Abstract
There is a dearth of research on Lesbian, Gay, Bisexual and Transgender (LGBT) young women in Northern Ireland, particularly in relation to health. This research addresses some of these gaps in knowledge and understanding of the issues through exploring the perceptions of a sample of young LGBT women aged 18–25 towards access to and provision of health services in Northern Ireland. A qualitative, exploratory approach was employed, using semi-structured face-to-face interviews as the data collection method. Obtaining a sample was difficult, due to the hidden nature of the population. Issues with chain referral as a sampling method are described. Following transcription, narratives were analysed using thematic content analysis according to Newell and Burnard (2006). Nine young women who identified as either lesbian, gay or bisexual were interviewed. Participants recalled negative perceptions of school-based health provision where the issue of homosexuality was often silenced. Findings indicate a reluctance to disclose sexual orientation to health care providers, perceptions of invisibility within health care and health information environments, and a lack of tailored provision that adequately addresses the needs of the young women. There were some positive experiences of occasions when the young women’s sexual orientation was acknowledged and accepted. Future health promotion strategies addressing the needs of young gay or bisexual women should consider their sexual identity as an integral component and should take steps to ensure that those promoting such strategies are perceived to be trustworthy. The research has implications for all those working with young people, particularly with minority groups.

Keywords
LGBT; young women; health services; health promotion; Northern Ireland

Introduction
Northern Ireland is a society in transition, one in which the traditional conflicts have receded and a more diverse society has been revealed. Within this evolving society more attention has recently focussed on minority groups such as those with disabilities, minority ethnic groups and those who identify as other than heterosexual, typically Lesbian, Gay, Bisexual, and Transgender (LGBT). In many ways, particularly in
Northern Ireland, young people's health has been hijacked by 'risk'; risk of obesity, smoking, teenage pregnancy and a focus on ‘lifestyle’ changes to prevent disease. An area where there is a dearth of research relates to young LGBT women's experiences and interactions with health services in Northern Ireland. The aim of this research was to explore the perceptions of a sample of young women who identified as either lesbian, gay, bisexual or transgender, aged 18–25 towards access to and provision of healthcare services in Northern Ireland. Specifically, the objectives were to examine the perceptions of young LGBT women of health care services, to identify examples of good practice where they exist and to identify gaps in health care services as identified by the young women themselves. By doing this insight is gained into good practices where they exist and the findings can help inform all those working with young people to better address the diverse needs of young LGBT women and other minority groups.

**Health issues for young LGBT women**

Mayock et al. (2009) in a large scale Irish study report that young LGBT people as a whole are more vulnerable to psychological distress. They report that over 60% of respondents directly attribute stress and depression directly to their non-heterosexual identity. There is a large body of evidence which supports the claim that poor emotional health can be as a result of homophobic attitudes and heterosexism in society leading to lowered self-esteem and confidence and increased stress particularly for young gay women (Meyer 2003; Douglas-Scott et al., 2004; Dolan, 2005; Greenfield, 2007; O’Hanlan and Isler, 2006). The Northern Ireland Young Life and Times Survey (2005/2006) showed that young women’s sexual orientation (when not heterosexual) can have an adverse affect on mental health, with one in two same sex attracted young women registered as suffering a mental health condition (Young Life and Times, 2005). Research suggests that internalised homophobia, the transformation of external negative societal messages into self-hatred, denial and an impaired sense of self (Greenfield, 2007) and feelings of shame have all given rise to health problems such as self-harm (Herek, 2007).

Much of the sexual health research available specifically relating to LGBT women is from the USA (Dolan, 2005) and examines older women rather than younger women. In the UK a number of large scale research projects have recently reported a lack of awareness of sexual health issues generally among LGBT women (Hunt and Fish, 2008). In Northern Ireland research carried out by Louden (2003), Quiery (2002/2007) and McAlister and Neill (2009), point to a worrying lack of availability of sexual health information for young LGBT women.

**Health environments for young LGBT women**

For many young people school serves as an important (and often the only) source of health information (Schubotz et al., 2004). Rolston et al. (2005) discuss how in Northern Ireland sexual health provision in schools is invariably modelled on the biological aspects of sex, rather than any frank discussion of emotions, pleasure or desire. McAlister et al. (2007) identify that the failure to discuss homosexuality at school can lead to feelings of shame which can be detrimental to emotional wellbeing (see also Rolston et al., 2004; Rolston et al., 2005; Mayock et al., 2009). Along with abortion, homosexuality is one of the most avoided topics in Northern Ireland schools,
particularly in Catholic Maintained Schools, leading to the isolation of LGBT young people (Rolston et al., 2004; Schubotz et al., 2004; McNamee et al., 2008). Louden (2003) state that the religious ethos which often prevails in Northern Ireland schools can lead to invisibility of young LGBT people.

A European report (Takács, 2006) identified fear of discrimination and stigma as barriers to accessing health care settings for young gay women. It also highlighted the fact that lesbian and bisexual women do not tend to access health care services in the same way as their heterosexual counterparts, in the form of regular health checks or attendance for screening procedures. This has been widely reported in research from the USA (Diamant et al., 2000; Dolan, 2005). There is a substantial body of evidence to support the claim that many LGBT women worldwide have experienced negative reactions from health care providers (McNair, 2003; Henderson et al., 2002; Mayer et al., 2008). A recent Irish report states that many LGBT women have faced homophobia when accessing mainstream healthcare services (Mayock et al., 2009), while Louden (2003) reports young LGBT people in Northern Ireland as having had negative experiences also with their General Practitioner (GP).

Safe spaces and assurances of confidentiality have been identified by Garofalo and Bush (2008) as critically important in any health care or health promotion for young LGBT people. Louden (2003) highlighted that in Northern Ireland young LGBT people are often afraid to disclose sexual orientation to health practitioners due to fears of breach of confidentiality. Many young LGBT women may not be ‘out’ to their immediate family and therefore are reluctant to reveal their sexual orientation to health care professionals, particularly in rural areas where the young person’s family is known by the practitioner (Mayock et al., 2009). From the literature, assurances of confidentiality appear to be important and may need to be stressed with LGBT young people; this is recommended by Garofalo and Bush (2008).

**Potential barriers to accessing services**

McNair (2003) and Mayock et al. (2009) state that the assumption of heterosexuality can be enough to silence a young gay female into non-disclosure of sexual orientation to any health care provider. Westersta et al. (2002) also cite this heterosexism as contributing to the invisibility of LGBT women within health care services. A recurring issue in research relating to young LGBT women and their interactions with health care environments is the visibility or invisibility of issues relating to them in the physical environment (for example the waiting area). Visibility of literature relating to non-heterosexual relationships has been reported to put young LGBT women at ease when they access a service and posters can also help in this regard (Dootson, 2000). If healthcare environments were more conducive to gay identities this could lead to improved self esteem and thus improved health outcomes (Rosario et al., 2006).

A lack of dedicated services specifically for young LGBT women in the health service in Northern Ireland has been recognised by Louden (2003) and Quiery (2007). It is important therefore to investigate whether young LGBT women themselves perceive that there are gaps and to ascertain what they would like to see implemented. This information can inform health promotion and youth work for young LGBT women and lead to a deeper understanding of how future programmes, initiatives or services should be structured.
Methods
Since limited research exists on the subject of young LGBT women’s perceptions and experiences of health services, particularly in Northern Ireland, the approach was exploratory. Semi-structured interviews were utilised as the data collection method. As young women were the focus of the research and as it was about their perceptions and experiences, the approach taken was one of feminist research, which recognises women’s stories as legitimate sources of knowledge (Campbell & Wasco, 2000). The approach to interviewing was collaborative, emphasising that the young women themselves were the primary experts in terms of their knowledge and perceptions of healthcare services.

Generating and accessing a sample
Estimates in relation to the size of LGBT community in Northern Ireland vary. The Northern Ireland Young Life and Times Survey (Young Life and Times, 2005) reported that 8.8% of the young people surveyed indicated they had been attracted to someone of the same sex. The Lesbian Advocacy Services Initiative estimates that there are 75,000 lesbian and bisexual girls and women in Northern Ireland (Quiery, 2007). This is based on the OFMDFM figure (OFMDFM, 2004) of 10% of the population being LGBT. Keenan (2009) estimates that there are approximately 12,650 lesbian and bisexual women in Northern Ireland aged between 16 and 25 years. The age range of 18 to 25 was chosen for this research because this age group is most commonly associated with ‘coming out’ for young LGBT people (Floyd and Bakeman, 2006; YouthNet, 2003; Quiery, 2007).

The difficulties in accessing this group of young women and gaining a sample cannot be overstated. Many youth groups were contacted in the voluntary sector in an attempt to gain a pool of young women who might potentially be able to take part in the research. In practice this did not come to fruition. An issue raised by leaders of LGBT-specific groups was that young people in their groups had been heavily consulted of late for other research (consultations unrelated to healthcare), and that they were reluctant to take part as they had not received feedback or finished reports from previous research. Funding issues represented a further barrier to accessing a sample as some youth groups had folded or become inactive. Even when young women were accessed, more often than not they did not wish to participate.

Nine young women were eventually recruited using a sampling method called chain-referral or ‘snowball sampling’. This method used several key contacts made through previous work colleagues to access three young gay women who then referred the researcher onto their friends and contacts who were willing to participate. A drawback of this sampling method was the homogeneity of participants it yielded in terms of ethnicity, religion, background, class and educational attainment. This problem has been identified by Meyer and Wilson (2009) and Malterud et al. (2009) when sampling lesbian, gay or bisexual populations particularly using chain referral. Because it was based on networks of friends and peers in the Northern Ireland context and it began with a Catholic respondent, the sample was almost completely Catholic (n=8), illustrating how groups of young people in Northern Ireland are still polarised between the two main faiths. This may be somewhat surprising in the LGBT context as there is some evidence that young gay people have more diverse contacts than young people
who are not LGBT (Leach, 2009), although other research confirms that in Northern Ireland sectarian divisions still remain in terms of contact and mixing, even socially, irrespective of sexual orientation (Hughes et al., 2007; McAlister et al., 2009).

Data collection
The areas of interest during the semi-structured interviews were young women’s perceptions and experiences of health services including sexual health services, mental health services and sources of health information. Interviews were held at a time and location convenient to the young women and were recorded with their consent. Thematic analysis was applied using Newell and Burnard’s (2006) framework. This coding framework suited the exploratory nature of the study; it also enabled the diverse answers to be coded and analysed in a structured way. It is a seven stage framework, which begins immediately after data collection by drafting up fieldnotes and then producing verbatim transcripts. Following this each transcript was read, re-read and notes made on the margins based on general themes becoming evident. Subsequently, open coding was carried out on all the themes emerging; the themes were then reduced if necessary by merging those which were similar. A shortened list of category codes was then produced. The codes were verified by an independent second party to enhance credibility and trustworthiness of findings, as recommended by Granheim and Lundman (2004).

While every effort was made to represent a variety of young women it is recognised that the findings are not generalisable to the lesbian population as a whole. Nevertheless, by using in-depth interviews it is hoped that this research will contribute to a greater understanding of young lesbian women’s experiences of their interactions with health-related services in Northern Ireland. In-depth interviews are commonly used to explore perceptions of health care services including issues relating to communication and how to make care more ‘patient centred’ (Chapple and Rogers, 1998; Evans, 2002).

Profile of participants
All of the young women were white, able-bodied and did not show any presenting signs of physical disability. At the time of interview the young women were living in a variety of locations across Northern Ireland: although they all lived in urban areas at time of interview, only four young women were originally from cities, the remainder were from smaller towns and villages but no longer lived there. Their ages ranged from nineteen up to twenty five years, with the mean age being twenty two. At the time of interview four were in full-time employment, two were at university and working part-time, one was in full-time vocational training and one in part time vocational training and not in employment. One young woman was not in employment, education or training (NEET) at the time of interview. With regard to educational background, all of the young women had completed second level education, four had completed third level education (university, two in progress), and eight had attended Roman Catholic Maintained schools, while one attended an integrated school. With regard to involvement in youth provision, three of the nine young women interviewed had been involved in LGBT specific youth work provision, and another had attended many courses in a women’s centre for a number of years. One had been involved in non-specific youth provision for many years and the remainder had not been involved in
any youth provision. Eight young women identified as either gay or lesbian, while one identified as bisexual and none identified as transgendered.

Many of the young women in the study were ‘out’, confident about their sexuality, articulate, educated to university level and involved in youth work activities. This may have had an impact on the young women’s perspectives and outlook on services they had received, for example an increased self awareness or increased awareness of their rights as a service user. However, it also serves to illustrate some of the difficulties accessing populations with low visibility for research purposes.

Results

Perceived health Issues for the young women

Many of the young women spoke about specific health issues which were prevalent either for themselves or their peers. When asked specifically about health issues affecting young women who identify as LGB the issues raised were mainly in relation to mental health. The majority for example felt that depression and stress were more common among young gay women than among their heterosexual peers. A typical response was ‘em I think there’d be … easier for like a gay woman to get depressed’ (Megan, 19). The impact of stress on physical health was also apparent, particularly during the stage of ‘coming out’ to friends and family. Katie (19) described some of the stress she was under at that time:

… around the time that I came out I was also doin’ my exams in school… it was really really stressful … see it was my parents I was really worried about … it did put a lot of stress on me like an’ I noticed like my appetite an’ stuff went down … // like I lost a lot of weight … cause the stress of the exams an’ stuff just made it really really hard on top of everything …

‘Coming out’ therefore appears to have exacerbated stress that young people already experience at this age, and can be illustrated in both Katie’s and Megan’s narrative, where they use terms such as ‘burden’, ‘hard’, ‘pressure’ and ‘triggers’ indicating frustration or mounting anxiety. Many of the young women attributed stress or anxiety to their having to come to terms with their sexual orientation and /or negative reactions of others finding out.

Another related health issue raised by several of the young women was self harm. Alexandra (22) explained:

they [gay women] just have to deal with a lot more stuff ye know comin’ out and just the general prejudice an’ all the rest of it … // … you do turn to things like that ye know to make the pain inside go away ye know you do try to … // … I know a lot of people that used to do it [self-harm] when they were younger and eh and ye know they almost they turned out to be bisexual or gay or …

Most of the young women thought that alcohol is a large part of the gay social ‘scene’ and described it as being important and necessary to gay identity, ‘fitting in’ and personal confidence. They clearly saw a relationship between alcohol/drug use and mental ‘feelgood’, a feeling of self-confidence, and they were aware of how the resultant loss of inhibitions impacted on physical and sexual health. Some directly
attributed to the use of alcohol or drugs a short-term release from poor emotional health and well-being.

**School as a source of health education**

Overall there appeared to be a perceived lack of health information and provision in schools as recalled by the young women in relation to mental health, sexual health and emotional wellbeing. Health information was sparse and none of the young women recalled seeing any literature or promotional material which was not targeted towards heterosexual young people. Among the most frequently used phrases used when describing the sex education they received were ‘shit’ or ‘crap’. The impact of the religious ethos on a school’s teaching particularly in relation to sexual health is illustrated by Phoebe (20) as she described ‘Education for Love’, the programme of sex education that is still used in some Catholic schools:

… they’re very em tame em language like em gettin married before you have sex, um, no contraception all this here em basically just what the religion is they would teach …

Most of the young women described the heterocentric focus of sex education in their schools, noting how the issue of homosexuality or same sex relationships was ignored and effectively silenced. Katie (19) also recalled how any discussion around relationships or sexuality in her school was ‘always boy girl, man wife’ and Ellie (24) stated that relationships which were not heterosexual were ‘not even talked about or considered’, or ‘brushed under the carpet kinda thing’ (Megan, 19). Phoebe (20) described an instance in which a teacher in her school was much more forthright in silencing the issue, by actively condemning homosexuality:

the teacher at the time said ‘oh yeah homosexuals go to hell’ and I had just came out to my friends that week and my friends started lookin’ at me … // … eh, so, so that kinda thing, so that kinda scared me …

The examples given of how issues relating to homosexuality were ‘hushed’ or ‘brushed under the carpet’ illustrate that the young women experienced degrees of silencing ranging from disregarding or ignoring homosexuality completely through to outright condemnation. Phoebe’s example of a teacher proclaiming that homosexuals ‘go to hell’ is a more explicit, damaging and demeaning example of silencing the issue and provoking shame. The findings of this research concur with Rolston et al. (2004) who describe what they call a ‘pervasive conservatism’ in the Northern Ireland school system, particularly in relation to ‘sexual morality’. Recent work by McAlevey and McCrystal (2007) describes school-based health education in Northern Ireland as being largely driven by a religious or moralistic paradigm. However, other research points to a lack of awareness among teachers on issues relating to sexuality teaching and more generally in health promotion. Jourdan et al. (2008) state that many teachers are not aware of their role in health promotion and that their role is poorly defined with minimal training.

**Sources of support at school**

When discussing the provision of information and support relating to mental and emotional health at school, the young women tended to focus on school counsellors. The perceived attitude of school counsellors towards homosexuality also impacted
upon the young women’s willingness to approach them. Phoebe (20) described one of her teachers who was also a school guidance counsellor in the following way: ‘I wouldn’t a went to the teacher no, the teacher was pretty old fashioned … // … I knew that he [the counsellor] … just wolda been just against it [her being gay]’. Generally, the school ethos, through silencing discussions of sexual orientation, and on some occasions not challenging homophobic bullying, had inculcated in the young women a feeling that school was simply not the place to discuss, or even reveal, their sexual orientation. Alexandra (22) for example recalled her experiences of bullying in school and how nothing was done by her teachers to alleviate her distress:

*the school knew it was goin’ on … that I was getting harassed by people but … they didn’t do anything about it they didn’t try and eh sort it out or ye know tell these people to back off or ye know it’s natural it’s not like she’s doin anything wrong ye know* [bold denotes speaker’s emphasis]

The young women had all left school from three to seven years ago and Ruby (25) expressed a faint hope that things may be different now: ‘then again I left school seven years ago so things might be different now but I doubt it’. Almost all of the young women recalled having at least one teacher whom they could confide in or felt comfortable talking to if they had problems. While this was obviously of value to the young women, it appeared to be very much based on the individual teacher. Also, while individual teachers can be supportive, the larger school structure and ethos can effectively undermine such support due to the pervasiveness of heterosexism and at times outright homophobia, where it exists.

**Invisibility of young LGBT women within services**

A common issue identified by the young women was the lack of health services that addressed their specific needs, in both urban and rural areas. Many noted that services targeted at the gay population generally were primarily male-focussed. Megan (19) spoke of her perceptions of a sexual health clinic:

*The only place I have seen was for gay men it wasn’t anything about lesbians in it I think it was about like same-sex relationships like about Aids and like HIV an’ everything it wasn’t like there was nothin’ about like lesbians.*

The perceived lack of services appeared to be exacerbated by the relatively more visible presence of gay men, and many identified specific health services for gay men. The language used by the respondents in their description of services (‘you have to go searching’, ‘there’s nothin’) points to an overall lack of specific provision for young gay women.

In terms of health education and information specifically targeting young lesbian or bisexual women the general perception was that this was greatly lacking in much the same way that health service provision was. Regarding sexual health information Alexandra (22) illustrated some of the confusion that she felt around issues surrounding sexual health:

*there’s no information about any of these and if there is you know it’s all directed towards straight people and how straight people can prevent it and ye know gay men too with the whole condom thing but then it brings it back to the subject topic about how do women prevent it.*
Health information searching involved a complex navigation of sources and hunting rather than it being readily available to the young women. Active seeking of information was also more likely to risk outing themselves. Again, the volume of literature and visibility of Aids and HIV in relation to gay men in health campaigns was recognised by the young women. This is significant; since the dearth of information relating to lesbian women’s sexual health could perpetuate the myth of ‘lesbian immunity’ which is stressed by Dolan (2005).

Many of the respondents also discussed the lack of visibility of the health concerns of young lesbian women in mainstream healthcare environments such as GP’s surgeries or GUM clinics. Phoebe’s comments provide an example:

… normally if you went into like your doctor’s surgery you didn’t see any posters … // … there’s no direct eh posters eh directed at our audience there’s nothing like.

Most suggested that the environment of mainstream health services could be made more conducive to young gay women and more ‘gay friendly’. Increasing visibility in the form of posters in the waiting area or notices displaying acceptance of same-sex relationships and also the use of inclusive language by staff may give young women ‘clues’ to a positive acceptance of their sexual orientation and alleviate the stress or fear of homophobia or discrimination in the care they receive.

Perceptions of practitioners
All of the young women said that if they had a health issue they would first approach their GP. The relationship with their GP appeared to be crucial to their perceptions of doctors generally; many said they liked a doctor because they were ‘dead on’. The gender of the GP, did, however appear to play a role in how comfortable the young women felt. Phoebe (20) originally had a male GP but asked to be changed to a female practitioner to feel ‘more comfortable’. Such a change was not always a possibility, as illustrated by Emily (25):

… my family GP is a man for a start an’ ye know there’s no em option to say ask for a female doctor, ye know that’s just never an option …

Disclosure of sexual orientation to a GP more often than not resulted from having to answer questions related to their assumed heterosexual orientation. Ellie’s (25) example illustrates this point:

… they (doctors) made me give like a urine sample for a you know pregnancy test and I said look I’m not pregnant an’ they made me take it anyway and I was look I’m not pregnant and they said ‘how do you know you’ve said you’re sexually active? how do you know?’ I said ‘well my partner’s a girl’ an’ stuff an’ they made me do it anyway …

Most of the young women thought that the onus was on the doctor to obtain information about sexual orientation from the young woman, rather than the other way around. Some suggested a doctor should ask them their sexual orientation; others suggested that the use of more neutral language by practitioners (e.g. ‘partner’ instead of ‘boyfriend’) would present less of a hurdle for them to ‘come out’. Respondents appeared to be less likely to reveal their sexual orientation to a doctor when the doctor
knew the family and many of the young women described a wariness of disclosing sexual orientation when they were younger, when many had lived in smaller communities. Fear of confidentiality being breached was a big issue. Comments such as ‘everybody knew everybody else’s business’ (Ellie, 25), ‘oh god ye wouldn’t tell your doctor for fear he would tell your ma’ (Emily, 25) ‘you’d be the talk of the town’ (Ruby, 25) ‘I’d be very wary’ (Isabella, 21) were common. Though none of the young women actually recounted experiences of confidentiality breaches, it was clear that this posed a significant barrier to their disclosure of sexual orientation, particularly when they were younger. There was a general perception that in larger cities there was increased confidentiality within health services, in part due to anonymity as Ellie (25) described:

... people who are brought up in the rural communities feel a lot more comfortable comin into the city to use services because like they don’t know anybody.

Under the right circumstances (preferably a female GP, welcoming environment, assurances of confidentiality, trust and a good relationship) some of the young women said they would disclose their sexual orientation.

**Examples of good practice**

Many of the young women had had positive experiences where they had discovered networks and peers who were sources of support. Jessica (25) had attended courses and had received counselling in a women’s centre:

... I done counselling there and it was great it really was, and there was life coaching in there as well so classes in that on Thursdays... //...Yeah it was great // I only started chattin’ when I was at, when I was at the women’s centre for a while.

Clearly Jessica’s story reveals the importance of having time to create a bond and trust with the workers in order to feel comfortable enough to reveal herself and open up to others. Three of the young women interviewed had been part of a youth group which was specifically for young women who identify as other than heterosexual. Each of these young women spoke fondly and positively about the youth group as somewhere where they ‘could be themselves’, ‘feel comfortable’ and about how it was a ‘safe space’. Ellie (25) described how she felt ‘lucky’ to have been part of the group and would recommend it to other young women. Phoebe’s positive recollections of attending the youth group largely centred on her ‘bein in a group of people the same as you’ and ‘not judged in any kinda way’. More generally though, most of the positive examples of activities, programmes or providers given by the young women contained an element of their sexuality being identified and accepted, places where they could feel safe.

**Discussion**

The young women’s discussions around drug and alcohol use illustrate difficulties they had in expressing their sexual identity openly. Clearly ‘coming out’ to friends, family and to themselves was a period of increased stress and anxiety. At this point many of the young women were coming to terms with a sexual identity which was different from the assumed heterosexuality. Carving out a sense of self within a possibly hostile environment had lead some of the young women to feel ‘down’ or ‘depressed’. This was identified by the young women themselves as a trigger for alcohol or drug use. The
concept of ‘fitting in’ was also important. The gay ‘scene’ represented a space where they could be themselves, but within that there is the need to ‘fit in’ by possibly conforming to a different norm, one which may include the use of excessive alcohol or taking drugs. The reasons for using drugs or alcohol were cited mainly as a release of pressure, acceptance and to increase confidence. This is corroborated by other research (YouthNet, 2003; Sarma, 2007). There are tensions evident between – on the one hand – fitting in to mainstream society, a desire for open recognition and acknowledgement of their sexual orientation and – on the other – an acknowledgement of difference within service provision and by health care providers.

The Department of Education in Northern Ireland issued all primary and post-primary schools with 'Relationships and Sexuality Education (RSE) Guidelines' in August 2001 (Department of Education Northern Ireland, 2001), stating that RSE should be taught ‘within the school’s moral framework’. This leaves much room for interpretation and a lack of consistency across schools could result. The majority of the young women in this research had attended Catholic Maintained Schools, and there did appear to be a lack of consistency in what sex education they received. The influence of the ‘moral framework’ was often criticised by the young women themselves, as illustrated by their comments that the sex education they received was ‘shit’ or ‘crap’. Rolston et al. (2004, 2005) report that ignoring and silencing of issues relating to homosexuality is most pronounced in the Roman Catholic Maintained Sector and that teachers were actually instructed to leave these issues out of sex education teaching. The absence of structured sexual health education covering all aspects of sexuality, including sexual orientation, appeared to increase the invisibility that the young women in this research already felt.

Among the young women interviewed, there was a general sense of holding back their sexual orientation from practitioners unless it was absolutely necessary to divulge. There was an apparent gap to be bridged between themselves and the practitioner in raising the subject of their sexual orientation. There was also a feeling that the health care provider should facilitate this ‘coming out’, wishing the doctor would ‘just ask’ rather than the young women themselves having to broach the subject of their sexual orientation; this was also found by Eliason and Schope (2001). The issue of the right to privacy and the need for tailored health care is complex: on the one hand one young woman in this study said it was ‘not the doctor’s business’ while another young woman thought it was good for a doctor to know ‘sexual preferences’. Recent research carried out in Northern Ireland by Thompson et al. (2008) report the findings from a study of GPs and practice nurses that the majority were likely to avoid LGBT issues altogether unless specifically asked. Hinchliff et al. (2005) also found that many GPs would feel uncomfortable discussing issues relating to homosexuality with patients. It is clear there is a substantial communication gap to be bridged. Malley and Tasker (2007) describe this conundrum as a ‘Catch-22’, and recognise that there is increasing recognition that sexual identity should be addressed by practitioners in the way that other variables are dealt with such as age, culture, family status or dis/ability.

Some common themes emerged through analysis of the young women’s perceptions of existing services, their examples of good practice where they exist and the gaps in provision they identified. Central to their positive perceptions of health services was the concept of ‘being themselves’. Many of them recounted positive experiences and a
commonality among them was the venue, person or family member allowing the young
women to be themselves without judgement, where their sexual orientation was
acknowledged and recognised, a finding that echoes research carried out by Crowley et
al. (2007). This meant a physical ‘escape’ for some in the form of a move to a city that
was perceived to be more anonymous, a deliberate strategy of seeking out LGBT
specific organisations, or accessing counselling services. Examples of good health
outcomes for the young women were generally based on positive emotional wellbeing
and avenues of increased social contact rather than physical health outcomes.

Their discussions also alluded to the lack of available social venues apart from bars
or nightclubs on the gay ‘scene’ generally. They expressed the wish that they could
socialise, meet other gay young people and form meaningful friendships somewhere
that was not on the ‘scene’, a scene which some of them felt was male dominated and
surrounded by alcohol and drug use (see also Valentine and Skelton 2003). Many felt
that this would have a positive effect on emotional wellbeing. The young women in this
sample who had the opportunity of attending specific services or LGBT groups
appeared to have had resoundingly positive perceptions of the impact of these on their
emotional and social health. Central to recollections of positive spare-time activities was
the acceptance of their non-heterosexual identity (see Fish and Anthony, 2005; Crowley
et al., 2007; Mayock et al., 2009). By sharing stories and engaging in peer support
networks, these young women could identify the issues that were important to them.

Trust and assurances of confidentiality were important for the young women in this
research. There was a particular issue around the women’s recollections of being
younger and fearing breaches of confidentiality with their family doctor. This was most
pronounced for those from rural areas. Loudes (2003) also recognised that fears
around GP confidentiality were extremely prevalent amongst young lesbian and gay
people. Similarly, the fear of being identifiable as gay by approaching an LGBT society
stall for fear of being ‘outed’ to peers or friends is one which has implications for both
the location of health services which are targeting young gay women and also for the
way in which health promotion messages in general are communicated. Future health
promotion initiatives for this group may need to pay particular attention to strategies
that explicitly assure confidentiality. They must be perceived to be confidential so that
they are more attractive. The qualities of the person who facilitates the delivery of any
health message to young gay women appears to be vital. Certain characteristics such as
gender, perceived empathy, understanding, trustworthiness, acceptance of identify
other than heterosexuality and the delivery of the message in a non-judgmental way
all improved perceptions of the service.

The value of factors protective of their health was also evident among the
respondents. Group involvement, friendship and leader support gave the young
women involved in specific LGBT youth provision a ‘safe space’ to grow and learn.
Many of the young women described a family member (or the collective family), a
teacher or youth worker as being significant in promoting their self-esteem or acting as
a ‘protector’, especially in relation to the school setting. The quality of responsiveness in
those providing health messages appeared to be key in the young women’s confidence
in them. Gilligan (2000) also describes how just one of these supportive relationships can
counter the harm of negative relationships. This is illustrated by the experience of
Phoebe (20) who, despite having some negative experiences in school, recognised that
having good family and friends around her alleviated the potential stresses arising from negative comments from teachers or peers. This suggests that health promotion is more than simply an exercise of ‘information giving’; it is a complex myriad of interpersonal relationships, supports, belonging and resilience. Ellis (2007) found in an investigation of British lesbian identity that the use of informal support systems was extremely important. Srof and Welsor-Friedrich (2006) also state that the combination of families, health care providers and peers can be an important source of engaging marginalised young people in health promoting activities in a positive way.

The research participants recognised the need for greater training for those working with young LGBT women (for example teachers and doctors), particularly in their use of language. Recent UK NHS guidelines have been produced to deliver improved care to LGBT young people (Department of Health 2007a; 2007b). Locally some organisations have published sexual health resources for young lesbians (McAlister and Neill, 2009), while others have published resources for use with young women who identify as other than heterosexual (Neill and McArdle, 2008). A training resource to tackle homophobia for use with school staff and pupils has also been produced (Youthnet, 2009). While these developments are obviously of value, real equality of opportunity cannot be achieved without first addressing the structural reasons for existing discrimination (Casals, 2004).

Four of the young women in this study made reference to comments made by Iris Robinson MP in 2008 who had compared homosexuality publicly to paedophilia saying ‘there can be no viler act, apart from homosexuality and sodomy, than sexually abusing children’ (Belfast Telegraph, 2008). Non-discriminatory policies are, for the young women in this research project at least, having little direct impact on their perceptions of health care systems or society at large. Policy makers cannot be separated from the policies they introduce. Kitchen and Lysaght (2003) state that much of the legislation relating to sexual diversity in Northern Ireland is weak and does little to change sexual conservatism and institutionalised heterosexism and homophobia, particularly in health care services. In a similar vein, McNamee et al. (2008) and King and Bartlett (2006) state that while legislation can improve the status, visibility and awareness of homosexuality, legislative frameworks do not automatically lead to more favourable attitudes, or changes in structures to increase equality. This also requires an increased level of resources for work to provide awareness training and actively promote equality in the education or health care systems. This general point of course also applies to other marginalised groups such as Travellers, minority ethnic groups and people with physical/learning disabilities.

Conclusion

Many of the young women in this research described a sense of being different while growing up, along with feelings of isolation and difficulty in accessing other gay or bisexual young people particularly in arenas which are off ‘scene’. School was not a particularly valuable source of health information or support; it was a place where the issue of homosexuality was silenced to varying degrees. Such silencing ranged from being ‘brushed under the carpet’ to students being told that homosexuals ‘go to hell’.

There is a strong sense that the young women in this research feel invisible; invisible within mainstream health care services (i.e. lack of services), invisible within health care environments and invisible within gay men’s health, young people’s health and women’s health services. This research makes it apparent that young women are
acutely aware of this invisibility. It is likely that such invisibility is in part due to much current health policy rhetoric and focus being on ‘risk behaviours’ such as teenage pregnancy, gay men’s condom use and other ‘lifestyle’ factors. The causes of such invisibility are structural (policy, society), institutional (schools, services) and professional (practitioners, teachers) and the issue requires attention on all three fronts if it is to be addressed satisfactorily.

Issues of confidentiality, trust and disclosure of sexual orientation appear to be complex both for health care practitioners and the young women themselves. Positive recollections of health promoting people or ‘spaces’ all included the recognition and acceptance of the young women’s sexual identity. Finally, the research poses some questions about degrees of exclusion: if these are the perceptions of young gay women who are educated, articulate and reasonably confident, what are the perceptions and experiences of those who do not have these advantages and who may be ‘beyond reach’ of research such as this? There are implications here for all those who work with young people in minority groups.

References


Biographical Note
Duana McArdle has an MSc in Food Biotechnology and recently completed an MSc in Health Promotion at the University of Ulster. She works for the Women’s Resource and Development Agency delivering health awareness programmes to community groups in disadvantaged areas working with marginalized women. She also works in a research capacity for the Public Health Agency and has a keen interest in work with women of all ages and backgrounds.

Contact Details
Duana McArdle
Tel: 0044 7835592411
Mobile: 00 353 87 2843315
Email: duanamcardle@yahoo.ie or duanamcardle@gmail.com