Adolescent Experiences of Disclosing Sexual Orientation to Healthcare Professionals

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BPS	British Psychological Society
GP	General Practitioner
HIV	Human Immunodeficiency Virus
HRA	Health Research Authority
IPA	Interpretative Phenomenological Analysis
LGB	Lesbian, Gay, Bisexual
LGBT	Lesbian, Gay, Bisexual and Transgender
NHS	National Health Service
REC	Research Ethics Committee
GUM	Genito-Urinary Medicine

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Preface

For consistency, this thesis has been written and formatted using American Psychological Association (APA) 6th edition formatting. Paper one journal submission guidelines can be found in paper 1: Appendix G and paper two journal submission guidelines can be found in paper 2: Appendix J.

Summary thesis abstract

The aim of this research was to examine the experiences of adolescents disclosing their sexual orientation, with specific focus on making the actual disclosure from the young person's perspective. There is a paucity of existing literature in this field and it is hoped that this thesis will add to the body of knowledge related to lesbian, gay and bisexual adolescents.

Chapter one examines the current knowledge around the impact on, and experience of, young people who disclose lesbian, gay or bisexual sexual orientation in any setting. Findings are discussed under three main categories; Reactions to disclosure, Consequences of disclosure and cultural and ethnic differences. It is recognised that there is overlap between these areas with factors that will inevitably interact.

The second chapter investigates the experiences of adolescents who have disclosed their sexual orientation to a healthcare professional. Analysis of interviews with seven participants indicated four main themes: Identity formation, the moment of disclosure, additional influences of disclosure and professional roles and responsibilities. These themes are discussed in the context of existing theories and current research. Clinical implications, study limitations and future research avenues are also discussed.

Chapter three contains the author's reflections on the process of completing the thesis, along with personal reflections of the thesis topic and reasons for beginning this investigation.

Paper 1 – Literature review

Abstract

This review examines the current literature investigating the impact on and experiences of young people disclosing lesbian, gay or bisexual orientation.

Appropriate search terms were entered into the following databases: The Allied and Complimentary Medicines Database (AMED), MEDLINE, PsycINFO, SPORTDiscus, AgeLine, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycARTICLES, Biosis Citation Index, Current Contents Connect, Data Citation Index, Derwent Innovations Index, Medline SciELO Citation Index, Web of Science Citation Index, (also including: Conference Proceedings, Book Citation Index, and Index Chemicus) and Zoological Record.

Relevant papers were then selected following the application of inclusion and exclusion criteria; ten articles were selected for review. Articles were critically appraised and assigned a rating based on their strengths and weaknesses. Findings were synthesised yielding the following categories: reaction to disclosure, consequences of disclosure and cultural and ethnic differences. The paper concludes with a discussion of the findings as well as the implications of this review.

Key Words: Sexual orientation, disclosure, impact, experiences, consequences.

Introduction

The terms ‘sexual orientation’ and ‘sexual identity’ are sometimes used interchangeably in colloquial conversation, however, these two terms have distinct differences. The term sexual orientation is used to describe an enduring pattern of romantic and/or sexual attraction towards others (Perrin-Wallqvist & Lindblom, 2015), and is thus just one part of an individual’s sexual identity. The term ‘sexual identity’ is more complex than this description of attraction; it encompasses multiple factors such as an individual’s identified gender, biological sex, sexual beliefs and values and their sexual orientation (Yarhouse, Tan & Pawlowski, 2005). Non-heterosexual orientation is therefore just one aspect of a non-heterosexual identity.

Disclosing that one is lesbian, gay or bisexual (LGB) refers to an acknowledgement that one’s attraction to others is different from the heterosexuality assumed by a heteronormative society. Disclosure therefore requires a realisation of this sexual orientation (Spigarelli, 2007). As with ‘sexual orientation’ and ‘sexual identity’; ‘disclosure’ and ‘coming out’ are used synonymously in common discourse. Several distinctions exist, however, between the two terms. Firstly, disclosure of one’s sexual orientation can be defined as a single event, albeit an event that must take place time and time again in a multitude of settings. ‘Coming out’ on the other hand refers to the process of forming a sexual orientation identity for lesbian, gay and bisexual individuals (Floyd & Stein, 2002). Thus disclosure can be seen as one part of the ‘coming out’ process. This process often progresses over many years, during which time a sense of self is developed by the individual along with a more public lesbian, gay or bisexual identity (Cass, 1996). Secondly, deciding to disclose one’s sexual orientation to others involves an intricate cost-benefit analysis of potential gains and losses (Schope, 2002). A person who identifies as lesbian, gay or bisexual has to choose whether to disclose to each new individual they meet regardless of how ‘out’ they may be in their lives overall. Choosing whether to conceal or reveal one’s sexual orientation is one of the most difficult decisions LGB individuals have to make (Sabat, Trump & King, 2014) with this group reporting ongoing hostility and discrimination from family, friends and co-workers despite improving social attitudes towards minority sexual orientation (Herek, 2009). It comes as no surprise therefore that research in this area has identified a high prevalence of shame, stigma, stress, substance misuse and mental distress amongst the LGB population (Meyer, 2003; Yarhouse, Tan & Pawlowski, 2005; Legate, Ryan & Weinstein, 2012; Ryan, Legate & Weinstein, 2015).

Research in this area has traditionally focused on sexual identity and sexual orientation disclosure of lesbian, gay and bisexual adults. It is becoming increasingly acknowledged

that individuals are recognising their sexual orientation earlier than in the past, with self-awareness of sexual orientation commonly occurring in adolescence (Frankowski, 2004; Floyd & Bakeman, 2006). As previously mentioned, disclosure of non-heterosexual orientation is often filled with anxiety; research suggests that for adolescents the processes and consequences of either coming out or not coming out are both fraught with real psychological and sometimes physical danger (Perrin, 2002). Non-heterosexual youth can have increased risks to their physical, emotional and social health, often as a result of social stigma and isolation (Frankowski, 2004), with societal attitudes towards homosexuality having a decisive impact on the extent to which individuals, particularly adolescents, have disclosed or hidden their sexuality (Heinze & Horn, 2009). A first-hand account of experiencing social stigma and isolation as a lesbian is given by a 15 year old gay rights activist during a speech to a panel of youth and legal professions in San Francisco (De Vries, 1998). De Vries describes being aware of her sexual orientation from a young age and reports beginning the process of coming out when she was 11 years old. Despite a supportive reaction from her parents after disclosing her sexual orientation to them at age 12, she experienced harassment from peers for defending non-heterosexual others despite not yet being out at school herself. Following a disclosure of her sexual orientation at school aged 13, she received varied reactions from students. A minority of students were accepting and continued on as before, the majority however began to make embarrassing and hurtful comments. The author describes losing friends as a result of her disclosure with other females in her class actively avoiding her. A period of increased isolation at school occurred with younger children running away from her, scared by stories of her being a ‘recruiter’ or a ‘child molester’.

Though the above described first-hand account is just one person’s experiences following disclosure, it provides a level of insight into the unique challenges faced by young people disclosing their sexual orientation. To date there has yet to be a review that has collectively captured and systemised information on the impact on, and experience of, adolescents who disclose a non-heterosexual sexual orientation. This current review therefore aims to redress this issue. Due to the limited amount of research specifically focusing on adolescent disclosure of non-heterosexual orientation, disclosure in all available contexts (e.g. to friends, family, at school) will be included in this review. The review will seek to answer the following question:

What is the impact on, and experience of, young people who disclose a non-heterosexual sexual orientation?

Method

A review of the literature was conducted to identify the current knowledge around young people's experiences of disclosing their LGB sexual orientation to others and the impact that making this disclosure may have. The following search strategy outlines the process of selecting articles appropriate for the review. The results are accurate as of a search completed on the 28th September 2016.

Search strategy

EBSCO host was used to search the following databases: the host sites from which the search was conducted in the following databases: The Allied and Complimentary Medicines Database (AMED), MEDLINE, PsycINFO, SPORTDiscus, AgeLine, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and PsycARTICLES. ISI Web of Science was used to search the following databases: Biosis Citation Index, Current Contents Connect, Data Citation Index, Derwent Innovations Index, Medline SciELO Citation Index, Web of Science Citation Index, (also including: Conference Proceedings, Book Citation Index, and Index Chemicus) and Zoological Record. A hand search of relevant journals and article references was also undertaken.

Search terms:

The following specific search terms were used and searched by abstract:

*Adoles** or *child** or *Teen** or *"young people"* or *youth.*

AND *"sexual orientation"* or *sexuality* or *lesbian* or *gay* or *bisexual* or *homosexu** or *LGBT*

AND *disclos* or "coming out"*

Initial inspection of the search results highlighted a high volume of articles focused on the disclosure of sexual abuse or Human Immunodeficiency Virus (HIV). The following title search term was therefore added to screen out these articles as this was not the focus of this review:

NOT *abuse* or *"human immunodeficiency virus"* or *HIV*

Duplicates were removed. Following the World Health Organisation's (WHO) (2014) definition of a 'young person', as well as, guidance from NHS England (2015) for Children and Adolescent Mental Health Services (CAMHS) to include individuals up to age 25; the returned articles were limited by age to include 13-25 year olds. The remaining articles were examined for particular relevance. Eligibility for inclusion was determined via article title, with abstracts and full texts being read to provide clarity where necessary. Articles were excluded from the review on the following bases:

1. Not being specifically about the disclosure of LGB sexual orientation. (Disclosure in this instance refers to the formal definition: the event of informing someone of one's sexual orientation rather than the 'coming out' process of forming one's overall sexual orientation identity).
2. Lack of focus on either the experience or impact of disclosure.
3. Investigating the effect of an intervention.
4. Relating to parental experiences, parental sexual orientation or parental disclosure.

Ten articles were selected for inclusion in the final review. Figure 1 below depicts the process of article selection.

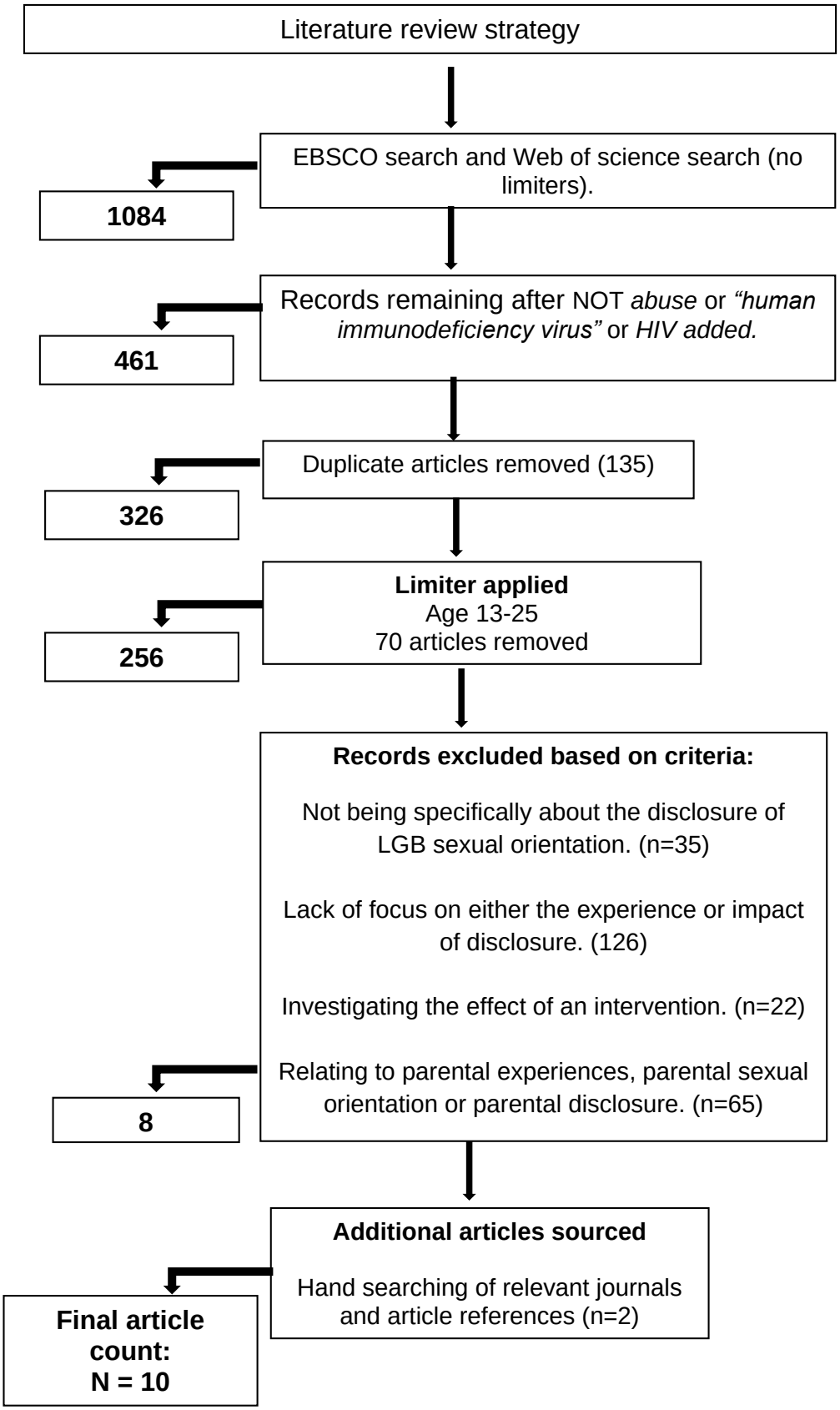

Figure 1: Literature review search strategy

Two other papers were identified as being potentially suitable from reading the abstracts. One article was a brief personal account from a 15 year old LBGT rights activist who identified as a lesbian (De Vries, 1998). The article was excluded from the formal review on the basis that it was not able to be critiqued as a piece of literature. The information within was however incorporated into the introduction of this review so that this individual narrative was not lost. The second article was a piece of grey literature not available online. The authors and relevant institutions were contacted, however the paper was not made available so had to be discounted from this review. The inability to access what may have been a relevant piece of literature for this review demonstrates the negative impact of publication bias on academic knowledge. The term publication bias refers to the favouritism given to research showing positive or socially desirable outcomes - making it more likely that these papers will be published over those which show inconclusive or less desirable (but not less academically important) outcomes. In order to minimise the impact of publication bias on this review, the searches described above were not limited in a way that would exclude grey literature from the results.

A data extraction table outlining the title, authors, participant information, methodology, study aims, study locations and key findings for each of the ten articles selected for review can be found below.

Table 1: Studies investigating the experience and/or impact for adolescents and young people disclosing non-heterosexual sexual orientation.

Number	Study title, authors and date	Participant information	N	Methodology	Study aims	Study location	Quality score and appraisal.
1	Lesbian, Gay and Bisexual youth and their families: Disclosure of sexual Orientation and its consequences. D'Augelli, Hershberger & Pilkington (1998)	LGB youth aged 14-21	105	Quantitative questionnaire administration and interview.	To investigate disclosure to family members including what reactions youths get from different family members and what, if any, patterns of victimisation are associated with disclosure	USA	17 Very Good
2	Being out at school: the implications for school victimisation and young adult adjustment. Russell, Toomey, Ryan & Diaz (2014)	LGBT Youth aged 21-25	245	Quantitative Multivariate structural equation model	To consider whether coming out as LGBT in adolescence has benefits for mental health/wellbeing	USA	18 Very Good
3	Disclosure of Sexual Orientation and subsequent substance use and abuse among Lesbian, Gay and Bisexual Youths: Critical role of disclosure reactions. Rosario, Schrimshaw & Hunter (2009)	LGB youth aged 14-21	156	Quantitative Structured interview at 3 time points measuring disclosure reactions, subsequent substance use and potential covariates.	To examine the relationship between disclosure and substances use and abuse as well as whether reactions to disclosure are important for subsequent substance use.	USA	18 Very Good
4	Families of Gay, Lesbian and Bisexual youth: What do parents and siblings know and how do they react? D'Augelli, Grossman & Starks (2008)	LGB youth aged 15-19	516	Quantitative	To examine disclosure to parents and siblings and how familial knowledge of and reactions to sexual orientation may affect adjustment, self-esteem, internalised homophobia and mental health.	USA	17 Very Good

5	Victimisation of Lesbian, Gay and Bisexual youth in community settings. Pilkington & D'Augelli (1995)	LGB youths aged 15-21	194	Quantitative	To investigate the prevalence, context and likely correlates of victimisation experiences following disclosure of sexual orientation.	USA	18 Very Good
6	Qualitative Research on Family Disclosure and Substance Use Among Sexual Minority Youth Grafsky (2011)	LBG youth aged 14-21	22	Qualitative	To understand the experience of disclosure of sexual orientation to family and describe the meaning of the experience. To explore whether adolescent substance use is related to the process of disclosing one's sexual orientation to family; and if so, how.	USA	18 Very Good
7	Family and friendship relationships after young women come out as Bisexual or Lesbian. Oswald (2000)	Lesbian or bisexual women aged 18-23.	6 LB women. 25 of their family and friends also interviewed.	Qualitative. Analysed using grounded theory open coding techniques	To investigate the impact of coming out on family and friend relationships using multiple accounts.	USA	15 Good

8	Experiences regarding coming out to parents among African American, Hispanic and White Gay, Lesbian, Bisexual, Transgender, and Questioning Adolescents. Potoczniak, Crosbie-Burnett and Saltzburg (2009)	High school age LGBT adolescents aged 14-18	Not stated	Qualitative Phenomenological focus group interviews. Analysed using constant comparative method	To advance understanding of ethnically diverse GLBTQ adolescents coming out experiences to family.	USA	18 Very Good
9	"Coming out" stories of Gay and Lesbian young adults. Rossi (2010)	Lesbian and Gay youths aged 18-25	53	Qualitative	To explore coming out for the first time to parents.	USA	17 Very Good
10	Coming out as Gay: a phenomenological study about adolescents disclosing their homosexuality to their parents. Perrin-Wallqvist & Lindblom, 2015	Lesbian and Gay individuals disclosing sexual orientation as adolescents. Age not specified	6	Qualitative: Interpretative phenomenological analysis. Retrospective account of adolescent experience	To explore how it felt before and after disclosure of sexual orientation to their parents.	Sweden	17 Very Good

Critical Appraisal

The National Institute for Health and Care Excellence (NICE, 2015) recommends the use of the Downs and Blacks checklist (1998) and the Critical Appraisal Skills Programme (CASP, 2013) in the development of their guidelines. Furthermore both of these assessment tools have been recognised as being a high quality method of appraising academic literature (Deeks et al, 2003). The appraisal of the ten articles selected for review will therefore be guided by these tools, along with recommendations for qualitative research taken from Elliott, Fischer & Rennie (1999) and Yardley (2000). A summary and critique of each paper is presented below. To aid clarity, the summaries and appraisals have been divided into separate quantitative and qualitative sections according to the methodology used within each paper.

Quantitative papers: Summary and critique

Five papers included in this review utilised quantitative methodology. A critical appraisal of these articles was conducted using an adapted version of the Downs and Blacks checklist (1998) (see appendix A). This adapted checklist was used to score each article out of a total 24 points. Full details of this scoring system is available in appendix A. Based on this scoring system, all five articles were rated as 'very good' as they all scored between 17 – 24 points. Individual quality scores are included in table 1 above. An example of a critique using this scoring system is provided in appendix B and a summary of the remaining article appraisals is provided in appendix C.

D'Augelli, Hershberger and Pilkington (1998) studied family reactions following an adolescent's disclosure of lesbian, gay or bisexual sexual orientation. In addition to investigating these reactions to disclosure, the study clearly stated an additional aim of exploring the subsequent consequences of this disclosure. 105 14-21 year olds participated in the study by completing a survey about the nature, circumstances and reactions surrounding their disclosure. The survey used was taken from prior research on lesbian and gay youth (D'Augelli, 1991). However, no validity or reliability data was presented for this measure. The Brief Symptom Inventory (BSI) (Derogatis & spencer 1982) and the Rosenberg Self-Esteem Inventory (RSEI) (Rosenberg, 1965, 1979) were also administered with reliability and validity measures reported for both the BSI and the RSEI. The combination of measures used sought information on four main areas: sexual orientation and behaviour, social aspects of sexual orientation, disclosure within the family, and adjustment levels. It was unclear whether the sample population were representative of lesbian, gay and bisexual youth in general. The description of data

outcomes and statistical analysis methods appeared to be appropriate however, exact probability values and confidence intervals were not reported. Findings demonstrated that the extent of disclosures to family and the reactions to that disclosure play a critical role in adjustment for LGB youth. Only half of mothers and siblings and one quarter of fathers were fully accepting of the disclosed sexual orientation. Negative reactions were twice as common among fathers with around one quarter of fathers and ten percent of mothers being described as rejecting following sexual orientation disclosure. In many cases, disclosure to family members was associated with both threats of, and actual verbal and physical abuse. Compared to gay males, lesbians were threatened with physical attacks more often, and were more frequently the victim of actual physical attacks perpetrated by mothers. Overall, brothers of gay males were the most physically threatening and by far the most common assailants. Almost half of the participants also reported losing friends due to disclosing their sexual orientation with more than one quarter of those who had disclosed stating that they had been physically hurt by other students at school.

A clear aim to investigate the impact of coming out as LGBT in adolescence on levels of school victimisation, psychosocial adjustment and mental health and wellbeing was stated by Russell, Toomey, Ryan and Diaz (2014). Using a sample of 245 LGBT 'Latino' and 'White non-Latino' young people. Participant characteristics were adequately described, however, findings are limited by the specific inclusion of only the aforementioned ethnicities. Measures used collected data on: the disclosure of LGBT status at school, self-reported LGBT school victimisation, life satisfaction and socio-demographic characteristics. The Centre for Epidemiologic Studies Depression scale (CES-D) (Radloff, 1977, 1991) and the Rosenberg Self Esteem scale (1979) were used to measure depression and self-esteem respectively. With the exception of these two established questionnaires, no validity or reliability data on the measures used was provided. Initial statistical analysis demonstrated that being out at school showed a strong positive correlation with both school victimisation and life satisfaction, and was associated with depression. A multivariate structural equation model was used to test whether LGBT victimisation at school mediated the associations between being out at school and levels of adjustment. Results showed that LGBT-related school victimisation is strongly associated with negative adjustment, however, when the effects of LGBT victimisation are accounted for, being out at school was positively associated with young people's adjustment.

Rosario, Schrimshaw and Hunter (2009) conducted research on the impact of LGB disclosure and the reactions to that disclosure on substance misuse among 156 LBG youths aged 14-21. Reporting of participant demographics indicates that a range of socio-economic and ethnic diversity was represented in the sample. A structured interview was completed at recruitment to gather information on sexual orientation disclosure, reactions to that disclosure, levels of substance use and abuse and potential covariates of substance use (depression and anxiety symptoms). Follow up interviews occurred at six months and one year later. Reliability and validity data was presented for all measures utilised. Statistical analysis using correlation and linear regression to examine the role of disclosure and subsequent disclosure reactions on substance use appears appropriate however analysis was limited to data collected at the time 1 interview as data collected at six month and one year follow up was not reported on. This omission was justified by the researchers by stating that few new disclosures occurred at follow up interviews. However in doing to the authors have lost the ability to compare the impact of disclosure and disclosure reactions on substance use over time. Based on time 1 data, findings showed that substance use was prevalent amongst LGB youth however disclosure itself was not significantly associated with substance use or abuse. The number of negative or rejecting reactions to sexual orientation disclosure was however associated with subsequent substance use. This association remained even after controlling for demographic factors and possible confounders such as emotional distress.

D'Augelli, Grossman and Starks (2008) examined parental and sibling awareness of LGB youth's sexual orientation including the reaction of family members to disclosure subsequent consequences for the young person. 516 LGB 15-19 year olds were recruited to the study which aimed to broaden the literature on disclosure to include wider family members rather than just parents. This aim is, however, inferred from the article as no specific objective is stated. The authors provide a detailed description of participant demographics which demonstrates a range of ethnic and socio-economic diversity. Data was gathered via structured interview using a mixture of interview questions and measures with demonstrated reliability and validity. Findings suggest youths were more likely to have disclosed to mothers than fathers, however mothers were found to be just as likely as fathers to react negatively to the youth's disclosure. A similar finding was echoed with disclosure to siblings in that female siblings were more likely to be told than male siblings. However, when disclosure to siblings occurred, male siblings' reactions were found to be significantly ($p<0.05$) more negative than female siblings. Disclosure to both parents and siblings was associated with lower internalised homophobia but higher levels of verbal victimisation from parents.

Based on previous research documenting victimisation as a consequence of sexual orientation disclosure in adults (Comstock, 1991; Herek, 1989), Pilkington and D'Augelli (1995) cite a clear aim to extend investigations in this area to young people. A survey of 194 LGB youths was used to assess three main areas: The prevalence of victimisation, the contexts in which victimisation may occur and any correlates of victimisation based on sexual orientation. Males made up the majority (73%) of respondents with two thirds of participants identifying themselves as white. It is uncertain whether this sample reflects a true representation of the wider population. The survey instrument was not named and no reliability or validity measures were given. Results indicated that respondents had experienced an average of three forms of victimisation ranging from verbal abuse to armed assault. This did not differ between genders however 'non-white' respondents reported significantly fewer forms of victimisation than 'white' respondents ($p<0.01$). Threats of physical violence were common across multiple social contexts. 36% of respondents indicated they had been verbally insulted by a direct family member with females being more likely to report being threatened or actual physical assault following disclosing their sexuality to family members with mothers being the most commonly reported perpetrator. In social contexts, 43% of males and 54% of females reported losing at least one friend as a result of disclosure and 7% of respondents recalled having been physically hurt by a school teacher as a result of their sexual orientation. Fewer youth reported victimisation following disclosure in the employment environment, however nearly half of respondents with work experience reported they had not disclosed their sexual orientation in the work environment for fear of the consequences. Those identifying as 'white' were significantly ($p<0.05$) more comfortable disclosing their sexual orientation in their community compared to 'non-white' respondents. The results of this study, having been completed over 20years ago, should however be considered in the context of changing social perceptions around sexual orientation.

Qualitative papers: Summary and critique

Five of the papers included in this review utilised qualitative methodology. A critical appraisal of these articles was completed using the Critical Appraisal Skills Programme (CASP, 2013) (see appendix D), which scored each article out of a total of 20 points. Full details of this scoring system is available in appendix D. All five articles were rated as good (11 – 15 points) or very good (16 – 20 points) based on this scoring system. Individual quality scores are included in table 1 above. A full example of this critique is provided in appendix E with a summary of the remaining article appraisals available in

appendix F. Additional guidance on assessing the quality of qualitative research was provided by Elliott, Fischer & Rennie (1999) and Yardley (2000).

Grafsky's (2011) objective to understand adolescent's experience, and the process of, disclosing non-heterosexual sexual orientation to their family of origin was well-defined, as was the secondary aim of exploring whether adolescent substance use was related to their experience of this disclosure. Demographic questionnaires and semi-structured interviews were used to collect qualitative data from 22 non-heterosexual 14-21 year olds. Purposeful sampling techniques were used to recruit participants of varying gender across the specified age range, however this sampling method did not manage to maximise the variation in degree of substance use across participants. Ethical considerations – particularly regarding participants under 18 years old – were well considered with advocate presence being offered to support individuals. Interview transcripts were analysed using constructivist grounded theory (Charmaz, 2006). Whilst this method appears appropriate in completing the overall research aims, Interpretative Phenomenological Analysis (IPA) may have been appropriate in addressing the specific objective of understanding the adolescent's experience of disclosure. Findings did not indicate that substance use was directly related to disclosure experiences, however they highlighted that the use of substances was a way for youth to cope with issues related to sexual orientation more generally. From this research, the experience of disclosure to family of origin was understood to be a complex event not simply an isolated moment in time, related to the broader familial relationship history. One third of youths described a decrease in closeness with parents following disclosure with the passage of time being vital to supporting adjustment in relationships.

Oswald (1999) stated a clear aim of understanding what happened when young females came out as lesbian or bisexual to family members and friends. Six females aged 18-23 years old were interviewed about how disclosing their sexual orientation affected their relationships. Grounded theory coding techniques were used to develop an overall picture of how relationships with friends and family changed as a result of this disclosure. Participants had all come out within the last two years minimising the impact of memory on disclosure events and experiences. Friends and family members identified by the six participants were also interviewed to provide a multi-perspective approach to data collection therefore providing a more comprehensive investigation into the research issue. Details of data analysis are not given by the author, without which it is difficult to surmise whether analysis was sufficiently rigorous (Yardley, 2000). Findings were however clearly stated and suggested that for the lesbian and bisexual women

interviewed, the process of coming out to friends and family could be understood in the context of three identified areas. These areas were: changes in communication including conflict and asking questions, changes in relationship structure such as having to re-negotiate closeness and distance and define the boundaries of relationship networks, and changes in beliefs around homosexuality and bisexuality. The research article makes no mention of reflexivity so it is difficult to determine the influence the researcher has over the interpretation and process of the data, thus reducing the value of this papers contribution to academic knowledge in this area.

Potoczniak, Crosbie-Burnett and Saltzberg (2009) used focus groups to investigate the experiences of racially diverse LGBT adolescents when coming out to parents. The study had a clear aim to increase the external validity of the current literature by including more ethnic diversities in research investigating the developmental issues of LGBT adolescents. Other than a description and prevalence of the different ethnic diversities included and the statement that participants were aged 14-18; no participant demographic information or details of numbers of adolescents interviewed is presented. Data was analysed using an adapted version of the constant comparative method (Glaser & Strauss, 1967) and demonstrated rigour through a detailed account of the data analysis. Findings indicated that only a minority of these individuals had reported acceptance from their parents on coming out. African American participants shared a common pattern of extremely negative reactions to disclosure, often resulting in physical attacks and being temporarily or permanently expelled from the home. For many participants, particularly African American and Hispanic participants, social support was vitally important and often sourced from extended family members or peers. Results also highlighted the significance of religious and cultural based responses to sexual orientation with stronger religious or cultural beliefs within families being associated with more negative reactions to the adolescent's disclosure. Some reflexivity is discussed with regard to the impact of having a gay white male interviewer in the context of ethnically diverse participants however discussion of the role of the research in the analysis of data is limited.

Rossi (2010) interviewed 53 lesbian and gay young people aged 18-25 about coming out to their parents. The aims and hypotheses of the study were clearly stated and participant demographics were presented. Data was collected via tape recorded interviews. Following the initial recounting of their coming out stories, participants were asked additional questions designed to probe autobiographical episodic memory. Analysis of memory content was then conducted – a brief description of this analysis

suggests sufficient rigour was achieved. Results suggest that disclosure of sexual orientation is experienced as a critical life transition with mothers being told first 96% of the time. Parental highlighting of heterosexual normative events such as marriage and children, along with expression of concern over their child's safety and health were common experiences for the youth at the time of disclosure. A theme of experiencing negative affect at the moment of coming out was identified along with a perception of negative affect for the parent being disclosed to.

Perrin-Wallqvist and Lindblom's (2015) study on coming out aimed to gain an understanding of adolescent's experiences when coming out to their parents. Semi structured interviews were conducted with 6 participants with experience of disclosing their sexual orientation to their parents as an adolescent. IPA analysis was an appropriate methodology given the intention to explore and understand the experience and perception of a real world phenomenon (Smith and Osbourne, 2008). As well as ethical considerations, the dependability and credibility of the study results was discussed in the context of a qualitative research project. This discussion highlighted a number of strategies that had been used to demonstrate credibility (Elliott, Fischer & Rennie, 1999). Limited details on how interview data was processed, however, means that it is difficult to determine if analysis was sufficiently rigorous. Four main themes were identified from the data: feelings of alienation, uneasiness and fear, self-acceptance / comfort with one's own sexuality and feeling whole.

Synthesis

The reviewed literature will be discussed under three main categories; Reactions to disclosure, Consequences of disclosure and cultural and ethnic differences. These categories emerged through a thematic analysis of the ten articles selected for review. The thematic analysis was completing using guidance from Braun and Clarke (2006). The 'consequences to disclosure' category has been sub-categorised into the different contexts in which disclosure occurred, i.e. to friends, to family, and at school. Although presented separately for the sake of clarity, these categories contain several areas of overlap as many factors related to disclosure exist across several categories and will inevitably interact.

Reactions to disclosure

Several of the identified articles highlighted that reactions to disclosure played a critical role in young people's experience of disclosing their sexual orientation (D'Augelli,

Hershberger & Pilkington, 1998; D'Augelli, Grossman & Starks, 2008; Potoczniak, Crosbie-Burnett & Saltzberg, 2008; Rosario, Schrimshaw & Hunter, 2009; Perrin-Wallqvist & Lindblom, 2015). More positive reactions were associated with higher levels of self-acceptance and adjustment whereas an accumulation of negative or rejecting reactions were found to be associated with increased internal homophobia and substance misuse. Mothers were more often disclosed to than fathers (D'Augelli, Hershberger & Pilkington, 1998) however there is some disagreements between the different articles about parental reactions to disclosures. D'Augelli, Hershberger & Pilkington's (1998) findings suggest that negative reactions were twice as common among fathers (26% rejecting) with only 10% of mothers being described as 'rejecting.' D'Augelli, Grossman and Starks (2008) however, found that mothers were equally as likely as fathers to be rejecting. One could argue that this difference is partially accounted for by the ten year gap between these two articles, perhaps hypothesising that an increase in social acceptance of homosexuality (Herek, 2009) has led to a decrease in father's rejecting reactions, making them more equitable with mother's reactions. However, given that D'Augelli, Grossman and Starks (2008) found that approximately 50% of both mothers and fathers reactions were rejecting, this hypothesis does not appear to be fully supported.

Overall, the reviewed research suggests that the reactions received during and after making a disclosure may have a significant impact on LGB adolescents, particularly with regard to levels of self-acceptance. In addition it could be hypothesised that the prevalence of rejecting reactions from parents, or the possibility this may happen, could mean that making a disclosure of one's sexual orientation could be experienced as an anxiety provoking a difficult event. Further research would however, need to be conducted to test this hypothesis.

Consequences of disclosure

The consequences of disclosing one's sexual orientation identified in the reviewed literature were varied. Both negative and positive consequences were identified with most positive consequences being related to the self and most negative consequences being related to relationships or interactions with others. In terms of the self, several studies presented evidence for disclosure having an impact on the individual that overall was positive. Positive impacts identified include: increased life satisfaction, decreased depression and positive adjustment (Russell, Toomey, Ryan & Diaz, 2014) and increased self-acceptance and comfort with one's own sexual identity (Perrin-Wallqvist & Lindblom, 2015).

Family

Studies investigating disclosure to family members identified many young people experienced increased victimisation from family members, increased familial conflict, threats of violence and actual physical violence as a result of disclosing their sexual orientation (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998; Oswald, 2000; D'Augelli, Grossman & Starks, 2008; Potoczniak, Crosbie-Burnett & Saltzburg, 2009). Findings from two of these studies (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998) agreed that female young people were most likely to experience physical assault from family members with mothers being the most common perpetrators. Given the widespread findings on increased victimisation, threats and harm it is not surprising that disclosure to family members was often associated with increased feelings of isolation and alienation (Oswald, 2000; Grafsky, 2011; Perrin-Wallqvist & Lindblom, 2015) and more negative affect (Rossi, 2010) for young people.

Friends

Social support from friends was deemed to be very important, particularly in the context of having had negative reactions from family members (Oswald, 2000; Potoczniak, Crosbie-Burnett & Saltzburg, 2009). Changes in communication and a re-evaluation of closeness were also found to be consequences of disclosing sexual orientation to friends, as well as some increases in conflict (Oswald, 2000). Some articles reviewed highlighted that this changing communication and conflict led to more open relationships and in some cases a positive re-evaluations of friend's beliefs about homosexuality (Oswald, 2000). Two other studies however, found that disclosure of one's sexual orientation led to a breakdown of peer relationships with friendships being lost (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998). Factors that may contribute to whether friendships are lost, maintained or strengthened are unclear, indicating a need for further research.

School

Similar to the consequences of disclosing one's sexual orientation to family members, the three studies included in this review that investigated disclosure in the school environment identify increased victimisation as a result of sexual orientation disclosure (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998; Russell, Toomey, Ryan & Diaz, 2014). The studies also reported that as well as verbal victimisation, a number of LGB young people described being physically assaulted by peers at school with 7% of young people reporting being physically hurt by a teacher as

a result of their sexual orientation (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998).

In summary, the literature reviewed indicates that making a disclosure of one's sexual orientation can lead to consequences that have a significant impact on adolescents' lives. The findings suggest that this impact may be such that adolescents experience increased victimisation, threats of harm and physical violence both from family members and within the school environment. In terms of the impact on friendships, disclosure may lead to a re-negotiation of relationships. This re-negotiation mat result in a breakdown or loss of friendships or in some cases may serve to strengthen friendships by creating a more honest and open relationship.

Cultural and ethnic differences

The ten papers included in this review used participants from a wide range of cultural and ethnic backgrounds. Whilst many of the overall themes extracted from these different papers remain constant across the range of this diversity, there are some key cultural and ethnic differences suggested by the articles reviewed. Research into disclosure in different contexts suggests that participants who identified as 'white' were more comfortable disclosing their sexual orientation to others than those of other ethnic backgrounds (Pilkington & D'Augelli, 1995; Potoczniak, Crosbie-Burnett & Saltzburg, 2009). When combined with evidence that accepting reactions from families of diverse ethnicities were much rarer (Crosbie-Burnett & Saltzburg, 2009) than for young people who identified as 'white' (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998; Oswald, 2000; D'Augelli, Grossman & Starks, 2008), this decreased level of comfort is not surprising. The research suggests that when faced with rejecting reactions and negative consequences, it is especially important for young people from minority ethnicities to have the support of extended family members and friends as they are more likely to be evicted from the family home as a result of cultural and/or religious beliefs following disclosure of their sexual orientation (Potoczniak, Crosbie-Burnett and Saltzburg, 2009).

Findings indicate that cultural background and ethnicity may influence the impact and experience of making a disclosure or one's sexual orientation. Adolescents from minority ethnic backgrounds may experience making a disclosure as more difficult than their majority ethnicity counterparts. However, the impact of cultural and religious beliefs on young peoples' experiences of disclosing their sexual orientation and the various types of

impact that making those disclosures has, is something that needs to be more fully explored in research in order to facilitate greater understanding in this area.

Discussion

A review of the literature was conducted to investigate the impact on and experience of young people disclosing their non-heterosexual orientation. To date much research in this area has focused on adult experiences of disclosure. With sexual orientation being recognised by individuals at a younger age than before (Frankowski, 2004; Floyd & Bakeman, 2006), it is becoming increasingly important to expand current knowledge to include the views and experiences of young people. The aim of this review was therefore to capture and synthesise the limited knowledge in this area, particularly in reference to the following question: What is the impact on, and experience of, young people who disclose a non-heterosexual sexual orientation?

Ten articles meeting the criteria for review were identified. Each article was critically appraised and given a rating based on their identified strengths and weaknesses. The findings from each article were then synthesised into three main themes: reactions to disclosure, consequences of disclosure and cultural and ethnic differences. These themes highlighted both the positive and negative impact that disclosing one's sexual orientation can have as well exploring young people's experience of making such disclosures. Findings overall indicated that the more positive impact of disclosure on adolescents was in relation to impact on the self. Positive impacts included increased life satisfaction and self-acceptance and in some cases increased communication and openness in friendships. Though some of the positive impact on adolescents was associated with interactions with others, it appears fair to conclude that overall, for adolescents, interactions and shared experiences with others gave rise to the majority of negative impact and experiences. The negative impacts of making a disclosure on adolescents included: increased victimisation, threats of harm, physical violence, increased isolation, and in some cases a loss of friendships. Receiving negative reactions to the disclosure made also appears to be related to increased levels of internal homophobia and substance misuse. In addition, findings suggest that for adolescents from minority ethnic and cultural backgrounds, disclosing their sexual orientation was more likely to have a negative consequences and impact compared to adolescents who identified as 'white.' Very little research evidence provided information on adolescents' experience of making a disclosure of their sexual orientation.

Of the ten articles identified, nine were conducted in the United States of America and one articles was conducted in Sweden, it may therefore be difficult to generalise the findings of this review to other locations.

It should also be recognised that many of the experiences and consequences discussed are taking place at a developmental period that is challenging for most adolescents. For young people already processing and questioning their own self-perceptions, navigating one's sexual identity at time same time, is especially challenging. Non-heterosexual young people have the added hurdle of having to constantly negotiate when and how to reveal their sexual orientation.

Clinical Implications and future research

Given that the vast majority of articles reviewed were conducted in the United States, the applicability of findings outside of this location may be limited. It is therefore important to develop a literature base around adolescent disclosures from a UK perspective. Nevertheless, the findings of this review may have significant implications for the role of both school based and mental health professionals in cultivating positive experiences within LGBT youth as well as demonstrating the need for guidance for parents, carers, educators and healthcare providers when encountering LBGT youth disclosing their sexual orientation. There may exist a specific role for Clinical Psychologists in aiding understanding of the experiences of young people disclosing their sexual orientation, particularly given the identified potential for negative psychological impact. All youths including those who may be questioning their sexuality may seek information on this topic from professionals in health care settings, thus, health care professionals should be able to provide factual, current and non-judgemental information to such individuals (Frankowski, 2004).

It is important therefore to add the experiences of adolescents disclosing their sexuality in health care settings to the current knowledge base, in an attempt to understand the factors that potentially hinder or help disclosure process and thus provide adequate social and psychological support to non-heterosexual young people. This is particularly salient given the potential for psychological distress from some of the negative impact and experiences identified in this review.

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Appendix A: Downs and Black (1998) checklist and scoring system

ALL CRITERIA	DESCRIPTION OF CRITERIA (with additional explanation as required, determined by consensus of raters)	POSSIBLE ANSWERS
1	**Is the hypothesis/aim/objective of the study clearly described?** Must be explicit	Yes/No
2	**Are the main outcomes to be measured clearly described in the Introduction or Methods section?** If the main outcomes are first mentioned in the Results section, the question should be answered no. **ALL** primary outcomes should be described for YES	Yes/No
3	**Are the characteristics of the patients included in the study clearly described?** In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given. Single case studies must state source of patient	Yes/No
4	**Are the interventions of interest clearly described?** Treatments and placebo (where relevant) that are to be compared should be clearly described.	Yes/No
5	**Are the distributions of principal confounders in each group of subjects to be compared clearly described?** A list of principal confounders is provided. YES = age, severity	Yes/No
6	**Are the main findings of the study clearly described?** Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions.	Yes/No
7	**Does the study provide estimates of the random variability in the data for the main outcomes?** In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported	Yes/No
8	**Have all important adverse events that may be a consequence of the intervention been reported?** This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events (COMPLICATIONS BUT NOT AN INCREASE IN PAIN).	Yes/No
9	**Have the characteristics of patients lost to follow-up been described?** If not explicit = NO. RETROSPECTIVE – if not described = UTD; if not explicit re: numbers agreeing to participate = NO. Needs to be >85%	Yes/No
10	**Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?**	Yes/No
11	**Were the subjects asked to participate in the study representative of the entire population from which they were recruited?** The study must identify the source population for patients and describe how the patients were selected.	Yes/No/UTD
12	**Were those subjects who were prepared to participate representative of the entire population from which they were recruited?** The proportion of those asked who agreed should be stated.	Yes/No/UTD
13	**Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?** For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. Must state type of hospital and country for YES.	Yes/No/UTD
14	**Was an attempt made to blind study subjects to the intervention they have received?** For studies where the patients would have no way of knowing which intervention they received, this should be answered yes. Retrospective, single group = NO; UTD if > 1 group and blinding not explicitly stated	Yes/No/UTD
15	**Was an attempt made to blind those measuring the main outcomes of the intervention?** Must be explicit	Yes/No/UTD
16	**If any of the results of the study were based on "data dredging", was this made clear?** Any analyses that had not been planned at the outset of the study should be clearly indicated. Retrospective = NO. Prospective = YES	Yes/No/UTD
17	**In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?** Where follow-up was the same for all study patients the answer should yes. Studies where differences in follow-up are ignored should be answered no. Acceptable range 1 yr follow up = 1 month each way; 2 years follow up = 2 months; 3 years follow up = 3months.....10years follow up = 10 months	Yes/No/UTD
18	**Were the statistical tests used to assess the main outcomes appropriate?** The statistical techniques used must be appropriate to the data. If no tests done, but would have been appropriate to do = NO	Yes/No/UTD
19	**Was compliance with the intervention/s reliable?** Where there was non compliance with the allocated treatment or where there was contamination of one group, the question should be answered no. Surgical studies will be YES unless procedure not completed.	Yes/No/UTD
20	**Were the main outcome measures used accurate (valid and reliable)?** Where outcome measures are clearly	Yes/No/UTD

	described, which refer to other work or that demonstrates the outcome measures are accurate = YES. ALL primary outcomes valid and reliable for YES	
21	**Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population?** Patients for all comparison groups should be selected from the same hospital. The question should be answered UTD for cohort and case control studies where there is no information concerning the source of patients	Yes/No/UTD
22	**Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same time?** For a study which does not specify the time period over which patients were recruited, the question should be answered as UTD. Surgical studies must be <10 years for YES, if >10 years then NO	Yes/No/UTD
23	**Were study subjects randomised to intervention groups?** Studies which state that subjects were randomised should be answered yes except where method of randomisation would not ensure random allocation.	Yes/No/UTD
24	**Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable?** All non-randomised studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.	Yes/No/UTD
25	**Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?** In nonrandomised studies if the effect of the main confounders was not investigated or no adjustment was made in the final analyses the question should be answered as no. If no significant difference between groups shown then YES	Yes/No/UTD
26	**Were losses of patients to follow-up taken into account?** If the numbers of patients lost to follow-up are not reported = unable to determine.	Yes/No/UTD
27	**Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance <5%** Sample sizes have been calculated to detect a difference of x% and y%.	1-5

This appraisal only used questions: 1, 2, 3, 6, 7, 10, 12, 18, 20, 25, 26, 27 as other questions were not deemed to be relevant to the observational studies included in this review.

Scoring system:

Articles scored 2 points when a criterion is fully met, 1 point when a criterion is partially met, 0 points if a criterion is not met or it is impossible to determine.

Articles are scored out of a total of 24 points. Articles scoring under half are scored as below average. Articles scoring 0-8 poor, 9 – 16 are rated good; those scoring 17 – 24 are rated very good.

Appendix B: Full quantitative appraisal example

Quality criteria PAPER 1	Comments PAPER 1	Score and Rating (Yes = 2, partly = 1, unable to determine = 0, no = 0)
1. Is the hypothesis/aim/objective of the study clearly described?	Yes	2
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.	Yes	2
3. Are the characteristics of the patients included in the study clearly described ? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.	Partially – does however state that this is available elsewhere.	1
6. Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).	Yes	2
7. Does the study provide estimates of the random variability in the data for the main outcomes? In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the standard error, standard deviation or confi- dence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	No	0
10. Have actual probability values been reported?	No	0
12. Were those subjects who were prepared to participate representative of the entire population from which they were recruited?	Partially	1
18. Were the statistical tests used to assess the main outcomes appropriate?	Yes	2
20. Were the main outcome measures used accurate (valid and reliable)?	Yes	2
25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?	Yes	2
26. Were losses of patients to follow-up taken into account?	Yes as not applicable	2
27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?	Unsure as no power calculation provided	1
Total		17

Appendix C – summary of other quantitative appraisals

Quality criteria	Paper 2	Paper 3	Paper 4	Paper 5
1. Is the hypothesis/aim/objective of the study clearly described?	2	2	1	2
2. Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.	2	2	2	2
3. Are the characteristics of the patients included in the study clearly described ? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.	2	2	2	2
6. Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).	2	1	1	2
7. Does the study provide estimates of the random variability in the data for the main outcomes? In non normally distributed data the inter-quartile range of results should be reported. In normally distributed data the SE, SD or CI should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	1	2	1	0
10. Have actual probability values been reported?	0	0	0	0
12. Were those subjects prepared to participate representative of the entire population from which they were recruited?	1	2	2	1
18. Were the statistical tests used to assess the main outcomes appropriate?	2	2	2	2
20. Were the main outcome measures used accurate (valid and reliable)?	1	1	1	1
25. Was there adequate adjustment for confounding in the analyses from which the main findings were drawn?	2	2	1	2
26. Were losses of patients to follow-up taken into account?	2	1	2	2
27. Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%?	1	1	2	2
Total	18	18	17	18

Appendix D: CASP for qualitative studies

1. Was there a clear statement of the aims of the research?

HINT: Consider: What was the goal of the research? Why it was thought important? Its relevance

2. Is a qualitative methodology appropriate?

HINT: Consider: If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants? Is qualitative research the right methodology for addressing the research goal?

3. Was the research design appropriate to address the aims of the research?

HINT: Consider: If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

HINT:Consider: If the researcher has explained how the participants were selected? If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study? If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

HINT: Consider: If the setting for data collection was justified? If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)? If the researcher has justified the methods chosen? If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)? If methods were modified during the study. If so, has the researcher explained how and why? If the form of data is clear (e.g. tape recordings, video material, notes etc)? If the researcher has discussed saturation of data?

6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider: If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location? How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration?

HINT: Consider: If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained? If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)? If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

HINT: Consider: If there is an in-depth description of the analysis process? If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?

Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process? If sufficient data are presented to support the findings? To what extent contradictory data are taken into account? Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

HINT: Consider: If the findings are explicit? If there is adequate discussion of the evidence both for and against the researchers arguments? If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)? If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider: If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature? If they identify new areas where research is necessary? If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Rating system:

Articles are scored 2 points when criterion is fully met, 1 point when criterion is partially met, 0 points if criterion is not met or it is impossible to determine.

Articles are scored out of a total of 20 points. Articles scoring under half are scored as below average. Articles scoring 11 – 15 are rated good; those scoring 16 – 20 are rated very good.

Appendix E - full qualitative appraisal example

Quality criteria	Comments **paper 6**	Score
1. Clear statement of aim	Describe the process of disclosing a non-heterosexual identity to family and describe the meaning of the experience from the perspective of both youth and parents. Explore whether adolescent substance use is related to the process of disclosing one's sexual orientation to family; and if so, how.	2
2. Is qualitative methodology appropriate?	Yes	2
3. Was research design appropriate to address aims?	Constructionist grounded theory use justified and seemingly appropriate	2
4. Was the recruitment strategy appropriate to the aims?	Strategy fully explained and seemingly appropriate to the aims	2
5. Was the data collected in a way that addressed the research issue?	Youth interviews conducted	2
6. Has the relationship between researcher and participants been adequately considered?	Some discussion on this present however specificity and depth a little lacking.	1
7. Have ethical issues been taken into consideration?	Ethical principles covered however little discussion that taking part in research could have itself caused distress	1
8. Was the data analysis sufficiently rigorous?	Yes	2
9. Is there a clear statement of findings?	Yes	2
10. How valuable is the research?	Valuable	2
Total 18		

Appendix F - Summary of other qualitative appraisals.

Quality criteria	Paper 7	Paper 8	Paper 9	Paper 10
1. Clear statement of aim	1	2	2	2
2. Is qualitative methodology appropriate?	2	2	2	2
3. Was research design appropriate to address aims?	2	2	2	2
4. Was the recruitment strategy appropriate to the aims?	2	1	2	1
5. Was the data collected in a way that addressed the research issue?	2	1	2	2
6. Has the relationship between researcher and participants been adequately considered?	0	2	0	0
7. Have ethical issues been taken into consideration?	1	2	1	2
8. Was the data analysis sufficiently rigorous?	2	2	2	2
9. Is there a clear statement of findings?	1	2	2	2
How valuable is the research?	2	2	2	2
Total	15 good	18 Very good	17 Very good	17 Very good

Appendix G – author guidelines

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

Submit manuscripts electronically through the Manuscript Submission Portal.

John Gonsiorek
Past President, APA Division 44 (Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues)
Santa Fe, NM

Manuscript Types

Psychology of Sexual Orientation and Gender Diversity® (PSOGD) accepts a variety of article types consistent with the journal's mission as described above, including:

Standard articles containing a maximum of 7,500 words of text. These will be the most typical articles.

Longer, monograph-style articles containing a maximum of 12,000 words of text. These longer contributions will not be typical and to be considered, must provide a particularly enhanced coverage of the topic addressed.

This can take the form of:

an especially extensive literature review with a methodological critique and/or public policy implications explicated;

description of an interlocked series of research projects;

a synthesis of material on sexual orientation and gender diversity with material from other aspects of psychology and/or other disciplines;

or similarly extensive contributions.

AUTHORS MUST OBTAIN PRIOR APPROVAL OF THE FOUNDING EDITOR PRIOR TO SUBMITTING THIS ARTICLE TYPE.

Brief reports are research-oriented and contain a maximum of 4,000 words of text.

Case Studies are clinically/practice-oriented (including industrial/organization practice) and contain a maximum of 3,000 words of text. All ethical and risk management considerations regarding informed consent, confidentiality, and other relevant concerns must be addressed. Case studies must also situate the case in question in relevant theoretical, empirical, and methodological matrices.

Book Reviews are generally a maximum of 1,000 words. In addition to books, relevant films and other media may be considered. Potential authors may submit books and other media to be considered to the Book Review Editor, Carlton W. Parks. The Book Review and Founding Editors will make final selection of books/media to be reviewed and reviewers.

Letters to the Editor should be limited to 500 words. In unusual circumstances, the Founding Editor may allow a longer limit with the author.

Commentaries may address developments in the behavioral sciences and related fields, the legal system, national or world events, as these pertain to the content areas of PSOGD. These should be a maximum of 1000 words, unless a longer length is allowed by the Founding Editor.

The list above is not meant to be exclusive. Other article varieties may be accepted under unusual circumstances. However, authors must contact the Founding Editor, John C. Gonsiorek, PhD prior to submission of any article type other than the above to discuss and get approval.

As a rule of thumb one double-spaced page of standard font and size text contains about 300 words. If submissions contain an unusually larger number of references for the article type and/or unusually large tables/charts/graphs, authors may be required to reduce these. "Words" refers to words and other symbols or characters.

Manuscript Preparation

Manuscripts submitted to *Psychology of Sexual Orientation and Gender Diversity* should be prepared in accordance with the *Publication Manual of the American Psychological Association*, 6th Edition (2010).

Review APA's Checklist for Manuscript Submission before submitting your article.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page.

After the abstract, please supply up to five keywords or brief phrases.

Psychology of Sexual Orientation and Gender Diversity encourages submissions from all countries and aspires to disseminate knowledge about sexual orientation and gender diversity internationally.

To this end, authors should submit abstracts and keywords in English and, if they wish, in addition provide abstracts in any other language(s) relevant to the submission in question.

Specifically, authors may submit abstracts and keywords in languages in addition to English in the following circumstances:

When the research subjects or content matter involve non-English speaking populations

When the authors are based in a non-English speaking country or comprise a multi-national team with some members from non-English speaking countries.

There may be other circumstances where authors wish abstracts in other languages to be included. These should be reviewed and approved by the Founding Editor.

Note that all submissions must include an abstract and keywords in English.

Also, abstracts in more than two languages are encouraged when more than one non-English speaking countries are involved, as per #1 and #2 above.

Finally, *Psychology of Sexual Orientation and Gender Diversity* can publish the main article text only in English.

Public Significance Statement

Authors submitting manuscripts to Psychology of Sexual Orientation and Gender Diversity are required to provide a short statement of one to two sentences to summarize the article's findings and significance to the educated public (e.g., understanding human thought, feeling, and behavior and/or assisting with solutions to psychological or societal problems). This description should be included within the manuscript on the abstract/keywords page.

View Guidance for Translational Abstracts, Public Significance Statements, and Social Media Messages

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Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

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Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

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If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

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Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

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Authored Book:
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Chapter in an Edited Book:
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

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Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

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Paper 2 – Empirical paper

Abstract

Current literature suggests that adolescence is a crucial period of development during which people are exploring and acknowledging their sexual orientation. However, research into the actual experience of lesbian, gay and bisexual young people when disclosing their sexual orientation is lacking. The current study used Interpretative Phenomenological Analysis to qualitatively investigate the experiences of adolescents disclosing their sexual orientation to a healthcare professional. Seven participants contributed to the research with finding suggesting that the experience of disclosing to a healthcare professionals is pervaded by difficult emotional and cognitive processes which take place in the context of a still developing identity formation. Factors influencing disclosures were also identified along with discussion around the roles and responsibilities of healthcare professionals and their ability to meet the specific needs of LGB youth. The clinical implications of this study are discussed along with study limitations and possibilities for future research.

Key Words: Sexual orientation, lesbian, gay, bisexual, disclosure, experiences, adolescent

Introduction

Homosexuality in the United Kingdom (UK) has a somewhat difficult history, being illegal in Britain until being decriminalised in England and Wales by the Sexual Offences Act, 1967 (homosexual acts were not decriminalised in Scotland and Northern Ireland until 1980 and 1982 respectively). This legislation only referred to homosexuality between males and set the age of consent for sex between consenting males at 21. Sexual intercourse between females was entirely omitted from law, however this was often also viewed as offensive within society (Jivani, 1997). Despite this new-found legality, homosexuality was still viewed pejoratively, being classified as a mental illness until 1973 when it was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) (APA, 1968). Homosexuality was only removed from the International Classification of Diseases (ICD) with the publication of the ICD-10 in 1992 (WHO, 1992).

Social change for same sex relationships has emerged relatively quickly in the years ensuing its declassification as a mental illness, with the introduction of various legislation helping to reduce inequality. In 2000, the age of consent for homosexual intercourse was lowered to 16, matching that for heterosexual consent (UK government, 2000). The introduction of the Civil Partnership Act in 2004 meant that same sex relationships were legally recognised, though this union lacked some of the legal rights of a marriage. Further attempts at equality were made with the introduction of the Equality Act (UK Government Equality Office, 2010) which aimed to prevent discrimination on the basis of several protected characteristics including race, religion and sexual orientation. The Marriage (same sex couples) Act (UK Government, 2013), eventually provided same sex unions with equal legal rights and responsibilities as a heterosexual marriage. Despite these advances in equality, some of the scars of history remain with lesbian gay and bisexual (LGB) people constantly fearing discrimination, marginalisation and oppression as a member of a minority sexual orientation (Swim, Pearson & Johnston, 2008; Hanckel & Morris, 2014).

Research has suggested that belonging to a minority sexual orientation can result in increased emotional distress, mental health difficulties, and lower self-esteem (Meyer, 2003). In addition to increased risks to their physical, emotional and social health (Perrin, 2002), young people who disclose their sexual orientation to others, are often at risk of both psychological and physical danger (Frankowski, 2004). Thus societal attitudes towards homosexuality have a critical impact on an individual's decision to either disclose or hide their sexual orientation (Heinze & Horn, 2009). This is of particular

concern during adolescence, given that 'coming out,' both to oneself and to others, is recognised as a key process within LGB identity development (Cass, 1979; Rotheram-Borus & Langabeer, 2001).

Research into sexual orientation disclosure has typically focused on adult populations. However, it is becoming increasingly recognised that awareness and exploration of sexual orientation is occurring earlier than in the past, often during adolescence (Frankowski, 2004; Floyd & Bakeman, 2006). Moreover, in a recent report by the J Walter Thompson Innovation Group (2015) only 48% of 13 to 20 year olds identified as completely heterosexual, making it increasing important to consider disclosure from the perspective of adolescents. What little research does exist in this area has highlighted the challenging nature of navigating one's sexual orientation at a time when young people are already processing their own self perceptions and developing their individual identity (Saewyc, 2011). A few studies have investigated the impact of disclosing sexual orientation, finding both positive and negative consequences for adolescents. Positive consequences of disclosing one's sexual orientation included increased life satisfaction, decreased depression and positive adjustment (Russell, Toomey, Ryan & Diaz, 2014) as well as increased self-acceptance and comfort with sexual identity (Perrin-Wallqvist & Lindblom, 2015). Negative consequences for adolescents disclosing their sexual orientation tended to be related to their interactions with others. Consequences included increased familial conflict, threats of and actual physical violence, and the loss of peer relationships (Pilkington & D'Augelli, 1995; D'Augelli, Hershberger & Pilkington, 1998; Oswald, 2000; D'Augelli, Grossman & Starks, 2008; Potoczniak, Crosbie-Burnett & Saltzburg, 2009). These negative consequences may have an impact on both adolescent's physical and mental wellbeing, potentially making it more likely for LGB individuals to require access to healthcare services.

Investigations into LGB peoples' access to healthcare suggest that this population may present with different mental and physical health concerns than heterosexual people (Volpp, 2010; Sandfort, Bakker, Schellevis & Vanwesenbeek, 2006). Some of these physical health risks are associated with specific sexual behaviours, for example men who have sex with men may have an increased risk of contracting hepatitis A and B (Cotter et al, 2003) and are at risk of contracting HIV through sexual risk taking behaviours such as having unprotected sex with someone known to be HIV positive (Halkitis, parsons, & Wilton, 2003). Some of the literature in this area also suggests that smoking, drinking alcohol and substance misuse is more prevalent in the LGB population than a comparable heterosexual population (Crothers, Haller, Benton & Haag, 2008; Valanis et al., 2000). As such LGB people may be more at risk of health conditions

associated with these behaviours. In addition to these physical health risks, a systematic review of mental health in LGB populations found that LGB people have a higher risk of mental disorder, suicidal ideation and deliberate self harm compared to heterosexuals (King et al, 2008). Suicidality and self-harm behaviours is of particular concerns in LGB youth. Ramafedi et al (1998) reported that around 42% of LGB adolescents had attempted suicide, with suicide attempts for LGB youth more likely to be fatal than attempts made by heterosexual adolescents. Despite these increased risks to both physical and mental wellbeing, evidence suggests that LGB people may be less likely to access specific services. For example, recommended vaccinations against hepatitis available for men who have sex with men have a lower than expected uptake rate (MacKellar et al, 2001; Cotter et al, 2003). Similarly, research into women's accessing of healthcare demonstrates a lower uptake of services, with lesbian and bisexual women being less likely to undergo mammograms (Koh, 2000), or receive smear tests (Aaron et al, 2001). Keogh and Henderson's (2004) study investigating homosexual men's use of healthcare in the UK suggested that gay men were more likely than heterosexual men to have visited their GP in the past year, however, only 27% of those surveyed had informed the GP of their sexual orientation. Though the reasons why LGB people have difficulties accessing healthcare services is not fully known, what is clear is that healthcare professionals need to be aware of an individual's sexual orientation in order to provide accurate assessment and treatment.

Study rationale

There is a limited amount of research investigating young people's experiences of disclosing lesbian, gay or bisexual (LGB) sexual orientation in any setting. Research that has been conducted varies in both quality and focus, with little attention paid to the direct disclosure experiences of young people themselves. Despite these limitations, the literature in this area does seem to suggest a significant possible role for both school based and mental health professionals in fostering positive development amongst young people who identify as lesbian, gay or bisexual. Despite the identification of this potential role for health care professionals, little research specifically investigating the disclosure of non-heterosexual orientation in a healthcare context has been conducted. What research has been conducted, is not particularly encouraging; a survey of lesbian, gay and bisexual youths indicated that only 13 of 102 had disclosed their sexual orientation to their healthcare provider, despite two-thirds reporting a desire to do so (Allen, Glicken, Beach, & Naylor, 1998). In addition, the existing literature base lacks any specific focus on the disclosure experiences of young people themselves or the psychological processes that may occur during a disclosure experience. Research into these areas will

not only provide a critical understanding of disclosure experiences during this key developmental period, it may also contribute towards understanding the factors that potentially hinder or help the decision to disclose one's sexual orientation in a healthcare setting. A decision that can have a crucial impact on whether professionals are able to provide adequate and appropriate medical, social and psychological support to young people. Investigations into this area are particularly salient given the potential for psychological distress that has been highlighted by previous research. The current study therefore aims to address these identified gaps in the literature by qualitatively investigating experiences of disclosing lesbian, gay or bisexual orientation to healthcare professionals during adolescence, using the research questions listed below.

Research Questions

1. What are lesbian, gay and bisexual people's experiences of disclosing their sexual orientation to healthcare professionals in adolescence?
2. What sense do they make of these experiences?
3. What psychological processes occur when making this disclosure?

To the author's knowledge, no other research has qualitatively investigated experiences of LGB individuals making a specific disclosure of their sexual orientation to a healthcare professional. The current study's focus on an adolescent population within this context is also unique, as most disclosure literature is focused on adult populations.

Interpretative Phenomenological Analysis (IPA) was utilised to answer these questions as the individual's own experiences of making disclosures was of primary focus. This methodological approach has its roots in phenomenology (Husserl, 1927) and hermeneutics and is thus concerned with experiences and interpretation respectively. IPA utilises the idea of the 'double hermeneutic' – namely that the researcher has to interpret and make sense of the participant's own interpretation and sense-making of their experience (Smith, 2004). IPA is therefore well suited to answering the research questions posed.

Method

Design

Given the dearth of previous research in this area, this study used an exploratory design using individual semi-structured interviews to capture the participant's remembered experience of disclosing their sexual orientation to healthcare professionals. Semi-structured interviews were selected as the method of data collection as they enable the researcher the flexibility to explore any areas of interest that may arise during the discussion (Smith & Osborn, 2008). This ability to adapt one's questioning therefore enables a more complete investigation of the participant's disclosure experiences. Interpretative Phenomenological Analysis (IPA) (Smith et al, 1999) was chosen as the appropriate methodology to complete the current research. IPA methodology focuses on direct experience as well as how the experience is made sense of (Smith, Flowers & Larkin, 2009); thus meeting the objectives of the current study.

Participants

Recent guidance from NHS England (2015) prompts Children and Adolescent Mental Health Services (CAMHS) to consider adolescence as occurring up to age 25. This upper age limit was therefore adopted within the current study. Inclusion criteria for the research were that participants must be aged between 16 and 25 years old, must identify as either lesbian, gay or bisexual and must have disclosed their sexual orientation to a healthcare professional during adolescence. Individuals were that were experiencing active symptoms of psychosis, and those unable to communicate fluently in English, were excluded from the study.

Nine people expressed an interest in taking part in this research. Two of these did not attend the arranged meeting with the interviewer. Seven participants were interviewed for the study. Of these, six were recruited via a local university and one via a Child and Adolescent Mental Health service in the Staffordshire region. All participants were current full time students. Collectively, these seven participants had disclosed their sexual orientation to nineteen separate healthcare professionals, consisting of: four Clinical Psychologists, four Sexual health clinic staff, three Nurses, two Hospital doctors and six General Practitioners (GP) (see Table 2 for details).

IPA studies involve using a reasonably homogeneous sample in order to find a closely defined group for whom the research question will be significant. Though participants represented a range of different ethnicities (see Table 2 for demographic data), the current sample can be considered homogenous as they were all full time students in a

similar age bracket, who had experienced making a disclosure of their sexual orientation to at least one healthcare professional.

Table 2: Participant demographic details

Number	Gender	Age	Identified Sexual Orientation	Disclosure Age(s)	Professional(s) disclosed to.	Identified ethnicity
1	Male	23	Gay	14 – 18	GP Psychologist	White Estonian
2	Male	18	Bisexual	18	GP Sexual health clinic staff	Black Jamaican
3	Female	23	Bisexual	16 – 21	2 Psychologists Sexual health clinic staff GP	White British
4	Female	20	Lesbian	14 – 16	GP	White British
5	Female	17	Bisexual	17	Psychologist Nurse	British Indian
6	Male	24	Gay	17-18	Sexual health clinic staff Hospital doctor GP Nurse	White British
7	Male	22	Gay	16 – 22	GP Nurse Hospital doctor Sexual health clinic staff	White British

Procedure

Participants were recruited using poster advertisements placed at the following research sites: Child and Adolescent Mental Health Services (CAMHS) in the Staffordshire region, a local university, a local LGB health project and two local sexual health clinics. Poster advertisements (see Appendix A) contained the contact information of the researcher and requested interested parties to make contact. On contacting the researcher, individuals were provided with an electronic copy of the study information sheet (Appendix B). Individuals were then invited to attend a face to face meeting with the researcher held on university premises. At this meeting the study was described in full and any questions regarding participation were answered before participants were given the choice of whether they wished to provide consent for and proceed with the study.

Those who consented to participation then completed an audio recorded interview about their disclosure experiences. A semi structured interview schedule (Appendix C) was devised to elicit information of relevance to the study, however in order to capture the full details of disclosure and richness of the topic being investigated, this interview schedule was only intended to act as a basic guide for the discussion. The researcher exercised caution in their manner of questioning so as to reduce any questioning bias, instead allowing the participants to take the lead in sharing their experiences. Interviews lasted between 30 to 60 minutes. Audio recordings were transcribed ensuring participant anonymity and the transcripts analysed using IPA.

Ethical Considerations

Ethical approval to carry out this study was granted by South Central – Oxford B Research Ethics committee (Appendix D). The Health Research Authority (HRA) and two local NHS trusts' Research and Development departments also provided approval for the study (Appendices E, F and G). The study was completed in accordance with guidance form the British Psychological Society's (BPS) (2010) Code of Human Research Ethics.

The NHS research ethics committee (REC) were cautious about allowing under sixteen year olds to take part in the study as they deemed demonstrations of Gillick competency only to be applicable to clinical practice and not research, thus the original minimum recruitment age (13) had to be increased to 16.

Prior to interviews, the aims of the research were discussed in full with participants and a detailed information sheet provided. Following their initial agreement to take part, each participant provided informed consent via signed consent form (Appendix H) and were reminded of their right to withdraw from the research any point up until the final analysis was completed. Following the interviews each participant was debriefed and invited to ask any further questions they had about the study.

Though inclusion criteria dictated that participants will have disclosed their sexual orientation to a healthcare professional, it was acknowledged that disclosure to friends and/or family may not have occurred, thus creating potential anxiety for any such participants. Processes of anonymity and confidentiality were therefore discussed prior to gaining informed consent to participate. It was also recognised that the subject matter of the interviews may involve discussion of sensitive, difficult or negative experiences. In response to this possible source of distress, it was ensured that the researcher could enable information and access to appropriate local support services, if needed.

The Researcher

As both a lesbian and a healthcare professional the researcher could identify strongly with many aspects of this study. Given a belief that an individual's point of view is shaped by their relative and subjective perceptions, rather than the identification of an absolute truth; the researcher would consider themselves a relativist. This position recognises the subjective influence that the researcher themselves may have had on the interview questions asked and subsequent analysis of the data. Qualitative methodology such as IPA, however, makes allowances for subjectivity and calls for qualitative researchers to utilise their own experiences to aid the comprehension of the phenomenon under investigation (Elliott, Fischer & Rennie, 1999). To safeguard against any excessive influence of researcher subjectivity, two independent colleagues reviewed the analysis process and consulted on the development of codes to ensure the analysis was sufficiently rigorous and that any assertions made were grounded in the data. The final themes and subthemes were shared with one participant to ensure they represented a valid reflection of the data.

Analysis

Analysis of the interview transcripts was completed using the procedure outlined by Smith, Flowers and Larkin (2009). All audio recordings were transcribed by the researcher to facilitate familiarity with the data. The first transcript was read and re-read with descriptive codes and summary comments being noted in the margin. The transcript was then re-read, adding descriptive, linguistic and conceptual codes and comments. Similarities between codes were identified and modified with interpretive codes being noted in the other margin. These were modified after each subsequent reading of the transcript until a list of emergent themes were expressed. This process was followed for each of the six remaining transcripts. Each individual transcript was carefully considered so as not to impede the development of newly emerging themes.

The emergent themes from all transcripts were listed and clustered together. These groups of themes were then reviewed leading to the development of a recurrent superordinate themes list to incorporate the clustered themes. Following guidance from Smith, Flowers and Larkin (2009), a super-ordinate theme was only classified as recurrent if it was present in at least half of the participant interviews.

Finally, relevant quotes were identified to illustrate each theme. Evidence of the analysis process can be seen in Appendix I.

Results

The analysis yielded four main themes relevant to participants' experiences of disclosing a non-heterosexual orientation to a healthcare professional. The themes identified along with the associated subthemes are outlined in table 3 below. Each theme is discussed using direct participant quotes to illustrate the meaning and interpretations reflected by each theme.

Table 3: Main and subthemes

Theme	Main themes	Subthemes
1	The journey to an integrated self	a) The abnormal self b) Yearning to belong c) An evolving identity emerges
2	The presence of distress, uncertainty and judgement	a) A fear and anxiety inducing experience b) Sizing up safety c) The dehumanised deviant
3	Layers of influence	a) Viewing the present through the lens of the past b) The cultural misfit
4	Disservice to the individual	a) An undeserving recipient of adequate care b) The professional's failure to take ownership

Though the main focus of this study was to investigate and capture the experiences of young people when disclosing their sexual orientation to healthcare professionals, all participants discussed these experiences with reference to the process of forming a non-heterosexual identity.

1. The journey to an integrated self

The development of the self was evident across all participants. This theme represents the processes undertaken to explore ideas of the self both internally, and externally in relation to others, as part of the ongoing progression of identity formation and integration.

Participants seem to describe a process of change forming an altered view of the self over time. Subthemes represent the stages of identity formation as identified in the data analysis.

1a) The abnormal self.

Participants all used pejorative descriptors of themselves or their identified sexuality perhaps suggesting the presence of an internalised critical voice or internalised homophobia. Views of the self ranged from feeling insecure about themselves as a person, to regarding oneself with a sense of hatred and disgust. Many participants expressed feelings of guilt and shame at their identified orientation, particularly when talking about their younger perceptions of self. Most participants articulated a sense that their sexual orientation was inherently wrong or abnormal; suggesting that lesbian, gay and bisexual individuals may find the development of a positive sense of self difficult when faced with growing up in a heteronormative societal context. This negative view of oneself and the perceived lack of understanding by others is demonstrated by participant 1 below.

"If you have a not ordinary sexual orientation. Again the word 'ordinary', that's a hard word for gays, bisexuals or lesbians – we are not normal. It becomes normal over time. (…) I didn't like myself, I hated myself. And I didn't go out - I didn't like it, I hated people and I was scared of their reactions as well. Because of misunder… actually they didn't understand what I am, who I am, and I couldn't say that to anyone as well" (Participant 1)

1b) Yearning to belong.

When viewed in relation to heterosexual others, this sense of the self as 'different' and defying majority social expectations seemed to manifest itself being an outsider characterised by an ardent need to belong. This suggests that those identifying as lesbian, gay or bisexual, who are trying to reconcile this part of their identity with wider social norms, may question, hide or even deny expression of the self as a non-heterosexual in order to find acceptance or at least avoid rejection.

"So the main reason I went to see the psychologist was literally the…I tried to find myself, tried to understand why me? Why is it happening with me, why me?" (Participant 1)

"It was basically a case of, I'm fine saying that I like girls and such, you should be fine saying you like boys. I'm like, that's my choice, not yours, I prefer to keep it on the low low. It's just like, coming from where I do and such, I don't have… the black community isn't as open and friendly as some of the white community. This isn't something they need to know, so I just keep it to myself mostly" (Participant 2)

In addition to questioning the self in terms of societal and community inclusion, participants portrayed a sense of questioning their understanding of who they are as a whole. This may be attributable to their developmental stage as 'young people' and may be representative of the complexity of identity development at this stage in life. Lesbian, gay and bisexual young people may have the additional challenge of processing their sexual orientation alongside other aspects of their development. Participant 4 describes this in the context of a developing same sex relationship whilst at school.

"It was just me and her trying to get on with our relationship. It was our first relationship so not only were we, if you take away the homosexuality part, it was also our first relationship, we were… we had these feelings and we were just being introduced to the concept of relationships. (…) So it was kind of us going, just trying to figure ourselves out." (Participant 4)

1c) An evolving identity emerges

Participants progressed through their perceptions and questioning of the self and began to demonstrate the development of an individual identity. For some this process was more developed, with their identified sexual orientation appearing to be well integrated with their overall identity. For others identity development and formation was still evolving. Many of the participants made references to personal growth and self-acceptance over time, suggesting that this evolving process of identity formation develops with age and experience.

Integrating a non-heterosexual orientation into one's identity posed more challenges for some participants than others. This appeared to be particularly the case for those that perceived their culture and community to be less accepting of minority sexual orientations (the influence of culture and community is discussed further in theme 3b). For these individuals being a 'minority within a minority' i.e. being lesbian, gay or

bisexual within a minority ethnic group, resulted in the need to distance themselves from their community in order to find acceptance elsewhere.

"I think it's just general stuff I guess, like the Jamaican community just ain't fond. So you've got all this stuff around you like yeah, being gay? No no, I can't do that, can't take none of that. And they literally have songs about killing gay people so I'm just like under wraps. For me, I don't care if they're my loving family or so, I'm going to save my skin - cos if you haven't noticed I'm not the most like 'black' of the black people. Like bit of an Oreo going on here." (Participant 2)

However it was being achieved, this integration of a non-heterosexual orientation into one's identity appeared to increase the individuals comfort in making disclosures and could therefore contribute to the experience of making a sexual orientation disclosure to a healthcare professional.

2. The presence of distress, uncertainty and judgment

The moment of disclosure to a healthcare professional was a significant and distressing event. Participants' often experienced high levels of fear and anxiety. The uncertainty of the situation led them to assess the level of safety and protection available in the situation. Overall the exploration of their emotions and cognitions regarding making a disclosure, along with reflection on their perception of the professional's reaction, contributed to the way participants made sense of their disclosure experiences.

2a) A fear and anxiety inducing experience

Participants were often uncomfortable about disclosing their sexual orientation and thus found the moment distressing. Several participants reported having to build up the confidence to disclose and feeling panicked and anxious about the possible reaction of the professional. This indicates that disclosing one's sexual orientation is a highly emotive experience with concerns about the professional's reaction suggesting a fear of perceived rejection or judgement by the professional. Participant 1 describes the moment he disclosed his sexual orientation to his psychologist below. His repetitive use of the word 'hard' indicates a wish to emphasise how difficult the disclosure experience was.

Similarly his description of being 'locked in' and wanting to 'get away' from the pain, gives a sense of feeling trapped and wanting to escape the emotions being experienced.

"I remember when, I wasn't sure how to say it, I tried to express myself… I cried, I definitely remember I cried. It was hard just to say that, just to… it was hard, it was really hard. (…) You're like closed, you're locked in and you don't know who you can speak with or what you can do to sort of take that pain away. To get away from it. So that's why it was really hard to actually, when I said it because, I'm sure that actually again I was scared of the reaction" (Participant 1)

The emotive nature of making a disclosure was often tempered by the circumstances; with those disclosures made in response to a direct question about orientation seemingly less anxiety provoking than those disclosures made without being directly asked. Professionals making an assumption of heterosexuality was experienced as frustrating and unjust by participants.

The emotional response to making a disclosure was not always negative. For two participants, making a disclosure to a healthcare professional, though anxiety provoking, was the only option they felt they had to discuss their sexual orientation with someone. For these individuals talking to family members or friends was ruled out as an option as they perceived cultural barriers and negative opinions about homosexuality would be too great. Making a disclosure to a healthcare professional in these cases may have been perceived as an outlet which provided a sense of relief from isolation for the individual.

"Yeah so she was one of the kind of first people that I told really and someone that… I don't know. I guess it felt safe to do that with her [Psychologist]*. Obviously even more so because I hadn't told anyone else that I knew... it felt like it was the one place I could be open and be myself and I could talk about things that made me feel quite vulnerable."* (Participant 5)

2b) Sizing up safety

The moment of disclosure was associated with a variety of cognitions and therefore perceived in a variety of ways. One notable difference was related to the type of professional being disclosed to. Professionals who had an ongoing or repeated interactions that had led to the development of a therapeutic relationship were viewed as

being relatively safe to disclose to. In this sense it appears that participants were more comfortable and likely to disclose if they felt personally validated by the professional or if the professional had demonstrated they could be trusted through the alliance that the participant felt had formed.

"That relationship with her [Psychologist] *was very different to one with your GP – it was very personal. It didn't feel like it was a relationship where they see you for ten minutes, see your symptom and that's it – she saw the whole of me. She wouldn't just see the sexuality aspect, she'd strive to see me"* (Participant 5)

For professionals who saw the participant for a single appointment or whose interactions were irregular, disclosure was thought of as being a very personal revelation to a practical stranger. Though this lack of familiarity with the professional arguably increased the uncertainty and fear of judgement for participants, this emotional distance also seemingly had the advantage of being appraised as protective for the individual disclosing.

"I knew I was going to be in and out of that room in five minutes so whatever they really thought, they couldn't do anything about it either way. (Participant 4)

Regardless of the perceived relationship with the healthcare professional, the moment of disclosure gave rise to thoughts of uncertainty for most participants. In the extract below, one participant describes this as an internal 'battle'. The use of the term 'battle' suggests the presence of an impending attack and the subsequent need for defence. This use of language by participant 5 therefore provides insight into the warring thoughts she experienced in relation to making a disclosure, emphasising the difficult internal conflict involved in deciding to disclose her sexual orientation.

"I guess in some ways it was kind of a weird thing actually because it felt like a bit of a battle. So there was one side that I really wanted to be able to tell her but on the other side there was this fear that I think was inherently coming from me of I don't actually… what if something bad happens here and how will she respond? So thoughts questioning on those lines of how will she respond, will she be shocked, will she say something negative?" (Participant 5)

Participants also internally deliberated over what reaction would be received and if making the disclosure would in some way have negative consequences on the healthcare professional's opinion of them or adversely affect their treatment. Immediately following the disclosure participants recalled having thoughts querying the validity of the reaction they received from professionals. A common thought identified was whether the reaction received truly represented the professional's opinion or if there was a professional mask in place to hide their true responses. The extract from participant 1 below demonstrates a level of suspicion of the genuineness of healthcare professionals. Reactions to disclosures as perceived by participants are discussed more fully in subtheme 2c below.

"Like not… because she's like a professional as well she's got some kind of… like any kind of psychologist - she knows how to behave. She's much older, she's a person and I realised that even if I'm going to say something that she is not going to show any of her reaction, real reaction because she does her job. (…) she would not show her real emotions even if she… she definitely had some." (Participant 1)

2c) The dehumanised deviant

This subtheme discusses the reaction of professionals as subjectively perceived by participants. Perceived reactions following disclosure varied. For some the experience of disclosing one's sexual orientation was seemingly met with a negative reaction from the healthcare professional. Reactions tended to be judged as negative when the professional responded with obvious discomfort, made a judgemental or discriminatory comment, or treated the person differently or unjustly as a result of the disclosure. An example of this type of reaction is provided by participant 6.

"They were so, so 'lecturey.' They kept telling me 'oh you're not being safe' and it was so mortifying for me because I just thought, I didn't come here to be lectured, I've come here for some help. I've come here to get myself better and I just found it so… I just found it really embarrassing the whole thing. I kind of felt, not ashamed but upset by this experience of being lectured by this person. " (Participant 6)

This reaction left the individual feeling belittled and not understood by the professional. For this participant undergoing an experience such as this had adverse effects on their mental health and wellbeing.

"I remember saying afterwards I just feel so low. It's just one of those things where if you are working in that field you know with gay men you can't be judgemental at all in that field and it will actually do anything but be helpful to that person" (Participant 6)

Experiencing a negative reaction from healthcare professionals left participants feeling frustrated and often stigmatised. Such treatment was perceived as being unjust and failed to meet participants' expectations of how they should be treated. Moreover it invited comparisons with how they predicted they would have been treated if they had been heterosexual.

"I feel like it's almost like a stigmatisation, it's a horrible thing to say. (…) but it's almost like you wouldn't ask that, I doubt they'd ask that to a straight couple." (Participant 7)

Overall, these reactions from healthcare professionals resulted in participants feeling dehumanised; either through feeling they were being reduced down to merely a demographic rather than existing as a whole person, or because the reactions received felt as though an integral part of themselves was being dismissed and thus mistreated by the healthcare professional. Participants tended to utilise certain strategies in an attempt to mediate the reaction from the healthcare professional. A common strategy used was to make the disclosure using same sex pronouns when talking about a partner. This was viewed by participants as a more tentative approach to disclosing which enabled them to feel more protected when revealing their sexual orientation. Some participants used the knowledge of anti-discrimination legislation as a protective strategy to help mediate the potentially negative effects of a healthcare professional's reaction.

"Whether they like it or not they have to sign a piece of paper that says I will not discriminate against people based on this and this and this. So they will basically have to conform to what is a heteronormative but is also a fairly accepting culture." (Participant 4)

3. Layers of influence

This theme explores the different experiences and beliefs that influenced the participant's disclosure experiences. This influence emerged not only in terms of affecting the decision to make a disclosure to a healthcare professional, but also played a significant role in shaping how the participant's experienced and made sense of that disclosure.

3a) Viewing the present through the lens of the past

Throughout interviews participants referred to and described previous experiences of disclosing their sexual orientation to others. The way that they made sense of these prior interactions was indicated by the subsequent beliefs they formed around their sexual orientation and its disclosure. Previous recipients of disclosures included, friends, family members and other non-healthcare professionals (such as teachers). Those that had made a number of previous disclosures often described negative or disapproving reactions, particularly from family members.

"My mum said 'it's a phase, you'll grow out of it' and walked off like, no chance for me to answer – just bye" (Participant 3)

"Complete denial. 8 months kind of denial. My brother just thought I was an idiot. My dad used to say 'you don't know what you are yet' but you know, you thought I was straight before and apparently that was ok?" (Participant 4)

Negative past experiences were common amongst participants. This particular participant also described the impact of being forced to disclose her sexual orientation to her parents following an incident at school. In addition to being forced to make a disclosure the following extract from participant 4 highlights their perception of being vilified and treated unjustly as a result of their sexual orientation, especially in comparison to heterosexual others.

"The head of year reported false information to my father – he basically rang up to say me and my girlfriend had been inappropriate in public, even though we were just holding hands. He basically told my father we were full on making out even though there was a straight couple next to us making out and we were just holding hands. They got no phone call home so that was interesting!" (Participant 4)

For most participants, previous negative disclosure experiences created a sense of wariness about disclosing to a healthcare professional, possibly contributing to the sense of anxiety and concern at the moment of disclosure as discussed in theme two. These negative reactions to past disclosures were understood by participants as demonstrating that their minority sexual orientation was in some way a threat to others. This led to the belief that it is necessary to protect oneself from such potential repercussions by choosing to not disclose their sexual orientation. Despite this idea that the decision to disclose is a personal choice, all participants expressed frustration at the heteronormative assumptions of society and viewed this in the context of constantly having to justify 'who they are' to others. This was particularly evident in participant 3 who questioned her identified sexual orientation as a result of being faced with stereotypical views of what a bisexual person should be.

"Then they ask like how many men have you slept with? So I'm counting them off, and how many women? And there is a lot more men than women and it's like – am I bisexual enough for this?" (Participant 3)

For some, notably those describing disclosures to healthcare professionals in sexual health and medical health settings, the idea that disclosure is a personal choice was disregarded when non-disclosure was perceived as having potentially adverse repercussions to health. Thus medical need tended to mediate fears about the consequences and reaction of making a disclosure. This is highlighted by both participant 2 and participant 6 below.

"Like you know… what are you going to do? Hide it from the NHS and endanger yourself? So I thought I'd go for it" (Participant 2)

"Obviously there is a key difference between the medical side of things in healthcare like disclosing my sexuality – I have no problems with that at all if it helps bring me the treatment I need or the help that I need." (Participant 6)

Belief in the confidential nature of disclosing to a healthcare professional also moderated the influence of negative past disclosures for some. The reassurance that confidentiality in such settings provided, enabled them to believe that disclosing to a healthcare

professional was relatively ‘safe’, regardless of past experiences. This was particularly evident when the interactions with the healthcare professional were regular in nature, such as with a psychologist. In these instances the ongoing relationship with the professional was often used as a way of testing out or practicing disclosing in order to build confidence in disclosing to others.

3b) A cultural misfit.

Participants identified themselves as belonging to a range of ethnicities. Data analysis indicated that the different cultural beliefs held by individuals shaped their perception and understanding, not only of their disclosure experience but also of the way they made sense of themselves as a non-heterosexual. For participants identifying as white British there existed a sense of being a minority group within the wider community but also an appreciation that there was some cultural and societal acceptance of their sexual orientation.

For those participants who identified as Estonian, Jamaican and Indian the sense of cultural disapproval was strong. For all three of these participants there was an intense reluctance to disclose their orientation to members of their own community as they feared the judgement and consequences that may follow. The impact of this lack of community acceptance on disclosures to healthcare professionals can be demonstrated by participant 5 who was concerned that her doctor, being a member of her community, would break her confidentiality as a result of cultural disapproval. The ‘fear’ of being ‘judged’ negatively within her community is repeatedly expressed, giving an indication of just how fearful she is of receiving a negative reaction.

“I think for instance I wouldn’t disclose to my GP because he is of the same culture and knows my family, (…) I think its fear of being judged with my GP and its fear of him and it’s fear of being judged and not being understood and it’s a fear of that going back to my parents at a time when I’m not ready for that.” (Participant 5)

4. Disservice to the individual.

This theme represents participants’ attempts to make sense of their experiences in the context of their expectations of the professional’s roles and responsibilities. Participants struggled to reconcile some of their disclosure experiences and subsequent treatment

paths with their personal needs and expectations of the service. They therefore tried to understand their experiences by considering practical and personal justifications for their needs not being met.

4a) An undeserving recipient of adequate care

This subtheme describes the perception that the care or advice provided was insufficient or irrelevant for a person identifying as lesbian, gay or bisexual. Participants described the availability of information, advice, support and education as lacking in relation to the specific needs of LGB individuals. Extracts from both participant 4 and participant 3 highlight a sense of frustration at this lack of information and care.

"It was more of a…not everyone is straight, can we…? It was nice, it was good that they were telling me this but at the same time it wasn't relevant to me." (Participant 4)

"I didn't understand it, there is no sort of guidance. You think they would cover it in sex ed but that is literally just sperm meets egg (…) so like who do you go and talk to? There has got to be someone who you can just go and say 'I'm LBGT' what do I do with that? Where do I go from here? What does that mean in terms of my life?" (Participant 3)

When providing advice or treatment, some professionals were seen as being too heavily focused on any risks to physical health that may be associated with the disclosed sexual orientation rather than focusing on the original reason for accessing services. In the case of participant 7, the extract below demonstrates again that interactions with healthcare professionals can be frustrating. His explanation for not needing a repeated test appears to go unrecognised by professionals suggesting that he does not feel listened to or appropriately understood by the healthcare professional.

"Every time we go to the GP, me and my partner, no matter what the problem, as soon as we say we are a couple, they always make us get an AIDS test – they always say that is what we need to have done. I always explain to them that we have been a monogamous couple for 4 years, neither of us have had sex with another person for 4 years but they always make us do it again" (Participant 7)

Despite recognition that the professional involved had a duty of care to ensure the wellbeing of the individual, the introduction of questions around 'stereotyped risk for non-heterosexuals' was perceived as stigmatising, judgemental and often irrelevant. These perceptions often led to a decrease in trust and increased disappointment in the healthcare professional.

4b) The professional's failure to take ownership

Participants strived to make sense of the inadequate support they received from healthcare professionals. In addition to wider societal influences such as living in a heteronormative culture, participants perceived healthcare professionals as personally failing to meet expectations and fulfil the responsibilities of their role. This demonstrated a belief that healthcare professionals operate with a lack of ownership with regards to being able to appropriately respond to, and support the specific needs of lesbian, gay and bisexual individuals. Actively seeking to increase their knowledge and understanding of the LGB community was viewed as an integral part of the healthcare professional's responsibility towards this client group. Participants perceived their experiences of inconsistency in care and being passed from one professional to another as an indicator that healthcare professionals had failed to take ownership of and live up to this responsibility.

"But yeah, just that cos I mean even with the doctor it was just – 'do you need to see a mental health person?' Almost like even being quite young, the doctors didn't give any real guidance on it. Like they'll address the issue at hand and then just pass you off somewhere else" (Participant 3)

This failure was particularly evident to those participants who had comparable experience of very responsive and understanding care which had met their specific needs – such as those who had made disclosures in LGBT specific services.

"So I only go to the specific LGBT clinic, I mean like the one set aside for LGBT people to go to like an evening clinic. I've always felt very comfortable – obviously I can't assume the sexual orientation of the doctor or nurse at the clinic – but I've always felt more comfortable disclosing there, always been very professional, definitely less anxious about disclosing it there" (Participant 7)

Discussion

This study used Interpretative Phenomenological Analysis to explore the experiences of making a sexual orientation disclosure to a healthcare professional during adolescence. This section of the report will discuss these findings in relation to the aims of the research and existing literature. The research questions were:

1. What are lesbian, gay and bisexual people's experiences of disclosing their sexual orientation to healthcare professionals in adolescence?
2. What sense do they make of these experiences?
3. What psychological processes occur when making this disclosure?

Findings indicated that all participants struggled with the process of identity development. More specifically, the integration of their sexual orientation into their wider identity formation. This may have impacted how they experienced making a disclosure of their sexual orientation. The self was typically referred to in pejorative terms with individuals articulating a strong sense of 'not belonging' throughout interviews and indicating a level of emotional distress around identity formation. This finding is consistent with previous research into belonging to a minority sexual orientation which has been associated with feeling 'different' or 'abnormal' (Striepe & Tolman, 2003), lower self-esteem and mental health difficulties. (Hughes, Haas, Razzano, Cassidy, & Matthews, 2000; Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Meyer, 2003). In his work on shame, Gilbert (1998) describes two subtypes: internal shame and external shame. Internal shame is defined by Gilbert as being, criticism and negative evaluation originating within the self. The pejorative nature with which participants referred to themselves suggests that they may experience a level of internal shame relation to their sexual orientation. Rotherham-Borus and Langabeer's (2001) model asserts that adolescent sexual orientation identity development can be categorised into four distinct stages: Diffuse – where sexual orientation is not focused on, Foreclosed – where sexual orientation is not questioned but assumed, Moratorium – where sexual orientation is being explored but remains unresolved and, Achieved – where the sexual identity is fully formed and committed to. Findings from this research demonstrated consistency with the moratorium and achieved stages of this model, with the identified questioning of the self showing progression into identity development and formation over time.

The findings indicate that making a disclosure to a healthcare professional during a time where the sense of self is still in development was experienced as both challenging and

stressful by all participants. Much of this distress at the moment of disclosure, appears to be attributable to a fear of how the professional will react, and fear of being rejected or reprimanded as a result of their sexual orientation. In addition to disclosing being a feared and anxiety provoking experience, participant interviews highlighted that individuals may look for, or seek out, factors to evaluate how making a disclosure might be received by the professional. This evaluation of whether it is 'safe' to disclose provides insight into the experience of LGB adolescents making a disclosure, as it indicates a level of uncertainty or insecurity may be present. These findings are supported by previous research indicating that lesbian gay and bisexual individuals are often insecure about making disclosures (Röndahl, 2009) and are fearful of prejudice and discriminatory acts as a result of their sexual orientation (Swim, Pearson & Johnston, 2008). Participant's made sense of their experiences in the context of their perceptions of how the healthcare professional reacted. Some reactions from healthcare professionals were viewed as stigmatising, dehumanising and dismissive of the person as a whole entity. These perceptions may again suggest that participants experienced shame as a result of their sexual orientation. Gilbert (1998) describes external shame as a subtype of shame that involves distress at the perception that others may view the person negatively. Lesbian, gay and bisexual adolescents experiencing both internal and external shame about their sexual orientation may indicate the presence of a level of internalised homophobia. Internalised homophobia refers to negative attitudes, assumptions and beliefs about one's own homosexuality (Szymanski, Chung & Balsam, 2001) and has been identified as a factor in depression, anxiety and suicide in lesbian and gay populations (Igartua, Gill & Montoro, 2009). Professionals' reactions may therefore be critical in their influence on these psychological processes. Reactions that were interpreted as positive or neutral were validating and reassuring to the individual however the professional nature of the interaction sometimes led to questioning if the professional's reaction reflected their personal opinion.

The way participants made sense of their experiences of disclosing sexual orientation to a healthcare professional was influenced by factors external to the actual moment of disclosure. The most common additional factor identified in the research was previous disclosure experiences. Social constructionist theory advocates that there is no absolute truth, instead our reality is understood in relation to our perspective; a perspective shaped by previous experience (Burr, 2001). Thus participants' experiences of disclosing to a healthcare professional is intrinsically linked and influenced by previous disclosure experiences. When viewed from a social constructionist perspective, the subjective experiences of individuals will be constructed by their prevailing cultural frameworks as

well as the social significance of sexual orientation as designated by others (Vance, 1998). For participants with negative past experiences of making a disclosure, disclosing their sexual orientation to a healthcare professional may have involved an increased experience of fear and anxiety. The findings also suggest that this, in turn, may have contributed to need to assess the relative safety of making a disclosure. Past experiences may therefore had a significant impact on the psychological processes involved in making a disclosure, in particular the participants, emotional processing and perceptions of the event.

Culture and community were observed to be significant factors, influencing not only an individual's disclosure experience but also how they made sense of their experience. Being lesbian, gay or bisexual was deemed to be more unacceptable within a minority cultural or ethnic group, compared to those who identified as white British. Therefore, those from a minority cultural or ethnic background made sense of their disclosure experience to a healthcare professional in the context of being a deviant in the eyes of their community. As well as influencing their experience of making a disclosure, this also impacted on their sense of self and ongoing identity formation. Previous research has indicated that belonging to an ethnic minority group increases stigmatisation and discrimination for those who do not identify as heterosexual (Balsam, 2002). Findings also indicated methods to mediate the effects of additional influences on disclosure experiences. These will be discussed further in the clinical implications section below.

Participants' experiences of disclosing to a healthcare professional were both influenced by, and had influence on, the perceived role and expectations of the professional. Participants expressed frustration at the presumption of heterosexuality both at a society level and specifically by professionals encountered. These heteronormative assumptions are documented in work on 'queer theory' which defines heteronormativity as a pervasive societal bias where everyone is expected to behave as, and is presumed to be a heterosexual in order to preserve social norms (Pullen, Thanem, Tyler, & Wallenberg, 2016). This presumption of heterosexuality left participants questioning the adequacy of the care they had received. Findings also indicated that participants experienced a lack of understanding, support and provision within healthcare services. Over half of the participants experienced feeling stigmatised or dismissed after disclosing their sexual orientation to a healthcare professional. This was most commonly as a result of the healthcare professional's focus on stereotyped health risks for LGB individuals, even when discussion of these risks was not appropriate or relevant. Participants made sense of this experience by suggesting that professionals had failed to take responsibility or action to improve their knowledge and understanding of the needs of LGB people. This

lack of action to rectify perceived gaps in professionals' knowledge may have further reinforced participants' beliefs around being undeserving of adequate or appropriate care. Professionals should therefore take a more active role in ensuring they are able to meet the needs of this community.

In summary, the findings of this research indicate that making a disclosure of one's sexual orientation may involve emotional, perceptual and cognitive processes related to an individual's experience and sense making of the disclosure event. The experience of lesbian, gay and bisexual people disclosing their sexual orientation to a healthcare professional during adolescence is characterised by feelings of fear, anxiety and uncertainty. As well as these emotional experiences, participants experienced making a disclosure to healthcare professional as potentially unsafe, dehumanising or dismissive, and lacking in terms of knowledge and understanding of the needs of LGB people. Sense making of these experiences highlighted participants' negative beliefs about themselves - that they were an outsider and may therefore be subjected to negative judgement from others, including healthcare professionals. These experiences were not made sense of as an isolated event; instead sense making occurred in the context of one's past disclosure experiences and their cultural and ethnic background. Disclosure experiences often involved a sense of frustration, for example, at the perceived lack of knowledge from healthcare professionals or the prevalence heteronormative assumptions

Clinical implications

Disclosure of one's sexual orientation is often thought of as a one way process with the responsibility being on the person making the disclosure. However, recognising the influence healthcare professionals can have on a person's ability to make that disclosure is vital to ensuring the healthcare needs are adequately met. Though professionals do not have the ability to control external influences such as past experience or cultural background, there are some areas that have been highlighted within this research to which professionals can contribute.

Findings suggest a need for increased understanding and awareness of the specific needs of the LGB community. Participants indicated that healthcare professionals were often dismissive of their needs as an LGB person or overly focused on health risks often stereotypically associated with the LGB community. Improvements in understanding and awareness of the LBG community could be achieved through specialist training and support for healthcare professionals. Training should include information on being

cautious about presuming the heterosexuality of an individual, with particular focus on the influence of sexual orientation stereotypes and the influence of living in a heteronormative society, as well as encouraging professionals to be mindful of their own assumptions. In addition to relevant training, healthcare professionals should also strive to use gender neutral pronouns, such as 'partner' in order to demonstrate an open and unassuming discussion. Professionals should also follow the most up to date guidance from their professional bodies on good practice (BPS, 2008; GMC, 2013; NMC, 2015; HCPC, 2016), all of which assert that professionals should be non-judgemental, approachable and act in a way that demonstrates dignity and respect to their service users.

The results of this study suggest that LGB people experience making a disclosure to a healthcare professional and anxiety and fear provoking. Anxiety around the professional's possible reaction and the potential for a rejecting response, creates uncertainty and insecurity. This uncertainty and insecurity prompts LGB individuals to assess the relative safety of making a disclosure. Healthcare services could help to alleviate the anxiety and worries about disclosing their sexual orientation by having information on local and national LGB services available in waiting rooms and clinic rooms. The presence of such items may demonstrate an LGB friendly environment thus encouraging the idea that it is safe for one to make a disclosure. As well as providing an LGB friendly approach, this may also enable LGB individuals to see their healthcare professional as a source of understanding and knowledge on where to access LGB specific services. The findings of this research indicate that should a sexual orientation disclosure be made, healthcare professionals should acknowledge the disclosure and ensure that their responses are validating and reassuring to any concerns the individual may have. This is of particular importance during adolescence when the development of identity and integration of sexual orientation may still be in progress. Where possible professionals should take the time to foster a positive working relationship with the individual to maximise the person's comfort should they wish to disclose.

In addition to the aforementioned general clinical implications, there are some specifically identified roles for clinical psychologists highlighted by the findings of this study. Clinical psychologists may have a specific role in contributing to the understanding of the experiences of adolescents, particularly considering potential psychological impact making a disclosure of one's sexual orientation may have. Many participants in this study demonstrated having a negative perception of themselves often expressing feelings of shame and guilt whilst processing their sexual orientation. Clinical Psychologists,

particularly those working within child and adolescent services may therefore, be required to help individuals explore and process their emotions in relation to their sexual orientation in the context of individual therapy. In addition the unique understanding and perspective that clinical psychologist can provide through a thorough formulation of an individual's difficulties and experiences, would be of great value to colleagues from other specialties and the wider healthcare professional community. Dissemination of this information may be in direct forms such as by providing consultation to colleagues; or by more diffuse methods such as using knowledge in this are to influence policy and procedure or through the provision of training to other staff groups.

Limitations and future research.

This research used a small sample size, however in line with the use of an IPA approach, this small sample size enabled a more detailed exploration of participants' experiences. The findings of this research should not be assumed to be representative of all experiences of making a LGB sexual orientation disclosure during adolescence. The results are however, consistent with the wider literature around minority sexual orientation and disclosures. This consistency contributes to the credibility of these findings, indicating that the results may be transferable. Nevertheless, more research is needed to replicate and validate the themes identified, as well as potentially identify further themes.

Ethical approval to interview adolescents under the age of sixteen was not granted by the NHS ethics board. As such some of the accounts included in this study are retrospective in nature as can be seen by the participant age compared to the age of disclosure in table 2 above. Some of the participant accounts may therefore be affected by memory bias. To reduce this the distance between the disclosure event and age at recollection was kept to a minimum. Future research may wish to address this issue by seeking ethical approval to conduct research including adolescents below age 16. Future research could also limit interviews to adolescents who have recently disclosed their sexual orientation to a healthcare professional. It is also recognised that this research focused only on the young persons' perceptions of making a disclosure and did not investigate the alternative experience of the healthcare professional. Additional research investigating the perspective of a healthcare professional being disclosed to may make a valuable additional contribution to the findings of this research, by providing increased understanding of the processes and experiences involved in the overall interaction.

A range of health professionals were identified as being in receipt of the disclosures investigated in this study. It may be interesting for future research to focus on specific professional groups to investigate if any differences exist as a result of the type of professionals being disclosed to, this would also have the advantage of increasing homogeneity within the sample. As the first study to specifically investigate the experiences of LGB making a disclosure of their sexual orientation to a healthcare professional during adolescence, this project does however provide a good overall introduction and overview of the topic.

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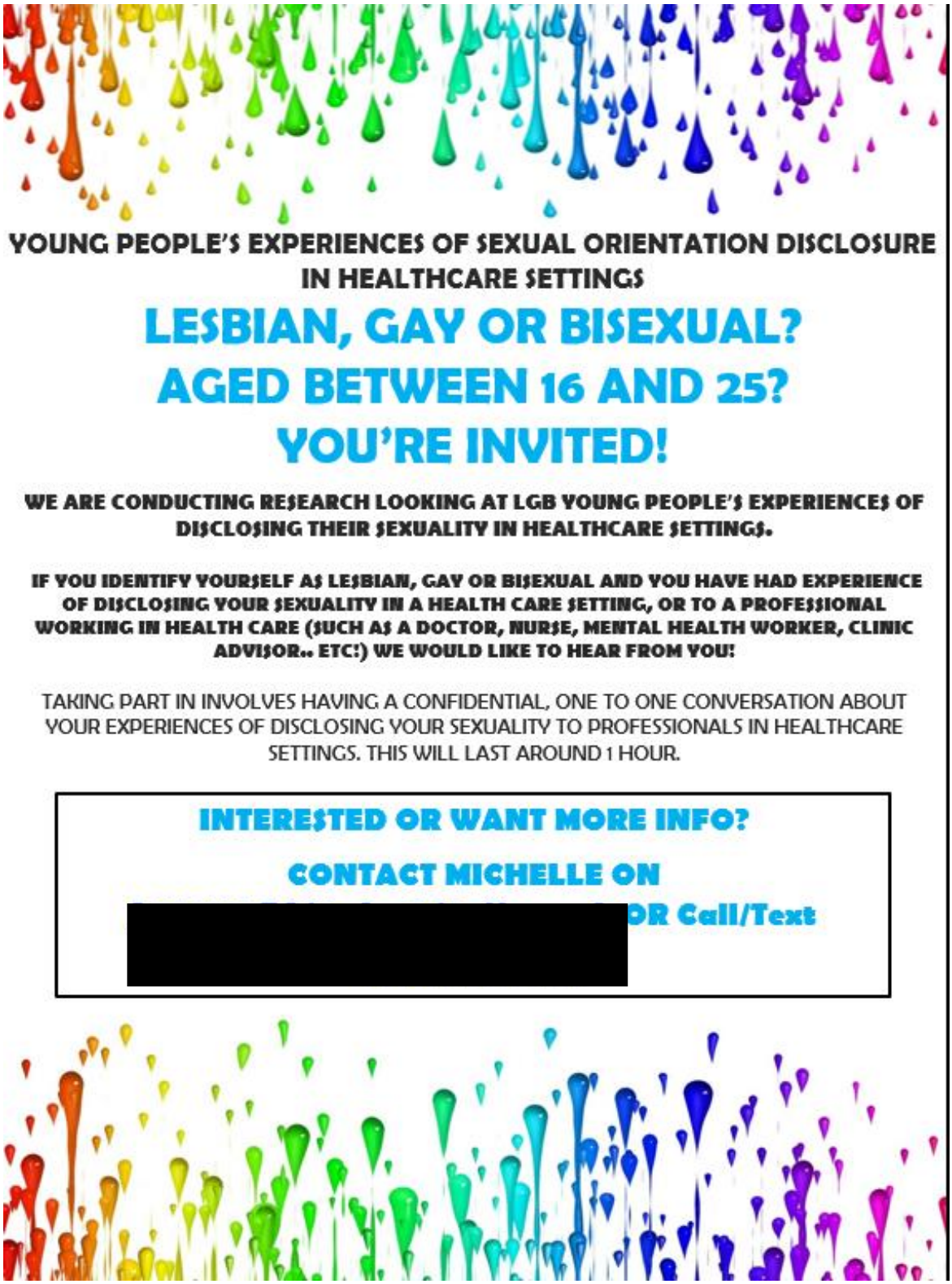
Appendix A – Poster



Appendix B - Information sheet

IRAS ID: 202744

STAFFORDSHIRE UNIVERSITY
Faculty of Health Sciences

Version 3.0
Date: 07.10.16

Keele University

Young people's experiences of sexual orientation disclosure in healthcare settings.

This information sheet will try to help you understand what being involved in this research would involve and why the study is being done. Being a part of the study is entirely up to you so before you decide, please take the time to read through this information sheet. You will also get the chance to speak to the researcher directly if there is anything that is not clear or if you want to know more. If you do not want to take part then that is fine, you will be looked after by your health care professionals just the same.

If you identify as Lesbian, Gay or Bisexual, are aged between 16 and 25 and have experience of disclosing your sexual orientation to professionals working in health care settings then we would like to invite you to take part.

What's it all about?
This study is being conducted as part of a Clinical Psychology doctorate qualification. It is interested in hearing about the different experiences young people have when disclosing their sexuality in healthcare settings. It doesn't matter if your experiences have been positive or negative, we just want to find out what that experience was like for you. Anyone aged between 16 and 25 years old, who identifies themselves as Lesbian, Gay or bisexual and has experience of disclosing this sexuality in a health care setting (such as a sexual health clinic, Child and Adolescent Mental Health Service (CAMHS) or doctor's surgery), or experience of disclosing your sexuality to a professional working in health care (Such as a doctor, nurse, CAMHS worker, clinic advisor.. etc!) can take part.

Why?
For some people coming out as Lesbian, Gay or Bisexual can be very difficult, particularly if you're still trying to figure it out yourself. Most people tend to come out to friends, family or other people they trust first, but for some, even speaking to people you know well, can be scary. This study is interested in peoples experiences of coming out to people you don't know so well, people who you meet as part of their job, specifically those working within health care. Finding out about young people's experiences of disclosing their sexuality to these people may help us understand the things that make it easier for someone to disclose their sexuality and things that may make it harder. This information can be used to help make health care services more approachable and help to reduce anxiety and stigma that may be associated with sharing sexual orientation to health care professionals.

Do I have to take part?
NO! You don't have to take part. If you decide you don't want to take part that's fine. Your decision will not have any impact on the care you receive from your health care professionals. Taking part is up to you.

What will I be asked to do if I agree to take part?
If after reading this information sheet you would like to take part then contact the researcher to arrange a meeting with you to go through a consent form with you, checking you're aware of what is involved and you are happy to agree to it. The meeting is likely to take place at Staffordshire university, however if you are unable to get there then an alternative venue can be discussed with

you. You will also be given the opportunity to ask any questions you have about the study. You still do not have to take part – if at this point you decide not to get involved then that's ok.

If you do decide to take part in the study you will be invited to attend a confidential (What you say will not be shared outside of the research team, unless there are exceptional circumstances where somebody is at risk from harm), voice recorded, one to one conversation with the researcher. This will focus on your experiences of disclosing your sexuality to professionals in healthcare settings. The study is interested in your experiences, good or bad, and how you felt about disclosing your sexual orientation in this environment. The meeting is expected to last around 1 hour, however it may be longer or shorter than this.

What happens to the interview recording?
The audio recording made will be transcribed. This means that everything you have said will be written down. It is hoped that this data will help the researcher to understand how young people experience disclosing their sexual orientation to health care professionals and how they make sense of those experiences.

You will not be identified on either the voice recording or the written transcript. Data will be anonymously stored on a password protected drive which only the researcher has access to. As part of Staffordshire University regulations this audio and written data will be securely and anonymously stored for 10 years and then permanently destroyed.

What are the possible risks and / or disadvantages of taking part?
Although it is not envisaged that there will be any risks or disadvantages involved in this research, it is recognised that some people's experiences may not have been positive. The researcher has a duty of care to do everything reasonably possible to make sure you are safe. Should anyone taking part in the study experience distress as a result of talking about their experiences then the researcher will provide support in accessing local services such as younger minds or the local LGBT provision if needed.

What are the possible benefits of taking part?
This study cannot guarantee any specific benefits to you and you will not be reimbursed for your participation as funding for this is not available. Your participation will allow the researcher to explore the experiences of young people disclosing their sexuality and this information may be used to help make health care services more approachable and help to reduce anxiety and stigma that may be associated with sharing sexual orientation.

What if I decide to take part, and then change my mind?
Taking part is up to you. If at any point before or even during the interview you decide you no longer wish to take part then your information and contributions will be withdrawn. You can opt out of the study at any point up until the final data analysis has been completed.

What will happen to the results of the research project?
The final results of this study may be available in one or more of the following sources; scientific papers in peer reviewed academic journals, presentations at local meetings or conferences. Again, all your personal details will be anonymised so no one will know it is you.

Who has reviewed the study?
All research within the NHS has to be reviewed by the Research Ethics Committee to ensure participants' interests are protected. This study has been reviewed by south central Oxford NHS Ethics Committee and approved by Staffordshire University's Independent Peer Review Committee.

If I decide I want to take part what will I be asked to do?
If you decide that you would like to take part in this research project, contact the research team on the details below. They will arrange a meeting to go through the information to allow you to give informed consent to take part and sign a consent form.

Please contact Michelle Lowe if you are interested in taking part.
Tel: [redacted]
Email: [redacted]

This project is supervised by Dr Ken McFadyen. He can be contacted on:
Email [redacted]
Work Phone [redacted]
Office Location Room 206 Science Centre Leek Road Stoke-On-Trent ST4 2DF

If you have any complaints about how this study is conducted please contact Ken Mcfadyen on the above details, or North Staffordshire Combined Healthcare's Patient Advice Liaison Service (PALS) on Telephone: 01782 275031 or freephone 0800 389 9676 Email: patientexperienceteam@northstaffs.nhs.uk

Further information and support

Younger Minds - North Mind 83 Marsh Street North Hanley, Stoke-on-Trent ST1 SHN Tel: 01782 262100 Website : htt12://nsmind.org.uk/support-for- young-people/younger-mind/	Gay and Lesbian Youth Information Centre A website filled with information for young LGB people. Includes info on bullying, coming out. health, housing and a section for parents. Web: www.galyic.org.uk	Mid staffs mind Barn 3, office 9 Dunton business village, staffordshire, ST18 9AB **Phone:** 01785 747070 **Email:** midslaffsmind@gmail .com **Website:**	X2Y LGBT Youth Group for Wolverhampton and the surrounding areas. Postal address: C/0 Terrence Higgins trust bond house, bond street, wolverhampton WV2 2AS Telephone : 01902 711818 Email: info@x2y.org.uk Web : www.x2y.org.uk

Thanks for taking the time to read through this information

Michelle Lowe
[redacted]

Appendix C – Interview Topic guide

Topic Guide for interviews.

Participants will take part in a one to one interview lasting approximately one hour. Interviews are aiming to explore and understand experiences of sexuality disclosure in health care settings amongst adolescents. The initial interview question will ask the participant to think about a specific occasion that they have disclosed their sexual orientation within a health care setting and ask them to relay their experiences of doing so. The interview content will be largely participant led and will therefore not follow a formal interview schedule, however the following interview questions have been prepared to guide and/or prompt the subsequent discussion topic:

What was the run up to your involvement in services?

What had happened on the day prior to you coming out?

What happened when you came out?

How did you come out?

What was happening for you/ how did it feel to come out?

What was going through your mind at that point?

What sort of reaction did you get to coming out?

What sort of reaction were you expecting/predicting? Did this change, and if so, how?

What was it like for you having come out?

What did you think about on the way home?

What do you think was the most significant part of your experience, and why?

Have you had any other experiences of coming out?

Appendix D – NHS Research Ethic Committee Approval

NHS
Health Research Authority
South Central - Oxford B Research Ethics Committee
Whitefriars
Level 3, Block B
Lewin's Mead
Bristol
BS1 2NT
Telephone: 0207 104 8043

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

02 August 2016
Miss Michelle Lowe
[redacted]

Dear Miss Lowe **Study title:** **Adolescent experiences of sexual orientation disclosure in healthcare settings, an IPA study.**

REC reference: **16/SC/0381**
IRAS project ID: **202744**

Thank you for your letter of 27th July 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Claudia Bywater, nrescommittee.southcentral-oxfordb@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion
The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.
Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.
Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials
All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites
NHS sites
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

Document	*Version*	*Date*
Copies of advertisement materials for research participants [recruitment	2.0	25 July 2016

poster]
Copies of advertisement materials for research participants [Recruitment poster tracked copy]
Covering letter on headed paper [Covering letter detailing amendments post REC review]
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor indemnity] 01 August 2015
Interview schedules or topic guides for participants [Guide interview schedule] 2.0 25 July 2016
Interview schedules or topic guides for participants [guide interview schedule - Topic guide tracked copy]
IRAS Application Form [IRAS_Form_24062016] 24 June 2016
IRAS Checklist XML [Checklist_24062016] 24 June 2016
IRAS Checklist XML [Checklist_27072016] 27 July 2016
Letter from sponsor [Letter from sponsor] 04 April 2016
Other [Sponsor indemnity - professional Negligence] 13 July 2015
Other [Sponsor indemnity - public product liability] 13 July 2015
Other [demograpics form] version 1.0 05 June 2016
Other [HRA protocol tracked copy]
Participant consent form [Consent form] 2.0 25 July 2016
Participant consent form [consent form tracked copy]
Participant information sheet (PIS) [Participant information sheet] 2.0 25 July 2016
Participant information sheet (PIS) [PIS tracked copy]
Research protocol or project proposal [Research Protocol] 2.0 25 July 2016
Summary CV for Chief Investigator (CI) [Chief investigator CV] version 1.0 05 June 2016

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review
Reporting requirements
The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:
- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.
User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training
We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/ **16/SC/0381 Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.
Yours sincerely

Pp
[redacted]
Chair

Email:nrescommittee.southcentral-oxfordb@nhs.net

Enclosures: "After ethical review – guidance for researchers" *Copy to:* [redacted]

Appendix E – HRA Approval letter

NHS
Health Research Authority

Miss Michelle Lowe
[redacted]
Email: hra.approval@nhs.net

10 October 2016

Dear Miss Lowe,

Letter of HRA Approval

Study title:	**Adolescent experiences of sexual orientation disclosure in healthcare settings, an IPA study.**
IRAS project ID:	**202744**
REC reference:	**16/SC/0381**
Sponsor:	[redacted]

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England
The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators",* issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **202744**. Please quote this on all correspondence.

Yours sincerely,

Emma Stoica

Senior Assessor

Email: hra.approval@nhs.net

Copy to:

[redacted]

Appendix F - Trust Research and Development approval (Trust 1)

Dear Michelle

RE: IRAS 202744 Confirmation of Capacity and Capability at [redacted]
Full Study Title: Adolescent experiences of sexual orientation disclosure in healthcare settings, An IPA Study

On behalf of [redacted], Associate Medical Director, this email confirms that [redacted] **NHS Trust** has the capacity and capability to deliver the above referenced study.

We agree to start this study on receipt of Green Light from Janssen**.**

If you wish to discuss further, please do not hesitate to contact me; good luck with your study.

Best wishes
[redacted]

[redacted]
Data Quality Officer

[redacted]

Normal working days are Monday to Thursday

Appendix G – Trust research and development approval. (Trust 2)

Dear Michelle

Confirmation of Capacity and Capability at [redacted] NHS Trust

Short title:	Adolescent Experiences of Sexual Orientation Disclosure in Healthcare Settings
IRAS ID.:	202744
Principal Investigator:	Michelle Lowe

This email confirms that [redacted] NHS Trust has the capacity and capability to deliver the above referenced study. The Trust accept the HRA Statement of Activities, v1 dated 10/10/2016 as confirmation of our participation.

You have notified us that our site will purely be a participant identification centre (PIC), and we therefore give our permission for study advertising and referral of participants ONLY to take place. Please note that no other research activity should take place on site.

Confirmation of Capacity and Capability for the above research has been granted on the basis described in the HRA approval application. The documents received are:

Document	Version	Date
Research Protocol	2.0	25/07/2016
Participant Information Sheet	3.0	07/10/2016
Consent Form	3.0	07/10/2016
Recruitment Poster	2.0	25/07/2016
Demographics Form	1.0	05/06/2016
Interview Schedule	2.0	25/07/2016
HRA Statement of Activities	1.0	10/10/2016
HRA Schedule of Events	1.0	10/10/2016
Sponsor Insurance		01/08/2015
Letter from Sponsor		04/04/2016
Chief Investigator CV		05/06/2016
Supervisor CV		09/05/2016

For further information regarding how to notify us of any amendments to the study please refer to the Amendments Guidance for Researchers .

If you wish to discuss this further, please do not hesitate to contact me.
Kind regards
[redacted]

Appendix H – Consent form

Centre Number:
Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project**: Adolescent experiences of sexual orientation disclosure in healthcare settings, an IPA study.**

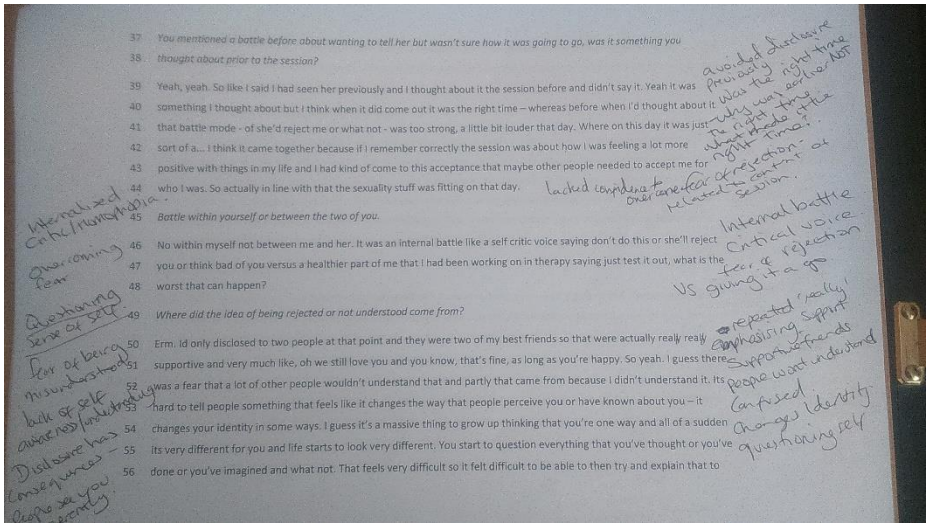
Name of Researcher: Michelle Lowe

	Please initial box
1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time up until the final analysis without giving any reason, without my medical care or legal rights being affected.	☐
3. I agree to take part in an interview with the researcher lasting approximately 1 hour and give my consent for this interview to be voice recorded.	☐
4. I understand that as part of the research write up; direct examples of speech may be used. These quotes will be anonymised. I am happy for any relevant part of my interview to be directly quoted.	☐
5. I agree to take part in the above study.	☐

Name of	Participant	Date	Signature
Name of Person taking consent		Date	Signature

Appendix I – Evidence of IPA analysis

Coding of transcripts:



37 *You mentioned a battle before about wanting to tell her but wasn't sure how it was going to go, was it something you*
38 *thought about prior to the session?*
39 Yeah, yeah. So like I said I had seen her previously and I thought about it the session before and didn't say it. Yeah it was
40 something I thought about but I think when it did come out it was the right time – whereas before when I'd thought about it
41 that battle mode - of she'd reject me or what not - was too strong, a little bit louder that day. Where on this day it was just
42 sort of a... I think it came together because if I remember correctly the session was about how I was feeling a lot more
43 positive with things in my life and I had kind of come to this acceptance that maybe other people needed to accept me for
44 who I was. So actually in line with that the sexuality stuff was fitting on that day.
45 *Battle within yourself or between the two of you.*
46 No within myself not between me and her. It was an internal battle like a self critic voice saying don't do this or she'll reject
47 you or think bad of you versus a healthier part of me that I had been working on in therapy saying just test it out, what is the
48 worst that can happen?
49 *Where did the idea of being rejected or not understood come from?*
50 Erm. Id only disclosed to two people at that point and they were two of my best friends so that were actually really really
51 supportive and very much like, oh we still love you and you know, that's fine, as long as you're happy. So yeah. I guess there
52 was a fear that a lot of other people wouldn't understand that and partly that came from because I didn't understand it. Its
53 hard to tell people something that feels like it changes the way that people perceive you or have known about you – it
54 changes your identity in some ways. I guess it's a massive thing to grow up thinking that you're one way and all of a sudden
55 its very different for you and life starts to look very different. You start to question everything that you've thought or you've
56 done or you've imagined and what not. That feels very difficult so it felt difficult to be able to then try and explain that to

Emergent themes identified from each individual transcript:

The development of superordinate themes:

Appendix J – Author guidelines

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

Please note that The ***Journal of Homosexuality*** uses CrossCheck™ software to screen papers for unoriginal material. By submitting your paper to The ***Journal of Homosexuality*** you are agreeing to any necessary originality checks your paper may have to undergo during the peer review and production processes.

Manuscript Submission. Address manuscripts to the Editor: Dr. John P. Elia, jpelia@sfsu.edu

Prospective authors are to send the following items as e-mail attachments: (1) a cover letter indicating that the manuscript is not under consideration for publication elsewhere; (2) a blinded (i.e., with no references or indications as to the author's name) electronic copy of the manuscript; (3) an unblinded copy (complete with author's name, academic degree, professional affiliation, contact information, and any desired acknowledgment of research support or other credit) of the manuscript; and (4) a free-standing abstract of no more than 150 words excluding the title of the manuscript, which is to appear at the top of the page, and 5-7 key words. Also, manuscripts are to be submitted in English using Microsoft Word (in 12-point font, *Times New Roman*, double-spaced (with headers bearing the title or partial title of the manuscript), paginated, and with one-inch margins (top/bottom, left/right)). Manuscripts must not exceed 10,000 words (inclusive of references). Authors are to follow the publication guidelines of the *Publication Manual of the American Psychological Association,* 6th edition (2009). Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source.) All accepted manuscripts, artwork, and photographs become the property of the publisher.

Media Review Submission. Send media reviews (e.g., book reviews, film reviews, reviews of instructional/training DVDs, reviews of websites, and reviews of other media forms directly to Dr. Mickey J. Eliason, Ph.D., Media Review Editor, at meliason@sfsu.edu

Reviews of single books, films, DVDs, or websites should not exceed 5 pages (approximately 1,500 words) (double-spaced, in Times New Roman 12 font, 1 inch margins (top/bottom and left/right). Composite reviews (a review of 2 of more books, films, etc. in a single review may include additional pages, which should

be negotiated with the media review editor). Reviewers should present a "balanced review" (of the strengths and weaknesses of the item(s) under review) whenever possible. The bibliographic information of the book or other form of media under review should be written using the following format (or a similar format depending on the type of media being reviewed).

References. References, citations, and general style of manuscripts should be prepared in accordance with the APA Publication Manual, 6th ed. (2010). Cite in the text by author and date (Lee, 2009) and include an alphabetical list at the end of the article.

Illustrations. Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

Color Reproduction: Color art will be reproduced in the online production at no additional cost to the author. Color illustrations will also be considered for the print publication; however, the author will bear the full cost involved in color art reproduction. Please note that color reprints can only be ordered if the print reproduction costs are paid. Art not supplied at a minimum of 300 dpi will not be considered for print. Print Rates: $900 for the first page of color; $450 for the next 3 pages of color. A custom quote will be provided for authors with more than 4 pages of color. Please ensure that color figures and images submitted for publication will render clearly in black and white conversion for print.

Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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PAPER 3 – Reflections

Introduction

According to Tate and Sills, (2004) learning is achieved through the critical reflection of our experiences and by using personal and theoretical knowledge to examine and understand those experiences in different ways. The British Psychological Society (BPS) asserts that clinical psychology trainees should leave doctoral training with the ability to be reflective scientist practitioners with regards to both clinical and research skills (BPS, 2014). Similarly the Health and Care Professions Council's (HCPC) standards of proficiency document provides guidance which states that: we should have an awareness of, and an ability to reflect on the personal assumptions we may bring with us into clinical practice in order to learn from our experiences and develop safe and effective practice (HCPC, 2012). The use of reflective models can therefore provide an effective structure to consolidate learning (Finlay, 2008). Many different such models exist including: Schon's (1983) work on reflection in action and reflection on action, Kolb's (1984) learning cycle and, John's (2000) ten C's of reflection. The author has chosen to use the experiential learning model (Boud, Keogh & Walker, 1985) to influence the structure of this reflective commentary. Boud, Keogh & Walker's model espouses four main stages to guide reflective practice and learning:

1. Returning to the event or experience
2. Considering the experience in detail including an evaluation at both the emotional and cognitive level
3. Re-evaluate the event in light of experience, knowledge and experimentation, seeking to understand the meaning of the experience.
4. Plan for what might be changed in future.

These four stages will be used as a general guide during the following reflections on the process of completing an Interpretative Phenomenological Analysis (IPA) research project investigating lesbian, gay and bisexual adolescents' experiences of disclosing their sexual orientation to healthcare professionals. Topic selection and reflections on the personal nature of this topic will also be included. The reflective commentary will be concluded with points of learning from completing this study, including ideas for what may be changed for future research endeavours

Topic selection

The author conducted a qualitative research project investigating adolescents' experiences of disclosing their sexual orientation to a healthcare professional. This

project was completed in partial fulfilment of the requirements of a degree of doctorate in clinical psychology. Prior to achieving a place on the doctoral training programme the author worked as both a researcher and as a clinician in Child and Adolescent Mental Health Services (CAMHS). As part of this clinical role, it was noticed that there were multiple occasions where there was confusion amongst the different professionals working with an individual regarding the client's sexual orientation. This was particularly evident in the case of one adolescent who had disclosed that they were bisexual to their previous CAMHS clinician but had refused to comment on their sexual orientation to their current CAMHS social worker – despite the parent's unwillingness to accept the adolescent's sexual orientation and the resulting familial conflict being cited as the reason necessitating social worker involvement. Thought around the adolescent's disclosure to one clinician but not another, prompted thoughts around the process of disclosure for the individual and how disclosures to healthcare professionals may be experienced by adolescents, particularly when considered in the context of their ongoing development. Thus these experiences shaped the author's choice of research area when considering topics as part of the clinical psychology doctoral training. The author has also reflected on the impact of personal and professional influences of research topic, as presented below.

Personal versus Professional

The author was able to relate to several aspects of this research project, both on a personal and a professional level. On a personal level the author identifies as a homosexual and as such has reflected that they have a vested interest in giving voice to members of a minority sexual orientation. The planning and completion of this project has therefore been laden with both emotional and cognitive content for the author. An awareness of this was particularly apparent during the data collection phase of the study when some aspects of participants' experiences were similar to the author's personal experiences of 'coming out'. In these moments the author recognised the need to encourage participants to fully lead the discussion so as not to influence the content of what was being said.

Being also a healthcare professional, the experience of completing this project has equally evoked emotions and cognitions on a professional level. Listening to participants' experiences of disclosing their sexual orientation to a healthcare professional was often both thought provoking and humbling. One of the most striking reflections from a professional perspective was the extent to which professionals are in a position of power over their clients. This position of power is not a new concept and has been discussed many times throughout doctoral training, however the effect of 'the powerful clinician'

seemed particularly relevant in the context of participants recalling their adolescent disclosure experiences. Considering power dynamics post event, makes the author realise quite how daunting it must be to disclose a very personal piece of information to what amounts to a relative stranger. Looking back the author believes this represents the crux of their experiences with choosing this research topic; it represents the clash of their personal and their professional lives, which up until this point had been kept relatively separate. Whilst this revelation may have caused some emotional and cognitive stresses along the way, it is also the reason why the author has been steadfastly enthusiastic about the subject matter, thus providing drive and determination to complete the project. The impact of personal and professional influences on completing each stage of the research project will be discussed in more detail below.

Completing the research.

Boud, Keogh & Walker's (1985) guidance of returning to the experience, evaluating the emotional and cognitive content and re-evaluation the event is again used below to consider the overall experience and individual stages that constituted conducting the research project. Each stage will be examined in term with any pertinent reflections noted.

Ethical Approval

Gaining ethical approval to complete the project was experienced as a time consuming and often frustrating process. The NHS research ethics committee (REC) were cautious about allowing under sixteen year olds to take part in the study as they deemed demonstrations of Gillick competency (Gillick v West Norfolk & Wisbech Area Health Authority,1985) only to be applicable to clinical practice and not research, thus the original recruitment age range (13-18) had to be amended (to 16-25). This meant that some participant experiences may have occurred a number of years in the past thus introducing the potential for memory bias. This, however disappointing, was not an insurmountable issue and may indeed go some way to accounting for the paucity of research in this area. Feelings of frustration and disbelief did however occur when a fellow trainee was granted ethical approval to interview 12-17 year old based on the demonstration of Gillick competency. This highlighted the inequality and inconsistency of the NHS ethical review process. A change in process following approval from an NHS REC led to long delays in the overall approval process. This change was implemented in March 2016, mid ethical approval for this study. The changes made meant that rather than seeking research and development (R&D) approval from the relevant NHS trusts following approval by an NHS REC, the project first had to be approved by the Health

Research Authority (HRA). This change in process was designed to streamline the ethical approval process by making many of the local trust R&D checks more centralised thus shortening the R&D approval process following REC approval. Unfortunately during the changeover to the new system, the HRA were unable to meet the demands for projects submitted to them and therefore experienced a high backlog of projects. This led to a period of great stress characterised by multiple phone calls to the HRA to chase up the status of the project, eventually culminating in the submission of a complaint over the time the process was taking. Delays encountered meant that HRA approval was granted nearly three months after REC approval had been given. It then took a further month for one of the projects research trusts to confirm R&D capacity and capability.

Recruitment and participant interviews.

My previous role within the local CAMHS service helped to facilitate recruitment, as did meetings with department leads for a local NHS trust based LGB health and support project. Nevertheless recruitment proved difficult. Peer supervision and reflective group meetings organised as part of the course were useful in managing the anxiety that recruitment difficulties created. It was recognised that the specific requirements of the study meant that it was necessary for LGB people to have made a disclosure to a healthcare professional as part of the inclusion criteria – something existing research suggests only around 12% of LGB people do (Allen, Glicken, Beach, & Naylor, 1998). The author realised that they themselves had not disclosed their sexual orientation to a professional in this context despite considering themselves open about their sexual orientation in all aspects of life.

Interviews were viewed as an enjoyable experience. Participants seemed keen to talk about their experiences and valued the opportunity to have their voice heard. This led the author to wonder whether this enthusiasm to discuss their experiences was related to the lack of opportunities to do so in other forums. Being a minority sexual orientation is recognised as having unique stressors linked to living in a heteronormative society. The experience of which has been found to resemble racism and sexism (Swim, Pearson & Johnston, 2008). Although the author's role within interviews was firmly that of a researcher, it was noted that clinical skills were utilised in order to establish and maintain rapport with participants and to put them at ease regarding any anxiety over the interview process.

Data Analysis

All of the author's previous research experience had been quantitative in nature. As such the doctoral thesis was viewed as an opportunity to become familiar with a different methodological approach with the support of their academic institution. Though time

consuming in comparison to quantitative methods, the data analysis phase was experienced as enjoyable by the author who relished the challenge of trying to master this new approach. Careful consideration was given to the process of data analysis, with the author being mindful of their potential influence and interpretation of the data both as a lesbian and as a healthcare professional. Though undertaking a research project that on such a personal topic may be a cause for criticism, the author believes that their personal knowledge of the phenomenon under investigation made it possible for them to explicitly recognise their own assumptions and biases. True impartiality is rare in research and the author is confident that their personal connection to the topic has enabled a deeper level of awareness than if they had attempted to research an area where their subjective influences and biases were less well known.

Conclusion

Contemplating conducting a doctoral level thesis was a daunting prospect for the author, despite having some previous knowledge and experience of conducting large research projects. Part of the author's role prior to commencing training was as a researcher on a National Institute for Health Research (NIHR) funded multi-centre randomised controlled trial (RCT). Responsibilities as part of the RCT did not however include the application for ethical approval or creating of a study protocol as these were under the jurisdiction of the wider research team. The study undertaken for the doctoral thesis was therefore the first time that the author had independently designed and completed a research project without the support of other researchers. Completion of the Integrated Research Application System (IRAS) form as part of NHS ethical approval often appeared repetitive. Completion of this process however proved to be a valuable experience which instilled confidence in the author's ability to complete such a task. This was a vital learning experience for the future as the author enjoys undertaking research projects and is keen to use these skills to commence further projects throughout their career.

The necessary act of critically reflecting on one's own experiences, biases and assumptions has also been a valuable learning experience. Undertaking this project has allowed the author to view their own personal and professional identities from a different perspective and has increased their awareness of self and how they may subjectively influence or interpret events. This learning is applicable both in the context of the author's sexual orientation, their chosen careen and the interaction between these two identities.

One of the most noticeable and broad ranging learning points has been the realisation that the author has the ability and competency to manage a heavy workload in conjunction with high stress levels. It is recognised that, in the past, the author has not always responded to high levels of stress in productive ways but the timescales and deadlines imposed by this project has increased their confidence and ability to do so. The experience of undertaking this project has highlighted the author's organisational abilities, though these have at times been tested by processes outside of the authors control, for example delays in ethical approval. The ability to adjust the organisation of tasks accordingly in the face of such unforeseen external pressures, provides a level of assurance that is greatly appreciated.

The knowledge gained during this experience does suggest some possible changes for future research endeavours. One such change would be a change in expectations around timescales and an acknowledgement that at times, one is at the mercy of others. More importantly however future projects may involve some appreciation for periods of discomfort regardless of its origin, as the author has observed that the most prominent and beneficial learning points achieved have been in relation to the challenges faced, rather than the things that proceeded as expected.

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