Coming Out Conversations and Gay/Bisexual Men’s Sexual Health: A Constitutive Model Study

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Coming Out Conversations and Gay/Bisexual Men's Sexual Health

A Constitutive Model Study

Jimmie Manning

"I thought my family would know me better. That is the
same person that they have loved for years. But they didn't. They
just saw me as another stereotype. I was just, just another gay
man who slept around and. And that's what they saw right then."

—Mark, 22

"You would think that if anyone knew not to ask those kinds
of things, it would be my doctor. But no. There he was, acting
like everything you hear about gay men is true. And from my
experience it’s not."

—Evan, 33

The epigraphs for this chapter come from two men who were interviewed
for this research project. Although they deal with interactions involving two
different social identities (family members and health care providers, respec-
tively), they help illustrate a recurring theme introduced by gay men who
talked about their coming out experiences: a suspicion regarding sexual health
that often seems to permeate coming out conversations. Of course, the con-
text of coming out to a family member is much different than that of coming
out to a health care provider. As the participants in this study note, coming
out to a family member makes it feel as if more is at stake because of the en-
during and highly personal nature of families. If there is rejection by a family
member, that feels more important and more permanent than rejection from
a health care provider. As one participant said, “You can always find a new
doctor. Finding a new family member is a lot harder to do.” Yet, at the same
time, because a coming out conversation with a health care provider is articu-
lated as less intimate—participants used terms such as “clinical” or “official”
to describe these experiences—it does not mean that the implications of such conversations cannot have highly personal meanings. As one participant offered, “It hurt to hear him [the doctor] say it more than anyone else. Because he’s educated on this stuff. He knows the research on a deeper level. And so if he still sees us [gay men] that way, that’s a pretty good mark of how society sees us.” Moreover, and as the data in this study reflect, those seeing health care professionals already feel vulnerable. Rejection based on sexual identity can make an already anxiety-inducing situation even scarier.

This chapter, then, focuses on coming out conversations between gay men and family members as well as between them and their health care providers. Both are presented with the goal of helping health care clinicians and other interested professionals to understand the coming out experiences of gay and bisexual men so that they can foster open lines of communication beyond the coming out conversation. Although it may seem curious to pair coming out disclosures in both family and health care contexts, the interview data used for this study will establish how the discourses are linked.

One immediate relationship between the two discourses is that coming out experiences with family members and health care providers were the only two contexts listed by those who participated in the study where questions about sexual health came up. In both contexts, even if the recipient of the coming out disclosure meant well by introducing sexual health, many times their statements or questions were not well received. This study looks across both of those experiences to examine how they might be interlinked and how each informs the other. Even though many people have wonderful and accepting coming out experiences, coming out can still be nerve-racking (Adams, 2011; Manning, 2014). Those in coming out conversations—both the person disclosing sexual orientation and the receiver of the coming out disclosure—are often highly sensitive about the moment and might be at a loss about what to say, how to offer support, how to acknowledge their feelings, or about communication during the conversation in general (Manning, 2014). These anxieties can cause or allow for emotional health concerns (Manning, 2014). However, as this chapter demonstrates, there is a possibility for those who are coming out to especially feel dehumanized when topics of sexual health are introduced by the receiver to sexual health conversations.

To unpack these experiences, this study begins by presenting a constitutive, theoretically inclusive model of coming out. This model helps to explain how lesbian, gay, and bisexual (LGB) people come to understand their non-heterosexual identity, how they go about communicating that identity with others, and how notions of coming out are culturally engrained. Special care is taken to point to how all three levels of this model tie into emotional, and sometimes physical, health.
A CONSTITUTIVE MODEL OF COMING OUT

Rust (2003) defines coming out as “the process by which individuals come to recognize that they have romantic or sexual feelings toward members of their own gender, adopt lesbian or gay (or bisexual) identities, and then share these identities with others” (p. 227). Research about coming out has happened primarily in three contexts. First, sociopsychological studies have helped to explain a person’s cognitive understandings and emotions as they begin to realize and explore their nonheterosexual sexual identity. These studies include both a person’s psychological identity development as well as the understandings they have about what it means to be LGB. Next, cultural studies have explored how cultures and societies make sense and react to nonheterosexual identities and behaviors. These studies look at social constructions of sex and sexuality as well as what Baxter (2011) would call distal discourses, or larger cultural discourses that people draw from when they interact with others. Finally, and most recently, interactive studies have started examining how people communicate sexual identity. That includes both their performances, or how they say and do things; as well as proximal discourses, or the things they actually say to other people. All three areas have yielded rich and useful findings that help both explain coming out in many different academic disciplines and professional study areas and explore coming out from a variety of epistemological stances. These three strands of coming out research are combined here in a Constitutive Model of Coming Out (figure 3.1) that illustrates the interplay of their different dimensions as they come together into a collective whole.

The Cognitive Level

At the center of this model is the Cognitive Level of coming out. This level draws primarily from the sociopsychological research and particularly explores how LGB individuals cognitively make sense of their nonheterosexual identity as well as the psychological effects resulting from their acceptance or rejection of it. The research in this area began with Cass’s (1979, 1984) Homosexual Identity Formation Model (HIM). This model is widely cited and recognized. In fact, during the preparation of this chapter, twenty-three different guides, pamphlets, brochures, or websites were examined that offered information about coming out. They all pointed to HIM either explicitly or indirectly by listing its various stages. HIM not only serves as the germinal and most largely recognized model involved with the coming out process (Rust, 2003), but it has also been the driving force for research about coming out in virtually all social scientific disciplines (Rust). This psychological model
examines the mental stages a LGB person goes through as he or she develops his or her understanding of self in terms of sexual orientation: Identity Confusion, Identity Comparison, Identity Tolerance, Identity Acceptance, Identity Pride, and Identity Synthesis (Cass, 1979; see table 3.1). These various stages are described as “goals” individuals strive toward “to acquire an identity of ‘homosexual’ fully integrated within the individual’s overall concept of self” (Cass, 1979, p. 220). In other words, to find an adjusted sense of mental health, someone would need to go through all of the stages of the model.

As other researchers continued to explore coming out, they soon came to realize that HIM, although an excellent beginning model, was also entrenched in a rigid structure that did not necessarily allow for psychosocial differences in coming out experiences across cultures. An examination of some of the thought processes included in table 3.1 helps to illustrate this idea. Because of this, psychologists, sociologists, and sex scientists from other disciplines expanded on Cass’s findings to develop more nuanced understandings. Troiden’s (1988, 1989) research was the first notable extension of HIM, rejecting its linear stage by stage progression and arguing instead for a horizontal spiral where an individual could progress both up and down and back and forth across stages as she or he becomes more or less comfortable with certain elements of her or his own life and begins to accept or reject them. The model basically retains the essential elements of Cass’s model, with the spiral element reflecting the struggles in moving forward and backward in the process. Similar to the Troiden model, but removed from the Cass foundation,
Table 3.1. Cass’s (1979) Stages of Homosexual Identity Formation

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Representative Thought Process</th>
</tr>
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<tbody>
<tr>
<td>Identity Confusion</td>
<td>Person begins to realize he or she has a nonheterosexual identity</td>
<td>“I think I might be gay.”</td>
</tr>
<tr>
<td>Identity Comparison</td>
<td>Person begins to compare their sexual identity to his or her idea of heterosexuality</td>
<td>“It’s going to be harder for me to have kids if I decide that I want them. Or get married.”</td>
</tr>
<tr>
<td>Identity Tolerance</td>
<td>Person begins to present nonheterosexual identity to others</td>
<td>“I guess if I really am gay I should tell Andrea. She probably will be the most accepting.”</td>
</tr>
<tr>
<td>Identity Acceptance</td>
<td>Person is more open to sharing identity and will begin to interact with other nonheterosexual people more frequently</td>
<td>“You know, hanging out with gay guys is a lot more fun than I thought it would be. I should introduce Andrea to the group.”</td>
</tr>
<tr>
<td>Identity Pride</td>
<td>Person begins to enjoy, appreciate, or even celebrate nonheterosexual identity; a sense of “us versus them”</td>
<td>“Tomorrow is going to be so fun! My first gay bar! No dealing with boring straight people!”</td>
</tr>
<tr>
<td>Identity Synthesis</td>
<td>Person begins to see the commonality of their identity and the identities of others as part of an integrated romantic and sexual world</td>
<td>“I don’t think I ever want to get married, but I would like to be in a nice partnered relationship and maybe live in the burbs.”</td>
</tr>
</tbody>
</table>

is D’Augelli’s (1994) life span approach to sexual orientation identity development. This model emphasizes six developmental areas in sexual orientation that occur throughout life: exiting heterosexual identity, developing a personal gay identity status, developing a gay social identity, becoming a gay offspring, developing a gay intimacy status, and entering a gay community. Key to this model is the notion of “developmental plasticity” (p. 320), the way one must spontaneously respond to environmental factors or stimuli (D’Augelli, 1994). Also key is “interindividual differences” (p. 321) highlighting the distinctive developmental circumstances for an individual person based on sexual identity (D’Augelli, 1994).

As helpful as these models were for helping to identify and explore cognitive aspects of sexual identity, they also received criticism for their lack of cultural awareness and for retaining such a strong focus on the individual. Many
of the studies ignored racial and ethnic considerations of coming out (Chan, 1995; Gonzales & Espin, 1996; Greene, 1994; Loiacano, 1989), asserted a hegemonic whiteness (Rosario, Schrimshaw, Hunter, & Braun, 2006), or undermined bisexuality (Rust, 1996), thus suggesting a need for a diverse sample of research participants. Finally, critiques suggest that many cognitive coming out models are often flawed because they almost always place a single person into the core of the analysis, allowing culture, community, and especially communicative relationships to be ignored or minimized in developing coming out scholarship (Diamond, 2003; Peplau & Garnets, 2000). Research continues in the cognitive realm, however, and is being supplemented by a rich body of research exploring cultural and relational dimensions of coming out.

The Cultural Level

The outer edge of the constitutive model represents the Cultural Level of coming out. It engulfs both inner levels for two reasons. First, a culture will almost certainly have an impact on the relationships and individuals in it. Within a given culture, identities and relationships are defined, rewarded, controlled, limited, or otherwise negotiated. As such, a person’s cognitive and communicative abilities or understandings will be impacted by the cultures that surround and make intelligible what identities and relationships mean. Second, and in line with the first point, because cultures form the very notions of sexual identity, sexual orientation, coming out, or other related terms, and given that cultures are malleable and able to be changed, cultural understandings come into play with how a person’s identities and relationships are communicated and psychologically processed. In other words, and in drawing from notions of constitutive theorizing (Baxter, 2004; Manning, 2014), interaction constitutes or creates social worlds. Observing both these constructions and how they are being constructed, then, allows for very real understandings of things that are not always physically tangible. For example, a concept such as the closet is one that is not literal—it cannot be touched, smelled, tasted, or physically handled—but rather is one that exists because people interacting agree, on some level, that it exists. That does not mean that the closet does not have profound effects upon those who experience it. Rather, it suggests that social interaction is what creates a notion of the closet.

Many scholars have explored constructions of the closet, but the most recognized and cited of these articulations is Sedgwick’s (1990) epistemological interrogation of the closet. Published as the now-classic Epistemology of the Closet, the book, which is an exercise in literary criticism that analyzes texts from well-known writers such as Melville or Proust, especially focuses on how
binary oppositions of *homo* and *hetero* make sexuality much too simplified. As Sedgwick asserts, “Virtually any aspect of modern Western culture must be, not merely complete, but damaged in its central substance to the degree that it does not incorporate a critical analysis of modern homo/heterosexual definition” (1990, p. 1). In Sedgwick’s view, matters of sexuality are negotiable but culturally embedded, and as such what is closeted and uncedoted is negotiable as well. That is, if someone is to come out of the closet, what does that mean? Can one really uncedot all of their sexuality? Even if someone acknowledges a socially labeled sexual identity, what does that really tell about who they are as a sexual being? Sedgwick’s analysis also leads to questions about whether aspects of identity other than sexuality can be closeted. Those questions are certainly worthy of exploration.

Although Sedgwick’s work was largely grounded in literary criticism, it has inspired the research of many who explore coming out at the Cultural Level by using ethnographic or other qualitative approaches. For example, Adams (2011) drew from Sedgwick (1990) to describe ways, or *situational paradoxes*, that allow for confusion or frustration for nonheterosexual people. Most of these paradoxes put blame on the person coming out, whether that be for coming out too early or too soon, to one person before another, or even for being nervous about revealing sexual identity. In reflecting on these paradoxes, he notes that,

> Paradox occurs when a person with same-sex attraction is held accountable—by self and others—for taking a wrong course of action, making the wrong move; there are consequences for a person who comes out or does not, who comes out too soon or not soon enough, who completes the coming-out process or finds completion impossible, or who comes out most of the time, some of the time, or never at all (Adams, 2011, p. 112).

As Adams’s work demonstrates, work at the Cultural Level helps to make evident how cultures situate people and identities. Other scholars who have explored how coming out is facilitated or informed by culture include Bacon (1998) who enacted a language-oriented study of coming out, later extended by Tawake (2006), that positions coming out narratives as a cultural form of rhetoric aimed toward a queer movement of liberation.

As that all implies, the Cultural Level also includes the political implications associated with coming out and LGB identity in general. Observations made at the Cultural Level point to some of the ways that sexuality can be constructed in contemporary culture. Unlike the Cognitive Level, where findings are based more on an individual’s psychological response, the Cultural Level tends to explore how meaning circulates throughout a culture. That means media representations, public law and policy, organizational rules, and
any other intelligible aspect of a culture will play into individuals' and societies' understandings of coming out. These understandings are often negotiated with other members of a culture at the Relational Level.

The Relational Level

Recently, scholars have begun to explore the interpersonal disclosures that occur as part of coming out. Coming out, in the communicative sense, is not isolated from the individuals who are sharing or receiving coming out disclosures; nor are they separated from the cultures that inform, surround, and otherwise make intelligible what it means to come out. As such, the Relational Level is nestled between the cultural and cognitive levels of the model. The Relational Level focuses on coming out as it occurs in interpersonal relationships. Specifically, it explores proximal discourses, or the things people say directly to each other as they relate to coming out. Those proximal discourses will draw from distal discourses, or the elements of culture that allow a coming out disclosure to be understood. So, for instance, if someone says, “I’m gay,” that proximal disclosure ties into a larger, distal idea of “coming out.” Depending on an individual’s experiences and ideas about coming out, he or she will respond with another proximal utterance that draws from a distal discourse. That could be, “You know it’s an abomination” (drawing from a distal discourse of religion), “God made you perfectly, and if that’s gay then so be it” (drawing from a different distal discourse of religion), “But you don’t act gay!” (drawing from a distal discourse that suggests LGB people behave a particular way), or, as was common for the participants of this study, “Are you being careful sexually?” (drawing from a distal discourse that gay or bisexual men are at risk to contract sexually transmitted diseases or infections). These notions of proximal and distal discourses are developed from a line of theorizing that communication theorist Leslie A. Baxter refers to as the second iteration of Relational Dialectical Theory (Baxter, 2011).

Many of the studies at the Relational Level came later than studies explored in the Cognitive or Cultural Levels, as they were often in response to critiques of those two areas that assumed how communication would occur between people based on psychological or cultural indicators. Plummer (1995) was among the first to interrogate those assumptions, exploring how people tell their sexual stories, including stories of coming out. Later, scholars explored coming out as a performative act that has implications for both the speaker and hearer (e.g., Chirrey, 2003; Speer & Potter, 2000). These studies, situated in the Cultural Level, began to point to the importance of exploring coming out interactions. On the Cognitive front, studies
began to explore the impacts of coming out on an individual level as they related to others. These include studies exploring psychological processes leading to decisions to disclose sexual orientation (e.g., Franke & Leary, 1991; Griffith & Hebl, 2002); the consequences or effects of such a disclosure with family members (e.g., Cramer & Roach, 1988; Schope, 2002); or effects of coming out in the workplace (King, Reilly, & Hebl, 2008; Russ, Simonds, & Hunt, 2002).

A different, but related, body of relational coming out research has focused more on coming out conversations and the types of interaction that occurs when a person reveals his or her sexual identity to another. For example, narratives of coming out conversations were used to develop a typology of six salient and nonexclusive ways (meaning a single conversation could fall into multiple conversation types) coming out conversations tend to occur: as pre-planned, emergent, coaxed, forced, romantic, or educational/activist (Manning, in press; see table 3.2).

Regardless of conversation type, and as one might expect, coming out conversations tend to follow a particular format (Manning, 2006). They usually begin with an introduction, prefacing that an important, perhaps life-changing conversation, is taking place. Introductions can be quite short ("Mom, do you have a minute? There's something we need to talk about."), but they can also be longer and involve a story or narrative to introduce the idea that the conversation will be about sexual orientation. The introduction can also be from the receiver of the coming out disclosure, as he or she might hint or even forcefully demand that someone should come out (as is demonstrated in the typology). In professional situations, such as a conversation with a healthcare provider, it is quite possible that an introduction as presented in this trajectory will not exist.

For most conversations, however, after the introduction a disclosure is made. These are often direct ("I'm gay.") but they can also be indirect or ambiguous ("And so I think now, I might start dating other women."). That leads to the reaction period, where questions or comments about the disclosure are discussed (and that the data about families presented in this study largely explores). Finally, closing statements are made that usually contain some sort of indication as to where the parties stand, where the relationship might be going, and that often include particularly memorable messages for both the person disclosing and the receiver. These four elements of a coming out conversation (the introduction, disclosure, reaction, and close) are not normative in the sense that they suggest what should happen in a conversation, but rather offer a trajectory of what one might expect if they are involved with a discursive coming out experience.
<table>
<thead>
<tr>
<th>Conversation Type</th>
<th>Defined</th>
<th>Representative Dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-planned</td>
<td>An LGB person decides he or she is going to come out to another in advance and prepares accordingly</td>
<td>Arturo: Mom, the reason I invited you here to have dinner tonight is because there is something I want to share with you.</td>
</tr>
<tr>
<td>Emergent</td>
<td>An LGB person sees an opportunity to introduce her or his sexual and romantic identity into conversation and takes it</td>
<td>Abuela: I just saw on the news what is happening in Russia with gay and lesbian people. It is disgusting to see people being treated so poorly! We are all God’s people. Arturo: You know, Abuela, I’m glad to hear you say that. There’s something I’ve been meaning to share with you for a while now, but I wasn’t sure how to bring it up.</td>
</tr>
<tr>
<td>Coaxed</td>
<td>An LGB person is encouraged to share his or her sexual and romantic identity</td>
<td>Juan: You know, brother, there is nothing you cannot tell me. Arturo: I know that, Juan. Juan: I want us to be close, and that means sharing everything about our lives—including who we love.</td>
</tr>
<tr>
<td>Forced</td>
<td>A person demands that an LGB person share her or his sexual identity</td>
<td>Lucy: You keep telling me you aren’t interested in dating right now, but I know what’s up. Tell me, Arturo, or I’ll tell everyone and shame you in front of our whole high school!</td>
</tr>
<tr>
<td>Romantic</td>
<td>An LGB person comes out through romantic or sexual advances</td>
<td>Miguel: Oh, I’ve had too much to drink tonight, my friend. Arturo: Me too. Maybe that’s why I’ve got the courage to finally tell you how I feel about you after all of these years.</td>
</tr>
<tr>
<td>Educational/Activist</td>
<td>An LGB person comes out, usually to an audience of people, as a means of educating or encouraging others</td>
<td>Arturo: I thank you all for inviting me to speak to your group today. Before I begin, however, I believe it is important that you know my perspective is one that is informed by my sexual identity.</td>
</tr>
</tbody>
</table>
EXTENDING THE RELATIONAL LEVEL: FAMILIES AND HEALTH CARE PROVIDERS

The study presented in this chapter is situated in the Relational Level and moves toward ideas of what might ought to happen in order to create open, affirming coming out conversations. It extends existing work about coming out conversations (Manning, 2006, 2014, in press) to explore how interactions are occurring between gay and bisexual men and their families as well as between them and their health care providers in coming out conversations where topics of sexual health are introduced. Specifically, it expands on a finding noted by Manning (2014) regarding a theme found in the initial coding of his data, "frustration with concerns about sexual health," that saturated for men but not for women. That men articulated this experience in their narratives of coming out conversations, whereas women did not, was notable in and of itself. However, it also points to an underexplored area of health communication research regarding gay or bisexual men and health care providers. Studies of lesbian interaction with medical professionals abound, mostly from the 1990s. Eliason and Schope (2001) suggest that this attention paid to lesbian health issues might be because many studies about gay male health were directed toward HIV/AIDS treatment and practices; therefore, the body of research exploring lesbian health care needs served as a way of supplementing the large amount of attention paid to gay and bisexual men. Additionally, because so much research about men who have sex with men was aimed at HIV/AIDS prevention, other avenues of inquiry were not explored.

Many concerns shared by lesbian participants in those studies add to the context of this study. For example, lesbian women often complain that they receive counseling or education about inappropriate or unnecessary issues such as reproductive health (Lehmann, Lehmann, & Kelly, 1998). That mirrors data in this study that shows many times gay men felt the counseling or advice they received was unneeded or unwarranted. The education lesbian participants reported might have been a result of heteronormative assumption, where a physician or other health care provider assumed the female patient as heterosexual (Lehmann, Lehmann, & Kelly, 1998). As that suggests, many health care providers do not inquire about sexual orientation, and lesbian women report that they do not come out on their own, either. In one study, 60 percent of the women surveyed were out to their parents, but only 31 percent were out to their physician (Lehmann, Lehmann, & Kelly, 1998). Hitchcock and Wilson (1992) found evidence that when lesbians do come out, it is often only after trust is established with a health care provider, and that can be long into the relationship. Lesbian women in rural communities might especially feel apprehension, as many report they are concerned that their sexual identity
could be leaked by a health care provider and so they are reluctant to share it (Tiemann, Kennedy, & Haga, 1998). These findings are in harmony with the data collected and analyzed for this study, and they add context to the larger picture of LGB sexual health.

METHODS

The data used in this manuscript come from a larger qualitative research study exploring coming out narratives provided by 182 gay, lesbian, and bisexual participants. Thirty participants were individually asked to share the stories of their most recent and a most memorable coming out experiences in an interview session. After each narrative was provided, participants were asked to consider both the positive and negative communicative elements. An additional 130 participants also provided two coming out narratives through an open-ended online survey, again identifying positive and negative communicative elements of those experiences. Finally, in response to mentions of sexual health in the original data, twenty-two additional gay and bisexual men were recruited and interviewed to talk about coming out experiences with physicians.

Participants for the study were located through snowball sampling (Manning & Kunkel, 2014), beginning with seven online groups centered around discussion of LGB issues. Fifteen men and fifteen women provided the interviews. Of the 130 participants responding to the survey, sixty-two identified as men, sixty-seven as women, and four of the participants also identified as transgender. One person refused to identify in terms of sex. Those being interviewed about their health care experiences were all biologically male and identified as men, with eighteen identifying as gay and four identifying as bisexual. The participants ranged in age from eighteen to seventy-two years old, with a mean age of 31.4 years. The participants were racially and ethnically diverse, with white, non-Hispanic participants only making up 65 percent of the sample.

For the purposes of this study, only interviews and surveys with more than a passing mention of sexual health were included; and then only those for participants who identified as men. That led to data from thirty-five diverse participants and featuring seventy coming out narratives. Ultimately, initial interview transcripts, completed surveys, and follow-up interview transcripts allowed for three forms of data that could be analyzed using a multiadic approach (Manning, 2013). This multiadic approach allowed participants both the freedom to tell their often unheard stories (Manning, 2010) while simultaneously serving as a triangulated form of data collection to ensure valid results (Manning & Kunkel, 2014).
Data Analysis

The multiadic data set was initially explored using a standard thematic analysis approach (Braun & Clarke, 2006). After initial themes were developed and considered, two additional forms of analysis were enacted. First, a modified version of Spradley’s (1979) semantic coding was applied, specifically Manning and Kunkel’s (2014) approach to taxonomic development. The goal of this taxonomic development is to create categories that describe specific types of or possibilities for communication. For this study, that meant a list of salient possibilities or ways sexual health was introduced in coming out conversations. Second, to draw comparisons and contrasts across the two cases (family contexts and health care contexts) and to explore for contradictions within each of the two cases, Baxter’s (2011) contrapuntal analysis was applied. Contrapuntal analysis is intimately tied to Relational Dialectical Theory and involves examining themes or discourses and examining where they compete, contradict, or otherwise come into tension. Attention was especially paid to where family, health care, and invoked distal/cultural discourses came into interplay. That is, even though families and health institutions will certainly add to ideas of what it means to come out as well as what it means to be LGB, they are only but two systems of discourse that play into a larger social discourse of what it means to come out. Yet, at the same time, the focus of this study also allows for discourses in each of the domains, families and health care, to be considered in comparison to and as they might help to build each other. How this analysis functions will become more apparent as results and data exemplars are presented and explained.

RESULTS

The results of the analysis are presented here in each contextual domain, beginning with family coming out experiences and then moving into health care domains.

Families Expressing Concerns about Sexual Health

The taxonomic coding allowed for the development of a typology showing three ways sexual health was introduced in coming out conversations with family members: most often as an added thought, which was viewed as caring; sometimes as a central concern, which was viewed as negative; and, for a couple of participants, as an irrational sidebar, which was viewed as negative and hopeless.
Sexual health as added thought. In many cases, family members introduced sexual health as an added thought during the conversation, often toward the end. As one man shared about his sister, “She then told me, ‘I have to say it, I know you are probably safe but be careful. It can be a dangerous sexual world out there.’” He later acknowledged, “I know she told me to do that because she cared. It represented the love she felt for me and that she wanted the best for my life.” Another gay man shared, “After it was done, they hugged me and my dad joked, ‘I don’t know how to give you the same sex talk for this, but you do know to be safe right?’” When asked about this interaction in a member check interview, the participant shared, “The way he did it was kind of nice. It kind of said, ‘I don’t know if I get what it means to be gay, but I’m trying.’ And introduced in that context, it was a nice way to let me know that he still had my best interests at heart.” As these examples demonstrate, mentioning sexual health as a side thought in the overall coming out conversation was often not seen as a negative thing. On the contrary, participants indicated that it showed positive concern.

A notable exception to this positivity was mentioned by two participants who said a parent mentioned HIV/AIDS by name. In one case, the participant was upset because his mother mentioned that she would always have to be concerned about HIV and AIDS. As he shares,

It was all fine, pretty boring actually, and then out of nowhere, toward the end, she goes, “And now I have to worry about whether or not you’re going to get AIDS, but I’ll get over it.” I kind of stopped, but my back was turned to her so I don’t know if she noticed or not. But then I just went up the stairs and to my room and I cried. Out of all of it, that hurt the most... She was saying I was a burden. That now I was just something scary to her that she had to think about. And like she wanted to say more, but was resisting, and just had to get that in.

Another participant shared a story about his father, writing, “At the end my mom asked my dad if he had anything to say. And he goes, ‘You know most gay men get AIDS. I expect you to not be one of them.’ It was cold and monotone. I almost wish he would have said nothing at all.” In this instance, the participant was coming out to his mother and father together, and although his mother talked quite a bit, his father was silent except for that utterance.

Sexual health as central concern. For many family members, mostly parents, sexual health was mentioned as a central concern in coming out conversations. As one man described in telling about coming out to his parents, “My mother didn’t say anything for about five minutes. She just cried. My dad sat there looking down. Then when my mom finally talked, she said,
'now I’m scared. You know, most gay men get AIDS. I don’t want that for you.”' Later in his narrative, the participant expressed how his mother’s worry seemed genuine but created a situation where he felt he needed to take care of her and make sure that she was OK in the interaction. He also regretted that “virtually the whole thing was about AIDS and sex.” Although most of the parents described their parents as heartbroken or even angry about the possibility of the contraction of AIDS or other diseases, some mentioned that things were stated more matter-of-factly. As one participant wrote, “She said she knew already, then she gave me a lecture on safe sex.” When asked about the lecture in a follow-up interview, the participant noted, “I guess the more I think about it all, the more it is funny to me. Coming out is more than about being sexual, but that is what people think about. So I think that is why she decided then was the time to give me ‘the talk.’ And that was about all the conversation was.”

Despite the matter-of-fact nature of the talk, this participant still, like all of the participants who mentioned these experiences, saw the discussion of sexual health as negative. As he shared, “I know it was an easy thing for her to jump to and discuss, because she follows all of the safe sex and other health stuff. But I was hoping for more emotional stuff and questions about how happy I am. We’re talking about my love life, not just my sex life.” Other participants agreed. “I didn’t come out to my dad just to hear him lecture me on AIDS for an hour,” one gay man said. A bisexual man shared, “Every time I thought we would move on to another topic, they kept going back to how dangerous gay sex was and how I had to be careful.” Another gay man said that he came out to both of his parents separately and received a similar response both times: “I was worried about hearing about religion. Instead I got a lecture on gay sex. It made me wish I never told them.” As these exemplars demonstrate, topics of sexual health dominating coming out conversations were not appreciated.

**Sexual health as irrational sidebar.** Though it was rare, some mentioned that—especially in the case of a coming out conversation where disclosure was not well received—a parent or sibling brought up sexual health in an aggressive or highly dramatic way. As one participant shared in his narrative,

She said she was going to be supportive, and she said that we should keep it from my dad for now. Then I went to hug her, and she held her hand up, and I said “I thought you were going to be supportive.” She started saying, “I think we should go and have you tested.” I told her that I was not sexually active and I did not even have a boyfriend and everything I told her she kept repeating, “I think we should go and have you tested.” Then she started crying and yelling things about AIDS and gay men not controlling their sex and that I needed to get in the habit now. Then she
said it was not me being gay that was bad but the “gay lifestyle” was and that she had to protect me from it.

This participant’s written narrative demonstrates how some recipients of coming out disclosures mention two aspects of a person: his or her nonheterosexual identity, and then some aspect of who the person truly is. That consideration is important to considering the tensions between loving and stereotyping expressed by participants.

**Contradicting discourses in families: loving versus stereotyping.** In the case of gay and bisexual men, constructions of nonheterosexual identity frequently include ideas of promiscuity that are almost always framed as a health risk, or the listing of health risks, especially HIV or AIDS, that are mentioned without any explicit link to promiscuity, but where participants felt it was implied. In fact, during interviews many of the men made it clear that their parents tried to not point at them as being promiscuous, but rather as gay men in general. As one man stated, “She [my mother] said it wasn’t me she was worried about, but you never knew about other gay men.” Another shared, “My sister said that there were lots of sickos who were gay because their family didn’t accept it, and so they did dangerous things, and that I had to be careful.” At the same time, participants rejected this pathologizing of other gay men and saw it as more of a reflection of who they are. As one man shared, “OK, so you can say all you want that it’s not what I do that worries you, but if you’re afraid I’m going to get AIDS, then yeah, you are worried that I’m like the other guys. Because you’ve already said that’s why they get it.” As another participant succinctly put it, “Basically, they [my family] see me as a stereotype. They didn’t put it that way, but when half of what they’re saying is about sleeping around and catching diseases, then that’s how they’re seeing me then.”

This frustration played into a commonly expressed tension for the gay and bisexual men of being seen as the family member they love and being seen as a stereotype by their family members. The push and pull of that experience was important in their narratives and their overall evaluation of the coming out conversation. When sexual health was brought up as an added thought in coming out conversations, the men reported that it showed caring and concern. When it became the main topic of the conversation or used as an attack point, that made them feel more like they were not being viewed as a person but more as a stereotypical gay man. It is important to note that those who said it was brought up in the coming out conversation stated that it continued to come up in future conversations about their sexual identity. “My mom doesn’t like to talk about it at all,” one man shared, “but when
she does, it is always about me making sure to be safe and to avoid men on the Internet.” He and other men frequently expressed that this made them feel as if being gay were only about sexual aspects and not romantic aspects of the identity. “Not once have they asked me about dating or a boyfriend,” a participant said. “Instead, it is always about being safe. Little do they know I’m more likely to have a broken heart than an STD with how my love life goes.”

Health Care Providers Expressing Concerns about Sexual Health

The taxonomic analysis reviewed three ways sexual health was introduced in conversations with health care providers: as a routine question, which was usually reviewed as positive; as an act of suspicion, which was reviewed as negative; and as a nerve-racking experience, which was viewed as negative and incompetent. Negative case analysis is also provided for the health care provider taxonomy, as two participants explained they did not reveal their sexual orientation to a health care provider. One participant explained he was afraid his health care provider would tell his parents; and the other because he felt it was none of his health care provider’s business.

Sexual health as routine question. In interviewing the participants for this study, all but two said they came out to a physician during a routine question, or, in some cases, when the physician asked a heteronormative question and they felt as if they did not want to lead the physician down a wrong path. When it was mentioned in a routine or matter-of-fact way, this made patients feel better. “My doctor asked me if I was sexually active, and I said yes,” one participant shared. “And then he asked me if there was anything he should know about my sex life or if I had any questions, and I said, ‘Well, I’m gay.’ And he goes, ‘Thanks for telling me. Anything else?’ and then that was that.” When asked why that made him feel comfortable, he responded, “Because he was cool about it. So I thought, well, if I ever have any issues I don’t think he’ll be judgmental or grossed out.”

Similar stories involved correcting a doctor when he or she mistakenly identified the participant as heterosexual. “My doctor goes, ‘So you do you have a girlfriend?’ when she was asking me all the medical questions, and I go, ‘No, but I have a boyfriend.’ And she just smiled and joked about putting her foot in her mouth. I told her not to worry about it.” When asked why that situation made him comfortable, he responded, “Because she admitted right up front it was insensitive, what she did, but she didn’t make a big deal out of it.” Unfortunately, quite a few participants shared experiences where a “big deal” was made.
Sexual health as act of suspicion. When asked about his most recent coming out experience, a participant shared a written narrative that included the following:

The most recent experience I had coming out to someone was my doctor. He has been the family doctor for a long time, so he has basically seen me grow into the man I am today. When I went to see him, I was already embarrassed because of the reason I was there. I know now that what I had was a hemorrhoid, and that my father who has never had sex with a man started getting them in his twenties. I had anal sex where I received it for the first time just a week before I got one, so I didn’t know what was wrong and thought it was because of that. My boyfriend told me it wasn’t because he had let me give it to him many times and it never happened to him. I thought I should check to make sure. When I told the doctor this story, all he did was lecture me about how dangerous gay sex is and making sure I had condoms and telling me that it really was not a good practice. Then he told me that I should reconsider my activities before I get in some real trouble. I was embarrassed and humiliated and I have not gone back to the doctor since. To tell you the truth I believe he probably doesn’t care.

The narrative speaks for itself in terms of why the participant saw the interaction as a negative one. The suspicious reaction of the physician created a situation where open communication could not continue and the doctor-patient relationship was terminated. When asked about how this situation might have impacted other relationships, he shared:

The next doctor I went to, I was scared to tell her. And I made sure it was a woman, because I thought she might be more open minded. But I told her and told her about the problem and she told me it may be that the sex helped it along, but that most people don’t get a hemorrhoid from having anal sex. I never got that with my family’s doctor because all he was worried about was me getting worse things than a hemorrhoid.

In interviewing participants for this portion of the study, many other stories of suspicion were shared. Some said their doctors seemed suspicious of whether or not they were telling the truth about their sexual activity. As one interview exchange progressed:

**Participant:** He looked at me and goes, “You really only had three partners? Ever?” Now what man do you know to lie about sex?

**Jimmie:** Well—

**Participant:** Scratch that. That’s the problem. Straight men can have all the sex they want, and it’s great. Gay men do it, and we’re whores.
Jimmie: So do you think that’s how the doctor saw you?

Participant: As a whore?

Jimmie: Well, yeah.

Participant: No doubt. Every time I go to him, he reminds me of my sexual health and asks me if I need condoms. Bitch didn’t do that once when he thought I was straight.

Similar stories were shared where the physician would suggest an HIV/AIDS test, or in other cases, as one participant called it, “a full battery of STD tests.” One participant complained because his doctor kept insisting that he was bottoming during sex. “I don’t even bottom, but he kept telling me that it was OK because he knew gay men do that. They do, but I haven’t.”

Sexual health as a nerve-racking experience. A third approach mentioned by participants involved physicians acting nervous. “He was literally shaking, like the clipboard was moving,” one participant shared. “When I told him that I was gay, he stopped asking all the sex questions he used to ask at my annual physical,” said another participant. “He just looks at the questions, and then kind of pauses, and then moves on.” Some participants shared that their physicians tried to engage conversation about sex, but that it was awkward. As one interviewee narrated:

So I go, “No, no. You should know I’m gay.” And he goes, “Oh. OK. Well, that’s a perfectly acceptable answer. Congrats on that!” And I thought in my head, “Did he just congratulate me for being gay?” And it must’ve shown on my face because then he goes, “Sorry. I guess that’s kind of a strange response. I was just trying to be affirming.” But the way he said it, it was almost like a robot. I mean, it was nice and all. He was really trying. But it was so... awkward. Especially because I was half naked.

Concerns about stigma and privacy. As mentioned, two participants in the interview sessions mentioned they did not come out to their physicians. One participant said it was because of his concerns that his physician would stigmatize his sexual identity:

Participant: He doesn’t seem like the kind of man who wants to hear that his patient is gay.

Jimmie: Tell me about that.

Participant: I think, uh, it is a lot of how he acts.

Jimmie: Mnhm.

Participant: And, when you go to his office, it is decorated with crosses and other religious stuff. And, uh, the magazines, they all are religious,
too. So I don’t really get the feeling, or it doesn’t seem like he would be comfortable hearing it.

**Jimmie:** So the way the office is decorated is part of what deters you?

**Participant:** Yeah. There’s Bible verses and everything.

As can be seen from the participant’s description, he avoids coming out to his health care provider because he is nervous that religious dogma might prevent that provider from being accepting. In his explanation, he draws from a common cultural discourse that those who display their Christianity in public ways are likely to reject nonheterosexual people.

The other participant saw it as none of his physician’s business. “Sex is private,” he said, “and unless I have a disease or need help, then he doesn’t need to know.” When asked about sexual health needs, he responded that he was safe and so he was not in need of a physician’s care. “In college every semester in the pride alliance they gave us a safe sex talk,” he said. When asked how he responds to questions about sex from his physician, he replied, “Like I said, doctors don’t really need to know about your sex life unless something is wrong. And that will not apply to me. When they ask those questions, I refuse to answer.”

**Contradicting discourses in health care conversations: individuality versus deviancy.** Using contrapuntal analysis to examine conflicting themes revealed that many times those coming out to health care providers experienced a tension between discourses of their individual identities as people and their deviancy as connected to minoritized sexual identity. Easily the most dominant theme that illustrates this discursive tension involved health care provider suspicion of the possibility of committed and monogamous relationships. Participant narratives such as this one were not uncommon:

I told him no, I was gay. After that he asked me if I was sexually active. I said yes. He asked me if I was safe. I told him yes. He asked me what that meant, and I told him that me and my partner after being together for two years had been tested three times in a year’s time and were negative, and so we stopped using condoms. Well, that was the end of it. He would not hear of it. He told me that gay men could never have that “luxury” and that we had to be extra careful. I told him I trusted my partner, and he said something along the lines of “well, I hope you trust him with your life.” I was offended. I know me and my partner are remaining faithful.

As the close of that excerpt reflects, the cultural stereotype of promiscuous gay men is in tension with the identity of the couple.
Even for those participants who were not partnered were frustrated by the messages regarding monogamy they received. “My doctor asked me if I was sexually active, and I said yes,” one man shared as part of his coming out conversation narrative. “Then he asked me how many partners I had in the last year. I told him one. He goes, ‘Are you sure?’ I said yes. And he goes, ‘You know what you tell me is confidential.’ I was angry.” Once again, a tension between socially constructed gay behavior comes into conflict with the provider-patient relationship. Some participants speculated this kind of behavior could result from doctors not actually knowing any gay men. As one especially frustrated participant shared:

He started asking me about my sex life, whether I had done it and all that. I told him, yes, yes, I have. And then he started talking about anal sex like he was reading it out of a dictionary or something, only a really boring dictionary that uses lots of words. I finally stopped him and said, “Yes, I know what it is. I’ve done it plenty of times.” He then started telling me how tender the ass tissue is, only in doctor words, and I was looking at him the whole time thinking, “Has this guy ever talked to a gay guy before?” I feel sorry for the kid who just came out of the closet who has to listen to this guy. He doesn’t know shit about anal sex!

This participant, like many others, suspected that his health care provider did not know gay men, but, as he framed it, “Kind of a medical diagram of what a gay man is supposed to be. Which doesn’t get at half the story.”

Just as with the family interviews, participants also reported frustration with being asked about being tested for HIV by their health care providers. “It is insulting that they would do that,” one participant shared. “It’s like they assume every gay men is doing something that means he should be tested.” Another participant was frustrated that questions about HIV testing were asked even after his physician had screened for other risky behaviors. As he shared, “He went down a list, asking me if I had sex, with who, if I’m being safe. And then after all of that he still asked me if I wanted an HIV test. I told him I didn’t need one, but he told me he thought it would be OK. I have a strong suspicion he only did that because I’m gay.”

Connecting Discourses: Distal Stereotypes in Proximal Context

At first glance, it might appear that there is no relation between the two typologies of how sexual health is introduced in coming out conversations with family members or health care professionals. On one hand, and as alluded to at the beginning of the essay, family relationships are often highly personal, and
the communication that happens within families, as well as the cultural communication that constitutes notions of what families are, is steeped in rituals, rules, and emotional expectations (Caughlin, Koerner, Schrodt, & Fitzpatrick, 2011). On the other hand, communication with health care providers is often constructed—sometimes fairly and sometimes unfairly—as being rather anonymous and even depersonalized. In some ways, this makes sense as the relationships between patients and providers are often limited both by interpersonal time available to develop a relationship (Rotter & Hall, 2006) as well as the implicit rules of privacy that tend to govern patient-provider interaction (Petronio & Sargent, 2011). Although this can be problematic in many contexts beyond LGB care, as Stevens (1995) implies it is particularly problematic in situations such as patient-provider interaction with LGB individuals who find themselves immersed in a history of both distal and proximal discourses steeped in assuming, stigmatizing, or insensitive interaction. As the data reflect, however, these same negative and dehumanizing aspects of cultural constructions of same sex attraction can still be invoked in coming out conversations with family members—family members who have had the time and interaction to better know the person coming out.

Moreover, participants articulated connections between the conversations happening with health care providers and conversations happening with family members; this illustrates how these discourses act not in isolation but in an interplay with each other. As one man explained, “After I came out to my doctor, and he seemed nervous about it, I decided not to come out to my family. If he could not handle it, I expect that they could not handle it either.” Another was worried about privacy. “I still haven’t come out to my parents, but I hope I will some day. But that means not coming out to my doctor, because if he told them that would be a huge mess.” Other men talked directly about how one conversation influenced another. As one man said, “Coming out to my doctor made it easier to come out to my parents. I was now armed with facts I could use if they had concerns.” Another shared, “After my parents accepted me, I was empowered. It made coming out to my doctor who goes to our church and is very religious a lot easier. Who cares what he thought?” Still, others reported that even with accepting parents they were afraid to come out to a health care provider, just as those who had an affirming experience with a health care provider reported they did not come out to one or more parents.

This notion that coming out experiences with health care providers plays into coming out experiences with family members and vice versa can be related to knowing or not knowing the individual who will receive the disclosure. For example, if two parents continuously talked about “the disgusting
and perverted social illness of homosexuality,” that proximal discourse might make it to where their child refuses to come out. This study’s data also help present the idea that there are also what I call discursive specters, or experiences that come with one discourse or interaction that encourage or discourage a person from engaging it in another time and place. For instance, the participant who said his doctor rejected him decided not to come out to his parents because, as he noted, if his “educated” health care professional who “knows the research on a deeper level” was rejecting him, he could not expect his parents to be accepting. Based on his interaction with this father, he was enacting segmentation (Baxter, 2011), or the purposeful avoidance of a discursive interaction because one knows that introducing a particular discourse—in this case same-sex attraction—could lead to conflict.

Yet those who received affirmation and affection often reported the situation as empowering, and that in later conversations where the reception was not so well-received the remnants of those past acceptances lingered and allowed the situation to be less stressful. That is, the discursive specter of where the discourse had successfully been previously remained in a future conversation. Those in coming out conversations should consider how their interaction is not but one conversation but rather another link in an on-going chain of discourse—and how that link in the discourse is negotiated can have an effect on future links. Moreover, if one is trying to be caring and conscientious in a coming out situation, the person coming out might not be ready to receive this love and support because a negative discursive specter is at play from earlier in the discursive chain. Given the tensions that can arise when sexual health is introduced to coming out conversations, it is important to consider how to talk about sexual health in ways where segmentation can be avoided and positive discursive specters constructed.

DISCUSSION

This study presents some strong considerations for how those who might receive a coming out disclosure should respond. Given the openness of many cultures that continue to decline in homophobia (Manning, 2009; Kaufman & Johnson, 2004), it is hard to imagine that most people will not have someone come out to them during their lifetimes. The data explored here through a lens of constitutive pragmatism, or the blending of various research findings across paradigm and tradition, offer some insights. Such an approach allows for the current findings to be considered practically as they are situated in a larger
body of research. That allows some of the silos that often accompany research about sex, gender, and sexuality (see Manning, Vlasis, Durr, Emerson, Shandy, & De Paz, 2008) to be softened so that research from different disciplines can be used together for practical application.

**Families.** As the data presented in this study reflect, family members should not be afraid to acknowledge a need for safe sex, but they also should not dwell on the topic. The responses of some family members discussed in this study—such as the mother who was afraid to hug her son after he came out to her—demonstrate that fear is still a possibility and education about sexual health is still in order on a large scale. Moreover, a family member exhibiting care and creating a space of openness is ideal. Even if the person receiving a disclosure feels as if their love and care for the LGB person is evident, that same vulnerable person coming out might not see things in the same light. Hearing explicit affirmation can be helpful. Family members interested in creating an open and affirming environment for those coming out to them should consider Manning’s (2014) research exploring positive and negative communicative behaviors in coming out conversations (see tables 3.3 and 3.4).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Defined</th>
<th>Representative Dialogue or Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Communication Channels</td>
<td>The receiver of a coming out disclosure invites future discussion about the revealer’s sexual and romantic identity</td>
<td>“And, so you know, any time you want to talk about this aspect of your life I am open to hearing about it!”</td>
</tr>
<tr>
<td>Affirming Direct Relational Statements</td>
<td>The receiver of a coming out disclosure directly and explicitly expresses value of the person and their relationship</td>
<td>“Mikey, I’m just happy you told me, I love you and I am so proud to be your mother!”</td>
</tr>
<tr>
<td>Laughter and Joking</td>
<td>The receiver of a coming out disclosure uses gentle humor to show acceptance</td>
<td>“Damn, Maria. You’re so hot, you make me want to be a lesbian, too! Seriously, though, congrats, and thanks for telling me!”</td>
</tr>
<tr>
<td>Nonverbal Immediacy</td>
<td>The receiver of a coming out disclosure uses appropriate touch as a means of showing affection</td>
<td>Hugs, taking a hand while talking, rubbing a shoulder or arm while talking</td>
</tr>
</tbody>
</table>
### Table 3.4. Negative Communicative Behaviors in Coming Out Conversations (Manning, 2014)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Defined</th>
<th>Representative Dialogue or Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressing Denial</td>
<td>The receiver of a coming out disclosure asks about or insists that the LGB person is confused about her or his identity</td>
<td>“You’re not a lesbian. That new girl you’re hanging out with has just convinced you that you are!”</td>
</tr>
<tr>
<td>Religious Talk</td>
<td>The receiver of a coming out disclosure invokes religion as a critique of identity</td>
<td>“It just goes against the Bible.”</td>
</tr>
<tr>
<td>Inappropriate</td>
<td>The receiver of a coming out disclosure asks questions, makes comments, or expresses concerns that violate privacy expectations</td>
<td>“So, I just need to know, how do two girls do it? It doesn’t even make sense since, you know, there’s nothing to stick in.”</td>
</tr>
<tr>
<td>Questions, Comments,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shaming Statements</td>
<td>The receiver of a coming out disclosure directly admonishes judgment toward the LGB person</td>
<td>“Well, I’m sorry, but that gay stuff is just disgusting.”</td>
</tr>
<tr>
<td>Aggression</td>
<td>The receiver of a coming out disclosure displays physical or verbal behaviors that are intimidating or hostile</td>
<td>“I’m going to kick the shit out of you, you disgusting faggot!”</td>
</tr>
</tbody>
</table>

As those suggestions indicate, it is not only important for the receiver of a coming out disclosure to be mindful about the situation, but the person disclosing can also take steps to better prepare him or herself for what might happen in such conversations.

**Health care interaction.** The findings of this study also allow considerations for health care providers. First, they should be sensitive when bringing up HIV tests or other HIV/AIDS-related topics. As the data reflect, gay and bisexual men were insulted and felt discriminated against when physicians suggested they should be tested for HIV. Physicians and other health care professionals might find themselves frustrated by the participants’ interpretation of an invitation for an HIV test to be discriminatory, as the U.S. Preventitive Services Task Force recommendation statement suggests that clinicians screen everyone for HIV infection, and not only men who sleep with men, who is aged fifteen to sixty-five (Moyer, 2013). As that indicates, the discrimination perceived by gay and bisexual men could very well be nonexistent—but, given that they probably do not see other patients’ interaction with health care professionals, men who sleep with men might not understand that this as invitation is offered
to a large body of patients that includes others beyond them. In other words, a larger distal discourse related to HIV and AIDS is coming into play with the proximal discourse between patient and doctor, and that allows gay or bisexual patients to feel as if they are being discriminated against even when they are not.

One simple fix for this problem is for health care providers to educate their patients. A statement such as, “You know, the U.S. Preventative Services Task Force recommends that we encourage just about everyone, regardless of age, gender, race, or sexual orientation, to be tested for HIV,” could help to make it evident that it is not a recently disclosed sexual orientation driving that invitation but a larger standard of health care that applies to multiple people of multiple backgrounds. Additionally, health care providers should consider that even if they feel as if they are personable with patients and perhaps forging a relationship, that their identities as health care providers creates a presentational-rhetorical role (Manning, 2014) that constructs a systemic power difference where clinicians are seen as all-seeing, scientifically informed experts. Moreover, that role of health care provider almost certainly is enmeshed with professional standards, and so a tension between what a health care professional must say professionally versus what they need to say personally is likely at play. Health care providers must be cognizant of this tension and how it comes into play with the expectations and understandings of patients who often feel vulnerable in health care settings.

As this all establishes, it is not always so much about the actual coming out conversation itself—although that is quite important—but about the setting or scene created for the conversation to occur. For example, the forms that people fill out prior to seeing a health care provider often provide options for relational status that exclude same-sex relationships (Hitchcock & Wilson, 1992). Choices often include single, married, or even widowed that, at best, assume marriage equality is in play and, at worst, does not allow for the idea that nonheterosexual identities exist. Extending options could allow for affirmation prior to interaction that allows coming out as LGB to a health care provider to be more welcoming. As some participants also indicated, waiting rooms are not always a welcome space for LGB people. As Hitchcock and Wilson (1992) note, something as simple as the presence of LGB-oriented magazines (such as The Advocate or Out) can allow for a friendly environment.

As the data reflect, this welcoming environment must also lead to welcoming interaction. Almost thirty years ago Kus (1985) found that LGB people reported experiences similar to what the men in this study articulated: that many doctors seemed to behave as if they never had any interaction with other nonheterosexual people. Kus’s suggestion is echoed here: the easiest way to remedy this lack of experience and to rid one’s self of negative preconceptions
is by talking with other LGB people. That might seem like a challenge for health care professionals who feel they have no LGB friends or family members—but making those connections can be as easy as sponsoring focus groups where LGB folk share their experiences. Another possibility is volunteering to present to LGB-oriented groups to talk about a health topic they may have an interest in hearing about, especially a topic that is not a stereotypical choice. Short of any research evidence about interacting with LGB communities, these options can present a good-faith effort to listen and learn.

Past research has indicated that those with nonheterosexual orientations might have anxieties about sharing their romantic or sexual identities with health care providers because they fear their privacy will be compromised and those who they might not be ready to or do not want to share their identity with—whether that be friends, coworkers, or community members—will react negatively (Tiemann, Kennedy, & Haga, 1998). This concern is particularly prevalent in smaller communities, especially if specialized care is being sought and provider choice is limited. Just as privacy management of sexual and romantic identity is a systemic concern, so too is the issue of sexual health. Manning (2014) argues for a holistic communicology of sexual health that is inclusive of both relational aspects of sexuality as well as medicalized and mental health concerns so that connections across all areas can be made and, consequently, both personalized and public health programs aimed at sexual health improved. The data presented in this chapter certainly lend credence to this idea, but future studies can probe even deeper into these connections. For example, research on lesbian women’s health alone demonstrate that their health is correlated with increased risk for alcohol and drug problems, suicide attempts, depression, and physical or verbal abuse (Lehmann, Lehmann, & Kelly 1998). What—at the cognitive, relational, and cultural levels—is occurring to allow such statistics? New studies measuring cultural progress would be of benefit, as would studies empirically demonstrating the connections between LGB health and various cultures. Even in the face of increased civil rights and acceptance, a holistic sense of research about LGB persons and their sexual health is imperative.

A CONCLUDING THOUGHT: SEEING BEYOND THE SEXUAL

Along those lines, and in the interest of a holistic communicology of sexual health, it might be time to retire the terms sexual orientation or sexual identity and replace them with romantic and sexual identity. Such a turn would avoid the heteronormative trappings of otherness in language about nonheterosexual
people (Foster, 2008; Manning, 2009) and allow them both romantic and sexual identities while still acknowledging that LGB people—as with people in general—can have a sexual existence without notions of romance being involved (Manning, 2011). Given the connection between discourses of coming out across contexts—especially considering that they are constitutive of all experiences as they are lived in different places and at different times—it could be helpful for all to remember that talk between health care providers and their patients might seem to be ostensibly about health, but these conversations are part of a larger series of conversations about romantic and sexual identity that LGB people experience (Adams, 2011; Manning, 2014). Perhaps that is the biggest lesson imbued by this research: A coming out conversation is never in isolation, and its impact never limited to the only the people involved. The experience is carried by the participants into future interactions, making the connections between health, individuals, relationships, and cultures inevitable and enduring.

NOTE

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