HCPs working in physical health settings across primary, secondary, and in-patient settings
- Studies which reported on HCPs understanding of their knowledge, views, and attitudes when working with LGBTQ+ SU (i.e. participants considered the factors related to why they held the knowledge they did rather than only stating what they know)
- Studies that used qualitative methodology and analysis, allowing for greater exploration of the understanding clinician's hold about their knowledge, attitudes, and views when working with LGBTQ+ people rather than a surface level assessment of knowledge or willingness to work with LGBTQ+ individuals. Survey based qualitative studies were included provided the study focused on analysing the open-ended questions of the survey.

Exclusion criteria:

- Studies that did not include reflection from participants about their views, for example, research that solely focused on understanding staff knowledge about LGBTQ+ people's healthcare without further exploration about staff's perception of their own knowledge
- Non-qualitative studies
- Studies that focused on staff working in health care outside of physical health care (i.e. mental health)
- Studies where the central voice was not physical health care staff (i.e. the sample was mainly LGBTQ+ SU with one or two staff members interviewed)
- Studies published in Non-English languages
- Studies that used a secondary data source or analysis

Search strategy

The electronic databases ASSIA, Medline, PsychINFO and PubMed were used to conduct a systematic search. To increase the chances of relevant studies being pulled through from the search, international terms such as ‘GLBT’ were included, alongside more ‘traditional’ labels such as gay or lesbian. As many studies considering the needs of LGBTQ+ individuals within healthcare have focused on mental health settings, this was specifically included as an exclusion term.

The following Boolean search terms were combined: [gay OR lesbian OR bisexual OR sexual minority OR gender minority OR LGBT* OR GLBT* OR trans*] AND [clinician OR treating OR practitioner] AND [healthcare OR physical OR health] AND [attitude OR perception OR understand* OR view OR knowledge OR behaviour] NOT mental health.

Studies were first reviewed by their titles, and when thought to be relevant their abstracts were read. Following this, the full text was read of studies thought to be relevant. Additional articles were identified through manually searching reference lists of relevant studies. The search is outlined in Figure 2.

Quality Appraisal

The Critical Appraisal Skills Programme qualitative checklist UK (CASP, 2018) was designed to aid in systematic review of qualitative literature. The tool uses three broad domains to allow for ready comparison of quality across identified studies. The overarching questions used in these domains are: Are the results valid; what are the results, and will the results help locally (how valuable is the research)?

Each study was appraised according to the CASP criteria.

The LGBTQ+ rights in each country were also considered to provide a context in which the HCPs were working in. Country policy was generally provided in distinct categories encompassing marriage and adoption rights, legal protection for LGBTQ+ identities, rights specifically for gender minority people (such as transgender people), and conversion therapy. The author notes at the time of submission (six months following the initial literature search) that LGBTQ+ rights are being challenged in the USA (ACLU, 2022). This reflects the challenge of presenting such information which can be contested. For example, having legal protection may not fully reflect the actual lived experience of LGBTQ+ people within that country, or the dominant narratives that may exist in media. Furthermore, the information exists solely in the time frame in which it was captured.

Thematic Synthesis

A thematic synthesis approach was used to answer ‘what do physical health care staff say about their knowledge, attitudes, and beliefs regarding providing care for LGBTQ+ people?’. Thomas and Harden (2008) proposed a thematic synthesis approach to bring together and integrate findings from multiple qualitative studies. Their approach suggests using three stages, the first two remain ‘close’ to the study through coding and grouping initial codes into descriptive themes. The third stage involved ‘going beyond’ the primary studies and applying analytical themes to generate new interpretive explanations and hypothesis. Following these steps, 115 codes were generated initially through line-by-line coding of each text. These codes were then grouped into seven descriptive themes. The final stage generated four broad analytical themes to answer the review question.

Figure 2

Flow chart illustrating systematic literature search

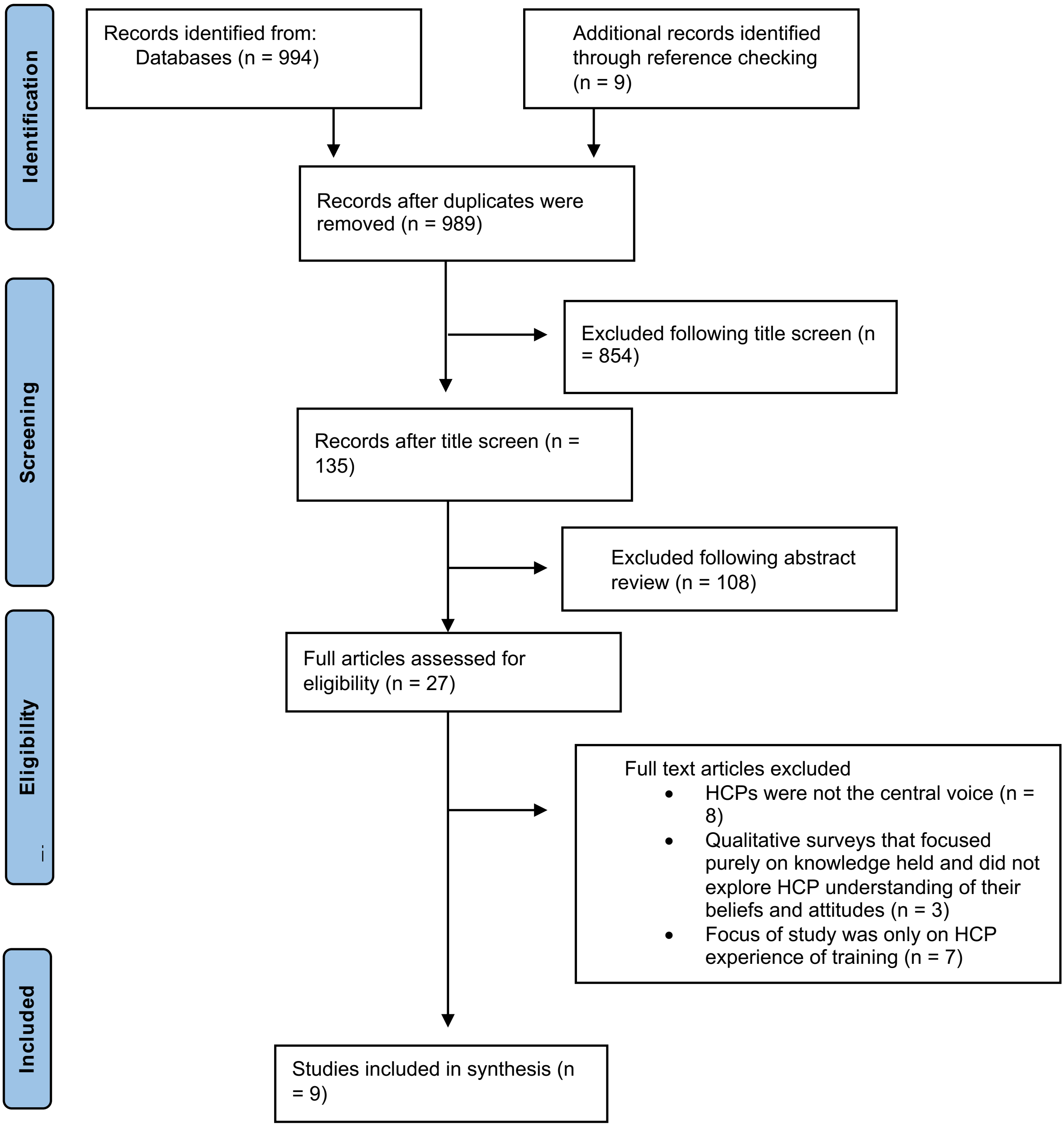


Table 1
Key information by study

Study	Study Aims	Participants and settings	Sampling	Participant demographics	Study design	Analysis	Key findings
Paradiso, C., and Lally, R. (2018). USA	1. To explore the knowledge, attitudes, and beliefs of nurses when working with transgender people 2. To use the information gathered to inform education needs for nurses	**Participants:** 11 nurse practitioners **Settings:** Family (4), Adult (3), Women's health (2), Mental health (1), Nurse midwife (1) **LGBTQ+ population considered:** Transgender people	Purposive sampling was used to identify participants with maximum variation in working with transgender people	**Age, gender, ethnicity, and sexuality demographics were not provided**	Focused semi-structured interviews	Content analysis	Four main themes were identified: 1. *Knowledge gaps*, including personal and professional knowledge gaps 2. *Uncertainty and fear* *3. Caring with intention and pride* 4. *Creating an accepting environment,* including meeting people where they are and the environment sends a message

Sutter, M., Simmons, V., Sutton, S., Vadaparampil, S., Sanchez, J., Bowman-Curci, M., Duarte, L., Schabath, M., and Quinn, G. (2021). USA	A two-part study that aimed to explore oncologists experiences and perspectives in providing care for LGBTQ+ service users. The connected study used quantitative methods to analyse the first part of the survey.	**Participants:** 450 oncologists were sent the survey, 149 responded. 86 (56%) provided written responses to at least one open ended question **Settings:** 45 cancer centres across the USA. **LGBTQ+ population considered:** All aspects of LGBTQ+ identity were included	Random sample of oncologists chosen from National Cancer Institute-designated comprehensive cancer centres as outlined by the American Medical Association. A cancer centre where previous research had been conducted was excluded from the study	**Participant genders:** 64% male 36% female **Participant ages**: Mean age 46.6 **Participants ethnicity (only majority were reported):** 64% White **Participant sexual orientation (only majority were reported):** 91.9% Heterosexual	Qualitative paper survey (where survey was split into two parts and the other part was quantitative)	Inductive content analysis	Four main themes were identified: 1. *Experiences of working with LGBTQ patients with cancer,* including positive, negative, and ambivalent experiences as well as lack of experience 2. *Reservations in treating LGBTQ patients,* including communication barriers, and lack of knowledge 3. *Suggestions for improving cancer care,* which included information-related suggestions and

							providing affirming care 4. *Microaggressions*
Tamargo, C., Mitchell, E., Wagner, L., Simon, M., Carlos, R., Giantonio, B., Schabath, M., and Quinn, G. (2022). USA	To explore clinicians experiences of working with LGBTQ+ service users in oncology settings	**Participants:** 490 healthcare professionals. 228 responded to one or more open ended questions 37.3% nurses 30.3% registered doctors Other professions were not specified **Settings:** Members of the Eastern Cooperative Oncology Group and American College of	Random sampling	**Participant genders:** 48 male 167 female 1 Male to female transgender **Participant age was not reported** **Participant ethnicity:** 170 White 14 mixed race 12 Black 9 Asian 1 American Indian/Alaska Native 1 Pacific Islander 1 'other' 18 did not answer	Qualitative online survey	Inductive and deductive content analysis and constant comparison method	7 themes were identified: 1. *Lack of experience* 2. *Pronouns and gender identification* 3. *Perceived patient attitudes* 4. *Positive experiences* 5. *End of life care* 6. *Clinical care* 7. *Education and training*

		Radiology Imaging Network (ECOG-ARIN) Cancer Research Group in 2016 **LGBTQ+ population considered:** All aspects of LGBTQ+ identity were included		**Participant sexual orientation:** 185 heterosexual 8 bisexual 6 gay 6 lesbian 2 'other' 21 did not answer			
Dorsen and Van Devanter (2016). USA	To explore nurses' attitudes towards LGB patients	**Participants:** 19 nurse practitioners **Settings:** Primary or outpatient care **LGBTQ+ population considered:** Lesbian, gay, and bisexual people	The sampling strategy was not specified	**Participant genders:** 16 female 3 male **Participant ages:** Mean age 41.6 years **Participant ethnicity:** 11 White 5 Black 3 Asian	Semi-structured interviews	Grounded theory	An overall theme was identified as *'Open arms, conflicted hearts'*. 3 sub-themes were developed from this: 1. *Feeling at home* 2. *Struggling to maintain professionalism* 3. *Finding comfort under the umbrella of diversity*

				Participant sexual orientation: 16 Heterosexual 3 Homosexual			
Lu, P., Chun Hsu, A., Green, A., and Tsai, J. (2022). Taiwan	To explore medical student's perception of their values and preparedness to care for LGBT patients	**Participants:** 89 medical students **Settings:** Two medical schools (one private and one public) **LGBTQ+ population considered:** Lesbian, gay, bisexual, and transgender people	Sampling had two phases. **Phase one:** Random sampling through administering a survey to 1545 medical students. 1120 (72.5%) responded. Responses were then analysed. **Phase two:** Random sampling was used to hold initial focus groups with students who had completed	**Focus group participant gender:** 41 male 29 female **Interview participant gender:** 11 male 8 female **Participant sexuality, age, and ethnicity was not reported.**	Focus groups (n = 70) and individual interviews (n = 19)	Inductive thematic analysis	Four main themes were identified: 1. *Attitude and perceptions,* including self-perceived openness, and uncertainties in communication 2. *Bias and stereotypes*, including biases formed in training and reflexivity 3. *Preparedness and skilfulness*, including treating everyone the same way, lacking skills, and lack of

			the first survey. Participants were then recruited through snowball and convenience sampling methods for focus groups. Purposive sampling was used to identify participants to interview				confidence in asking questions 4. *Curriculum*, including adequacy and community participation
Knight, R., Shoveller, J., Carson, A., and Contreras-Whitney, J. (2014). Canada	To explore the perceptions and experiences of clinicians providing sexual health services for LGBTQ youth	**Participants:** 5 doctors 19 nurses **Settings:** Sexual health services across five communities **LGBTQ+ population considered:**	Purposive sampling was used to select clinicians that specialized in providing sexual health services at drop in or appointment clinics	**Participant gender:** 4 male 20 female **Participant ages:** six in 25-40 years category 18 in >40 years category	Semi-structured interviews	Inductive and deductive thematic analysis	Three main themes were identified: *1. Experiences providing LGBTQ youth sexual health care within the heterosexual status quo* *2. Reflections on clinical practice and the social*

		All aspects of LGBTQ+ identity were included		**Participant ethnicity:** 24 Euro-Canadian **Participant sexuality was not reported**			*determinants of LGBTQ youth sexual health* 3. *Changing practices or reproducing the heterosexual status quo*
Sefolosha, A., van Wyk, N., and van der Wath, A. (2021). South Africa	1. Explore and describe the experiences of nurses regarding caring for LGBTQ youth in primary health care clinics 2. Explore and describe the basic social processes involved in facilitating LGBTQ youth-inclusive	**Participants:** 7 nurses **Settings:** Public based and university based primary healthcare clinics **LGBTQ+ population considered:** All aspects of LGBTQ+ identity included	Initial sampling was used to interview five nurses followed by a theoretical sample of three nurses (one participant was part of initial interviews)	**Participant gender:** 7 female **Participant age:** Mean age 48.5 years **Participant ethnicity and sexuality not reported**	Semi-structured interviews	Grounded theory	A substantive theory was developed *' Reframing personal and professional values to facilitate LGBTQ youth-inclusive primary healthcare by nurses'*. The theory consists of three main phases: 1. *Recognising barriers of facilitating LGBTQ youth inclusive care* 2. *Recognising the need to change values and attitudes* 3. *Applying strategies to promote interaction with LGBTQ patients*

	primary health care						
Gannon, T., Phillips, B., Saunders, D., and May Berner, A. (2022). UK	To explore the knowledge, attitudes, and behaviours of paediatric, teenage and young adult oncology clinicians treating LGBTQ+ patients	**Participants:** 8 clinicians (3 paediatric oncologists, 2 clinical nurse specialists, 1 speech and language therapist, 1 occupational therapist, 1 psychologist) **Settings:** Paediatric oncology services in a UK based hospital **LGBTQ+ population considered:** All aspects of LGBTQ+ identity included	Random sampling via advertising email	**Participant gender:** 8 female **Participant age:** Median age 39 years **Participant ethnicity was not reported** **Participant sexuality:** None identified themselves as being LGBTQ+	Semi-structured interviews	Inductive thematic analysis	Ten themes were identified: 1. *Benefits and harms of disclosure and non-disclosure* 2. *Barriers and facilitators of enquiry by HCP/disclosure from patient*, including expected outcomes, structural factors and patient age and development 3. *Parental-carer and patient dynamic* 4. *The patient as an individual outside of their cancer diagnosis*

5. *Discussing sex as part of cancer care*
6. *Lack of confidence in knowledge of LGBTQ cancer care*
7. *Knowledge of appropriate language*
8. *How knowledge of LGBTQ+ cancer care might be acquired*
9. *The 'third party' as the expert on the topic of LGBTQ+ cancer care*
10. *Visible LGBTQ+ affirming materials*

Taliaferro, L., Mishtal, J., Chulani, V., Middleton, T., Acevado, M., and Eisenberg, M. (2021). USA	To understand paediatric and family medicine residents' perceived ability to work with LGBQ youth	**Participants:** 24 paediatric or family medicine residents **Settings:** Exact settings not specified **LGBTQ+ population considered:** Lesbian, gay, bisexual, and queer people	Purposeful and snowball sampling	**Participant gender:** 15 female 9 male **Participants age not reported** **Participant ethnicity:** 18 White 4 Asian 2 Black **Participant sexual orientation:** 21 Heterosexual 1 Gay 1 Lesbian 1 Bisexual	Semi-structured interviews	Grounded theory and content analysis	A main theme arose of physicians not feeling adequately prepared to provide quality care to LGBQ youth. Three main themes were identified regarding recommendations for a formal training programme: 1. *Medical school training: earlier and integrated approach* 2. *Training content: specific and comparative* 3. *Training strategies: Face to face, simulated and virtual*

Literature review

Nine studies were identified, and their key features are outlined in Table 1.

Participants and settings

Studies were selected on the basis that they had physical HCPs as the central voice within the research, and the research focused on their experiences of working with LGBTQ+ people. All studies included met this main criterion, with some variation about who was included and the setting of the study.

There was variation in settings that studies were completed in, ranging from oncology services to sexual health clinics, with some sampling from across different settings. Additionally, the HCPs who were invited to take part in research were primarily nurses, nurse practitioners, and doctors (both qualified and in training). Most studies utilised semi-structured interviews to collect their data, with two studies using open-ended questions from a two-part survey.

One noted variation in the studies was the location in which they were completed, perhaps reflecting that the needs of LGBTQ+ SU in healthcare are becoming more widely considered. However, most studies were completed in North America. Five of the studies were conducted in the United States of America (Dorsen and Van Devanter, 2016; Taliaferro et al., 2021; Tamargo et al., 2022; Paradiso and Lally, 2018; Sutter et al., 2011), one was conducted in Canada (Knight et al., 2014), one in Taiwan (Lu et al., 2022), one in South Africa (Sefolosha et al., 2021) and one in the UK (Gannon et al., 2022). All studies were reported in English.

The included countries stance on LGBTQ+ rights are summarised in Table 2.

Table 2

LGBTQ+ rights within each country

Country	**Legal stance on same-sex marriage and adoption**	**Legal protection for LGBTQ+ identities**	**Specific legislation regarding gender minority individuals**	**Stance on conversion therapy**
USA (Santos et al., 2021)	Same-sex marriage legalised in all states in June 2015. Same-sex couples are legally able to adopt in all states.	Sexual orientation and gender identity are not specifically named in discrimination laws but are considered to be included under ‘sex’, providing some protection from discrimination.	Individuals are able to self-determine gender on passport. In 2022 over 230 anti-transgender laws were introduced, mainly regarding definitions as to who can access public restrooms. 19 states have banned transgender people from participating in sports in their gender identity.	20 states ban conversion therapy for minors. A federal ban on conversion therapy has been proposed.
Canada (Rights, 2022)	Same-sex marriage legalised in July 2005. Same-sex couples are legally able to adopt in all provinces. Three provinces will	LGBTQ+ people are protected from discrimination in law.	Discrimination against gender identity and/or gender expression is prohibited in law.	Practicing conversion therapy is illegal.

	grant parental status to three or more intentional parents.			
Taiwan (Taiwan, n.d)	Same-sex marriage legalised in May 2019. Same-sex couples cannot currently jointly adopt a child, however they may adopt the biological child of their partner.	The constitution does not specifically name sexual orientation or gender identity as protected characteristics, however the rights are explained to extend to ‘other’ classifications including sexual orientation.	Individuals are able to change gender on documentation without requiring surgery. A ‘third gender’ option is currently being added to official documents.	Conversion therapy is banned, and anyone practicing conversion therapy is liable to prosecution.
South Africa (Venter, n.d.)	Same-sex marriage legalised in November 2006. Same-sex adoption legal since 2005. Same-sex adoptive parents are entitled to adoption and/or parental leave.	LGBTQ+ people are protected from discrimination in law, with an explicit statement that this must include transgender people. There is a proposed bill – ‘Prevention and Combating of Hate Crimes and Hate speech Bill’ that would outlaw hate crimes and hate speech.	There are laws that allow people to alter their sex status which allows them to receive new identity documents and passports that match their gender identity. The law stipulates they must have undergone medical or surgical treatment, such as hormone replacement therapy.	The South African Society of Psychiatrists has spoken out against conversion therapy, however it is not banned in law and is thought to still be used.

UK (LGBT, n.d.)	Same-sex marriages legalised in March 2014 in England and Wales, December 2014 in Scotland and in January 2020 in Northern Ireland. Same-sex couples legally able to adopt from December 2005 in England, September 2009 in Scotland, and December 2013 in Northern Ireland.	LGBTQ+ people are protected from discrimination in law, with explicit protection included for transgender youth. Homophobic and racist chants are being banned at football matches.	The Gender Recognition Act 2004 allows for transgender people to change their legal gender and acquire new identity documents.	The English government has stated it's intention to ban conversion therapy for sexual orientation, however this has not yet been put in place. Conversion therapy for transgender people is not included in this ban. The Scottish government has committed to introducing legislation regarding conversion therapy by end of 2023. Northern Ireland politicians have called for a ban on all types of conversion therapy. The Welsh government is seeking legal advice as to whether it can introduce its own ban.

Quality appraisal

Overall, all the studies had a good methodological quality. All studies clearly stated their aims, other than Dorsen and Van Devanter (2016) where the aims were not in the main text, and used appropriate methodology. The recruitment strategy was generally outlined clearly, other than in Dorsen and Van Devanter (2016) where the recruitment strategy was not stated. Generally, the data collection process was appropriate for study designs, except for in Sutter et al., (2020) and Tamargo et al., (2022) which partially satisfied this criterion. Both studies were one part of two-part studies, where surveys were sent to HCPs that consisted of closed questions and open questions. Their counterpart studies used quantitative methods to analyse the first part of the survey that used closed questions, whilst the included studies used content analysis to identify themes from the open-ended section of the survey. Although the approach itself is not problematic, for the purposes of this review the approach is deemed a lower quality compared to semi-structured interviews which allow for prompting and follow up questions, further enabling HCPs to reflect and consider their responses. However, both studies discussed how HCPs understood their knowledge and attitudes and were suitable to include in this review.

Only four of the studies sufficiently considered the relationship between researcher and participants (Dorsen and Van Devanter, 2016; Gannon et al., 2022; Paradiso and Lally, 2018; Selofosha et al., 2021), with one study partially meeting this criterion where the risk of bias was considered in the analysis stage but not more broadly (Taliaferro et al., 2021).

A further consideration of the quality of studies can be seen in Table 3. All studies were thought to have analysed their data sufficiently and provided a clear process of how this was achieved. All studies make a valuable contribution to research.

Table 3

Summary of quality appraisal according to CASP criteria

Paper	Clear aims?	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Relationships considered?	Ethical issues considered?	Data analysis rigorous?	Clear findings?	Valuable contributions?
Knight et al., (2013)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Gannon et al., (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Taliagerro et al., (2021)	Yes	Yes	Yes	Yes	Yes	Somewhat	No	Yes	Yes	Yes
Sefolosha et al., (2021)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Lu et al., (2022)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Dorsen and Van Devanter (2016)	Somewhat	Yes	Yes	Somewhat	Yes	Yes	Yes	Yes	Yes	Yes
Tamargo et al., (2022)	Yes	Yes	Yes	Yes	Somewhat	No	No	Yes	Yes	Yes
Sutter et al., (2020)	Yes	Yes	Yes	Yes	Somewhat	No	Yes	Yes	Yes	Yes
Paradiso and Lally (2018)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Synthesis of findings

Four broad analytical themes were generated to answer the review question. These were: *A willingness and desire to provide quality care; A lack of knowledge and experience; Working in heteronormative spaces; Whose responsibility is it?*

Direct quotes from the study participants, or quotes from the primary research have been used to help illustrate themes.

A willingness and desire to provide quality care

Participants in all studies expressed a desire to provide quality care for LGBTQ+ individuals, with some recognition that this may require a different approach or understanding than currently held.

- **The dilemma of treating everyone the same**

  A common theme that arose across papers was related to HCPs querying whether LGBTQ+ SU require different care to heterosexual and cisgender people. For some, there was a clear sense that LGBTQ+ individuals did not require a different approach and could be treated as if they had the same healthcare needs and would receive the same quality of care without needing to understand their identity.

  "Some of the most confident statements given by HCPs were that knowing a patient identified as LGBTQ+ would not change their medical management stating, 'it wouldn't impact on the treatment decisions'" (Gannon et al., 2022, pg 10)

  "I treat the patient for who they are, white, black, straight, male, gay. You're coming in with an issue. I'm gonna treat you for that particular issue, so I try to just treat everybody fairly." (Dorsen and Van Devanter, pg 3273)

However, other participants discussed that LGBTQ+ SU may require different care and approaches than they are used to providing. The authors of Gannon et al., (2022) suggest HCPs need to hold knowledge of appropriate language and how cancer can be acquired in LGBTQ+ individuals to provide better care. In this study, some participants moved from a position of believing that treating everyone the same was appropriate to wondering whether it may be important to consider difference. This was echoed in other papers where care for transgender individuals was discussed. One participant took this a step further and reflected on the beliefs their colleagues held about working with LGBTQ+ SU and whether a difference in approach is required, describing how everyone may be offered the same ‘bowl of oatmeal'.

“I think sometimes providers just think it’s all oatmeal – that you know, despite the obvious differences, that in the end, they can just translate healthcare into the same bowl of oatmeal for everybody… there are both cultural and biological differences that are unique to gay, lesbian, bisexual, and transgender people…. context is important, that you have to be able to contextualise people’s lives… in order to take care of them in a way that’s meaningful” (Dorsen and Van Devanter, 2016, pg 3724)

“*Maybe we should be looking for something different… I used to always think that by providing care that was the same to people, that I was doing the right thing, but that’s not in fact correct… we should be culturally appropriate all the time”* (Dorsen and Van Devanter, 2016, pg 3724)

Some participants were able to go a step beyond this and did not want to treat LGBTQ+ patients as a homogenous group. Some were able to discuss the unique experiences that certain identities might experience within healthcare. Multiple participants reflected that ability to recognise the individual often came from the clinical or personal experience, rather than from formal teaching. Some spoke about how relying purely on experience may not be the most helpful approach. However, some HCPs believed that having more clinical experience overall may impact their ability to keep up with emerging evidence in supporting LGBTQ+ SU.

"It really has just been based on experience… learning through trial and error… I'm sure there's a better way to do it besides trial-and-error with every patient you meet" (Taliaferro et al., 2021, pg 187).

"I have an assumption that the longer you've been doing this and the older you are the harder it becomes to stay in touch with more recent developments in what good healthcare looks like." (Gannon et al., 2022)

In addition to this, Gannon et al., (2022) acknowledged that LGBTQ+ youth may have increasingly unique needs for clinicians to consider regarding their care. These unique needs ranged from needing to consider the complexity of parental involvement, to considering the potential impact their health conditions may have on their development or fertility and how this may interact with their LGBTQ+ identity. They raise that these issues may be missed within LGBTQ+ youth due to some clinicians holding the view it may not be 'relevant' to their client group.

This proposed a dilemma in how clinicians approach LGBTQ+ individuals. It was strongly considered across studies that it was important for LGBTQ+ individuals to not feel ‘othered’. HCPs across studies who reported having more experience working with LGBTQ+ SU tended to emphasise that to ensure LGBTQ+ people received high quality treatment, there did need to be a different approach that could capture their different needs. For example, participants in Knight et al., (2014) discussed the need to have material that was designed for gay men to support their sexual health needs and the difficulty in obtaining these in their service. Overall studies seemed to agree that it was important to provide quality care for LGBTQ+ individuals, but the practicalities of how to do this were more difficult to agree on.

- **Recognising social stigma**

Across studies, participants showed a willingness and desire to provide quality care by considering the stigma that LGBTQ+ individuals may experience, both in their personal lives and when accessing health care. Some participants reflected on how stigma and prior negative experiences in healthcare may make it difficult for LGBTQ+ SU to be trusting of clinicians. Although HCPs in the studies reviewed recognised this as a barrier to LGBTQ+ SU accessing better care, it was not always apparent where HCPs thought the responsibility lay for improving this. Some used negative language to describe how SU may initially present with them, despite acknowledging this may be due to the stigma LGBTQ+ SU may expect to encounter from HCPs.

“Due to discrimination, the LGBTQ patients I have worked with are very hostile at first expecting they are going to be treated differently and judged” (Tamargo et al., 2022, pg 5)

Some participants reflected about why stigma exists in physical healthcare settings, noting that social biases influenced their training from an early stage. Some participants shared that LGBTQ+ issues in healthcare were rarely discussed in training except in relation to men who have sex with men and discussing sexually transmitted diseases (STD). Lu et al., (2022) reported that participants were aware of biases presented in training about gay men and links with STDs. Participants suggested biases can be useful and are "impressions based on life experiences" (Lu et al., pg 8). Some participants in this study reported their fear that they would begin to believe these biases, moving away from the clinical utility into holding personal beliefs that would "affect their reasoning bias" (Lu et al., pg 8) when supporting LGBTQ+ individuals.

"Some respondents reported an awareness that teachers might have bias against LGBT individuals… They pointed out that teachers would 'directly say male homosexual individual would get AIDS'" (Lu et al., 2022, pg 8)

"...were concerned that these biases would 'gradually make [them] think it's right' and that they would 'commit these biases to memory'" (Lu et al., 2022, pg 8)

Participants across studies also recognised they may hold their own stigma or bias, that came from their personal beliefs or wider dominant narratives that exist for LGBTQ+ people. These personal biases are explored more deeply in a later theme. This was reflected across studies where some participants noted that it felt easier to discuss LGBTQ+ care in relation to sexual disease, as their disease was considered to be directly related to their identity. As such, HCPs felt more comfortable to assume the identity of the SU without needing to ask. Some participants noted feeling uncomfortable with this, and wanting to do better, but feeling unsure about how to approach this differently.

"Participants were able to discuss sexual orientation with LGBTI patients in circumstances where male patients presented with anal sores… According to the participants, such ailments suggest that the patient could be homosexual or engaging in a male-to-male sexual relationship" (Sefolosha et al., 2019, pg 1307)

- **The importance of communication and role models**

  Across studies, participants reflected on what did help them to act on their willingness and desire to provide good quality care for LGBTQ+ SU. A key theme within this was the importance of relying on their communication skills and creating a space where LGBTQ+ patients could feel safe to be themselves.

  "..he must be free for whatever he want to tell me, I'm here to come and help him, he must never be afraid that I'm going to say this and that, no…" (Sefolosha et al., 2021, pg 1311)

  Participants also spoke about the value of having role models of clinicians who were able to positively interact with LGBTQ+ patients to learn from, to develop in their own skill and provide better quality care.

  "My attending was the one who actually told me about how to ask these questions [about identity]…. I think looking at her, observing her doing it, was really helpful to me" (Taliaferro et al., 2021, pg 188)

A lack of knowledge and experience

- **The fear of getting it 'wrong'**

  All studies had themes related to participants reporting a lack of knowledge about working with LGBTQ+ individuals. One of the ways in which participants discussed the impact of their lack of knowledge was related to a fear of saying something wrong to their clients, and perhaps verging into ignorant or homophobic/transphobic stances without realising.

  "*some oncologists reported fear of offending someone by using inappropriate language…"* (Sutter et al., 2021, pg 873)

  "we found that a commonly cited barrier for enquiry [about identity] by HCPs was over fear. This included fear of: 'getting it wrong', 'embarrassing themselves', and 'making (patients) feel uncomfortable" (Gannon et al., 2022, pg 6).

  Participants spoke about how fear of getting it wrong meant they did not always know how to ask about identity, or topics which they deemed to be 'sensitive' related to anatomy or sex. Participants spoke about their desire to have more knowledge and training on how to be better able to ask these questions. One participant spoke about feeling like they had let a patient down due to the team's lack of knowledge and ability to work with LGBTQ+ individuals.

  "Screened a [transgender] patient for on oncology clinical trial… if we should enroll the patient according to her presenting gender identity or gender assigned at birth…. Ultimately the patient declined being screened for the study because of the hesitation

regarding treatment. I believe we did the patient a disservice" (Tamargo et al., 2022, pg 4)

Participants identified approaches that could help overcome this fear. For some, this meant explicitly naming the fear within the clinical team, describing that when this happened the team were more comfortable in asking questions related to identity. Participants spoke about how having these conversations between staff helped them to develop the confidence to then take this into their wider clinical work. Another approach that helped participants to overcome this fear was in drawing on the support from external teams, such as gender identity clinics.

"One participant noted that one such discussion 'brought down all barriers to be able to talk about [sexual orientation/gender identity] between staff because it was something that became very comfortable after that." (Gannon et a., 2022, pg 6).

However, some participants did not share this fear of offending their LGBTQ+ SU, and instead believed that identity was not important in relation to healthcare unless directly related to their condition, and most commonly regarding sexual health risks. This came up across multiple studies, and there appeared to be a lack of reflection regarding this stance and how it may impact the quality of care that LGBTQ+ individuals receive.

"I am trying to treat them on original gender. Do not ask. Do not tell." (Sutter et al., 2021, pg 874)

"when asked how sexual orientation might influence care or medical needs, the vast majority of participants in this study framed LGB health solely in terms of sexual practices… in lieu of a more comprehensive discussion of LGB health risks and health inequalities." (Dorsen and Van Devanter, 2016, pg 3722)

- **Navigating 'sensitive' topics**

  Participants expressed their worries about their lack of knowledge in relation to having what they considered 'sensitive conversations'. These were often in relation to discussing topics such as identity, sex, transitioning and use of pronouns. This, alongside the fear of getting it 'wrong', meant multiple participants spoke about not knowing 'how' to ask these questions. For some, this aspect of lacking knowledge led to them reporting feeling inadequate in their abilities to care for LGBTQ+ SU. Some participants expanded on how this feeling decreased their confidence in supporting LGBTQ+ SU and how this could feel difficult to overcome.

  "… I just felt woefully inadequate… I do not know what I am supposed to be looking for [in supporting trans people with reproductive health]…I felt inadequate as a healthcare provider. That was the daunting part of it for me." (Paradiso and Lally, 2018, pg 52).

  "...how much to question their patients' feelings regarding sexual orientation and gender identity: 'this whole issue of emerging identity is very tricky'. This is a specific issue of concern in treating paediatric patients and has not been given focus in previous literature." (Gannon et al., 2022).

- **A lack of teaching/learning opportunities**

Participants noted their frustration at their own lack of knowledge in this area. Despite feeling willing to learn and improve on their knowledge, many spoke about how their initial training had not usefully incorporated LGBTQ+ issues, and that further opportunities to learn were limited. Across studies, participants also spoke about having a willingness to learn more.

However, some participants in Sutter et al., (2020) spoke of acquiring LGBTQ+ knowledge as being an additional task that they did not have time for as there are other priorities within healthcare, including the healthcare for other minoritised groups.

"In an NHS pressed on resources and time and energy it sometimes feels like yet another thing to have to worry about" (Gannon et al., 2022, pg 7)

"At our institution we have had issues with cultural sensitivity in regards to underrepresented racial/ethnic minorities, so that would probably be the first educational priority." (Sutter et al., 2020, pg 873)

For participants who did express a desire for more formal training regarding LGBTQ+ healthcare, they suggested this should be embedded within training rather than being a standalone module. Participants reflected on how giving space for LGBTQ+ identities completely separately to their usual training may increase bias, rather than reduce it.

"..you don't want to make it so much that they're some kind of other group that it becomes almost like you're stereotyping or profiling in a way" (Taliaferro et al., 2021, pg 189)

Furthermore, clinicians who identified as being part of the LGBTQ+ community reflected on how their own identity could hinder their own learning if they leant into an assumption that they are aware of LGBTQ+ health needs solely because they themselves are LGBTQ+. They discussed how this would be a representation of their own bias that might mean they miss the needs of the person in front of them. This highlights how it was important for all HCPs to be able to reflect on and understand the knowledge, attitudes, and beliefs they hold towards their LGBTQ+ SU.

"*As part of the LGBT community myself, this survey is making me aware of my own lack of knowledge regarding health inequalities and challenges that the LGBT community might face*" (Tamargo et al., 2022, pg 6)

- **Personal vs professional values**

  Some participants openly discussed holding negative views of the LGBTQ+ population. In all studies these views were often associated with the religious beliefs held by the HCP.

"I personally think it is wrong" (Tamargo et al,, 2022, pg 6)

"They perceived LGBTI as a 'taboo object', 'unreal', 'immoral', 'exhibition of anti-Christian behaviour'." (Sefolosha et al., 2021, pg, 1306)

Generally, these participants believed that their personal beliefs could be held separately from their professional values, and as such they would treat LGBTQ+ SU the same as they would a heterosexual or cisgender patient. There was little reflection evident about whether these beliefs may unconsciously alter their treatment of

LGBTQ+ individuals. However, some participants shared that being involved in these studies had given them the opportunity to start reflecting on these issues, and that they would likely continue to reflect after their interview.

"Indeed, one participant found the discussions from the interview for this study were a start to initiate reflection and how their practice could be changed to improve LGBTQ+ health: 'having research forums like this and being able to sit and reflect and think about it probably makes it easier to think about how you do this in real time.'" (Gannon et al., 2022).

In studies where negative views were openly discussed, they were often paired with a reliance on stereotyping to distinguish who was LGBTQ+. One participant described their shock at learning their patient was gay, due to their belief that gay people did not live in their rural town. This participant ended up in the same belief that her stereotyped viewpoint would ultimately not impact on her ability to care for the person in front of her.

"...you know it was a shock to me because I'm from a rural area... lesbians, gays... are still... I can say a 'no go' area... Okay they actually do exist" (Sefolosha et al., 2021, pg 1306)

Leaning on stereotypes also arose when not related to religious beliefs. Multiple studies reported participants discussing that they had never worked with someone from the LGBTQ+ population, particularly in relation to transgender people. Some participants reported being able to tell who was LGBTQ+ by looking at them. No participants were reported to have reflected on possible links between the personal belief they held about who 'looks' LGBTQ+, or their belief that they had not supported any LGBTQ+ SU, and whether they felt confident to ask about people's identities in their professional lives. It is acknowledged this may have been outside of the scope of the presented studies, or personal reflections may not have been included by authors.

"I have no experience speaking with patients of the LGBTQ community. If I did, it was not [to] my knowledge" (Tamargo et al., 2022, pg 4)

Working in a heteronormative space

Some participants spoke about how the ways in which teams are set up impact on their ability to provide better care. A common issue was related to paperwork and forms being non-inclusive in nature and requiring HCPs to be quite rigid in asking about gender identity. Participants reflected on how this made it more difficult for them to talk about gender identity in a more supportive way.

"Some people say 'I'm neither'. I'll say 'Well look at my screen. I have to pick one or the other, the screen won't let me go on. Why don't we base it on your genitals?'... It would probably be better to offer as many options as you can give." (Knight et al., 2014, pg 667)

Furthermore, one participant spoke about the difficulty of working in a team where only heteronormative resources were available. She discussed having to 'smuggle' in gay specific information for a sexual health clinic, whilst also describing the information as 'graphic'.

"*I have a book that we smuggled in from the States that goes through gay male sexuality… around HIV prevention in a very graphical, gay male way*" (Knight et al., 2014, pg 667)

Another participant described the difficulty in standing up to a colleague regarding the incorrect use of pronouns about a client. Participants across studies spoke about the difficulty in changing the heteronormative space they worked in, whether that was through the paperwork they had to use or challenging openly held anti-LGBTQ+ views within the team.

"…referred to the patient as a [transphobic slur]. I found this problematic…other faculty member laughed and didn't think there was anything wrong with the use of an insensitive pronoun…" (Sutter et al., 2021, pg 874).

However, some participants were reluctant for the spaces they work in to change. Some shared their worry that by creating a more inclusive or non-heteronormative clinical environment through displaying LGBTQ+ specific information, they would alienate other SU who accessed their clinics. This may link into the HCPs personal beliefs about who is most important to ensure they feel 'safe' and able to access healthcare.

"if you're a parent, you wouldn't want to see things like that on the wall you have to take the parents kind of concerns and feelings into consideration as well" (Gannon et al., 2022, pg 8)

Whose responsibility is it?

- **LGBTQ+ people hold the knowledge**

Across studies, participants discussed how they gained more knowledge about LGBTQ+ health. Some reported using google to find out information quickly to better support their LGBTQ+ SU, either in session or shortly afterwards. Most often, participants spoke about learning only when they met a SU who was LGBTQ+, or from speaking with LGBTQ+ people in their personal or professional lives.

"I have a lot of friends that identify as LGBTQ+ and so I would ask them…" (Gannon et al., 2022, pg 10)

"I am caring for a patient who began the public transition from male to female and I have learned much from this patient's experience in the context of greater possibility of transgender persons" (Sutter et al., 2021, pg 872)

None of the studies reported participants reflecting on whether a reliance on LGBTQ+ people to be teachers and 'make up' for their lack of knowledge may impact on their LGBTQ+ SU. Some LGBTQ+ participants spoke having a greater involvement in fostering LGBTQ+ knowledge in their teams, however, this did not extend to a reflection on how this impacted on their work in the team.

"I am a gay male physician and have significant involvement in my community, medical center and medical school in relation to LGBTQ issues, education and awareness" (Tamargo et al., 2022, pg 6)

- **Everyone's responsibility?**

  Although participants generally broached the idea of making up for a lack of education as coming from training institutions, participants did remark on how it should not be left to individuals within a team to carry the knowledge and encourage better care for LGBTQ+ patients.

"..Everyone should be responsive without a nurse having to be the champion for transgender patient any more than they are champions for all patients." (Tamargo et al., 2022, pg 6)

However, some participants discussed their beliefs that non-clinical services might be better suited to support LGBTQ+ SU regarding their identity, and that clinical services can better focus on de-stigmatising health specific stigma. Other participants noted that to support LGBTQ+ patients to access external services, then clinicians firstly need to be aware of the existence of external services. When participants were aware of how external services could support them, they described this way of working as beneficial.

"…one oncologist noted having expertise from their gender dysphoria clinic was 'invaluable in assisting…. In the care of my patients'. Other oncologists described the involvement of social workers in identifying unique needs of their patients." (Sutter et al., 2021, pg 872)

Discussion and limitations

The most striking theme from this review is related to the lack of knowledge that HCPs identify for themselves when working with LGBTQ+ SU. This review also highlights that there are some areas in which HCPs were more reflective in their understanding of the knowledge, beliefs, and attitudes they held towards LGBTQ+ SU. For example, participants across studies were able to reflect on why they lacked knowledge regarding LGBTQ+ healthcare, and how their exposure to stigmatised views whilst training may impact on their attitudes throughout their career. However, in the studies reviewed it was not often reported that participants had reflected more deeply on the personal stigmas and biases they held towards LGBTQ+ individuals, with participants often moving to a position that these would not impact on their ability to carry out their job respectfully and thoughtfully when working with LGBTQ+ individuals. However, research suggests that these types of attitudes can negatively impact on care that is provided (Westwood, 2022). Some clinicians were not aware of the biases they held and how they may impact their practice. For example, LGBTQ+ communities are more likely to be viewed as promiscuous (or 'overly sexual') (Rice et al., 2021). Staff describing material designed for gay men as ‘graphic’ when working in a sexual health clinic (Knight et al., 2014) may suggest the team held such stigmatised views. Rice suggested that these associations can lead to people expressing more stigma and discrimination towards LGBTQ+ people, particularly in LGBTQ+ people who do have an STD, despite research suggesting these biases are not as valid as commonly believed (Everett, 2013). This is supported by the evidence regarding healthcare inequalities for LGBTQ+ people and the reports of stigma and discrimination within healthcare. However, participants generally shared a desire to provide better quality of care.

In addition, the importance of approaching healthcare through an intersectional lens was missing in discussions with participants. Bowleg (2012) discusses how viewing healthcare through individual identity, such as solely focusing on gender or ethnicity, misses the context of someone’s whole experience as they may be impacted by multiple systems (such as racism and homophobia) of oppression within healthcare.

Limitations

Thomas and Harden (2008) discuss how the researchers own experiences and interpretation will inevitably shape the analytical themes that are created when using thematic synthesis. This review was conducted by a trainee psychologist who identifies as being part of the LGBTQ+

community. The researcher's own negative experiences of accessing healthcare and experiencing stigma will have influenced the final analytical themes presented in this review. The researcher attempted to overcome this by explicitly looking for the 'good' and exploring this through the first theme of '*a willingness and desire to provide quality care'.* Supervision was used to help the researcher to reflect on their own positioning. Despite this, it is felt that the themes are reflective enough of the studies presented. The themes found also reflect other research considering both the experiences of HCPs (e.g., Stewart and O'Reilly, 2017) and provide the 'other side' of themes reported in research focused on the experiences of LGBTQ+ SU (e.g. Casanova-Perez et al., 2021; Logie et al., 2019; McCann et al., 2021; Schwab et al., 2022).

Another limitation is related to the voices represented within this review. The review question remains broad, using the term 'physical health care staff', however, most staff voices in this view are those of doctors and nurses. It was decided to keep the breadth in the question to include studies that did include staff voices of allied health professionals. Furthermore, it is likely that participants who took part in all studies may be more 'allied' with members of the LGBTQ+ community and innately desire to provide better care. Even in studies where negative attitudes were openly discussed, these were within a context of wanting to provide quality care despite this. Possibly there are HCPs in the workforce who do not believe that improving healthcare for LGBTQ+ patients is a priority, and they may be less likely to take part in these studies. As such, although these studies do present some level of breadth of viewpoint, it is likely that it does not consider all aspects in how HCPs consider (or do not consider) these issues.

Clinical implications

Participants reflected that when LGBTQ+ health was included in training, it was often based on stigmas around sex in the LGBTQ+ community. Although some participants reflected on the impact of social stigma on these training experiences, more often these ideas were presented as ‘fact’ and not seen as being harmful. This indicates that training needs may start at a level of making clinicians aware of how deeply heteronormativity is embedded within healthcare. This is especially important as research focused on LGBTQ+ SU experiences within healthcare have reported that often SU can feel uncertain about meeting new HCPs due to previous negative experiences (Maragh-Bass et al., 2017). Currently, within the NHS there is a push to deploy LGBTQ+ ‘basic awareness training’ (Willo, 2021). Although this will go some way to helping HCPs gaining surface level knowledge about LGBTQ+ healthcare, some research that argues that simply having diversity training regarding LGBTQ+ issues are not enough to combat heteronormativity within healthcare (Dean et al., 2016). A recent open letter from clinical psychologists in the UK also requested that training programmes commit to including teaching on gender identity development with the aim to ‘increase the number of clinical psychologists who are skilled in working with this [transgender] population’ (Open letter to the ACP-UK, 2022). The studies included in this review suggested that there are HCPs who are keen for LGBTQ+ healthcare to be better embedded within training in this way. As such, it will be important for clinical teams and training programmes to consider how to adapt their training to better represent the breadth of people and the intersection of identities that HCPs will support throughout their career. Research has suggested some ways in which this can be achieved, such increasing exposure to LGBTQ+ SU within usual clinical examinations (Knockel et al., 2019). Participants also found the input of external staff teams and organisations helpful when supporting LGBTQ+ SU, which is an important aspect of delivering high quality healthcare (Ndoro, 2014). HCPs should be encouraged to develop these links.

One of the themes focused on the heteronormative spaces that HCPs found themselves working in. Research suggests that LGBTQ+ SU are more likely to trust HCPs who worked in non-heteronormative environments (Utamsingh et al., 2015). Clinical spaces should have accessible and visible LGBTQ+ affirming materials available (Gannon et al., 2022). Demographic recording systems should also be updated to accurately capture identity without impacting on healthcare needs (e.g., ensuring anyone with a cervix is invited for cervical screening, regardless of gender identity).

Some participants reflected that taking part in the study helped them to begin a journey of reflection with the care they provide to LGBTQ+ individuals. For some professions, such as nursing and psychology within the UK, reflective practice is embedded within training process and is a crucial part of the profession. Taking part in reflective practice, either in a group setting or individually through journaling, may help HCPs to integrate new knowledge into their clinical work (Mann et al., 2009). However, not all healthcare disciplines are introduced to this space within their training. These spaces do not always need to be formal, and participants shared their experiences of having conversations with LGBTQ+ colleagues that also helped them to develop in their knowledge. Where possible, it may be helpful for healthcare teams to introduce elements of reflective practice, both formal and informal, into their teams. Considering the model proposed by Flentje et al., (2020), any interventions which reduce the amount of minority stressors encountered by LGBTQ+ SU in healthcare could help to improve the overall health of this population.

Research implications

Much of the research regarding LGBTQ+ experiences within healthcare is focused on adults and are often diagnosis and identity specific. This is reflected within this review, where only three of the nine studies reviewed considered the voices of HCPs working with LGBTQ+ youth. The authors of these studies also reflected on the unique needs of LGBTQ+ youth and how much of the current knowledge is based on research on LGBTQ+ adults (Gannon et al., 2022). Often where research is completed with LGBTQ+ youth, the focus is on their mental health or the adverse outcomes they experience, and few studies have provided in-depth interviews and analysis with either LGBTQ+ youth or HCPs that work with them to consider how to provide the best quality of care. Supporting young LGBTQ+ people within healthcare to have better experiences may help to mitigate the longer-term impact of minority stressors, allowing them to have better health throughout their life. It will also be important for any future research to consider the intersection of identities that people come with, rather than solely focusing on LGBTQ+ identity.

As suggested by Stewart and O'Reilly (2017), it will be important for future research to develop ways in which to improve teaching regarding LGBTQ+ health into training programmes. Research should also continue to consider the current interventions that are in place within clinical settings, such as the NHS rainbow badge or diversity training, and whether these improve the experiences of LGBTQ+ SU.

Conclusion

This review suggests there is a desire within HCPs to provide better quality care for LGBTQ+ SU, with a recognition that there is a lack of knowledge within teams to do this currently. HCPs were also able to reflect on the knowledge, beliefs, and attitudes they held towards LGBTQ+ SU, however it was difficult for this to extend to a more personal level. It is suggested that future research considers the experiences of LGBTQ+ youth and the HCPs that work with them as their experiences are considered less in the literature. It will also be important for clinical training programmes to better embed LGBTQ+ healthcare needs throughout the curriculum.

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NICOLE WILLIAMS BSc (Hons)

SECTION B: EMPIRICAL PAPER

“*I DIDN’T COME HERE FOR YOUR JUDGEMENT”* ALONGSIDE “*THEY UNDERSTAND YOU AND ENCOURAGE YOU*”*:* EXPLORING THE NARRATIVES OF YOUNG BLACK AND MIXED-RACE LGBTQ+ PEOPLE WHO HAVE A PHYSICAL HEALTH CONDITION AND THEIR EXPERIENCES WITHIN PHYSICAL HEALTH SERVICES.

Word Count: 8000 (+313)

A thesis submitted in partial fulfilment of the requirements of
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Doctor of Clinical Psychology

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SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) individuals experience health inequalities. Young people living with a health condition are also more likely to experience adverse mental health outcomes. Developing positive identity can help to mitigate the impact of this. Young black LGBTQ+ people have additional barriers to developing positive identity. Current research rarely considers the intersection of these identities for young people despite the stigma and discrimination they may face, and the impact this may have on their mental and physical health. A narrative approach allows these voices to be heard in research.

Eight participants were interviewed using a narrative approach. Interviews were analysed using content and thematic narrative analysis. Global summaries of each interview were developed and 'plot lines' emerged from these. A central plot related to identity development, with two plots embedded in these exploring experiences of illness and of healthcare. Participants had positive experiences of healthcare despite encountering stigma. Access to positive role models and being able link in with various communities allowed participants to integrate and accept their identities. A key discussion point in this study is the ways in which healthcare staff could become role models for young LGBTQ+ people and help them to integrate and accept their identities.

Key words:
LGBTQ+, health, intersectionality, narrative, identity

Introduction

Health inequalities

Health inequalities are defined as "avoidable, unfair and systematic differences in health between different groups of people" (Williams et al., 2022, pg 1). Health inequalities impact 'groups' of people and within England are thought about within four separate categories (King's Fund, 2021), although people may fall into more than one; socio-economic factors, geographical location, specific protected characterises (such as sexuality or ethnicity) and socially excluded groups (such as people experiencing homelessness). The National Health Service (NHS) long term plan has committed to systemically reduce health inequalities to ensure that better care is provided to all types of people (NHS long term plan, 2019).

A theoretical framework used to consider the existence of health inequalities is intersectionality. The intersectional framework argues there are multiple marginalised social categories that people can fall into (e.g., ethnicity, gender, sexual orientation) and these will intersect at an individual level and a social-structural level made apparent through systems of oppression and privilege (e.g., racism and homophobia) (Bowleg, 2012). Research that does not use an intersectional lens, such as focusing on race or gender individually to consider health outcomes, is not always sufficient to explain inequalities. Bowleg (2012, pg 1269) gives the example of a middle-class Latina lesbian accessing healthcare and how her experience is impacted by "interlocking sexism, heterosexism, and racism at the macro level" and mirrors existing separate literature regarding lesbian women's and ethnic minority women's experience of healthcare (e.g. Aaron et al., 2001; Krieger et al., 1993). Focusing on just one aspect of her identity would miss the context of her whole experience.

Lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) people are one such group that experience health inequalities, both in terms of their physical and mental health (Institute of Medicine, 2011). Young LGBTQ+ people face increased levels of mental health symptoms and suicidality in particular following discrimination in relation to their identities (Huebner et al., 2004; Rivers, 2001).

Minority Stress Theory

One theory that may explain the worse mental and physical health outcomes for young LGBTQ+ people is minority stress theory (MST) (Meyer, 2003). MST theorises that stigmatising events are unique psychosocial stressors that can lead to negative health outcomes (Meyer, 2003). MST is specific to 'minority status' (e.g. sexual orientation), and 'minority identity' (e.g., Lesbian). It is important to consider MST through an intersectional lens (Williams et al., 2020) as other minority identities (such as gender or ethnicity) can impact on the type of discrimination experienced as well as coping methods (Hatzenbuehler, 2009). Meyer described two different types of stressors that LGBTQ+ individuals may experience, alongside general stressors. Distal stressors refer to external events (such as experiencing discrimination from an individual, group, or institution) and proximal stressors refer to the internal psychological processors that can occur, such as expectation of rejection and internalised homophobia. Distal stressors may also include the influence of dominant narratives that can hold negative perceptions of minority statuses. For example, media conversations about transgender children and whether it is moral to use gender affirming care such as puberty blockers (Lawrie, 2021), and religious decisions as to whether same-sex couples can be married in churches (Sherwood, 2023). Dominant narratives in the UK have become more accepting of LGBTQ+ identities, with more visible LGBTQ+ people being in positions of power and greater legal protection against discrimination (Equality Act, 2010).

Within LGBTQ+ youth, minority stressors predict negative psychological and physical health outcomes (Flentje et al., 2020; Kelleher, 2009; Quinn et al., 2015). Young people who have health conditions are more likely to face isolation, increased pressure within family units, and poorer mental health than their peers (Combs-Orme et al., 2002; Hysing et al., 2007; Mercer et al., 2015). These difficulties are similar to outcomes that young LGBTQ+ people may face. For young people with a physical health condition who are also LGBTQ+, minority stressors may impact, and possibly worsen, their usual symptoms. Links between physical health symptoms and stress have been well researched, such as inflammation and pain in rheumatoid arthritis worsening after experiencing stress (Thomason et al., 1992).

Furthermore, young LGBTQ+ people will spend greater amounts of time in healthcare settings compared to their peers where 13% of LGBT people report experiencing discrimination, with this number rising to 19% amongst people from black minority groups (Bachmann & Gooch, 2018). LGBTQ+ service users within the NHS have reported experiences of overhearing negative and homophobic comments (Somerville, 2015), and report delaying access to health services. In response to this, there has been a push to promote the safety and inclusion of LGBTQ+ staff and service users in the NHS (Hancock, 2020). Although these changes are positive, there has been little research done to understand the current experiences of young LGBTQ+ people with a physical health condition within NHS physical health services.

The role of identity

Meyer suggested that the impact of stressors can be mediated through a variety of ways, including access to community and social support, and the ability to integrate minority identity into values and life. One way in which this could be achieved is through the development of positive self-identity and self-acceptance (Camp et al., 2020). Erikson (1968) considered identity to be related a sense of who a person is and who are they in relation to their contribution to society (Hoare, 2002). Erikson proposed a lifespan approach to identity development that included eight distinct stages (Table 1).

Table 1
Erikson's suggested life stages

Stage	Age (years)	Description
Trust vs. Mistrust	0-1.5	Development of attachment to caregiver and development of sense of hope or mistrust
Autonomy vs. Shame and Doubt	1.5-3	Focus is on developing independence and control over physical abilities. Aim is to better gain self-control without impacting on self-esteem.
Initiative vs. Guilt	3-5	Primary focus is on relationship building outside of attachment figure. Play is a key element at this time.
Industry vs. Inferiority	5-12	Focus is on developing a sense of competence and achievement, striving to be what is valued by society
Identity vs. Role Confusion	12-18	Exploration of personal values, beliefs, and goals and where they 'fit' in society
Intimacy vs. Isolation	18-40	Focus is on forming strong and intimate relationships with a variety of people and being part of an accessible community.
Generativity vs. Stagnation	40-65	Focus is on a sense of 'giving back' to society through work and/or childcare. Attempting to build a legacy.
Ego Integrity vs. Despair	65+	Focus becomes centred on reflecting about life and what has been achieved or not achieved

The adolescent stage is thought to be extremely important in overall identity development due to the physical and cognitive changes that are occurring at this time alongside greater social expectations being placed on young people as they grow.

Arnett (2004a; 2004b), proposed an update to Erikson's theory named 'emerging adulthood' which occurs between the ages of 18-25 and has five features (Table 2). He suggests that emerging adulthood is key in the exploring of different identities and many at this point may feel 'in-between' adolescence and adulthood.

Table 2
Arnett's emerging adulthood features

Feature	Description
Age of identity exploration	Grappling with 'who am I' in relation to work, school, and love.

Age of instability	Possible likelihood of frequent changes in residence e.g., going to college, moving in with friends or a partner
Self-focused age	Less likely to be ‘tied in’ to responsibilities such as having children and as such can focus on who they want to be and where they want to go
Age of feeling in-between	Beginning to take responsibility for self but not yet feeling like an adult
The age of possibilities	Holding to the hope that life will be better than previous generations

Tsang et al., (2012) used these theories to consider how positive identity may be formed or enhanced for young people. They suggest three strategies can help this process; promoting self-esteem, fostering exploration and commitment, and reducing self-discrepancies between the different ways their identity can be viewed, such as their real self, versus the perception of others.

Identity development may be different for young people who have a physical health condition as the perception and integration of their health condition into their identity can impact on overall quality of life (Steinberg, 2020; Van Bulck et al., 2018). This is challenging as research suggests that young people with a physical health condition have fewer opportunities than their counterparts to explore identity (Olsson et al., 2009). Discovering an LGBTQ+ identity has culturally different milestones in identity development, including explicitly recognising queer attraction, questioning identity, and decisions related to coming out (Hall et al., 2021). Young black LGBTQ+ people are also less likely to have access to community support, as well as experiencing more discomfort about coming out which can delay identity integration and positive self-identity development (Rosario et al., 2004). Social media and the internet can be a safe space to explore and understand identity (Morris, 2020) and can provide an area in which counter narratives can be presented (Bates et al., 2020).

Although Erikson argues that adolescence is a key time of development for all, it is an especially important time for young black LGBTQ+ people who are living with a physical health condition. Those who can accept their health condition (Steinberg, 2020), as well as their sexual or gender identity (Camp et al., 2020) are more likely to develop a positive self-identity which can mediate minority stress (e.g., Pepping et al., 2019). Having access to positive LGBTQ+ role models and receiving strong social support is important to positive self-identity development (Bruce et al., 2015).

Current research

Studies have considered young people's experiences of living with various health conditions (Atkin & Ahmad, 2001; Benson et al., 2000; Sawyer et al., 2007), with relatively few studies considering the experience of LGBTQ+ people within physical health settings. Those that do tend to be diagnosis and identity specific and explore adult experiences. For example, considering lesbian, gay men, and bisexual people's experience of cancer care (Fish & Williamson, 2016), and transgender people's experiences within mental health or gender identity services (Benson, 2013; Ellis et al., 2015). Research has rarely focused on young people in this area, despite the role that identity plays in the transition to adulthood (Tsang et al., 2012) and the importance of positive self-identity development in both young black LGBTQ+ people and those with a physical health condition (Bruce et al., 2015; Sharpe et al., 2013).

Stern (2021) conducted a systematic review into the perspectives of LGBTQ+ youth and paediatricians. The findings suggest that largely LGBTQ+ youth are not routinely asked about their gender or sexual minority identity, and in one study, 71% of youth reported wanting LGBTQ+ specific healthcare clinics (Snyder at al., 2017). This raises concern as to whether the stressors that these young people may be experiencing due to their minority identity are not considered despite their impact on physical health.

Allowing people space to tell their stories can be empowering and help to develop positive self-identity (Elderton et al., 2013) which can help mediate the impact of minority stress. Narratives have been used in research as a way of allowing people to tell their whole story including 'coming out' in LGBTQ+ adults and in relation to resilience (Bacon, 2003; Bower et al., 2021). There has been a call for health psychology research to implement the use of narratives (Stephens, 2010). This method allows for LGBTQ+ young people with a physical health condition to consider their experience as a 'whole'. When multiple people are given an opportunity to tell their stories, group narratives are harder to dismiss than individual stories, and as such can hold more political power (Plummer, 2006).

Rationale and aims

Allowing young LGBTQ+ people who have a physical health condition an opportunity to tell their story may contribute to our understanding of their current experiences of healthcare. Currently there is limited research considering the experiences of young people who have minority identities alongside their physical illness, despite health inequalities and proposed strategies to reduce them. As such, the aims of the study were to explore the narratives of young LGBTQ+ living with a physical health condition.

The following research questions will be considered:

- **a.** What stories do LGBTQ+ young people with a physical health condition tell about their relationship with staff and the process of coming out to health care providers?
- **b.** What stories do LGBTQ+ young people tell about navigating their physical health condition in the current social context?
- **c.** What stories do LGBTQ+ young people with a physical health condition tell about their identity?
- **d.** How are the dominant discourses surrounding LGBTQ+ identities, including those on social media, represented in the personal stories of young people?

This study in rooted in the NHS values (NHS England, 2021), particularly *everyone counts* as the stories of a group that are marginalised and occupy little space in the literature are heard. This study also values identity, with *respect* and *dignity* being highly important.

Methods

Design

To help answer the proposed research questions, this study follows a qualitative design using narrative methodology. There are multiple approaches to a narrative method and there is not a set structure to analysis (Reissman, 2008). However, there are commonalities, and this study draws upon holistic content, performative, and thematic narrative approaches (Bamberg, 1997; Riessman, 2004) and pays particular attention to the social context (Phoenix, 2013) in which the narrative was told to consider the presence of dominant narratives and whether these are subverted.

Epistemological position

This study sits between a social constructionist and critical realist position. Certain labels and language are used that are in line with a critical realist approach (e.g. the use of LGBTQ+ and long-term physical health conditions as a concept), and it is considered that the experiences participants narrate are 'real'. However, the assumption is held that narrative interviews are socially co-constructed to help participants make sense of their experiences (Esin et al., 2014). Furthermore, the narratives may also allow participants to explore their identity and how they relate to dominant and community narratives.

Participants

The inclusion criteria were:

- *Aged 13-24.* This was decided by Erikson's (1968) life stage theory with the addition of the emerging adulthood stage as proposed by Arnett (2004a; 2004b). Participants in these developmental stages were thought to be able to co-construct a narrative of their life and talk about sexual orientation and/or gender identity.

- *Required support (or previously required support of) a paediatric team and were followed up at least once every three months.* Rather than define specific conditions that would constitute a physical health condition, participants were screened by the level of input required to support them with the belief that support of at least every three months indicated a condition that is likely to impact on daily functioning.
- *Part of the LGBTQ+ community*. Those who were questioning their gender or sexual orientation were invited to take part to capture narratives related to uncertainty and ongoing development of identity.
- *English speaking individuals*. As the narrative method relies heavily on language, participants were required to have a good level of spoken English to ensure that the meanings of narratives were not lost in translation.

Eight participants were recruited via social media. An unofficial snowball sampling may have occurred, as it is unknown in which spaces the recruitment poster was shared by potential participants. It is not known whether participants accessed the same online support communities or if the recruitment poster was shared in spaces for LGBTQ+ people who have a physical health condition. Participants had varying characteristics in terms of their ethnicity, health condition, and LGBTQ+ identity (Table 4). All were over the age of 20.

Participants were informed that the purpose of the research was to increase the presence of young LGBTQ+ voices in the literature and to better understand their experiences. Participants were also made aware this study was being conducted as part of the researcher's doctoral course.

Procedure

An advert was posted on twitter, and posters (Appendix C) were displayed in two NHS Trusts' paediatric waiting room. The poster and information sheet (Appendix D) were shared with a paediatric LGBTQ+ support group based in one of the NHS trusts. Participants contacted the first author by email, and an initial online meeting was set up to provide further information on the study and share the consent form (Appendix E); participants were given the opportunity to ask any questions and given a period of 72 hours to think about whether they would like to take part. Three potential participants dropped out at this stage.

Interviews were conducted online to allow for participants who could not easily travel to take part. Interviews were set for a time that was convenient to participants (e.g. outside of work or school hours). Prior to interview, demographic information was collected, and participants recruited via social media were given the option of providing contact details of someone they trusted should they become distressed. They were reminded they could request to stop the interview or take a break at any time. Interviews lasted between 30-87 minutes. Participants were given the opportunity to discuss their interview experience after recording, and responses were recorded by hand. Interviews were transcribed and anonymised by the researcher (see Appendices G and H for transcribed interview and example analysis). Participants were sent a debrief form (Appendix I) that contained information if they needed further support. Participants were also provided with a £10 gift voucher as a 'thank you' for their time. A summary of the findings of the study were sent to participants (Appendix J) and the ethics committee (Appendix K).

Interview

Interview questions were kept open to limit the interference of researcher assumptions (Fehér, 2011) and to allow participants to provide their own narrative. A broad question was used to initiate the interview and follow up questions were used to encourage and complete timelines or clarify points. Questions were generated within each interview to help participants to expand or continue their narratives. As some participants may be newly exploring or understanding their LGBTQ+ identity, some prompts were developed prior to interview to aid in participants talking about this aspect of their life if required. Example questions are shown in Table 4.

Table 3

Example interview questions

First question to all participants	Perhaps you could begin by telling me something about yourself and your story up to and including your time receiving services for your physical health?
Example broad follow up questions	What happened next? Could you please say a bit more about… ? Can you tell me more about X chapter in your life?
Example identity specific follow up questions	Can you tell me more about your experience of discovering your gender/sexuality/other identity? Can you tell me about whether you have spoken to your healthcare team about…?

Analysis

Each transcript was analysed in turn. The researcher immersed themself within the narratives through reading and listening to each interview several times. Narratives were sequentially ordered to help the researcher understand the sequence of events in the young people's lives. 'Global impressions' (Leiblich et al., 1998) were developed by considering the structure, performance, and content of each interview which provided information on the narrator's 'strategic aims' (Reissman, 2008, p.77) and allowed for the underpinning emotional content to become apparent. This process also allowed the researcher to identify main themes from each interview. Particular attention was given to the performance of the narrative and what was important for each participant to communicate to the researcher. The positioning of the researcher and turning points in the story were also considered. Narratives were considered through the lens of identity and how participants navigated their own. The presence of dominant cultural narratives and community narratives were considered in the stories of participants. Dominant narratives are stories that are repeatedly told in society through major institutions, such as in media. Dominant narratives can influence societies, shaping beliefs, values, and identities for most people living there (Mankowsi & Rappaport, 2000). For this study, dominant cultural narratives were the main narratives that existed in England at the time to provide a context in which participants were living.

Community narratives are stories told in social contexts and are stories that are told within groups of people about the group they belong to (Mankowsi & Rappaport, 2000). The main community narratives explored in this research are the LGBTQ+ community and communities of people with long-term physical health conditions. The cultural backgrounds of participants meant that some narratives they grew up with may have differed to dominant narratives in England. These are presented as cultural community narratives.

Global impressions were compared taking note of similarities and differences. The researcher also created a ‘master’ narrative (Appendix L) to help consideration of the research questions in the context of a whole story and to identify a broad storyline which highlighted the similarities and differences of the participant’s experience. Plots and subplots were developed from the global summaries and master narrative to answer the proposed research questions.

Reflexivity and quality assurance

An underlying assumption of the narrative approach is that narratives will be co-constructed between the narrator and interviewee as well as being influenced by social constructs and the interviewers’ own experiences (Esin et al, 2014). To help with this, a research diary was kept (Appendix M) that allowed for an ongoing reflection on personal biases. The researcher also considered their own identity as a member of the LGBTQ+ community and who does not live with a long-term health condition. Supervision was used to reflect on their positioning as a white researcher who works for the NHS, and how this may have impacted the story's participants felt able to tell in the current social and political climate. Participants were sent their global summaries and given the opportunity to provide feedback and consent to their inclusion in this study (Glesne, 2006).

Ethics

Ethical approval was received from the Brent Research Ethics Committee and the Health Research Authority. The British Psychological Society's Code of Human Research Ethics (Oates et al., 2021) was followed.

Results

Participant information is presented in Table 4.

Table 4
Participant demographic information

Pseudonym and preferred pronouns	**Age**	**Gender Identity**	**Sexual orientation**	**Ethnicity**	**Area of UK**	**Diagnosis and age of diagnosis or onset of symptoms**
Elliot (they/them)	20	Non-binary	Bisexual	Black Caribbean	London	Rheumatoid arthritis, 10
Janelle (she/her)	20	Female	Lesbian	Black	London	Central vision loss, 5
Frank (he/him)	23	Male	Bisexual	Mixed race	South East	Arthritis, 20
Willow (they/them)	21	Non-binary	Bisexual	Black Caribbean	South East	Asthma, 5
Angela (she/her)	24	Female	Lesbian	Black Caribbean	South East	Inflammatory Bowel Disease, 3 months
Tyler (any)	21	Genderqueer	Questioning	Black	North	Rheumatoid arthritis, 16
Billy (they/them)	22	Genderqueer	Questioning	Black British	London	Arthritis, 17
Lamar (he/him)	23	Male	Bisexual	Black Caribbean	London	Hunter’s syndrome, 17

To help the reader gain a sense of participants and the framework in which storylines were considered, a summary and ‘global impression’ (Lieblich et al., 1998) of each narrative are firstly presented. Emerging themes are presented as storylines across the narratives and held as a group, with closeness or distance from group narratives considered.

Participants' summary and 'global impressions'

Table 5

Global impressions

Participant	**Global impression**
Elliot	Elliot is a 20-year-old black Caribbean non-binary person. They had been living with Rheumatoid arthritis since a young age which was officially diagnosed at the age of 10. Their story is driven by their passion for social activism, especially related to racism and LGBTQ+ needs. Their experience was one of having to constantly push back against dominant narratives about young black people. Elliot emphasised the importance of finding the right communities where they experienced love and understanding. Their struggles are described openly in relation to the pain they live with, as well as their fear of being rejected due to their gender identity. After a difficult experience coming out to family, Elliot withdrew from all support including their physical health team for the fear of rejection. Over time Elliot has felt the narrative in society has changed with discrimination in any form not being tolerated. Elliot believes this change has stemmed from conversation and staff holding better knowledge. Their story ends in a place of hope for the future and wanting to pass onto younger generations the importance of fighting on. *'I will say I'm strong now. I don't feel that fear before. Because I know that there are people out there, that people will support me and love me for who I am today.'*
Janelle	Janelle is a 20-year-old black African lesbian woman. She was diagnosed with central vision loss at the age of 15. Janelle's main storyline was regarding her parent's separation when she was five, grappling with her father's decision to leave which did not fit with her culture's approach to family. She overcomes this by talking about her mother with a deep sense of pride. She celebrates black women in her story and subverts dominant narratives about the abilities of black single mothers.

	Janelle began to discover her sexuality at the age of 16 and has not yet out come out to anyone in her life. She used the conversation to widen the researchers understanding about how the UK is a safe place to explore sexuality compared to her home country. Her choice of language regarding her healthcare team was positive. Although she had negative experiences from staff, there was an air of reluctance to name these events as discriminatory. Janelle was uncertain when talking about her identity and became withdrawn through the interview, perhaps reflecting the importance of needing to feel safe in these conversations. She ended with expressing an interest in meeting young people who live with a physical health condition and/or LGBTQ+. Janelle's account is marked by a passion when talking about her mother. *'But before the condition I was actually very active you know, I felt very happy staying with my mom even though my dad never cared.'*
Frank	Frank is a 23-year-old, mixed race man who identifies as bisexual. He was diagnosed with arthritis at the age of 20 but had received support from physical healthcare for years prior to this. Frank's story centred on the pain and difficulty of living with his health condition and how this had disrupted his sense of self and who he wants to be. The impact on his mental health is a core storyline and he talks with joy about the online communities he has found for knitting and connecting with other LGBTQ+ people. Frank's experience of discovering his sexuality is marked by shame, fear, and confusion culminating in a doctor referring to LGBTQ+ people as an 'abomination'. This was a turning point for Frank who recognised the injustice of this and opted to continue to come out to health care staff despite the continuing fear of their rejection. He firmly rejected dominant cultural narratives about LGBTQ+ people being harmful and has used this to continue to engage in conversations with people in his life about sexuality. Frank positioned the researcher as someone who can support change, discussing the difficulties that disabled people face. He weaves hope into his story and holds strong to a belief that he will recover and grow stronger. *'I didn't come here for your judgement, I came here to seek service.'*
Willow	Willow is a 21-year-old black Caribbean non-binary person. They have been living with severe asthma since they were five years old. Willow became tired towards the end of the interview and requested that it finished early. Willow's story began with painful stories about loss and discrimination, including being the only black person in their school and facing rejection due to their gender identity. Throughout school they grappled with narratives about their

	health being used as an excuse to leave class and conveyed their desperation for classmates to understand the reality of their illness. They had experienced loss early in their life and grew up with their grandmother who also lived with asthma. Their experience with healthcare teams have been mixed and they were conflicted about how to respond to the discrimination they had received. However, Willow's doctor was a strong role model in their life who became a father figure. Willow's strongest message was that they were '*grown now*' and felt more equipped to cope with life. Their story ends with their experiences of medical school and gaining more knowledge about their own condition, inspiring them to consider how changes could be made to improve healthcare for all. *'I'll say until when I started in medical school. I never even knew what all these asthma action plans was... Perhaps this is something we can improve on as doctors today.'*
Angela	Angela is a 24-year-old black Caribbean lesbian woman. She suffered from stomach problems as a baby which was later diagnosed as Crohn's disease. Angela's narrative was marked by the impact her illness had on the family, expressing sadness that her mother had suffered from anxiety and depression during this time. The church had been an important community for Angela and her family. Angela's account was blunt and honest about the realities of her condition including the long times she spent in hospital as a child. Angela's hardest point was when she had a stoma bag fitted whilst feeling confused about her sexuality, sharing that she had prayed that God would '*just take my life away*'. She grappled with community narratives within her culture that LGBTQ+ identities are a social phenomenon and had subverted these narratives to accept her identity as one part of her that did not define all of her. Angela's tone turned from tired and sad to joy as she spoke about the LGBTQ+ friends she made once she was able to return to school. Angela's story ended with her wondering how to integrate her faith and sexuality. *'Not only did I you know, have to navigate a shiny new diagnosis, and also a stoma bag at that age, you know, but I was also adding to the confusion about my sexuality, you know, on top of that'*
Tyler	Tyler is a 21-year-old black person who identifies as genderqueer. They were diagnosed with rheumatoid arthritis at the age of 16.

	Tyler's main narrative centred on the pain and suffering they had experienced throughout life. They skirted around the topic of their early life, informing the researcher it had been difficult and a source of pain they did not want to share. Their story was punctuated with shame and a desire to hide their illness from bullies at school, feeling trapped in dominant narratives that visible illness should be hidden. The message they received from their mother to *'push on'* helped them to keep moving forward and gain friendships. Staff had also held an important role in Tyler's life and they felt understood and cared for. Their exploration of their gender identity was difficult, feeling like they had to prove they were normal to others. Tyler became joyful in tone when talking about their LGBTQ+ friends and community as they were introduced to community narratives that reject 'normal', a marked difference from where they started the conversation. The researcher noticed a response to their story of sadness at the pattern and rejection that Tyler has faced in their life. *'And people might not like you, but you have to make them. You have to prove to them that being LGBTQ isn't bad. It's normal.'*
Billy	Billy is a 20-year-old black British person who was born with both sexual organs, who prefers the term genderqueer to describe this. They suffered with swollen and painful joints for many years before being diagnosed with arthritis at 17. Billy's story was a joyful and hopeful narration about the movement of LGBTQ+ rights in the world, offset against a harrowing childhood where their uncle called them *'a product of hell or Satan'* for being genderqueer. Their rescue came when they were nine in the form of their uncle's friend, Mr. Peter, who took Billy in and gave them a sense of what it is to be loved and accepted in life. Their experience in healthcare had been mixed as they routinely challenged dominant narratives about gender being binary. Billy's passion grew throughout their narrative as they recounted experiences of meeting other LGBTQ+ people and finding community that embraced them. Their relationship with Mr. Peter is a sustaining force in their life and Billy uses what they learnt from him to encourage and inspire other LGBTQ+ people living with physical health conditions. Billy's story took the researcher on a powerful journey from outright rejection in multiple areas in their life, to seeing positive change across the world and the desire to keep this change going. *'Mr. Peter was really special. And I have committed myself to be just like him, turn people's lives around.'*
Lamar	Lamar is a 23-year-old black Caribbean bisexual man. He was diagnosed with Hunters syndrome at a very late age of 17 after years of living with painful symptoms.

	Lamar’s story started in a place of loss and grief, centred on the loss of his parents, and being diagnosed with a rare disease in the same year. The main narrative in his story was how he overcame cultural narratives that caused him to feel shame about his bisexuality, beginning in a place where he believed he had an *‘evil spirit’* to one where he was passionate about making the world better for young LGBTQ+ people. His conflict continued as he battles with shame about his rare disease. He was most passionate when talking about the positive impact of black celebrities coming out as LGBTQ+. His true hero is Lil Nas X who chose to openly be himself in a world where that could lose himself fans and money. He spoke with joy about the ways in which Lil Nas X has subverted dominant narratives about black men, and how this helped him to embrace his own identity. The researcher was drawn into Lamar’s passion and pride and could not help but feel hopeful. Lamar’s lasting message was that he wants to make sure no other young LGBTQ+ person feels like he did, alone and confused. *‘...you're also black like Lil Nas X... So they treat you the way they will treat him. So having a celebrity who's also LGBTQ is part of it. It's something that also impacted society a lot.’*

Emerging storylines

The following section presents an interpretation of the collective storylines that emerged. The storylines are presented as overarching ‘plots’ with ‘subplots’. Two main plots are presented within an overarching central plot, as the experience of identity development will impact on and be impacted by experiences of illness and healthcare. This allowed for the presence and influence of dominant narratives to be discussed across plots. A visual representation of the findings can be seen in Figure 1.

Plot 1: Navigating illness

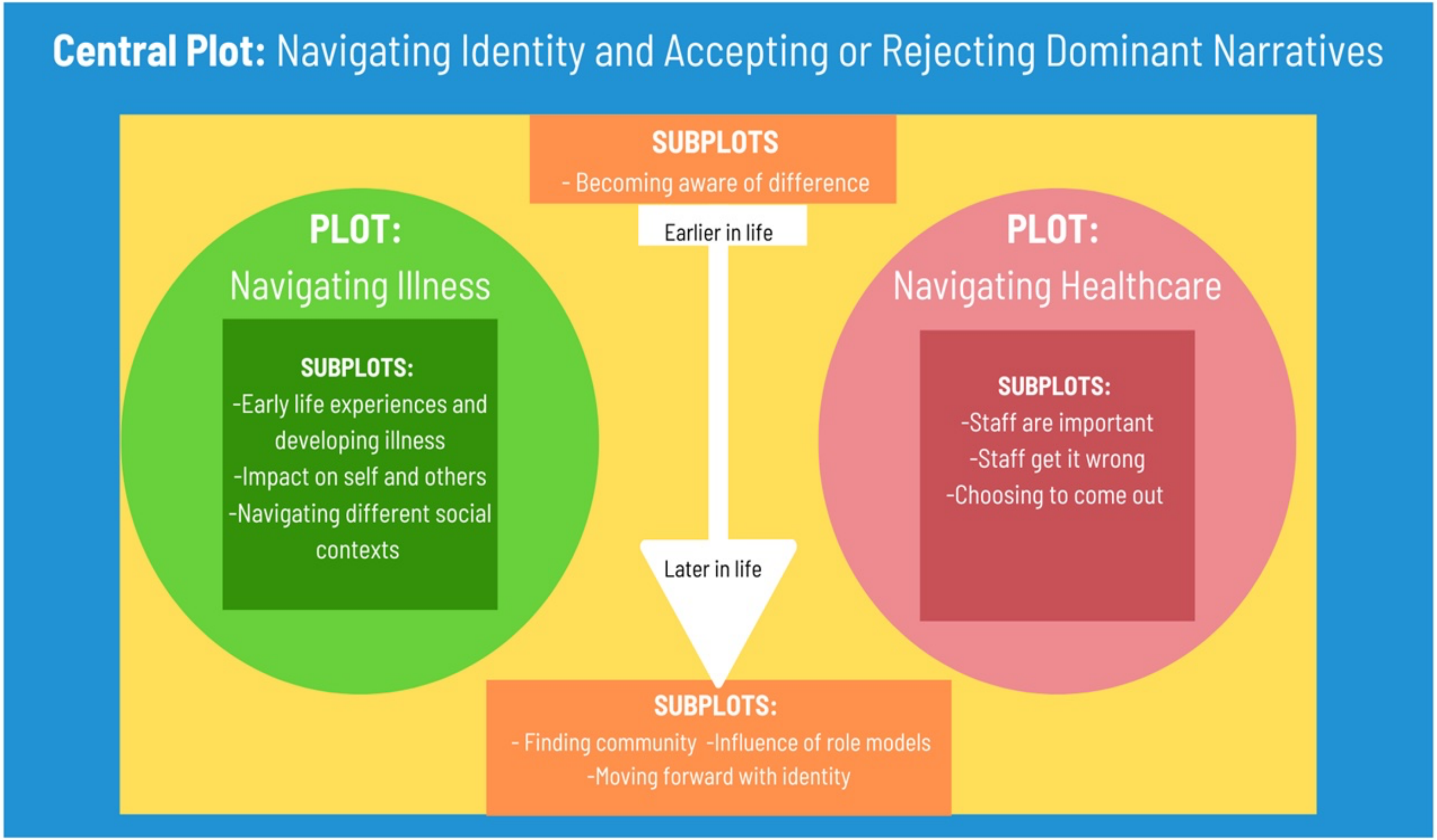
- *Early life and developing illness*

  All participants spoke about their early life (example quotes provided in Table 6). Participants early lives were varied, although all recounted challenging experiences including grief, parental divorce, and financial difficulties. For Janelle, the separation of her parents when she was five was a pivotal event that influenced her later relationship with her culture. Similarly, the death of Lamar’s parents was an overarching presence in his narrative. Their death marked a shift in his life and his language and tone conveyed his feeling of being a ‘burden’ due to his worsening physical health and the impact this had on the wider family.

  Participants who developed symptoms later in life spoke of their life prior to becoming unwell. For all, these times were reflected on positively and there was a

Figure 1

Visual representation of emerging storylines



Central Plot: Navigating Identity and Accepting or Rejecting Dominant Narratives

SUBPLOTS

- Becoming aware of difference

Earlier in life

Later in life

PLOT:

Navigating Illness

SUBPLOTS:

-Early life experiences and developing illness

-Impact on self and others

-Navigating different social contexts

PLOT:

Navigating Healthcare

SUBPLOTS:

-Staff are important

-Staff get it wrong

-Choosing to come out

SUBPLOTS:

- Finding community -Influence of role models

-Moving forward with identity

sense of loss and longing with an emerging core narrative that life was better when they were well.

All participants discussed when they first received support from healthcare teams and received a diagnosis. There was a core narrative that receiving a diagnosis is helpful. Lamar recalled his time in hospital as enjoyable, as it allowed him to take a break from working in his uncle's shop, which was something he did not enjoy. There was a difference in the experience of this process with Janelle and Elliot finding it time consuming and frustrating.

Table 6

Example quotes demonstrating experiences of early life and developing their illness

Participant	**Example quote**
Janelle	*'Although I do not know what transpired between them* [parents]. *Yes. For the.. I just feel is not enough reason. Yes. To be separated. Because I knew from lots of documentaries I've been watching, the African ways that's not how it's done. Yeah. We both times we do not see divorce as an option. Yeah, we just try to face family issues.'*
Frank	*'So um.. before that time* [before diagnosis], *life was a very good one, I normally go out play with friends, you know, and normally engage in social activities a lot. So I tend to, you know, visit more family friends, I was very happy while I was in school. So eventually on to when these things started, I, you know, my happiness reduced, and I am not being able, you know, to do the things I used to do before.'*
Janelle	'*Although sometimes it was* [process of being diagnosed] *just sometimes annoying and frustrating because it had to be repeated. Yeah, like five times or so. So doing the same thing over and over again was somewhat annoying…'*
Angela	*'And then my mom according to her she needs to be changing my diaper for like, 15 times in a day, you can imagine that.'*
Lamar	'*Yeah, they tests my urine, test blood samples and saliva and everything. Just basically they did a lot of tests on me for those days*

	and I actually, it was something that I enjoyed because for those days I didn't have to work in the shop.'

- *Impact on self and others*

A core narrative shared across participants was that having a health condition is negative and reduces quality of life (example quotes provided in Table 7). Angela and Frank shared their struggles with their mental health which they directly related to their physical health and living with their conditions. All participants who were living with arthritis also spoke about how their pain and swelling would worsen when they were more stressed or anxious. Frank found that one way of helping him to lessen his anxiety was engaging in his hobbies, such as knitting, and accessing a local counselling service, whilst Billy used Chinese medicine techniques they learnt from Mr. Peter to help reduce their swelling and pain.

Three participants also discussed how their ill health impacted on their family, showing gratitude to their parental figures for shouldering their 'burden' and providing support. There was a presence of a dominant narrative for these participants that being ill is inherently shameful or 'worse' than being able bodied when it impacts others that was difficult to reject or challenge. There was also a possible internalisation that family struggles were a direct result of their illness.

Table 7

Example quotes demonstrating impact of health on self and others

Participant	Quote
Frank	'*Erm, at some point, I realised that, um, anxiety symptoms started coming up. So I needed to seek some counselling service, because, you know, I started feeling quite a lot of anxiety.'*

Elliot	*'And for them, because it took take almost half of their life savings, you know, just trying to make me better. So the process, you know, and I think the help that I was getting was, was quite expensive at the time, because as a child, they will try every possible way to help you, you know, get back your feet, so it was quite expensive. And it was quite tough for them to meet the standard of expenditure for, for me as a person, you know, up till this day, so I'm always I'm always grateful for them'*
Lamar	*'So my uncle wasn't able to cope with the bills, because his shop is not to be, he'd just lose the shop. And it will be something that would impact on the shop negatively. So I decided to just go find out more, what's the problem?'*

- *Navigating different social contexts*
  All participants spoke about being ill in different contexts in their life, such as with family, friends, school, and church (example quotes provided in Table 8). Three participants described how their ability to learn at school was disrupted due to the symptoms affecting their ability to see, hear, or be seated for long periods of time.

  All participants shared experiences of encountering negative dominant narratives at school that people with health conditions are 'lazy' or making up their symptoms. Willow recalled feeling judged by their classmates who accused them of pretending to have chest pain so they could leave a lesson. Willow conveyed this story with a tired tone, explaining they wished they could safely stay in lessons and learn.

  Participants spoke about extra decisions they make due to their conditions, such as taking aides that would mark them as someone who is visibly different, choosing who to tell about their condition for fear of being judged, or not taking part in activities to conserve their energy. Lamar spoke about choosing to not tell anyone about his rare diagnosis after a friend became fearful of him and his health. This experience impacted him deeply and he became ashamed and withdrawn, interacting with dominant narratives about black men being ‘hard to reach’ in healthcare.

Table 8

Example quotes demonstrating experiences of navigating different social contexts

Participant	Quote
Janelle	*‘Yeah, but when I was in high school, in middle school, sorry, I was having difficulties, you know, reading and, you know, it just, I cannot even follow what was happening this because sometimes I feel pain sometimes. I strained my eyes a lot to look at what's going on.’*
Willow	*‘And then they're kind of giving you judgmental words. Like that... Like, like you're pretending kind of [sighs], uh.. pretending those, that you don't want to attend this particular class or you don't like the teacher or trying to give you some judgmental words like that. But... I don't know I tried to make them understand that I cannot be leaving class. I'm just, I'm even wish... wishing myself I wish it would be possible for me to stay the way other people are staying to learn comfortably in class without having one or two conditions.’*
Lamar	*‘Once I didn't actually specify to my friend that it is a rare disease, I just told her that it is a health condition. It's just something that makes my face swollen. And she felt scared from that day. Every time she's around me. Maybe she thought it's maybe an evil spirit or something..’*

Plot 2: Navigating healthcare

- *Staff are important*

A core narrative that emerged was of the importance of healthcare staff in all participants’ lives, and shared appreciation for the work they do (example quotes provided in Table 9). The roles which staff had played in participants lives varied, although their influence was long lasting in all narratives. Four participants described the importance of staff in their life as being like ‘family’, taking on the roles of parents or siblings. Lamar described how his experience with staff had inspired him to accept people he came across in life in a similar manner.

Other participants also shared that healthcare staff had influenced their own approach towards difference in others. Tyler spoke about how their healthcare team understood how their physical health impacted on their mental health and encouraged them to continue with treatment despite missing appointments. Their language suggested an appreciation for staff standing with them when times are difficult. Frank also spoke about staff becoming 'part' of him as he became more comfortable with their care.

Table 9

Example quotes demonstrating importance of staff

Participant	Quote
Lamar	*'I think maybe it is in their training to always accept people. And always, no matter who the person is, just to the person, like your brother or their sister. So that's something that I admire a lot. And I am trying to copy the type of life to accept everyone, no matter who the person is.'*
Tyler	'*Most times I'll maybe, I don't meet my appointment and they will bear with me and will understand that, um, I'm someone facing challenges. And yeah, and they'll bear with me and they know that I'm facing some challenges, and will understand that.'*
Angela	*'But there's this particular doctor we are very close to, are very close, was very close to my mom. And then at some point the illness was becoming so uncontrollable, they even had to kind of deny the, they wanted to kind of just chase us away from the hospital because it took. And I think that was during that period, my mom couldn't afford a particular thing. I can't really recall what that was. But something actually happened. And then they were kind of fed up with the condition, trying to like, you know that, oh, tell my mom we can't handle this case, trying to maybe put a transfer later, transfer me to another hospital. But there is this doctor that is kind of close my mom that didn't allow them to do that.'*
Willow	*'Yeah, to me, I, to me, he* [doctor] *just seemed like a father'*

- *Staff get it wrong*

Although all participants spoke to the importance of staff in their life, and the appreciation they held towards them, seven participants provided accounts of experiencing discrimination and stigma in healthcare (example quotes provided in Table 10). Four participants spoke about encountering stigma from staff in relation to their LGBTQ+ identity. Frank spoke about a doctor calling bisexual people ‘strange’ and ‘abominations’ after asking about his sexuality, resulting in Frank's withdrawal from accessing services and experiencing shame and guilt about his identity. This experience made it difficult for Frank to reject narratives from his culture regarding sexuality, masculinity, and blackness.

Elliot also spoke about withdrawing from services due to a fear of encountering further stigma and not being accepted by staff due to their experiences of racism. However, Elliot also spoke about the narratives shifting in healthcare, and largely feeling more supported and accepted by their health team nowadays. Elliot believed that training for staff and gaining more information and exposure to different types of people was key to these changes.

Billy recounted multiple stories of staff reacting to their genderqueer identity with shock, disbelief, and denial. However, their main frustration was due to systemic issues that create barriers for individuals who are neither ‘male’ or ‘female’. Their experience was of having to push against dominant narratives about gender being binary and choosing to subvert narratives by living openly rather than as a ‘secret’ and having control over their own body.

Janelle’s experience was distant from the core narrative. She reflected on whether discrimination exists when it is not overtly visible, debating how she could know if healthcare staff hold negative perceptions about her if she does not know what they are thinking.

Table 10

Example quotes demonstrating difficult experiences of staff

Participant	Quote
Frank	'*So this doctor was actually trying to ask me my sexuality, so so when I made a disclosure about my sexuality, he was like, well, it's so strange that these days people are tends to be a, you know, attractive to both people of the same different sexualities... it feels like an abomination... I felt ashamed at that moment.'*
Elliot	*'So, sometimes those hurdles, were always there because sometimes you go to the hospital, sometimes you have to meet the health worker that doesn't want to treat you right now that doesn't want to give you a treatment just because you're not white, just because you're from a minority ethnicity.'*
Billy	*'I don't think it's been easy. Anywhere, anytime. What's your sex male, female and you're ticking them both? It's never been easy... It's only recently I discovered in most online forms. You can you fill them both. And then initially, when you fill them both, the form will be cancelled.'*
Janelle	'*Yeah, you know, sometimes people could discriminate you, but don't say how to, you know, you do not know about it? Yes. So, that's just basically what I'm trying to see. Because I do not know what, uh, some persons feel. But as far as, uh, I am not being told, and it doesn't come to my notice. So I will say it doesn't exist.'*

- *Choosing to come out*

All participants spoke about their relationship with their LGBTQ+ identity, and their decision to come out to healthcare staff (example quotes provided in Table 11). Two core narratives existed in relation to this which were not mutually exclusive as both could be present for participants dependant on context. Although all participants spoke on this topic, some were ambivalent about the decision.

The first core narrative was that it is important for staff to be aware of LGBTQ+ identity to provide better care. The five participants that shared this narrative were in a stage in their life where they had been able to create connections with other LGBTQ+ people and regarded their identity as positive. To do this, participants subverted cultural community narratives to help them move towards identity integration. However, each participant was fearful of rejection when making the decision to come out to staff. Frank spoke about choosing to reject cultural community narratives and inform healthcare staff despite this fear due to his belief that he would receive better care.

The second core narrative was that it is not necessary to come out to healthcare staff. The three participants who had not come out to healthcare had also not come out to their family, although two participants had LGBTQ+ friends who were supportive. Janelle shared that she would consider disclosing her sexuality to staff if it was directly relevant to the intervention she was receiving. Angela queried whether it was necessary to come out to staff at all, using a confused tone which indicated this was not something she had considered before. Willow expressed being somewhere in-between these, having opted to mark their gender identity as non-binary on paperwork. However, Willow had never had a discussion with staff about this, brought up by themselves or by staff.

Table 11

Example quotes demonstrating participant decision to come out to staff

Participant	Quote
Frank	*'...due to past ideas that I have gotten and also from past experience, when I was 18/19. So, this actually brings a lot of fear to me about disclosing my sexuality* [to staff]... *Okay, so when I disclosed, I let them know, I was monitoring their reaction, you know, it was not just that this reaction, but the days that I've been meeting with them, I was trying to see if they have these kind of discriminatory acts towards me.*' *'I just give I just needed to you know, say this thing* [come out] *now, so, that these people* [staff] *may come to understand me very well and you know, so that they could know how they could, um interact with me and also give me a complete service and appropriate service that because you know, when people tend to understand you better, they will have some these um... maybe strategies on how to treat you better.'*

Angela	‘*Is that necessary* [to come out to staff]*? To me? I just think it's okay.’*

Central plot: Navigating identity and accepting or rejecting dominant narratives

All participants spoke about identity, including their gender, sexuality, physical health, and ethnicity. Participants were at varying stages of developing a positive relationship with different aspects of themselves. For participants who were further along with developing a positive relationship with their health, gender and/or sexuality, there was a core narrative that it is important to support others with their developing identities.

- *Becoming aware of difference*

  A core narrative was that it is difficult to realise you are different (example quotes provided in Table 12). Billy and Willow recounted stories of being made aware of their difference at a very young age. Willow shared their story of realising they were the only black child in class and the loneliness that accompanied this.

  Billy recalled discovering their difference through using public bathrooms and having other people shame them. These experiences led to them dealing with feelings of shame about their body and genderqueer identity. When they started to experience attraction to multiple kinds of people, they felt nervous to explore their sexuality for fear of rejection from the people they pursued. Their tone was light whilst discussing this, conveying they held a different perspective on these experiences now and had embraced a LGBTQ+ community narrative that their difference made them special.

  Participants had varied experiences in terms of discovering their LGBTQ+ identity. Angela spoke about discovering an attraction to women after realising she felt more comfortable and closer to female friends. Her straightforward recounting of this suggested it had been a simple process for her. Lamar’s process was more difficult. Due to his upbringing and cultural belief in evil spirits, he believed he had been possessed when he noticed his attraction to men. His fear of this led to him researching it online and becoming connected to an LGBTQ+ community, ultimately helping him to begin the process of accepting this part of his identity and rejecting cultural community narratives.

Table 12

Example quotes demonstrating participants becoming aware of their difference

Participant	Quote
Willow	*'And then when I was in, in kind of high school, I was the only... I was the only black in my class. And then they'll be like, woah your hair is standing and then almost everybody in the class your hair is kind of curly you know, all those kinds of feelings. I was like, Oh, I'm the only one who has this. I'm the only one.'*
Billy	'*And the next person standing by me says, Hey, you're not standing right? You're not supposed to be here. I don't know what to call you. Are you a boy? Are you a girl? I don't know what you are.* [Laughs] *So at that point, I felt a little bit confused.'*
Lamar	'*For me, I felt it isn't normal. You know, every guy should get attracted to um, a lot of girls. But to be also attracted to guy like you, I felt you, it might be something that maybe animal spread it, because my uncle, always um... my parents are especially always telling me a lot of stories about um, evil spirits attacking in some kind of village, or both horror stories, and I just go with that mentality that oh no, oh God, it can be an evil spirit or maybe a mental issue. So um, I do my own research, I found out that there's something like an LGBTQ where I can belong there.'*

- *Finding community*

All participants spoke about the various communities they had in their life, and there was a core narrative that finding the right community can help you to be understood (example quotes provided in Table 13). The discussed communities included LGBTQ+, religious, social justice, health, and black communities. Some communities overlapped, such as online forums for LGBTQ+ people living with a physical health condition. The type of help provided by these communities were varied. For Angela, the church provided a huge amount of practical support when she was growing up and had remained an integral part of her life.

The power of acceptance through a community was especially prominent in the narratives of Elliot, Frank, Willow, Tyler, Billy, and Lamar. Elliot shared how being a part of the LGBTQ+ community helped them to feel protected from the stigma they encountered in the world.

Lamar shared how finding an online community of LGBTQ+ people helped him to realise he was not battling an evil spirit, and instead led him to embracing and loving his LGBTQ+ identity.

Table 13
Example quotes demonstrating finding community

Participant	**Quote**
Angela	'…*they* [the church] *did so much support; financially, emotionally, socially. You know, they even came visiting me in the hospital. And I was so glad they gave my mom some stuffs, maybe food stuff, clothing and so many things…'*
Elliot	*'Well, looking at the LGBTQIA community, you know, they're always there, you know, in, in trying to protect their own, you know, from getting bullied or from getting stigmatised, or from getting, you know, all kinds of bullying,'*
Lamar	*'But yeah, so later on, I found out that I am not the only one who also has feelings for both males and females. Yeah, I found out that there's something, like LGBTQ community where everyone with that, you can actually tell anyone that you are LGBTQ, and the person will feel comfortable with you.'*

- *Influence of role models*

Participants spoke about various people throughout their life who had helped them to accept and integrate their identities (example quotes provided in Table 14). People who showed excitement and pride in the identities of participants supported the development of a positive identity. For example, Mr. Peter embedded in Billy that their difference made them special, and as such they needed to celebrate who they were and stand proud in their identity. This helped Billy to overcome cultural narratives that they were ‘satanic’. Billy reflected that Mr. Peter’s influence kept them going, including times when they did not want to be alive.

Three participants spoke about role models in terms of people and organisations that were in positions of power. Elliot remarked on the growing acceptance of LGBTQ+ and black players in football and changes that the premier league were putting in place to combat homophobia and racism at games. Their tone was excited and hopeful when discussing these changes. For Lamar, the presence of black LGBTQ+ celebrities had a huge impact in accepting his own identity. He spoke about Lil Nas X coming out and the hope this had provided for him, as well as many other LGBTQ+ black men. There was a core narrative amongst these participants that having more visible LGBTQ+ people in positions of power are important to the progression of LGBTQ+ rights.

Although all participants had spoken about the influence of healthcare staff and the important role they held in their life, no participants recounted stories of healthcare staff being in the position of celebrating and encouraging them to integrate minoritised aspects of their identity.

Table 14

Example quotes demonstrating the influence of role models

Participant	**Quote**
Billy	‘*If I didn't have Mr. Peter to hold, I think I would have slipped off. Yeah. Honestly, I considered as a kid. If I wasn’t taken away at seven, I thought of running in front of a train. I think it crossed my mind about twice. Why didn't you run in front of this moving train here one time and I let it go. But it wasn't a very strong feeling. Because Mr.*

	Peter was at the corner Always when he comes around, he tells me you're a special boy. I always remember.'
	'*They are here, we accept them and as a result, they are going ahead to even call for LGBTQ persons who would, who would want to be trained as nurses, as healthcare providers and all that, that has gone a long way to help.'*
Lamar	'*So myself I was excited and discovering that Lil Nas X is also a gay, is an LGBTQ, aw yo I will be excited more,* [it] *made me very happy and I decided to embrace it more because the world is getting to the point where maybe someone LGBTQ maybe one day will become a president or someone who will be maybe the richest man in the world or the richest woman or um yeah, so I decided to embrace mine* [LGBTQ+ identity] *and move with it.'*
	'*You know, if we're going to have maybe a celebrity who is a black, and he's an LGBTQ, I think maybe people will have reacted to blacks being LGBTQ differently, because, um, let me use Lil Nas X as an example. Now. You know, he's LGBTQ. And um he makes a lot of people around the world love the LGBTQs.'*

- *Moving forward with identity*
  Participants stories tended to end with reflection and their hopes for the future (example quotes provided in Table 15). Hopeful narratives were either individual and focused on the participant's own life, or outward and based on hopes for how the world might change. Frank's use of language suggested a determination to keep moving forward and achieve in life with a belief that he would one day live without arthritis. Frank had not experienced positive illness narratives and found it difficult to imagine living a fulfilled life with arthritis.
  Participants who held a more outward hope for the future were more likely to hold a positive identity with their health and LGBTQ+ identity and were beginning to become role models themselves. Billy already held experience of supporting other LGBTQ+ people who have a physical health condition and had been invited to speak about their experiences at a national conference. Their

language conveyed their pride that they are visibly and vocally black, LGBTQ+ and living with a health condition. Billy also considered some of the discourses present about transgender athletes and LGBTQ+ people in the media, and how these detract from the changes that they are pushing for.

Lamar also shared an outward hope for the future, expressing his wish that no LGBTQ+ person would feel they are possessed by an evil spirit because of their identity. Elliot also spoke about countries in the world which hold more progressive rights than the UK for LGBTQ+ people, and their hope that society would become more accepting.

Table 15

Examples quotes demonstrating moving forward with identity

Participant	**Quote**
Frank	'*But I think, in this chapter of my life right now, with this condition that I have, I think the only thing I tend to do is try to keep myself focused, I try to push harder, I try to recover as fast as possible. So you know, I can be able to meet up with life, I can be able to pursue my dreams, you know, things like that. I think that is the only belief and I strongly believe that I'm gonna fight through this someday.'*
Billy	*'And when I was speaking, as an LGBTQ+ person, I was also speaking, as somebody who has a big, debilitating, challenging disease that is supposed to make me dislike trying to do any kind of physical work. I was encouraging them. I told them, I'm supposed to be worse than any one of you here now. [Laughs].'* *'I do remember, athletes who are, uh, gender queer, always ended up being dropped, because most of the times they are in athletics of women, and then they say no you have a phallus. So if you have a phallus you're a man, you you're not supposed to be here because you seem to be stronger. Ordinarily, that athlete can just go for surgery and become a trans woman, and you will still have all the firstly you all the physical attributes there, you will be stronger, and so on and so forth. But the person decides to be natural, and you're punished for that.'*
Lamar	*'Yeah. Because we don't actually want a world, where to be like me when I was little where I had the feelings for both male and female.*

> *And I thought it was something like an evil spirit. I didn't say like, it's no more I was scared. I mean, we thought that maybe it's a mental issue or something, maybe it was normal. But actually we have to encourage them to also embrace the fact that it's your life, it's your choice, your decision.'*

Discussion

This study aimed to explore narratives of young LGBTQ+ people who have a physical health condition, and their experiences of physical health services. The results of this study are considered through the proposed research questions and their relation to existing literature, as well as limitations and implications for future research and clinical practice.

What stories do LGBTQ+ young people with a physical health condition tell about their relationship with staff and the process of coming out to health care providers?

All participants positioned healthcare staff as important to them and narrated positive experiences, with staff being able to uniquely understand their health. This fits with research that suggests staff can play an important role in meeting the needs of young people with a physical health condition (e.g., Dyson et al., 2012) as well as providing alternative narratives about the relationships that can exist between healthcare staff and young black or mixed-race people.

However, seven participants shared difficult experiences they had within healthcare, including experiencing minority stressors leading to some withdrawing from healthcare. Some of these experiences made it more difficult for participants to move towards identity integration (Rosario et al., 2004) and can contribute to dominant narratives, such as black men being 'hard to reach' in healthcare (Mount et al., 2012)..

For example, Frank’s experience made it difficult reject narratives from his culture regarding sexuality, masculinity, and blackness (E.g., McKeown et al., 2010).

The decision to come out was varied and related to the relationship that participants had with their own identity and the intersection of these. The act of coming out itself can be an important part of identity integration for LGBTQ+ people (Coleman, 1982). Research suggests that young black people can feel less comfortable with coming out and may have shared their identity with less people when compared to white youth in similar situations (Roasario et al., 2004). All participants who came out to staff had overcome previous negative experiences and felt empowered that their LGBTQ+ identity was important for staff to be aware of. This is in line with research that suggests that one route to reduce health disparities is for healthcare staff to be aware of identity (Hughes et al., 2022). This includes staff holding greater knowledge on supporting people from different ethnic backgrounds and the intersection of identities (Bowleg, 2012). Participants who had not come out their healthcare teams were in earlier stages of developing a positive identity and may have had less opportunity to reduce self-discrepancies as suggested by Tsang et al., (2012), and held dominant narratives that sexuality or gender identity is unimportant unless directly related health conditions. Research suggests that healthcare staff can lack knowledge and confidence in having conversations about sexuality and gender identity (e.g., Paradiso & Lally, 2018), and can also hold dominant narratives about it being unimportant (e.g., Dorsen & Van Devanter, 2016).

What stories do LGBTQ+ young people tell about navigating their physical health condition in the current social context?

A core narrative for participants was that having a physical health condition is hard and impacts on quality of life. Participants had particularly been impacted at school, experiencing bullying, time off from school, and shame about their illness in this context reflecting research and dominant narratives people with health conditions are 'lazy' or making up their symptoms (e.g., Runions et al., 2019; Sawyer et al., 2007). All participants had been supported through this by family members, where there was a shared narrative to '*push on*' despite the hardship. Overall it was difficult for participants to reject dominant narratives about health conditions and to embrace positive illness narratives (Brokerhof et al., 2020).

In line with research, participant's physical health conditions impacted on their mental health as well as their experience of isolation and community (Combs-Orme et al., 2002; Hysing et al., 2007; Mercer et al., 2015). Stories also reflected research about identity formation in young people with physical health conditions, in their held beliefs that life was better before they became unwell (Wicks et al., 2019).

The impact of their health on others was also explored in participant's stories. Research has suggested that parental worries about finances and health can impact on children (Pao & Bosk, 2011), especially when their child is ill, which is in line with the stories that the young people told.

What stories do LGBTQ+ young people with a physical health condition tell about their identity?

Participants were in varying stages of identity development, particularly in developing a positive identity with their LGBTQ+ identity and accepting or distancing themselves from their physical health condition. The influence and importance of role models in building identity was integral to all stories which has been shown to be important in research considering LGBTQ+ and/or ethnicity positive identity development (e.g., Gomillion & Giuliano, 2011; Yancey et al., 2002) which may help reduce the impact of minority stressors.

Some participants told stories about their culture and ethnic identities, exploring difference in cultural upbringing and generational decisions, as well as the presence of cultural narratives in their lives.

Although not explicitly addressed by any of the participants, it was notable to the researcher that healthcare staff were not present in stories about identity. Although healthcare staff influenced participants lives and helped them to feel understood and accepted, no stories were told about healthcare staff promoting self-esteem or reducing discrepancies in relation to minoritised identities. For young people who may spend a significant with healthcare staff, it will be important to consider how healthcare staff could step into this role.

How are the dominant discourses surrounding LGBTQ+ identities, including those on social media, represented in the personal stories of young people?

Dominant discourses were represented in all stories in different ways. Cultural narratives regarding LGBTQ+ identities were present in some stories, with varied impact on participants. These narratives were generally influenced by religion and were negative. Participants who resisted these narratives talked about linking in with communities or having a role model who provided an alternative community narrative for them to hold to. Being able to resist these narratives boosted participants self-esteem and allowed them to feel prideful in their identity. This is especially important for people of colour who may not have equal access to LGBTQ+ communities despite the benefits they can receive (Parmenter et al., 2021).

Social media and identity were primarily discussed in terms of the online spaces that participants had found to be able to connect to other LGBTQ+ young people. These spaces were described as positive in all stories that included them, and they were spaces that presented an alternative narrative to the dominant narratives (Fish et al., 2020).

Largely participants found acceptance and belonging within these spaces, which ultimately allowed them to accept themselves and being able to pass these onto other young people as well. One participant spoke to wider discourses about LGBTQ+ identities in media, including about transgender athletes and the Qatar world cup.

Methodological considerations and limitations

Using a narrative method allows for a huge breadth of data to be collected, cementing the participant's stories into their wider life. Although there are multiple advantages to this, it is challenging to fully represent the individual participants and their rich lives within the word count. Presented results are tailored to answer the research questions.

Additionally, the nature of narrative research and the unstructured approach to the interview will have suited some participants more than others. Some participants were able to speak freely and required little prompting to elicit their narrative, where others found this to be a more challenging experience and there was a greater degree of co-construction in their narratives. For these participants there may have been some unspoken aspects to their stories. Although the timeline for this research meant that only one interview could be conducted with each participant, it would have been helpful to have more opportunities to meet with participants to elicit underlying aspects to their narratives.

A possible unofficial snowball sampling occurred due to recruitment happening through social media. Although recruiting through social media in health research can allow increased access to potential participants, samples drawn from social media may not be representative (Miller et al., 2021). It was also unclear whether there were overlaps in participants online life.

Furthermore, the researcher's own biases and life experiences played a part in the construction and interpretation of interviews. The researcher's own identity and positioning influenced the stories told, due to being a white LGBTQ+ person who works in the NHS. For example, the researcher held power in choosing which stories to represent and how to present the intersection of identities. Dominant narratives about the NHS, such as ‘clap for the NHS’, may have also made it difficult for participants to speak more freely about their experiences. Researchers who hold different identities may have elicited alternative narratives from participants, as well as generating different and valid interpretations.

This study had hoped to recruit participants from a wide range of ages; however all participants were aged 20 or older. The recruitment strategy utilised research-oriented hashtags which may mean the audience reached was naturally older. People under the age of 16 also faced additional obstacles to take part, due to requiring parental consent. The nature of the study may mean potential participants under this age did not feel comfortable involving their parental figures in this process.

However, all participants in this study were from a black-Caribbean, black-African, or mixed-race background which gives voice to a group that are not always given space in research. Research suggests social media recruitment can reach groups that are historically less likely to be in research (Bioth, 2017). As this study did not explicitly recruit for black or mixed-race participants, it was necessary to consider how the research questions would be approached considering this area of identity. The study ended up being embedded in the intersectional framework more explicitly than initially been proposed. However, the intersection between other important aspects, such as socio-economic status, have not been explored. It is hoped the narratives presented can build upon existing research with hope that it will help provide better support for young black LGBTQ+ people in healthcare.

Clinical implications

Healthcare staff were spoken about in positive terms and were integral to the wellbeing of participants. Staff could offer a place of understanding and acceptance for participants, and their value was well felt in all stories. It will be important for staff to be reminded of and celebrated for the work they are already doing. Staff may not be aware of the long-lasting impact they have on the lives of young people they work with, and the ways this could be utilised to further boost the self-esteem and positive identity in young people. Research has begun to explore direct ways in which staff can be doing this through an intersectional lens, including using rainbow badges and lanyards to indicate openness to talking about LGBTQ+ identity (Huckridge et al., 2021). The current study suggests that staff could be in a privileged position to improve the lives of young LGBTQ+ people by helping them to explore, celebrate and embrace their various identities. This could be achieved through increasing staff knowledge on the importance of positive identity and how this can help to reduce the impact of minority stress. Staff being able to ask questions about sexuality and gender identity and smoothly integrate this into provided care could have life-long ramifications for young people. Additionally, many of the young people spoken to in this research had highly benefited from finding online LGBTQ+ communities, particularly when these incorporated experiences of chronic health conditions. Health teams may be an important area in which these spaces could be started. Many health trusts already run groups that allow young people with health conditions to socialise and share experiences. Expanding these to incorporate other aspects of identity, including LGBTQ+ and ethnicity could be valuable. Incorporating these spaces into healthcare settings may increase opportunities for black and mixed-race LGBTQ+ people to access support that otherwise have additional barriers for them to become integrated within.

Research implications

Due to the nature of this research, the sample size was small, and the breadth of information gathered was large. Future research may want to consider focusing on the key findings found in this research more deeply, such as considering how healthcare staff can play a role in young LGBTQ+ people developing a positive identity and increasing access to community support for LGBTQ+ young people with a chronic health condition. This research could be taken further to consider the intersection and integration of identity to help staff better approach individuals as a whole. This approach may help to reduce the minority stress that can be encountered within healthcare.

Future research should also consider how to recruit participants from a wider range of ages and differing stages of identity development.

Furthermore, the narratives of participants showed they held multiple areas of strengths and resources. Future research could consider how these resources can be harnessed to further reduce the impact of minority stress and support young people to develop a robust and positive identity.

Conclusion

The findings present a rich contribution to the understanding of the lives of young LGBTQ+ people who have a physical health condition. They navigate additional challenges in their life to reach a place of positive self-identity. Although experiences of healthcare were mixed and participants had encountered minority stressors, a clear message from narratives was the importance of healthcare staff in the lives of young people who helped them to feel understood and supported. Participants who were further along their journey in developing a positive identity were more likely to be linked in with an LGBTQ+ community and have been influenced by a role model who could provide support and introduce participants to community level narratives. This research suggests that healthcare staff could be in a unique position to step into being role models and to support young LGBTQ+ people with a physical health condition to develop a positive self-identity.

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Section C: Appendices

Appendix A: Critical Appraisal Skills Programme qualitative checklist UK (CASP, 2018)

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Appendix B: Author's guide to submission to the Journal of LGBT Youth

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Appendix C: Recruitment poster

Canterbury
Christ Church
University

What's it like to have a physical health condition and identify as LGBTQ+?

We want to hear your experiences about living as a 13-24 year old who has a physical health condition and an LGBTQ+ identity

By understanding your experiences, we can help other young people who have both an LGBTQ+ identity and a physical health condition in the future

If you're interested in finding out more, please contact me:
Nicole Williams
n.williams328@canterbury.ac.uk

This research has been given ethical approval from the Brent Research Ethics Committee.

Exploring the narratives of LGBTQ+ young people who have a physical health condition and their experiences within physical health services
01/04/2022 Version 2

Appendix D: Participant information Sheet

Information about the research

Study title: Exploring the narratives of LGBTQ+ young people who have a physical health condition and their experiences within physical health services

Hello. My name is XXXX and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

This research study is supervised by Dr XXXX.

What is the purpose of the study?

We want to understand the stories and experiences of young people who have both an LGBTQ+ identity and a physical health condition. It is our hope that by understanding your experience, we can contribute to future research that is focused on improving experiences of young LGBTQ+ people who have a physical health condition.

Why have I been invited?

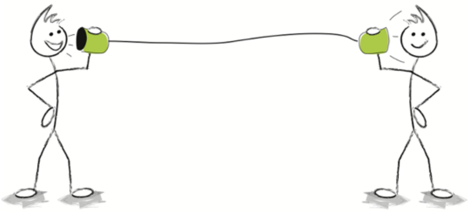
You have been invited as you have shared that you have an LGBTQ+ identity and a physical health condition.

Do I have to take part?

No, you do not have to take part in the study. You can stop being a part of the study at any time, without giving a reason. You can ask as many questions as you like before you decide whether you would like to part or not.

What will I be asked to do?

You will be invited to an online one-to-one interview with myself, that will last for 1 hour, although you may choose to talk for more or less time. This will be a chance for you to tell your story about living with a physical health condition and an LGBTQ+ identity. You can share as much or as little about what feels important to you. After we have met and I have had a chance to write out the interview (also called a transcript), I will share my thoughts on our interview (if you would like I can share your transcript with you) and you will have the chance to give me feedback on this. You will receive a £10 voucher as a thank you for taking part.



To help me with this project, I will audio-record the interviews and will follow some guidelines to make sure you and your data stay safe:

- I will assign a code number to your interview recording and transcript. This will be stored with your name on a password protected excel sheet that only I can access.
- I will remove your name and details when I write out the interview and before discussion in supervision.
- Any quotes used in the write up of my project and reports of the study will be anonymised, which means no one will know that you said them.
- Once the study is finished, your anonymised data will be kept for several years in case it needs to be checked. You can ask about who will keep it, whether it includes your name, and how long it will be kept.

What are the possible disadvantages and risks of taking part?
Attending an interview and sharing your experiences may mean you discuss some topics which are upsetting or distressing for you. I will make every effort to create a safe and comfortable space within the interviews to discuss your experiences. You will be free to not answer questions, take a break or to stop the interview at any time. At the end of the interview, I will provide a list of contact details for support services.

What are the possible benefits of taking part?
I cannot promise this study will help you but I hope that the information I get through this study will help in creating a resource for young LGBTQ+ people who have a physical health condition.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given later in the form.

Will information from or about me from taking part in the study be kept confidential?
In this research study we will use information from you. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study we will save some of the data in accordance with university policy.
We will make sure no-one can work out who you are from the reports we write.

Part 2 of the information sheet

Concerns and Complaints
If you have any questions, concerns, or complaints about the study, you should ask to speak to me and I will do my best to help you with this. You can contact me by leaving a message on the 24-hour voicemail phone number XXXX. Please leave a contact number and say that the message is for me ([Name]) and I will get back to you as soon as possible. If you are still unhappy after we talk and wish to complain

formally, you can do this by contacting Dr XXXX, Clinical Psychology Programme Research Director, Salomons Institute for Applied Psychology

How will my information be used?

We will need to use information from you for this research project.

This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

If I am worried about you, I will have to let your parent or GP know. I would also discuss this with my research supervisors. I would do my best to speak with you about this first.

I will ensure you and your data are kept safe (confidential) through the following means:

- Identifying information (e.g., consent forms) will be kept securely on an encrypted USB.
- Interviews will be audio recorded, will be stored on an encrypted USB and deleted after transcription.
- The transcripts will be stored anonymously i.e. with any identifying information removed or changed as appropriate.
- Anonymised excerpts from the transcripts will be used in the write up of the project, and in any future publications.
- In accordance with University policy, anonymised transcripts will be stored securely by the University and deleted 10 years after the study has been completed.
- Please also note that individuals from Canterbury Christ Church University or regulatory authorities may need to look at the data collected for this study to make sure the project is being carried out as planned. This may involve looking at identifiable data. All individuals involved in auditing and monitoring the study will have a strict duty of confidentiality to you as a research participant.

What are my choices about how my information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can I find out more about how my information is used?

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Or accessing Canterbury Christ Church University research privacy notice at https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notcies.aspx
- By asking the main researcher (XXXX, Trainee Clinical Psychologist. XXXX).
- By sending an email to XXXX (Data Protection Officer, for Canterbury Christ Church University)
- By ringing us on XXXX (Canterbury Christ Church University)

Will I be contacted after the interview?
Once all the interviews have been completed, I would like to contact you to check if you still want to be included in my research and to update you. In order to do this, I would need to keep a copy of your contact details. I would then destroy these once the study is complete.

What will happen to the results of the research study?
I hope that the results of the study will be published in relevant academic journals, and may be presented at relevant conferences. All quotations from the data used in any written or verbal presentations and publications will be anonymised. I will give you the option of receiving a summary of the results if you would find this interesting.

Who is sponsoring and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and has received a Favourable Opinion from the Brent Research Ethics Committee and approval from the Health Research Authority (HRA).

Thank you for reading this form!

XXXX
Trainee Clinical Psychologist
Salomon's Institute for Applied Psychology
Canterbury Christ Church University

Appendix E: Participant consent form

Date of form: 01/06/22
IRAS number: 304052
Version number: 3
Participant Identification number for this study:

CONSENT FORM

Title of Project: Exploring the narratives of LGBTQ+ young people who have a physical health condition and their experiences within physical health services

Name of Researcher: XXXX

Please initial box

1. I confirm that I have read and understand the information sheet dated 09/06/22 (version 4) for the above study. I have had the opportunity to ask questions which have been answered in a way that I understand. ☐
2. I understand that my participation is voluntary and that I am free to say I no longer want to take part in the study at any time without giving any reason. ☐
3. I understand that data collected during the study may be looked at by Dr XXXX, Dr XXXX, and Dr XXXX. I give permission for these individuals to look at my data. ☐
4. I agree for the interview to be audio-recorded and transcribed (written out). ☐
5. I agree that quotes from my interview and other data may be used in published reports of the study findings and that this will be anonymised (people won't know that I said it) ☐
6. (Optional)I agree for my anonymous data to be used in further research studies ☐
7. (Optional) I agree for XXXX to have my contact details to contact me once all the interviews are complete, to check I still want to take part in the study.
8. I agree to take part in the above study. ☐

Name of Participant____________________ Date________________

Signature ___________________

Name of Person taking consent ______________ Date_____________

Signature ____________________

A copy of this form will be kept safe on an encrypted device, and then will be stored safely by Canterbury Christ Church University. You will be given a copy to keep for yourself.

Appendix F: Interview transcription symbols

Transcription symbols	Example	Explanation
[square brackets]	**F:** I don't know what's going on. Is it really unattractive, or something else. [Nicole: Mmhmm] And this has actually made	Represent overlapping speech that doesn't interrupt the speaker but is audible. This is often the researcher actively listening.
(2), (.)	**F:** Yeah, they are just normal people (3) You know, the only interest we share together is that we,	Numbers in brackets represent pauses in seconds. (.) represents a brief pause between words
Hyph-	**F:** because you know, when- when people tend to understand you better, they they will have some these	A broken off utterance or stutter
.?!,	**F:** And because it's, you know, what you want for yourself, it's your own life!	Used to note intonation rather than grammar
"speech marks"	**F:** he was like, "well, it's so strange that these days people are tends to be a, you know, attractive to both people of the same different sexualities".	Used to indicate another person's words

Appendix G: Transcribed and analysed interview example

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Appendix H: Example initial analysis form and thought process

Initial analysis: active listening, creating chronology of story, and noticing presence of narratives

Interview analysis:

Active listening:

1. Who are the characters in this conversation:
   - Myself
   - Frank
2. What are the main events? Where/when do they occur?
   - Diagnosed with arthritis when 20
   - Started to have anxiety and accessed counselling
   - Got more invested in knitting and met people online
   - Interaction with doctor which was negative – feeling of this allowed something to change?
3. As researcher, how am I positioned in relation to the participant?
   - Positioned somewhat alongside
   - Sometimes positioned as someone who can bring around change?
4. How am I responding emotionally and intellectually to this participant?
   - Sad response to story about coming out to a doctor, visceral response to the use of the word abomination.

Chronology of story:

Prior to pain was a busy and active person, went out to play with friends, engaged in lots of social activities, felt happy in school. Experienced pain and swelling as a teenager, starting when they began having growing pains. Was able to manage with painkillers for a while. Started having treatments and being started on medication as a teenager, then diagnosed with arthritis age 20. Remembers feeling shocked that it kept getting worse. During this time thinks he missed about 40% of his schooling to go to hospital etc. Developed anxiety, accessed counselling which also helped to reduce their physical symptoms. Realised that stress leads to more pain etc. Felt unsure of what they should do with their life as their school was so disrupted. Focused on knitting to keep themselves occupied and to have fun. Began to get involved in knitting forums online, helped them to feel happy because they could engage with people without needing to leave home.

Began to discover sexuality at a similar time to experiencing pain. Was fearful about being harmful to society and tried to not tell people who he thought might have a negative reaction. Had some negative experiences in the past. At 18 had come out to a doctor as he was asking for his sexuality, doctor responded that it was 'strange' he was bisexual. Described as an abomination. Felt ashamed.

Thought it was important to come out to his physical health team but feared what the reaction would be, felt they needed to know so they can provide a complete service and have a fuller understanding of him. Worried that without this information then health services couldn't provide a better service. Experienced health team as very supportive, thought they were well informed. Not faced discrimination from health care team.

Found living through covid very tough, felt there was a loss of independence for him as his isolation increased and he had to be reliant on others. Supported by his older brother, emotional support from other LGBTQ people. Being part of the LGBTQ+ community is important for him.

Current focus is on moving forward, holding hope for the future.

Presence of dominant narratives of health
Ill health is unattractive
If you're ill then life is disrupted?
Something about recovery being necessary/important – hard to tolerate the idea that this may be lifelong
Can't be independent if you have a disability

Presence of dominant narratives of being queer
Better to hide sexuality due to discrimination/only come out when you're ready
Being LGBTQ+ is 'wrong' – religiously based and coming from a healthcare staff
Being LGBTQ+ impacts your mental health
LGBTQ+ people are harmful to society
Brave to come out

Other dominant narratives

Turning points
Impact of not being consistently in school has impacted their progress
Seeking counselling for their anxiety, helped to reduce their pain and arthritis symptoms too
Bad experience coming out to doctor – looks back on it now with a sense of not deserving that kind of judgement, came to seek their service HOWEVER also affected their willingness to come out in the future

Community narratives
Important for health teams to be aware – if they don't know they can't work with all of you
Being LGBTQ+ is good/positive/shouldn't be hidden
Community is important/necessary (for disability and queerness)

How do they 'perform' their story? What identities do they talk about? What do they want me to know?

- Push and pull between how terrible it has been and how they've managed to focus on looking after themselves
- Important to believe things will get better/their condition will end
- Fear of discrimination is very live in their life
- Alluded to past bad experiences, provided details on one such experience

- It’s important to be understood – so people can treat you better
- Emphasis on how well he was treated by his health team compared to past experiences
- Emphasis on staying positive despite the negative experiences he has had
- Bad experiences made him grown stronger. Important for him to convey that it doesn’t matter to him so much anymore what people say about him. His strength comes from what he believes about himself
- Being able to reflect on current life was described as emotional for him – a point of connection between us. Important for him to convey something to me? – a usefulness for him in the conversation?

Appendix I: Participant debrief form

Sources for support

Title of Project: Exploring the narratives of LGBTQ+ young people who have a physical health condition and their experiences within physical health services

Thank you so much for taking part in an interview. Sometimes when we talk about our experiences we can feel a bit upset, or like we want to talk to someone who will understand.

I have included some organisations that are LGBTQ+ friendly and offer support to young people. If you feel it would be helpful, please do contact them.

https://www.stonewall.org.uk/help-and-advice - stonewall holds a vast amount of information and resources for LGBT people, as well as a list of services and groups that might be local to you.

https://www.theproudtrust.org/young-people/ - provides an instant messaging service on Tuesdays and Thursdays from 12pm-6pm.

https://giveusashout.org/ - text 'SHOUT' to 85258 to speak with a crisis counsellor via text for free. This is a 24/7 service.

https://www.childline.org.uk/get-support/ - childline support children and young people with their worries. You can call for free on 0800 1111, or speak with a counsellor via instant message on their website.

https://mindout.org.uk/get-support/ - a mental health service that is set up and run by LGBTQ+ members. You can access support via instant message from 5.30-7.30pm most evenings and 2-4pm on Sundays (check website for their times each day).

If you are worried about yourself, or for your child, please contact your GP in the first instance. You can also attend A&E if you are very worried and feel unsafe, or you are worried for your child's safety, and you will be supported there.

Appendix J: End of study summary report for participants

Dear [participant name]

I hope this letter finds you well. I am getting in touch with you with a final update on my research project looking at the experiences of young LGBTQ+ people who have a physical health condition. I would like to thank you again for taking part in this research, and I have provided a summary of the findings for you. Your voice matters, and you deserve to be heard. I would also like to invite you to provide any feedback you might have.

The questions I set out to answer were:

- What stories do LGBTQ+ young people with a physical health condition tell about their relationship with staff and the process of coming out to health care providers?
- What stories do LGBTQ+ young people tell about navigating their physical health condition in the current social context?
- What stories do LGBTQ+ young people with a physical health condition tell about their identity?
- How are the dominant discourses surrounding LGBTQ+ identities, including those on social media, represented in the personal stories of young people?

I have put my ideas about these questions below – these are 'themes' that stood out to me after I listened to the interviews several times. I was especially interested in what was similar or different between interviews, and what this might mean for how people develop and accept their identity. There were lots of amazing stories that I was told, and I've been able to share a fraction of this in my study.

Theme: Navigating illness

This theme was about how participants experienced their illness throughout their life, including experiences of developing symptoms, being diagnosed, and being ill in different settings (such as school or church).

Early life and developing illness

Participants often started their story by sharing who they had grown up with, and any difficulties that had happened at these times such as grief, divorce, and financial difficulties in the family and how these experiences had influenced them in life. Participants who developed symptoms later in life often had a strong sense that life was better before they were unwell (quote: '*Before that time [before diagnosis], life was a very good one, I normally go out to play with friends, and normally engage in social activities a lot'*). It was felt that participants longed for their life before developing symptoms. Participants generally described receiving a diagnosis as being helpful, however for some the process was time confusing and frustrating (quote: '*Sometimes it was just annoying and frustrating because it had to be repeated… doing the same thing over and over again was somewhat annoying'*).

Impact on self and others

Being ill impacted on participants in several ways, including on their own mental health and wellbeing. Participants had found different ways to help them cope with the impact, including through engaging with hobbies, accessing counselling, and using alternative medicine to help with pain relief (quote: '*I realised that my anxiety symptoms started coming up. So I needed to seek some counselling'*). Participants also reflected on the impact of their health on their family and friends around them. Some worried about their parents mental health, or the financial strain that was placed on family who supported them to attend hospital appointments or took time off work to care for them (quote: *my uncle wasn't able to cope with the bills.. he'd just lose the shop. And it will be something that would impact on the shop negatively'*).

Navigating different social contexts

School was a particularly difficult time for participants as they experienced extended periods away from education due to their illness, as well as managing their symptoms at school which affected their ability to learn. Participants encountered judgement from classmates and could feel tired and fed up of having to defend their abilities to others (quote: '*and then they're kind of giving you judgemental words, like you're pretending kind of [sighs]*'). Participants also spoke about the extra decisions they have to make to navigate the world, such as whether to take aides that would mark them as someone who is visibly different and who to tell about their condition. Some participants experienced negative remarks from friends after sharing their health with them, which caused them to feel shame and not want to let others know for fear of a similar response (quote: *'I just told her [friend] that it is a health condition. It's just something that makes my face swollen. And she felt scared from that day'*).

Theme: Navigating healthcare

This theme was about the experiences participants had in healthcare, including relationships with their healthcare staff.

Staff are important

Everyone who took part in the study spoke about how staff were important to them. For some, healthcare staff felt like their family and they had been supported by staff through difficult times in their lives. Healthcare staff could be inspiring, and some participants spoke about wanting to be accepting of others in the same way that their health team had been for them (quote: *'I think maybe it is in their training to always accept people. And always, no matter who the person is…. That's something I admire a lot'*).

Staff get it wrong

Although the importance of healthcare staff in the lives of participants was very clear, most participants had also had negative and upsetting experiences with their healthcare teams. These could be due to their LGBTQ+ identity, ethnicity, or other factors. Experiencing stigma from healthcare staff meant some participants withdrew from their support and felt some shame or guilt about who they are (quote: '*sometimes you have to meet the health worker that doesn't want to treat you right now… just because you're not white'*). Participants could also run into difficulties such as being asked about their gender and their response not being believed by staff. However, some participants spoke about the positive changes they had noticed within healthcare and shared their belief that these types of difficulties happened less or were getting better.

Choosing to come out

Choosing whether to come out as LGBTQ+ to healthcare staff was an individual decision that was influenced by lots of factors. Participants who were more linked in to LGBTQ+ communities felt more comfortable to come out to staff. There was a shared belief for these participants that healthcare staff being aware of their LGBTQ+ identity would make sure they received better care (quote: '*I just needed to you know, say this thing [come out] now, so that these people [staff] may come to understand me very well and you know…. Give me a complete service'*). Other participants did not hold this belief and felt they might come out to healthcare staff if it was directly relevant to their health condition, whereas some had not considered it prior to interview.

Theme: Navigating identity and accepting or rejecting dominant narratives

This theme was about how participants viewed themselves and their identity and how their identity interacts with the wider world. 'Dominant narratives' are ideas or beliefs that are held within a society or culture and can be influenced by many things. For example, for many years the dominant narrative was that same-sex marriage should be illegal in the UK. This has now changed, with the dominant narrative being that same-sex marriage should be supported.

Becoming aware of difference

All participants told stories about when they became aware of how they were different to other people around them. These included stories about noticing differences in their body, their health, their skin colour, and their ability to 'fit in' with the majority. The experience of realising difference was tricky for some participants, causing them to feel shame and discomfort with their identities (quote: *'I was the only black in my class… I was like oh, I'm the only one who has this. I'm the only one*').

Finding community

Being part of a community was key to many of the participants stories. There were lots of different kinds of communities that were spoken about, such as LGBTQ+, religious, social justice, health, and black communities. One of the most powerful things that could come from being a part of a community was feeling accepted for 'who I am'. This acceptance could help participants to feel protected from the stigma they encountered in the rest of the world (quote: '*I found out there's something, like the LGBTQ community where everyone with that, you can actually tell anyone that you are LGBTQ, and the person will feel comfortable with you'*).

Influence of role models

Being able to accept and celebrate identity was heavily influenced by who participants were surrounded by. Participants had lots of different kinds of role models that influenced their lives including family, friends, celebrities, and organisations. Some role models helped participants to reject narratives that were negative about their identity as they passed down the message that being different is what made participants special. Having visible LGBTQ+ role models in positions of power was also important to participants, especially role models who were also black and proud of their identities (quote: *'if we're going to have maybe a celebrity who is a black, and he's an LGBTQ, I think people will have reacted to blacks being LGBTQ differently'*).

It was interesting to me that no participants spoke about healthcare staff in their stories about identity and role models, despite the positive relationships many of the participants had with their healthcare staff teams.

Moving forward with identity

Stories tended to end with a reflection on participants current stage of life and their hopes for the future. For some, these hopes were individual and centred on being able to meet other young people like themselves, or their hopes that they might be able to recover from their health condition (quote: *In this chapter of my life right now, with this condition that I have… I try to recover as fast as possible. So you know, I can be able to meet up with life, I can be able to pursue my dreams*). For others, they held outwards hopes for how the world may become a more accepting place for black and/or mixed-race LGBTQ+ people. Those who had been most supported to accept and integrate their identities were also thinking about how they themselves could step into being the role model for other young people.

What next?

I would like to find out what you think of the results, and if you feel they match with your experiences of being a young LGBTQ+ person living with a physical health condition. I would be really grateful if you could provide me with any feedback. I hope this research will be used to improve and better understand the healthcare experiences for young LGBTQ+ people. Please email me at nw328@canterbury.ac.uk.

Some of the recommendations I have made following this research is that healthcare teams set up spaces for young LGBTQ+ people who have physical health conditions to socialise and share their experiences. I have also recommended that these spaces are set up specifically to support young people who are black or mixed race. I am also planning to publish this research for other people to read. I hope this will help others to learn and provide young people with better care.

Finally, I would like to thank you for taking the time to participate in this research. It was a privilege to be trusted with your story and you have made a valuable contribution.

Warm wishes,
Nicole Williams

Appendix K: End of study report for ethics

Dear Brent Research Ethics Committee,

Re Project: **Exploring the narratives of LGBTQ+ young people who have a physical health condition and their experiences within physical health services**

I am writing to send a short summary of findings and details of dissemination regarding the above study.

The study's abstract is as follows:

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) individuals experience health inequalities. Young people living with a health condition are also more likely to experience adverse mental health outcomes. Developing positive identity can help to mitigate the impact of this. Young black LGBTQ+ people have additional barriers to developing positive identity. Current research rarely considers the intersection of these identities for young people despite the stigma and discrimination they may face, and the impact this may have on their mental and physical health. A narrative approach allows these voices to be heard in research.

Eight participants were interviewed using a narrative approach. All participants came from a black-African, black-Caribbean, or mixed-race background. Interviews were analysed using content and thematic narrative analysis. Global summaries of each interview were developed and 'plot lines' emerged from these. A central plot related to identity development, with two plots embedded in these exploring experiences of illness and of healthcare. Participants had positive experiences of healthcare despite encountering stigma. Access to positive role models and being able link in with various communities allowed participants to integrate and accept their identities. A key discussion point in this study is the ways in which healthcare staff could become role models for young LGBTQ+ people and help them to integrate and accept their identities.

I plan to share of summary of findings to all participants who requested ongoing communication about the study via email. We also hope to publish the findings in the peer reviewed journal 'Journal of LBGT Youth'.

Kind regards,
Nicole

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Appendix L: Master narrative

Chapter 1: Pre-diagnosis and development of physical illness	Participants tended to begin their story by recounting aspects of their childhood and setting the social context of their life. This tended to include who they had lived with growing up, early experiences of loss and grief, their memories of life prior to developing symptoms of their physical health condition, and their early experiences of school and developing friendships. Participants who had been born with a physical health condition recounted stories they had been told by their parents of how this impacted their lives as a young child. Participants then moved into sharing how they first noticed changes in their physical health and the beginning stages of accessing healthcare, including who first took them to a doctor. Participants recounted mixed emotions about this time in their lives, expressing some relief that they might have medical interventions which may reduce their symptoms, alongside the challenge of navigating their symptoms in different settings including school and home.
Chapter 2: Accessing healthcare and discovering LGBTQ+ identity	The middle part of stories generally began with recounting the process of diagnosis and medical interventions they had received over their life. Participants who had been diagnosed at a young age focused more on their journey of gaining more knowledge about their condition and beginning to feel more confident in managing their own condition with less support from family. All participants recounted positive experiences with healthcare staff and teams and there was a clear shared sense that healthcare staff held an important position in their lives, with terms such as ‘family’ and ‘friend’ being used to describe relationships with their supporting staff. However, all but one participant recounted experiencing discrimination and stigma from their physical healthcare teams in relation to multiple minority identities, including LGBTQ+ identity and ethnicity. This was embedded in participants stories about beginning to understand and explore the ways in which they were ‘different’ from their peers, including the colour of their skin, their health condition, and their LGBTQ+ identity. All participants explored their journey to integrate and accept (or distance themselves from) these parts of their identity. For some, they were in the initial stages of this process, whilst others could talk about this process in depth. The importance and influence of role models was spoken about in all the recounted stories. These included parental figures, healthcare staff, friends, and communities. Role models held significant power to strengthen or subvert the dominant narratives that were held by participants. For participants who were more able to embrace a positive outlook on their minority

	identities, clear role models were described who helped them to celebrate who they were as well as helping them to navigate the negativity they may receive from the world. Importantly, these role models did not need to have the same minority identity to support the young person. The influence of healthcare staff was notably missing in this specific process, despite being able to influence participants in other ways.
Chapter 3: Stepping into the future	Participants ended their stories by reflecting on their current position in life and thinking on their hopes for the future. Participant hopes included having their family be supportive of their LGBTQ+ identity, being able to access communities of other young people who are in a similar position to them, and hope that their physical symptoms may reduce as they get older. Participants who had a positive relationship with their identity also shared their hope that the world would continue to become more accepting of LGBTQ+ people, and shared their ideas of how they might encourage younger generations. There was a sense that these participants were beginning to explore their own possible identity as a role model for others in their life.

Appendix M: Excerpts from research diary

Meeting with potential supervisors, Jan '21:

- Met with [name] today. What a relief! It's such a different experience talking to people who 'implicitly' get it and think that research in this area is important. I didn't feel like I had to justify my interest or convince them that my community is important to hear. They've told me to think about it, and they'll be thinking about whether I'm the right fit for this too. I feel hopeful for the first time.

Starting proposal process, March '21:

- This is hard and confusing. Realising how little I know about research and how 'out of my depth' I am. I've never done qualitative research before! We did have a lecture on narrative methodology which sounds interesting. There's barely any research in this area, so I think that could be a nice starting point. [internal supervisor] was also quite excited by this idea.

Proposal given go ahead, June '21:

- That was better than expected! I'd heard about some people having a nightmare getting their projects approved by the uni, and had convinced myself I'd be in the same boat. I've been lucky tho, and had my proposal approved straight away. There's some amendments and bits I need to think about, but overall it's a really positive start.

Experiences in uni, March '22:

- Lots of talk in the uni at the moment about transphobia. Makes me take a step back and reflect on my own experiences growing up, I feel like a lot of the conversations that happen now are similar to the ones I heard growing up that were so painful. It does give me more passion for this research. LGBTQ+ young people deserve to feel heard by the world. I feel a lot of pressure to 'do right' by them. I feel glad I'm using narrative where I can quite explicitly take a social justice stance. I spoke with my supervisors about this, and they warned me to expect some kickback. It feels sad that it's so controversial for people to exist as themselves. My supervisor spoke about their colleague who received death threats for openly supporting LGBTQ+ youth in their work. Although I think this project is so worthwhile, I don't think I'd appreciated the emotional tax it might place on me. Need to make sure I look after myself.

Meeting with supervisors following ethics, April '22:

- Discussing my ethics review with my supervisors has been really helpful actually. All 3 of them were really annoyed on my behalf, which I hadn't expected. They helped me make sense of why I was so upset and uncomfortable about the questions asked and we wondered whether some was coming from homophobia. I feel like a bit of a fool for not connecting that myself, but I suppose that's why it's important to talk about it. [internal supervisor] had also spoken to more senior researchers at uni, who also felt that the panel had been unfair to me and gone beyond their job description. Just feel tired and fed up at this point. I have been told that I can reject the ethics recommendations provided I can give a good enough rationale. I'll need to go away and think about that more.

Ethics approval, June ‘22:

- Finally we have approval! Now to go through the R&D for each trust… I've heard from some other trainees that this can be just as bad as the actual ethics process. In the meantime I can recruit through twitter. I hate the idea of that, I'm not a massive fan of social media, I've never been on twitter. In fact I actively avoid it.

Initial response from twitter, August ‘22:

- Feel so overwhelmed at the moment. My post had been up for less than 24 hours and I've had 70+ people contact me about the study. I had to take it down, but people kept contacting me, I think it's being shared in friend and support groups. It's really made me feel like this project is genuinely valuable. I have no clue how I'm going to cut this down and work out who to interview.

Meeting with supervisors, Oct ‘22:

- It's been a frustrating few months. So much work on outside of the MRP and placement is busy. From the high of the initial interest from participants, I now feel like I'm in a low trying to work out how to do part A. We're also delayed in thinking about who I decide to interview. We didn't think about this as we'd expected the majority of participants would come through the NHS. There's been talk about us going back through ethics which feels me with dread. It's hard to balance what's best for the project and the participants, and also making sure I complete the course in a good time frame.

Meeting with supervisors, Nov ‘22:

- Success on 2 accounts! I've submitted a draft of my part A. We've also decided that I won't go back through ethics. I'm excited to get going with interviewing but also slightly terrified. Narrative is interesting and I still think it's the right methodology, but it’s quite vague in some respects.

Screening of participants, Nov ‘22:

- The saga continues! Met with my first potential participants today to go through the information sheet and consent. The first person I met with was confusing. They kept contradicting themselves, and at one point it sounded like they were pretending to be their mum! I'm upset as it left me feeling very on edge the rest of the day. It's unfair to other people. I've emailed my supervisors as I really need support with this, I think it's the most anxious I've felt on the course? However, I did meet with one participant today who gave me a lot of hope. They seemed so interested and passionate about the research, we even had a good chat about the ethics around paying participants and how little they are often paid. There is hope within the misery at the moment. I wonder if that's a narrative for myself? Hope within misery. Something to think about.

Re-reading narrative bits, Nov ‘22:

- For the first time I'm regretting using narrative analysis. It seems so daunting. How do I do it?! Oh for the comfort of clear cut questions and a nicely set out interview schedule. I'll have to brave it and trust that my clinical skills will come through. I've elicited narratives in many ways before, this time it's just official and will be a barrier to me completing this course.. and of respecting my participants and their value…

Interview 1, Nov ‘22:

- First narrative interview today. Felt quite stressful to begin with as I felt so unsure, really realising that although narrative has some really lovely qualities, it's quite intimidating to use as it's so dependent on what is brought by the person. Although I had a clear opening question, my prompts are more vague and is down to my decision making in the moment about what I follow up or not. I don't feel like I trust myself really, like do I actually know what I'm doing? I've felt so sceptical so far in the process of meeting with people, and so to finally have my first interview felt like a real win. I was quite moved by some of the things they were saying, and how passionately they spoke about justice in so many different areas. They also challenged the ideas I had about this process - I already know I was biased and assumed that it would be mainly hardships and discrimination. I was very wrong! There was so much that they said that I think I've probably missed a lot of nuance in the prompts I used. On to the next!

Interview 3, Dec ‘22:

- Really quite moved by today's interview. I wasn't sure if he would feel comfortable telling his story, but once he got started it was very powerful. I feel quite emotional thinking about some of his experiences. I hadn't expected it. Some of the words he told me had been used about him by staff were really hard to hear, and made me think of my own experiences. His interview was short, I think he found it difficult to expand on things, but I'm hopeful that there's a lot in there despite the length. Hopefully I'm starting to get a hang of eliciting narratives from people. I think it's hard to tell right now, and I won't have a better idea until I start transcribing them. I imagine there's just so much I've missed of each one.

First transcription, Dec ‘23:

- Transcribed my first interview today. I decided to start with the shortest so I could feel a 'win' with transcribing. It's important to take whatever you can on this course. And wow. What a story. It's amazing to listen back and hear how much I had missed the first time around. Although the interview was short, there was such a lovely depth to it. I hadn't expected this. I'm so impressed and amazed by the people I've spoken to. It helps to reignite me through the frustration. I want to do right by my participants. I wonder what the narrative is there?

Beginning to write, Feb '23:

- Almost there with my interviews now, so it's time to start thinking about the write up and analysis. Been talking to other trainees about their approach to narrative which is helpful. Identity is central to my study so I need to use an approach that can honour that. I also want to make sure identity theories are threaded into my write up – it seems an integral part of the write up will be related the development of positive identity in relation to LGBTQ+ identity as well has having a physical health condition. It's hard to know how in depth to go with the theory – Feels like there needs to be solid basis of what is identity and how does it develop, and then move into what's most relevant. Also spent some time reflecting on my participants, we hadn't anticipated that all would come from a black background. I wonder what it is that has allowed people who might not usually be heard in this topic area to engage in this project – perhaps recruiting online allowed different people to see it or 'removed'/distanced the study from some of the associations with healthcare?

Reflections on race and positioning, March '23:

- [internal supervisor] has sent me some reading on empowering black voices in qualitative research. It looks really helpful and is expanding my reflection on my positioning as a white psychologist in the interviews. I need to find a way to integrate the participants identities and consider intersectionality more broadly. If we had known from the outset it would have been helpful to set up the project using ideas from this reading.

Meeting with supervisors, April '23

- Met with supervisors following them reading a draft of part b. A lot of our conversation was around intersectionality and how to embed this more throughout the MRP. We spoke about how our initial 'lens' was from the LGBTQ perspective when starting this project – it's important to ensure that other lenses around race and culture aren't missed, especially as none of us are black. One way to do this will be to honour the work of black researchers or psychologists. It's tricky in the word count to give 'justice' to all of these aspects, and I will need to think about how I approach the viva in order to show my thinking process.

Appendix N: Interview schedule

Interview schedule:

1. Go over consent
2. Collect demographic interview
3. Collect physical health information
4. Re-explain process of interview (one broad question with follow up)
   - I will let you talk for as long as you want to begin with, please tell me as much as you feel comfortable to and anything you think might be relevant! I am very interested in knowing your life story
   - If there is anything you don't want to tell me more about that is ok

   START RECORDING
5. Ask first question

"Perhaps you could begin by telling me something about yourself and your life story up to and including your time receiving services for your physical health?"

General prompts:

"and then what happened?"

"let's go back to this chapter of your life"

"can you tell me more about this character in your life"

“can you remember a time when X”

Specific prompts:

“Can you tell me more about your experience of discovering your gender/sexuality/other identity?”

“Can you tell me about whether you have spoken to your healthcare team about…?”

“Can you remember/tell me about a time where you faced discrimination regarding…?”

END RECORDING

6. Debrief
   - Check in with how they are feeling
   - How did they find it?
   - Let them know you are especially interested in the above research questions!
   - Inform them you will be sending a debrief form

- Let them know you will be requesting for a voucher to be sent to their email address, check this is all ok
- Any questions about the research?
- Would you like a copy of your transcript?
- Would you like a copy of the easy read results?

Appendix O: Letter of favourable opinion from ethics committee

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Appendix P: Letter of approval from HRA

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