

**Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or  
attending early stages of therapy**

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## Abstract

**Background:** Identities within the lesbian, gay, bisexual, transgender, or otherwise queer (LGBTQ+/queer) spectrum have been subject to various marginalising constructions over time, including as a criminal offence in the legislative field and a mental illness in the psychocomplex. In recent decades, in the United Kingdom, socio-legislative narratives about queerness have become increasingly accepting. **Rationale:** Older members of the LGBTQ+ community are in the unique position of navigating their current lives from within histories of criminalisation and pathologisation. This seems to contribute to mental health vulnerability in this population (Semlyen et al., 2016; Watkinson et al., 2024), potentially creating challenges in seeking psychological help such as therapy sessions. The Network Episode Model posits that the first step in seeking help is entering the role of the help-seeker, an interactive process between individuals and their social and treatment networks (Pescosolido et al., 2013). For older queer people, this process may be shaped by the marginalising contexts in which they lived their younger years. A literature review identified older queer people's constructions of the help-seeker role as a previously unexplored research area. **Method:** Semi-structured interviews were conducted with eight people identifying as LGBTQ+ and aged 50+ who were either waiting for therapy or in the early stages of therapy. These were analysed using Foucauldian Discourse Analysis, examining how participants constructed the help-seeker role as available or unavailable to them based on historical, political, and sociocultural pressures. **Findings:** Participants mobilised three main discourses to talk about the help-seeker role: 1) a legitimacy discourse where they became eligible to attend services only in times of mental health crisis and, in queer services specifically, only if they performed their queerness in the 'right' ways; 2) a discourse about the importance of help-seekers being understood by their therapists and non-clinical staff as a function of empathy, mobilised especially in terms of trauma and ethnocultural diversity; and 3) a discourse about help-seekers beyond the act of

seeking help, as social subjects who rely on their social networks to facilitate entry into the help-seeker role or who facilitate help-seeking for others in the queer community; and as self-helpers who ‘work on’ themselves as an adjunct to therapy, feeling responsible for ‘fixing’ their own mental health difficulties. **Conclusion:** These discourses are discussed in terms of their historical provenance and the institutions or social groups that they might harm or benefit. Suggestions are made for how counselling psychologists, allied mental health professionals, and mental health services could contribute to the deconstruction of discourses that make the help-seeker role unavailable to older queer people.

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## Glossary

Term	Definition
Ageism	Age-based discrimination
Cis	Cisgender, i.e., identifying as their assigned-at-birth gender
Discourse	Set of statements about a particular topic that imbue it with social meaning
LGBTQ+	Lesbian, gay, bisexual, transgender, or otherwise queer including but not limited to asexual, pansexual, non-binary, intersex
Queer	As above
Queerphobia	Discriminatory/antagonistic attitudes towards queer/LGBTQ+ identities
Trans	Transgender, i.e., identifying as a different gender than their assigned-at-birth one
Straight	Heterosexual, i.e., a man sexually/romantically attracted to a woman or vice versa
Ways-of-being	Ways that someone enacts their identity in the world as influenced by dominant discourses; it is not intended to imply that there is a single 'right' way to be, but to acknowledge the potentially infinite ways that identities could be performed at the interactional edge between individuals and societies
Ways-of-thinking	Ways that someone feels able to think as a social subject in the world as influenced by dominant discourses; it is not

intended to imply that there is one ‘right’ way to think, as  
above

Single quotation marks (‘ ’) These highlight my use of discursive devices, not intended  
to be read as absolute truths

Double quotation marks (“ ”) Quotes from other authors or participants

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## **1. Introduction**

### **1.1 Reflexive Statement: Part I**

I am starting this journey with a reflexive consideration of why I chose to examine constructions of the help-seeker role among older queer people. For me, reflexivity sits at the heart of Counselling Psychology (CoP). It is defined as a reflection on the self and ways in which the self may influence processes such as therapy or research (Dixon & Chiang, 2019). My purpose is not to attain objectivity, but to acknowledge that my subjectivity played a role in constructing what I present here as a novel contribution to knowledge about older queer people (Kasket, 2016). On a personal level, my experiences in academia prior to the Professional Doctorate foregrounded the need for objectivity in science and clinical practice, which to me felt like an erasure of my individuality and pushed me away from the field of psychology for several years. In embracing subjectivity here, I aim to uphold a psychology that welcomes uniqueness both in its scientist-practitioners and help-seekers.

Initially, I felt reluctant to focus on older queer people. Although my literature review highlighted this population's experiences of help-seeking as a pressing gap, I attempted to identify other gaps among younger subsets of the queer community, but was not successful. Through supervision and personal therapy, as well as journaling, I became aware that I was relating to older queer people as fundamentally different from me as a queer person in my 20s. I believe this prejudice may have originated from my sense of disconnect from the queer community. I grew up and came out as bisexual in Romania, where I encountered a lack of acceptance. In response, I distanced myself from my queerness, enacting my identity only in the safety of online spaces. This distance persisted when I emigrated to the United Kingdom, limiting opportunities to meet other queer people and embed myself in the community. From the outside looking in, I did not perceive myself to share a community with queer elders, and

instead understood them primarily as *older* rather than *queer*, assuming their lives would be too different from mine for me to engage with them in an academically worthwhile way.

My othering of elders could have stemmed from personal experiences with older family members, whom I interpreted as ‘set in their ways’, particularly in terms of scepticism about psychological interventions. Perhaps fearing that older queer people would similarly engage with therapy from a place of unwillingness, I might not have wished to give them a voice in my research in order to protect the therapeutic professions—and my own identity as a trainee Counselling Psychologist (CoP)—as worthy and helpful. These assumptions were challenged at several points during the research process. In the first stages of reviewing the literature, I drew on the concept of reflexivity as mutual collaboration (Finlay, 2002a) and discussed my ideas with colleagues at my work placement at the time, an LGBTQ+ organisation staffed by LGBTQ+ people. Older colleagues anecdotally corroborated the need for research on help-seeking among queer elders, and were supportive of me conducting this research even as a younger person without a strong sense of community belonging. As my otherness was welcomed, I started to welcome their otherness too (Cooper, 2009). Interviewing my participants also contributed to me reevaluating my preconceptions. As discussed in the *Analysis* and *Discussion* chapters, together with my participants, I co-constructed an older queer help-seeker who is very open to psychological intervention, yet navigates a system that does not always meet their needs. Most of all, I became attuned to another foundational concept at the heart of CoP: the uniqueness of human beings (Manafi, 2010). I stopped seeing queer older help-seekers as a group that excluded me, and started seeing them as people whom I could come to understand by listening to their stories.

I might have also been motivated to pursue this research as my ‘in’ to secure community belongingness from my position as an outsider to the queer community. For me, to be a queer person means to be an activist, a perception shaped by activist leanings among

my social network as well as the queer community's history of activism, outlined in the *Literature Review*. Activism likewise comports with my professional identity, with CoP being founded on social justice (Kennedy & Arthur, 2014). I operate from within a core belief of not-good-enoughness and, to offset this, I tend to seek perfection in all I do. As I perceive activism to be a requirement of 'doing' queerness and CoP 'perfectly', I might have resonated with older queer people's help-seeking as a research topic given its themes of invisibility and unmet mental health needs, which invite social justice action. Through the writing of this project, I have been able to allow myself greater flexibility in who and how I can be as a therapist, researcher, and person; I discuss this further in the reflexivity sections appended to the *Methodology*, *Analysis*, and *Discussion* chapters. I also aim to grant this same appreciation of uniqueness to my participants and older queer people more generally.

## **1.2 Chapter Overview**

This thesis aims to examine how older LGBTQ+ people in the United Kingdom construct the help-seeker role while waiting for or actively receiving psychological therapy. It is situated within a social constructionist paradigm wherein 'reality' is not an objective entity but something created between individuals through the ways they speak about certain topics (Willig, 2022), such as LGBTQ+ identities or help-seeking.

LGBTQ+ people have faced delegitimation throughout history, being relegated to the fringes of society: abnormal, criminal, diseased, mentally ill (Todd, 2016). In recent decades, the narrative has begun to change to one of acceptance and celebration (Collins et al., 2023). Older members of the queer community are in the unique position of straddling these two narratives: having been young adults in a time of widespread anti-LGBTQ+ sentiment, and living their older years today, in a more welcoming social and legal landscape. This invites a question of how older queer people navigate these shifts in who they are 'allowed' to be.

It also invites a consideration of how these shifts might influence mental health in this population. Past research has documented an increased risk of poor mental health among sexually and gender minoritised individuals (Plöderl & Tremblay, 2015), with the highest risk among older age groups (Semlyen et al., 2016). Several contributing factors have been identified, including: lifetime experiences of prejudice and discrimination (Abatiell & Adams, 2011); loneliness due to rejection from families (Guasp, 2010) or deaths in their social networks (Lyons et al., 2010); caregiving responsibilities rooted in a history of mistrust of professional help (Westwood et al., 2020); and invalidation of their queerness from within and outside the queer community, including care services (Kneale et al., 2021; McCann & Brown, 2019). This tapestry of risk factors highlights a link between older queer people's mental health and the ways in which society understands and reacts to queerness, both now and formerly in older queer people's lives. The tapestry also seems particularly focused on exclusion: older queer people excised from families, communities, and services.

Arguably, this population has also been excised from research, with a preponderance of studies about younger counterparts (Potter et al., 2011). As a result, while older queer people's mental health needs have been documented, it is less clear how they engage with mental health services to meet those needs, especially from within a legacy of disempowerment under criminalising and pathologising systems. The Network Episode Model (Pescosolido, 1992), a theoretical model of how people seek help, posits as the first step the assumption of the role of the help-seeker.

This research fills the gap in the literature about older queer people and provides a platform for often-unheard voices, investigating how this population speaks about the help-seeker role and how, through these discursive means, they are enabled to or hindered from entering the role and engaging with mental health services. Given the abovementioned

tapestry of social exclusion, this may involve older queer people negotiating their legitimacy as users of services and members of the queer community.

The next section in the chapter considers in greater detail the contemporary history of LGBTQ+ identities in the legislative and psychological fields, to deepen understanding of older queer people's early lived experiences. As I am based in the United Kingdom as a researcher and mental health practitioner, I have restricted my exploration to the U.K. landscape; a global examination of LGBTQ+ lives and histories, while worthwhile, is beyond this project's scope. Then, I discuss what it is like being LGBTQ+ today in terms of experiences of prejudice and mental health, pinpointing older queer people as a particularly vulnerable population about whom little has been published in terms of seeking psychological help. To conclude this first chapter, I review the literature that is available about older queer people's help-seeking for mental health difficulties, and I introduce the research question that has driven this investigation.

### **1.3 Literature Review**

#### ***1.3.1 Brief History of LGBTQ+ Rights***

This section provides an overview of how LGBTQ+ rights have evolved in the United Kingdom from the Middle Ages to the present day, grounding the rest of the text in the sociohistorical and legislative context surrounding queerness. Sexual identity and gender identity are considered separately.

##### **1.3.1.1 Sexual Identity**

The United Kingdom holds a lengthy history of criminalising certain enactments of queerness. 'Buggery', or anal penetration, between men was established as a crime subject to the death penalty in the Buggery Act 1533 (Johnson, 2019). The death penalty remained in force until the Offences Against the Person Act 1861, which replaced it with imprisonment (Johnson, 2019). An 1885 addition to this Act, the Labouchère Amendment, expanded the list

of chargeable offences to include all sexual activity between men (Gillard, 2023).

Expressions of sexuality between women were never regulated legislatively (Smith, 2002).

The Sexual Offences Act 1967 brought about a landmark change for queer rights, decriminalising homosexuality (Dockray & Sutton, 2017). The Act pertained to England and Wales, with Scotland following suit in 1981 and Northern Ireland in 1982. It passed at a time when the political world was moving towards a “permissive society” (Ramsay, 2018, p.119) under Prime Minister James Wilson. This ‘permissiveness’ was scaffolded by activist campaigning from groups such as the Homosexual Law Reform Society for the acceptance of LGBTQ+ individuals (Definitive Decades, 2024), as well as sympathetic portrayals of queer people in the media (e.g., the 1961 film *Victim*; Burton, 2010).

Two decades later, the socio-legislative landscape backtracked towards oppression. Margaret Thatcher’s government introduced Section 28 as part of the Local Government Act 1988, prohibiting the promotion of homosexuality (Todd, 2016). Schools responded by excluding queer-specific sex education or queer identities more generally from their curricula, and queer students are noted to have seldom received support for bullying (Greenland & Nunney, 2008). Section 28 was embedded in a bigger tide of anti-queer sentiment fomented by the HIV/AIDS epidemic. The first cases of HIV/AIDS were recorded in 1982 in the United Kingdom among men having sex with men, with whom the syndrome became associated in the public mind (Berridge, 1996). Newly freed of its definition as a crime, queerness nonetheless continued to be perceived as other: a vector of illness and, in the years before effective treatments were available for HIV/AIDS, a bringer of death (Treichler, 1987).

In the wake of HIV/AIDS and Section 28, violence against queer people increased (Severs, 2024). Activist groups were, once again, an important catalyst in challenging the anti-queer tide. The radical, non-violent group OutRage!, for example, organised vigils,

citizen arrests, disruption of police and ecclesiastical operations, and protests such as mass same-sex kissing (Bowcott, 2020). Such campaigning for and normalisation of LGBTQ+ lives likely contributed to the shift in attitudes towards queer people noted among respondents to the National Survey of Sexual Attitudes and Lifestyles (Natsal): in 1990, approximately 50% of 3,342 British respondents aged 16-44 indicated that same-sex relationships are 'always wrong', compared to approximately 25% of 12,110 respondents in 2000 (Watt & Elliot, 2017).

Against this background of increasing acceptance, Section 28 was repealed in 2003. Same-sex civil partnerships were legalised in 2005, and marriages in 2013 in England and Wales, 2014 in Scotland, and 2020 in Northern Ireland (Barker & Monk, 2015; Fairbairn, 2020). Correspondingly, the percentage of Natsal respondents indicating that queer relationships are 'always wrong' dropped to approximately 20% in 2010, within a sample of 9,902 16-44-year-olds (Watt & Elliot, 2017).

### **1.3.1.2 Gender Identity**

So far, my sociohistorical and legislative consideration of queerness has encompassed sexual orientation only. Transness, enacted for instance through cross-dressing, was never illegal in the United Kingdom, but was nonetheless shrouded in silence and invisibility under dominant gender norms in the 20<sup>th</sup> century (Shopland, 2021). For instance, Laurence Michael Dillon, the first British trans man to receive gender-affirming surgery in 1945, relocated to India after being outed by the press (Collins, 2017). Trans-affirming texts also occupied an underground space, such as the journal *Urania* which was privately circulated between 1916 and 1940 among members of the radical feminist and trans-inclusive organisation Aëthnic Union and their trusted others (Oram, 2001). The clandestineness of transness was, arguably, augmented by the 1971 court case *Corbett v Corbett*. At a time when same-sex couples could not marry, Arthur Corbett was granted an annulment of his marriage to trans woman April

Ashley on the grounds that, legally, Ashley was judged to be a man per the gender assigned to her at birth (Sharpe, 2002). Legally, one's gender remained their assigned-at-birth gender until the Gender Recognition Act in 2004 (Sharpe, 2007). This was precipitated by several court cases where trans plaintiffs disputed discrimination based on their transness. Most pivotal of these was *Goodwin v United Kingdom* in 2002, wherein the European Court of Human Rights ruled that the United Kingdom had failed to uphold the rights of trans people to a private life, marriage, and starting a family (Sandland, 2003).

While the Gender Recognition Act 2004 seemed to bring trans people into the fold of 'normality' with valid, visible identities, concerns have been raised about its requirements. For one's gender to be legally recognised, they need to supply proof of having lived as that gender for a minimum of two years, plus two medical reports diagnosing them with gender dysphoria (His Majesty's Courts and Tribunals Service, 2022), or distress stemming from a mismatch between one's embodied gender and their mental representation of their gendered self (Dhejne et al., 2018). These prerequisites have been discussed as delegitimising. Nirta (2021), for example, suggested that a trans person's power to 'officially' self-identify as a particular gender becomes nullified, and moreover that the gender binary becomes reinforced such that gender-nonconforming enactments of transness are erased. Further delegitimation has recently come from a Supreme Court ruling that legal gender can only mean assigned-at-birth gender for the purposes of the Equality Act 2010, which enshrines several characteristics as protected against discrimination, including gender reassignment (Home Affairs, 2025). This was in the context of rising anti-trans sentiment in the United Kingdom, specifically from trans-exclusionary radical feminist (TERF) circles wherein trans women are spoken of as a threat to cis women's identity and safety (Armitage, 2020). Anecdotally, trans people report worry about what the ruling means for their status in U.K. society, particularly their eligibility to use single-sex spaces and services (e.g., Gegisconfused, 2025). The

Equality and Human Rights Commission (2025) is, at the time of writing, consulting on a code of conduct adapting the Equality Act 2010 in light of the ruling.

### **1.3.1.3 Summary**

This brief history of queer rights highlights the impact of legislative and sociocultural spheres on what it means to be queer, as well as their mutual influence on each other in terms of shaping and upholding dominant attitudes towards queerness. Arguably, it also highlights that sexual identity and gender identity have followed different trajectories: while the former appears to command majority acceptance, the latter continues to be subject to legal and social upheaval and uncertainty.

### **1.3.2 *LGBTQ+ Identities According to the Psy-Complex***

Attitudes about queerness have also historically been influenced by the psy-complex, referring to professions such as psychology and psychiatry which work with the human mind (Ingleby, 1985). This section discusses the pathologisation of queerness in psychoanalysis and behaviourism, and considers contemporary developments.

#### **1.3.2.1 Psychoanalysis**

In psychoanalysis, same-sex attraction was originally theorised as a deviation from the norm of heterosexuality (Hegarty, 2017). Libido as postulated by Freud refers to an innate force or energy that powers psychological processes such as hate or self-destructiveness and forms the basis of sexual desire (Zepf, 2010). In childhood and adolescence, libidinal drives progress through the oral, anal, phallic, latent, and genital stages of psychosexual development (McKinney, 2010). Early psychoanalytic theory linked homosexuality to an arrest of libido in the phallic stage (Elkatawneh, 2013), and trans identities to repressed same-sex desires (Gherovici, 2017). While Freud himself considered it a social injustice that queer people had to abide by society's sexuality and gender norms (Lewes, 1988), other practitioners disagreed. Edmund Bergler, American psychiatrist and psychoanalyst, wrote,

“[F]or me [homosexuals] are sick people requiring medical help” (Bergler, 1956, p.28).

Indeed, the American Psychiatric Association (APA) listed homosexuality as a sociopathic personality disturbance in its first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952, feeding into constructions of queerness as a disease to be treated. In the DSM-III, in 1980, transsexualism similarly appeared as a diagnosis (Drescher, 2010).

### **1.3.2.2 Behaviourism**

Efforts to cure homosexuality also came from the behaviourist faction of psychology (Davison, 2020). After the Second World War, there was a boom in behaviourism driven in part by mounting criticism of psychoanalysis as a non-evidence-based therapeutic modality (Wright, 2013). Behaviourists asserted that homosexuals could be conditioned out of their same-sex attraction by learning to associate it with an unpleasant stimulus, such as nausea. As Davison (2020) recounts, the largest study of this kind started in Czechoslovakia in 1950 under physician and sexologist Kurt Freund. Over seven years, 222 men with homosexual tendencies were treated with aversive techniques. Results were not promising. In Freund’s own words, participants remained “almost exclusively homosexual” (1960, p.325). The uptake of Freund’s research in other parts of the world was slow. Against the backdrop of the Cold War, with Czechoslovakia falling on the Russian side of alliances, publication was scant. When the research reached the West, it was in the form of early material where Freund expressed positive views on aversion therapy (Agramonte, 1962). This omission or misrepresentation of Freund’s later conclusions was compounded by the widespread polemic pitting psychoanalysis against behaviourism. Hans Eysenck, staunch critic of psychoanalysis, translated Freund’s work and disseminated it in the United Kingdom (Eysenck, 1960). Taking an optimistic stance on aversion therapy as a homosexuality cure, Eysenck spearheaded a shift towards behaviourism in psychological practice and research (Davison, 2020).

### **1.3.2.4 Contemporary Developments**

As queerness became increasingly accepted among the public, aversion therapy lost support (Davison, 2020). Subsequently, the DSM-II delisted homosexuality (Bayer, 1987). Trans identities continued to be pathologised until the DSM-5, which adopted the term *gender dysphoria* to shift the focus from disorder to distress (APA, 2013). This lens of distress has, nonetheless, been critiqued as pathologisation under a new guise, creating an obligately distressed trans person subject to psychological or medical intervention (Davy & Toze, 2018). I pursue this argument further in the *Discussion* (see section 4.3.1.4). Despite these diagnostic changes, conversion therapy, aversion therapy's successor, continues to be offered today through any therapeutic, spiritual, or medical effort to change someone's sexual/gender identity (Haldeman, 2022). In 2020, the LGBT Foundation and the Hornet Gay Social Network surveyed 8,092 queer participants from over 100 countries (Adamson et al., 2020). Asked whether they or someone they knew had attended conversion therapy, 20.1% responded affirmatively. Although this was a self-selected, non-representative sample, the enduring use of conversion therapy has been recognised as a humanitarian issue (United Nations, 2020). Several countries, including France, Mexico, and Canada, have banned conversion therapy, and more are set to follow (Haldeman, 2022). A ban in the United Kingdom has been planned since 2018 by successive Conservative and Labour governments (Pyper & Tyler-Todd, 2024), backed by the British Psychological Society (2022) as well as the Memorandum of Understanding signed by 29 organisations in the healthcare and therapy space (British Association for Counselling and Psychotherapy, 2024). This marks a slow albeit promising change from the field's early pathologisation of queerness, in line with the Health and Care Professions Council's best-practice guidelines (Clayton, 2022).

### ***1.3.3 LGBTQ+ Lives Today***

Having considered queerness through a historical lens—as criminal, diseased, mentally ill, abnormal, socially excluded—the review will examine queer experiences today, touching on prejudice and its mental health impacts.

### **1.3.3.1 Prevalence and Discrimination**

In the United Kingdom, straight people represented 93.6% of the 44.9 million adult respondents in the latest Office for National Statistics census in 2021 (ONS, 2023). A further 1.5% of respondents identified as gay/lesbian and 1.3% as bisexual. In terms of gender identity, 0.5% of 45.7 million respondents indicated that they did not identify with the gender assigned to them at birth (ONS, 2023).

Despite the prevalence of LGBTQ+ identities, queerness has retained a measure of social unacceptability, enacted through prejudice, discrimination, and violence. According to a survey by Stonewall (2017), an organisation established in response to Section 28 to champion LGBTQ+ rights in the United Kingdom, 21% of 5,375 British queer respondents reported that they experienced a hate crime over the past year. For trans individuals, this proportion rises to 41%. Participants also reported discrimination when house-hunting (10%), visiting a café, restaurant, bar, or nightclub (17%), visiting a place of worship (28%), and attending a sports event (10%). Other research has suggested that sexually minoritised individuals are more likely than straight individuals to have experienced emotional, physical, or sexual abuse in childhood (Balsam et al., 2005), bullying and victimisation in adolescence (Amos et al., 2020), and early-life homelessness as well as intimate partner violence (McLaughlin et al., 2012). This climate of adversity linked to LGBTQ+ identities invites action from CoP. The discipline’s social justice ethos and scientist-practitioner stance offer a bridge between an academic recounting of marginalised experiences among queer people and practical interventions ‘out there’, challenging the status quo in society and promoting equality (Vera & Speight, 2003).

### 1.3.3.2 Stressors and Stigma

Experiences of adversity could become stressors for queer people, exceeding their ability to cope (Lazarus & Folkman, 1984). In the minority stress theory (MST), Meyer (2003) suggests that stressors may leave queer people vulnerable to mental ill health. The theory utilises several key concepts from social psychology and sociology, outlined below.

Social identity theory (SIT; Tajfel, 1978; Tajfel & Turner, 1979) discusses how people establish their identity as social subjects by categorising themselves as belonging to specific social groups but not others on the basis of similarities or differences. Queerness thus becomes not-straightness/not-cisgenderism, enabling LGBTQ+ people to band together as an in-group, distinct from the out-group of straight/cis people. Through this sorting of people into groups, inter-group processes are triggered, including stigma from dominant groups (i.e., straight/cis people) towards minority groups (i.e., LGBTQ+ people) (Lewis et al., 2024). Stigma is defined as the social devaluation that occurs when an individual possesses a characteristic that is perceived negatively (Crocker et al., 1998), serving the purpose of subjugating ‘undesirable’ minority groups in the competition for social capital to dictate society’s values and culture (Lewis et al., 2024). MST conceptualises stigma as the basis of stressors experienced by LGBTQ+ people, assumed to lead to poor mental health (Meyer, 2003). Stressors can be distal or proximal. Distal stressors are occurrences ‘out there’, wherein stigma is directed at LGBTQ+ individuals by other people or institutions, such as through discriminatory policies or unfair treatment (Frost & Meyer, 2023). Proximal stressors refer to self-directed stigma: LGBTQ+ people may internalise negative attitudes towards their own or others’ queerness, manifesting for instance as negative self-beliefs, a negative worldview rooted in expectations of rejection, or the concealment of one’s queer identity (Hoy-Ellis, 2023). Identity concealment as a stressor may, on the surface, appear paradoxical, as it can be protective against discrimination and victimisation (Hoy-Ellis, 2023). However, it

has been linked to psychological distress in the longer term (Hoy-Ellis & Fredriksen-Goldsen, 2016; Lehavot & Simoni, 2011).

In its original iteration, MST accounted only for stigmatising experiences among sexually minoritised individuals, specifically those identifying as gay, lesbian, or bisexual (Meyer, 2003). In other words, it did not extend to trans or gender non-conforming identities (Testa et al., 2015), nor to people who inhabit other stigmatised identities beyond queerness (Tan et al., 2020). In the case of gender minoritised individuals, the sociocultural context of cisnormativity—privileging people who identify within the binary of man or woman as assigned at birth (Baril & Trevenen, 2014)—has been discussed as a key contributor to distal and proximal stressors (Frost & Meyer, 2023). Testa and colleagues (2015) developed a version of MST specifically for gender minoritised individuals, naming it the Gender Minority Stress and Resilience (GMSR) Measure. This acknowledges stressors uniquely experienced by gender minoritised people, including misgendering and lack of identity validation within a cisnormative framework which constructs them as ‘other’ (Frost & Meyer, 2023; Tan et al., 2020). It likewise includes gender-related equivalents to proximal and distal stressors experienced by sexually minoritised people, such as gender-related discrimination or internalised negativity towards transness in oneself or others, known as transphobia (Testa et al., 2015). In their critical review of the gender-related stress literature, Tan et al. (2020) conclude that the GMSR is a useful expansion of MST, able to explain the experiences of trans and gender non-conforming individuals living in a cisnormative sociocultural framework.

Tan et al. (2020) also identify intersectionality as a factor overlooked in the original MST. While MST does consider the influence of multiple minoritised identities on stigma experiences and mental health, it does so additively, as a sum total, such that those identities are assumed not to intersect in inseparable ways with unique impacts on how people live in

the world (Frost & Meyer, 2023). Arguably, an additive rather than intersectional perspective flattens complexity; social power structures can privilege one aspect of a person's identity while marginalising another, with this process being subject to change in different contexts and at different times in the person's life (Few-Demo, 2014). A study by Everett et al. (2019), for example, suggests that the social repercussions of gender non-conformity differ between White and Black or Latina sexually minoritised women. Among the former it seems linked to higher levels of distal stressors, while among the latter this is reversed. This could be underpinned by a reported tendency among sexually minoritised women of colour to privilege dichotomised performances of womanhood, as feminised 'femmes' or masculinised 'butches', possibly in a pushback against androgyny becoming normativised in lesbian communities by White-led feminism in the 1970s (Loulan, 1990; Rothblum, 2010). Such enmeshment of identities is captured in the Temporal Intersectional Minority Stress (TIMS) Model, an extension of MST put forward by Rivas-Koehl et al. (2023). TIMS is inclusive of both sexually and gender minoritised individuals, and situates stigma experiences within societal hegemonies dictating dominance of certain groups over others, as contextualised by sociocultural norms, politics, histories, generational legacies, and lifespans (Rivas-Koehl et al., 2023).

It is important to note that stigma is not an exclusively inter-group process, experienced by LGBTQ+ people from outside the community under social norms of heterosexuality and cisgenderism (Sellnow-Richmond et al., 2022). The queer community is also arrayed in social hierarchies such that stigma can occur within the community, enacted upon queer people who perform their queerness less normatively, by queer people who inhabit more privileged identities (Sellnow-Richmond et al., 2022). Sources of social privilege in the LGBTQ+ community generally mirror those outside the community, including youth, conforming to standards of physical attractiveness, abledness, middle-class

status, being White, identifying as cis and especially as a man, and inhabiting a monosexual sexuality referring to attraction to only one gender (Bollas, 2023; Rosati et al., 2021; Taylor, 2016).

Sexually and gender minoritised individuals experiencing stigma, whether from within or outside the LGBTQ+ community, can cope with the resultant stress through voluntary or involuntary strategies (Miller & Kaiser, 2001). The distinction lies in the sense of control elicited by the strategy. Control may be gained by removing oneself from the situation, for example, or undertaking problem-solving such as activist work (Compas et al., 2001; Crocker et al., 1998). Involuntary strategies are perceived as being outside conscious control and rely on psychological mechanisms (Miller & Kaiser, 2001).

Accounting for the latter, Hatzenbuehler (2009) reworked MST into the psychological mediation framework (PMF), positing that LGBTQ+ individuals do tend to experience a high incidence of stigma, but this may not always result in mental ill health: psychological processes play a mediating role. To date, research has documented several such processes that may contribute to mental ill health among LGBTQ+ individuals in a social context steeped in both historic and current anti-LGBTQ+ stigma. These include: hopelessness (Plöderl & Fartacek, 2005; Russell & Joyner, 2001; Safren & Heimberg, 1999); low self-esteem (Hirsch et al., 2017; Khdir & Latifoğlu, 2021; Plöderl & Fartacek, 2005); and emotional dysregulation (Hatzenbuehler et al., 2008; Matthews et al., 2002).

PMF's focus on psychologically mediated coping invites a consideration of resilience. Resilience is defined as an adaptive response to adverse circumstances, allowing these to be overcome; since its introduction in the 1970s, it has grown beyond its initial conceptualisation as an intrapsychic construct into a relational phenomenon between individuals, families, and communities (de Lira & de Morais, 2018). Thus, resilience can entail protective psychological processes like hope (Kwon, 2013), as well as support within

the family unit (Domínguez et al., 2015; Power et al., 2010) and community-level factors like a sense of pride in a collective queer identity (Mason et al., 2015) and activist efforts to promote queer rights (DiFulvio, 2011). Intersectional perspectives, like TIMS (Rivas-Koehl et al., 2023), suggest an additional layer to resilience wherein resources available to one identity can be co-opted for coping with stressors associated with another identity, such as spiritual practices contributing to effective coping for queer people (Sanders & Munford, 2015).

#### **1.3.3.4 Mental Health Risk**

MST and its subsequent expansions (including GMSR, TIMS, and PMF) are upheld by research suggesting LGBTQ+ people as more likely to experience mental health difficulties than straight/cis counterparts. In 2015, Plöderl and Tremblay undertook a systematic review of the literature on LGBTQ+ mental health. Out of a total of 199 studies, 53% were recent at that time, having been published after 2011, and 13% were nationally representative. Selection criteria were stringent, including the use of pre-defined samples (e.g., participants belonging to a particular city), the presence of a straight control group, and the focus on specific mental health conditions. The authors reported a higher risk of depression, anxiety, suicide attempts, suicide deaths, and substance misuse among sexually and gender minoritised groups. As a meta-analysis of mental health risk was not performed, inferences cannot be drawn about any statistical differences between LGBTQ+ and straight/cis individuals. Nonetheless, general trends provide useful insight into the wider population.

The authors also suggested that LGBTQ+ individuals may not be a homogenous group in terms of their mental health experiences, flagging that bisexual people generally had a higher risk of poor mental health than gay/lesbian counterparts. This is in line with MST (Meyer, 2003), and especially its later iteration as TIMS which entails a sensitivity to context

(Rivas-Koehl et al., 2023). Bisexual individuals tend to experience more stressors than gay/lesbian individuals, owing to prejudice and discrimination coming from both outside and within the LGBTQ+ community, with bisexuality invalidated as a symptom of confusion, sexual promiscuity, or attention-seeking (Barker & Langdrige, 2008; Beach et al., 2019). In contrast, there was a lack of focus on trans experiences in Plöderl and Tremblay's (2015) review. Only one study looked at trans participants' data separately from LGB participants. This may suggest a wider bias both in research and in society whereby LGBTQ+ people are seen as having an umbrella identity with shared values, experiences, and issues (Fassinger & Arseneau, 2007). Moreover, as trans people tend to experience the highest rates of prejudice (Stonewall, 2017), MST—specifically its GMSR incarnation (Testa et al., 2015)—would place them in a position of greater psychological vulnerability. This has been corroborated by smaller, more recent studies (e.g., Carmel & Erickson-Schroth, 2016; Coswosck et al., 2022; Su et al., 2016). One additional masking of in-group differences could stem from research typically using samples that skew young, White, and educated, due to a combination of sociocultural factors that may make people outside of those groups less likely to participate in studies. Older, less educated individuals and/or individuals of colour may be subject to unique stressors, including but not limited to ageism, classism, and racism, potentially leaving them vulnerable to psychological distress (Carden et al., 2022). Rates of mental ill health may therefore be underestimated in research, and there seems to be a gap where the experiences of the most vulnerable subsections of the LGBTQ+ community are not routinely captured.

### ***1.3.4 Older Queer People: A Vulnerable Population***

Addressing this gap, I will now discuss older queer adults as a potentially vulnerable population, focusing on their experiences of mental ill health documented in past research as

well as the risk factors they uniquely experience at the intersection of queerness and older age.

#### **1.3.4.1 Prevalence of Mental Ill Health**

Semlyen et al. (2016) performed a meta-analysis of 12 health population studies run between 2008-2013 in the United Kingdom. The incidence of common mental disorders (CMDs) was evaluated, comprising different subcategories of depression and anxiety and evaluated using the General Health Questionnaire-12 (Goldberg et al., 1997). Analyses were adjusted for covariates including gender, ethnicity, education, smoking, disability, and marriage/co-habiting. CMDs were suggested as more prevalent among LGB than straight individuals, with the highest prevalence in those aged 55+. More recently, Watkinson et al. (2024), drawing on data from 1,520,457 respondents to the English General Practitioner (GP) Patient Surveys, reported a higher probability of trans individuals aged 65+ self-reporting a mental health condition than older cis individuals; age-based comparisons within the trans group were not performed. This vulnerability among older LGBTQ+ people may initially seem surprising. Ageing tends to be associated with robust mental health (Thomas et al., 2016). According to the 2014 Adult Psychiatric Morbidity Survey (National Health Service [NHS], 2016), the average past-week prevalence of CMDs in adults aged 65+ is 10.2% ( $n=2,251$ ) compared to 18.9% for ages 16-64 ( $n=5,295$ ). Psychological mechanisms may contribute to this difference. Older adults appear to have an increased capacity for adaptive coping strategies such as problem-solving (Gooding et al., 2012). As suggested by PMF, adaptive responses to stressors can protect against mental ill health (Hatzenbuehler, 2009). However, no research to date has examined such psychological mechanisms in older queer adults. Although the general older adult population may display these protective psychological factors, it is unclear whether the same can be said of those who identify as LGBTQ+.

#### 1.3.4.2 Risk Factors

Furthermore, this population may experience unique risk factors as people who are older and queer and for whom, according to TIMS (Rivas-Koehl et al., 2023), those identities may interact to create specific difficulties in a societal hegemony that devalues both queerness and older age (Taylor, 2016). Older LGBTQ+ adults are more likely to be childless and to live alone than straight counterparts (Grabovac et al., 2019; Guasp, 2010). Biological families are also likely to be estranged (Guasp, 2010), especially for trans people (Hughes, 2016). Loneliness is a salient concern given its documented relationship with depression (e.g., Domènech-Abella et al., 2017; Erzen & Çikrikci, 2018; Van As et al., 2021). Additionally, friend groups tend to be similar in age, developing care needs concurrently (Westwood et al., 2020). There is a history of informal caregiving in the LGBTQ+ community, particularly between friends, an artefact of the HIV/AIDS epidemic when formal support was limited (Shiu et al., 2016). According to a Carers U.K. survey (2022), 28% of LGB ( $n=536$ ) carers reported that formal services did not meet the care recipient's needs, creating a requirement for informal caregiving; for straight counterparts ( $n=12,879$ ), this proportion was 22%. Past stigma in health and social care settings may additionally contribute to a sense of mistrust, reinforcing reliance on informal care (Brotman et al., 2003). As carers, LGBTQ+ people may be susceptible to depression, particularly older counterparts whose declining health may bring additional stressors (Pinquart & Sörensen, 2003). Indeed, older LGBTQ+ carers seem to be at higher risk of poor physical and mental health than non-caregiving counterparts (Fredriksen-Goldsen, 2011). It may also be difficult to share caregiving responsibilities among friends; friend groups shrank during the HIV/AIDS epidemic and were often not replenished (Lyons et al., 2010). Loneliness and potential caregiving combine to raise concern about older queer adults' mental health.

Moreover, depending on their age, older LGBTQ+ people could have been young adults in a climate of criminalisation and/or pathologisation, with lifetime discrimination likely to be higher than for younger counterparts (Abatiell & Adams, 2011). Existing at the intersection of ageism and queerphobia, this population may also be at risk of identity erasure. Knauer (2016) suggested that “the very notion of gay and lesbian elders [becomes] impossible because seniors are not sexual and homosexuals are, by definition, only sexual” (p.55). Ageist perceptions of older people as child-like, helpless, or inhabiting painful/pathological bodies may be incompatible with sexual behaviour and, therefore, queerness (Gott, 2005). In addition, queerness tends to be performed on the queer scene: in bars, clubs, pubs, and saunas (Browne & Bakshi, 2011), often involving alcohol and drug use (McCann et al., 2013) and casual sex (Taylor & Falconer, 2015), perceived as incongruous with older people’s lifestyles (McCann & Brown, 2019). This may result in exclusion by younger queer adults through processes of within-group stigma, deepening concern over the availability of community support (McCann & Brown, 2019).

The invisibility of older people’s queerness may also be an issue when formal care is sought, such as residential or personal care (Kneale et al., 2021). Heteronormativity may manifest as care providers not acknowledging same-sex partners (McParland & Camic, 2018) or trivialising the death of same-sex partners (Fenge & Fannin, 2009), linked to fears in older queer service users of “going back in the closet” (Price, 2012, p.526). Care also involves specific risks for trans people. Misgendering may be feared if medical transition was never sought; so can negative reactions to surgical scarring (Hunter et al., 2016). As a whole, the literature on older LGBTQ+ adults in the United Kingdom is under-developed (Potter et al., 2011; Williams & Freeman, 2005). Applying an intersectional lens to available research, it seems that older queer adults may experience more stigma and stressors than younger counterparts, potentially associated with a greater incidence of mental ill health. This

increased vulnerability pressingly calls for further investigation, which this project aims to fulfill.

### ***1.3.5 Help-Seeking in Older Queer People***

Having considered older queer people's mental health risks, the question that arises is whether there is a correspondingly high rate of help-seeking. This section will examine service use in this population, drawing on theory to discuss potential help-seeking barriers.

#### **1.3.5.1 Service Engagement**

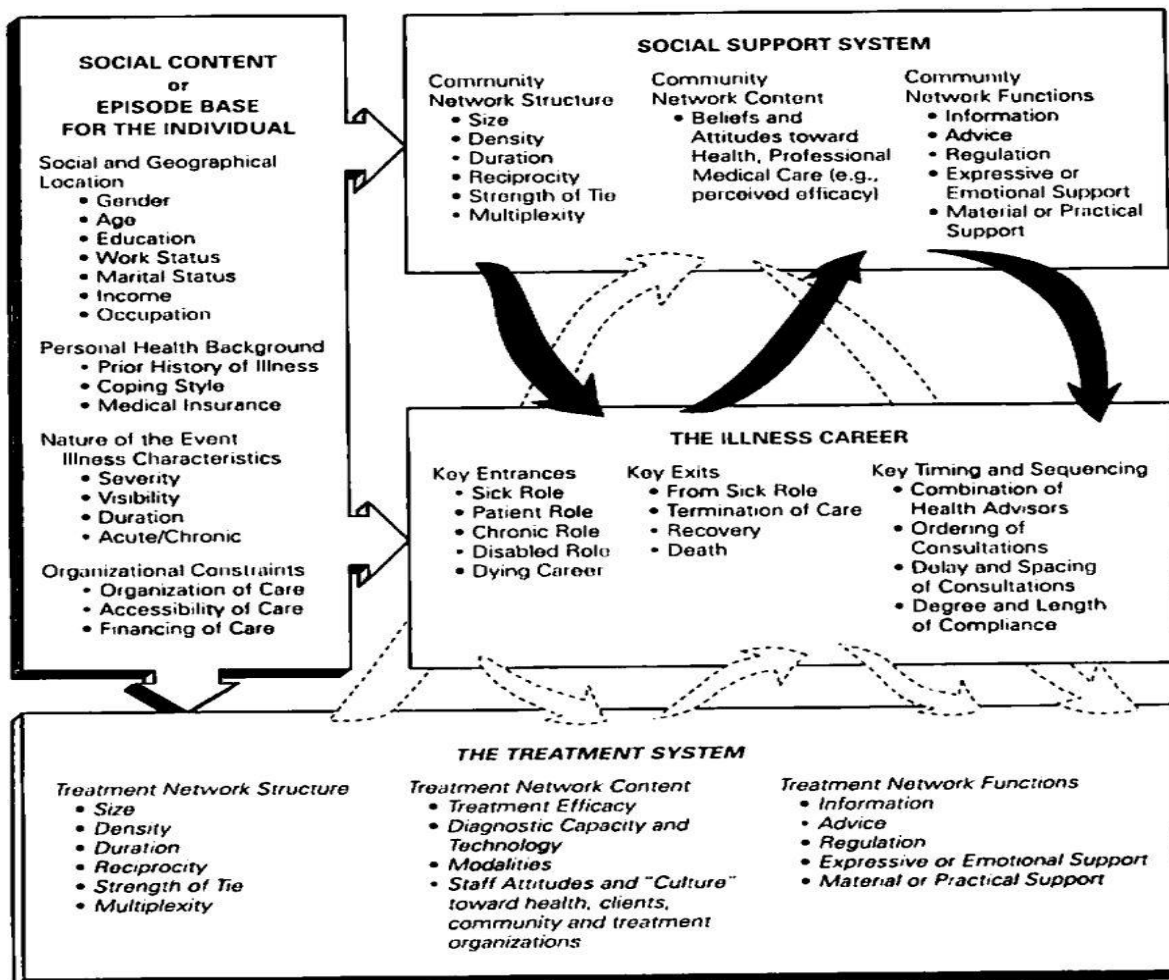
No studies to date have investigated rates of help-seeking in U.K. older queer adults. It is, nonetheless, possible to extrapolate from general gerontological research. In the United Kingdom, in 2021-22, 1.24 million people accessed NHS talking therapy services for CMDs (NHS, 2022). Of these, 6.03% were aged 65+, representing the lowest engagement of any age group. Two explanations for this could be relevant. Firstly, revisiting the 2014 Adult Psychiatric Morbidity Survey, a lower proportion of people aged 65+ were recorded as having CMDs (10.2%) compared to younger cohorts (18.9%) (NHS, 2016), which could translate into a lower need for services. Secondly, the service engagement data refers to the years 2021-2022, post-COVID-19. Some older people, aware of their risk of infection, have reported persistent, self-imposed social isolation, potentially leading to help-seeking delays (Age U.K., 2020). Social isolation may increase risk factors such as loneliness or contact with prejudiced family members (Salerno et al., 2020). Therefore, among older LGBTQ+ people already at risk of poor mental health (Semlyen et al., 2016; Watkinson et al., 2024), higher vulnerability may have been present during the COVID-19 isolation policies and may continue to be present today if they self-isolate, marking the low rate of help-seeking as a concern worthy of investigation.

#### **1.3.5.2 Theoretical Underpinnings of Help-Seeking**

Help-seeking can be further understood through the lens of the Network Episode Model (NEM; Pescosolido, 1992). The model's second version, the NEM-II, is adapted for use in mental health, conceptualising help-seeking as an interactive process between the factors in Figure 1 (Pescosolido et al., 2013).

**Figure 1**

*Network Episode Model II*



*Note.* This figure is replicated from Pescosolido et al. (2013, p.518) under licence 6263691331600 for copyright permission (see Appendix A for full licence details).

According to the NEM, the process of seeking help starts with a shift in identity from a 'well' person who does not require help, to a 'sick' person who does require help (Grue, 2016). This process occurs at the interactional edge between the prospective help-seeker and

their social network, which comprises friends, family, and community, as well as their treatment network made up of clinical and non-clinical staff (Pescosolido et al., 2013). Help-seekers and their social and treatment networks are theorised to influence each other in multidirectional ways (Pescosolido et al., 2013). Networks can either facilitate or hinder entry into the ‘sick’ role and associated help-seeking behaviour, for example through attitudes towards mental health, support offered to navigate care systems, or the availability of help in terms of distance and waiting times (Pescosolido et al., 2013). Moreover, networks are posited to be embedded in the wider social milieu subject to cultural, historical, and political influences (Boydell et al., 2013), which is aligned with CoP principles (Manafi, 2010). Given its sensitivity to context, the NEM seems particularly relevant to older queer people whose meaning-making about being ‘sick’ may be shaped by the historical pathologisation of queerness as a mental illness or a vector of disease through HIV/AIDS transmission (Kunzel, 2017). The concept of a ‘sick’ role draws on primarily Western conceptualisations of illness as deviance from the social norm of good health, impairing productivity in a society which values economic achievement (Parsons, 1951). This could perpetuate the stigma attributed to ‘sick’ people deemed to have broken this norm (Varul, 2010). The term *help-seeker role* will be used instead, drawing on this project’s CoP roots of upholding an ethical, respectful, and non-maleficent stance (British Psychological Society, 2021).

### **1.3.5.2 Help-Seeking Theory through a Gerontological Lens**

Having identified the NEM’s relevance to older queer people, I will now consider its validity in capturing this population’s help-seeking experiences. This has not been queried in older queer people specifically, but conclusions can be drawn from general gerontological research. Choi and colleagues (2006) investigated help-seeking among depressed older adults in the United States using the NEM-II. Secondary data was used from a study on post-acute care (Morrow-Howell et al., 2006). Participants’ use of medical, psychological, and social

services over six months post-discharge was assessed through structured interviews ( $n=140$ ) and statistically analysed. Social networks did not significantly contribute to participants' experience of depression, an unexpected result given the robust link between depression and loneliness (e.g., Domènech-Abella et al., 2017). One potential explanation could be the methodology used. This was a quantitative study based on secondary data originally gathered through the Older Americans Resources and Services questionnaire (Fillenbaum & Smyer, 1981). Questions focused on the quantity of social interaction, such as the number of times a week participants talked to someone. However, according to the NEM, the quality of social interaction is equally important (Pescosolido et al., 2013). Social and treatment networks can be facilitative of help-seeking in two key ways in the NEM: through practical means such as the sharing of information or advice, and also through emotional means such as a warm, supportive relational style (Pescosolido et al., 2013). Herein is highlighted the difficulty of investigating a process as multi-layered and socially grounded as help-seeking by means of standardised quantitative methods, which may not capture crucial details.

To address these critiques, Beatie et al. (2022) trialled the NEM-II qualitatively. Fifteen interviews were conducted with Canadian older adults. Transcripts were analysed using the framework method (Ritchie & Spencer, 1994), an offshoot of thematic analysis (Gale et al., 2013). The framework method does not subscribe to any one epistemology (Gale et al., 2013). Beatie and colleagues (2022) used it with a social constructionist lens, viewing help-seeking as a subjective process that is made sense of in interaction with others. This was an insightful choice given the central role of social networks in the NEM, enabling a holistic view of help-seeking as constructed through sociocultural, historical, and political understandings of what it means to be mentally unwell and to seek formal help. In Beatie et al. (2022), the decision to seek help was driven by a shift in identity from someone able to cope alone to someone needing help. This shift tended to happen when participants felt ready

for change, noticed an unmanageable worsening of their symptoms or, in the case of carers, moved past the boundaries of the caring role and into the help-seeker role. In support of the NEM, social networks were an essential factor in either facilitating or hindering entry into the help-seeker role, depending on the level of support or encouragement from trusted others. Treatment networks were similarly essential, particularly the quality of the relationship between help-seekers and professionals, with empathy and compassion playing a facilitative role in the continued seeking of help. Overall, Beatie et al. (2022) concluded that the NEM is a valid model for gerontological research. It will, therefore, be used throughout the rest of this project as a lens to understand how older queer people are enabled to or disabled from becoming help-seekers by their social and treatment networks, as enacted within wider sociocultural, historical, and political contexts.

### ***1.3.6 Negotiating Entry into the Help-Seeker Role***

This section discusses factors that could potentially hinder entry into the help-seeker role for older queer adults. Material was drawn from a PsycInfo search using the terms “LGBTQ or lesbian or gay or homosexual or bisexual or transgender or homosexual or queer or sexual minority”, “help seeking or treatment seeking or treatment engagement or service utilisation”, and “mental health or mental illness or mental disorder or psychiatric illness”. This yielded approximately 100 results. Some of the studies below were drawn from this pool, identified as appropriate to the topic of entry into help-seeking based on their abstracts. Other useful studies were tracked down through citations. The addition of “older adults or elderly or seniors or geriatrics” generated no relevant articles. Therefore, the considerations that follow are extrapolated from research focused either on younger cohorts or across the lifespan.

#### **1.3.6.1 Dismissal of Mental Health Concerns**

Social norms are part of the fabric of social and treatment networks in the NEM (Boydell et al., 2013), acting as an important influence on how people construct the roles they inhabit in the world, including the help-seeker role (Van Dijk, 2009). Looking at British LGBTQ+ youth aged 16-25, McDermott et al. (2018) conducted interviews ( $n=29$ ) and administered questionnaires ( $n=789$ ) to explore help-seeking for self-harm and suicidality. Transcripts were examined using thematic analysis through a constructionist lens. It is worth noting the study's ambiguity about participants' progress through the help-seeking process. If participants were recruited post-treatment or in advanced stages of treatment, inaccurate retrospective recall might be a concern (Bolger et al., 1989), with treatment experiences colouring participants' help-seeking narratives. McDermott and colleagues (2018) reported that participants decided to seek help after becoming unable to cope alone, mirroring Beatie et al.'s (2022) conclusions and implying that the initial shift into the help-seeker role is similar for both younger and older people. This seems to also entail a negotiation of social norms about mental health. In particular, McDermott et al.'s (2018) young participants spoke of mental ill health in adolescence/early adulthood as non-urgent, transient, and attention-seeking, liable to be dismissed by adult practitioners. From within this construction, they delayed seeking help until their distress became too severe for them to regulate on their own.

Older queer people may operate under similar constructions that they are not entitled to formal help until crisis. Unlike the transience of 'young' mental ill health, 'old' mental ill health has been discussed in public perception as an unavoidable part of ageing (Ouchida & Lachs, 2015), perhaps 'unworthy' of therapy within a context where public health resources are under strain (Bar-Haim et al., 2023; Rethink, 2024). This could be partly enacted through the tendency among GPs to attribute older people's mental health symptoms to physical conditions (Rodda et al., 2011), under-referring to psychological therapies (Frost et al., 2019). As GPs are often the first port of call in an older person's treatment network (Klap et al.,

2003), such misattribution may delegitimise the help-seeker role, hindering service engagement.

### **1.3.6.2 Mental Health Stigma and LGBTQ+ Stigma in Interaction**

There is a theme of intersectionality in McDermott et al.'s (2018) interview extracts which was not explored in detail. Internalised mental health stigma seems to interact with internalised LGBTQ+ stigma, reinforcing a sense of abnormality or otherness. Modelled on negative public attitudes towards mental ill health within social or treatment networks, mental health self-stigma can leave sufferers feeling ashamed (Clément et al., 2015) and less willing to engage with services (Vogel et al., 2007). This mental health stigma, in its external and internalised iterations, is arguably rooted in social norms wherein mental wellness is an expected, essential part of functioning in society, and those who fall outside the norm become social pariahs (LeBlanc & Kinsella, 2016). At first glance, mental health self-stigma seems less relevant for older adults, who have generally been noted to have more positive mental health attitudes than their younger counterparts (Mackenzie et al., 2019). Nonetheless, this has not been investigated specifically in older LGBTQ+ adults. Having lived through a time when queerness was equated to mental illness, this population may be particularly susceptible to mental health self-stigma (Hegarty, 2017), especially as stigmatised groups (e.g., LGBTQ+) are theorised to seek to minimise their connection to other stigmatised identities (e.g., mental ill health). The Best Little Boy in the World hypothesis, originally referring to gay men but now used more broadly, suggests that sexually/gender minoritised individuals overcompensate for their stigmatised queer identity by seeking achievement in other aspects of their lives (Tobias, 1976; Ying et al., 2022). Poor mental health may be interpreted as *non*-achievement, a personal failure or a confirmation of abnormality/otherness (Perone, 2014). Through this lens, help-seeking becomes an admission of that failure and

otherness, and may, therefore, remain unavailable for older queer people until extreme distress, as for McDermott et al.'s (2018) younger queer participants.

### **1.3.6.3 Fear of Stigma from Practitioners**

Stigma from an external rather than internalised source may also impact how older queer people enter the help-seeker role. Foy et al. (2019) examined LGBTQ+ participants' concerns about accessing mental health treatment through the NHS in a qualitative study that thematically analysed an online questionnaire. Of 136 participants, 41.9% discussed minority stressors in the form of concern that they might experience stigma from their treatment network for their sexual/gender identity. This was corroborated more recently by Pitt et al. (2024), who analysed eight interviews from bisexual, cisgender women in the United Kingdom. The authors' reflexive thematic analysis identified biphobia anticipated from practitioners as a key barrier to treatment engagement, in addition to a worry that practitioners would not understand the complexities of being bisexual. However, these studies are not without drawbacks that limit their applicability to help-seeking among older populations. In Foy et al. (2019), 51.4% of participants had completed treatment, and an additional 15.4% had terminated treatment prematurely; moreover, participants had attended an average of 11.6 sessions, representing a stage of therapy possibly several weeks or months removed from their initial help-seeking. As for Pitt et al.'s (2024) participants, they were either recounting past treatment experiences or speaking of ongoing therapy with an undisclosed number of attended sessions, although the numerical split between these was not documented. Retrospective recall bias might restrict the studies' conclusions to help-seeking *memories* rather than the help-seeking *process*, as in McDermott et al. (2018). Furthermore, the average age among Foy et al.'s (2019) sample was 29.6 years without comparisons between younger and older cohorts, and participants in Pitt et al. (2024) were aged 19-30. It is possible that older populations also negotiate worries of practitioner stigma when entering

the help-seeker role, although the texture of these could differ. Older queer adults likely remember the pathologisation of queerness; some may have undergone aversion/conversion therapy. They may, therefore, approach treatment today from a position of mistrust (Addis et al., 2009; Westwood, 2013), potentially constructing the help-seeker role as disempowered, subject to trauma or delegitimisation from professionals (Dickinson et al., 2012). In the absence of research, it remains unclear how past negative constructions of queerness in the mental health system may influence older queer people's current negotiations of the help-seeker role.

Not all research has suggested that older queer people face difficulties when entering help-seeking. Cronin et al. (2021) conducted a study in Australia involving 592 LGB individuals with a mean age of 29.4. Participants completed an online questionnaire on mental health, service use, and engagement barriers. Compared to younger adults, those aged 50+ reported fewer barriers, both general (e.g., time) and minority-specific (e.g., feared discrimination). The authors speculated that older participants may have experienced comparatively low lifetime discrimination. Large-scale decriminalisation of homosexuality occurred between 1975 and 1997 in Australia (Lennox & Waites, 2013), when participants would have been children, teenagers, or young adults. Experiences of discrimination may have been few, accounting for a low expectation of stigma from the treatment network and thus enabling entry into the help-seeker role. However, this is only applicable if Cronin et al.'s (2021) participants resided in Australia in that timeframe, and relevant data is not available. Moreover, the political and sociocultural background of older queer people in the United Kingdom would likely be different, as stigma continued to be brewed by Section 28 and the HIV/AIDS epidemic through the 1980s to the early 2000s (Todd, 2016). Another explanation could be the measures used by Cronin and colleagues (2021). Questions about minority barriers touched on four concerns: care being declined, lack of training/competency,

stigma from community residents, and unkind/unfair treatment. The item regarding stigma is of particular interest. It refers to community residents rather than mental health professionals. Participants may have interpreted it as stigma in their social communities or stigma from other service users in community-based settings. Alternatively, participants' fear of discrimination from professionals may have been masked by the questions on general barriers. One item asked about bad treatment experiences in the participants' social circle. Such indirect exposure to stigma could be internalised (Miller & Kaiser, 2001), resulting in a perception that taking on the help-seeker role for oneself could lead to similarly poor treatment. As noted previously, it is difficult to distil the experience of help-seeking into quantitative data. This is especially relevant for older queer people, where complexity abounds and identities interact in ways still unmapped by research.

The importance of adding to this research base cannot be overstated: giving voice to people left behind by services, society, and research, who are particularly vulnerable to mental ill health and who potentially encounter unique challenges negotiating their entry into the help-seeker role within social and treatment networks rooted in a history of marginalisation. This project provides an opportunity to identify and deconstruct some of these challenges, supporting more equitable access to psychological therapy for older queer people.

#### **1.4 Conclusion and Research Question**

An increased risk of poor mental health appears to manifest at the intersection of older age and queerness (Semlyen et al., 2016; Watkinson et al., 2024). Several factors may feed into this vulnerability, including loneliness (Guasp, 2010), caregiving responsibilities (Fredriksen-Goldsen, 2011), high lifetime stigma (Abatiell & Adams, 2011), and a delegitimisation of older people's queerness (Knauer, 2016).

Despite the documented mental health needs in this population, service engagement remains low (NHS, 2022). This may be linked to older queer people's particular constructions of the help-seeker role, entry into which is theorised as the first step in the help-seeking process (Pescosolido et al., 2013). As constructions are typically rooted in sociocultural, political, and historical contexts (Burr, 2015), experiences of queerness as abnormal in older queer people's past and present—as criminal, diseased, mentally ill, subject to victimisation, excluded from the queer community and broader society—may impact the way they feel able to engage with the mental health system.

Research on this topic is comparatively scant. Existing studies mostly pertain to younger queer cohorts. McDermott et al. (2018) suggested that help-seeking may become synonymous with dismissal for LGBTQ+ youth, their concerns not taken seriously due to their age. Older counterparts may also expect dismissal, drawing on narratives of mental ill health as unavoidable in older age and therefore not 'worthy' of help (Ouchida & Lachs, 2015). Dismissal may be particularly relevant in the context of GPs acting as 'gatekeepers' to psychological treatment (Frost et al., 2019; Klap et al., 2003). As entry into the help-seeker role has been noted to be avoided until a crisis point in younger and older populations (Beatie et al., 2022; McDermott et al., 2018), it is possible that a process of self-dismissal of initial mental health concerns might also be at play. This could have important implications for how services frame their eligibility criteria, either perpetuating or challenging dismissal narratives.

A further gap in the literature is intersectionality. The interaction between mental health stigma and LGBTQ+ stigma during help-seeking was passingly acknowledged in prior research (i.e., McDermott et al., 2018) and has since remained unexplored. To an older queer person who has lived through the criminalisation and/or pathologisation of queerness, the help-seeker role may feed into a perception of the self as abnormal, transgressing mental wellness and gender/sexuality norms (Perone, 2014). This population may also construct

help-seeking as disempowering or traumatising, informed by lived experiences of the psychocomplex seeking to cure queerness (Dickinson et al., 2012). Indeed, Foy et al. (2019) and Pitt et al. (2024) reported that LGBTQ+ help-seekers may fear stigma from mental health professionals, contributing to help-seeking delays. However, these studies' samples skewed young, which hinders their generalisability to older adults. Moreover, some participants had completed treatment, potentially introducing retrospective recall bias (Bolger et al., 1989); this could also be relevant in cases where participants were in the later stages of treatment. To date, queer people's meaning-making about help-seeking has not been captured exclusively before and/or during early treatment. Drawing on the NEM, research in this area could identify how older LGBTQ+ people's social and treatment networks, operating within histories of pathologisation and criminalisation, might influence their ability or willingness to enter the help-seeker role and access mental health services. Implications could extend to services' messages about their therapeutic offerings as well as practitioners' treatment approaches, contributing to narratives of help as salubrious and encouraging uptake of the help-seeker role among older LGBTQ+ individuals with unmet mental health needs. Such practical applications mark this research topic as highly relevant to CoP in terms of service operations and clinical work, and as a fulfilment of its social justice ethos.

The following research question is, therefore, proposed: How do older LGBTQ+ adults in the United Kingdom who are on a waiting list for therapy or in the early stages of therapy speak about and construct the role of the help-seeker?

## **2. Methodology**

This section is dedicated to the methodology I chose to answer the above research question, covering the following: research aims; justification for adopting a qualitative lens; epistemology and ontology; method of analysis; recruitment criteria and protocols; data collection and analysis; ethical concerns; plus a reflexive statement.

### **2.1 Aims**

My aim was to explore how older LGBTQ+ people in the United Kingdom draw on discursive devices to construct their role as help-seekers while waiting for or receiving psychological treatment. This nests within two overarching aims: furthering social justice through spotlighting the often-silenced voices of older queer people; and generating practical insights to facilitate entry into the help-seeker role for older queer people with unmet mental health needs.

### **2.2 Qualitative Lens**

In the NEM, help-seeking is theorised as an interactive process between an individual and their social and treatment networks (Pescosolido et al., 2013). Some prior studies have examined help-seeking quantitatively. Choi et al. (2006) captured the social context of help-seeking through the quantity of interactions between help-seekers and others. Less amenable to quantitative exploration is the quality of interactions with key others in social/treatment networks (e.g., supportive or antagonistic), which the NEM posits as an essential factor in enabling or hindering entry into the help-seeker role (Pescosolido et al., 2013). This research, therefore, adopts a qualitative lens for a multi-dimensional exploration of help-seeking. Qualitative methods are recommended when the context of participants' lives is of interest as in the present case (Burr, 2015; Marecek, 2003), and also align with my social justice aim of creating a platform for under-researched voices.

### 2.3 Epistemology

Epistemology is a branch of philosophy concerned with the nature of knowledge, its scope, origins, limits, and other related issues (Braun & Clarke, 2013). What is understood as knowledge has varied throughout history. The early 20<sup>th</sup> century was shaped by the emergence of structuralism, a school of thought that arose in the field of linguistics and was then taken up more widely, including in arts, economics, and social sciences (Moulines, 1996). Structuralism theorises that phenomena possess an underlying and stable essence available for objective investigation (Javad & Masoud, 2016).

During the mid-20<sup>th</sup> century, prominent thinkers in France spearheaded a movement that critiqued structuralism (Lincoln & Guba, 2003). This came to be known as post-structuralism. It is worth noting that this is a contemporary way of conceptualising these thinkers' work, and at the time they might have rejected a label unifying their theoretical positions (Peters & Wain, 2003). Generally, post-structuralism argues that there is not a single, fixed reality underpinning existence (Sandu, 2011). Rather, reality and knowledge of reality are actively constructed by individuals through language (Burr, 2015), and can be *deconstructed* and *reconstructed* (Wetherell, 2001; Willig, 2022). This is conceptualised as the basis of the discursive turn that occurred in the social sciences in the 1970s and 1980s (Willig, 2022), when attention shifted from the objective essence of phenomena to discursive practices that “systematically form the objects of which they speak” (Foucault, 1969/1972, p.49). The theoretical framework of social constructionism emerged from this interest in discursive practices as a “legacy” of post-structuralism (Elder-Vass, 2012, p.4).

I position myself within post-structuralism and social constructionism for the purposes of this research. Arguably, social constructionism fits well with CoP. Firstly, it advocates a plurality of realities, each shaped by the individual's subjectivity and none more 'true' than others (Willig, 2022). CoP espouses a similar stance towards therapeutic

approaches, which are all assumed to be potentially beneficial (Strawbridge, 2016). Secondly, complexity and uncertainty sit at the heart of CoP, as does reflexivity, such that the therapist does not impress their ‘expert’ knowledge on the help-seeker but co-produces with the help-seeker available ways to think and to be (Dixon & Chiang, 2019). This aligns with social constructionism’s basis in “complexity, uncertainty, and doubt and [...] a reflexivity about its own production and its claims to knowledge” (Ball, 1995, p.269). Lastly, CoP upholds social justice (Orlans & Van Scoyoc, 2009), as evidenced by its contribution to the establishment of affirmative psychological treatment for LGBTQ+ populations (Bieschke et al., 2007; Israel et al., 2003). Social constructionism similarly constitutes a tool for the deconstruction of discourses maintaining marginalisation (Burr, 2015). Given the above, I feel an affinity for social constructionism from within my professional identity as a trainee CoP.

## **2.4 Ontology**

This section considers my ontology, referring to the philosophical study of the nature of reality (Braun & Clarke, 2013). Traditionally, social constructionism is paired with a relativist ontology, which posits that reality spans a potentially infinite number of versions, each of them unique to the individual experiencing it (Willig, 2022). However, I have chosen a critical realist ontology instead. Critical realism understands reality as driven by ‘real’, independent, unobservable structures that generate observable phenomena interpretable by individuals through the lens of discourses (Zhang, 2022). The help-seeker role thus becomes socially constructed within ‘real’ treatment and social systems and practices. Parker (1992) highlights that a relativist approach could potentially obscure the ‘real’ effects of discourses on people’s lives. In addition, given relativism’s assumption that realities are infinite and unique, there is a risk that oppression might be legitimised as one of many equally valid realities (Burr, 2015). As a trainee CoP striving to facilitate empowerment (Cooper, 2009), I feel more closely aligned with critical realism than relativism.

## **2.5 Method of Analysis**

I will now present an overview of my method of analysis, namely Foucauldian Discourse Analysis (FDA). I provide background on Michel Foucault, a French philosopher, author, and activist whose theories form the cornerstone of FDA. I compare FDA with other methods, and consider how FDA ties into my social constructionist and critical realist lens.

### **2.5.1 Background**

Foucault is considered a founder of post-structuralism (Kolozova, 2021). A key aspect of his work is the concept of power as relational and localised, enacted moment to moment through interactions between individuals or between individuals and institutions (Bevir, 1999). Power is theorised to construct knowledge through discursive practices, defining what people can think, feel, do, and be in the world (Olsson, 2010). Reciprocally, knowledge feeds back into social hierarchies of power, upholding them (Olsson, 2010). This mutual relationship was termed power/knowledge by Foucault (1980) and is the principal lens of FDA (Keller, 2017). I draw on both power/knowledge and the NEM as my theoretical frameworks, focusing on how dominant norms and narratives are enacted within social and treatment networks and thus influence constructions of the help-seeker role. More granular details on my approach to FDA are in section 2.8.1, *Conducting FDA*.

Foucault has written extensively on the application of power/knowledge to sexuality. Volume one of *The History of Sexuality* (Foucault, 1976/1978) describes sexuality as a social construct shaped by prevailing discourses, including the *psychiatrisation of perverse pleasure*. This refers to the identification of ‘normal’ versus ‘abnormal’ sexual behaviour, the latter presumed to link to mental illness and require treatment. Historically, this discourse has been prominent regarding LGBTQ+ identities as explored in the *Literature Review*, highlighting the relevance of FDA to help-seeking among older people who are queer.

### **2.5.2 Comparing Methods of Analysis**

Other analysis methods could have also generated worthwhile insights. Grounded Theory (GT) is typically used for topics unaddressed in prior research/theory (Charmaz, 2006). While there is little research into older LGBTQ+ people's mental health/help-seeking (Potter et al., 2011), this does not extend to theory. Meyer's (2003) MST and its later reworkings (including GMSR, TIMS, and PMF) offer a robust understanding of psychological vulnerability in this population. Moreover, help-seeking is a broader field saturated with theoretical accounts, including the NEM (Pescosolido et al., 2013), limiting GT's applicability.

Interpretative Phenomenological Analysis (IPA) is another approach I considered. IPA would have focused on older queer people's idiosyncratic experience of seeking help (Eatough & Smith, 2017), fulfilling my social justice objective of privileging silenced voices. However, it would not have offered scope to explore power dynamics, key to understanding LGBTQ+ people's historical, sociocultural, and political positionality.

A third alternative could have been Discursive Psychology (DP; Potter & Wetherell, 1987). Like FDA, DP is interested in the ways people speak about certain subjects. Dissimilarly, it examines negotiations of meaning and social objectives in talk (Willig, 2022). This granular focus seemed less pertinent to help-seeking than FDA's focus on how discourses make available certain ways-of-being, including the help-seeker role (Willig, 2022).

### ***2.5.3 Link to Epistemology and Ontology***

An analysis method aligned with the researcher's epistemology and ontology has been highlighted as vital for the project's rigour (Harper, 2012), defined as a demonstration of the researcher's integrity and competence (Finlay, 2006). Both FDA and social constructionism evince an interest in ways of talking and how these imbue phenomena with social meaning (Burr, 2015). In terms of ontology, FDA and critical realism synergise through their joint

focus on the ‘real’ impacts of discursive practices on people’s lives (Parker, 1992), here relating to how older queer people are discursively enabled or disabled to enter the help-seeker role.

## **2.6 Participants**

I will now discuss my inclusion criteria and recruitment strategy.

### ***2.6.1 Inclusion Criteria: Overview***

As FDA is less interested in generalisability than variation in language patterns (Potter & Wetherell, 1987), smaller samples (i.e., under 10 participants) are encouraged to allow for in-depth engagement with every participant’s data (Coyle, 2007; Malterud et al., 2016).

Therefore, I planned to recruit between four and eight participants who:

- Identified as LGBTQ+;
- Were aged 50+;
- Lived in the United Kingdom;
- Spoke English conversationally;
- Were either on a waiting list for therapy, or in the beginning stages of therapy having attended a maximum of five sessions;
- Were seeking help as a new treatment episode, defined as a minimum of 90 days having elapsed since last accessing therapy (Keeler et al., 1988; Tansella et al., 1995; Teh et al., 2010).

To capture highly under-represented perspectives, I intended to recruit at least one bisexual and one trans participant. My final sample consisted of eight participants as detailed below.

**Table 1***Demographic Characteristics of Participants*

<b>Pseudonym</b>	<b>Age</b>	<b>Sexuality</b>	<b>Gender identity</b>	<b>Ethnicity</b>	<b>Waiting list vs in therapy</b>
David	63	Bisexual	Trans man	White British	In therapy
Jamie	58	Lesbian	Unsure	White British	In therapy
Jordan	53	Gay	Cis man	Black British	Waiting list
Lily	51	Straight	Trans woman	White British	Waiting list
Sarah	61	Bisexual	Cis woman	White British	In therapy
Mark	52	Gay	Cis man	White British	In therapy
Charlie	73	Gay	Cis man	White British	Waiting list
Oliver	52	Gay	Cis man	White British	In therapy

**2.6.2 Inclusion Criteria: Reasoning**

I recruited across LGBTQ+ identities rather than spotlighting a single one. This is potentially concerning as lesbian and gay voices have historically been privileged over others (Clarke & Peel, 2007). I might have recreated this privileging, with five out of my eight participants identifying as gay/lesbian. Furthermore, my broad-brushstroke approach might have erased crucial differences between identities (Fassinger & Arseneau, 2007). I attempted to mitigate this by creating space specifically for those voices under-represented in past research, namely bisexual and trans voices (Ghorbanian et al., 2022; Hawthorne et al., 2020). FDA provided further mitigation as it does not seek homogeneity in participant accounts, offering scope to engage with differences and contradictions (Potter & Wetherell, 1987).

In terms of age range, I defined older adults as aged 50+. This counters the traditional definition of older age as 65+ (ONS, 2019). In queer research, however, the lowering of this setpoint to 50+ has become established practice (e.g., Boggs et al., 2017; Fredriksen-Goldsen, 2014; Fredriksen-Goldsen & Kim, 2017; Fredriksen-Goldsen, Hoy-Ellis, et al., 2015; Hawthorne et al., 2020; Kneale et al., 2021). McCann and Brown (2019), as well as Schope (2005), suggested that the meaning of older age differs between LGBTQ+ and non-LGBTQ+ individuals, the former tending to feel that they become ‘old’ at an earlier point in their lives. This has been linked to the young-coded ways that queerness is typically performed: on the ‘scene’ in bars, clubs, pubs, and saunas (Browne & Bakshi, 2011), often involving substance use (McCann et al., 2013) and casual sex (Taylor & Falconer, 2015), perceived as excluding older lifestyles.

I selected participants who were able to speak English to a conversational level, perhaps excluding particularly vulnerable members of the LGBTQ+ community, for example, asylum-seekers or non-verbal individuals. Interpreter services were outside the project’s scope, but could be explored in future research.

I also selected participants who were either on a waiting list for therapy or in the early stages of attendance. This addresses a gap in previous research wherein queer people’s help-seeking has primarily been captured post-treatment or in later treatment stages (e.g., Foy et al., 2019), potentially biased by long recall periods (Bolger et al., 1989). The dual recruitment strategy—from waiting lists and ongoing therapy—was also a practical decision as the initial recruitment wave focusing only on waiting lists was unsuccessful. To limit the recall period, participants in active therapy attended a maximum of five sessions, suggested by Horvath and Marx (1990) as the first stage of therapy. As evidenced in the *Analysis*, waiting-list and in-therapy participants did not significantly differ in discourse utilisation.

An additional criterion was participants being in a new help-seeking episode, excluding those in treatment within the previous 90 days (Keeler et al., 1988). These individuals could have extensive support needs, recreating power dynamics that silence the most vulnerable populations. My intent was to bolster the study's robustness, a facet of which is confirmability wherein the data pertains to the phenomenon under study (Lincoln & Guba, 1985), i.e., current constructions of the help-seeker role. Importantly, however, the NEM understands help-seeking as an iterative process (Pescosolido et al., 2013) such that past experiences may have informed participants' current constructions.

It is worth noting my lack of criteria regarding mental health diagnoses, intended to avoid re-enacting power dynamics wherein I legitimise/delegitimise certain kinds of psychological experience. Moreover, mental health discourses tend to fall under overarching umbrellas, e.g., intrinsic pathology (Hunt & Brookes, 2020). A spectrum of psychological difficulty thus becomes relevant.

### **2.6.3 Recruitment**

Recruitment occurred in two waves. The first wave employed purposive sampling (Robinson, 2014) at a U.K. LGBTQ+ mental health charity where I had previously volunteered. After securing the service manager's approval, I displayed my recruitment poster (Appendix B) on the premises and sent emails to therapists asking them to monitor their caseloads for clients eligible to participate. The second wave, begun after the first yielded no participants, applied this same approach to other U.K. LGBTQ+ mental health organisations. Additionally, I shared my poster in online queer social media spaces, and accessed participants' social networks through snowball sampling (Braun & Clarke, 2013).

Once someone contacted me, I emailed them the study information sheet (Appendix C). If interested, they had a phone call with me for screening, detailed in the *Ethics* section.

Individuals willing to be interviewed were emailed the consent form (Appendix D), or given a copy in person to read and sign.

## **2.7 Data Collection and Materials**

Next, I discuss my choice to conduct semi-structured interviews (SSIs); I describe the interview schedule's development, plus interview logistics.

### ***2.7.1 Using SSIs with FDA***

FDA is commonly performed on textual data such as policy documents (Arribas-Ayllon & Walkerdine, 2017). However, finding such data to fit a specific research question can pose practical difficulties. SSIs are a widely accepted alternative, entailing questions prepared by the researcher but also flexibility to deviate from these and pursue other relevant topics brought up by participants (Willig, 2022). This synergises with FDA's focus on naturalistic talk replicating non-research social interactions where discourses are spontaneously mobilised (Price & Smith, 2021). Moreover, SSIs are suggested as a suitable tool for the generation of rich, in-depth data (Braun & Clarke, 2013), relevant to the complexities of older queer help-seeking. SSIs also create opportunities for marginalised voices to be heard (Byrne, 2004) per this study's social justice aims.

### ***2.7.2 SSIs Compared to Other Data Collection Methods***

I considered two other data collection methods. Structured interviews did not seem appropriate as they rely entirely on questions and topics prepared in advance by the researcher (Braun & Clarke, 2013). I felt unable to create a comprehensive interview schedule given the limited existing literature on older queer help-seeking. I was also keen to allow space for an organic discussion between myself and participants, to avoid effacing their unique viewpoints through my thoughts/assumptions. Further, structured interviews are not typically recommended for FDA, lacking the freedom for discursive practices to be used naturally (Braun & Clarke, 2013; Willig, 2022).

Focus groups were the second method I considered. They are suggested as a suitable choice for FDA, encouraging spontaneous talk between group members (Finch et al., 2003). However, a dynamic group setting may not have elicited the detailed, multi-faceted meaning-making that I aimed to capture, for example by moving on from speaker to speaker too quickly or inhibiting sensitive topics (Liamputtong, 2011).

### **2.7.3 Interview Schedule**

FDA typically seeks to analyse naturalistic talk within the research question's remit (Price & Smith, 2021). Therefore, I developed broad questions, intending the interviews to be driven by participants where possible (Appendix E). I included some suggested prompts to ask if participants struggled to naturally elaborate on relevant topics. These prompts were informed by discourses extrapolated from past literature about older queer people's mental health and help-seeking, including:

- The intersecting 'abnormality' of being queer and mentally ill (McDermott et al., 2018);
- Poor mental health as inevitable in older age (Ouchida & Lachs, 2015);
- Help-seeking as disempowering in a discriminating or pathologising mental health system (Dickinson et al., 2012; Foy et al., 2019; Pitt et al., 2024).

These discourses served as a loose guide, especially as this is the first study focusing on help-seeking exclusively among older queer people. As seen in the *Analysis*, participants did mobilise some of these discourses, but also mobilised others.

It fell outside the scope and practicalities of this project to draw on lived-experience expertise in co-constructing the interview schedule. The *Discussion* considers this further, when exploring limitations.

### **2.7.4 Interview Logistics**

I conducted five interviews in person, at the LGBTQ+ mental health charity where I carried out the initial wave of recruitment, which I selected to foster a sense of safety for participants (Goh, 2018). I met with the remaining three participants over Zoom. Interviews lasted between 45-60 minutes, offering sufficient time to establish rapport while not being taxing (Shaw, 2010).

## **2.8 Data Analysis**

Having discussed data collection, I will now address data analysis and examine the quality of my work.

### **2.8.1 Conducting FDA**

FDA can be approached in multiple ways, described by Potter and Wetherell (1987) as a craft particular to the researcher and the research topic rather than a widely applicable set of instructions. Here, I primarily drew on Carla Willig's (2022) six-step method, which I chose due to its accessibility and clarity as I had no prior experience with FDA. This method is not concerned with genealogy, or the historical exploration of how discourses originated (Hook, 2005). Given that historical constructions of LGBTQ+ identities as criminal or pathological may be in living memory for participants, I felt that a genealogical lens would enrich the analysis. Therefore, I blended Willig's method with steps 13 through 20 suggested by Ian Parker (1992) in his codification of FDA. This blended method is laid out below and was conducted using the qualitative data analysis software NVivo (version 15):

1. I amalgamated the transcripts into a single text, iteratively reading it and familiarising myself with its contents. From this amalgamated transcript, I then selected extracts to be analysed as described below. Willig (2022) terms this process *coding*, and defines it as a selection of all material that is relevant to the research question, whether directly (e.g., utilising keywords such as “older” or “queer” or “seeking help”) or indirectly (e.g., broader talk about mental health in society). I did this coding in

NVivo by highlighting in different colours the different topics that participants broached to discuss help-seeking and mental health in the context of older age and queerness. Appendix F exemplifies some of these colour-coded annotations.

2. Once I annotated the amalgamated transcripts in their entirety, I started the analysis proper by identifying *discursive objects*: significant discussion points typically stemming from the interview schedule.
3. Next, I considered the *discourses* that participants drew on to speak about discursive objects.
4. Stage three focused on *action orientation*: what the participant might be achieving in the interaction by constructing discursive objects in a particular way.
5. I considered *subject positions*, referring to the roles that participants adopt through their use of discourses. From within these roles, participants construct their version of reality (Bamberg, 1994) and sense of who they are (Burr, 2015).
6. Stage five addressed *practical implications*. Actions, behaviours, and ways-of-being are constructed as legitimate or illegitimate through discourses.
7. I examined *subjectivity*, defined as an individual's idiosyncratic psychological experience. Notably, FDA acknowledges that actual psychological experience cannot be captured. What is considered is the range of psychological experiences that could result from participants' use of discourses.
8. I considered the historical provenance of discourses.
9. I described the way discourses have changed over time, if applicable.
10. I identified institutions upheld/challenged by discourses.
11. I identified groups of people served/harmed by discourses.
12. I considered which social agents might want to promote/dismantle these discourses.
13. I linked discourses to other discourses creating oppression.

14. I discussed how discourses privilege the narratives of dominant social groups.

As the final seven steps branch out beyond participants' material and into a consideration of wider mechanisms of power in society, I addressed them briefly in the *Analysis* and gave them more comprehensive scope in the *Discussion*.

In the interest of conciseness, the *Analysis* chapter does not showcase all transcript extracts that could have been pertinent to the research question. I chose which extracts to include based on how clearly they illustrated the discursive devices mobilised therein, or whether they offered a worthwhile contribution to the analysis, such as a contrasting viewpoint (Riley et al., 2021). This process introduced a measure of subjectivity into the analysis; indeed, subjectivity and iteration are considered to be pivotal aspects of FDA (Steady et al., 2016). A complete and immutable analysis is assumed to be impossible, and as the researcher, my role was to actively construct meaning from the transcripts (Steady et al., 2016). Resultant challenges include a risk for the analysis to become never-ending, and for me to inadvertently privilege certain extracts or discourses over others, blinkering interpretation due to my own expectations or preconceptions. To address these challenges, I engaged in dialogue with my peers, clinical colleagues, and supervisors (Finlay, 2002a), drawing on free association techniques to invite a breadth of new perspectives (Parker, 1992). Dialogue with others also helped me identify a suitable stopping point when I felt pressure to keep going and produce a 'perfect' analysis. In terms of gaining awareness of my subjectivity and, where applicable, mitigating this, I used journalling and personal therapy to explore how I interacted with the research process (Ortlipp, 2008). Section 2.10, this chapter's reflexivity segment, discusses my subjectivity further in the interest of transparency and rigour (Probst, 2015).

Similar to the lack of co-production in designing the interview schedule, it was outside the study's remit and timeline to member-check the analysis by inviting participants

to review a draft version and feed back to me on whether they feel that the discourses and sub-discourses accurately capture their lived experiences (Lloyd et al., 2024). I explore this more fully as a limitation in the *Discussion*.

### **2.8.2 Quality Assurance in Qualitative Research**

Here, I evaluate this project's quality in greater detail. The quantitative paradigm relies on the concepts of reliability, validity, and generalisability to assess research quality (Tobin & Begley, 2004). These are associated with a structuralist lens that understands reality as stable and objective, and privileges data that captures this reality accurately and is extensive enough to apply to wide populations. Qualitative research, in contrast, with its focus on uniqueness, subjectivity, and complexity, would be more appropriately evaluated through alternative concepts, such as contribution, credibility, and rigour as suggested by Spencer and Ritchie (2011).

Contribution refers to the knowledge created by the study and, in turn, the benefits created by this knowledge. Given the dearth of research into LGBTQ+ help-seeking for mental health difficulties, and the documented psychological vulnerability of older queer individuals (Semlyen et al., 2016; Watkinson et al., 2024), this study provides an important step forward, not only advancing the conversation but also suggesting 'real' changes to mental health provision. I return to this point in the *Discussion*.

The next criterion, credibility, refers to the plausibility and coherence of the data and conclusions. To evidence this, I included quotes from my participants to support the discourses and sub-discourses I identified. I additionally located these discourses and sub-discourses into the wider discursive landscape in society, cursorily in the *Analysis* and in more depth in the *Discussion* (Willig, 2022).

Rigour is the last of Spencer and Ritchie's (2011) criteria, divided into three sub-criteria: reflexivity, auditability, and defensibility. Reflexivity involves reflecting on the

impact of my subjectivity on the research. There are four reflexive sections in this project, considering my choice of research topic, my methodological and analytical decisions, and the content of my *Discussion* as related to my journey on the Professional Doctorate. Auditability refers to transparently documenting my decision-making, as done here in the *Methodology* chapter and in Appendix F which exemplifies an annotated and analysed transcript. Lastly, defensibility refers to the logic, rationale, and justifiability of the research, addressed in the *Methodology* chapter.

There is some debate in the field regarding the application of rigour to FDA specifically. Hansen and Triantafillou (2022) highlight that there has been some reticence towards systematising FDA as a method of enquiry with fixed pointers that need to be met for it to be ‘good’, linked to a rejection of FDA as a “regime of truth” (p.559). Regardless, Hansen and Triantafillou (2022) argue that it is helpful and perhaps necessary to have such pointers in the current discursive climate about research, which demands a transparent, accountable approach to methodology. They suggest four pointers to assess the quality of FDA: curiosity, nominalism, conceptual grounding, and exemplarity. I will use these to consider how my use of FDA has met standards of methodological rigour beyond the generalist qualitative standards captured above.

Curiosity, according to Hansen and Triantafillou (2022), refers to the data collection and analysis being grounded in a question of ‘how?’, guided not by preconceptions but by an openness to unexpected findings. Although my interview schedule was informed by past literature regarding older queer people’s mental health and help-seeking, the questions were broad and open-ended, allowing for a variety of possible answers. Indeed, while the data captures some discourses consistent with past literature, it also introduces inconsistencies and novelties, such as a reported absence of worries about being dismissed by practitioners within a discourse of mental ill health as unavoidable in older age (Ouchida & Lachs, 2015). The

*Analysis* and *Discussion* chapters delve more deeply into the new insights suggested by this study and the ways in which these align or challenge previous research. Moreover, the reflexive sections appended to each chapter aim to underscore any preconceptions I may have held, as well as my attempts at mitigating their influence.

The second of Hansen and Triantafillou's (2022) criteria, nominalism, recalls Spencer and Ritchie's (2011) credibility. Nominalism examines whether participants' words are analysed at face value, without being judged against prevailing norms nor stretched into unfounded conclusions. To fulfil the former, I drew on the CoP principle of welcoming the other (Cooper, 2009), engaging with the data in a non-judgemental, open-minded way familiar to me from my therapy work. In terms of the latter, the various reflexivity sections act as a vehicle of accountability, exploring how my expectations shaped the data-gathering and analysis. Additionally, the *Analysis* chapter includes key quotes from participants to demonstrate the provenance of my conclusions. The *Discussion* does diverge somewhat from the face value of the data, linking it to power structures and dynamics not directly mentioned by participants. I am explicit when I suggest these more speculative conclusions, and highlight them as an opportunity for future research.

Thirdly, Hansen and Triantafillou (2022) discuss conceptual grounding as clarity in defining the concepts analysed through FDA. Here, key concepts include the help-seeker role, LGBTQ+ identities, and older age. The help-seeker role is borrowed from the NEM (Pescosolido et al., 2013) and detailed in the *Introduction*. The LGBTQ+ umbrella is broken down in the *Glossary* and delineated in the *Methodology* in terms of inclusion criteria and participant demographics. Older age is similarly defined in the inclusion criteria as 50 years of age and above. These definitions position the study within an under-researched niche—older queer people's help-seeking—thus contributing to the generation of novel insights, which is a secondary purpose of conceptual grounding (Hansen & Triantafillou, 2022).

Moreover, the *Discussion*, when considering limitations, outlines what types of older queer help-seekers the study does not encompass. Hansen and Triantafillou (2022) also envisage conceptual grounding as an attunement to the context within which concepts are constructed and embodied. The *Discussion* aims to fulfil this through an exploration of the help-seeker role as shaped by the historical, political, and sociocultural contexts of older queer people's lives.

The last criterion of rigour in FDA is exemplarity, namely: to what extent are the findings representative of the sociopolitical practices in which they are situated, and to what extent do they relate current power practices to historical contexts? I address these points through the analytical steps borrowed from Parker (1992), focused on the current and historical provenance of discourses as well as what discourses 'do' in terms of upholding or challenging certain social groups, practices, norms, and institutions. These feature briefly in the *Analysis* and are detailed in more depth in the *Discussion*. Furthermore, in section 2.8.3 below, I address my own deployment of discourses in constructing this project and its contributions to knowledge, particularly my mobilisation of reflexivity, linking this to normative practices in the CoP field.

### ***2.8.3 Critical Discussion of Reflexivity in FDA***

As captured above, reflexivity tends to be talked about as a quintessential part of rigour in qualitative research (Spencer & Ritchie, 2011). Reflexivity also features in discussions of rigour in an FDA context, specifically Hansen and Triantafillou's (2022) criterion of nominalism which necessitates a compartmentalisation of the researcher's judgements and expectations. Arguably, the seeking of rigour through reflexivity invokes a structuralist assumption of an underlying 'truth', an 'accurate' version of the analysis that can be unearthed by cataloguing the researcher's decisions and peeling away their subjectivities (Nixon & Power, 2007). In this project, I attempted to steer clear of the search for 'truth' by

adopting a co-constructive stance in my reflexive statements: I framed my subjectivity as a fellow ‘participant’ in the research process, shaping the data collection, analysis, and conclusions in ways that, although open to interrogation, are a formative and indelible part of the study.

However, such rejection of an ultimate analytical ‘truth’ may result in an uncritical deployment of reflexivity. Alejandro (2021) discusses two approaches to reflexivity, either as a set of techniques or a set of social practices. In the former, reflexivity becomes a methodological tool, not unlike a microscope in a laboratory, embedded into the research process as a way for the researcher to interact with and transform their data. In contrast, reflexivity-as-social-practice takes a step back and considers how reflexivity is created within discourses about research, and within the institutions and social groups in which those discourses operate. Alejandro (2021) advocates for this latter, “de-technicis[ed]” (p.168) approach to reflexivity in research adhering to a post-structuralist paradigm such as FDA. I will, therefore, dedicate this section to an exploration of what reflexivity is ‘doing’ in this study, centring its social function and provenance.

Bright and colleagues (2024) write about reflexivity as a technology of the self—this is a Foucauldian concept denoting practices through which an individual transforms themselves in the pursuit of a higher state of being, like happiness, wisdom, or perfection (Foucault, 1988). In a research context, reflexivity-as-technology-of-the-self could serve to establish the researcher’s academic identity (Bright et al., 2024). Academic identity, for me, entails being a trainee CoP, operating within a scientist-practitioner discourse wherein producing research and keeping abreast of new academic insights become essential to competent clinical practice (Jones & Mehr, 2007). The scientist-practitioner discourse also places the ability to reflect, as part of research and therapeutic processes, at the heart of professional effectiveness (Blair, 2010). Thus, my reflexive statements might have

represented ‘proof’ of my ‘good-enoughness’ as a trainee CoP, deserving of embodying a fully-fledged CoP professional identity once I embark on my post-doctoral career. Another layer to my academic identity is that I am a queer researcher interested in queer topics. Identity consolidation can involve the negotiation of insider/outsider perspectives (Bright et al., 2024), which I attempted to do through reflexivity by recording my shift from a position of disconnect from the queer community (see *Reflexive Statement: Part I*), to ‘writing into being’ a new way to claim my queer identity by doing queer research (see *Reflexive Statement: Part IV*).

My mobilisation of reflexivity as ‘proof’ of my professional identity seems to mirror the concern of CoP with its own identity as a field of psychology. There is a discourse of ‘otherness’ in CoP’s endeavours to define itself, doing so through distinctions from other branches of the psy-complex such as psychotherapy or clinical psychology (Moore & Rae, 2008). Moore and Rae (2008) refer to this as the production of a “maverick” (p.384) discipline and practitioners, rejecting mainstream norms (e.g., structuralism, or the seeking of an underlying, inner ‘truth’ in research or therapy) yet creating its own in-group norms (e.g., reflexivity). The process of delineating a group identity can be driven by political instability, particularly for groups like CoP that position themselves as sociopolitical actors invested with the responsibility to contribute to social change (Rafalin, 2010). For me, the increase in right-wing populism in the United Kingdom (Schmidtke, 2025), especially rising anti-LGBTQ+ sentiment manifesting through an increase in TERF rhetoric (Armitage, 2020) and hate crimes (Stonewall, 2023), might have underpinned my engagement with reflexivity as a norm within CoP. The stakes of doing ‘good’ research in the queer arena—i.e., deconstructing the marginalisation of older queer people—might have felt particularly high, spurring me to enact reflexivity-as-technology-of-the-self to become a competent trainee CoP doing socially mutative queer research.

Outside of a political context, an additional sociocultural influence on the privileging of reflexivity in FDA and CoP could be individualism in Western societies (McCabe & Holmes, 2009). Reflexivity entails a deep dive into the self as a fixed, isolated entity, as contrasted against other conceptualisations of selfhood, for example at a relational level (Li, 2024). I arguably enacted this here, and doing so might have been a deployment of my power as the researcher: centring my voice instead of participants' voices, in an exercise that arguments against reflexivity have discussed as self-indulgent, not benefitting the analytical effort (Finlay, 2002b). Harrison (2013) discusses CoPs as invested with power by the social systems within which they operate, for instance through a discourse of 'expertness' wherein individuals who hold a certain qualification are endowed with more knowledge, and therefore more power, than individuals who do not. Harrison (2013) suggests an intentional, mindful use of this power to deconstruct marginalising narratives and practices. In the case of reflexivity, it could be deployed in an empowering way for readers by "voicing the unspoken" (Finlay, 2002b, p.544), potentially inspiring insights into their own ways-of-thinking/being as individuals but also as relational selves in communities and societies. Here, one such 'unspoken' aspect that I tackled in my reflexive statements is belongingness to the queer community, normatively performed on the queer 'scene'. My intention was to challenge these norms and broaden available ways of being queer, synergising with a key takeaway from the analysis about legitimising older enactments of queerness that may not meet mainstream community norms.

## **2.9 Ethics**

Having examined the quality and methodological rigour of this project, I will move on to a consideration of ethics. The study received ethical approval from London Metropolitan University on 28<sup>th</sup> May 2024 (Appendix G). Throughout the research process, I referred to the British Psychology Society's principles of respect, integrity, social responsibility, and

benefit maximisation/harm minimisation as guidelines for ethical conduct (Oates et al., 2021). Below, I consider how I upheld these guidelines through informed consent, preventing psychological harm, navigating my blended role as researcher and therapist, and ensuring participant confidentiality.

### ***2.9.1 Informed Consent***

I electronically shared an information sheet with prospective participants, detailing: the study's aims; the type of data to be collected and method thereof; data use and storage; confidentiality; participants' right to decline to answer any interview questions and to withdraw at any time and for any reason up to two weeks following interview (with data being destroyed if the withdrawal occurs post-interview); expected time commitment; possible participation risks; debriefing procedure; the study's expected outcomes/benefits and how these will be circulated among participants; and my contact details along with my supervisor's (Appendix C).

### ***2.9.2 Psychological Harm: Recruitment***

I similarly strove to facilitate informed consent by having a screening phone call with prospective participants. This served the additional purpose of screening out individuals experiencing acute distress in their daily lives, recommended when participation involves discussion of sensitive topics that may create lasting psychological harm (Oates et al., 2021). However, this created tension between the ethical principles of non-maleficence and autonomy (Newman & Kaloupek, 2004): I had a duty to protect participants, yet risked disempowering vulnerable individuals through my exclusion clause.

I navigated this tension in three ways. Firstly, the screening protocol was adapted from Draucker et al. (2009), who purposed to assure the psychological safety of vulnerable individuals and also privilege their autonomy. During screening, I transparently discussed the nature of the interviews with prospective participants, as well as the possibility that they

might experience distress. We also explored their current levels of distress through a series of questions (Appendix H) and collaboratively assessed whether participation was likely to negatively impact them in a severe manner and/or in the long term. It is worth noting that I did not feel it necessary to exclude any prospective participants. Secondly, my recruitment pool at LGBTQ+ mental health organisations was unlikely to include highly distressed individuals as such organisations do not routinely offer crisis services (e.g., London Friend, n.d.-a). Lastly, for participants on waiting lists, I scheduled interviews within a week of their therapy start date so they would receive support promptly. Participants in active therapy already had access to regular support.

### ***2.9.3 Psychological Harm: Interviews***

Despite these measures, given this study's sensitive topics, I was prepared for the possibility that participants might experience distress during interviews (Oates et al., 2021). There was no pressure or coercion for participants to answer any particular questions or continue with the interview. I invited participants to turn the voice recorder off themselves if they wanted to stop, placing that power with them and mitigating any social discomfort (Speer & Hutchby, 2003).

Additionally, I followed Cocking's (2008) distress protocol. I closely monitored participants for signs of distress during interviews, ready to implement relevant actions per the protocol (e.g., pausing/terminating the interview). Further details are in Appendix I. I did not feel it appropriate to initiate the protocol with any participants.

During debriefing, I offered participants the opportunity to ask questions and share any concerns. I also offered to practise distress reduction techniques with them, such as breathing/mindfulness exercises, if desired. Participants received a debriefing sheet summarising the study's aims and expected outcomes, signposting mental health resources,

and providing contact details (Appendix J). Consenting participants also received a follow-up call the next day to check their feelings.

#### ***2.9.4 Dual Role: Researcher and Therapist***

Having considered harm reduction, I will now reflect on the ethical issues potentially posed by my dual role as researcher and therapist (Thompson & Russo, 2012). There was a risk for participants to request therapeutic support from me, particularly when I stepped out of my researcher role to facilitate breathing/mindfulness exercises during the debrief (Oates et al., 2021). There was an additional risk for participants to divulge information they might not have wished to share for research purposes if I made use of therapy-style skills to facilitate exploration during interviewing (Kvale & Brinkmann, 2009). This blurring of roles may have further been compounded by holding the interviews at an LGBTQ+ organisation which provides mental health services.

To mitigate these risks, I intended to openly discuss any ethical concerns or dilemmas with my supervisor (Thompson & Russo, 2012), although ultimately this was not relevant. Moreover, I clearly described my role as a researcher and the nature of the interview as distinct from a therapy session during the recruitment process (e.g., Appendix C) and on the day of the interview prior to commencing (Thompson & Russo, 2012). The distinction was further reinforced by holding in-person interviews in a room designated as a social (non-therapeutic) space. I additionally planned to signpost mental health resources to participants requesting therapeutic support from me and unwilling to wait until their therapy (Oates et al., 2021); this was, however, not necessary.

#### ***2.9.5 Confidentiality***

Regarding participants' confidentiality, I observed the Data Protection Act 2018 and General Data Protection Regulation. I used participants' data solely for the project's completion. I recorded interviews using the Olympus DS-9000 encrypted recorder, which I

stored in a locked file cabinet. During interview transcription, I removed all identifying information from participants' accounts. I uploaded the anonymised transcripts to the secure cloud service Box per London Metropolitan University's recommendations (2022), and retained sole access. I stored identifying data in a separate folder from the anonymised transcripts so no links could be made back to participants. Once the project was complete, I destroyed all identifying data. I will retain the anonymised transcripts for five years to enable publication.

## **2.10 Reflexive Statement: Part II**

Here, I examine my influence on methodological design and implementation, an essential aspect of rigour in qualitative research (Spencer & Ritchie, 2011). I noticed an inner conflict when considering my methodology. My prior research had been limited to quantitative methods. I felt torn between staying in this familiar, quantitative territory, and embodying CoP's ethos of privileging individuality and complexity through qualitative investigation. Part of this was also a need to be a 'perfect' trainee CoP and do qualitative research as I felt that a trainee CoP 'should'. I believe this also influenced my choice of FDA. CoP's social justice roots resonate with me, and FDA felt like 'proof' that I was engaging with my research through a social justice lens. Moreover, it might have been an attempt to correct for a perceived lack of social justice involvement in other areas of my life, especially in queer spheres as discussed in *Reflexive Statement: Part I*.

Regarding recruitment, I initially assumed it would be quick and straightforward. I can link this to my inexperience with qualitative research, plus an expectation that, as a queer researcher/therapist, I would receive ready support from the queer community through participation. When recruitment proved challenging, I noticed a sense that I was not a 'good enough' queer person to 'deserve' community support. I disengaged emotionally from the research process, a longer-standing coping pattern for me, which contributed to me adhering

closely to the interview schedule and not asking many follow-up questions. This was a missed opportunity to delve deeper into certain topics, for example GPs' role in facilitating/hindering help-seeking. Consequently, transcripts focused on the experience of being a help-seeker now rather than referral journeys, limiting comparison with prior research about GPs-as-'gatekeepers' of psychological treatment for older people (e.g., Frost et al., 2019).

Additionally, I did not ask participants about their use of informal emotional support, flagged by the NEM as a potential influence on the help-seeker role (Pescosolido et al., 2013). I may have assumed the necessity/superiority of formal mental health care, possibly linked to: a need to bolster my good-enoughness as the omnipotent therapist able to help everyone; and my own tendency to access therapy rather than social support. Informal emotional support would have been important to capture considering the queer community's history of informal caregiving (Shiu et al., 2016). Moreover, this presumed universal usefulness of therapy sits at the core of this project, which ultimately seeks to facilitate therapy attendance for older queer people. It would be worthwhile for subsequent research to understand more about older queer people's experiences of informal help-seeking, and where they feel informal help-seeking fits into their repertoire of wellbeing tools.

I do not claim to have disclosed all my expectations/assumptions/motivations, some of which might have escaped my awareness. Reflexivity typically strives for thoroughness and iteration rather than completeness (Day, 2012; MacMillan, 2003). I will, therefore, continue this reflexive thread in the *Analysis* and *Discussion*.

### 3. Analysis

#### 3.1 Chapter Overview

In this chapter, I examine key interview extracts through an FDA lens, focusing on how participants use discursive devices to create ways of being help-seekers while navigating their social and treatment networks. This is a novel topic of investigation, contributing to knowledge about what helps or hinders older queer people in assuming the help-seeker role and accessing mental health services. I start by considering discourses about legitimacy in terms of the attributes an individual must possess to become a help-seeker. Then, I focus on the dynamic between the individual and their therapist, which is discussed by mobilising the importance of being understood and the different and sometimes conflicting ways in which this understanding can be created. The final discourse captures the social dimensions of help-seeking wherein social and treatment networks can variously enable or hinder entry into the help-seeker role. The chapter ends with a reflexive consideration of my analytic process.

#### 3.2 Discourse: Legitimacy

The first discourse considers how participants negotiate their legitimacy as help-seekers in terms of acute distress as justification for help-seeking and ways in which queerness ‘should’ be enacted to be eligible for help from queer services.

##### 3.2.1 *Sub-Discourse: Legitimacy Granted by Distress*

I present extracts from four participants who reflect on the point at which they decided to access services, starting with Lily.

Lily: When I [...] went to [the assessment], all I knew is I was desperately upset.

*(aged 51, straight, trans woman, White British, waiting list)*

For Lily, legitimacy seems created by the intensity of her distress, making available the role of the help-seeker through a “desperate[ion]” that extinguishes any other ways-of-being. This is echoed by David.

David: [hesitantly] But I didn't expect [...] to feel quite so fractured by everything [death of mother]. I really am struggling a bit at the moment. (*aged 63, bisexual, trans man, White British, in therapy*)

David says he “really [is] struggling”, then, contradictorily, adds that he is struggling “a bit”. This may be linked to the sense of unexpectedness in his account. He seems surprised by his “fractured[ness]” following his mother’s passing, speaking of it hesitantly and emphasising that he did not expect to feel this way. It may be difficult for him to own his struggle if he is in the initial stage of emotional processing. Indeed, in the next sub-discourse, I explore David’s subject position that he ‘should’ only talk about queer topics as a help-seeker in a queer service. Perhaps, for him, queerness represented a less emotionally challenging topic of exploration than grief. Interestingly, it seems that what enabled David to enter the help-seeker role (i.e., acute distress) is different from what enabled him to remain in the help-seeker role and engage with his therapist (i.e., being queer in the ‘right’ way by only talking about queerness). Like David and Lily, Oliver also mobilises a discourse of intense emotional need when discussing his entry into the help-seeker role.

Oliver: And everything seemed to kind of come to an organic head [...]. I had suicidal thoughts. (*aged 52, gay, cis man, White British, in therapy*)

Oliver speaks of a psychological crisis point as a discursive object that is “organic”, as though having a life of its own and thus, perhaps, being unpredictable/uncontrollable in its suicidality and needing to be contained by an external other, i.e., a therapist. In contrast, for Charlie, his moment of crisis initially led to him turning down help.

Charlie: My doctor offered me counselling. I said, “Don't be silly. I'm a British man. I don't need that kind of thing.” Yeah, so after a fortnight of not sleeping because the incident [nightmare about childhood sexual abuse] happened in the night, and I was

terrified to sleep in case it happened again, I kind of crawled back to the doctor and said, “Counselling, please.” (*aged 73, gay, cis man, White British, waiting list*)

Charlie positions himself as a “British man” who does not “need that kind of thing”, meaning therapy. His imperviousness to emotional difficulties seems to stem from his Britishness, perhaps under a ‘stiff upper lip’ discourse wherein adversity is met with stoicism, described by Capstick and Glegg (2013) as the “domain of the unspeakable” (p.242). For Charlie, this unspeakableness seems to create a sense of power, differentiating him from ‘weak’ individuals who need to talk about their emotional difficulties and also from his “silly” doctor who assumes that talking about emotional difficulties is helpful. There seems to be a link to Charlie’s masculinity too. Elsewhere in the interview, he talks about a childhood defined by “little boys [being] seen and not heard”, reinforcing the sense of unspeakableness and highlighting that his meaning-making about gender has strong roots in his historical sociocultural context. There also seems to be a strictness about gender roles that has stayed with Charlie since he was an unheard little boy, such that his subject position as a “British man” prevents him from becoming a help-seeker who would have to speak about his difficulties and be heard by a therapist.

Charlie’s entry into the help-seeker role seems to have come about at a tipping point where the intensity of his sleep difficulties and emotional distress made the unspeakable speakable and he “crawled back” to his doctor as a last resort. The “crawl[ing] back” evokes a sense of humbleness: the doctor ‘knew’ what Charlie needed all along, and now Charlie is forced to admit it. A help-seeker in this situation might enter therapy from a position of disempowerment, potentially feeling destabilised in their sense of self, or finding it difficult to develop a trusting, egalitarian relationship with a professional perceived to be more knowledgeable than them. Amalgamating Charlie’s help-seeker with Oliver, David, and Lily’s accounts, such an individual may come into services at a high level of emotional

distress, possibly at risk of harming themselves, and with an urgent expectation of being helped yet potentially encountering challenges in speaking openly about their experiences.

### **3.2.2 Sub-Discourse: The ‘Right’ Ways to be Queer**

I will now address the second sub-discourse of legitimacy, which concerns being queer in the ‘right’ ways. I am using ‘right’ to mean a version of queerness perceived to grant access to queer services. Lily considers what it is like to access queer services as an older trans woman who began identifying as trans in the 2-3 months before the interview.

Lily: If there’s a trans part and you’re my age, there’s sort of two ways, there seems to be almost two routes of sort of accessing it [transness]. I think what you might call cross-dressing and this is much, tends to be older. But then there's also like, the more formally trans, “I'm trans” people, which is much more sort of political... sort of a protest [...] a very student age sort of thing. And for me, the broader set of all these services like [name of queer service] etcetera are very much focused on our trends. [...] I feel like I'm halfway between these sort of two counts. [...] I sort of feel slightly excluded. [...] I think it can be off-putting. It’s not so much sort of “oh, I don’t like that colour, I like this colour”. It’s sort of... You know, I feel I have to... hide a part of myself to come here [to the service] and engage with that world. Because [...] I don’t hate TERFs. (*aged 51, straight, trans woman, White British, waiting list*)

Lily speaks of “accessing” transness, constructing it as something external to the self that must be ‘entered into’ via pre-determined routes, namely: cross-dressing, which she identifies as primarily belonging to older people, and the adoption of a formal trans identity, which she ascribes primarily to students. This latter route is “political”, “a protest”, and seems to entail a public-facing element whereby one’s trans identity is not only one's personal identity but also an activist endeavour; this may juxtapose with a more underground, out-of-

the-public-eye ‘older’ transness that may not be politically charged or politically ‘correct’. Lily additionally constructs the political-protest route as a current trend in the queer community. She refers to queer mental health services en masse, as a “broader set” that is “very much focused on our trends”. In terms of action orientation, services seem to become enactors of social and/or political trends; moreover, this enactment seems ubiquitous. Practical implications could include older individuals who are not ‘trendy’ in their transness feeling like there are no services that cater specifically to them and, therefore, becoming delegitimised as help-seekers and not accessing help, or accessing help from a position of inauthenticity as discussed below.

The concept of ‘trendy’ political-protest transness seems to allude to impermanence: a vogue that comes and goes, with gender perhaps acting as an accessible but temporary vehicle for activism. Notably, Lily mobilises students as the group most likely to adopt this political-protest transness, a group generally associated with youth, life transitions/transitoriness, fluidity of identity, and the rejection of social norms (Christie, 2009). This recalls broader discourses wherein transness, particularly in young people, is constructed as a phase rather than a ‘true’ aspect of the self (Arcieri & DeLucia, 2022). For Lily, her deployment of trans ‘trendiness’ may reflect the contemporary nature of this discourse. Alternatively, she may be speaking of trends to highlight her own sense of gender uncertainty. In another part of the interview, she identified her goal for therapy as “work[ing] out where [she] fit[s] into this world”, saying she feels “terrified” that her transness is “not serious”. David speaks of similar motivations to enter the help-seeker role, considered further on.

Lily goes on to construct her identity as both help-seeker and trans woman as something “halfway”: not entirely in the camp of older transness/cross-dressing, nor entirely in the camp of political-protest transness. She draws on a preference-based binary to

construct her personal experience of transness: “I don’t like that colour, I like this colour”. This may contrast against the political-protest version of transness: liking one colour over another does not tend to have impactful consequences, whereas choosing one gender over another does tend to have impactful social, cultural, political, and medical consequences. As a subject, Lily thus seems to become “slightly excluded” due to not performing transness in the ‘trendy’ political-protest way. It is unclear from her account whether she feels excluded from ‘trend-following’ queer services or from the broader queer community. Indeed, there may be a certain permeability between services and community for her at the intersection of social and treatment networks. She speaks of services as a “world”, implying that queer mental health is not an issue that can be addressed in isolation but rather a part of a bigger queer whole: to engage with queer services, a service user must engage with the queer community.

Regarding her subjective psychological experience, Lily speaks of finding it “off-putting” to engage with services from within this sense of exclusion, a hindrance overcome through the intensity of her distress (“I was desperately upset”), similar to Charlie in the previous sub-discourse. Nonetheless, barriers seem to persist in that Lily feels unable to be authentic, “hid[ing] a part of [herself] to [...] engage”, perhaps to avoid judgement from her therapist or other staff. The hidden part is her ‘off-trend’ politics, namely that she does not “hate” TERFs as political-protest transness might require of her. TERFs are trans-exclusionary radical feminists, a fringe position within feminism wherein gender is conceptualised as binary and is defined, unchangeably, by biology (Mitchell, 2022). Trans women become excluded, deemed to be men and portrayed as a threat to cis women (Armitage, 2020). A countermovement that problematises and excludes TERF ideology is prominent in some queer and feminist spaces (Mitchell, 2022). Echoing Charlie, Lily seems to embody a certain strictness about her identity: the ‘right’ way to ‘do’ transness is to be

politically aligned against TERFs, such that other political leanings are not ‘allowed’ if one wants to engage with queer services or community.

A queer help-seeker’s legitimacy seems to become a question of whether they enact their queerness in the ‘right’ way to be considered eligible to participate in the queer community, of which queer services are a part. There is also an important consideration of who answers this question. Lily seems to endow mental health organisations with the power to enforce sociopolitical trends around ‘rightness’ of identity. The holding of this power is not new for the psy-complex. A blanket view of queerness as psychologically pathological was prevalent in the 20<sup>th</sup> century, as discussed in the *Literature Review* (see section 1.3.2). From Lily’s perspective, the field seems to have moved on from blanket ‘wrongness’ to specifically positioning ‘off-trend’ or politically ‘incorrect’ queerness as ‘wrong’. The help-seeker, then as now, becomes powerless to authenticate their own identity, instead deferring to institutional authority to delineate which (queer) ways-of-being are available or unavailable to them.

I will now move on to an excerpt from David, who discusses how legitimacy is retained after the initial point of service access.

David: It's [one-on-one therapy] the most challenging because [...] you're on the spot. [...] I'm very conscious I'm taking up someone's time [...]. I'm feeling a bit guilty because we're not spending very much time talking about gender-specific issues. We're talking about family a lot. And I feel, I feel it's a bit... um, it's not the best use of time. (*aged 63, bisexual, trans man, White British, in therapy*)

For David, engaging in therapy appears to mean “taking up” a therapist’s time, creating a subject position wherein the help-seeker is put “on the spot”, like a performer having to make “best use” of their audience’s time. The context of David’s therapy might be relevant: he was attending an LGBTQ+ charity, which requested a small donation per session, and this donation could be on a sliding scale accounting for the help-seeker’s financial

situation. The organisation's charity status and the low-cost nature of sessions might have contributed to this sense of the therapist's time as a scarce, overtaxed resource that had to be used well.

David constructs "best use of [his therapist's] time" as discussing "gender-specific issues" rather than topics less related to one's queerness, like family. To be a legitimate queer help-seeker, one seemingly must have the 'right' identity at the point of access as in Lily's account, and must also continue to 'do' queerness in therapy by bringing up queer topics. David speaks of "guilt" when he does not 'do' queerness in his sessions. Like Lily, he may be attending therapy from a position of inauthenticity, primarily bringing in the queer parts of himself rather than the holistic whole. A help-seeker's legitimacy thus becomes fluid, continually negotiated and renegotiated. In the NEM, such negotiation/renegotiation happens jointly between help-seekers and services (Pescosolido et al., 2013). Services' 'queer' label may create a therapeutic "world" (in Lily's words) where only queer topics are welcome. David then introduces a new angle on what is available for therapeutic exploration.

David: [H]ow much do you need to talk about something if it's clear? And if it isn't that clear, then is it real? [...] I don't know what it is. It must be psychological. Or something else. Another "ology". [...] I don't think I could even put a strong case together for myself... not at this point. That's what I thought that would be the outcome. By coming here, I thought I would be able to form, put a form together and present it as a case [to access a gender identity clinic]. (*aged 63, bisexual, trans man, White British, in therapy*)

David appears to construct queerness as worth talking about only if it is not "clear", resonating with Lily's account that she sought therapy to "work out where [she] fit[s] into this world". Per the construction's action orientation, queerness, or more specifically transness, becomes something that needs to be confirmed by an "ology". This appears to bring a

medico-legal lens to the legitimacy discourse whereby gender identity has to be certified by a professional, mirroring the requirements of the Gender Recognition Act 2004 outlined in the *Literature Review* (Brunskell-Evans, 2019). Indeed, David speaks of his goal for therapy as “put[ting] a form together and present[ing] it as a case” to a gender identity clinic where he was hoping to discuss medical transitioning. This calls to mind a court case: cisgender unless proven trans, with the decision made by an authority figure and not the person themselves.

The help-seeker role may thus become a layperson role, without knowledge or authority, while the therapist becomes the knowledgeable expert holding decision-making power. As a layperson, the help-seeker may enter therapy from a subject position of holding certain expectations about the outcome (i.e., exploring their sexual/gender identity with the therapist so it can be ‘officially’ confirmed), which may feed into the conditions for making “best use” of it: transness/queerness becomes the only available topic of exploration because it is the only thing that needs to be ‘stamped’ by the “ology”. Combining Lily’s and David’s accounts, it seems that to be a legitimate trans help-seeker, one must align with ‘on-trend’ transness but not be entirely “clear” in their identity and intend to use therapy to gain more clarity, especially in a queer service. In terms of practical implications, this may delegitimise older trans help-seekers who already feel “clear” in their identity and may wish to discuss other topics, potentially leading to them not seeking help or limiting their search to non-queer services. In contrast, Oliver speaks of an unclear queer identity as a hindrance to help-seeking.

Oliver: There need to be more spaces where people feel like they're held without, without judgment. People who, um, I suppose they are straight or thought they were straight, are married, have children, and they just went, “Oh, right, no, I'm not, what do I do?” Exactly. What do you do? Where d’you go? What do you do? (*aged 52, gay, cis man, White British, in therapy*)

Oliver talks about coming out later in life, after achieving the ‘straight’ milestones of marriage and children, and how there seem to be no services that cater specifically to this population—he repeats his question of “what do I/you do?” three times, creating a sense that there is no available recourse for someone in this position. Although he does not use the words, Oliver seems to mobilise “halfway” identities, like Lily: people who identified as straight for most of their lives but are now questioning this. “[S]paces” in the treatment network are constructed as judgemental towards “halfway” identities. The following question arises: when does someone become queer ‘enough’ to access queer services? As in Lily’s account, queer services become enmeshed in a bigger queer “world”, such that questioning help-seekers who do not use the ‘queer’ label may feel like they do not belong in the queer community and, therefore, are not eligible for help from queer services.

### **3.2.3 Summary**

Participants mobilised legitimacy both at the point of entry into the help-seeker role and during the course of their therapeutic journey. When becoming a help-seeker, legitimacy seems granted by distress that, when acute enough, can break down barriers to access. It also appears to be granted by the ‘right’ queer identity. This ‘rightness’ manifests itself on a spectrum: for Lily it is political; for David it is a matter of being unclear in his queerness and wanting to explore and confirm it through therapy; and for Oliver, on the opposite end from David, queerness must *not* be unclear to enable help-seeking. Notably, David speaks of gender identity, while Oliver speaks of sexual identity. It could be that the medico-legal context of transness, which places emphasis on ‘expert’ others who must officialise one’s gender, makes available this facilitative role of identity ambiguity. Then, once someone inhabits the help-seeker role, it seems that they continue to negotiate their legitimacy to retain the role, for example through the topics they choose to discuss. The onus of legitimacy seems placed on the help-seeker throughout all accounts: although negotiated at the interface

between queer individuals, queer services, and queer community, legitimacy seems ‘done’ by the individual through their distress, their identity, and their engagement in the therapy.

### **3.3 Discourse: Importance of Being Understood**

Here, the focus shifts from what the help-seeker ‘does’ to what services and therapists ‘do’ to enable help-seeking, namely: creating a sense that the help-seeker is understood through sameness between the help-seeker and the therapist/other staff, or through a robust therapeutic relationship.

#### ***3.3.1 Sub-Discourse: Understanding Through Sameness***

Charlie discusses his initial point of contact with the service through the lens of a discourse of sameness or shared experience.

Charlie: Each of the therapists who you have the opportunity to see has been through sexual abuse [...]. When I rang up to ask them what sorts of things they do, the man, the man I spoke to, who I think was actually the CEO of the organisation, he kept saying to me, “I understand exactly what you’re talking about there”. When I said, “I’ve been a victim of CSA [childhood sexual abuse]”, he said, “I’ve been there as well”. (*aged 73, gay, cis man, White British, waiting list*)

He emphasises the ubiquity of this shared experience throughout the service, from “each of the therapists” to the person who answered his phone call, presumed to be the CEO. From within this sameness, Charlie, as a help-seeker, positions himself as being understood by the other. There might be a link to Oliver’s point about the need for more non-judgemental therapeutic spaces—within Charlie’s subjective psychological experience, the assurance that the staff/therapists have “been there as well” might confer a sense that he will be met with empathy. As a help-seeker who feels understood, Charlie is able to join the service’s waiting list.

#### ***3.3.2 Sub-Discourse: Understanding Despite Difference***

Unlike Charlie, Jordan speaks about being understood by his therapist not due to similarities between them, but *despite* their differences.

Jordan: And the quality of the counsellors was, well, like [name of therapist] who was just excellent [...]. It wasn't that he [therapist] had anything special, he had to be Black or he had to be gay to understand, it wasn't that. He just had an understanding that was born of experience and his natural talent. [...] I didn't find counsellors like him during the years afterwards. Maybe they say the first one was the best but whatever the case, I did see that there was not that kind of relationship established.  
*(aged 53, gay, cis man, Black British, waiting list)*

For his first experience of therapy in his 20s, Jordan, as a Black and gay man, had a therapist who was White and straight but showed Jordan “an understanding that was born of experience and his natural talent”. Understanding, as a discursive object, seems more nebulous than in Charlie’s account, related to the professional and personal characteristics of the therapist. Jordan constructs this first therapeutic experience as special, something he has not found again during his engagement with services over the years—his “first one [being] the best” possibly implying that all subsequent therapists must necessarily be less than “the best”. As a help-seeker waiting for therapy today, Jordan draws on this past experience with his treatment network and seems to position himself as disappointed, perhaps demoralised, not expecting to meet “the best” again.

### ***3.3.3 Sub-Discourse: Understanding Hindered by Difference***

Continuing Jordan’s account, “the best” seems elusive nowadays due to a specific set of circumstances in the mental health field, as he outlines below.

Jordan: And I believe that [...] the NHS therapy world should be reflective of and representative of [city] [...] where you will be able to speak to people who come from your community, from your same nationality as you in ways and cultural

understandings. [...] [B]ut I don't see that in the therapy services... I see only a cookie-cutter kind of therapist [...] [whose] knowledge [...] needs to have more representation from ethnic groups, from women, from people across the board [...]. And they see it from a different perspective because they're not from the community. And it doesn't ring true. So people don't engage. (*aged 53, gay, cis man, Black British, waiting list*)

Jordan constructs therapy, particularly therapy provided by the NHS, as “a world”. While Lily’s “world” of services was embedded within the queer community, Jordan’s “world” seems to be an ethnocultural one. Currently, the therapy world according to Jordan lacks ethnocultural representation and nuance, being populated by “cookie-cutter” therapists (later in the interview described as “women, English, in their 60s”) who may not have the “knowledge” to help “people across the board”. Understanding between a therapist and help-seeker would, through this lens, be achieved through sameness in terms of ethnocultural background. As this sameness is lacking, Jordan’s help-seeker continues to be disappointed, their ethnocultural needs unmet. From this subject position of unmet need, the help-seeker does not engage with services. Notably, whereas in the previous extract Jordan spoke of his own experiences, here he seems to become a spokesperson referring to help-seekers more generally, using “you/your” rather than “I/my”. He could be enacting a help-seeker-as-help-facilitator role that I will explore in detail later, emphasising the depth of his community’s need for ethnocultural nuance in therapy so that, through this study’s dissemination and implementation, this need might be met. He also seems to mobilise a sense of power through numbers, pitting all disappointed, disengaged, ethnoculturally minoritised help-seekers against the ‘Englishness’ rooted in treatment networks. By lacking knowledge of ‘non-Englishness’, “cookie-cutter” therapists seem to create a non-welcoming space for ethnoculturally minoritised populations, perpetuating marginalisation per the

power/knowledge paradigm. Prospective help-seekers from these populations may feel that services cannot understand them, that “cookie-cutter” perspectives do not “ring true”, and may self-silence by not seeking out services or by not speaking of their cultural affiliations and meanings in session. Jordan then moves on from “cookie-cutter” therapists to “cookie-cutter” treatment that assumes that “everybody needs the same way”.

Jordan: And we cannot think that it’s cookie-cutter for everybody and everybody needs the same way. And that’s why I don’t believe in all these umbrella terms...

Sometimes I think we need to break it down and look specifically at what the needs are of the individuals under these banners. Because my needs might be different to Jack’s to Jill’s. (*aged 53, gay, cis man, Black British, waiting list*)

For Jordan, “umbrella[s]” and “banners” mask differences between help-seekers’ unique needs as individuals. He seems to say he does not want to be perceived by a therapist as an LGBTQ+ person assumed to share the same needs with other LGBTQ+ people, but as a person who is Black and who is gay and on whom those identities will have had impacts that are particular to Jordan and not to “Jack” or “Jill”. In other words, he seems to argue for the dismantlement of monolithic discourses about queer identities (Fassinger & Arseneau, 2007), to be replaced by a sensitivity to individuality and intersectionality. Given past experiences with “cookie-cutter”-ness in his treatment network, Jordan’s subjective psychological experience might include worry that he will be misunderstood or not understood at all by his future therapist, and/or that he might receive protocolised treatment that fails to meet his idiosyncratic needs. This worry may be experienced as a proximal stressor as per minority stress frameworks (Douglass & Conlin, 2022), potentially exacerbating his mental health difficulties while he waits for therapy.

### **3.3.4 Summary**

Both Charlie and Jordan seem to position actual or anticipated understanding from the treatment network—inclusive of clinical and non-clinical staff—as an enabler of entry into the help-seeker role. There are multiple facets of what understanding means: a shared experience between help-seeker and therapist/other staff; a shared cultural “world”; a feature of the therapeutic relationship arising from the therapist’s skill. Charlie and Jordan are the only participants who constructed a facilitative role for understanding. As Charlie was seeking therapy for CSA, a traumatic background might necessitate a guarantee of safety through sameness before engagement can occur, for example by ‘levelling the playing field’ so the therapist is not a ‘well’, powerful other treating a ‘victim’ who is disempowered and ‘unwell’. Jordan may have likewise been grappling with power dynamics arising from seeking therapy as an older Black, gay man in a setting dominated by “women, English, in their 60s”, implied to be White and straight and assumed to have different life experiences. For Jordan, understanding may become the foundation of a connection between himself and his therapist where he is seen as a unique human being and not a stereotyped ethnocultural and sexual minority.

### **3.4 Discourse: Help-Seekers Beyond Help-seeking**

Having considered the importance of the help-seeker’s personal characteristics (negotiating legitimacy) and the treatment network’s characteristics (creating understanding) in enabling help-seeking, I will now focus on constructions of the help-seeker role that go beyond the act of seeking help from a mental health practitioner, namely: help-seekers as social subjects navigating queer therapy spaces that often double as social spaces; help-seekers as influenced by their social networks; help-seekers as queer community members with civic responsibilities; and help-seekers as providers of their own help.

#### ***3.4.1 Sub-Discourse: Help-Seekers as Social Subjects in Social Spaces***

Mark talks about attending therapy at an LGBTQ+ centre with which he had prior “history” due to the centre also organising social events and thus occupying a joint space between social and treatment networks; this “history” served a dual and contradictory role of both facilitating and hindering Mark’s help-seeking.

Mark: I had history with it [therapy venue]. I’d been here many times before. And I used to meet my friend who... um, who died a couple years ago. He used to come here. [pause: 10 seconds] So, in a sense, it was sort of bittersweet, but actually coming here and having my new experience, my current experience, may have helped me move forward, because it’s a building I was familiar with having time down in my 20s [...] com[ing] to various [social] groups with various people, including my friend who died couple of years ago. So, yeah, uh, it made it easier and... and difficult. (*aged 52, gay, cis man, White British, in therapy*)

Mark constructs the venue as a familiar place where, in his younger years, he attended “various [social] groups with various people”. One of these various people, a friend of Mark’s, recently passed away. To be a help-seeker in this particular venue, therefore, seems to also mean being a friend and a mourner. Mark employs a contradiction to describe the impact of these multiple meanings on his help-seeking, which was made both “easier” and “difficult”: as part of his subjectivity, seeking help might have been easier due to his familiarity and comfortableness with the venue, yet difficult due to putting him in touch with memories of his friend and, thus, with his grief. He qualifies this contact with his memories/grief as “bittersweet”: having a “new experience” in the venue (i.e., therapy) seems to have enabled him to “move forward” in his processing of the grief. Seeing as it is common for LGBTQ+ mental health spaces to act as community hubs and straddle the line between social and treatment networks (e.g., ELOP, n.d.-a; London Friend, n.d.-b; MindOut, n.d.), Mark’s experience may not be isolated. A help-seeker’s meaning-making about the therapy

venue will likely be idiosyncratic, dependent on their personal circumstances, and may involve reluctance or eagerness to revisit memories, as well as comfort or difficulty in returning to a known place, variously enabling or hindering entry into the help-seeker role. Pivoting to current rather than historic circumstances, Mark speaks of his therapy venue's social environment as a helpful adjunct to his treatment.

Mark: More importantly, however, having the LGBTQ+ space to go to is still very important because I can then relax and I can talk about the mundane things. I can talk about what's really going on, because I don't have to explain that I'm attracted to men in whatever way. Because if I say I'm attracted to men, that also, in many ways, tells you nothing. You don't know what kind of men. You don't know in what ways. You don't know what my sexual preferences are. You don't know what my emotional preferences are. (*aged 52, gay, cis man, White British, in therapy*)

The “LGBTQ+ space” that Mark mobilises as a discursive object is a weekly social drop-in that takes place at the same venue where he attends therapy. He seems to construct the shared queerness in the space as a gateway to openness such that he can talk about both “mundane things” and “what’s really going on”. In contrast, in social situations where he has to disclose and “explain” his queerness, openness becomes impeded. Mark speaks of such disclosure as a false intimacy: the receivers of his disclosure assume they know something about him, whereas he feels like he has “[told them] nothing”. A discourse about labelling could be in use here. Entering the LGBTQ+ ‘box’ by attending queer events with queer people is constructed as safe, an “important” opportunity for “relax[ation]” and connection, possibly linked to everyone in attendance also inhabiting that same ‘box’. Outside of queer events, when Mark enters the ‘box’, he is its only inhabitant. The ‘box’ becomes restrictive, reductionist, no longer a space for Mark to be authentic but a projection of other people’s assumptions, stereotypes, or prejudices about Mark-as-a-gay-man. For an opposing

perspective, David speaks of the wider social context of his therapy as hindering his entry into the help-seeker role.

David: Give me a moment to just think about why I wouldn't have come here [before the death of his mother]. I suppose [...] I don't like groups. I mean, I'm very much a one-to-one person. [...] I feel uncomfortable in groups. I'm not used to them. I don't really understand them. [...] I can't really cope with it. (*aged 63, bisexual, trans man, White British, in therapy*)

For David, the social groups hosted by the venue seem to be a threat: a source of discomfort, unfamiliar and eluding understanding. Engagement with the service's therapy offering does not have a prerequisite of group attendance. However, David seems to conflate the two, entering a subject position wherein being a help-seeker in the venue becomes synonymous with being exposed to groups. Notably, in this particular venue, groups take place on the ground floor and people coming to therapy have to walk through the social space to reach the therapy rooms on the basement level below. David constructs the groups as a barrier (potentially physical if a group is present when he attends sessions) that would have prevented him from seeking help before his mother's passing, at which point his level of distress seems to have overcome any such hindrances as per the section on legitimacy granted by distress. Now that David is in therapy, the groups seem to have become a stressor with which he "can't really cope". Practical implications include a help-seeker role that might be challenging to retain if the venue is not experienced as safe, raising questions about how safety in blended therapy/social spaces might be managed to enable sustained treatment engagement.

#### ***3.4.2 Sub-Discourse: Help-Seeking Facilitated by Personal Social Networks***

Here, I shift focus from the role of social spaces to the role of the help-seeker's personal social network. Jamie, for instance, recounts how their partner was crucial in enabling them to become a help-seeker.

Jamie: And she [partner] said to me, "[...] [M]y doctor is a really good doctor".

Because you know, the attitude previously to people with depression was pull yourself together. If you ever went or if they took you seriously, they'd lock you up in a mental hospital and give you drugs or electroconvulsive therapy. (*aged 58, lesbian, unsure of gender, White British, in therapy*)

Jamie's partner provides an endorsement of her doctor, which seems crucial for Jamie entering the help-seeker role with the same doctor. This entry appears to hinge on an assurance of the doctor's "good[ness]". In terms of action orientation, help-seeking thus becomes a matter of extremes: 'good' practitioners will help you, whereas 'bad' practitioners will dismiss you and expect you to "pull yourself together" (from within a 'stiff upper lip' discourse), or they will "lock [you] up" and treat you with "drugs or electroconvulsive therapy" (from within a discourse of incarceration where 'help' becomes loss of freedom or agency). There was one other instance of help-as-incarceration in the interviews, in Oliver's account.

Oliver: [...] I had an episode in 2019 where I did actually attempt, um, failed my, my attempt [suicide] [...] and I didn't tell anyone... I just went to the GP the next day, and they did actually ask their self-harm question. And I was so paranoid that they were going to lock me away, I just said no and I just carried on. (*aged 52, gay, cis man, White British, in therapy*)

Oliver positions himself as a help-seeker who had to self-censor during a GP appointment following a suicide attempt, in order to avoid being "lock[ed] [...] away". This resulted in no further help being offered at that time, Oliver "just carr[y]ing on" alone.

Elsewhere in the interview, Oliver constructs this “silent struggle” with mental health difficulties as a “repetition” or “cycling” of “secrets that [queer people] have to hold on to before [they] come out”. Historically, both mental illness and queerness have been unavailable for conversation, enacted in private to avoid stigma or the ‘real’ repercussions of stigma such as being “lock[ed] [...] away” (Lanzoni, 2005; Love, 2001). This similarity could reframe the entry into the help-seeker role as a “com[ing] out” in the sense of disclosing the “secret” of one’s mental health difficulties. It also creates a question of how older queer people might be able to break the cycle of silence and secrecy to enter the help-seeker role from within histories of criminalisation and pathologisation; or, indeed, whether it is their responsibility to break the cycle or this might be more suitably placed with treatment or social networks.

Pooling Jamie’s and Oliver’s accounts, it seems that mental health services are embedded within a legacy of mistrust, and successful entry into the help-seeker role may require trust to be rebuilt. In Jamie’s case, practitioner endorsement from their personal social network was a key part of this rebuilding. Similarly, Sarah constructs the support of trusted others as a crucial source of facilitation for her help-seeking.

Sarah: Management and [...] my colleagues [...] were very supportive. But it got to a point where it [mental health] was still not [...] working. And they said, you know, they suggested some counselling, which I went to this counsellor for, and it kind of got into the stuff around my mum and around that kind of area. (*aged 61, bisexual, cis woman, White British, in therapy*)

Sarah seems not to have thought of therapy as an available option until it was ‘spoken into being’ by her managers and work colleagues. Her help-seeker appears not to know that they *can* seek help, relying on information from more knowledgeable others to make this possible. Arguably, mental health is positioned as a communal responsibility that spans the

breadth of one's social network, including but not limited to partners, family, friends, community, and employment.

### ***3.4.3 Sub-Discourse: Help-Seekers as Bearers of Social Responsibility***

I will now consider how help-seekers themselves might take on this role of help-facilitators. Oliver positions the help-seeker as a member of the LGBTQ+ community who has a responsibility to be “kind” to other community members by spreading the word about mental health services.

Oliver: I think for everyone also to stand up and do a video post [...] saying [...] what's available [...] because, you know, it's only when you ask that you know, otherwise you're sitting in silence [...]. I think that's just people being kind to each other within the community [...] because I do see things where people aren't kind to each other [...]. We went through all of it, these protest marches, for you to say that to that person, you know? [...] Genuine people talking about genuine subjects, rather than Z-list celebrities tapping on to something where it just, it's, yes, it's good that they're making a noise, but you know, it's a bit like someone talking to me from an American beach [...] a beautiful body talking from a beach in California about something, versus someone talking on [name of local beach] about something. You are slightly more relatable. [...] I'm not going to listen to whoever unless we have the same backgrounds. (*aged 52, gay, cis man, White British, in therapy*)

Elsewhere in the interview, Oliver talks about taking up this social responsibility himself through community outreach, particularly a blog documenting his personal experiences with mental health difficulties and services. He thus inhabits a dual subject position as seeker of help for himself and also facilitator of help for others. He constructs such community outreach/“kind[ness]” as something that older LGBTQ+ individuals are entitled to after undertaking activist efforts (“protest marches”) in their younger years. This

seems to resonate with the generational rift among trans people in Lily's account, wherein younger people appear to enact a different transness from older counterparts. For Oliver, the rift pertains to younger vs older understandings of how community 'should' be performed. This may add a new facet to the influence of the queer community on the help-seeker role as theorised by the NEM, with community belongingness not only legitimising access to queer services but also providing recourse to a repository of information about treatment networks. It could additionally represent a reclaiming of power such that knowledge of "what's available" is not exclusively the domain of institutions that could deploy it for oppressive purposes (e.g., aversion therapy in the 20<sup>th</sup> century; Eysenck, 1960), but is now held within the community as a helpful resource.

Like Jordan, Oliver speaks of the help-seeker as a hypothetical—or perhaps universal—being 'out there' rather than himself from within his own experiences. This seems to emphasise a widespread need for help in the queer community; or it could be an instance of Oliver embodying his social responsibility by sharing community insights with me to facilitate help-seeking via this research. As in Sarah's account, Oliver's help-seeker is an unknowing social subject, gaining access to information regarding "what's available" in terms of help by asking more knowledgeable others. These more knowledgeable others are constructed as "genuine people talking about genuine subjects", contrasted against "Z-list celebrities" or a "beautiful body" on a Californian beach. It does not seem sufficient for the more knowledgeable other—the help-facilitator—to hold the relevant knowledge. They must also be relatable, having the "same backgrounds" as the prospective help-seeker in order to become credible and worth "listen[ing] to". The interview does not capture how Oliver understands a shared background beyond localness, inviting further questions about who decides what counts as relatable in the queer community. Do you need to live locally? Have a particular skin colour, sexual or gender identity, or neurotype? A particular upbringing?

Depending on the answers, as part of the subjective practical implications for help-seekers-as-help-facilitators, they may feel able to engage with their local queer communities, possibly deriving a sense of social connection and civic worthiness from it; or they may feel excluded as not relatable ‘enough’. Relatedly, Jordan positions himself not as a passive recipient of therapy but as a help-seeker who actively tries to dismantle the “cookie-cutter”-ness in mental health services.

Jordan: So, yeah, again, I'm disgruntled with it [“therapy world”] [...]. I've learned a lot over the years, and there's no point, you know, just screaming at the wind. I tried to do things that are constructive with as much as I can with, um, the counselling. (*aged 53, gay, cis man, Black British, waiting list*)

Elsewhere in the interview, Jordan describes these “constructive” activities as providing training for anti-racist practices in queer and NHS services. In his subject position of help-seeker-as-activist, Jordan seems to gain agency: instead of “screaming at the wind” due to his “disgruntle[ment]”, he leverages what he has “learned [...] over the years” and through activism he attempts to improve the experiences of queer people of colour in mental health services. While Oliver’s help-seeker acts as a community liaison disseminating knowledge about services, Jordan’s help-seeker collaborates with services to improve their therapeutic offering. This activist help-seeker role seems emotionally protective within Jordan’s subjective psychological experience, equipping him with an empowering outlet for his “disgruntle[ment]” and embedding him within the LGBTQ+ community.

#### ***3.4.4 Sub-Discourse: Help-Seekers as Their Own Help-Facilitators***

Here, I present help-seekers as bearers of responsibility towards themselves rather than others, facilitating their own help alongside therapy attendance. Oliver describes a need to “manage [his] day-to-day living” that is located with him, not his therapist.

Oliver: And you realise that whilst they [mental health services] are there, one still has to manage one's own day-to-day living, and that's the loneliest thing when you're in this particular place [experiencing suicidal ideation] [...] It's a silent struggle sometimes, but I work around it with positive distractions, I think that's the way of doing it, but yeah, I just feel like I'm falling, I'm kind of building the parachute as I'm falling. (*aged 52, gay, cis man, White British, in therapy*)

As discursive objects, mental health services seem positioned as limited in their remit: “there” but not in a “day-to-day” sense, potentially creating a gap between the learning of coping skills that is done in therapy and their implementation in daily life. Oliver describes this implementation as “building the parachute as [he is] falling”, with death implied at the bottom of the “fall”. The help-seeker seems to be in a life-or-death situation, motivated to help themselves by weaving together a “parachute” of coping skills outside of therapy, yet potentially finding it challenging to do so while in crisis. For Oliver, the “parachute”-building is “the loneliest thing”, “a silent struggle”: something that is done on his own, with the practical implication that it cannot be spoken about with others, perhaps not even his therapist, which might block Oliver from recruiting another pair of hands to contribute to the “parachute”. Sarah similarly mobilises the self as something that must be “work[ed] on” outside of therapy.

Sarah: [...] I am having some sessions with work [...] which I found quite, quite useful. [...] I sort of look through books [self-help materials based on cognitive-behavioural therapy] and keep myself well, kind of working on myself in a way. (*Demographics: 61, bisexual, woman, White British, in therapy*)

As therapy is only “quite useful”, a need arises for this supplemental self-help “work”. A discourse of mental wellness seems applicable, wherein an ‘unwell’ self is an ‘incomplete’ self, requiring intervention to be “ke[pt] [...] well” (Perone, 2014). This process

is implied to be perpetual or periodic, perhaps creating a requirement for a help-seeker to become a self-helper even after the end of therapy. Moreover, Sarah, like Oliver, speaks of self-helping as a solo endeavour. Mental illness seems localised within the self, as something to be rectified, with the self endowed with at least partial responsibility for this rectification. The modality of Sarah's therapy—cognitive-behavioural therapy (CBT)—might have increased the availability of the self-helper role for her. Due to CBT's often-practical nature, it may be perceived as more accessible than other modalities to implement on one's own, extraneous to therapy.

### **3.4.5 Summary**

Seven of my eight participants spoke of social networks as pivotal influences on their entry into the help-seeker role. The person who did not, Lily, was awaiting treatment and might not have been aware of or exposed to the service's social dimensions. Social networks may blend into treatment networks when current or historical social experiences in the therapy venue impact the availability of the help-seeker role. Social networks may also include help-facilitation from trusted others who might share information about treatment networks or vouch for practitioners to deconstruct mistrust. Help-seekers themselves may become help-facilitators, disseminating knowledge about available help, or undertaking activist collaboration with services to create more inclusive practices. Some participants, in contrast, spoke of a joint help-seeker/self-helper role that occurs in isolation, highlighting that self-helping, whether as an adjunct to help-seeking or as a standalone role, might be subject to unique pressures and processes outside of direct social involvement.

### **3.5 Reflexive Statement: Part III**

To conclude this chapter, I discuss my analytical choices and the possible reasons behind them in the interest of transparency and methodological robustness (Spencer & Ritchie, 2011). I devote significant page-time to legitimacy. This may have been an attempt to

put a Foucauldian ‘stamp’ on my work, legitimising myself as a good ‘enough’ trainee CoP. Moreover, I have historically felt powerless under a traumatising medical system, which has perhaps informed my deconstruction of institutional power as enacted by services and ‘expert’ therapists. This may have also been driven by my unease with my own ‘expertness’ during clinical work. For me, ‘expertness’ does not feel like an available position as a trainee without ‘enough’ skills, nor as someone reluctant to assume the role of ‘expert-as-traumatiser’. I seem to have produced an account of ‘expertness’ wherein mental health services and practitioners become an oppressive force. I could have provided more nuance by acknowledging the reality of power between help-seekers and their treatment networks. If power is granted by knowledge, then, generally, therapists/other staff will hold more power than help-seekers due to their knowledge of clinical techniques/service operations. Equalising this power imbalance may be possible, but perhaps not fully. It may be worthwhile to consider how treatment networks might deploy their power with helpful outcomes; I make suggestions to this effect in the *Discussion*.

Relatedly, I found it difficult to navigate my own power as the researcher while writing the *Analysis*. I initially used tentative language to construct my arguments, “I wonder if...”, “I get the sense that...” In giving participants a voice, I attempted to silence my own, perhaps feeling that I lacked the ‘right’ to have a voice on older queer help-seeking. This may be connected to my perceived lack of belongingness to my participant group: I am younger than 50+, and although I am a queer help-seeker, identifying as bisexual and attending my own therapy, I do not feel queer ‘enough’ as discussed in previous reflexivity sections. Queer ‘enough’, for me, would mean activist engagement. This adds a new facet to my emphasis on legitimacy and power. By mobilising activist topics in the *Analysis*, I might have been trying to claim my own queerness, my own voice as a queer researcher. Discussions with my

supervisor were instrumental in enabling me to challenge my tentativeness and embody the role of the researcher more authentically.

This tentativeness might have also contributed to my choice to remove my own quotes from interview extracts. Ostensibly, this ensured brevity, yet in doing so, I disowned my co-constructive influence on the interviews. I note my positivistic mindset assuming that there could be a ‘real’ account untainted by my influence. As before, this could be rooted in perceived non-belongingness to my participant group, their stories not being mine to tell. Alternatively, it might reflect the newness of the researcher role for me. This is the first time I have conducted qualitative research, and this lack of prior knowledge and experience left me feeling like I was going in ‘blind’. Moreover, my interview schedule was sparse, intended to encourage naturalistic talk, but within this sparseness I felt unsure whether I was saying the ‘right’ or ‘wrong’ things. Attempting to preserve a sense of good-enoughness, I might have avoided disclosing my own potentially ‘wrong’ quotes. Hindsight has enabled me to reflect on the distinction between choices and mistakes. For me, the process of conducting this research has been embedded into a broader journey of personal growth: I am shifting into a sense of embodied good-enoughness wherein I feel able to own my choices whether ‘right’, ‘wrong’, or otherwise.

Another enactment of my power as the researcher was privileging queerness more than older age. This may be because participants’ stories of older age did not meet my assumptions of older people as ‘set in their ways’, as discussed in *Reflexive Statement: Part I*. Four of my participants—Charlie, Lily, Oliver, and Sarah—spoke of older age as liberating them from normative expectations, allowing them to experiment with new queer identities. While this does not seem directly linked to help-seeking, I created space in the *Analysis* for constructions of queerness and could have done the same for constructions of older age.

Overall, I seem to have produced an older queer help-seeker who must negotiate power dynamics to legitimise their help-seeking, and who is queer first and older second. I will now progress to the *Discussion*, slotting my version of the help-seeker into the wider discursive landscape.

## 4. Discussion

### 4.1 Chapter Overview

This study's principal aim was to investigate discursive constructions of the help-seeker role among older LGBTQ+ people waiting for or attending early-stage therapy. The help-seeker role is a concept borrowed from the NEM, which posits that the first step to accessing mental health services is to assume the role of the help-seeker, a process shaped by social interactions with friends, family, and communities, as well as clinical and non-clinical staff. Eight participants were interviewed regarding their help-seeking journeys within their social and treatment networks; they were aged 50+ and variously identifying as gay, lesbian, bisexual, and trans. Interviews were analysed through an FDA lens, hybridised from Willig's (2022) and Parker's (1992) guidelines.

I start by summarising the discourses identified in the *Analysis*. Next, I localise them within sociocultural, political, and historical contexts, implementing Parker's (1992) guidelines to examine their relationship to macro structures like institutions, political bodies, and broad social groups. There follows an exploration of implications for help-seeking theory, and for services, CoPs, and allied mental health professionals. I discuss the study's limitations and highlight opportunities for future research. To conclude, I provide a final reflexive account of my choices in this chapter as embedded in my journey through the Professional Doctorate.

### 4.2 Summary of Results

Participants mobilised three discourses to discuss what it means to be an older, queer seeker of psychological help: help-seekers as negotiators of legitimacy; help-seekers as variously understood or misunderstood by their treatment networks; and help-seekers beyond help-seeking, as social subjects or isolated self-helpers.

The negotiation of one's legitimacy as a help-seeker seems to shape the help-seeking journey from the point of first contact to session attendance. Legitimacy appears to take the

form of a question of ‘rightness’: is the prospective help-seeker distressed to the ‘right’ intensity to warrant professional help? Moreover, in the case of queer-specific services, does the prospective help-seeker inhabit the ‘right’ queer identity? The first question needs to be answered only once, by the help-seeker themselves making a judgement on whether they have become unable to cope alone. If the answer is yes, then the role of the help-seeker becomes available.

In contrast, the second question requires continual negotiation and re-negotiation. Queerness, unlike distress, is not self-affirmed by the help-seeker, but must be proven to their social and treatment networks: to services and therapists, and to the queer communities in which those services and therapists operate. This proof can be at a sociopolitical level, with help-seekers benchmarking their labels and queer enactments against the perceived majority and, if they do not pass muster, engaging with queer services from a place of ‘hiding’ or inauthenticity, or not engaging at all. The proof can, alternatively, be interactional, created between the help-seeker and the therapist through the topics discussed under a construction of queer services as being only for queer issues. This seems especially relevant for trans help-seekers navigating medico-legal pressures wherein transness must be ‘certified’ by an ‘expert’.

As suggested by the NEM, a supportive relational style from treatment networks is a key facilitator of entry into the help-seeker role (Pescosolido et al., 2013), here mobilised as help-seekers being understood by clinical/non-clinical staff in terms of their traumatic or ethnocultural experiences. Power dynamics seem to underlie this process. An important part of understanding for participants was visibility, for example, a trauma service publicising that they are staffed by therapists who have undergone trauma like their clients, or services more generally being ethnoculturally diverse. A lack of visibility could be interpreted as an exercise of power, perpetuating the silencing and stigma around trauma and ethnocultural

minoritisation. A represented help-seeker is empowered to access services; an unrepresented help-seeker, conversely, may not reach out to services, or may find therapy ineffective, although this could be mitigated by the therapist's humanistic skills.

Lastly, participants discussed the help-seeker role as enacted outside of the therapy room, or influenced by non-therapeutic social processes. This could include the navigation of therapy spaces that double as social spaces, often the case in queer services. Although not captured by the NEM, help-seekers in this study seemed to have idiosyncratic ties to or meaning-making about these therapy/social spaces, variously facilitating or hindering therapy attendance; I will expand on this in section 4.4, *Theoretical Implications*. The NEM does, however, portray help-seekers as social subjects within social networks, here represented by personal or community networks: participants spoke about relying on others to facilitate their entry into the help-seeker role, for example by disseminating information about available help or trustworthy practitioners; they also spoke about becoming help-facilitators themselves, which may have a protective effect for their mental health. Outside of the social realm, help-seekers may inhabit a dual role as self-helpers, creating their own "parachute" of strategies to become and remain mentally 'well' as a supplement to therapy.

Overall, to seek help as an older queer person means to grapple with questions of legitimacy both as a help-seeker and a member of the LGBTQ+ community. It means to seek an assurance that practitioners will understand the context of one's lived experiences. It means to be a socially embedded human being operating in social spaces and social networks that shape access to services. Finally, it also means to be a self-helper as an adjunct to formal help.

This study provides novel insights into the complexities of seeking psychological help as an older queer person. It is a previously under-researched area, with past literature identifying a mental health vulnerability in this population (Semlyen et al., 2016; Watkinson

et al., 2024) and low engagement with services among older people generally (NHS, 2022), yet primarily focusing on help-seeking barriers in queer youth (McDermott et al., 2018) or suggesting a paradoxical lack of barriers for older counterparts (Cronin et al., 2021). To understand why help-seeking does or does not occur, the NEM postulates that it is crucial to first understand how one becomes a help-seeker and how their interactions with friends, family, communities, and clinical/non-clinical professionals enable or disable this process (Pescosolido et al., 2013). The results discussed here are an initial step towards this. They provide a useful springboard for services to evaluate and update their messaging and operations in order to create a help-seeker role that feels more accessible to older queer people whose mental health needs may, to date, have remained unmet. They also support practitioners in developing a richer appreciation of this population's unique contexts, experiences, needs, and expectations, with direct applications for more affirmative and effective therapeutic practice.

### **4.3 Localising Discourses Socioculturally, Politically, and Historically**

In this section, I discuss the sociocultural, political, and/or historical provenance of each discourse and the advantages or disadvantages it creates for individuals and institutions (Parker, 1992). I go beyond the interview content and into a more interpretative domain, making no claims to 'truth'. Instead, I seek to embed older queer help-seekers into their wider contexts and stimulate discussion among researchers and mental health practitioners and services.

#### ***4.3.1 Discourse: Legitimacy***

##### **4.3.1.1 The Help-Seeker Role Delegitimised Within Sanism**

Participants discussed their entry into the help-seeker role as catalysed by a breakdown in their ability to cope alone. McDermott and colleagues (2018) suggested an equivalent process in younger LGBTQ+ people. Beatie et al. (2022), studying a non-

LGBTQ+ gerontological population, reported similar conclusions. There could be a certain universality, beyond age or sexual/gender identity, to this construction of psychological crisis as an enabler of help-seeking. This might be underpinned by norms of mental wellness, enforced through sanism, or prejudice against individuals with a diagnosis or perceived to have a diagnosis of mental illness (LeBlanc & Kinsella, 2016). Sanism is associated with a capitalist ideology which privileges economic achievement, defining the value of individuals through their ability to gain, maintain, and be consistently productive within employment (Baril, 2023). Mental illness becomes a barrier to productivity: a marker of socioeconomic ‘dead weight’, attracting stigma (Baril, 2023). Coping alone could be interpreted as a strategy to avoid this stigma, keeping mental illness private, as in Oliver’s “cycling [of] secrets”. The help-seeker role seems to become available only as a last resort, when distress is too intense to be privately suppressed.

For McDermott et al.’s (2018) young LGBTQ+ participants, help-seeking was a last resort also due to worry that practitioners would dismiss their distress as not severe ‘enough’ for professional support. Participants here, however, did not speak about worries of dismissal. This is surprising considering the perception that mental health difficulties are an expected part of ageing (Ouchida & Lachs, 2015), and the tendency of GPs to under-refer older people to psychological treatment (Frost et al., 2019; Rodda et al., 2011). As discussed in *Reflexive Statement: Part II*, my interview approach might not have enabled such exploration, focusing on participants’ current help-seeking rather than their referral journeys. Alternatively, as seven of the eight participants had been in therapy before, they might have felt more certain of what level of distress would count as severe ‘enough’ compared to a younger person potentially accessing therapy for the first time. This suggests a self-evaluative process wherein ‘copers’ benchmark their distress against the ‘right’ severity. If distress is deemed not severe ‘enough’, they may then *self*-dismiss their mental health concerns. Foucault’s

(1975/1977) concept of self-policing seems applicable here. This draws on the Panopticon, introduced by the founder of modern utilitarianism Jeremy Bentham and based on a notional prison arranged around a central guard tower (Elmer, 2012). According to Foucault (1975/1977), this all-seeing, ever-present disciplinary power becomes internalised as self-surveillance, suppressing non-normative ways-of-being to avoid punishment. Older queer people may self-police by staying in the ‘coper’ role to the point of crisis, such that outwardly they continue adhering to mental wellness norms and do not incur stigma, particularly through a minority stress lens wherein the chronic experiencing of stressors related to sexual/gender identity may create sensitivity to all stressors (Haight et al., 2023) and underpin avoidance mechanisms that increase distress (Mann et al., 2022); however, this is only one perspective and chronic minority stress could alternatively be linked to resilience depending on the availability of familial or community support (Cyrus, 2017). For younger people with potentially limited experience as socioeconomic subjects, internal policing might feel less relevant than the external policing in McDermott et al. (2018). Social norms about mental health that are enacted through such internal and external policing form the context in which social and treatment networks interact with the help-seeker in the NEM (Boydell et al., 2013).

It is worth considering how the U.K. therapy landscape might shape mental wellness norms. Improving Access to Psychological Therapies, now Talking Therapies (TT), was rolled out nationally in 2008 as part of the NHS (Clark, 2011). TT provide short-term psychological treatment for common mental disorders (Clark, 2011). The programme was founded by British economist Richard Layard and British clinical psychologist David Clark (Bruun, 2023). During their Parliamentary lobby, Layard and Clark framed TT as a dual psychological and economic solution, intended to create economic growth by enabling people struggling with mental illness to return to work and relinquish unemployment benefits

(Layard et al., 2006; Layard et al., 2007). Help-seekers are positioned as workers in an economic system; their help-seeking benefits this system, keeping it profitable, with distress benchmarked as severe ‘enough’ when it impacts socioeconomic functioning. The discourse about ‘benefit scroungers’ could likewise be relevant. Through this lens, individuals are perceived to be out of employment due to laziness or selfishness rather than legitimate mental or physical health difficulties (Roberts, 2017). It is a discourse that reinforces mental health and disability stigma (Patrick, 2017), and has resurged in the United Kingdom’s currently challenging economic climate (Fisher, 2023). This could contextualise participants’ mobilisation of severe distress as a legitimator of help-seeking: distress is benchmarked as severe ‘enough’ when it becomes so “desperate” and “fractur[ing]” that any other ways-of-being, which may include economic productivity, are rendered unavailable. However, participants did not explicitly make this link with economic functioning, which would benefit from further enquiry. In terms of the institutional impact of sanist discourses, the limited resources of mental health services might be protected from depletion by individuals only seeking help during crisis rather than routinely (Bar-Haim et al., 2023; Rethink, 2024). Politically, TT can continue to be regarded as a success without the need for further political and financial investment. There may, therefore, be limited appetite from authority bodies to encourage people to seek help outside of crisis.

This institutionally and politically upheld sanist framework, which makes available the help-seeker role only when distress is extreme, seems reflected in participant accounts. Lily, David, Oliver, and Charlie self-policed by coping alone with their mental health symptoms until these “[came] to an organic head”, becoming uncontrollable and creating a “desperate upset”, including suicidality, that exceeded their coping resources and required professional help.

#### **4.3.1.2 The Help-Seeker Role Delegitimised Within British Masculinity**

Discourses which silence emotions, invoked by Charlie as “British [men] [not] need[ing]” therapy, could also contribute to the delegitimisation of help-seeking outside of crisis. The British ‘stiff upper lip’ is a stereotype of stoicism in the face of adversity, notably associated with the Second World War (Boyce, 2012). One example is the *Keep Calm and Carry On* poster (Irving, 2014). Although it was not officially distributed in wartime Britain, the discovery of a copy in 2000 retrospectively defined that era’s threats (e.g., air raids) as negotiated through ‘carrying on’: emotions, like fear, being suppressed to enable the nation to function (Hodge, 2013; Irving, 2014). A more contemporaneous example is the 1937 musical-comedy movie *Damsel in Distress*, produced in Hollywood but set in the United Kingdom. In one song, American characters are encouraged to adopt British stoicism with the lyrics: “Stiff upper lip, stout fella / When you’re in a stew / Sober or blotto, this is your motto / Keep muddling through” (Allen, 1937). Extrapolated to mental health, an emotional ‘stew’ would be handled by ‘muddling through’ on one’s own rather than seeking help. It also seems relevant that these lyrics are directed at two male characters. There are records of masculinity being constructed as inherently resistant to emotions dating back to *A Treatise of Melancholie*, published in 1586 by English physician Timothie Bright (Bhattacharya, 2023). Over time, men’s imperviousness to emotion became fused with British imperialism, enacted as ‘muscular Christianity’ (Bhattacharya, 2023). This is a term coined by writer and barrister Thomas Collett Sandars in his review of the 1857 novel *Two Years Ago*, written by clergyman Charles Kingsley (MacAloon, 2013). Sandars described Kingsley’s ideal of a man as someone “who fears God and can walk a thousand miles in a thousand hours”, as cited in Hall (1994, p.7). Muscular Christianity gained popularity in Victorian Britain, to be exported to other nations variously portrayed as inhabited by children or savages prone to emotional expression, especially tearfulness (Bhattacharya, 2023; MacAloon, 2013). Within this legacy of male-coded stoicism, being a British man seems to require a silencing of emotional

distress: carrying on through thousands of miles, alone, as a measure of social ‘goodness’. Feeling distress, in contrast—and moreover, seeking help for that distress and thus speaking it into being—would mean to be ‘less than’: a child, a savage, excluded from ‘proper’ adult society. This may create a sociocultural pressure to cope alone and present as mentally ‘well’ in addition to the socioeconomic one previously discussed, enacted within the prospective help-seeker’s social and treatment networks. According to the TIMS framework (Rivas-Koehl et al., 2023), which brings an intersectional lens to MST (Meyer, 2003), discourses of emotional silencing would become applicable when an older queer identity intersects with a male gender identity and/or a British identity. These discourses arguably contribute to stigmatising attitudes towards mental health difficulties (Seamark & Gabriel, 2018; Turton et al., 2025) such that, to avoid stigma, a distressed older queer person who is British and/or male may not seek help until crisis. In the next section, I explore how discourses around queerness may similarly contribute to delays in help-seeking through stigma-avoiding processes.

Notably, these discourses of emotional silencing are shifting. In recent years, U.K. organisations have been undertaking mental health publicity. The Samaritans, for instance—a charity providing a listening service to individuals who experience suicidal thoughts or feel otherwise distressed—has distributed posters online and in physical places (e.g., train stations) featuring handwriting by real men with messages such as “Talking about your feelings is a potential life saver” (Samaritans, n.d.). The NHS also runs poster campaigns, such as showcasing the faces of real people across a variety of ages, overlaid with messages like “I just kept it all inside”; posters emphasise that “NHS Talking Therapies can help” (Department of Health and Social Care, 2023). Discursively, talking is positioned as a helpful step towards emotional wellness done by real, relatable people. Such campaigns are indispensable in discourse deconstruction and reconstruction (Sindoni, 2020). However,

changes to the ‘real’ impacts of silencing discourses—to people’s felt capacity to embody the help-seeker role—may be slow to follow. They may be especially slow for older people whose emotions have been unspeakable for longer than younger counterparts, potentially contributing to the injunction that distress must become extreme before help-seeking can be legitimately undertaken.

This slowness seems applicable to Charlie, who at first refused his doctor’s suggestion of psychological treatment under discourses of the British ‘stiff upper lip’ and masculinity-as-impervious-to-emotions. The initial option open to him was to ‘carry on’ alone, so he did not become ‘less than’, like his “silly” doctor. The help-seeker role did not become available until Charlie’s distress was exacerbated by a “fortnight of not sleeping”.

#### **4.3.1.3 The Help-Seeker Role Delegitimised Within Help-as-Incarceration**

The unspeakableness of emotions might interact with the unspeakableness of queerness to keep the help-seeker role unavailable until crisis for older queer people. Borrowing from the discourse *help-seekers beyond help-seeking*, this interaction was described by Oliver as a “cycling [of] secrets” to avoid being “lock[ed] away”, or “lock[ed] up” as in Jamie’s account. McDermott et al. (2018) suggested that a fear of being labelled ‘abnormal’—not conforming to norms of mental wellness and heterosexuality/cisgenderism—might act as a proximal minority stressor and trigger avoidance of help-seeking among LGBTQ+ youth. This study’s older queer participants did not speak of the label of abnormality as a worry in itself, but rather the label’s ‘real’ effects: the distal stressor of being “lock[ed] up/away” as a queer person experiencing poor mental health. This discourse of help-as-incarceration seems to inhabit the “borderland between crime and insanity”, in the words of English psychiatrist Henry Maudsley (1896, p.34). Before asylums became established in the United Kingdom in the mid-19<sup>th</sup> century, ‘lunatics’ fell under the law’s remit, corralled in prisons or workhouses (Suzuki, 1992). Asylums were

positioned as a means of liberation, curing rather than punishing ‘lunatics’ (Nichols, 2000). This narrative of liberation has been questioned in the literature, notably by Foucault who argued that asylums were a vehicle of social discipline (Lanzoni, 2005). In this view, asylums silenced the ‘mad’, who were sequestered from ‘normal’ society and subjected to invasive and sometimes non-consensual treatment (Bloch & Pargiter, 2002). Moreover, the construct of ‘madness’ itself is normatively derived. To be admitted to an asylum, a ‘lunatic’ would have had to be certified as such by a doctor. Certification relied on norms of mental wellness that persist today (e.g., hallucinations), but also intersected with other norms, including heteronormativity. During the time when imprisonment was the sentence for sexual activity between men, the defence of ‘lunacy’ could be used, and was likely to lead to institutionalisation (Janes, 2014). There are also accounts of queer people, primarily men who have sex with men, being given the ‘choice’ between prison and aversion therapy to ‘fix’ their queerness (MacCulloch & Feldman, 1967). Those who submitted to aversion therapy speak of it not as curative but as punitive and traumatic (Dickinson et al., 2012; Stapleton, 1975). This legacy of the suppression of mental difference and queerness seems echoed in participants’ narratives of help-as-incarceration. ‘Help’ becomes a tool of oppression, and treatment networks in the NEM become oppressors. As ‘help’ is enforced rather than sought, I argue that a legitimate *help-seeker* cannot exist through this lens. Queerness and mental health difficulties become unspeakable “secrets” to protect one’s freedom and personhood. This aligns with queer identity concealment in theories of minority stress, including the original MST (Meyer, 2003) and later iterations (e.g., TIMS, Rivas-Koehl et al., 2023), and extends concealment to encompass not only concealed queerness but also concealed mental health difficulties. Identity concealment is conceptualised as a protective strategy to avoid distal stressors (Hoy-Ellis, 2023), here operationalised as enactments of help-as-incarceration. From a position of identity concealment, help is not sought until it becomes deconstructed as

harmful and reconstructed as safe. I continue this argument when I discuss how entry into the help-seeker role seems to necessitate a reclaiming of power such that help is facilitated by the community for the community and not by coercive bodies of authority. This apparent need for processes of deconstruction and reconstruction implies a delay in help-seeking, during which mental health difficulties may become exacerbated. Exacerbation is especially likely if older queer people engage in identity concealment, as this has been linked to distress, including depression and anxiety (Dennis & Davis, 2025). Herein is highlighted the importance of clinicians and services facilitating the deconstruction of help-as-incarceration wherever possible. I suggest how this may be achieved when I discuss the project's practical implications.

Crucially, only Jamie and Oliver—two of eight participants—employed a discourse of help-as-incarceration. This could reflect queer elders' resilience, suggested to arise through lifetime experiences of stigma equipping them with various aptitudes that are protective for mental health (Koziara et al., 2022), such as emotion regulation and optimism (Feder et al., 2019). To an older queer help-seeker who is empowered in this way, a discourse where help becomes incarceration—a stripping-away of their power—may not feel relevant. The notion of resilience among queer elders might contextualise Cronin et al.'s (2021) research with its lone suggestion that older queer individuals experience fewer barriers to help-seeking than younger counterparts. However, a comparison of how resilience impacts help-seeking in younger and older queer populations is outside this study's scope, requiring additional research. Furthermore, Jamie and Oliver, who mobilised help-as-incarceration, disclosed experiences of neurodivergence. Today's construct of neurodivergence is embedded in a history of mental 'deficits' leading to institutionalisation (Greydanus & Toledo-Pereyra, 2012), which might have increased the availability of help-as-incarceration to them at the intersection of queer and neurodivergent identities.

For both Jamie and Oliver, help-as-incarceration resulted in avoiding services, or self-censoring during appointments. Through this “secre[cy]”, they arguably privileged their liberty over assuaging their emotional distress, highlighting that negotiations of safety-from-incarceration might precede negotiations of eligibility to seek help.

#### **4.3.1.4 Negotiating Legitimacy as a Queer Help-Seeker in a Queer Service**

A further legacy of the asylum could be the certification of ‘lunacy’. While certification in terms of a mental health diagnosis did not feature in this study, one participant mobilised the need for an “ology” to confirm one’s transness. This seems to locate transness within a medico-legal discourse, prevalent in the United Kingdom where gender is not a self-affirmed characteristic (Brunskell-Evans, 2019). For someone to officially transition to a different gender, a formal diagnosis of gender dysphoria is necessary (Brunskell-Evans, 2019). *Gender dysphoria* was first listed in the DSM in 2013, replacing *gender identity disorder* in an effort to depathologise trans identities (APA, 2013). Arguably, however, despite this shift in language, gender dysphoria continues to feature in a manual of *mental disorders*, which creates a world where some people are mentally ‘well’ and others are mentally ‘ill’; gender dysphoria thus seems to persist as a deviation from cisgender norms that is packaged as mental illness, similar to the history of queerness-as-‘lunacy’ (Drescher, 2015). Power dynamics likewise persist wherein gender dysphoria must be certified by an ‘expert’, a doctor or psychologist within a treatment network endowed not only with the capacity to treat, but also to ‘gatekeep’ transness (His Majesty’s Courts and Tribunals Service, 2022). It is within this context that this study’s trans participants accessed help. For a trans help-seeker, the purpose of therapy seems to be the certification of their transness through dialogue with their therapist. This help-seeker does not seem to attend therapy as a whole person with multifarious experiences and identities, but as a *trans* person only who must enact their transness by discussing trans topics. Notably, participants positioning

themselves elsewhere within the queer umbrella did not bring up this need for an exclusively queer focus in therapy.

The Best Little Boy in the World hypothesis (Tobias, 1976) could provide further context. The theory posits that individuals who inhabit stigmatised identities tend to seek high achievement to counteract said stigma. In recent years, trans identities have been subject to social and political attack more than other queer identities, for example through rhetoric by individuals identifying as TERFs (Miller, 2024) and the April 2025 ruling by the Supreme Court that trans people’s legal gender is their assigned-at-birth one (Home Affairs, 2025). There is also evidence to suggest that trans people in the United Kingdom experience the highest proportion of day-to-day anti-queer prejudice (Stonewall, 2017), as highlighted in the *Literature Review*. From this position of heightened stigma within their social networks, trans help-seekers may enter therapy in a compensatory mindset, endeavouring to make “best use” of the therapeutic space, potentially to avoid further judgement or stigma from within their treatment network. Services may contribute to this pressure for “best use”, putting forward messages that implicitly prioritise queer topics, such as website pages that emphasise queer issues—e.g., coming out—when listing the types of difficulties treated in the service (London Friend, n.d.-a). Therapists may also perpetuate “best use” in sessions, perhaps not being curious about the help-seeker’s identities or experiences outside of transness due to lack of time in shorter-term work. Alternatively, they may attempt to create a sense of acceptance of the help-seeker’s transness by focusing on it exclusively, especially in queer services founded on an ethos of acceptance (Hinrichs & Donaldson, 2017). Such privileging of exclusively trans topics may trigger conformity in help-seekers with people-pleasing tendencies, which Barr et al. (2023) describe as a possible adaptation among LGBTQ+ individuals to interpersonal conflict in response to distal stressors and associated trauma. By making transness speakable, therapists and services may inadvertently silence the non-trans aspects of

help-seekers' identities. As a trans person, entering and maintaining the role of the help-seeker seemingly becomes a balance of silencing and giving voice, created between help-seekers, therapists, and services. This has implications for bolstering queer affirmative therapeutic practice, which entails a sensitivity not only to queer-specific difficulties, inequities, and strengths, but also to other identities and communities inhabited by the queer person (O'Shaughnessy & Speir, 2018); I expand on this when I discuss the study's clinical applications.

Another type of trans certification was spoken about at the interface between queer services and queer communities which resulted in the exclusion of older ways of being trans. Here, the queer community—in which queer services are embedded—becomes the “ology”. Identity certification is no longer a case of *trans* or *not trans*, but rather *trans in the 'right' ways* or *trans in the 'wrong' ways*, with the ‘right’ transness creating community and service access. This ‘rightness’ was constructed as political by Lily, in turn constructed as the domain of younger people: to be trans is to have a formal, public identity that acts as a “political [...] protest” and includes ‘correct’ political views such as “hat[red]” of TERFs; this is contrasted against an apolitical older transness enacted primarily through cross-dressing. A similar discourse was employed by one participant in relation to questioning identities. Questioning does not seem to fall under the queer umbrella, such that those in the definitional no-man's-land between heterosexuality and queerness may feel that queer community and services are not for them. This adds a new dimension to Foy et al.'s (2019) and Pitt et al.'s (2024) research, which suggested worry of prejudice from practitioners as a key barrier to help-seeking. Here, the queer community is positioned as the dispenser of prejudice against questioning identities or older ways of being trans in a process of within-group stigma; a within-group process assumes that the Q in LGBTQ+ is inclusive of questioning identities, although this can vary (Panfil, 2020). Rivas-Koehl et al.'s (2023) intersectional lens on

minority stress would highlight that it is people at the intersection of older age and trans or questioning identities who are subject to distal and proximal stressors in this case. Distal stressors are not only defined as active discriminatory practices, but also a lack of something that other social groups receive (Moorhead et al., 2024). Distal stressors under discourses of queer certification could include a lack of representation of questioning or apolitical trans identities in mental health services' materials about eligibility (e.g., ELOP, n.d.-a). Proximal stressors would then relate to worry about an anticipated lack of welcome in services, as in Lily's account. SIT (Tajfel & Turner, 1979) could provide further insights into these community dynamics. According to SIT, social groups define their boundaries by making generalisations of sameness within the in-group and highlighting differences from out-groups (Hornsey, 2008). Those that fall outside the in-group's sameness are excluded (Abrams et al., 2005), such as questioning individuals or those enacting politically 'incorrect' older transness, so that the in-group, in this case the LGBTQ+ community, can retain a coherent identity and garner social status, legitimacy, and power (Hornsey, 2008). As a social group whose legitimacy is threatened by heteronormativity, the LGBTQ+ community may be especially likely to undertake such policing of its borders (Hornsey et al., 2003).

Historically, border policing was an important strategy for the queer community to protect its integrity. Despite the Sexual Offences Act 1967 decriminalising homosexuality, men having sex with men continued to be arrested for gross indecency (non-penetrative sexual activity) and importuning (making a sexual advance on someone in public) (Tatchell, 2017). Part of this was the deployment of 'pretty police': plain-clothes police officers approaching patrons in or around queer venues and offering sex (Clews, 2012). Accepting this offer would lead to an arrest and, if convicted, to being "lock[ed] away/up" (Clews, 2012). The queer community responded by excluding perceived out-group members to protect the safety of the in-group. Today, queer services seem to exist at the interface between

social and treatment networks, potentially enacting similar measures to protect the community, such as not including information in online materials on whether help-seekers who are questioning or identify as cross-dressers would be welcome (e.g., ELOP, n.d.-b). Older help-seekers who are not queer in the ‘right’ ways may themselves become enactors, inhabiting dual and conflicting identities: out-group members who are policed by their community through exclusion; yet also in-group members who *self*-police by not accessing services or presenting a false, norm-abiding self to services. These strategies could create a help-seeker role more suited to facilitating community cohesion rather than psychological wellbeing.

Lily, for instance, felt she had to “hide” her non-normative politics as a trans person to attend a queer service. David similarly spoke of the self-policing impact of “guilt” when exploring non-trans topics with his therapist, perceived as a breaking of “best use” norms which would only allow trans topics. If part of the healing potential of therapy is theorised to derive from the therapist welcoming the help-seeker’s ‘otherness’ (Cooper, 2009), then help-seekers who leave their ‘otherness’—i.e., non-normative queerness—at the door might be disadvantaged. Moreover, self-policing one’s authenticity or ‘otherness’ through the embodiment of a false self could represent a form of identity concealment as in minority stress theories, introducing concern about increased distress (Hoy-Ellis & Fredriksen-Goldsen, 2016; Lehavot & Simoni, 2011), which may counteract any therapeutic benefits. Alternatively, help-seekers may not engage with services at all, continuing to experience distress in their daily lives, like Oliver positioning himself as a willing help-seeker when he first started questioning his sexual identity, yet lacking a queer service where he felt eligible for help (“What do you do? Where d’you go?”). For older queer people, especially in queer services, entry into the help-seeker role seems to entail a legitimization of their queerness first and their help-seeking second, within both social and treatment networks. As Lily described,

older queer people who do not conform to norms of queerness may also experience exclusion from the wider community, therefore lacking a sense of community connectedness that could be psychologically protective (Fredriksen-Goldsen, Kim, et al., 2015). This positions older queer people as particularly vulnerable, and highlights the necessity of mental health services and practitioners taking steps to deconstruct discourses of eligibility based on ‘rightness’ of identity, making the help-seeker role more readily available to this population.

#### ***4.3.2 Discourse: Importance of Being Understood***

##### **4.3.2.1 Help-as-Recolonisation Within Hegemonic Whiteness**

So far, I have discussed how prospective help-seekers might self-police by delaying access to services or attending services as false selves under discourses of sanism, British-masculinity-as-impervious-to-emotions, help-as-incarceration, and queerness requiring certification. Self-policing may also manifest as lack of engagement with “cookie-cutter” therapists. Jordan positioned “cookie-cutter” therapists within White Britishness, middle age, and cis womanhood, implying that these therapists would fail to understand help-seekers of differing positionalities, especially differing ethnicities or cultures. From this position of being un-understood or misunderstood, ethnoculturally minoritised individuals may not access mental health services, or may do so while navigating proximal stressors in the form of worry about what kind of understanding, if any, they will receive from therapists, like in Jordan’s account. For Jordan, proximal stressors seemed to centre more around his identity as a Black British person than his queerness, unlike what might be expected from previous studies (Foy et al., 2019; Pitt et al., 2024). Intersectional perspectives on minority stress, such as TIMS (Rivas-Koehl et al., 2023), conceptualise identities as inextricably linked such that a person cannot be pared back to a single facet of themselves. In other words, Jordan’s experiences accessing help as a queer person cannot usefully be untangled from his

experiences as a Black British person. I will, therefore, devote some time to discussing the ethnocultural context in which Jordan took on the role of the help-seeker.

Psychology as delivered in mental health services is a postcolonial practice (Swartz, 2005), embedded in the ideology of whiteness which assumes and enacts the superiority of people whose skin is pale (Leonardo, 2013). Historically, psychology has silenced and erased people of colour (Swartz, 2005), which could reframe non-engagement with services among ethnoculturally minoritised individuals as self-policing: conforming to a normative whiteness that invisibilises them. One enactment of whiteness in psychology is the focus on the individual (Jovanović, 2022). Individualism can be traced back to the Reformation in 16<sup>th</sup>-century Europe when the individual became subjectified as an agent with power, autonomy, and value in the world (Buss, 2000). In therapeutic practice, individualism has been discussed as a reductionist lens that locates the problem of mental ill health inside the individual, investing them with the power and responsibility to effect cognitive, emotional, behavioural, and interpersonal changes (Morrow, 2013). The wider context of the individual's social network, and the way this context shapes and perhaps limits their ability to enact change, is not always addressed (Morrow, 2013). For help-seekers with heritage from previously colonised nations, this may act as a psychological recolonisation, defined as the imposition of another nation's ways-of-being/thinking (Ali et al., 2012)—in this case, an imposition of “cookie-cutter” White individualism, silencing ethnocultural subjectivities and, potentially, suppressing collective action against systemic oppression to maintain whiteness as the Western status quo (Awad et al., 2019). It is important to note the assumption of a West/East split along individualist/collectivist lines, which effaces each nation's cultural and historical nuances (Okazaki et al., 2008). These nuances fall beyond this project's scope, and may benefit from being un-silenced in further research.

In the interest of decolonising psychology, there have been calls for greater ethnic diversity in the U.K. profession (Turpin & Coleman, 2010). Nationally, the proportion of White-identifying therapists—84% of 26,940 practitioner psychologists per the latest Health and Care Professions Council survey in 2023—is similar to the proportion of White-identifying U.K. residents—82% of 59.6 million respondents in the 2021 census (ONS, 2025). Nonetheless, local therapist populations are not always ethnically representative of the communities with which they are involved (Turpin & Coleman, 2010). One contributor to this could be the disparity in admissions to psychology training programmes between White and ethnically minoritised students, with the latter suggested to navigate socioeconomic disadvantages in their educational journeys (Griffith, 2007). Under a Foucauldian paradigm of power/knowledge, the abundance of White perspectives in the field seems to sustain the existence of a psychology that is by White people for White people (Adams et al., 2018), constructing a help-seeker role that is not available to ethnically minoritised individuals unless they submit to recolonisation. This seems to mirror the interplay of distal and proximal stressors discussed by queer people elsewhere in relation to accessing therapy that is underpinned by and perpetuates heteronormativity, for example therapists pathologising queerness as mental illness with implications for the help-seeker's feelings and behaviours (Foy et al., 2019).

Interestingly, however, participants here did not mobilise their queerness as something liable to be misunderstood by their therapists, despite worries of anti-queer prejudice noted in past research among younger queer help-seekers (e.g., Foy et al., 2019; Pitt et al., 2024). The recent context around queer research and queer-affirming clinical work could provide one possible explanation. There has been a boom in texts that support queer affirmative practice (Davies et al., 2025). The framing of queer affirmative practice, as contrasted against ethnoculturally affirmative practice, might increase the former's availability for

implementation within services and by clinicians. A therapist understanding a help-seeker of a different social group is defined as a function of empathy (Elliott et al., 2018). In turn, empathy is grounded in knowledge about the out-group's unique positionality, and the therapist's reflection on their own biases with the goal of deconstructing these (Ridley & Lingle, 1996). Queer affirmative practice tends to primarily centre empathy-as-knowledge, arguing for an awareness of LGBTQ+ stressors which then creates a capacity in the therapist to discuss these (O'Shaughnessy & Speir, 2018). Furthermore, positivity towards LGBTQ+ identities is presented as an add-on to the therapist's relational repertoire (Alessi et al., 2019). In contrast, ethnocultural competency tends to be constructed as "doing the [...] deep, raw, challenging, personal, heartbreaking, and heart-expanding work" (Saad, 2020, p.16-17). It is not the *White therapist* doing the 'work' but the *White person* who can only step out of the hegemony of whiteness by actively reflecting on, deconstructing, and challenging their own and others' intentional or unintentional enactments of whiteness (Cornish et al., 2010; Saad, 2020). White therapists may not engage in the 'work' or may do so only cursorily to avoid the discomfort of being inherent participants in whiteness—termed *White fragility* by DiAngelo (2018). For similar reasons, training organisations may not engage with the socioeconomic barriers to greater ethnocultural diversity among trainees (Wood & Patel, 2017). While queer affirmative practice becomes accessible and, as inferred from participant narratives, seems to translate as therapists understanding help-seekers' queerness and thus enabling entry into the help-seeker role, ethnoculturally competent practice remains less evident. "Cookie-cutter"-ness may thus be retained both in terms of practitioner biases and lack of ethnocultural representation in treatment networks, perpetuating help-as-recolonisation and hindering help-seeking among ethnoculturally minoritised individuals. This suggests a need for services and therapists engaging with queer help-seekers to adopt an intersectional perspective, attuning

themselves to other aspects of help-seekers' identities, besides queerness, that might benefit from being unsilenced in sensitive and affirmative ways, such as ethnocultural affiliations.

Indeed, as a Black British person, Jordan recounted that, in the past, he did not engage with “cookie-cutter” services, and constructed this lack of engagement as a prevalent phenomenon. He laid the responsibility to change “cookie-cutter”-ness with therapists whose “knowledge [...] needs to have more representation from ethnic groups” in order for the help-seeker role to become viable for ethnically minoritised individuals in the queer community.

It is worth emphasising that the above is only one interpretation of why this study's participants did not speak about worries that therapists might not understand their queerness. Certainly, a plethora of research highlights a need for continuing improvement in queer affirmative practice in the U.K. mental health field (e.g., Braybrook et al., 2025; Horton, 2026; Mackay et al., 2025); I am not suggesting that this has reached a state of being ‘good enough’ for queer help-seekers. Alternative explanations could include that half of my participants (i.e., four of eight) were waiting for or accessing help via queer-specific services such that worries of anti-queer stigma might have been less relevant. There could also be something protective in being older, as results here mirror those of Cronin et al. (2021) wherein older queer people reported fewer minority stressors impeding them on their help-seeking journeys compared to younger cohorts. Older queer people, who have potentially inhabited their queer identity for a long time, might feel more secure in their queerness compared to a younger person (McLean et al., 2025). Therefore, they may be less likely to discuss it in therapy and thus less concerned about or exposed to anti-queer sentiment from their therapists. It is also possible that older queer people have access to unique sources of resilience—such as a sense of wisdom and perspective, religious or spiritual avenues of support, or a lack of concern about others' opinions of them (Huntley et al., 2026)—that may lessen any worries about experiencing stigma from their therapists. Moreover, in the interest

of keeping the interviews naturalistic, I might not have asked the appropriate questions to invite in discussions about anti-queer prejudice as a proximal stressor and/or barrier to help-seeking. In interviews conducted in person within the safety of an LGBTQ+ mental health charity (five of eight), discourses of anti-queer prejudice from practitioners might not have felt accessible to my participants. Future research could further investigate this discrepancy between younger and older queer help-seekers in the prevalence of worry about practitioners stigmatising their queerness.

#### **4.3.2.2 Client-Therapist Sameness Establishing Trust**

On the other end of the spectrum, Charlie mobilised “cookie-cutter”-ness as facilitative of help-seeking in the context of a shared traumatic background between him and his therapist, specifically CSA. Viliardos et al. (2023) noted a delay among men to seek help for CSA, reflecting Charlie’s account, and linked this to stigma. This stigma could arise under victim-blaming and perpetrator-absolving discourses. In early psychoanalytic theory, CSA was a non-entity; it did not occur as *abuse*. Rather, it was either an invention of the child’s reflecting a sexual longing for the adult caretaker as part of ‘normal’ psychosexual development (Freud, 1905/1953; Green, 2014); or it was initiated by the child who seductively coopted the adult into realising their fantasy (Wasserman & Rosenfeld, 2014). A second driver of CSA’s invalidation could have been sexual modernism. In the late 19<sup>th</sup> and 20<sup>th</sup> centuries, to be ‘modern’ and liberated from presumed Victorian norms of sexual repressiveness (Simmons, 2012) was to be transgressive, embracing so-called ‘perversion’ (Funke, 2018). One such normalised transgression was sexual activity between adults and children, constructed as innocuous and non-traumatogenic, and even facilitative of sexual development (e.g., Kinsey et al., 1953; Yates, 1978). Relatedly, CSA became an explanation for queerness, which in turn was no longer constructed as a crime or mental illness but a learned behaviour (e.g., Cameron & Cameron, 1995); under heteronormativity, learned

queerness has the potential to be unlearned, reinstating ‘normal’ sexuality. Lastly, CSA stigma could also derive from dominant discourses about masculinity. If men are positioned as invulnerable and impenetrable (Hlavka, 2017), a CSA survivor—rendered vulnerable and potentially penetrated—becomes ‘less than’ a man and is thus subject to ridicule (Scarce, 1997). This seems to synergise with discourses of men’s imperviousness to distress, as previously discussed. Together, these varied discourses constitute help-seeking for CSA as a threat: exposing the help-seeker to blame, minimisation of their trauma, and invalidation of their queerness and masculinity. Clinical and non-clinical staff who share a background of sexual abuse seem to lessen this perceived threat. SIT could provide an explanatory framework wherein the sameness creates an in-group, which activates depersonalised in-group trust (Yuki et al., 2005), or an expectation that interactions with in-group members will be positive (Foddy et al., 2009). Indeed, trust has been noted as a crucial facilitator of CSA disclosure for men (Viliardos et al., 2023). Sameness in this context appears to deconstruct threat-based discourses, as for Charlie who had an initial phone conversation with a man, presumed to be the service’s CEO. The man’s disclosure of CSA, plus his assurance that he understood Charlie “exactly”, seemed to enable Charlie-as-a-man to ‘own’ his experiences of CSA and associated distress, trusting that he will be safe from prejudice as a help-seeker in the service. From within this anticipated safety, Charlie was able to join the service’s waiting list. This suggests an important role for the treatment network in fostering a compassionate, supportive atmosphere to facilitate help-seeking, consistent with research by Beatie et al. (2022) investigating the NEM in a gerontological population.

#### ***4.3.3 Discourse: Help-Seekers Beyond Help-Seeking***

##### **4.3.3.1 Queer Mental Health Services as Safe Spaces**

Safety could similarly stem from the existence of services exclusively for LGBTQ+ help-seekers. Through this lens, mental health care is no longer delivered to queer people ‘out

there', by normative and disempowering institutions, but within the community, melding social and treatment networks. A safe space may thus be created, a concept originating from feminist literature that denotes spaces where people are safe *from* harm and safe *to* authentically be themselves (Lewis et al., 2015). An important enactment of safety to be authentic is the opportunity to connect with others free from prejudice or violence (Hartal, 2017). Blended therapy/social spaces for queer people arguably provide such opportunities, which Mark discussed as helpful for his emotional wellbeing. This ties in with literature suggesting social support and social network size as protective factors for older queer people's mental health (Fredriksen-Goldsen et al., 2013), particularly connections within the LGBTQ+ community (Fredriksen-Goldsen, Kim, et al., 2015). Attending therapy or social functions within queer services could also cushion against minority stressors. Vigilance has been discussed as a proximal stressor for queer people who may perform risk assessments in public spaces or social interactions situated within structural heteronormativity (Moorhead et al., 2024). Risk assessments may become redundant in queer-specific spaces that explicitly reject heteronormativity and thus potentially provide an assurance of safety (Hartal, 2018). Despite these possible benefits, the concept of a queer safe space has been discussed as paradoxical: Charlton (2024) argues for a safety that is always in flux, created between the occupants of the space and thus subject to contextual and relational pressures (e.g., Mark not having to "explain" his sexual attraction), rather than a fixed property of the space itself. A fluid safety would also be a subjective safety, countering dominant discourses of the queer community as a monolith (Fassinger & Arseneau, 2007). David, for instance, experienced the existence of a social 'safe' space in his therapy venue as a threat, preventing him from seeking help until crisis. Moreover, there could be a link to intersectional perspectives on minority stress (e.g., Rivas-Koehl et al., 2023): other identities inhabited by queer people could shape their experience of places designated as safe, potentially introducing distal or

proximal stressors. One example would be legitimization dynamics at the intersection of transness and older age, wherein safety is assured for trans people like David and Lily only if they perform transness in the ‘right’, often young-coded, ways. Jordan arguably also mobilised the notion of safety when discussing the lack of ethnocultural inclusivity in mental health services, which may be experienced as a traumatic (i.e., not safe) silencing of subjectivities of colour (Ali et al., 2012) that deters help-seeking. As Fox and Ore (2010) point out, a space that is purportedly safe for queer people and thus aims to minimise heteronormative power hierarchies, is not necessarily devoid of all power hierarchies or does not successfully erase them for everyone. It would be important to unsilence older queer perspectives on safety in queer services, deconstructing the effacement of their subjectivities under the monolith of younger “trends”, particularly those older queer help-seekers inhabiting multiple marginalised identities who might experience stressors like prejudice or invisibilisation from within the queer community (Sellnow-Richmond et al., 2022). Services-as-safe-spaces seem to create a help-seeker role where safety needs are not guaranteed to be met, potentially hindering entry into or continued engagement with the role. Under this assumption that safe spaces can never be completely safe, the Roestone Collective (2014) constructs them as “site[s] for negotiating difference and challenging oppression” (p.1346). To nurture such negotiation, the service/therapist could consult with the help-seeker on what safety looks like for them and whether it can be implemented in the venue. This could introduce agency into the help-seeker role for older queer people: instead of being subsumed under the monolith, they could have the opportunity to co-create a space that privileges their unique needs and positionalities as help-seekers and as people who embody intersecting identities, while offering the emotional benefits of social connection if this is wanted. Drawing on a queer affirmative framework, such spatial co-construction would represent an act of microaffirmation, endowing the help-seeker’s identity as older and queer (and possibly

other dimensions) with value (Rosati et al., 2022). For David, who felt threatened by the social groups in his therapy venue, negotiation of the therapy space could entail scheduling his sessions outside of group times. Additionally, while Mark-as-a-queer-person spoke of his venue as safe, he also discussed himself as a mourner of someone who used to access the service, which could warrant support from his therapist such as through a grief ritual in the space (Weller, 2015). There could also be more generally applicable ways to signal safety in therapy venues for older queer people; I suggest some potential ones when discussing the study's implications.

#### **4.3.3.2 Practitioner Endorsement by the Help-Seeker's Personal Social Network**

This consideration of what it means to seek help safely appears to connect to the legitimacy discourse considered previously. In Jamie's account, their construction of help-as-incarceration—wherein the help-seeker role was not available as 'help' could not be sought, only enforced—was overturned through endorsement of a specific practitioner by Jamie's personal social network. As above regarding therapist-client sameness, in-group trust seems to be a potent facilitator of Jamie's help-seeking. The distinction here is that the practitioner was not an in-group member automatically endowed with in-group trust (Yuki et al., 2005). Rather, Jamie trusted in their in-group's endorsement of the practitioner as an out-group member, which then seemed to install trust in the practitioner themselves as a “really good [doctor]” who would not “lock [Jamie] up” or dismiss their concerns. This underscores the interconnected nature of social and treatment networks in the NEM, such that they can influence each other in ways that then facilitate or hinder entry into the help-seeker role (Pescosolido et al., 2013). A similar process has been documented in political voters, where in-group endorsement is an important mechanism for the establishment of out-group trust (Arriola et al., 2022). This could have ramifications for discourse deconstruction, which could be more or less effective depending on its source. Deconstruction from the in-group

(i.e., a help-seeker's personal social network) might be accepted more readily than deconstruction from an institution such as the government or the NHS which, historically, have been part of a marginalising out-group. This could be suggested by Jamie not mobilising any mental health publicity attempts as facilitative of their help-seeking, only practitioner endorsement by their partner. I return to this point when I discuss this project's practical implications.

#### **4.3.3.3 Help-Seekers as Help-Facilitators**

Help-seekers themselves could also facilitate others' entry into the help-seeker role. Oliver spoke of himself as a joint seeker and facilitator of help, disseminating information about "what's available" in terms of mental health treatment on social media to enable other queer people to access help. Jordan also mobilised an activist help-seeker role working with services on anti-racist practices to install more inclusive treatment options for ethnoculturally minoritised individuals in the queer community. This responsibility towards fellow queer people could be a legacy of informal caregiving during the HIV/AIDS epidemic (Shiu et al., 2016). People living with HIV/AIDS often had limited access to formal care or avoided formal care due to worries about stigma from practitioners, relying instead on their communities to meet their palliative needs (Simms et al., 2012). For older queer people with lived experiences of this era, the boundaries between the role of the *help-seeker* and the *help-facilitator* might have become blurred, although neither Oliver nor Jordan explicitly made this link; further research might be beneficial to elucidate this further. In addition, experiences of prejudice from heteronormative family/friends might have led to the formation of 'chosen' families wherein queer people become deeply committed to their queer friends in a connection perceived as familial (Muraco & Fredriksen-Goldsen, 2011). This might add a layer of duty to informal caregiving as identified by Muraco and Fredriksen-Goldsen (2011). Under a social norm of families being responsible for the provision of care (Nocon &

Pearson, 2000), an older queer person might not feel able to relinquish the role of the help-facilitator when becoming a help-seeker themselves. During HIV/AIDS, informal care largely took the form of personal nursing (e.g., bathing) and domestic tasks (e.g., cooking) (Turner et al., 1994), as well as emotional support (D’Cruz, 2002). In this study, however, older queer people do not seem to become confidantes or informal therapists for their fellow queer community members. Rather, they become repositories of knowledge about treatment networks like Oliver; or activists collaborating with services to dismantle barriers to treatment engagement like Jordan. Mental health-related knowledge is positioned as a community resource, held by queer people for queer people to promote queer wellbeing, as a reclaiming of power from institutions enforcing ‘help’ as a disciplinary measure under sanist and heteronormative frameworks. As above, the NEM’s multidirectionally is emphasised (Pescosolido et al., 2013), with help-seekers acting within their social and treatment networks to facilitate other queer people’s entry into the help-seeker role. Help-seekers-as-help-facilitators may thus benefit from resilience through community activism, documented to combat minority stress (Chan, 2022), as in Jordan’s account wherein he gained access to a “constructive” outlet for his “disgruntle[ment]”. Resilience could likewise be bolstered for queer people in receipt of this help-facilitation, for example by accessing knowledge about mental health pathways or engaging with treatment that has been modified as a result of activism. In the queer resilience literature, these would be conceptualised as tangible community resources (Meyer, 2015), which may buffer against the detrimental mental health impacts of LGBTQ+ stigma (McConnell et al., 2018). Importantly, as noted in *Reflexive Statement: Part II*, my interview schedule may not have invited in an exploration of informal help-seeking or help-giving, which older queer people may engage in alongside becoming information-repositories or activists, subject to additional research.

#### **4.3.3.4 Help-Seekers “Working on” Themselves**

There was another portrayal of help-seekers-as-help-facilitators among participants, some of whom spoke of providing psychological help to themselves while attending therapy. Sarah constructed this as “working on” the self to “keep [the self] well”, recalling sanist discourses wherein the individual only has access to binary ways-of-being: either mentally well or mentally ill (Lavallee & Gagné-Julien, 2024). “Working on” the self—for example by reading self-help books as in Sarah’s account, or crafting a “parachute” of coping skills as in Oliver’s account—could be interpreted as a sanist injunction to avoid or escape mental illness. Another dimension of “working on” the self seems to be its solitary enactment. Sarah read self-help books on her own, and Oliver became the “loneliest” while undertaking a “silent struggle” against mental illness that seems located inside him, something faulty in the way he thinks or feels which he is responsible for ‘fixing’ on his own within an individualistic psychology (Harper, 1995). Through this lens, systemic entities, including health institutions and political bodies, become absolved of contribution to the aetiology of mental health difficulties, plus of any failure to provide helpful psychological treatment (Proctor, 2008). Indeed, for Oliver, therapy was not able to help with his “day-to-day living”, implying a lack of focus in the work on coping skills, or a barrier to implementing skills outside of sessions. Greater dialogue between therapists and help-seekers about practical coping could construct a well-resourced help-seeker rather than one “falling” through the air and urgently needing a “parachute”, like Oliver. Resources could perhaps include input from the help-seeker’s social network, putting forward a version of mental health that can be spoken about with, and scaffolded by, others. On the surface, such self-helping would likely promote emotional stability. However, Proctor (2008) likened it to self-policing: the help-seeker internalising the therapist’s knowledge of what constitutes ‘good’ emotional regulation and mental health, and deploying learned therapeutic tools to align with mental wellness norms. Through the therapist’s reflexivity about these norms, the help-seeker could instead be

supported to cope from a place of connection to their personal values about how they want to be in the world (Reveley, 2013). I consider this further in section 4.5.4, *Transtheoretical Implications: Coping with Intense Distress*.

#### **4.4 Theoretical Implications**

I will now consider how key points made above could apply to the theoretical landscape around help-seeking, providing novel insights to a field that has not previously spotlighted older queer help-seekers. The NEM embeds the help-seeker role in social and treatment networks that may facilitate or hinder entry into the role, for example through their attitudes about mental health and about the help-seeker's identity (as a queer person, an older person, or other intersecting positionalities), or through the emotional or practical support they are able or willing to provide (Pescosolido et al., 2013). Participants' accounts broadly align with the NEM. Speaking of their social networks, participants constructed the queer community as a repository of information about treatment pathways, which can introduce the help-seeker role as an available way-of-being to community members. Participants also highlighted the multi-directional interaction between the help-seeker and their community network, positioning themselves in the role of help-facilitators responsible for contributing to this repository. Partners and work colleagues were likewise part of participants' social networks, enabling entry into the help-seeker role by sharing information about available sources of help, or by endorsing specific professionals and thus installing trust in them to deconstruct barriers to help-seeking rooted in the historic enactment of help-as-incarceration. In terms of treatment networks, these encompassed both therapists and non-clinical staff. Participants constructed staff's ability to understand them—to engage with them from a position of empathy, especially as pertains to their ethnocultural or traumatic backgrounds—as a facilitator of help-seeking or an inhibitor if experienced or assumed as absent. Services as overarching institutional bodies straddled both treatment and social networks, becoming

enactors of young-coded “trends” in the queer community that may delegitimise older queer identities (e.g., politically ‘incorrect’ transness, or questioning rather than queer identities) and hinder help-seeking among this population. Lastly, help-seekers-as-help-facilitators seem able to bidirectionally shape their treatment networks, adopting an activist role in collaborating with services on ethnoculturally inclusive practices.

An important theoretical contribution from this study is that social and treatment networks can become unified in spaces that jointly host therapeutic and social activities. In such blended spaces, the socio-treatment network seems able to exert a passive influence (i.e., influencing simply by ‘being’ rather than ‘doing’) on the help-seeker role in addition to the more active influence described above. Arguably, help-seekers in blended spaces become social subjects. Their idiosyncratic social history in the space is thus incorporated into their socio-treatment network (e.g., personal relationships they might have formed with others in the space), as is their meaning-making about being a social subject in a queer venue (e.g., welcomed by some as a wanted opportunity for connection, or rejected by others who feel uncomfortable navigating gatherings of people). The specifics of such idiosyncrasies may make the help-seeker role more or less readily available. Furthermore, for queer people who exist within a history of marginalisation and violence, the safety of the space as a queer microcosm insulated from heteronormative pressures might be particularly important. However, this would likely introduce questions of how queer safety is defined and for whom: the same space may be unable to provide safety for all simultaneously, inviting services to consider ways to actively welcome multifarious queer identities. The theoretical formalisation of blended therapy/social spaces at the interface between social and treatment networks in the NEM could support services/practitioners in these considerations of help-seekers as social subjects with social needs. I offer some suggestions for how these social needs could be met below.

## **4.5 Implications for Services, Counselling Psychologists, and Allied Mental Health Professionals**

Here, I discuss this study's implications across five domains related to supporting older queer people to engage with, retain, and benefit from the help-seeker role: how therapists might be able to establish an effective and affirming therapeutic relationship with this population by drawing on a humanistic framework; adapting queer affirmative CBT to older cohorts; applying queer affirmative principles to psychodynamic work with older cohorts; transtheoretical implications including therapist-client matching and a focus on adaptive coping; and finally, strategies for services to signal that their therapy spaces are safe for older queer people. I am locating these implications within a queer affirmative approach to therapy, underpinned by the therapist relating to queer people in supportive, accepting ways, holding knowledge about LGBTQ+-specific experiences like minority stress while remaining sensitive to the individuality of queer people, and practising resistance to structural inequities and/or supporting queer help-seekers in doing so (Moradi & Budge, 2018).

### ***4.5.1 Establishing an Effective Therapeutic Relationship Through Humanistic Practice***

#### **4.5.1.1 Deconstructing “Cookie-Cutter”-Ness**

Participants' discourses and enactments of the help-seeker role were heterogeneous. This highlights the potential usefulness of a humanistic approach from the therapist, privileging the help-seeker's uniqueness (Mahon, 2023). There is concordance between humanism's sensitivity to uniqueness and a stance of queer affirmation, which, among other elements, similarly honours the multiplicity of ways to be queer (Moradi & Budge, 2018), especially in interaction with other identities (Pachankis, Soulliard, Morris, et al., 2023). Humanism is founded on the principles of congruence, unconditional positive regard, and accurate empathic understanding (Mahon, 2023). Per Carl Rogers' (1957) seminal writings on the therapeutic relationship, a congruent therapist is authentic with their clients, not

disassembling their internal world. As congruence requires familiarity with inner experiences—including biases, assumptions, and expectations—it could contribute to dismantling “cookie-cutter”-ness. I am using the term more broadly than Jordan’s ethnocultural interpretation of it, referring to any attribute of the help-seeker that could be approached assumptively or with prejudice, including but not limited to ethnicity, culture, sexuality, gender identity, age, ableness, neurodiversity, and socioeconomic status. I argue for therapists doing the “work” (Saad, 2020) of reflecting on their ways-of-thinking/being towards people inhabiting a minoritised/marginalised identity or several such intersecting identities, and, if applicable, inviting in more compassionate alternatives. In addition to being part of a queer affirmative framework (Moradi & Budge, 2018), doing the “work” is also foundational for a culturally affirmative approach to therapy. Cultural affirmation entails a stance of honouring cultural identities while acknowledging oppressive social practices associated with those identities (Mendoza et al., 2020). A culturally affirmative therapist should hold knowledge about different cultures while adopting an attitude of humility and always being open to learning from their help-seekers; they should be mindful of their own beliefs and engage in deconstruction of their own oppressive practices (Ertl et al., 2019). The “work” could happen through supervision, therapists’ own therapy, with friends/family or alone in their personal life, at work with fellow mental health professionals, and in sessions by connecting to their internal supervisors. It could be supported by training organisations and clinical supervisors normalising that it is human to rely on heuristic thinking like assumptions or stereotypes, helping therapists tolerate White fragility and continue the “work” (Prati et al., 2015). The psychodynamic concept of pre-transference could provide a useful theoretical framing. This is a concept coined by Andrew Curry (1964), a psychotherapist and a Black, presumed cisgender man. Pre-transference understands therapists’ assumptions about various social groups as a largely inevitable effect of living as social subjects in a society, yet also as a

therapeutic aid that can provide a useful lens when formulating the client's difficulties or the interpersonal dynamics in the room. Inherent to the "work", and to congruent relating, seems to be a renunciation of 'knowing' what a client is like and what it is like being them, as espoused by CoP principles (Gillies, 2010). This renunciation might open the door to uncertainty and anxiety, which may in turn lead to attempts to regain certainty, for example by adhering to protocolised, "cookie-cutter" treatment (Nehrig et al., 2019). A different stance on uncertainty and anxiety wherein they are welcomed as an indelible part of being human (Kierkegaard, 1985) could instead motivate the therapist on their journey of self-actualisation (Rogers, 1961). It could also support the therapist in congruently connecting with the client as one anxiety-experiencing human to another anxiety-experiencing human (Neville, 2013), contributing to a robust therapeutic alliance (Kolden et al., 2018) which is an essential factor in psychological change (Castonguay et al., 2018), particularly in a queer affirmative framework wherein it can contribute to positive therapeutic outcomes (Alessi et al., 2019).

#### **4.5.1.2 The Role of Curiosity**

Unconditional positive regard (UPR) entails the therapist holding a deep appreciation and acceptance of the help-seeker's uniqueness without the need for any prerequisites to be met (Bozarth, 2013). Deconstruction of biases through reflexivity as described above would likely contribute to UPR (Rennie, 2004). Curiosity is another contributor to UPR (Hoffman & Mizock, 2025) and a staple in queer affirmative practice (Singh, 2025), as well as an essential ingredient in cultural humility (Mosher et al., 2017). It refers to a stance of not-knowing: an openness to hearing and validating the help-seeker's personal version of their reality with all its queer and non-queer facets, even if different from one's own (Singh, 2025), welcoming rather than rejecting or judging their 'otherness' (Cooper, 2009). For older queer people, 'otherness' could be experienced as their emotional difficulties under mental wellness norms and/or their sexual/gender identity under heteronormativity, potentially leading to a "cycling

[of] secrets”. Such a help-seeker may attend therapy struggling to talk about these unspeakable “secrets”. This may be an opportunity for the therapist to break the silence and, with the help-seeker, reconstruct the reality in the therapy room as one where emotions and queerness *can* be spoken about. Suggested interventions include open-ended, non-assumptive questions about what it is like for the help-seeker to live with difficult emotions, to have ‘failed’ as a ‘coper’ and therefore transitioned into the help-seeker role, and/or to live in the world as a person who is older and queer. Additional points of unspeakableness to be made speakable by the therapist could include any ‘wrong’ ways in which the person enacts the queer or non-queer aspects of their identity, especially in queer settings which may trigger legitimisation dynamics. In this context, curiosity could also offer an opportunity to discuss minority stress at the intersection of older age and queerness, including stressors experienced within the LGBTQ+ community. Therapists could provide psychoeducation about minority stress, externalising stigma to combat shame (Budge, 2014), as well as normalising mental health symptoms like depression and anxiety in response to minority stressors (Pachankis, Soulliard, Morris, et al., 2023); the latter could contribute to the rewriting of mental wellness norms. Moreover, by modelling a curious, non-judgemental, and welcoming attitude towards any non-normativeness in their help-seekers, therapists could instil a sense of acceptance, and help strengthen help-seekers’ sense of community if they themselves are queer and willing to self-disclose as such (Budge, 2014). Lastly, curiosity could take a geographic lens wherein UPR is enacted through the therapist’s willingness to hear what the therapeutic space is like for the help-seeker and, where possible, make changes to improve the help-seeker’s experience and meet their needs, e.g., schedule sessions outside of social group times if the help-seeker finds it difficult to enter the venue when people are present in large numbers. Capitalising on help-seekers’ power to shape their treatment networks as their networks shape them, changes could also impact more permanently on the space itself, for example by

introducing environmental cues that signal safety for LGBTQ+ people. I pick up this thread of safety signalling again in section 4.5.5 when I discuss implications for services.

#### **4.5.1.3 Help-Seekers Understood by Therapists**

Returning to humanism, accurate empathic understanding is the final core condition that Carl Rogers (1957) discussed as necessary to foster a robust therapeutic relationship and support psychological healing. It refers to the therapist understanding the client's experiences with a high degree of precision, and communicating this understanding empathetically (Bozarth, 2013). Importantly, the humanistic modality acknowledges that therapists are not mind-readers and may sometimes misapprehend their help-seekers (Rollings et al., 2010). A curious, non-assumptive stance is considered key to navigating moments of inaccurate understanding (Rollings et al., 2010). This could entail the therapist delivering their understanding as a question rather than a statement, and checking with the client whether it matches their experiences (Brodley, 1996). The therapist would not be imposing their 'expert' reality, instead inviting the client to shape a shared reality with them. This is a crucial aspect of practising in an affirmative and empowering way with queer help-seekers, allowing therapists to step away from enactments of help as erasure or subjugation of queer subjectivities as a legacy of asylums and conversion therapies (Love et al., 2015). Accurate empathic understanding could become a technical tool to uphold the discursive importance of help-seekers being understood by their therapists. Moreover, it could play a role in combating minority stress. Whether help-seekers worry about being misunderstood in their queerness as in past research (e.g., Foy et al., 2019) or in their other identities intersecting with queerness like Jordan discussed here, accurate empathic understanding as a consistent therapeutic practice would decrease the incidence of actual misunderstandings as distal stressors, as well as proximal stressors in the form of worry about future misunderstandings. This would likely

have a facilitative effect on older queer people, and queer people generally, entering and retaining the help-seeker role.

#### **4.5.1.4 Integrating Humanism with Other Modalities**

Although this section has largely focused on humanistic therapy, I am not advocating for it as a superior modality. What I am suggesting is the integration of humanistic principles into other therapies with a focus on establishing an effective therapeutic relationship (Josefowitz & Myran, 2005). For more protocolised treatments such as CBT, this may entail expanding protocols to explicitly ‘allow’ a humanistic therapeutic relationship, with implications for how protocols are documented in therapy manuals and how they are spoken about during training and supervision.

#### **4.5.2 Adaptations for Affirmative CBT with Older Queer Help-Seekers**

I will now change focus to how CBT could be adapted to meet the needs of older queer people. This is not an attempt to produce a comprehensive manual of queer affirmative CBT— Pachankis, Harkness, Jackson, et al. (2022) have done so already, and their protocol has yielded positive outcomes across a number of clinical trials (e.g., Jackson et al., 2022; Pachankis, Harkness, Maciejewski, et al., 2022; Pachankis et al., 2020; Pachankis, 2015; Pachankis, Soulliard, Layland, et al., 2023; Yi et al., 2024).

One important aspect of queer affirmative CBT is the inclusion of stigma experiences in case formulations (i.e., hypothesising about the psychological mechanisms underpinning a help-seeker’s difficulties) and functional analyses (i.e., understanding behaviour as being preceded by a trigger and followed by certain consequences) (Pachankis, Harkness, Jackson, et al., 2022). Stigma experiences can pertain to LGBTQ+ identities plus other marginalised identities that intersect with queerness (Pachankis, Harkness, Jackson, et al., 2022), dovetailing with culturally affirmative approaches to CBT (Pantalone, Iwamasa, & Martell, 2019). This study suggests that it would be useful for clinicians to include older age in their

intersectional thinking, paying attention to social norms that shape stigma experiences in this age group and the discourses that maintain them, whether currently or historically. Queer people who are older may experience stigma from within the LGBTQ+ community, through legitimisation dynamics that normalise younger ways of being queer, particularly in the case of trans identities as in Lily's account. They may also experience stigma related to their mental health difficulties, upheld by discourses of emotional silencing such as British people having a 'stiff upper lip' or men being impervious to emotions, as discussed by Charlie. Discourses of emotional silencing seem to be shifting as explored in section 4.3.1.2, although it is worth noting that the shift may take time for older help-seekers who have likely been exposed to these discourses from an early age. Mental health stigma could additionally be reinforced by, and could in turn reinforce, stigma about queerness within discourses of help-as-incarceration underpinned by the history of psychiatric asylums and enforced 'cures' for queerness-as-mental-illness, as mobilised by Oliver and Jamie. Such norms and discursive practices, which are part of the fabric of the sociocultural landscape, can be a significant influence on queer people's beliefs about themselves, others, and the world (Carvalho et al., 2022). A sensitivity to these sociocultural pressures in case formulations and functional analyses could support older queer help-seekers in attributing negative beliefs not to inherent flaws within themselves, but to stigmatising power structures (Pachankis, Harkness, Jackson, et al., 2022), replacing the beliefs with more adaptive alternatives and lessening feelings of shame (Budge, 2014).

The current study also supports an intersectional awareness of older queer people's experiences of racism or other dimensions of ethnocultural marginalisation. For Jordan, marginalisation based on his identity as a Black person seemed more central to his daily experiences, and his engagement with mental health services, than his queerness. It might be worthwhile for clinicians to remain curious about the help-seeker's own unique narratives of

marginalisation, not assuming that queerphobia will be the only or foremost source of stigma for them.

It would likewise be important for clinicians to keep up to date with developments in the sociocultural and political spheres and how these might impact older queer help-seekers, and indeed queer help-seekers generally. Here, for instance, older trans people seemed to act on a pressure to be the best possible version of their trans selves (e.g., by only discussing trans topics in therapy), potentially in an attempt to overcompensate for stigma against a sociocultural and political background of increasing transphobia, in line with The Best Little Boy in the World hypothesis (Tobias, 1976). This may have implications for case formulations and functional analyses as described above, and for the feasibility of certain CBT techniques like the gathering of evidence to disprove negative beliefs and thoughts, as detailed below.

CBT is predicated on a dynamic of collaborative empiricism between the therapist and the help-seeker: together they identify the help-seeker's unhelpful thoughts and beliefs, and devise experiments to gather new evidence to challenge these (Tee & Kazantzis, 2011). This process may need to be modified to account for the role of queer community norms in the legitimation of older people's queer identities. If an older queer person—like Lily—holds a belief that they do not belong in the queer community because they do not conform to majority, young-coded norms of how queerness 'should' be performed, it may be difficult to gather evidence to the contrary if the community does indeed structure itself around these norms. In such cases, the reframing of negative beliefs and associated thoughts might require a compassionate, rather than evidence-based, approach (Canvin et al., 2022). For instance, the therapist and help-seeker could acknowledge queer community norms, while equipping the help-seeker with a sense that they are valid as a queer person even if they do not conform to them. Another avenue for navigating concerns about non-normative queerness could be

community connectedness, which is a core tenet of queer affirmative CBT (Pachankis, Harkness, Jackson, et al., 2022). The therapist could support the help-seeker in building their own micro-community wherein they surround themselves with similarly non-normative queer individuals. I suggest ways this could be done in a subsequent paragraph. Similar considerations apply to the modification of negative thoughts and beliefs derived from a heteronormative social framework, especially in the current sociocultural and political context privileging transphobic rhetoric (Armitage, 2020).

Behavioural experiments also feature prominently in CBT, providing opportunities to trial new ways of being and change underlying negative beliefs (Leahy, 2017). This study implies a need for clinicians to recognise that safety in the spaces in which behavioural experiments are conducted may not be a monolith that looks the same for all queer people. For example, queer-only spaces felt safe for some participants like Mark, but not others like David or Lily. Although it was not spoken about in this study, safety outside of queer-only spaces is likewise important. It would be helpful for therapists and help-seekers to discuss safety when planning behavioural experiments, and to consider whether the risk is ‘real’ (i.e., reasonable likelihood of verbal or physical harm) and should be mitigated or avoided, or perceived (i.e., expected due to past negative experiences but not likely to occur) and the help-seeker could benefit from being exposed to it and learning new, safer associations (Canvin et al., 2022; Carvalho et al., 2022; Rimes, 2023).

As touched on above, community connectedness is one of the tenets of queer affirmative CBT (Pachankis, Harkness, Jackson, et al., 2022), rooted in the psychologically protective effect of social relationships wherein queer people can be their authentic selves (Fredriksen-Goldsen, Kim, et al., 2015). This may be especially relevant for older queer help-seekers. Loneliness is a notable issue for older queer people according to past research (e.g., Grabovac et al., 2019; Guasp, 2010). The current study deepens concern over loneliness due

to norms of mental wellness and associated discourses of emotional silencing, which construct mental health difficulties as the responsibility of the individual to ‘fix’ on their own; Sarah and Oliver, for instance, position themselves as not only help-seekers but also self-helpers attempting to ‘fix’ their mental health in isolation. To combat loneliness, CBT could in part focus on strengthening older queer people’s social connections, which may involve the identification and deconstruction of practical barriers and negative thoughts and beliefs, assertiveness training, and bringing together micro-communities of queer people in creative ways (Pachankis, Harkness, Jackson, et al., 2022). Services could assist with this latter point, especially queer services that offer blended therapy/social spaces. One suggestion could be social groups for therapy attendees, which would serve the dual purpose of providing an opportunity for community connections to flourish, as well as dismantling discourses of emotional silencing by creating a version of the help-seeker that can be welcomed by others even if their mental health is not ‘fixed’.

Relatedly, another aspect of queer affirmative CBT is a strengths-based approach. One such strength notable among queer people is the community’s legacy of activism championing queer rights (Pachankis, Harkness, Jackson, et al., 2022). Activism featured in two accounts in this study: Jordan provided anti-racist training to services and Oliver set up a blog to act as a community repository of knowledge about mental health treatment pathways. Jordan in particular also spoke of activism as a source of resilience, corroborating past research (Chan, 2022). Moreover, from these accounts it seems that activism centres around generativity for older queer people, referring to a drive to contribute to the future wellbeing of the queer community, especially the wellbeing of younger generations (Rosati et al., 2021). There is, therefore, scope for clinicians to think with their older queer help-seekers about what generative pursuits they could undertake. Depending on the exact nature of these pursuits, they could bring the added benefit of combating loneliness by promoting

community connectedness, and particularly intergenerational connectedness which has been noted to protect against minority stressors (Powell et al., 2025).

Another strength among older queer people suggested here is resourcefulness, namely the use of self-help to supplement therapy in Oliver's and Sarah's accounts. Clinicians could support older queer people to enter a dual help-seeker/self-helper role, which may facilitate the replacement of unhelpful coping behaviours with more adaptive ones (Pachankis, Harkness, Jackson, et al., 2022). I discuss coping skills in more depth in section 4.5.4 below.

#### ***4.5.3 Adaptations for Affirmative Psychodynamic Work with Older Queer Help-Seekers***

Here, I will consider this study's implications for adapting psychodynamic therapy for older queer help-seekers. As with CBT, there are numerous texts discussing the application of a queer affirmative framework to psychodynamic work (e.g., Blechner, 2009; Cavitch, 2016; Collins & Levitt, 2021; Corbett, 2001; Corbett, 2009; Lemma, 2021; McBee, 2013; Sand, 2017), plus a recent state-of-the-science review by Burger and Pachankis (2024) discussing how this field could be advanced. I will not reiterate these points, instead taking a more specialist lens based on discourses mobilised by the older queer participants in this study. I am using 'psychodynamic' to refer to approaches rooted in psychoanalytic theory, which understands psychological distress as shaped by early-life experiences, including interpersonal patterns that may repeat with others in the here-and-now (Gomez, 2004). The difference lies in how psychodynamic psychotherapy is practised compared to psychoanalysis, for example mandating less frequent sessions, a shorter length of treatment, and speaking face to face rather than with the help-seeker on the couch (Levy, 2009).

The relationship between the therapist and help-seeker is a fundamental part of psychodynamic treatment, variously acting as a vehicle for the transference to play out and be interpreted by the therapist-as-observer (Stark, 2000), an opportunity for corrective emotional experiences (Stark, 2000), or in relational approaches an opportunity to develop a 'real'

relationship between people embedded in their respective histories and sociocultural contexts (Hadley, 2008). Therefore, I suggest that similar considerations apply as above in section 4.5.1 regarding the development of an effective therapeutic relationship based on curiosity, accountability, bias deconstruction, and a welcoming, non-judgemental attitude from the therapist. Gomez (2004) terms this “humanistic psychotherapy” (p.7), entailing egalitarianism and authenticity between the therapist and help-seeker. Given the historical position of psychoanalysis, and by extension psychodynamic practice, as a marginalising force that pathologised queerness as a mental illness (Hegarty, 2017), I propose it would be helpful for psychodynamic therapists to take a relational, humanistically inspired approach to working with older queer clients. This could contribute to the dismantlement of discourses of help-as-incarceration, wherein older queer help-seekers like Oliver and Jamie cannot participate in help, rather, it is enforced upon them by pathologising structures seeking to ‘cure’ queerness. Through such dismantlement, the help-seeker role in psychodynamic therapy may become more easily accessible to older queer people.

Psychodynamic practitioners could also overturn discourses of help-as-incarceration by extending their role from clinicians to advocates of social change (Collins & Levitt, 2021). Mollitt (2025) suggests that this does not need to involve direct activism from therapists (although it can), but can entail making space in the therapy for a consideration of minority stress and queer resilience as embedded in systems of power. As above, this highlights the usefulness of a relational approach that acknowledges what is ‘out there’—social groups and structures influencing the help-seeker’s sense of self and relatedness— rather than exclusively focusing on intrapsychic mechanisms (Collins & Levitt, 2021). This could contribute to de-pathologising queerness by locating the challenges with which it is associated, such as loneliness or mental health difficulties, within society, as opposed to a ‘flaw’ within the queer help-seeker’s psychological landscape (Collins & Levitt, 2021).

Moreover, psychodynamic therapy delivered within a group could be well suited to spotlighting the social processes that underpin distal and proximal stressors (Mollitt, 2025).

Notably, a queer affirmative framework would not necessarily have to be devoid of the exploration of intrapsychic mechanisms that is characteristic of some psychodynamic approaches. Exploration of unconscious processes, including conflicts, phantasies, and defences, can occur without seeking a psychological ‘cause’ of queerness as if it were a deviation from ‘normal’ sexual or gender identities (Charalampakis & Kaprinis, 2026). Rather, the purpose of exploration could be to generate insights about the help-seeker’s psychological and social functioning, supporting them in living a full, authentic life (Lemma, 2021). Moreover, exploration could be combined with affirmation and de-pathologisation by contextualising unconscious processes within the wider sociocultural context, for example defences being conceptualised as proximal stressors arising in response to distal stressors (Mollitt, 2025), the unconscious being understood as a repository for internalised norms about sexuality and gender (Rowland, 2025), or minority stress being considered as a factor in attachment wounds within relationships with primary caregivers (Santo, 2022).

A relational lens in psychodynamic work—with the therapist as an authentic subject co-constructing the dynamic in the room and open to exploring this, where relevant—would likely also offer older queer help-seekers the opportunity to feel understood, or productively work through any breakdowns in understanding (Stark, 2000), as per Jordan’s and Charlie’s accounts wherein an understanding therapist was a key enabler of entry into the help-seeker role. Understanding could additionally be facilitated by the psychodynamic therapist holding knowledge of minority stress, both related to queer identities and other intersecting identities, and creating space in the therapy to explore stigmatising social structures and dynamics as discussed above (Mollitt, 2025). Adapted to psychodynamic work, minority stress could be understood as an influence on queer people’s ego identity (i.e., sense of self), attachment style

(i.e., patterns of relational behaviour), and defence mechanisms that unconsciously regulate psychic conflicts and shape ways-of-being (Collins & Levitt, 2021). A relationship with an understanding other who holds queer-affirming views, like a therapist, has been noted to support psychological wellbeing among queer people, promoting a positive sense of self (Goldblum et al., 2016), a shift from an insecure to a secure attachment style (Medley, 2018), and the development of more adaptive defence mechanisms associated with lessened symptoms of anxiety or depression (Khademi et al., 2019).

More generally, a relational approach positioning the therapist as a subject in the therapeutic dynamic, able to impact upon the older queer help-seeker, would encourage an awareness of countertransference, specifically the norms about sexuality, gender, and other dimensions of identity held by the therapist (McBee, 2013). This arguably includes norms of how queerness ‘should’ be performed within the community and within LGBTQ+ services as a microcosm of the community. Therapists in these services may become enactors of community norms, for example assuming that transness is always political (per Lily’s account), that questioning identities do not count as queer (per Oliver’s account), or that queer therapy can only pertain to queer topics (per David’s account). Such interpersonal pressures may contribute to older queer help-seekers embodying a false self that defends against rejection by complying with norms (McBee, 2013), as Lily described when she spoke about having to “hide” her lack of political affiliation to engage with queer services. Repression of the true self can be associated with anger, simultaneously directed at the self in potentially destructive ways, and at those external others who perpetuate the marginalisation (Bojarski & Qayyum, 2018). A therapist who reflects on how norms play out in the countertransference, and if necessary rescripts them to become less oppressive, would arguably be able to work affirmatively with older queer people (Alessi et al., 2015), supporting them to embody their true selves in authentic, meaningful ways (Medley, 2018).

Section 4.5.1.1 above goes into more detail about ways in which therapists could deconstruct their normative beliefs.

Another implication of this study for psychodynamic practice is a focus in treatment on integrating disowned parts of the help-seeker's self. Disowning is liable to occur in response to social norms, ensuring compliance and fitting in (McBee, 2013). Participants here seemed to disown different aspects of themselves under the following discourses: emotional silencing, as mobilised by Charlie, encouraging the suppression of mental health difficulties; discourses of coping, which uphold mental wellness norms, similarly encouraging the suppression of mental health difficulties such that help-seekers delayed access to services, as recounted by four of the eight participants; help-as-incarceration pathologising mental illness and queerness; help-as-recolonisation othering help-seekers of colour; and lastly, discourses of legitimisation within the queer community othering older ways of being trans or questioning identities. The heterogeneity of these discourses—and, therefore, the heterogeneity of the aspects of self disavowed by older queer help-seekers—suggests a need for practising affirmatively in an intersectional way that acknowledges queerness alongside other identities. Furthermore, when working with queer people who are older, it would be important to be mindful of historical discourses and norms as well as current ones; discourses of emotional silencing, for instance, seem to be shifting as explored in section 4.3.1.2, but were still relevant for participants here. The psychodynamic therapist could respond to disowned parts with acceptance and empathy (Ehrensaft 2009; Fraser 2009; Hansbury 2005), making them more 'digestible' and tolerable and thus available for integration into the self (Stark, 2000); through this process the help-seeker would gain access to a sense of authenticity, vibrancy, meaningfulness, and resilience (Frank, 2021). Indeed, for queer people integration of their queerness into their ego identity is associated with positive attitudes towards themselves-as-

queer, community connectedness, and improved intimacy in relationships (Riggle et al., 2014).

Community connectedness could itself be a target of psychodynamic treatment with older queer people. This is suggested by the discourse of help-seekers-as-help-facilitators, mobilised by Oliver and Jordan, which comports with Collins and Levitt's (2021) suggestion that psychodynamic therapy should consider not only defence mechanisms but also relational coping. Relational coping is defined as resilience created through social support, such as queer community connectedness and queer activism (Collins & Levitt, 2021). These fall under a transtheoretical queer affirmative framework (Moradi & Budge, 2018), and in psychodynamic work therapists could incorporate a practical lens thinking with older queer help-seekers about how to become help-facilitators or engage in other types of activism.

#### ***4.5.4 Transtheoretical Implications: Coping with Intense Distress***

In this section, I discuss an additional way for therapists to work affirmatively with older queer help-seekers across different modalities, namely: a focus on adaptive coping in treatment, to account for intense distress legitimising the entry into the help-seeker role. Participants mobilised intense distress as a key enabler of entry into the help-seeker role, and moreover, may be likely to use avoidance as an unhelpful strategy to cope with minority and other stressors (Pachankis, Harkness, Jackson, et al., 2022) as implied by self-policing their distress through silencing and suppression under mental wellness norms and discourses of help-as-incarceration. A help-seeker in crisis might benefit from a clear discussion at the start of sessions about the therapeutic frame, boundaries, and goals, plus clarification of when and how “lock[ing] up” through sectioning under the Mental Health Act (1983) would be considered as a treatment option. This could help contain the help-seeker's intense emotions (Brown & Stobart, 2018), and empower them to disclose their distress with the knowledge that sectioning would typically not be used unless as a last resort when a help-seeker's safety

is at risk (Mind, 2026). An initial focus in the therapy on distress management strategies could also be helpful. These are conceptualised differently across therapeutic models, possibly including: practical skills per dialectical behaviour therapy (Linehan, 2014); sensory soothing per compassion-focused therapy (Lucre & Clapton, 2021); mindfulness as adopted by numerous approaches (Roemer et al., 2015); facilitating distress tolerance through emotional exposure exercises as in CBT (Pachankis, Harkness, Jackson, et al., 2022); or providing a corrective emotional experience per the psychodynamic discipline (Ernst et al., 2024). Pluralistic practice, a cornerstone of CoP (McAteer, 2010), seems relevant here. Therapists could hold varied knowledge of coping strategies, sharing this flexibly with help-seekers depending on the circumstances, e.g., immediate risks to self/others, number of sessions available, the help-seeker's own knowledge about what helps, etc. Ongoing, collaborative discussion about coping skills might be a way for therapists and help-seekers to build a “parachute” together, creating a help-seeker-as-self-helper who is supported rather than the “loneliest”. To locate such discussions within a queer affirmative framework, therapists might wish to normalise that queer people often need to consolidate their coping skills, to support them in negotiating minority stressors in adaptive ways (Pachankis, Harkness, Jackson, et al., 2022). As touched on in section 4.3.3.4 about help-seekers-as-self-helpers, the use of coping skills may serve the secondary purpose of complying with mental wellness norms. Reveley (2013) suggests that coping can be spoken about in deconstructionist ways, by reframing it as an enactment of the help-seeker's personal values. Therapists could draw on acceptance and commitment therapy for techniques to identify values and set values-based goals with their older queer help-seekers (Harris, 2019). Values related to challenging heteronormativity—within which coping skills could become devices of resistance—could further bolster queer affirmative work (Moradi & Budge, 2018).

Mental health services engaging with the queer community could also contribute to bridging the gap between therapy and day-to-day coping. Such partnership work unifying treatment and social networks could include community-based coping workshops, possibly co-facilitated by community members with lived experiences. This might normalise self-helping as a social rather than “lonel[y]” and speakable rather than “silent” way-of-being, with the potential to deconstruct norms of mental wellness at a grassroots level. As discussed regarding practitioner endorsement by the personal social network, grassroots deconstruction could be more effective than top-down deconstruction from institutions, although further investigation is needed.

#### ***4.5.5 Service-Level Implications: Creating an Accessible Help-Seeker Role***

In this section, I discuss what a queer affirmative framework for older LGBTQ+ help-seekers could look like at the level of service operations, focusing on the following: how services could signal to older queer people that they are safe to access therapy there; and matching one or more aspects of the help-seeker’s identity with that of their therapist.

##### **4.5.5.1 Safety Signalling**

As a population stigmatised under a heteronormative social order and policed through a range of means including prejudice, exclusion, and violence, older queer people—and queer people generally—tend to be attuned to issues around safety (Moorhead et al., 2024). It, therefore, becomes important for mental health services to signal to prospective queer help-seekers that they are safe to attend therapy. This draws on signalling theory, originally used in terms of job markets putting out information about available jobs that applicants then interpret positively or negatively, and similarly for applicants communicating key details about themselves to employers (Spence, 1973). Environmental cues are conceptualised as a powerful demonstrator of the norms active within a setting or institution (Kruk & Matsick, 2021), and research suggests they are used by queer people to make

assessments of risk and belonging (Wolowic et al., 2016) and to choose which companies or services to engage with (Cunningham & Melton, 2014). Arguably, environmental safety cues would contribute to the deconstruction of discourses wherein help becomes an oppressive act by producing a therapeutic space that welcomes rather than marginalises older queer identities. Cues of safety for older queer people may need to be more specialised than commonly used ones such as rainbow flags, which may be less effective for individuals who feel marginalised within the queer community (Hauksson-Tresch, 2021), for example older trans people such as Lily who may not conform to majority norms of transness. Suggestions include posters or artwork showcasing intersectionally marginalised ways of being queer, like transness-as-cross-dressing or queerness of colour, or décor of a textual nature explicitly naming these and other multifarious enactments of queerness. Notably, these are preliminary suggestions only. They would benefit from further study and direct consultation with older queer help-seekers within services to ensure acceptability and efficacy, and to forestall monolithic assumptions that safety signalling looks the same across all queer identities. Service users could be consulted about safety cues in therapy as suggested above in section 4.5.1.2, or in intake forms, surveys, or qualitative service evaluations.

According to Kruk and Matsick (2021), safety can also be signalled through diversity philosophies and programming, referring to statements made by institutions about their attitudes towards diverse identities. Through this lens, communication from services becomes essential in creating a version of help that feels safe for older queer people to access, thereby facilitating entry into the help-seeker role. Services could update the messaging in their written materials (e.g., website, social media, leaflets) to emphasise that they align with a queer affirmative approach, as well as a humanistic approach to ethnocultural positionalities rooted in empathy and a sensitivity to uniqueness. Messages regarding eligibility to access therapy could similarly be updated to become more inclusive of older queer positionalities.

Examples include explicitly naming questioning identities, or breaking down the queer ‘monolith’ by acknowledging that there may be variation in identities and experiences between younger and older queer people and that all these variations are welcome in the service.

Another role for messaging could be in constructing services as accessible at all times and not just in crisis, which could help normalise mental health difficulties and help-seeking. Part of this could be continued publicity campaigns about mental health and treatment pathways, overturning discourses of emotional silencing that uphold mental health stigma and thus, potentially, enabling older queer people to come forward sooner, before their difficulties reach a crisis point. Nonetheless, further research would first be needed about the effectiveness of discourse deconstruction depending on its provenance. It is also necessary to note that the limited resources and funding available to services could pose an impediment to providing help outside of crisis, which may translate into increased numbers of service users. Population-level longitudinal research into the benefits of ‘preventative’ mental health care might be needed to build a convincing case for such expansion in services’ scope. Furthermore, this suggestion is rooted in a Western understanding of mental health care as enacted in a therapeutic group/dyad where emotions, thoughts, and experiences are shared (Watters, 2010). There could be other knowledges of psychological healing in the United Kingdom’s multi-ethnic queer community that could benefit from further spotlighting.

Messages from services could act through another type of safety cue as well, namely: minority representation, defined as increasing the presence of a marginalised social group in an organisation, creating a sense that it is a safe place for members of that group (Kruk & Matsick, 2021). Written or visual materials from services could thus contribute to dismantling “cookie-cutter”-ness by bolstering the visibility of queerness and ethnocultural diversity among staff, where applicable, with particular attention to intersectional identities. This could

also be extended to other dimensions of identity subject to marginalisation, such as disability or neurodivergence. Moreover, messaging could underscore a shared background, such as trauma, between staff in the treatment network and the targeted help-seeker population, to create a sense of in-group trust facilitative of entry into the help-seeker role.

#### **4.5.5.2 Therapist-Client Matching**

One specialised way to signal safety through minority representation is therapist-client matching, referring to pairing together therapists and clients based on one or more shared aspects of their identities (Arora et al., 2025). Two participants, Charlie and Jordan, spoke about the importance of a similar background between the therapist and help-seeker to enable the help-seeker to feel understood, arguably creating safety from distal stressors like prejudices or misconceptions and consequently enabling them to enter and retain the help-seeker role. This was in the context of experiences of childhood sexual abuse for Charlie, and his ethnocultural identity as a Black person for Jordan.

To date, research is scant about matching between the therapist's and help-seeker's history of sexual violence, but there are preliminary suggestions that it can be validating (Bennett et al., 2022). In other areas like eating disorders, substance use, and severe mental health difficulties, disclosure from the therapist of their own experiences has been documented as helpful (Bassuk et al., 2016; Davidson et al., 2012; de Vos et al., 2016), establishing trust between the therapist and help-seeker as well as instilling hope in the help-seeker that they, too, will be able to recover (Cvetovac & Adame, 2017). For older queer people who have experienced sexual violence, such matching and disclosure may deconstruct silencing and stigmatising discourses, enabling them to enter the help-seeker role and speak about their own experiences, as in Charlie's account. Future research could examine this further, in bigger samples, to determine the clinical benefits.

In terms of ethnocultural matching, past research suggests it tends to be preferred by help-seekers but may not consistently be associated with improved treatment outcomes (Cabral & Smith, 2011), which may be attributed to the therapist's relational skills and ethnocultural competence and humility (Ertl et al., 2019). This reflects Jordan's account wherein his "best" experience of therapy was rooted in a robust therapeutic alliance with a therapist who did not match his identities as Black or gay. Jordan additionally discussed that ethnocultural matching can be helpful if a humanistic relationship cannot be established, perhaps within protocolised, "cookie-cutter" treatment. Two implications follow: firstly, that therapists should develop their relational skills and ethnocultural competence, comprised of awareness of their beliefs and attitudes, plus knowledge of diverse ethnocultural groups (Ertl et al., 2019), and that services and training institutions should facilitate this; secondly, that ethnocultural diversity among therapists should be increased via structural interventions, to support matching where preferred by help-seekers. Structural interventions could include the removal of barriers to entry into training for prospective therapists of ethnoculturally minoritised backgrounds (see Griffith, 2007, for a more detailed discussion), as well as hiring initiatives so that services can become ethnoculturally representative of their communities. Another structural intervention could be the blending of treatment and social networks: there might be scope for mental health services and practitioners to collaborate with ethnoculturally minoritised communities (or ethnoculturally minoritised subsections of the queer community) on adaptations to therapy, or on therapy programmes co-delivered with community members. This could contribute to the creation of a psychology that represents and understands different ethnocultural positionalities rather than imposing White ways-of-thinking/being.

Matching in terms of the therapist's and help-seeker's queer identity was not raised by participants. Nonetheless, it is a growing topic in existing research, and could potentially have underpinned some participant experiences seeing as three of eight were accessing queer

services staffed by queer therapists. Previous studies suggest nuance in terms of whether queer help-seekers prefer queer therapists and whether such matching benefits treatment. Burckell and Goldfried (2006) report that queer people are likely to select queer therapists if they seek to focus on queer topics in therapy, but otherwise not necessarily. Arora et al. (2025), in contrast, discuss how a shared queer identity, particularly when combined with a shared ethnocultural identity, can be essential for help-seekers to feel safe in therapy. As for effects on treatment, Baumann and colleagues (2020) suggest that matched LGBTQ+ identities can require a balance of negotiating differences and similarities in experiences and embodiments and beliefs related to queerness. For older queer help-seekers specifically, dynamics of legitimation within queer services might influence how they experience a shared queer identity with their therapist, which may trigger pressures to conform to community norms. It would be useful for future investigations to focus on this. A thread that runs through past research, as in this study, is the necessity of an accepting, curious, knowledgeable, intersectional, and deconstructionist approach (Arora et al., 2025; Baumann et al., 2020; Burckell & Goldfried, 2006). Previous sections discuss what this might look like in humanistic, CBT, and psychodynamic modalities.

#### **4.6 Dissemination**

Having discussed this study's theoretical and practical implications, I will now consider their dissemination. I plan to submit a journal article based on this study (Appendix K) to the *Psychology & Sexuality* journal for publication. This is an international journal interested in psychological experiences of gender and sexuality situated within sociocultural and historical contexts (Psychology & Sexuality, n.d.). Publication would further the study's social justice aims by canvassing a larger readership among researchers and mental health professionals, who may pursue the un-silencing of older queer voices in their own research or adapt their therapeutic practices and wider service operations to more affirmatively meet this

population's needs. I also plan to create a training package about working therapeutically with older queer people, to be offered to mental health organisations. This would support the implementation of the study's implications, contributing to the creation of a help-seeker role more accessible to older queer people.

#### **4.7 Limitations and Future Research**

Here, I move on beyond implications and their dissemination to the study's limitations; I also suggest directions for future investigation additional to those in previous sections. A significant portion of this study focuses on barriers to entering the help-seeker role. Participants were active help-seekers, waiting for or attending therapy, and thus the identified barriers may not be relevant to older queer people who feel unable to engage with mental health services at all. This creates an opportunity for further research as these individuals may have particularly difficult histories and/or complex mental health needs, and could be attempting to cope alone in a stigmatising climate. It would, however, be useful to note possible recruitment challenges as this population's relationship to mental health professionals or researchers may entail dynamics of power and safety.

Another missed population is older queer people with experiences of aversion/conversion therapy. These would be important voices to be heard as aversion/conversion therapy has been described as traumatising (Dickinson et al., 2012), highlighting a need to investigate mental health needs among these individuals and develop treatment options that feel acceptable.

Similarly, the sample was exclusively British and exclusively urban. The study cannot shed light on how older queer people who live in the United Kingdom as foreign nationals might construct the help-seeker role, which could involve a negotiation of legitimacy not only as a queer person but also a U.K. resident amid current discourses portraying immigration as unwelcome (Singer, 2017). Moreover, past research suggests that queerness may be

experienced differently in rural areas compared to urban ones, less community-based and more vulnerable to prejudice (McGlynn, 2018). Older queer people living rurally may experience help-seeking differently as well, potentially entailing a “cookie-cutter”-ness that delegitimises queerness or difficulties accessing services due to remoteness (Marshall & Cahill, 2021).

One additional missed population are older queer people concealing their queer identity in response to distal stressors, who may not have felt comfortable revealing themselves as queer by responding to my advertisement. Identity concealment among queer people is linked to reluctance to seek help (Grabski et al., 2022). It would, therefore, be important for future research to capture discourses about entry into the help-seeker role in this population, to generate insights about how best to facilitate their help-seeking journeys. However, recruitment could be challenging as it would require participants to let go of concealment measures. It may need to be approached in creative, deconstructionist ways that defuse stigma and create a sense of safety around disclosures of queerness.

The study may likewise present with limitations linked to the operationalisation of early-stage therapy as a maximum of five attended sessions (Horvath & Marx, 1990). Certain types of therapy are offered on a short-term basis, with a low number of total sessions, for example NHS Talking Therapies averaging 8.4 sessions per client in 2024-25 (NHS England, 2025). In such cases, five attended sessions would be less reflective of the beginning stage of therapy, and more so of the middle or latter stages. Future research could investigate how constructions of the help-seeker role might differ between beginning-stage and later-stage therapy. Implications could extend to how services and clinicians might facilitate the retention of the help-seeker role, not only entry into the role as was the focus here. This may contribute to reductions in drop-out rates, which the literature suggests as higher among

sexually minoritised individuals compared to heterosexual counterparts (Anderson et al., 2019).

A further limitation is the lack of co-production between myself and participants in terms of the interview schedule and analysis. This privileged my own voice as the researcher, my own ideas about what aspects of older queer people's discursive experiences were important to capture and what aspects could be dismissed. It would be worthwhile for future research to create space for co-production, where possible, not only providing a platform for older queer voices but also embedding those voices into the research process. By ensuring that researcher interpretations do not overshadow older queer people's own meaning-making, this would represent a step towards deconstructing oppressive discourses about this population.

The study's partial enactment of monolithic discourses is also, arguably, a limitation. While the study does discuss trans identities as subject to unique discursive pressures, it does not differentiate between participants' sexual orientations, which included gay, lesbian, bisexual, and straight. This is due to the small sample size creating difficulty in drawing clear distinctions, plus the study's focus on LGBTQ+ identities as a whole, which translated into broad interview questions that referred to 'queerness' rather than any one identity in particular. As this was the first piece of research about older queer people's help-seeking, it felt important to offer a platform to all silenced voices, with scope for subsequent research to adopt a narrower focus. This may be appropriate for significantly marginalised identities in the queer spectrum, such as asexuality or non-binary gender identifications (Matsuno & Budge, 2017; McInroy et al., 2022), which were not captured here.

Another aspect that could be improved in further research is the preponderant focus on what it means to be a *queer* help-seeker rather than an *older* help-seeker, as discussed in *Reflexive Statement: Part III*.

Future research could also spotlight older queer people's deployment of self-help. This seemed enacted in a solitary manner without the direct involvement of social and treatment networks, the exception being the likely influence of mental wellness norms creating an injunction to 'fix' one's own mental health difficulties. Given its solitary enactment, self-help may be less usefully conceptualised by the NEM with its focus on how social and treatment networks shape ways of sourcing help.

Lastly, the study adopts a social constructionist lens interested in unique subjectivities (Willig, 2022); FDA likewise utilises small samples so each participant's language patterns can be examined (Coyle, 2007). As generalisability was not sought here, future research about older queer people could branch out into quantitative methodologies, useful in establishing the clinical effectiveness of the therapeutic techniques suggested above.

#### **4.8 Reflexive Statement: Part IV**

In this final section, I consider how my experiences as a trainee CoP may have influenced the *Discussion*. I note the theme of capitalism throughout the *Discussion*, framed as a reductive ideology that privileges economic function over humanness. This could link to my disillusionment with the Professional Doctorate. In the first months of my first year, my cohort and I were informed that the course would be closing. This was explained as a financial decision, which, to me, was reflective of capitalistic values wherein revenue holds utmost importance. It left me with a sense of delegitimisation, feeling that CoP was not valued as a discipline when I personally saw significant value in it due to its humanistic grounding. My critique of capitalism may have been an attempt to regain a sense of legitimacy for myself and the profession, positioning participants' humanness—their complexity and uniqueness and social connectedness—as a vital influence on their entry into the help-seeker role.

For this same reason, I may have argued for a humanistic rather than “cookie-cutter” approach to therapy for older queer people. This may have also been underpinned by my experiences on my final work placement in a psychosexual service commissioned to treat difficulties of a sexual nature that lacked a physical cause. The service’s treatment protocols were highly manualised. I felt I lacked the flexibility to be curious about my clients outside of sex, or connect with them as a human to another human rather than an ‘expert’ to a patient. As I felt unsupported by the service and the psychosexual literature to practise per my CoP values, I may have sought to put together my own mini-manual of therapeutic approaches which enshrines humanism and flexibility.

On a more personal level, this project has introduced me to alternative ways of enacting my queerness. Belongingness has, historically, felt unattainable to me: I do not feel like I belong in the United Kingdom as a Romanian national, nor as a future CoP in a career space that values protocolised treatment, nor as a younger queer person in the queer community when I do not typically engage with social events or spaces such as Pride or queer bars/clubs. Like some of my participants, I do not feel I am queer in the ‘right’ ways. The *Discussion* was an opportunity for me to deconstruct what ‘rightness’ is and where it might come from socioculturally, politically, and/or historically: an opportunity to rewrite my own narrative such that myriad shades of queerness become available, such as a queerness enacted by un-silencing other people’s queer experiences in research and therapy. This has had ramifications for other parts of my life as I continue to construct, deconstruct, and reconstruct what it means to be a researcher, therapist, and human being.

#### **4.9 Concluding Remarks**

Baked into this study was a pursuit of social justice, to address the unmet mental health needs among older queer people through an examination of how they discursively construct the help-seeker role. This is a concept rooted in the NEM, which defines entry into

the role as a catalyst for treatment engagement (Pescosolido et al., 2013). This process of assuming and retaining the help-seeker role is understood as socially grounded, shaped by and in turn shaping social networks that include family, friends, and communities, plus treatment networks encompassing clinical and non-clinical staff (Pescosolido et al., 2013). The study offers a unique contribution to the help-seeking literature by exploring how a queer identity might influence these social processes, and moreover, within the wider LGBTQ+ literature, it privileges the previously unheard voices of older queer help-seekers.

These are voices embedded in a history of marginalisation. LGBTQ+ identities have variously been constructed as criminal, diseased, and psychologically pathological, subjugated through stigma, violence, and social exclusion. Although U.K. society has, in some respects, adopted more accepting attitudes, this legacy appears to contribute to mental health vulnerability among older queer people (Semlyen et al., 2016; Watkinson et al., 2024). According to an intersectional lens on minority stress (Rivas-Koehl et al., 2023), this vulnerability is exacerbated by risk factors specific to older age, such as loneliness, informal caregiving, and exclusion from within the queer community (Guasp, 2010; McCann & Brown, 2019; Westwood et al., 2020). Uptake of the help-seeker role in general gerontological populations is reported to be low despite age-related risk factors (NHS, 2022), and research to date has not spotlighted how older queer people specifically become able to engage with the mental health system. This is an important piece of the puzzle in responding productively to this population's mental health risks.

Instead, studies have primarily focused on younger queer counterparts. Key findings include a delay in entering the help-seeker role due to worries of dismissal and avoidance of perceived abnormality (McDermott et al., 2018), as well as fears of prejudice from practitioners (Foy et al., 2019; Pitt et al., 2024). Nonetheless, due to a dearth of research, it was unclear how or whether these would be mobilised by older cohorts.

To fill this gap, this study involved interviews with eight people in the United Kingdom aged 50+ and identifying on the LGBTQ+ spectrum; they were waiting for or receiving early-stage psychological therapy. Interviews were analysed through FDA, chosen due to its focus on dynamics of power in society (Olsson, 2010). These seemed relevant in the context of queer marginalisation, driving an exploration of help-seeking that foregrounded ways in which older queer people continue to be subjugated. Paired with a critical realist ontology, FDA enabled the study to generate ‘real’ implications that may contribute to the creation of a de-marginalised help-seeker role that is viable for older queer people.

As in past research, participants discussed the help-seeker role as unavailable to them until the point of mental health crisis. Legitimacy was negotiated in terms of the ‘right’ level of distress under discourses that stigmatise mental health difficulties, including sanism, the British ‘stiff upper lip’, and masculinity-as-impervious-to-emotions. These discourses may be particularly relevant within intersectional frameworks of minority stress that include older age, as this age group is likely to have been exposed to them the longest and to continue engaging with them even as they shift. Entry into help-seeking seems possible only once distress overrides worries of mental health stigma such that dismissal is not enacted by practitioners but by individuals themselves self-dismissing their early psychological concerns. This delay until crisis invites therapists to include a focus on adaptive coping in their agendas. Within queer affirmative approaches, coping could aim to bolster resilience against minority stress, for example through help-seekers becoming activists or help-facilitators as a form of community connectedness (Pachankis, Harkness, Jackson, et al., 2022). Implications for services include expanding the scope of their eligibility criteria to include help-seeking outside of crisis.

Another barrier to entry into the help-seeker role was created by discourses of help-as-incarceration, rooted in the history of psychiatric asylums and non-consensual treatments to ‘cure’ queerness. Through this lens, older queer people cannot become legitimate help-seekers until help is deconstructed as harmful and reconstructed as safe. Such discourse deconstruction seems to be particularly effective when originating within the help-seeker’s personal social network, such as through endorsement of certain practitioners. Therapists could contribute to this deconstruction by working affirmatively with older queer populations, which may entail undertaking activist efforts themselves, relating to older queer help-seekers as human beings rather than ‘experts’, and offering clarity around carceral practices, i.e., sectioning. In terms of services, implications include producing safe therapy spaces through environmental cues and the messages they put out regarding their attitude to diverse queer and intersectional identities.

Participants also negotiated their legitimacy in terms of being queer in the ‘right’ ways to access queer services. Unlike Foy et al. (2019) and Pitt et al. (2024), participants did not mobilise worries of anti-LGBTQ+ stigma from practitioners presumed to be straight and cis, but rather from within services as a microcosm of the broader queer community. Community borders become policed against non-normative enactments of queerness, such as politically ‘incorrect’ views and questioning identities, that breach ‘young’ community “trends”. For trans people, ‘rightness’ did not seem sufficient at the point of entry, but continued to be ‘proven’ throughout treatment under a medico-legal discourse wherein transness must be certified by an “ology”, limiting the remit of therapy to trans issues. As part of the help-seeker’s treatment network, services and mental health professionals are in a position to modulate this ‘rightness’ through the ways in which they construct eligibility criteria for entry into the help-seeker role, and through environmental cues defining which identities are welcome in therapy spaces. Therapists, moreover, can challenge norms of

‘rightness’ by adopting a queer affirmative framework, responding to help-seekers’ non-normative enactments of queerness with acceptance and curiosity across modalities. A sensitivity to countertransference in psychodynamic work would also be important as therapists may unwittingly become enactors of community norms. As for CBT, safety in normative spaces may need to be considered when planning behavioural interventions; norms may likewise limit the availability of evidence against negative cognitions, requiring a shift to compassionate restructuring.

Another key enabler of help-seeking was the treatment network—including the therapist and other staff—understanding the help-seeker as a function of empathy. This seemed particularly salient in the context of trauma and diverse ethnocultural positionalities, creating a sense of safety either through sameness between help-seeker and therapist/other staff, or through the therapist’s rejection of “cookie-cutter”-ness in favour of honouring the help-seeker as a unique individual with unique experiences and needs. I argue for a breaking down not only of the queer monolith, but also of relevant other monoliths including, but not limited to, ethnicity, culture, age, abledness, neurodiversity, and socioeconomic status. This invites a greater visibility of multifarious positionalities among staff in treatment networks, brought about through structural interventions and publicised through safety signalling; therapist-client matching, if preferred by clients, would thus become more feasible. Another implication is therapists across modalities drawing on humanistic principles to establish a robust and affirming therapeutic alliance, upheld by therapists doing the “work” (Saad, 2020) of deconstructing their biases intentionally and systematically. Furthermore, knowledge of social groups other than the therapist’s own is an essential ingredient in establishing empathy and understanding in the therapeutic relationship (Ridley & Lingle, 1996), suggesting a need for therapists to be aware of minority stress frameworks—including intersectional variations—and incorporate these into their different modalities of working. Minority

stressors, and the norms and discourses sustaining them, could be considered in formulations, whether in CBT, psychodynamic approaches, or elsewhere.

Additionally, help-seekers were spoken of as social subjects, embedded in blended social/therapy spaces that may be safe for some queer people but not others. This opens the door for therapists and help-seekers to discuss and construct together a safety adapted to the help-seeker's individual needs. It also opens the door for the inclusion of the physical venue itself, with all its attached meanings as part of a unified socio-treatment network, in the NEM, and for services to include environmental cues in their venues that signal safety to older LGBTQ+ people. In some participant accounts, help-seekers also became social subjects not only benefitting from support from their social networks, but also creating that support for others as knowledge-repositories in the community or as activists collaborating with services. Such community involvement could provide an avenue for resilience against minority stress (Chan, 2022). There may likewise be opportunities for collaboration between services and communities—including the queer community and ethnoculturally minoritised sub-communities therein—to consolidate a repository of therapeutic knowledge held within the community for the community, deconstructing the historic disempowerment of queer individuals and individuals of colour by the psy-complex and rebuilding trust.

Lastly, help-seekers facilitated their own help as well, supplementing therapy with self-help under mental wellness norms endowing them with the responsibility to 'fix' their mental illness alone and in silence, as individuals rather than parts of bigger systems. Implications include therapists framing self-help as an enactment of the help-seeker's values in life rather than an upholding of social norms, and thinking with the help-seeker about how self-help could be scaffolded by their social network. Through these deconstructionist lenses, self-help could become part of strengths-based therapeutic approaches championing older queer people's resourcefulness.

I intend this research to catalyse further conversation among researchers and mental health professionals about how and when older queer people feel able to become help-seekers. This breaking of silence would contribute to the creation of a psychology that upholds older queer people as valued, valid members of their queer communities and society as a whole, supporting them in seeking help when needed.

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## Appendix B

### Recruitment Poster

**LONDON METROPOLITAN UNIVERSITY**

# VOLUNTEERS NEEDED

Are you:

- Aged 50+
- Lesbian, gay, bisexual, transgender, or any other identity within the LGBTQ+ umbrella (including pansexual, asexual, non-binary, or intersex)
- On a waiting list for therapy/counselling OR currently attending therapy/counselling?

**Then you can participate in a research study looking at what it means to you to be seeking support for your emotional wellbeing.**

**WHO**

My name is Denisa and I am a trainee counselling psychologist. I am conducting this research study for my thesis. I identify as bisexual and non-binary and have experience both of receiving therapy as an LGBTQ+ person and providing therapy to LGBTQ+ people.

**WHAT**

Participation involves:

- A brief phone call with me to tell you more about the study and decide if you would like to come to an interview
- If we agree on an interview, this will last approximately 45-60 minutes
  - We will discuss your experiences of accessing therapy/counselling
  - There will be no pressure for you to talk about anything you do not wish to talk about
  - We can meet online or in person
  - **Refreshments will be offered if we meet in person**

**WHY**

There is a gap between older LGBTQ+ people's mental health needs and use of mental health services. I hope this study might help us understand your unique experience of seeking support, ultimately making therapy/counselling more accessible and affirming for older members of the LGBTQ+ community.

**NEXT STEPS**

If you are interested in coming to an interview or would like more information about the study, please contact me on:

- **Email: [dei0056@my.londonmet.ac.uk](mailto:dei0056@my.londonmet.ac.uk)**
- **Phone: 074 9749 3643**

I look forward to hearing from you!

**Research title:** Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or attending early stages of therapy

**Ethical approval:** Granted on 28/05/2024 by London Metropolitan University

## Appendix C

### Participant Information Sheet

**Title: Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or attending early stages of therapy**

Dear Volunteer,

You are invited to participate in a study exploring emotional well-being in older lesbian, gay, bisexual, transgender, and other sexual/gender minoritised (LGBTQ+) individuals. I am particularly interested in what it has been like for you to seek therapy.

You are eligible to take part if you are:

- LGBTQ+ (including but not limited to lesbian, gay, bisexual, transgender, queer/questioning, asexual, intersex, non-binary, and pansexual);
- Aged 50+;
- Able to speak English to a conversational level;
- On a waiting list for therapy OR actively receiving therapy.

You are **not** eligible to take part if you have attended more than 5 therapy sessions OR attended a previous course of therapy in the past 90 days.

The decision to seek therapy can be a complex one to make. As an older person who is LGBTQ+, you may have unique concerns, hopes, or expectations regarding therapy. At present, there is a call for more research in this area, especially as there is a gap between older LGBTQ+ people's mental health needs and the use of mental health services. Through this study, I hope we will better understand the various aspects of help-seeking you may navigate as an older LGBTQ+ person. Ultimately, I hope that this might help us close the gap between mental health needs and service use for older sexual/gender minoritised people, making therapy more accessible.

I am a trainee counselling psychologist studying towards a Professional Doctorate in Counselling Psychology at London Metropolitan University. This piece of research is intended to be my doctoral thesis. I also hope to submit the completed study for publication in an academic journal.

If you agree to participate, you will attend an interview with me (online or in person at your discretion), where we will discuss your emotional well-being and your thoughts and feelings about seeing a therapist. The interview will last between 45 and 60 minutes and will be audio-recorded on an encrypted voice recorder, securely stored in a locked file cabinet and accessed only by me.

**Please note that the interview will not be a therapy session. I cannot provide therapeutic advice or support during our time together.** If you are currently on a waiting list, we will try to schedule the interview as close as possible to the start date of your therapy (e.g., less than a week) so that you have quick access to support. If you need additional support in the interim, we can discuss this at the end of the interview, and I can provide a list of LGBTQ+-friendly services.

All information that is collected about you during the research will be kept strictly confidential. Your name or identifying information will be removed from the data and will not be quoted in the study. The anonymised transcript of your interview will be stored on the secure cloud service Box in line with London Metropolitan University's research integrity policy. Your signed consent forms will be kept in a separate location on Box so the interview data cannot be traced back to you. All identifying data, including the recording, will be destroyed after the project's completion. Anonymised data may be retained for up to five years to allow publication.

Please note that there are certain limits to confidentiality. Confidentiality may need to be breached if information is disclosed indicating a risk to your or someone else's safety. Insofar as possible, this will be thoroughly discussed with you.

Participation is entirely voluntary. If you do decide to participate, you will be asked to sign a consent form. You are free to withdraw this consent at any time during the study without giving a reason. You will retain the right to withdraw for up to two weeks after your interview, in which case your data will be destroyed. During the interview, if there are any questions you do not wish to answer, you may decline to do so without any repercussions.

Before you decide to participate, it is important to understand that the interview will touch on aspects of your experience as an LGBTQ+ person that may be difficult or distressing to discuss. Please take your time deciding whether or not participation in this study is something you would like to do and would be safe for you now.

If you are interested in participating, we will have a brief phone call to discuss the contents of the interview in more depth, possible ways the interview could affect your emotional well-being, and how you are currently feeling. This ensures that the interview will not have any adverse emotional effects on you in the long term. The phone call will take between 10 and 20 minutes. After the phone call, if you would still like to participate, we will schedule a day and time for the interview.

At the end of the interview, you will have the opportunity to spend a few minutes with me to discuss your experience of being interviewed. If needed, we will engage in distress reduction techniques (e.g., breathing/mindfulness exercises) so that you are able to resume daily activities from a place of emotional well-being. As mentioned above, information on sources of further support will be available. If you agree, I can also offer you a follow-up call the next day to discuss your feelings.

The Research Ethics Review Panel at London Metropolitan University has approved this study. It will be conducted following the ethical guidelines provided by the British Psychological Society.

All interviewees are invited to request a copy of the final study. The estimated date of completion is September 2025.

If you would like to take part in this study or have any queries, comments, or concerns, please do not hesitate to get in touch with me on [dei0056@my.londonmet.ac.uk](mailto:dei0056@my.londonmet.ac.uk) or 074 9749 3643.

Alternatively, you may contact my supervisor Dr Sebastian Cordoba on [s.cordoba@londonmet.ac.uk](mailto:s.cordoba@londonmet.ac.uk).

Thank you so much for your time.

I hope to hear from you soon.

Kind regards,

Denisa Ion

## Appendix D

### Consent Form

**Title: Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or attending early stages of therapy**

Please review the following statements in relation to the study above and, if you are in agreement, please provide your name and signature in the fields below.

- I understand that even if I agree to participate now, I am able to withdraw from the study at any time and for any reason, and to decline to answer any interview questions with no consequences whatsoever.
- I understand that I retain the right to withdraw from the study up to two weeks after I am interviewed, in which case my data will be destroyed.
- I have received a written account of the purpose and nature of the study, and I have had the opportunity to ask further questions.
- I understand that participation involves an interview that will be audio-recorded.
- I understand that all information I share as part of this study will be strictly confidential.
- I understand that the original data will be retained until completion of the study and subsequently destroyed.
- I understand that anonymised data (i.e., interview transcripts with all identifying information removed) may be retained for a period of up to five years to enable publication of the study.
- I understand that in any write-up of this research my identity and the identity of others I may speak about will remain anonymous (i.e., all names changed to pseudonyms and all other identifying information, such as place names, removed or disguised).

- I understand that there are limits to confidentiality. Confidentiality may need to be breached if I disclose information that indicates a risk to my or someone else's safety.
- I understand that the study will be accessible to others when completed and that excerpts from my interview (minus identifying information) may feature in the write-up.
- I understand that I may find the interview upsetting and that it may evoke a number of difficult and distressing feelings for me. If that is the case, the researcher will guide me through some brief distress reduction techniques (e.g., breathing/mindfulness exercises) at the end of the interview. The researcher will also provide information on services that can offer further support between the end of the interview and the start of my therapy.
- I understand that I have the right to access the write-up of the completed study, and details on how to gain access will be provided in the debriefing form.
- I understand that I am free to contact any of the people involved in this research with comments, questions, or concerns.

Signature of participant: .....

Signature of researcher: .....

Print name: .....

Print name: .....

Date: .....

Date: .....

## Appendix E

### Interview Schedule

#### Demographic Information

Age:

Ethnicity:

Gender:

Sexual orientation:

#### Questions

1. Could you tell me about your emotional well-being?
  - a. As an LGBTQ+ person?
  - b. As an older person?
  - c. In light of your physical health?
  - d. Have you spoken to your GP about your emotional well-being? If yes, what was that like for you?
2. How do you feel about seeing a therapist?
  - a. As an LGBTQ+ person?
  - b. As an older person?
  - c. In light of any past therapy experiences (including aversion/conversion therapy)?
  - d. Has anyone you know been to therapy? If yes, what do you make of their experiences?
3. Is there anything that has not come up so far that you would like to share?

## Appendix F

### Example Transcript

#### Part I: Clean Copy

Oliver: I find that I'm working for a diagnosis for ADHD.

Denisa: Mm-hmm.

Oliver: Um, which I realise has been underpinning most of my decisions, um, lifestyle, for years and years and years, if I look back.

Denisa: Yeah.

Oliver: And I've been doing a lot of research into that, which makes sense for some of the things that I feel, um.

Denisa: Yeah.

Oliver: Uh, I have... I call it frequency. So I have an anxious frequency, which is something which I have to manage.

Denisa: Sure.

Oliver: And that can be like an elevator drop, depending on certain things. Kind of... a bit like, a bit of a textbook, you know, I do the running.

Denisa: Mm-hmm.

Oliver: "Are you relatively well?" I do all this stuff. But there's still, it's always there, with regards to the mood that can, that can pivot kind of around the day, really.

Denisa: Mm-hmm.

Oliver: Because sometimes I need to be highly stimulated and sometimes I need to be under-stimulated, so I have to regulate that.

Denisa: Mm-hmm.

Oliver: At the moment it is a good day because we're talking about this, I have something to do later on, and all that stuff.

Denisa: Yeah.

Oliver: So, um. That's where I'm at at the moment. I have this underlying slight sense of dread that autumn is around the corner. I do have slightly catastrophic part of my brain that is always forward thinking and always has to look for the worst case scenario, which is probably why I was very good at my work, event management, so I'd always problem-solve based on something that wasn't there... Yeah. Did that answer your question?

Denisa: Yeah, yeah. Absolutely. So I think I'm getting these, like, top notes of okayness, and you doing an amazing job of kind of managing yourself, in a sense, plus this undercurrent of the anxiety and the dread kind of going on underneath.

Oliver: Yeah, it quietly simmers in the background. It's something I've learned to—and, um, since I stopped doing the drinking, drugs and that kind of thing, um, it, it's more elevated, more amplified, because I'm not numbing anything.

Denisa: Yeah.

Oliver: So I sometimes have to sit with feelings that are quite loud sometimes, but that's a good thing for me because I've learned to... process that once you come through the other side, every time it gets a little bit easier.

Denisa: Yeah.

Oliver: But yeah, it's a very, it's an ongoing process, and, you know, you kind of switch depending on circumstances, that kind of thing. But I've realized, with these services that are available, tapped into them. I'm sure we'll come on to that in a minute, but I tapped into them in February because it was very dark, dark time for me.

Denisa: Mm.

Oliver: And you realize that whilst they are there, one still has to manage one's own day-to-day living, and the loneliest thing when you're in this particular place, like where I'm living now.

Denisa: Yeah.

Oliver: It's very... again, alone and loneliness are kind of two different things, but, um, it's a silent struggle sometimes, but I work around it with positive distractions, I think that's the way of doing it, but yeah, I just feel like I'm falling, I'm kind of building the parachute as I'm falling.

Denisa: Mm.

Oliver: So every day is like a brand-new day because my short-term memory, knowing ADHD, it can be quite challenging to remember stuff.

Denisa: Yes.

Oliver: So that I get quite down about sometimes, because I...

Denisa: Yeah.

Oliver: It, it... yes. So that's where I'm at today.

## Part II: NVivo Annotations

Oliver: Uh, I have... I call it frequency. So I have an anxious frequency, which is something which I have to manage.

Denisa: Sure.

Oliver: And that can be like an elevator drop, depending on certain things. Kind of... a bit like, a bit of a textbook, you know, I do the running.

Denisa: M m-hmm.

Oliver: "Are you relatively well?" I do all this stuff. But there's still, it's always there, with regards to the mood that can, that can pivot kind of around the day, really.

Denisa: M m-hmm.

Oliver: Because sometimes I need to be highly stimulated and sometimes I need to be understimulated, so I have to regulate that.

Denisa: M m-hmm.

Oliver: At the moment it is a good day because we're talking about this, I have something to do later on, and all that stuff.

Denisa: Yeah.

Oliver: So, um. That's where I'm at at the moment. I have this underlying slight sense of dread that autumn is around the corner. I do have slightly catastrophic part of my brain that is always forward thinking and always has to look for the worst case scenario, which is probably why I was very good at my work, event management, so I'd always problem-solve based on something that wasn't there... Yeah. Did that answer your question?

Denisa: Yeah, yeah. Absolutely. So I think I'm getting these, like, top notes of okayness, and you doing an amazing job of kind of managing yourself, in a sense, plus this undercurrent of the anxiety and the dread kind of going on underneath.

Oliver: Yeah, it quietly simmers in the background. It's something I've learned to—and, um, since I stopped doing the drinking, drugs and that kind of thing, um, it, it's more elevated, more amplified,

### CODE STRIPES

- Unable to cope
  - Silencing
  - MH outside therapy
- Coding Density

Oliver: Yeah, it quietly simmers in the background. It's something I've learned to—and, um, since I stopped doing the drinking, drugs and that kind of thing, um, it, it's more elevated, more amplified, because I'm not numbing anything.

Denisa: Yeah.

Oliver: So I sometimes have to sit with feelings that are quite loud sometimes, but that's a good thing for me because I've learned to... process that once you come through the other side, every time it gets a little bit easier.

Denisa: Yeah.

Oliver: But yeah, it's a very, it's an ongoing process, and, you know, you kind of switch depending on circumstances, that kind of thing. But I've realised, with these services that are available, tapped into them. I'm sure we'll come on to that in a minute, but I tapped into them in February because it was very dark, dark time for me.

Denisa: M m.

Oliver: And you realise that whilst they are there, one still has to manage one's own day-to-day living, and the loneliest thing when you're in this particular place, like where I'm living now.

Denisa: Yeah.

Oliver: It's very... again, alone and loneliness are kind of two different things, but, um, it's a silent struggle sometimes, but I work around it with positive distractions, I think that's the way of doing it, but yeah, I just feel like I'm falling, I'm kind of building the parachute as I'm falling.

Denisa: M m.

Oliver: So every day is like a brand new day because my short-term memory, knowing ADHD, it can be quite challenging to remember stuff.

Denisa: Yes.

Oliver: So that I get quite down about sometimes, because I...

Denisa: Yeah.

I

Oliver: Yeah, it quietly simmers in the background. It's something I've learned to—and, um, since I stopped doing the drinking, drugs and that kind of thing, um, it, it's more elevated, more amplified, because I'm not numbing anything.

Denisa: Yeah.

Oliver: So I sometimes have to sit with feelings that are quite loud sometimes, but that's a good thing for me because I've learned to... process that once you come through the other side, every time it gets a little bit easier.

Denisa: Yeah.

Oliver: But yeah, it's a very, it's an ongoing process, and, you know, you kind of switch depending on circumstances, that kind of thing. But I've realised, with these services that are available, tapped into them. I'm sure we'll come on to that in a minute, but I tapped into them in February because it was very dark, dark time for me.

Denisa: M m.

Oliver: And you realise that whilst they are there, one still has to manage one's own day-to-day living, and the loneliest thing when you're in this particular place, like where I'm living now.

Denisa: Yeah.

Oliver: It's very... again, alone and loneliness are kind of two different things, but, um, it's a silent struggle sometimes, but I work around it with positive distractions, I think that's the way of doing it, but yeah, I just feel like I'm falling, I'm kind of building the parachute as I'm falling.

Denisa: M m.

Oliver: So every day is like a brand new day because my short-term memory, knowing ADHD, it can be quite challenging to remember stuff.

Denisa: Yes.

Oliver: So that I get quite down about sometimes, because I...

Denisa: Yeah.

I

#### CODE STRIPES

Coding Density

• MH outside therapy

• Unable to cope

• Silencing

Oliver: Yeah, it quietly simmers in the background. It's something I've learned to—and, um, since I stopped doing the drinking, drugs and that kind of thing, um, it, it's more elevated, more amplified, because I'm not numbing anything.

Derisa: Yeah.

Oliver: So I sometimes have to sit with feelings that are quite loud sometimes, but that's a good thing for me because I've learned to... process that once you come through the other side, every time it gets a little bit easier.

Derisa: Yeah.

Oliver: But yeah, it's a very, it's an ongoing process, and, you know, you kind of switch depending on circumstances, that kind of thing. But I've realised, with these services that are available, tapped into them. I'm sure we'll come on to that in a minute, but I tapped into them in February because it was very dark, dark time for me.

Derisa: M m.

Oliver: And you realise that whilst they are there, one still has to manage one's own day-to-day living, and the loneliest thing when you're in this particular place, like where I'm living now.

Derisa: Yeah.

Oliver: It's very... again, alone and loneliness are kind of two different things, but, um, it's a silent struggle sometimes, but I work around it with positive distractions, I think that's the way of doing it, but yeah, I just feel like I'm falling, I'm kind of building the parachute as I'm falling.

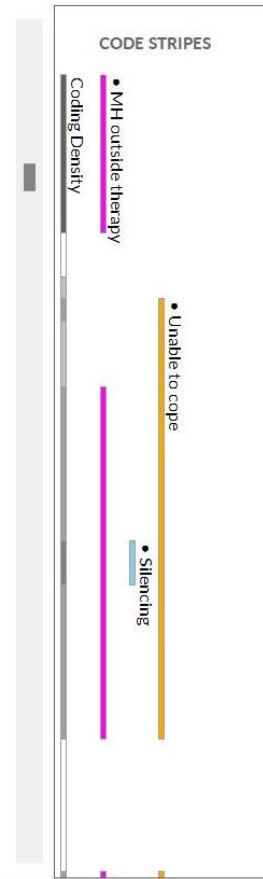
Derisa: M m.

Oliver: So every day is like a brand new day because my short-term memory, knowing ADHD, it can be quite challenging to remember stuff.

Derisa: Yes.

Oliver: So that I get quite down about sometimes, because I...

Derisa: Yeah.



### Part III: Free Association Based on NVivo Codes

#### *Unable to Cope*

Another layer of legitimacy could be entry into the help-seeker role, documented previously to be around a failure to cope alone. Perhaps this grants legitimacy to the act of help-seeking. The help-seeker becomes compelled to reach out, doing it as a last resort, seeking a container for their distress. You might go into it unwilling but feeling like you have no other choice. This sense of being taken by surprise by own mental health, things coming together, coming to an organic head to push you over the edge. Help in this sense might take the form of distress reduction. A negotiation then of the goals of therapy. Possible frustration when it doesn't happen quickly enough.

#### *MH Outside Therapy*

Substances having a numbing effect. Without them feelings bubbling up. But this is constructed as a worthwhile process. Again element of out-of-controlness, if you don't keep a handle on your mood it can pivot around the day. A lot of have to's. There's no choice. Sense

of being compelled. You have to go to therapy when too distressed to cope, and you have to exercise self-control and use your self-knowledge in order to cope. Back to knowledge is power but in this sense power is sanity – or what I call sanity – being well in yourself. An elevator drop, sudden, unexpected, as above.

### ***Silencing***

Loneliest thing, silent struggle, it's on you and you alone, you are responsible for your own mental health, a sense of isolation, shame perhaps linked to not talking, mental health struggles are shameful so you have to manage them by yourself. Broader theme around keeping difficult things secret? Gayness and mental health? Own parachute while falling, if you don't you'll die – again that idea that you *have* to do this.

## Appendix G

### Ethical Approval

#### Declaration

I confirm that I have read London Met's *Research Ethics Policy and Procedures* and *Code of Good Research Practice* and have consulted relevant guidance on ethics in research.

I confirm that I will carry out risk assessment before embarking on my research and if any risks are identified I will submit a report to Health and Safety.

I confirm that, before doing research abroad, I will carry out risk assessment incl. observing [UK Government travel advice](#). I will discuss any concerns with my supervisor and will submit any documentation that may be required.

<b>Researcher/Applicant signature:</b>	
<i>Denisa Ion</i>	
<b>Date:</b>	10/05/2024

#### Feedback from Ethics Review Panel

<b>Date of First Reviews:</b>		
<b>Reviewers ONLY</b>		
	<b>Approved</b>	<b>Feedback where further work required</b>
<b>Section A</b>	y	The proposal is clear and well supported.
<b>Section B</b>	y	This is a strong proposal, in which ethical issues have been considered carefully in a very professional manner. I only wonder if the researcher has considered the impact that other aspects of the identity could also be important to consider in the selection of participants, such as: occupation and economic situation, ethnicity and cultural context, (dis)ability, etc. My question is because those variables can create massive difference in LGBT!+/Queer experiences. I also wonder if the range of age is too wide. Experiences of discrimination and exclusion may vary a lot between a 50 year-old and an 80 year-old participant.

<b>Section C</b>	y	The risk assessment is thorough.
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**Applicant's Response**


*(Please highlight changes in the colour indicated for each version)*

Version*:	<b>1</b>	<b>2</b>	<b>2</b>	<b>4</b>	Other:	
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Reviewer's comment	Response	Page on application

<b>Date of approval</b>	28Feb2024 Update Approved 28May2024
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NB: The Researcher should be notified of the review outcome within two weeks of the submission of the application. If the outcome is re-submission of the application because of requests for further information or suggested adjustments of the project, a further two weeks from receipt of the re-submitted application applies, and so on. A copy should be sent to [research@londonmet.ac.uk](mailto:research@londonmet.ac.uk).

<b>Signature of RERP chair</b>	
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## Appendix H

### Screening Protocol

All screening will be conducted by a trainee counselling psychologist experienced in carrying out psychological assessments and managing distress.

**Suggested script:** *In the interview, we will talk about your emotional well-being as an older LGBTQ+ person and what it has been like for you to decide to seek therapy. We might touch on prejudice, discrimination, violence, stigma from mental health professionals, aversion/conversion therapy, or other kinds of sensitive topics. This might bring up complicated feelings. Individuals who are experiencing a high level of stress or emotional distress in their daily lives might be at risk of adverse mental health effects from participation. In such cases, it might be safest not to participate. Is it all right to ask you some questions to determine if there may be any risks to your mental health from participation?*

If no, thank them for their time and interest. If yes, carry on with the screening questions.

Screening Questions	NO	YES	Follow-up Questions		Acute Emotional Distress or Safety Concern? (Y/N)	Immediate Danger? (Y/N)
			If YES, ask the following:	Participant's Responses		
1. Are you currently experiencing a high level of stress and/or emotional distress?			a. Could you tell me a little about what you are currently experiencing?  b. Is your stress or distress getting in the way of you doing things you need to do			

		<p>(work, family obligations, etc.)?</p> <p>c. Is it getting in the way of you taking care of yourself?</p> <p>d. Have you recently sought help from emergency services or emergency helplines like the Samaritans for this?</p>			
2. Are you currently having thoughts of harming yourself?		<p>a. Could you tell me a little about what thoughts you are having?</p> <p>b. Do you have any plans to harm yourself?</p> <p>c. Could you tell me what your plan is? How and when do you intend to carry it out?</p> <p>d. Do you have the means to carry out your plan?</p>			
3. Are you currently having thoughts of harming someone else?		<p>a. Could you tell me a little about what thoughts you are having?</p> <p>b. Do you have any plans to harm someone else? Could you tell me who they are?</p> <p>c. Could you tell me what your plan is? How and when do you intend to carry it out?</p> <p>d. Do you have the means to carry out your plan?</p>			

4. Are there any reasons you can think of that might make participation in the interview too distressing for you?						
---	--	--	--	--	--	--

If answers to the screening questions are all no, then:

- Ask the participant how they think participation might affect them.
- Ask them how they might manage any distress that might arise due to the interview.
- If the participant agrees, schedule the interview.

If a participant’s responses reflect acute distress or safety concerns but not immediate danger, then:

- Make them aware that participation may increase their distress in the short term, may negatively impact their mental health in the long term, and may pose a risk to their safety.
- Suggest that participation might not currently be safe and that it might be inadvisable to schedule an interview—where possible, decide not to schedule an interview collaboratively.
- Suggest that the participant discuss their distress with their mental health professional once they commence therapy and offer to signpost services in the interim.
- Offer to do a follow-up call the next day to see if they are okay.

If a participant’s responses reflect imminent danger, then:

- Make them aware that you have a duty to inform any existing contacts with mental health services, such as a Community Psychiatric Nurse or GP.

- Suggest they present themselves to the local A&E department and ask for the on-call psychiatric liaison team.
- Offer to do a follow-up call to check in with them the next day.
- In extreme emergencies: Contact the police and ask them to use their powers under the Mental Health Act 1983/2007 to detain the participant and take them to a place of safety pending psychiatric assessment.

## **Appendix I**

### **Distress Protocol**

It is possible that some participants may become distressed during their involvement in the present research, particularly if exploring past experiences of prejudice, discrimination, hate crimes, stigma from mental health professionals, or traumatic aversion/conversion therapy. The researcher is a trainee counselling psychologist at London Metropolitan University and has experience in managing situations where distress occurs.

Below is detailed a multi-step protocol adapted from Draucker et al. (2009) and Cocking (2008) and designed to address participant distress in the context of research on sensitive topics. It is not expected that extreme distress will occur, nor that the relevant actions will become necessary. However, it is included in the protocol to account for emergencies.

#### **Mild distress**

##### ***Signs to look out for***

1. Tearfulness
2. Voice becomes choked with emotion/difficulty speaking
3. Participant becomes distracted/ restless

##### ***Action to take***

1. Ask participant if they are happy to continue
2. Offer them time to pause and compose themselves
3. Remind them they can stop at any time they wish if they become too distressed

#### **Severe distress**

##### ***Signs to look out for***

1. Uncontrolled crying/wailing, inability to talk coherently
2. Panic attack (e.g., hyperventilation, shaking, fear of impending heart attack)

3. Intrusive thoughts of the traumatic event (e.g., flashbacks)

***Action to take***

1. The researcher will intervene to terminate the interview.
2. The debrief will begin immediately.
3. Relaxation techniques will be suggested to regulate breathing/reduce agitation.
4. The researcher will recognise participants' distress and reassure them that their experiences are normal reactions to abnormal and distressing events.
5. If any unresolved issues arise during the interview, the researcher will accept and validate participants' distress, but suggest that they discuss these issues with mental health professionals and remind participants that this is not designed as a therapeutic interaction.
6. Details of counselling/therapeutic services available will be offered to participants.

**Extreme distress**

***Signs to look out for***

1. Severe agitation and possible verbal or physical aggression
2. In very extreme cases, possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

***Action to take***

1. Maintain safety of participant and researcher.
2. If the researcher has concerns for the participant's or others' safety, they will make them aware that they have a duty to inform any existing contacts with mental health services, such as a Community Psychiatric Nurse or GP.
3. If the researcher believes that either the participant or someone else is in immediate danger, then they will suggest that the participant/at-risk individual present

themselves to the local A&E department and ask for the on-call psychiatric liaison team.

4. If the participant is unwilling to seek immediate help and becomes violent, then the police will be called and asked to use their powers under the Mental Health Act 1983/2007 to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency.)

**Appendix J**  
**Debriefing Form**

**Title: Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or attending early stages of therapy**

Dear Participant,

Thank you very much for taking the time to participate in this research study. It is part of a doctoral project that I am conducting to explore emotional well-being in older LGBTQ+ people and their thoughts and feelings around accessing therapy. I would also like to publish the completed study in an academic journal. I hope that this project might contribute to efforts to make mental health care more accessible for older sexual/gender minoritised people, such as increasing referrals to psychological therapies from general practitioners or working with mental health services to improve the inclusivity and visibility of LGBTQ+ identities. Your involvement is much appreciated.

Please do not hesitate to contact me (details below) if you would like to receive the write-up of the study once complete, if you have any questions, concerns, or comments about the study or your participation in it, or if you would like to withdraw and request the destruction of your data (up to two weeks after the interview).

Email: [dei0056@my.londonmet.ac.uk](mailto:dei0056@my.londonmet.ac.uk)

Phone: 074 9749 3643

Alternatively, you may contact my supervisor Dr Sebastian Cordoba on [s.cordoba@londonmet.ac.uk](mailto:s.cordoba@londonmet.ac.uk).

If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support in confidence in addition to what you will receive from your therapist:

- **Antidote @ London Friend:** Service for LGBTQ+ people with alcohol or drug problems or questions (*website:* [www.londonfriend.org.uk](http://www.londonfriend.org.uk); *email:* [antidote@londonfriend.org.uk](mailto:antidote@londonfriend.org.uk); *phone:* 020 7833 1674)
- **ELOP (East London Out Project):** Holistic centre offering support services to LGBTQ+ people mainly in North and East London (*website:* [www.elop.org](http://www.elop.org); *email:* [info@elop.org](mailto:info@elop.org); *phone:* 020 8509 3898)
- **GALOP:** LGBT+ anti-violence charity for people who have experienced hate crime, sexual/domestic violence (*website:* [www.galop.org.uk](http://www.galop.org.uk); *email:* [info@galop.org.uk](mailto:info@galop.org.uk); *phone:* 020 7704 2040/0800 999 5428)
- **Gender Trust:** Helpline for transgender, transsexual, and genderqueer people (*website:* [www.gendertrust.org.uk](http://www.gendertrust.org.uk); *email:* [info@gendertrust.org.uk](mailto:info@gendertrust.org.uk); *phone:* 01273 234 024)
- **Imaan:** Support for LGBTQ+ Muslims, their family and friends, and those questioning their sexuality (*website:* [imaanlondon.wordpress.com](http://imaanlondon.wordpress.com); *email:* [imaanlgbtq@gmail.com](mailto:imaanlgbtq@gmail.com); *phone:* 020 3393 5188)
- **London Friend:** The United Kingdom's oldest LGBTQ+ charity offering one-on-one counselling as well as social groups and support groups for LGBTQ+ individuals in London (*website:* <https://londonfriend.org.uk/>; *email:* [office@londonfriend.org.uk](mailto:office@londonfriend.org.uk); *phone:* 020 7833 1674)
- **Regard:** A national organisation of LGBTQ+ people who self-identify as disabled (*website:* [www.regard.org.uk](http://www.regard.org.uk); *email:* [secretary@regard.org.uk](mailto:secretary@regard.org.uk))
- **Switchboard:** Helpline for all LGBTQ+ people, offering help with whatever you want to talk about (*website:* <https://switchboard.lgbt/>; *email:* [hello@switchboard.lgbt](mailto:hello@switchboard.lgbt); *phone:* 0800 0119 100)

## **Appendix K**

### **Journal Article for Psychology & Sexuality**

#### **Constructing the help-seeker role: Older LGBTQ+ adults on therapy waiting lists or attending early stages of therapy**

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#### **Abstract**

Older LGBTQ+ people are in the unique position of navigating their current lives from within histories of marginalisation. This seems to contribute to mental health vulnerability in this population (Semlyen et al., 2016), and may also create challenges in entering the help-seeker role as the first step in seeking mental health treatment according to the Network Episode Model (Pescosolido et al., 2013). Semi-structured interviews were conducted with eight people identifying as LGBTQ+ and aged 50+ who were either waiting for therapy or in the early stages of therapy. These were analysed using Foucauldian Discourse Analysis. Participants mobilised three discourses to talk about the help-seeker role: 1) a legitimacy discourse where they became eligible to attend services only in times of mental health crisis and, in queer services, only if they performed queerness in the 'right' ways; 2) a discourse about the importance of help-seekers' unique positionality being understood by therapists and non-clinical staff; 3) a discourse about help-seekers beyond the act of seeking help, as social subjects who rely on their social networks to facilitate entry into the help-seeker role or who facilitate help-seeking for others in the queer community; and as self-helpers who 'work on' themselves as an adjunct to therapy. These discourses are discussed in terms of their sociocultural, political, and/or historical provenance. Suggestions are made for how mental

health professionals and services could contribute to the deconstruction of discourses that make the help-seeker role unavailable to older queer people.

### **Keywords**

LGBTQ+; older people; mental health; help-seeking

### **Introduction**

People identifying as lesbian, gay, bisexual, transgender, or otherwise queer (LGBTQ+/queer) are embedded in a lengthy history of delegitimation. In the United Kingdom, homosexuality was illegal until the Sexual Offences Act 1967 (Dockray & Sutton, 2017). Section 28 also featured significantly in queer people's histories, introduced as part of the Local Government Act 1988 (Todd, 2016). It prohibited the promotion of homosexuality, with repercussions for schools' willingness to teach about queer lives (Todd, 2016). Its context was a tide of anti-queer sentiment fomented by the HIV/AIDS epidemic, wherein queerness became a dangerous vector of disease in public perception (Berridge, 1996). In the 1980s-90s, activism by queer rights groups increased acceptance for queer identities (Bowcott, 2020). Against this background, Section 28 was repealed in 2003. Same-sex civil partnerships were legalised in 2005, and marriages in 2013 in England and Wales, 2014 in Scotland, and 2020 in Northern Ireland (Barker & Monk, 2015; Fairbairn, 2020).

Transness, enacted for instance through cross-dressing, was never illegal in the United Kingdom (Shopland, 2021). Nonetheless, it was shrouded in silence and invisibility under dominant gender norms (Oram, 2001). Legally, one's gender remained their assigned-at-birth gender until the Gender Recognition Act 2004 (Sharpe, 2007). This allows people to change their gender, although not via self-affirmation but a diagnosis of gender dysphoria and proof of living as their chosen gender (His Majesty's Courts and Tribunals Service, 2022). A recent Supreme Court ruling has cast doubt over trans people's legislative status, restricting legal

gender to assigned-at-birth gender within the Equality Act 2010, which safeguards several characteristics against discrimination (Home Affairs, 2025).

What it means to be queer has, historically, been influenced not only by the legal field but also by psychology. The American Psychiatric Association (APA) listed homosexuality as a *sociopathic personality disturbance* in the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1952. In the DSM-III, in 1980, *transsexualism* appeared as a diagnosis (Drescher, 2010). LGBTQ+ people thus became pathologised as mentally ill and were subject to treatment, such as aversion therapy: this aimed to extinguish same-sex attraction by associating it with an unpleasant stimulus, like nausea (Davison, 2020).

As queerness became increasingly socially accepted, aversion therapy lost support (Davison, 2020). Subsequently, the DSM-II delisted homosexuality (Bayer, 1987), and the DSM-5 adopted the term *gender dysphoria* to shift understandings of transness from disorder to distress (APA, 2013). Nonetheless, this move to *gender dysphoria* has been critiqued as creating an obligately distressed trans person requiring psychological or medical intervention (Davy & Toze, 2018). Moreover, conversion therapy, aversion therapy's successor, continues to be offered today through any therapeutic, spiritual, or medical effort to change someone's sexual/gender identity (Haldeman, 2022).

In the social realm, 21% of 5,375 British queer people surveyed by Stonewall (2017) reported that they experienced a hate crime in the past year. Sexually minoritised individuals have also been suggested as more likely than straight counterparts to have experienced emotional, physical, or sexual abuse in childhood (Balsam et al., 2005), bullying and victimisation in adolescence (Amos et al., 2020), and early-life homelessness as well as intimate partner violence (McLaughlin et al., 2012).

Such historic and continuing marginalisation may have mental health implications. The minority stress theory suggests that sexually minoritised people who experience stressors associated with their minoritised identity, like stigma, are vulnerable to mental ill health (Meyer, 2003). Testa and colleagues (2015) developed a version of the theory that includes gender minoritised individuals, naming it the Gender Minority Stress and Resilience Measure. Intersectionality is another addition to the minority stress theory, with Rivas-Koehl et al. (2023) introducing the Temporal Intersectional Minority Stress Model, which situates stigma experiences within societal hegemonies dictating dominance of certain groups over others. Semlyen et al. (2016) upheld these theories of minority stress in a meta-analysis of 12 U.K. health population studies. Common mental disorders (CMDs) were reported as more prevalent among LGB than straight individuals, most highly among those aged 55+. A similar vulnerability was reported by Watkinson et al. (2024) regarding trans people aged 65+ compared to older cis individuals, drawing on data from 1,520,457 respondents to the English General Practitioner Patient Surveys.

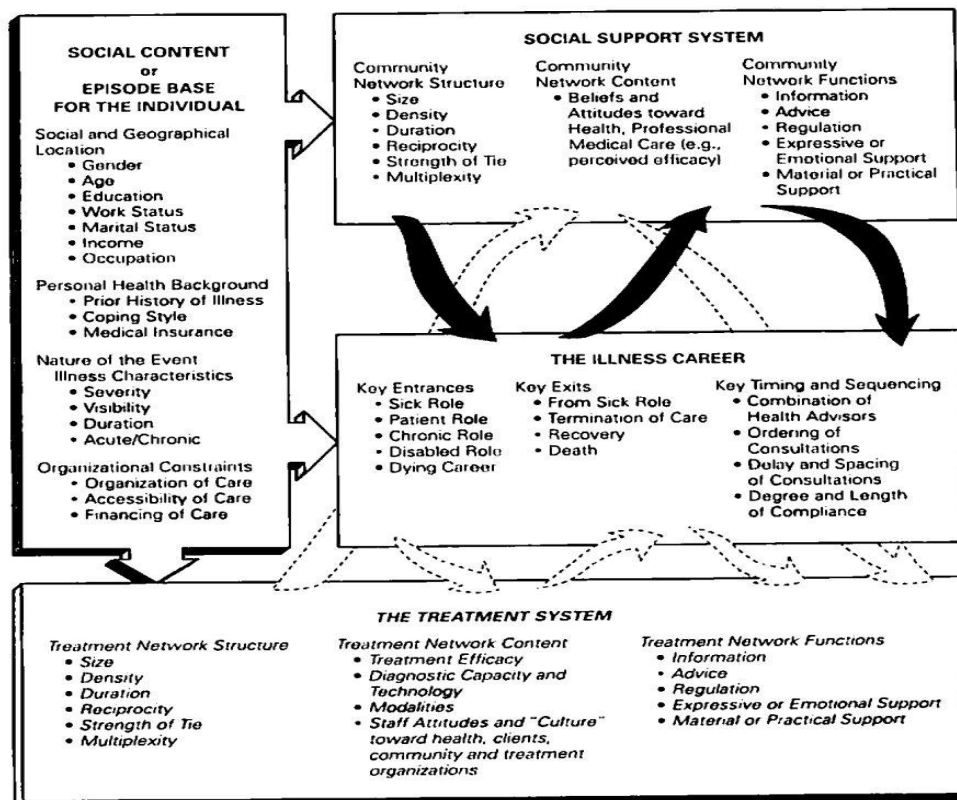
Unique risk factors could account for this psychological vulnerability at the intersection of older age and queerness. Older LGBTQ+ adults are more likely to experience loneliness than their straight counterparts (Grabovac et al., 2018; Guasp, 2010). They are also likely to become informal caregivers to friends with declining health, a legacy from the HIV/AIDS epidemic when formal support was limited or mistrusted (Shiu et al., 2016; Westwood et al., 2020). Moreover, older LGBTQ+ people's lifetime discrimination is typically higher than for younger counterparts (Abatiell & Adams, 2011). This population may additionally face identity erasure. Queerness tends to be performed on the queer 'scene' in bars, clubs, pubs, and saunas (Browne & Bakshi, 2011), perceived as incongruous with older people's lifestyles and possibly resulting in exclusion by younger queer adults (McCann & Brown, 2019).

Given these risk factors and older queer people’s associated vulnerability to poor mental health, the question that arises is whether they seek psychological help. Data specific to this population is not available, but can be extrapolated from general gerontological research. In 2021-22, 1.24 million people accessed talking therapies for CMDs through the National Health Service (NHS, 2022): 6.03% were aged 65+, representing the lowest engagement and creating concern that older queer people’s mental health needs might remain unmet.

Help-seeking theory could elucidate this further. The Network Episode Model’s second version (NEM-II) is adapted for mental health (Figure 1; Pescosolido et al., 2013).

**Figure 1**

*Network Episode Model II*



*Note.* This figure is replicated from Pescosolido et al. (2013, p.518) under licence 6263691331600 for copyright permission (see Appendix A for full licence details).

According to the NEM, the process of seeking help starts with a shift in identity from a ‘well’ person who does not require help, to a ‘sick’ person who does require help (Grue, 2016). This process occurs at the interactional edge between the prospective help-seeker and their social network comprising friends, family, and community, as well as their treatment network comprising clinical and non-clinical staff (Pescosolido et al., 2013). Help-seekers and their social and treatment networks are theorised to influence each other in multidirectional ways (Pescosolido et al., 2013). Networks can either facilitate or hinder entry into the ‘sick’ role and associated help-seeking behaviour, through practical means (e.g., sharing or withholding information) and emotional means (e.g., a supportive or antagonistic relational style) (Pescosolido et al., 2013). As the concept of a ‘sick’ role has been discussed as stigmatising (Varul, 2010), the term *help-seeker role* will be used instead to explore how older queer people are enabled to or disabled from becoming help-seekers by their social and treatment networks, as enacted within wider sociocultural, historical, and political contexts (Boydell et al., 2013).

Social norms are a critical influence on how people construct certain topics such as the help-seeker role (Van Dijk, 2009). Among British LGBTQ+ youth, McDermott et al. (2018) conducted interviews ( $n=29$ ) and administered questionnaires ( $n=789$ ) to explore help-seeking for self-harm and suicidality. Participants reportedly decided to seek help after becoming unable to cope alone, mirroring conclusions from general gerontological research (Beatie et al., 2022). They also discussed mental ill health in younger years as non-urgent, transient, and attention-seeking, liable to be dismissed by adult practitioners. From within these constructions, they delayed seeking help until their distress became too severe for them to manage alone. Older queer people may operate under similarly dismissive constructions preventing help-seeking until crisis, such as the perception of mental ill health as unavoidable in ageing (Ouchida & Lachs, 2015).

McDermott et al. (2018) reported an interaction between internalised mental health stigma and internalised LGBTQ+ stigma, reinforcing a sense of abnormality that hindered help-seeking. Mental health self-stigma is arguably rooted in social norms wherein mental wellness is an expected part of social functioning (LeBlanc & Kinsella, 2016), potentially leading to shame (Clément et al., 2015) and decreased willingness to access help (Vogel et al., 2007). Older adults reportedly experience less self-stigma than their younger counterparts (Mackenzie et al., 2019). However, this has not been investigated in older LGBTQ+ adults specifically. Having experienced the pathologisation of queerness-as-mental-illness, they may be particularly susceptible to mental health self-stigma (Hegarty, 2017), especially as stigmatised groups (e.g., LGBTQ+) tend to minimise their connection to other stigmatised identities (e.g., mental ill health) per The Best Little Boy in the World hypothesis (Tobias, 1976; Ying et al., 2022). This may impact the availability of the help-seeker role for older queer people.

External stigma may also influence older queer people's help-seeking. Foy et al. (2019) reported that 41.9% of 136 participants were concerned about stigma from therapists in a questionnaire about accessing NHS psychological treatment. This was corroborated by Pitt et al. (2024), who identified biphobia anticipated by practitioners as a key barrier to treatment engagement in interviews with eight U.K.-based bisexual, cisgender women. The average age in Foy et al. (2019) was 29.6 years without comparisons between younger and older cohorts, and Pitt et al.'s (2024) participants were aged 19-30. Older queer adults may also navigate worries of practitioner stigma when entering the help-seeker role. However, the texture of these could differ, potentially entailing mistrust born from the pathologisation of queerness and/or experiences of aversion/conversion therapy (Addis et al., 2009; Westwood, 2013). The help-seeker role may, therefore, become subject to minority stressors like trauma or delegitimation from professionals (Dickinson et al., 2012).

Not all research has suggested that older queer people face challenges seeking help. Cronin et al. (2021) administered a questionnaire to 592 LGB individuals in Australia. Compared to younger adults, those aged 50+ reported fewer barriers to psychological treatment, both general (e.g., time) and minority-specific (e.g., feared discrimination). The authors speculated that older participants may have experienced comparatively low lifetime discrimination, as homosexuality was decriminalised between 1975-1997 in Australia (Lennox & Waites, 2013) when older participants would have been children, teenagers, or young adults. However, the background of U.K.-based older queer people would likely be different, as stigma continued to be brewed by Section 28 and the HIV/AIDS epidemic through the 1980s to the 2000s (Todd, 2016). This highlights the need for a platform for these unique voices.

### **Summary and Research Question**

Despite older queer people's documented mental health needs, service engagement remains low (NHS, 2022). This may link to constructions of the help-seeker role rooted in older queer people's sociocultural, political, and historical contexts (Burr, 2015).

Research on this topic is scant. Studies mostly pertain to younger queer cohorts. Moreover, in certain studies, some participants had already completed treatment (e.g., Foy et al., 2019; McDermott et al., 2018; Pitt et al., 2024), potentially introducing retrospective recall bias (Bolger et al., 1989). To date, queer people's meaning-making about help-seeking has not been captured exclusively before or during early treatment. Drawing on the NEM, research in this area could identify how older LGBTQ+ people's social and treatment networks might influence their ability to enter the help-seeker role and access mental health services. Implications could extend to services' messages about their therapeutic offerings as well as practitioners' treatment approaches, contributing to narratives of help as salubrious and available to older queer people.

The current study fills this gap by answering the following research question: How do older LGBTQ+ adults in the United Kingdom who are on a waiting list for therapy or in the early stages of therapy speak about and construct the role of the help-seeker?

## **Materials and Methods**

### **Design**

In the NEM, help-seeking is theorised as an interactive process between an individual and their social and treatment networks; interactions within these networks either enable or hinder entry into the help-seeker role (Pescosolido et al., 2013). Given the centrality of the help-seeker's social context, a qualitative approach becomes relevant (Burr, 2015). Specifically, a social constructionist epistemology was used, focusing on discourses, or sets of socially meaningful statements that “systematically form the objects of which they speak” (Foucault, 1969/1972, p.49).

Foucauldian Discourse Analysis (FDA) was the analytical method. FDA is interested in power, theorised to construct knowledge through discursive practices, defining what people can think, feel, do, and be in the world (Olsson, 2010)—defining whether/how queer older people can enter the help-seeker role. Reciprocally, knowledge reinforces social structures of power (Olsson, 2010). Foucault (1980) termed this mutual relationship power/knowledge. This study combined power/knowledge with the NEM as its theoretical frameworks, focusing on how dominant social norms and narratives are enacted within social and treatment networks and thus influence constructions of the help-seeker role.

### **Participants**

The sample consisted of eight U.K.-based LGBTQ+ people, aged 50+ and waiting for or attending therapy (five sessions maximum) during a new treatment episode, i.e., minimum 90 days elapsed since previous treatment (Keeler et al., 1988). Table 1 provides further demographics.

**Table 1***Demographic Characteristics of Participants*

<b>Pseudonym</b>	<b>Age</b>	<b>Sexuality</b>	<b>Gender identity</b>	<b>Ethnicity</b>	<b>Waiting list vs in therapy</b>
David	63	Bisexual	Trans man	White British	In therapy
Jamie	58	Lesbian	Unsure	White British	In therapy
Jordan	53	Gay	Cis man	Black British	Waiting list
Lily	51	Straight	Trans woman	White British	Waiting list
Sarah	61	Bisexual	Cis woman	White British	In therapy
Mark	52	Gay	Cis man	White British	In therapy
Charlie	73	Gay	Cis man	White British	Waiting list
Oliver	52	Gay	Cis man	White British	In therapy

**Recruitment**

Participants were recruited through purposive sampling at U.K. LGBTQ+ mental health organisations and on social media, and through snowball sampling accessing participants' social networks.

**Data Collection**

Semi-structured interviews are commonly paired with FDA (Willig, 2022). Five interviews were conducted in-person at an LGBTQ+ mental health organisation, and three over video.

**Analysis**

FDA can be approached in multiple, idiosyncratic ways (Potter & Wetherell, 1987). Here, I blended Willig's (2022) and Parker's (1992) methods. I paid particular attention to

subject positions, or roles that participants discursively adopt from within which they construct their reality and self (Burr, 2015). I also focused on practical implications, defined as the ways-of-being<sup>1</sup> enabled or discouraged through discourses, as well as participants' subjective psychological experiences. From Parker (1992) I borrowed a sensitivity to the sociocultural, political, and/or historical provenance of discourses.

### **Positionality**

Reflexivity about how the author's positionality might have impacted the research is a key aspect of rigour in qualitative work (Spencer & Ritchie, 2011). I am a bisexual person in my late 20s, White and from a middle-class European background. I initially completed this project for my doctoral thesis in Counselling Psychology. Due to my age, I felt unsure whether I could give an accurate platform to older voices, and might have privileged what it means to be a queer rather than older help-seeker in my analysis. As a Counselling Psychologist, I might have also overly focused on experiences of formal mental health care instead of informal support.

### **Results**

Participants discussed the help-seeker role drawing on three discourses: legitimacy; the importance of being understood by therapists/non-clinical staff; and help-seekers beyond help-seeking, as social subjects and self-helpers.

#### **Discourse: Legitimacy**

Participants spoke of legitimacy as acute distress justifying help-seeking, and the 'right' performance of queerness granting access to queer services.

#### ***Sub-Discourse: Legitimacy Granted by Distress***

Four participants reflected on their decision to seek help.

Lily: When I [...] went to [the assessment], all I knew is I was desperately upset.

<sup>1</sup>Potentially infinite ways that someone enacts their identity.

For Lily, legitimacy seems created by the intensity of her distress, making available the role of the help-seeker through a “desperate[ion]” that extinguishes other ways-of-being. This is echoed by David.

David: (*hesitantly*) But I didn’t expect [...] to feel quite so fractured by everything [death of mother]. I really am struggling a bit [...].

David says he “really [is] struggling”, then, contradictorily, adds that he is struggling “a bit”. This may be linked to the sense of surprise in his account: he speaks hesitantly and emphasises that he did not expect to feel “fractured”. Oliver similarly implies a crisis that is “organic”, as though having an unpredictable life of its own.

Oliver: And everything seemed to kind of come to an organic head [...]. I had suicidal thoughts.

In contrast, Charlie’s moment of crisis initially led to an avoidance of help.

Charlie: My doctor offered me counselling. I said, “Don’t be silly. I’m a British man. I don’t need that kind of thing.” Yeah, so after a fortnight of not sleeping [...] I kind of crawled back to the doctor and said, “Counselling, please.”

Charlie positions himself as a “British man” who does not “need that kind of thing”, i.e., therapy, perhaps under a ‘stiff upper lip’ discourse wherein adversity is faced with stoicism and becomes the “domain of the unspeakable” (Capstick & Glegg, 2013, p.242). The increase in Charlie’s distress via sleep difficulties later made the unspeakable speakable, and he “crawled back” to his doctor as a last resort.

### ***Sub-Discourse: The ‘Right’ Ways to be Queer***

This sub-discourse concerns being queer in the ‘right’ ways, referring to a version of queerness perceived to grant eligibility to queer-specific services. Lily considers what it is like to access queer services as an older trans woman.

Lily: I think what you might call cross-dressing and this is much, tends to be older. But then there's also like, the more formally trans, "I'm trans" people, which is much more sort of political... sort of a protest [...] a very student age sort of thing. And for me, the broader set of all these services like [name of queer service] etcetera are very much focused on our trends. [...] I sort of feel slightly excluded. [...] Because [...] I don't hate TERFs.

Lily speaks of two paths to transness, namely: cross-dressing, which she ascribes to older people, and a formal trans identity, which she ascribes to students. This latter route is "political", "a protest", and seems to entail an element of activism juxtaposing against an 'older' transness that may not be politically charged or 'correct'. Lily constructs political-protest transness as a current trend in the queer community. She refers to queer mental health services en masse, as a "broader set" focused on "our trends", saying she feels "slightly excluded" due to not performing transness in the 'trendy' political-protest way (by not "hat[ing] TERFs", i.e., trans-exclusionary radical feminists). Services become enactors of sociopolitical trends and this enactment seems ubiquitous, creating a dearth of avenues for help for non-'trendy' older help-seekers.

Moving on to David's account, he discusses how legitimacy is retained after initial service access.

David: I'm feeling a bit guilty because we're not spending very much time talking about gender-specific issues. We're talking about family a lot. And I feel, I feel it's a bit... um, it's not the best use of time.

David constructs "best use of [his therapist's] time" as discussing "gender-specific issues". To be a legitimate queer help-seeker, one seemingly must have the 'right' identity as in Lily's account, and must 'do' queerness in therapy by bringing up queer topics or else they incur "guilt". A help-seeker's legitimacy thus becomes fluid, continually negotiated and

renegotiated between help-seekers and therapists. David then introduces a new angle on what is available for therapeutic exploration.

David: [H]ow much do you need to talk about something if it's clear? And if it isn't that clear, then is it real? [...] It must be psychological. Or something else. Another "ology".

David constructs queerness as worth talking about only if it is not "clear". Queerness, specifically transness, seems to need confirmation by an "ology". This appears to draw on a medico-legal discourse whereby gender identity must be certified by a professional, mirroring the Gender Recognition Act 2004. In contrast, Oliver mobilises unclearness as a hindrance to help-seeking.

Oliver: People who, um, I suppose they are straight or thought they were straight [...] and they just went, "Oh, right, no, I'm not, what do I do?" Exactly. What do you do? Where d'you go? What do you do?

Oliver talks about a lack of services for people coming out later in life. He repeats "what do I/you do?" three times, creating a sense that there is no available recourse for someone who is questioning their identity and may not feel like they belong in queer services/community.

### **Discourse: Importance of Being Understood**

This section considers how clinical/non-clinical staff may enable help-seeking by making the help-seeker feel understood through a shared background between them or a robust therapeutic relationship.

#### ***Sub-Discourse: Understanding Through Sameness***

Charlie discusses his initial contact with the service through a discourse of sameness or shared experience.

Charlie: Each of the therapists [...] has been through sexual abuse [...]. When I rang up [...] the man [...] kept saying to me, “I understand exactly what you’re talking about there”.

He emphasises the ubiquity of this shared experience throughout the service, from “each of the therapists” to the person who answered his phone call. From within this sameness, Charlie positions himself as being understood by the other and able to join the service’s waiting list.

***Sub-Discourse: Understanding Despite Difference***

Unlike Charlie, Jordan speaks about being understood by his therapist not due to similarities but *despite* differences.

Jordan: It wasn’t that he [therapist] had anything special, he had to be Black or he had to be gay to understand, it wasn’t that. He just had an understanding that was born of experience and his natural talent.

For his first experience of therapy in his 20s, Jordan, as a Black and gay man, had a therapist who was White and straight but understood Jordan through “experience” and “natural talent”. Understanding seems more nebulous than in Charlie’s account, related to the therapist’s professional and personal characteristics.

***Sub-Discourse: Understanding Hindered by Difference***

Jordan then outlines how this therapeutic understanding is elusive nowadays.

Jordan: [...] [Y]ou [should] be able to speak to people who come from your community, from your same nationality as you in ways and cultural understandings. [...] [B]ut [...] I see only a cookie-cutter kind of therapist [...] [whose] knowledge [...] needs to have more representation from ethnic groups, from women, from people across the board [...]. [T]hey see it from a different perspective [...]. So people don’t engage.

Jordan constructs therapy as populated by “cookie-cutter” therapists without the “knowledge” to understand “people across the board”, elsewhere described as “women, English, in their 60s”. As this “knowledge” is lacking, understanding between a therapist and help-seeker would require ethnocultural sameness. Without this, Jordan’s help-seeker is disappointed, their cultural needs unmet, and may self-silence by not engaging with services or not speaking of their cultural affiliations in session.

### **Discourse: Help-Seekers Beyond Help-Seeking**

The final discourse pertains to the help-seeker role going beyond the act of seeking treatment, namely: help-seekers as social subjects in social spaces and in their personal and community networks; and help-seekers as providers of their own help.

#### ***Sub-Discourse: Help-Seekers as Social Subjects in Social Spaces***

Mark mobilises his “history” with his therapy venue, an LGBTQ+ centre hosting social events which he previously attended. This “history” both facilitated and hindered Mark’s help-seeking.

Mark: I used to meet my friend who... um, who died a couple years ago. He used to come here. [...] [I]t’s a building I was familiar with [...]. [I]t made it easier and... and difficult.

Mark recounts that he used to meet a friend in the venue who has since passed away. To be a help-seeker seems to also mean being a mourner, making help-seeking both “easier” and “difficult”: easier due to his familiarity with the venue, and difficult due to putting him in touch with his grief. Seeing as it is common for LGBTQ+ mental health spaces to act as community hubs (e.g., ELOP, n.d.; London Friend, n.d.; MindOut, n.d.), Mark’s experience may not be isolated. A help-seeker’s meaning-making about the therapy venue will likely be idiosyncratic, variously enabling or hindering help-seeking. Mark then speaks of his therapy venue’s current social environment as a helpful adjunct to treatment.

Mark: [H]aving the LGBTQ+ space to go to is still very important because I can then relax and I can talk about the mundane things. I can talk about what's really going on [...].

The “LGBTQ+ space” is a weekly social drop-in for local queer people. Mark seems to construct the shared queerness in the space as a gateway to openness such that he can talk about both “mundane things” and “what’s really going on”. Being queer around other queer people is constructed as safe, an “important” opportunity for “relax[ation]” and connection. Contrastingly, David speaks of his therapy’s social context as hindering his help-seeking.

David: Give me a moment to just think about why I wouldn’t have come here [before the death of his mother]. I suppose [...] I don’t like groups. [...] I don’t really understand them.

In this venue, therapy attendees walk through the social space to reach the therapy rooms. David constructs the groups as a barrier (potentially physical) that would have prevented him from seeking help before his mother’s passing, at which point his level of distress enabled help-seeking per the legitimacy section.

### ***Sub-Discourse: Help-Seeking Facilitated by Personal Social Networks***

Here, the focus shifts from social spaces to personal social networks, with Jamie recounting how their partner was crucial in enabling them to become a help-seeker.

Jamie: And she [partner] said to me, “[...] [M]y doctor is a really good doctor”.

Because you know, the attitude previously to people with depression was pull yourself together. If you ever went or if they took you seriously, they’d lock you up in a mental hospital [...].

Jamie’s partner provides an endorsement of her doctor, which seems crucial for Jamie entering the help-seeker role with the same doctor. This entry appears to rely on an assurance of the doctor’s “good[ness]”. Help-seeking becomes a matter of extremes: ‘good’

practitioners will help you, whereas ‘bad’ practitioners will dismiss you and expect you to “pull yourself together” (recalling a ‘stiff upper lip’ discourse) or they will “lock [you] up” (recalling a discourse of help-as-incarceration within psychiatric asylums). There was another instance of help-as-incarceration, in Oliver’s account.

Oliver: [...] I [...] failed my, my attempt [suicide] [...] I just went to the GP the next day, and they did actually ask their self-harm question. And I was so paranoid that they were going to lock me away, I just said no and I just carried on.

For Oliver, worry about being “locked [...] away” resulted in self-censoring during a GP appointment following a suicide attempt, after which he “carried on” alone. Elsewhere, Oliver constructs this “silent struggle” with mental health difficulties as a “repetition” or “cycling” of “secrets that [queer people] have to hold on to before [they] come out”. Historically, both mental illness and queerness have been unavailable for conversation, enacted in private to avoid stigma or asylum incarceration (Lanzoni, 2005; Love, 2001). This could reframe the entry into the help-seeker role as a “com[ing] out” in terms of disclosing the “secret” of one’s mental health difficulties. Overall, it seems that entry into the help-seeker role may require negotiation of historical mistrust.

### ***Sub-Discourse: Help-Seekers as Bearers of Social Responsibility***

There now follows a consideration of how help-seekers themselves might become help-facilitators. Oliver endows the help-seeker with a responsibility to share information about mental health services with other LGBTQ+ community members.

Oliver: I think for everyone also to stand up and do a video post [...] saying [...] what’s available [...] because, you know, it’s only when you ask that you know, otherwise you’re sitting in silence [...].

Elsewhere, Oliver talks about fulfilling this responsibility himself through a blog documenting “what’s available” in terms of help. He thus inhabits a dual role as seeker of

help for himself and facilitator of help for others. The community becomes a repository of information about services, possibly representing a reclaiming of this knowledge from institutions that could deploy it for oppressive purposes (e.g., aversion therapy). Relatedly, Jordan positions himself as a help-seeker who actively tries to dismantle the “cookie-cutter”-ness in mental health services.

Jordan: [...] I'm disgruntled [with therapy] [...]. I've learned a lot over the years, and there's no point, you know, just screaming at the wind. I tried to do things that are constructive [...].

Elsewhere, Jordan describes these “constructive” activities as providing training for anti-racist practices in queer and NHS services. Jordan’s help-seeker-as-activist seems to gain agency: instead of “screaming at the wind”, he leverages what he has “learned” and, through activism, he attempts to improve the experiences of queer people of colour in mental health services. This activist help-seeker role seems protective for Jordan’s mental health, equipping him with an empowering outlet for his “disgruntle[ment]” and embedding him within the LGBTQ+ community.

### ***Sub-Discourse: Help-Seekers as Their Own Help-Facilitators***

Help-seekers may also become facilitators of their own help. Oliver describes a need to “manage” his mental health located with him, not his therapist.

Oliver: And you realise that whilst they [mental health services] are there, one still has to manage one's own day-to-day living, and that's the loneliest thing when you're in this particular place [experiencing suicidal ideation] [...] It's a silent struggle sometimes [...] I just feel like I'm falling, I'm kind of building the parachute as I'm falling.

Mental health services are positioned as “there” but not in a “day-to-day” sense, potentially creating a gap between the learning of coping skills that is done in therapy and

their implementation in daily life. Oliver describes this implementation as “building the parachute as [he is] falling”. The help-seeker seems to be in a life-or-death situation, motivated to help themselves out of crisis by constructing a “parachute” of coping skills, yet potentially finding this challenging while feeling distressed. For Oliver, the “parachute”-building is “the loneliest thing”, “a silent struggle”: done on his own and unable to be spoken about with others, perhaps not even his therapist. Sarah similarly mobilises the self as something that must be “work[ed] on” outside therapy.

Sarah: I found [therapy] quite, quite useful. [...] I sort of look through [self-help] books and keep myself well, kind of working on myself in a way.

As therapy is only “quite useful”, a need arises for this supplemental self-help “work”. This recalls mental wellness norms wherein an ‘unwell’ self becomes an unacceptable self, requiring intervention to be “ke[pt] [...] well” (LeBlanc & Kinsella, 2016). Like Oliver, Sarah speaks of self-helping as a solo endeavour. Mental illness seems localised within the self as something to be rectified, with the self at least partially responsible for this rectification.

## **Discussion**

This study aimed to investigate discursive constructions of the help-seeker role among older LGBTQ+ people waiting for or attending early-stage therapy. Participants mobilised legitimacy as a question of ‘rightness’: is the prospective help-seeker distressed to the ‘right’ intensity to warrant professional help? Moreover, do they inhabit the ‘right’ queer identity to belong in queer-specific services? Entry into the help-seeker role was also constructed as requiring clinical/non-clinical staff to understand the help-seeker’s unique positionality in terms of traumatic or ethnocultural experiences. Lastly, participants discussed being help-seekers-as-social-subjects in blended therapy/social spaces or in personal/community

networks where they may offer or receive help-facilitation. Help-seekers may alternatively become solitary self-helpers.

This is an under-researched area, with past literature identifying a mental health vulnerability among older LGBTQ+ people (Semlyen et al., 2016; Watkinson et al., 2024) and low service engagement (NHS, 2022), yet primarily focusing on queer youth's help-seeking (e.g., McDermott et al., 2018). To understand why help-seeking does or does not occur, the NEM postulates that it is crucial to first understand how one becomes a help-seeker (Pescosolido et al., 2013). These results are an initial step towards this, providing useful insights for services and practitioners to more inclusively engage older queer people. Below, I discuss the sociocultural, political, and/or historical provenance of each discourse.

### **Discourse: Legitimacy**

Participants discussed their help-seeking as catalysed by a breakdown in their ability to cope alone. An equivalent process has been reported in LGBTQ+ youth (McDermott et al., 2018) and non-LGBTQ+ gerontological populations (Beatie et al., 2022). This apparent universality of psychological crisis as an enabler of help-seeking might be underpinned by norms of mental wellness, enforced through sanism, or prejudice against individuals perceived as mentally ill (LeBlanc & Kinsella, 2016). Sanism is associated with a capitalist ideology which privileges economic achievement, defining individuals' value through their ability to gain and maintain employment (Baril, 2023). Mental illness becomes a barrier to socioeconomic functioning, incurring stigma (Baril, 2023). Coping alone could be interpreted as a strategy to avoid this stigma, keeping mental illness private. The help-seeker role thus becomes available only as a last resort, when distress “come[s] to an organic head” and becomes too “desperate” and “fractur[ing]” to be suppressed, as recounted by Lily, David, Oliver, and Charlie.

For McDermott et al.'s (2018) young LGBTQ+ participants, help-seeking was a last resort also due to worry that practitioners would dismiss their distress as not severe 'enough'. Participants here, however, did not disclose such worries. This is surprising considering dismissive discourses wherein mental health difficulties are a normal, unavoidable aspect of ageing (Ouchida & Lachs, 2015). As seven of the eight participants had attended therapy previously, they might have felt more certain of what level of distress would count as severe 'enough' compared to someone younger potentially accessing therapy for the first time. Foucault's (1975/1977) concept of self-policing seems pertinent. This entails the internalisation of power hierarchies and their disciplinary measures such that social subjects self-surveil for any non-normativeness and self-suppress this to avoid punishment from external social sources. Older queer people may self-police by coping alone until a crisis, outwardly adhering to mental wellness norms and evading stigma, particularly through a minority stress lens wherein the chronic experiencing of stressors related to sexual/gender identity may create sensitivity to all stressors (Haight et al., 2023) and underpin avoidance mechanisms (Mann et al., 2022). Self-policing could be upheld by the U.K. therapy landscape wherein NHS Talking Therapies was introduced in 2008 as a dual psychological and economic solution, intended to enable people struggling with mental illness to return to work (Layard et al., 2006). For younger people with potentially limited experience as socioeconomic subjects, this internal policing might feel less relevant than the external policing in McDermott et al. (2018).

Discourses which silence emotions, invoked by Charlie as "British [men] [not] need[ing]" therapy, could also contribute to the delegitimisation of help-seeking outside of crisis. The British 'stiff upper lip' is a stereotype of stoicism in the face of adversity, notably associated with the Second World War (Boyce, 2012). One example is the *Keep Calm and Carry On* poster (Irving, 2014). Although not officially distributed in wartime Britain, the

poster retrospectively defines that era as negotiated through ‘carrying on’: emotions, like fear, suppressed to enable the nation’s functioning (Hodge, 2013; Irving, 2014). Similarly, there are records of masculinity constructed as inherently resistant to emotions dating back to *A Treatise of Melancholie*, published in 1586 by English physician Timothie Bright (Bhattacharya, 2023). Over time, men’s imperviousness to emotions became fused with British imperialism, to be exported to other nations, variously portrayed as inhabited by children or savages prone to emotionality (MacAloon, 2013). Within this legacy of male-coded stoicism, being a British man seems to require a silencing of emotional distress to avoid becoming ‘less than’: a child, a savage, excluded from ‘proper’ adult society. This may create a sociocultural pressure to cope alone alongside the socioeconomic pressure previously discussed, applicable when an older queer identity intersects with a male gender identity and/or a British identity as per intersectional minority stress frameworks (Rivas-Koehl et al., 2023).

Emotions-as-unspeakable might interact with queerness-as-unspeakable to render the help-seeker role unavailable until crisis, as in Oliver’s “cycling [of] secrets”. In McDermott et al. (2018), unavailability was driven by a fear of being labelled ‘abnormal’ at the intersection of queerness and mental ill health. Participants here spoke rather of the label’s effects: being “lock[ed] up/away”. This discourse of help-as-incarceration recalls the asylum, described as a vehicle of social discipline by Foucault, sequestering ‘lunatics’ from ‘normal’ society (Nichols, 2000). The construct of ‘lunacy’ is itself normatively derived. A ‘lunatic’ would have had to be certified as such by a doctor, relying on norms of mental wellness which dovetailed with other norms, including heteronormativity. For instance, when sexual activity between men was illegal, the defence of ‘lunacy’ could be used, and was likely to lead to institutionalisation (Janes, 2014). ‘Help’ thus becomes a tool of oppression, to be enforced rather than sought. Arguably, the existence of a legitimate help-seeker is precluded, with

queerness and mental health becoming unspeakable “secrets” to protect one’s freedom and personhood. This extends the concept of queer identity concealment, protective against minority stressors (Hoy-Ellis, 2023), to include concealed mental health difficulties. Speakability may necessitate a reclaiming of power from institutions, for example practitioners being endorsed by the help-seeker’s personal social network as in Jamie’s account, or the queer community becoming a repository of knowledge about treatment pathways as in Oliver’s account.

A further legacy of the asylum could be the certification of ‘lunacy’, mobilised by David as the need for an “ology” to confirm his transness. This seems embedded in the medico-legal discourse prevalent in the United Kingdom where a legal gender change requires a diagnosis of gender dysphoria (Brunskell-Evans, 2019). *Gender dysphoria* replaced *gender identity disorder* in the DSM-5, intended to depathologise trans identities (APA, 2013). Nonetheless, gender dysphoria continues to feature in a manual of *mental disorders*, which arguably creates a binary where people can be either mentally ill or well, subject to ‘expert’ certification. This is the context in which this study’s trans participants became help-seekers: not as whole people with multifarious experiences and identities, but as *trans* people only who must ‘do’ transness in therapy by bringing up trans-related topics so their identity might be certified.

Lily spoke of services becoming the “ology” as enactors of community “trends”. Certification becomes a case of *trans in the ‘right’ ways* or *trans in the ‘wrong’ ways*. The ‘right’ transness, representing politically ‘correct’ views in Lily’s account, enables service access. A similar discourse was employed by Oliver regarding questioning identities. Those in the definitional no-man’s-land between heterosexuality and queerness may feel that queer community and services are not for them. While Foy et al. (2019) and Pitt et al. (2024) suggested worry of practitioner stigma as a barrier to help-seeking, here the queer community

becomes the dispenser of stigma. Within minority stress theories, stigma is not an exclusively inter-group process, but can be enacted upon queer people who perform their queerness less normatively, by queer people who inhabit more privileged identities (Sellnow-Richmond et al., 2022). As a social group threatened by heteronormativity, the LGBTQ+ community may be especially likely to undertake such policing of its borders, to retain a coherent identity and social status (Hornsey et al., 2003).

### **Discourse: Importance of Being Understood**

Practitioners were discussed in terms of their ability to understand help-seekers. Jordan spoke about “cookie-cutter” therapists, situated within White Britishness and constructed as unable to understand other ethnocultural positionalities. Feeling misunderstood/un-understood, ethnoculturally minoritised individuals may not seek therapy, self-policing their presence within a White, postcolonial psychology that has, historically, silenced and erased people of colour (Swartz, 2005). I am using *White* as in the ideology of whiteness, which assumes and enacts the superiority of pale-skinned people (Leonardo, 2013). One enactment of whiteness in psychology is the localisation of mental ill health inside the individual, disregarding their social context’s influence on their capacity to enact emotional change (Morrow, 2013). This may act as a psychological recolonisation by imposing White ways-of-being/thinking on help-seekers (Ali et al., 2012). Per the power/knowledge paradigm, White perspectives sustain a psychology that is by White people for White people (Adams et al., 2018), constructing a help-seeker role that is not available to ethnoculturally minoritised individuals unless they submit to recolonisation.

Contrastingly, Charlie mobilised “cookie-cutter”-ness as facilitative of help-seeking. This was in the context of a shared background of childhood sexual abuse (CSA) between him, his therapist, and non-clinical staff. Viliardos et al. (2023) noted a delay among men to seek help for CSA, reflecting Charlie’s account, and attributed this to stigma. This stigma

could arise under victim-blaming and perpetrator-absolving discourses, for example, early psychoanalytic ideas wherein CSA was an invention of the child's during 'normal' psychosexual development (Freud, 1905/1953; Green, 2014). A shared CSA background seems to lessen the threat of stigma perceived by prospective help-seekers, potentially creating a sense of trust (Viliardos et al., 2023) associated with an expectation of positive interactions (Foddy et al., 2009). From within this trust, Charlie was able to join the service's waiting list.

### **Discourse: Help-seekers Beyond Help-Seeking**

Trust could also arise in queer-specific services where treatment is delivered by the community for the community rather than by normative, disempowering institutions. A safe space may thus be created, a feminist concept denoting spaces where people are safe from harm and safe to authentically be themselves (Lewis et al., 2015). An important facet of safety is the opportunity to connect with others without prejudice or violence (Hartal, 2017), as discussed by Mark in blended therapy/social spaces; this could be protective for older queer people's mental health by augmenting their social connections (Fredriksen-Goldsen et al., 2013), particularly with queer others (Fredriksen-Goldsen et al., 2015). Queer-specific spaces may also reduce vigilance to minority stressors, by explicitly positioning themselves outside of social structures in which minority stressors are enacted, like heteronormativity (Hartal, 2018). Nonetheless, Charlton (2024) argues for a safety that is always in flux, created between the occupants of the space and subject to contextual and relational pressures. A fluid safety would also be a subjective safety. David, for instance, experienced the existence of a social 'safe' space in his therapy venue as a threat, delaying his help-seeking until crisis. Moreover, other identities inhabited by queer people could shape their experience of places designated as safe, per intersectional perspectives on minority stress (Rivas-Koehl et al., 2023). One example would be legitimation dynamics at the intersection of transness and older

age, wherein safety is assured for trans people like David and Lily only if they perform transness in the ‘right’, often young-coded, ways. Safety-as-subjective could be an opportunity for “negotiating difference and challenging oppression” (Roestone Collective, p.1346) in queer spaces. To foster such negotiation, the service/therapist could consult with the help-seeker on what safety looks like for them and whether it can be implemented in the venue. Drawing on a queer affirmative framework, such spatial co-construction would represent an act of microaffirmation, endowing the help-seeker’s identity as older and queer (and possibly other dimensions) with value (Rosati et al., 2022).

This consideration of seeking help safely arguably connects to help-as-incarceration wherein ‘help’ can only be enforced, making the help-seeker role unavailable. In Jamie’s account, help-as-incarceration was replaced with help-as-salubrious through their personal social network’s endorsement of a specific practitioner. Similar to a shared background between the help-seeker and clinical/non-clinical staff, trust seems to be a key facilitator of Jamie’s help-seeking: they trusted their personal network’s endorsement, which then installed trust in the practitioner as a doctor who would not “lock [them] up”. This could have ramifications for the effectiveness of discourse deconstruction depending on its source.

Help-seekers themselves could become facilitators of others’ help-seeking. Oliver described disseminating information about treatment pathways on social media to enable other queer people to seek help. Jordan similarly spoke about working with services on anti-racist practices, finding a “constructive” outlet for his “disgruntle[ment]” as a source of resilience through activism (Chan, 2022). This responsibility towards fellow queer people could be a legacy of informal caregiving during the HIV/AIDS epidemic (Shiu et al., 2016). People living with HIV/AIDS often relied on their communities to meet their palliative needs due to limited access to formal care or worries about stigma (Simms et al., 2012). For older queer people with lived experiences of this era, the *help-seeker* and *help-facilitator* roles

might blur together, although participants did not specifically make this link; further research could investigate this further. Through this lens, mental health-related knowledge becomes a community resource, held by queer people for queer people as a reclaiming of power from institutions enforcing 'help' as a disciplinary measure under sanist and heteronormative frameworks. Such community resources are noted to boost resilience among queer people (Meyer, 2015). Help-seekers-as-help-facilitators may also benefit from resilience through community activism, documented to combat minority stress (Chan, 2022). Some participants spoke about becoming their own help-facilitators. Sarah constructed this as "working on" the self to "keep [the self] well" while attending therapy. This recalls sanist discourses wherein the individual can only be mentally well or ill (Lavallee & Gagné-Julien, 2024). "Working on" the self could become a sanist injunction to avoid or escape mental illness. It also seems enacted in solitude: Sarah read self-help books alone, and Oliver became the "loneliest" in his "silent struggle" against mental illness within an individualistic psychology where he is responsible for 'fixing' himself (Harper, 1995). Systemic entities may thus be absolved of contribution to the aetiology of mental health difficulties and to any lapses in treatment provision or treatment helpfulness (Proctor, 2008). Indeed, for Oliver, therapy could not help with his "day-to-day living", implying a lack of therapeutic focus on coping skills, or a barrier to implementing skills outside sessions.

### **Theoretical Implications**

Participants accounts align with the NEM, which embeds help-seekers in social and treatment networks that can facilitate or hinder service access (Pescosolido et al., 2013). The facilitative effect of social networks included the queer community becoming a repository of information about treatment pathways, plus personal contacts endorsing specific professionals. Help-seekers-as-help-facilitators may themselves fulfill this role of information sharing, and may also collaborate with treatment networks to develop inclusive therapeutic

practices. Treatment networks encompassed both therapists and non-clinical staff, whose ability to understand the help-seeker—to relate to them empathetically—was crucial in enabling treatment engagement. Queer-specific services straddled treatment and social spheres, becoming enactors of young-coded “trends” in the queer community that may delegitimise older queer identities.

An important theoretical contribution from this study is that social and treatment networks can become unified in spaces that jointly host therapeutic and social activities. In such blended spaces, the socio-treatment network seems able to exert a passive influence (i.e., influencing simply by ‘being’ rather than ‘doing’) on the help-seeker role. Arguably, help-seekers in blended spaces become social subjects, whose idiosyncratic social history in and meaning-making about the space may make the help-seeker role more or less readily available. Furthermore, for queer people who exist within a history of marginalisation and violence, the safety of the space as a queer microcosm insulated from heteronormative pressures might be particularly important. This introduces questions of how queer safety is defined and for whom.

### **Implications for Therapists and Services**

This next section addresses the study’s implications for how therapists and services might support older queer people to engage with the help-seeker role. Implications align with a queer affirmative framework wherein the therapist relates to queer people in supportive, accepting ways, holds knowledge about LGBTQ+-specific experiences like minority stress while remaining sensitive to the individuality of queer people, and practises resistance to structural inequities and/or supports queer help-seekers in doing so (Moradi & Budge, 2018).

#### ***Establishing an Effective Therapeutic Relationship Through Humanistic Practice***

Participants’ discourses and enactments of the help-seeker role were heterogeneous. This suggests the usefulness of a humanistic approach from the therapist, privileging the

help-seeker's uniqueness through congruence, unconditional positive regard (UPR), and accurate empathic understanding (AEU) (Mahon, 2023). Per Carl Rogers' (1957) seminal writings on the therapeutic relationship, a congruent therapist is authentic with their clients, not dissembling their internal world. As congruence requires familiarity with inner experiences—including biases, assumptions, and expectations—it could contribute to dismantling “cookie-cutter”-ness. Therapists could reflect on their ways-of-thinking/being towards people inhabiting a minoritised/marginalised identity or several such intersecting identities, nurturing more compassionate alternatives where applicable (Saad, 2020), as aligned with queer affirmative and culturally affirmative frameworks (Ertl et al., 2019; Moradi & Budge, 2018).

UPR entails the therapist holding a deep appreciation and acceptance of the client's uniqueness without any preconditions (Bozarth, 2013). Deconstruction of biases, assumptions, and expectations as described above would likely contribute to UPR (Rennie, 2004). Curiosity is another contributor to UPR, referring to welcoming rather than rejecting or judging the client's ‘otherness’ (Cooper, 2009). For older queer people, ‘otherness’ could represent their emotional difficulties under mental wellness norms and/or their sexual/gender identity under heteronormativity, potentially silenced as unspeakable “secrets”. This may be an opportunity for the therapist to break the silence and, with the help-seeker, reconstruct the reality in the therapy room as one where emotions and queerness *can* be spoken about. Such discussions could include minority stress at the intersection of older age and queerness, including stressors experienced within the LGBTQ+ community.

AEU refers to the therapist understanding the client's experiences with a high degree of precision, and communicating this understanding empathetically (Bozarth, 2013). As therapists are not mind-readers, moments of inaccurate understanding may occur, and are navigable through a curious, non-assumptive stance wherein the therapist does not impose

their ‘expert’ reality on the help-seeker (Rollings et al., 2010). This is a crucial aspect of affirmative practice with queer help-seekers, allowing therapists to step away from enactments of help as erasure or subjugation of queer subjectivities (Love et al., 2015).

Although this section spotlights humanistic therapy, I am not advocating for it as a superior modality. Rather, I am suggesting it may be useful to integrate humanistic principles into other therapies to establish a robust therapeutic relationship (Josefowitz & Myran, 2005), particularly in a queer affirmative framework wherein it can contribute to positive therapeutic outcomes (Alessi et al., 2019).

### ***Cognitive-Behavioural Adaptations***

Queer affirmative cognitive-behavioural therapy (CBT) incorporates stigma experiences into case formulations (i.e., hypothesising about the psychological mechanisms underpinning a help-seeker’s difficulties) and functional analyses (i.e., understanding behaviour as being preceded by a trigger and followed by certain consequences) (Pachankis et al., 2022). Stigma experiences can pertain to LGBTQ+ identities plus other marginalised identities that intersect with queerness (Pachankis et al., 2022), dovetailing with culturally affirmative approaches to CBT (Pantalone, Iwamasa, & Martell, 2019). This study suggests it would be useful for clinicians to pay attention to the norms and discourses that shape stigma experiences among older queer people, whether currently or historically. These include legitimisation dynamics that normalise younger ways of being queer, and discourses of emotional silencing and help-as-incarceration that stigmatise mental health difficulties. Findings also support the inclusion of ethnocultural positionalities in intersectional considerations of stigma. Older queer help-seekers could thus be supported in attributing negative beliefs to stigmatising power structures (Pachankis et al., 2022), lessening feelings of shame (Budge, 2014).

CBT often involves the gathering of new evidence to challenge negative thoughts and beliefs (Tee & Kazantzis, 2011). This process may need to be modified to account for the role of queer community norms in legitimising older people's queerness. Community norms, if widely practised, may limit the availability of counter-evidence. Negative beliefs and thoughts may need to be reframed compassionately instead (Canvin et al., 2022).

Behavioural experiments also feature prominently in CBT, providing opportunities to trial new ways of being and change underlying negative beliefs (Leahy, 2017). This study implies a need for clinicians to recognise that safety in the spaces in which behavioural experiments are conducted may not look the same for all queer people.

Community connectedness is another tenet of queer affirmative CBT (Pachankis et al., 2022). The current study highlights concern over loneliness among older queer people who may attempt to 'fix' their mental health on their own under mental wellness norms. CBT could strengthen older queer people's social connections by deconstructing practical barriers, reframing negative thoughts and beliefs, assertiveness training, and bringing together micro-communities of queer people in creative ways (Pachankis et al., 2022). Services could assist with this latter point, especially queer services that offer blended therapy/social spaces, for example through social groups for therapy attendees.

Lastly, queer affirmative CBT takes a strengths-based approach. Participants spoke about two sources of strength, namely self-help and activism through help-facilitation for other queer people. Clinicians could support older queer help-seekers to become help-facilitators and/or self-helpers, which may contribute to the replacement of unhelpful coping behaviours with more adaptive ones (Pachankis et al., 2022).

### ***Psychodynamic Adaptations***

The relationship between the therapist and help-seeker is a fundamental part of psychodynamic treatment (Stark, 2000). I suggest that similar considerations apply as above

regarding the development of an effective therapeutic relationship based on curiosity, accountability, bias deconstruction, and a welcoming, non-judgemental attitude from the therapist. Gomez (2004) terms this “humanistic psychotherapy” (p.7). Given the historical pathologisation of queerness by psychodynamic disciplines (Hegarty, 2017), humanistic psychotherapy could contribute to the dismantlement of discourses of help-as-incarceration, enabling older queer people to enter the help-seeker role.

Psychodynamic practitioners could also overturn discourses of help-as-incarceration by extending their role from clinicians to advocates of social change (Collins & Levitt, 2021). Mollitt (2025) suggests that this does not need to involve direct activism from therapists (although it can), but can entail making space in the therapy for a consideration of minority stress and queer resilience as embedded in systems of power.

A queer affirmative framework does not need to exclude exploring intrapsychic mechanisms. Unconscious processes, such as conflicts, phantasies, and defences, can be examined without looking for a psychological ‘cause’ of queerness (Charalampakis & Kaprinis, 2026). Rather, exploration could generate insights about the help-seeker’s psychological and social functioning, supporting them in living a full, authentic life (Lemma, 2021).

A relational lens in psychodynamic work would likely also offer older queer help-seekers the opportunity to feel understood, or work through any breakdowns in understanding (Stark, 2000). Understanding could additionally be facilitated by the psychodynamic therapist holding knowledge of minority stress, which could influence queer people’s ego identity (i.e., sense of self), attachment style (i.e., patterns of relational behaviour), and defence mechanisms that unconsciously regulate psychic conflicts and shape ways-of-being (Collins & Levitt, 2021).

This study also suggests a sensitivity to countertransference, specifically the norms about sexuality, gender, and other dimensions of identity held by the therapist (McBee, 2013), including queer community norms of how queerness ‘should’ be performed. Such interpersonal pressures may contribute to older queer help-seekers embodying a false self that defends against rejection by complying with norms (McBee, 2013). A therapist who reflects on and adjusts countertransferential enactments of norms could support older queer help-seekers to embody their true selves in authentic, meaningful ways (Alessi et al., 2015; Medley, 2018).

Another implication is a focus in psychodynamic treatment on integrating disowned parts of the help-seeker’s self. Disowning is liable to occur in response to social norms, ensuring compliance and fitting in (McBee, 2013). Participants here seemed to disown different aspects of themselves, including: mental health difficulties under mental wellness norms and help-as-incarceration; queerness under legitimation dynamics; and ethnocultural positionalities under help-as-recolonisation. The psychodynamic therapist could respond to disowned parts with acceptance and empathy (Ehrensaft 2009; Fraser 2009; Hansbury 2005), making them more tolerable and available for integration into the self (Stark, 2000), thus putting the help-seeker in touch with a sense of authenticity, vibrancy, meaningfulness, and resilience (Frank, 2021).

Finally, like in CBT, community connectedness could be a target of psychodynamic treatment with older queer people. This is suggested by the discourse of help-seekers-as-help-facilitators, which comports with Collins and Levitt’s (2021) suggestion that psychodynamic therapy should consider not only defence mechanisms but also relational coping, or resilience created through social support.

***Transtheoretical Implications: Coping with Intense Distress***

Participants mobilised severe distress as a key factor in their help-seeking. A help-seeker in crisis might benefit from an initial discussion about the therapeutic frame, boundaries, and goals, to help contain their intense emotions (Brown & Stobart, 2018). A focus on distress management strategies could likewise be helpful, enabling therapists and help-seekers to build a “parachute” together.

Day-to-day coping could also be supported through partnership work between services and the queer community. This could include community-based workshops, normalising self-helping as a social rather than “lonel[y]” and speakable rather than “silent” way-of-being.

### ***Service-Level Implications***

As a population stigmatised under a heteronormative social order, queer people tend to be attuned to issues around safety (Moorhead et al., 2024). Therefore, it becomes important for mental health services to signal to queer help-seekers that therapy spaces are safe. Environmental cues can communicate the norms active within an institution (Kruk & Matsick, 2021). For older queer individuals, more specialised cues than commonly used ones such as rainbow flags, as these may be less impactful for those marginalised within the queer community (Hauksson-Tresch, 2021). Suggestions include posters or artwork showcasing intersectionally marginalised queer identities, such as transness-as-cross-dressing or queerness of colour. These ideas are preliminary and would benefit from further research and consultation with older queer help-seekers within services.

Kruk and Matsick (2021) also suggest that safety can be signalled through diversity philosophies and programming, which reflect an institution's stance on diverse identities. Services could update their written materials (e.g., website, social media, leaflets) to emphasise their alignment with a queer affirmative approach, as well as a humanistic

approach to ethnocultural positionalities. Additionally, eligibility messages could be revised to be more inclusive of older queer individuals.

Another role for messaging could be in constructing services as accessible at all times and not just in crisis, which could help normalise mental health difficulties and help-seeking. Nonetheless, limited resources and funding could pose an impediment to providing help outside of crisis. Population-level longitudinal research into the benefits of ‘preventative’ mental health care might be needed to build a convincing case for such expansion in services’ scope.

Messages from services could also promote safety through minority representation, increasing the visibility of marginalised groups within an organisation to signal it as a safe space (Kruk & Matsick, 2021). Written or visual materials could challenge “cookie-cutter”-ness by highlighting queer and ethnocultural diversity among staff, with a particular focus on intersectional identities. Messaging could additionally emphasise shared experiences, such as trauma, between staff and older queer people, fostering trust and enabling entry into help-seeking.

One specialised way to signal safety through minority representation is therapist-client matching, where therapists and clients are paired based on shared aspects of identity (Arora et al., 2025). Two participants, Charlie and Jordan, spoke about the importance of matching for feeling understood. This was in the context of experiences of childhood sexual abuse for Charlie, and his ethnocultural identity as a Black person for Jordan. To date, research is scant about therapist-client matching based on histories of sexual violence, but there are preliminary suggestions that it can be validating (Bennett et al., 2022). Past research suggests that ethnocultural matching tends to be preferred by help-seekers but may not consistently be associated with improved treatment outcomes (Cabral & Smith, 2011), attributed instead to the therapist’s relational skills and ethnocultural competence (Ertl et al.,

2019). Two implications follow: firstly, therapists should develop their relational skills and ethnocultural competence, with support from services and training institutions to increase their awareness of their beliefs and attitudes and acquire knowledge of diverse ethnocultural groups (Ertl et al., 2019); secondly, ethnocultural diversity among therapists should be increased via structural interventions, such as removing barriers to training for ethnoculturally minoritised individuals (Griffith, 2007) and hiring initiatives to better reflect community diversity within services. Another structural intervention could be the blending of treatment and social networks by collaborating with ethnoculturally minoritised communities or queer subgroups on therapy adaptations or co-delivered programmes.

### **Limitations and Future Research**

As participants were active help-seekers, waiting for or attending therapy, the identified discourses may not be relevant to older queer people unable to engage with services at all. Another missed population is older queer people with experiences of aversion/conversion therapy, plus older queer people based rurally or living in the United Kingdom as foreign nationals. Lastly, future research could use quantitative methodologies to establish the clinical effectiveness of the suggested therapeutic techniques.

### **Conclusion**

This study offers an important contribution to the LGBTQ+ literature by privileging the previously unheard voices of older queer help-seekers, noted in past research to experience particularly high rates of mental health difficulties (Semlyen et al., 2016; Watkinson et al., 2024). It draws on the NEM to explore how this population interacts with their social and treatment networks to construct the help-seeker role, either enabling or hindering service access (Pescosolido et al., 2013). Participants spoke about negotiating their legitimacy not only as help-seekers, but also as queer people within LGBTQ+-specific services upholding norms in the broader queer community. They discussed clinical and non-

clinical staff's ability to understand them as essential to treatment engagement, especially in terms of traumatic or ethnocultural positionalities. They constructed help-seekers as social subjects in blended social/therapy spaces that, uniquely, exert a passive influence on the help-seeker role wherein the individual's meaning-making about physically being in the space becomes a facilitator or inhibitor of help-seeking. Lastly, participants also constructed help-seekers as receivers and providers of help-facilitation within their personal or community networks, and as solitary self-helpers. Addressing this population's unmet mental health needs may require a continued breaking of silence about older queer experiences among researchers and mental health professionals.

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### **Declaration of Interest**

The author reports there are no competing interests to declare.

### **Biographical Note**

Denisa-Alexandra Ion is a Trainee Counselling Psychologist in her final year of study on the Professional Doctorate in Counselling Psychology at London Metropolitan University. Her research interests relate to mental health inequalities among gender and sexually minoritised individuals under the LGBTQ+ umbrella. She particularly focuses on the barriers experienced by LGBTQ+ people when accessing mental health services as well as their psychological outcomes after treatment. She positions herself at the intersection between research and therapeutic practice, providing LGBTQ+-affirmative psychological treatment in the NHS and charity sector. Her research has previously featured in the *Journal of Consulting and Clinical Psychology*.

### **Data Availability Statement**

Due to the sensitive nature of this research, participants consented to their anonymised data being retained for a maximum of five years only. In accordance with ethical considerations, the data will, therefore, not be made available.

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