

## Guest editorial

# Out for the counting

Bob Cant PhD MA PGCE Cert MVNPE

Senior Research Fellow, Institute of Primary Care and Public Health, London South Bank University, London, UK

Same-sex relations did not, as Philip Larkin might have put it (see below), begin in 1969 but that year saw the emergence of social movements that radicalised notions of sexuality throughout the post-industrial world and the developing world. A key distinguishing feature of these movements and their sister communities was that their activities and values were shaped by people who did not conform to dominant heterosexual narratives. While there was no immediate end to brutality, to discrimination and to liberal condescension, the whole agenda around sexuality has, since then, been largely determined by people who define themselves as lesbian, gay, bisexual or transgender (LGBT).

Sexual intercourse began  
In nineteen sixty three  
(Which was rather late for me)  
Between the end of the Chatterley ban  
And the Beatles' first LP.

(*Annus Mirabilis*, Philip Larkin)

*Coming out* is the term used to denote the processes of self-definition made by LGBT people about their sexuality. The term originates with the traditional process whereby young upper-class women made their debut into society and began to engage with its norms and rituals. Coming out is, thus, a social process rather than merely the disclosure of something that was previously hidden. A recent study (Lesbian, Gay, Bisexual and Transgender Youth Scotland, 2004) reveals that, among those young people who do *come out*, the average time between them acknowledging their homosexuality and coming out to others is 4.3 years. Porter and Weeks (1991, p. 2) interpret coming out stories as being, like all life stories, 'reconstructions, attempts to make sense of a complex reality, to provide a narrative structure for oneself as well as others'. Plummer (1995, p. 82) argues that 'the most momentous act in the life of any lesbian or gay person is when they proclaim their gayness – to self, to other, to community'. Other writers have criticised such a unidimensional approach, and Berube (1996, p. 152) refuses to endorse the 'belief that homosexuality could and should stand alone as the organising principle of our lives'; he argues that homosexualities will be 'significantly shaped by our

race, gender and class'. The view that sexuality is one of several key organising principles in the lives of individuals is shared by the author of this editorial; *coming out* may take a number of forms, but it acts as a core emancipatory value in the lives of many LGBT people.

One particular characteristic of *coming out* is that it has to be repeated. Challenging enough with family and friends, it is additionally problematic in situations where one already feels vulnerable such as on being admitted to hospital, seeking advice after being the victim of crime or taking up new employment. To establish appropriate professional relationships LGBT people may feel they have to disclose details about themselves which they would otherwise regard as intimate; the 'heterosexual assumption' (Weeks *et al*, 2001, p. 80) is widespread and results in many institutions being ill-prepared to even acknowledge the needs of their LGBT clients. Wilton (2000) and Fish (2006) highlight a wide range of negative experiences suffered by LGBT clients at the hands of health and social care professionals. The impact is not limited to those particular experiences alone, and Saddul (1996, p. 4) argues that 'repeated negative experiences may cause a person to delay or avoid seeking care'. The accumulated impact of negative experiences can result in misdiagnosis and neglect. In this issue, Fish explores the significance of competent care for lesbians in relation to their participation in breast and cervical screening.

*Coming out*, therefore, not only has an impact upon the individuals who take this step but it also has enormous ramifications for their friends, family and social networks. In the UK, there have been numerous legislative responses to the *coming out* of non-heterosexual individuals and communities. The most notorious of these was Section 28 of the Local Government Act (1988) which outlawed attempts by local authorities to 'promote homosexuality and pretend families'. It never resulted in any prosecutions but it succeeded in promoting fear and self-censorship amongst educators and funders until its repeal in 2003. Since 1997, a whole raft of legislation has been introduced in response to the political demands of the LGBT populations. The Civil Partnerships Act (2004) has been the most publicised, but lawmakers have also equalised

the age of consent for gay men (2000), enabled adoption and fostering by same-sex couples (2002), introduced anti-discriminatory legislation in employment (2003) and legalised the right of transgendered people to alter their birth certificates (2004). The Equality Act (2006) prohibits discrimination, both direct and indirect, on the grounds of sexual orientation in the provision of goods, facilities and services, in education and in the exercise of public functions. These laws have been designed to enable LGBT people, individually and collectively, to *come out* in a number of contexts without fear of prejudice or redress. There has been criticism, however, that they are more likely to be accessed by LGBT people who are middle class, affluent and enjoy strong social support. LGBT people who are additionally economically and socially disadvantaged may experience difficulties in benefiting from these legal changes.

Impressive though these laws are on paper, any law is only as effective as the policy makers and service providers make it. There is a responsibility on all those involved to resist any temptation to regard laws on the statute book as representing the end of the story. There are clearly considerable possibilities for dialogue between policy makers and service providers and representatives of the LGBT communities themselves. But dialogue is 'populated – over populated – with the intentions of others' (Bakhtin, 1981, p. 294) and there will be difficulties in establishing effective lines of communication between agencies with histories of mistrust and lack of respect. The LGBT voluntary and community sector might be expected to take on an advocacy role in relation to the new legislation, but it is often inhibited from doing so by the fact that it is tiny. A recent study (Barham *et al*, 2006) of the LGBT voluntary and community sector in London shows that in this city, which is traditionally a magnet for LGBT migration and has a higher percentage of LGBT residents than the national UK figure of 6%, there is no dedicated infrastructural support and the income of the sector is less than 1% of the income of the whole voluntary sector.

There is always sensitivity around numbers of LGBT populations, but failure to calculate the size of the population makes it easier to ignore their needs. Stonewall, the LGBT lobbying group, has begun to provide training and support around monitoring of sexuality, but the health and social care organisations associated with its Diversity Champions programme are few in number. The PIP report (Barham *et al*, 2006) calls on existing statutory services to launch a programme of equality audits to ascertain the impact of their services on their LGBT clients. There need to be more research initiatives to ascertain the range of needs as well as the numbers involved. Sigma Research has published widely on the needs of gay men in

relation to HIV, but this represents only one element of the needs of the LGBT populations. There should be similar research programmes to identify specific LGBT needs in relation to disability, employment, mental health, leisure, housing, etc.

The body of recent legislation has put the needs of the LGBT populations on the map, but the health and social care sector has a mountain to climb before it can claim to understand these needs and contemplate delivering services to help fulfil them.

#### ACKNOWLEDGEMENTS

I am very grateful to Jane Standing of the Kairos in Soho Project in London for the inspiration and the insights that she brought to the conversations about the LGBT voluntary and community work which we have had over a number of months. They proved invaluable in helping me to give shape to the article.

#### REFERENCES

- Bakhtin MM (1981) In: Holquist M (ed) Translated by Holquist M and Emerson C. *The Dialogic Imagination*. Austin: University of Texas Press.
- Barham D, Donahue K and Ekong E (2006) *Phase 1 Lesbian, Gay, Bisexual and Transgender Infrastructure Development Project (PIP): mapping the LGBT voluntary and community sector in London*. London: Kairos in Soho/London Change Up.
- Berube A (1996) Intellectual desire. *GLQ: a Journal of Lesbian and Gay Studies* 3:139–57.
- Fish J (2006) *Heterosexism in Health and Social Care*. London: Palgrave.
- Lesbian, Gay, Bisexual and Transgender Youth Scotland (LGBTYS) (2004) *Stakeholder Voice 2004*. [www.lgbtyouth.org.uk](http://www.lgbtyouth.org.uk) (accessed 4 September 2006).
- Plummer K (1995) *Telling Sexual Stories: power, change and social worlds*. London: Routledge.
- Porter K and Weeks J (eds) (1991) *Between the Acts: lives of homosexual men*. London: Routledge.
- Saddul RB (1996) Coming out: an overlooked concept. *Clinical Nurse Specialist* 10:2–5,56.
- Weeks J, Heaphy B and Donovan C (2001) *Same Sex Intimacies: families of choice and other life experiments*. London: Routledge.
- Wilton T (2000) *Sexualities in Health and Social Care: a textbook*. Buckingham: Open University Press.

#### ADDRESS FOR CORRESPONDENCE

Dr Bob Cant, Institute of Primary Care and Public Health, Faculty of Health and Social Care, London South Bank University, Erlang House, 103 Borough Road, London SE1 0AA, UK. Tel: +44 (0)207 815 8138; fax: +44 (0)207 815 8099; email [cantr@lsbu.ac.uk](mailto:cantr@lsbu.ac.uk)